FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: HB 1231	**COMPANION BILL:** SB 1526 (Harrell)
TITLE: Insurance Claims Payments to Physicians	**LINKED BILLS:** None
SPONSOR(S): Black	**RELATED BILLS:** None

Committee References

Insurance & Banking 15 Y, 0 N		Health Care Facilities & Systems		Commerce

SUMMARY

Effect of the Bill:

The bill adds allopathic physicians licensed under ch. 458 and osteopathic physicians licensed under ch. 459 to an existing regulatory framework that currently applies only to dental providers. The expansion extends specific protections regarding payment methods, notification requirements, claim denials, and enforcement mechanisms to physician practices without altering the substance of these regulations.

The rules apply to insurance companies, including health maintenance organizations (HMOs). The rules prohibit insurers from requiring doctors to accept only credit card payments. The rules also require insurers to notify physicians about changes in electronic payment methods, allow insurers to deny claims during periods when patients have not paid their premiums, and establish clear rules for when certain claims can be denied.

The bill is applicable to all contracts delivered, issued, or renewed between allopathic physicians and osteopathic physicians, and a health insurer or HMO on or after January 1, 2026.

Fiscal or Economic Impact:

None

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ANALYSIS

EFFECT OF THE BILL:

Payment Method Regulations

Under current law, health insurers are prohibited from mandating credit card payments as the sole means of reimbursement for dental services. The bill expands this prohibition to include physician services, ensuring that physicians cannot be forced to accept only credit card payments, which typically involve transaction fees that reduce provider compensation. This provision preserves payment method flexibility for physicians and protects their revenue streams from mandatory transaction fees. (Sections 1 and 2).

Electronic Fund Transfer Notifications

Under current law, insurers must provide notice to dental providers when initiating or changing payment methods or fees for electronic fund transfers. The bill entitles physicians to the same notification requirements. This allows physicians to prepare for and adapt to changes in how they receive payments, potentially affecting their practice's cash flow and accounting procedures. (Sections 1 and 2).

Premium Non-Payment Grace Period Claims

Under current law, insurers may deny claims if dental services were provided during a premium non-payment grace period, provided the insurer informed the provider of this circumstance in response to an eligible inquiry. The bill extends this provision to physician services. Physicians would have the same ability to verify patient eligibility and foresee potential claim denial risks before providing services during grace periods, potentially reducing uncompensated care. (Sections 1 and 2).

Prior Authorization Claim Denial Criteria

Current law provides specific criteria for when dental claims can be denied under prior authorizations. The bill applies the same criteria to physician claims. The criteria provide that an insurer may not deny a claim submitted for procedures specifically included in a prior authorization, unless at least one of the following is satisfied:

- Benefit limitations were reached subsequent to the issuance of the prior authorization;
- Inadequate documentation was submitted to support the originally authorized claim;
- Changes in the patient's condition or provision of new procedures post-authorization rendered the prior authorized procedure medically unnecessary;
- Changes in the patient's condition or provision of new procedures would have required disapproval under the terms and conditions of the patient's plan at the time of prior authorization;
- Services were provided during the grace period established under an applicable federal or state law or regulation, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such a request was made; or
- Responsibility for the claim belonged to another payor for payment, prior payment was already made to the dentist for the procedures in question, request was a fraudulent claim submission, or patient shown as ineligible at the time of service.

(Sections 1 and 2).

Regulatory Enforcement

The Office of Insurance Regulation (OIR) is mandated to enforce claims payment provisions. (Sections 1 and 2).

Compliance

The bill is applicable to all contracts delivered, issued, or renewed between allopathic physicians licensed under ch. 458 and osteopathic physicians licensed under ch. 459 and a health insurer or HMO on or after January 1, 2026. (Sections 1 and 2).

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Health Insurance

Health insurance is the insurance of human beings against bodily injury or disablement by accident or sickness, including the expenses associated with such injury, disablement, or sickness.[1] Individuals purchase health insurance coverage with the purpose of managing anticipated expenses related to health or protecting themselves from unexpected medical bills or large health care costs. Many individuals access health care coverage as a benefit of employment where the employer may contribute towards the cost of the employee's coverage while others may purchase coverage directly from an insurance company or from places like the Affordable Care Act's marketplace.[2] Health insurance may be purchased on an individual basis or for an entire family.

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[1] S. 624.603, F.S.

[2] *See* Healthcare.gov, *How to apply and enroll,* Apply for Health Insurance | HealthCare.gov (last visited March 17, 2025).

Managed care is the most common delivery system for medical care today by health insurers.[3] Managed care systems combine the delivery and financing of health care services by limiting the choice of doctors and hospitals.[4] In return for this limited choice, however, medical care is usually less costly to the patient due to lower out of pocket costs and the managed care network's ability to control the cost and utilization of health care services. Some common forms of managed care are preferred provider organizations (PPO),[5] exclusive provider organizations (EPOs),[6] and health maintenance organizations (HMO).[7] For services to be covered at the lowest out of pocket cost to the insured, the insured must utilize the managed care plan's network of providers, except in cases of an emergency. Different managed care companies have a variety of network and out of pocket cost arrangements based on an individual's or family's needs.

Office of Insurance Regulation

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida, as well as licensing, rates, policy forms, market conduct, claims, issuances of certificates of authority, solvency, viatical statements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[8] The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[9] For managed care entities to receive a license from OIR, the entity must meet financial guidelines, benefits, and policy standards as established under ch. 690.154, F.A.C.

The Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for the state, and regulates the quality of care provided by managed care organizations under ch. 408, F.S.[10]

Health Maintenance Organizations

Health Maintenance Organizations (HMOs) operate within a regulatory framework dually overseen by the OIR and AHCA. To offer a commercial health insurance plan in Florida, an HMO must obtain a license from the OIR[11] and a Certificate of Authority from AHCA. An HMO is also required to become accredited by one of the state's approved organizations: National Committee for Quality Assurance, National Association for Ambulatory Health Care, and American Accreditation HealthCare Commission.[12] Certificates of authority are granted by AHCA, if found to be compliant with the certification process, on a county by county basis or for a portion of a county.[13]

Most managed care enrollment in Florida is through an HMO. For the last quarterly submission to AHCA in September 2024, Florida HMOs reported over 8.2 million enrollees as shown in the table below.[14]

Group Type	**Q3 2024**
Small Group	168,194
Large Group	419,937
Individual	2,040,499

[3] Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers*, available at: health-insurance-guide.pdf (last visited March 17, 2025).
[4] *Id.*
[5] S. 627.6471, F.S.
[6] S. 627.6472, F.S.
[7] Part I of ch. 641, F.S.
[8] S. 20.121(3)(a), F.S.
[9] *See* S. 624.3161, F.S. The Code is comprised of chs. 624-632, 634-636, 641, 642, 647, 648, and 651, F.S.
[10] AHCA, *About the Agency for Health Care Administration*, https://ahca.myflorida.com/about-the-agency-for-health-care-administration (last visited March 17, 2025).
[11] S. 641.21(1), F.S.
[12] Agency for Health Care Administration, *Health Care Provider Certi* (last visited March 17, 2025).
[13] *Id.*
[14] Florida Office of Insurance Regulation, *Managed Care Report: Quarterly Data Summary as of September 30, 2024*, managed-care-report-2024-q3-11dec2024.pdf (last visited March 17, 2025).

Other	11,139
Healthy Kids	146,775
Medicaid	3,093,498
Medicare	1,798,581
Federal Employees	4,185
GRAND TOTAL	7,682,808

These plans provide comprehensive healthcare services to members for a fixed monthly premium.[15] Members typically select a primary care physician from within the HMO's network, who serves as the main point of contact for all healthcare needs and referrals to specialists.[16] HMOs maintain networks of healthcare providers, including primary care physicians, specialists, hospitals, and other healthcare facilities.[17] Members are generally required to receive care from within the HMO's network, with exceptions for emergencies or authorized out-of-network care, for services to be covered.[18]

Florida law, under ch. 641, F.S., provides various consumer protections, including guaranteed access to emergency services, coverage for essential health benefits[19] mandated by the Act,[20] and the right to appeal coverage decisions made by the HMO.[21]

Health Insurance Contracts

All health insurance policies issued in the state of Florida, with the exception of certain self-insured policies,[22] must meet certain requirements that are detailed throughout the Florida Insurance Code. At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[23]

Non-Payment of Premiums

Responsibilities of insured patients are also reflected in insurance contracts. Contracts set premium payment schedules and require that payments must be made in a timely fashion. In cases where this requirement is not met, any health insurer or HMO may cancel coverage for nonpayment of premiums after a statutory grace period.[24]

Before cancellation can occur, however, covered patients are protected by grace periods that extend the time frame in which premium payments may be submitted. A grace period is a period of time following the due date of a premium payment in which the insurance policy remains in force, even if the premium payment has not been made. The grace periods for policies or contracts issued in Florida are set in the Insurance Code,[25] and vary based on the premium payment schedule.

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[15] Medicare, What's an HMO? https://www.medicare.gov/health-drug-plans/health-plans (last visited March 17, 2025).
[16] *Id.*
[17] S. 641.19(12), F.S.
[18] Medicare, *What's an HMO?*, https://www.medicare.gov/health-drug-plans/health-plans (last visited March 17, 2025).
[19] Under the Patient Protection and Affordable Care Act, all non-grandfathered plans in the non-group and small group private health insurance markets must offer a core package of health insurance services known as the essential health benefits (EHB). *See Essential Health Benefits*, Healthcare.gov, Find out what Marketplace health insurance plans cover | HealthCare.gov (last visited March 17, 2025).
[20] Patient Protection and Affordable Care Act, (March 23, 2010), P.L. 111-141, as amended.
[21] Consumer Services, *Health Insurance & HMO Overview*, https://www.myfloridacfo.com/division/consumers/understanding-insurance/health-insurance-and-hmo-overview (last visited March 17, 2025).
[22] The Employment Retirement Security Act of 1974 (ERISA). 29 U.S.C. ch. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida.
[23] S. 627.413(1)(d), F.S.
[24] SS. 627.6043(1) and 641.3108(2), F.S.
[25] SS. 627.608 and 641.31(15), F.S.; The grace period of an individual policy must be a minimum of 7 days for weekly premium; 10 days for a monthly premium; and 31 days for all other periods. The grace period of an HMO contract must be at least 10 days. For group policies, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the

Pursuant to ss. 627.608 and 641.31, F.S., insurance policies and health maintenance contracts stay in force during grace periods. If the insurer or HMO does not receive the full payment of the premium by the end of the grace period, coverage terminates as of the grace period start date and the insurer or HMO may deny any medical claims incurred during the grace period. When a claim is denied at a later date, it is referred to as a retroactive denial.

The Insurance Code is silent on whether the insurer or HMO may advise a health care provider that a patient has not paid the applicable premium, and that the policy or health maintenance contract may be terminated in the future, possibly resulting in a retroactive claim denial.

Prompt Payment

Current law governs prompt payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, under ss. 627.6131 and 641.3155, F.S., respectively. These provisions detail the rights and responsibilities of insurers, HMOs, and providers for the payment of medical claims. The statutes provide a process and timeline for providers to pay, deny, or contest the claim, and also prohibit an insurer or HMO from retroactively denying a claim because of the ineligibility of an insured or subscriber more than one year after the date the claim is paid.[26]

Federal Patient Protection and Affordable Care Act

The Act introduced a set of claims-related requirements for insurers offering plans through the federally-facilitated and state-based insurance exchanges. The Act guarantees access to coverage and mandates certain essential health benefits, among other directives.[27]To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and moderate-income individuals to purchase qualified health plans on a state or federal exchange.[28]

According to the 2023 Market Report by the Florida Health Insurance Advisory Board, total enrollment in Florida's commercial health insurance market is 4,671,680 individuals which represents an increase of over eight percent from the prior year.[29] The largest group in this market has individual coverage, over 2.9 million Floridians, an increase of 16 percent over 2022, and the vast majority of this coverage has been purchased through the ACA marketplace.[30] For the 2024 Open Enrollment period, Florida's total number of ACA marketplace plan selections from new and continuing consumers was 4,211,902 plan selections, the highest number of selection among all states, federal or state based exchanges.[31]

Non-Payment of Premiums – Federal Law

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policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.

[26] SS. 627.6131(11) and 641.3155(10), F.S.

[27] The Patient Protection and Affordable Care Act (Pub. Law No. 111-148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111-152), which amended several provisions of the PPACA, was enacted on March 30, 2010. Together these two Acts are known as PPACA.

[28] In general, individuals and families may be eligible for the premium tax credit if their household income for the year is at least 100 percent but no more than 400 percent of the federal poverty line (FPL) for their family size. For residents of one of the 48 contiguous states or Washington D.C., 100 percent of the FPL for a family of four is $32,150; at 400 percent of the FPL for a family of four is $128,600. *See* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *HHS Poverty Guidelines for 2025*, available at: detailed-guidelines-2025.pdf (last visited March 17, 2025).

[29] Florida Health Insurance Advisory Board, *2023 Market Report*, fhiab-2023-market-report---adopted-(12-15-23).pdf (last visited March 17, 2025).

[30] *Id.*

[31] Centers for Medicare and Medicaid Services, *Marketplace 2024 Open Enrollment Period Report: Final National Snapshot (January 24, 2024)*, available at Marketplace 2024 Open Enrollment Period Report: Final National Snapshot | CMS (last visited March 17, 2025).

All qualified health plans (QHPs)[32] in the ACA marketplace are required to establish standard policies for the termination of enrollees due to the non-payment of premiums. The policy must be applied uniformly to enrollees in similar situations.[33] If an enrollee is delinquent with a premium payment, the QHP must notify the enrollee of the delinquency promptly and without undue delay, within 10 business days of the date from which the insurer should have discovered the delinquency.[34]

Individual health insurance plans purchased via the exchanges with a federal premium tax credit are not subject to the grace periods in Florida law. Instead, the Act requires insurers and HMOs to provide subscribers in these plans, a grace period of at least three consecutive months before cancelling the policy or contract if the enrollee previously paid at least a binder payment or the first month's premium payment.[35] The binder payment is due no earlier than the coverage effective date and no later than 30 calendar days from the coverage effective date.[36]

During the first month of the grace period, the insurer must pay all appropriate claims for services provided.[37] During the grace period, the insurer must also notify the Department of Health and Human Services (HHS) of the non-payment and notify providers of the possibility for denied claims when an enrollee is in the second and third months of a grace period.[38] For the second and third months, an insurer may pend claims and then must notify affected providers that an enrollee has lapsed in his or her payment of premiums and there is a possibility the insurer may deny the payment of claims incurred during the second and third months.[39]

Payment Methods for Health Care Claims

In March 2022, HHS issued guidance for covered entities[40] on the payment of health care claims by health plans through the use of virtual credit cards (VCC) and whether these transactions met the federal regulatory standards for electronic transactions. In model legislation, the National Council of Insurance Legislators has defined VCCs as an online credit card payment where no physical card is present and the number expires upon use at a credit card terminal or internet portal.[41] Instead of sending a paper check or an electronic payment transmission, some health plans have paid providers by sending these single use credit cards requiring the provider to then manually enter VCC numbers in order to receive payment. A transaction fee is incurred for each payment processed. For ACH transaction, the fee per item is based on volume, and can average in 2024 around $0.35.[42] For transactions by VCC, fees have been quoted as high as five percent.[43] HHS guidance concluded that payment by VCC was permitted; however, to meet the standards, the health plans must maintain certain privacy and confidentiality and transaction standards, including a one-to-one relationship between each electronic remittance advice (ERA) and electronic

[32] A "qualified health plan" is a plan that has been certified to meet the minimum standards of participation under 45 CFR §156.200 and is recognized as a QHP by the exchanges through which the plan is offered. Those standards include compliance with Exchange process and procedures, benefit design standards, licensure compliance in state where products are sold, in good standing in states where licensed products are sold, implementation of a quality improvement strategy or strategies consistent with the Act's goals, payment of applicable user fees, and compliance with reinsurance, risk corridors, and risk adjustment requirements.
[33] 45 CFR §156.270(c).
[34] 45 CFR §156.270 (f).
[35] 45 CFR §156.270(d).
[36] Centers for Medicare and Medicaid Services, *Health Plan Coverage Effectuation Webinar Training: Payment, Grace Periods, and Terminations (Navigator Training materials – January 2024)*, available at Health Plan Coverage Effectuation_Webinar_Jan_2024 (last visited March 17, 2025).
[37] 45 CFR §156.270(d)(1).
[38] 45 CFR §156.270(d)
[39] 45 CFR §156.270(d)(3).
[40] A "covered entity" is defined at 45 CFR §160.103, as a health plan, a health plan clearinghouse, or a health care provider who transmits any healthy information in electronic form in connection with a transaction.
[41] National Council of Insurance Legislators, *NCOIL Adopts Transparency in Dental Benefits Contracting Model Act (December 27, 2020)*, available at Transparency-in-Dental-Benefits-2020_final.pdf (last visited March 17, 2025).
[42] The Federal Reserve, *FedACH Services 2024 Fee Schedule*, available at FedACH Services 2024 Fee Schedule (last visited March 17, 2025).
[43] Cezary Podkul, The Hidden Fee Costing Doctors Millions Every Year, ProPublica (August 14, 2023), available at https://www.propublica.org/article/the-hidden-fee-costing-doctors-millions-every-year (last visited March 17, 2025).

funds transfer (EFT).[44] Once a plan submits a payment using the required standard with the specifications, any intermediaries acting on behalf of the health plan, including health care clearinghouses, financial institutions, and payment vendors, cannot alter, amend, or omit any information.[45]

Federal regulations also require that if a health plan pays providers via a VCC, the provider must be able to continue to request payments via EFT through the Automated Clearinghouse (ACH) Network using regulatory and ERA transaction standards, and the health plan is required to comply with those requests.[46] When a provider makes this request, the health plan must comply, regardless of whether the provider is in the plan's network or not or otherwise not affiliated with the plan.[47]

Many VCC vendors offer additional or value-added services directly or through business associates to dental providers for additional fees above the transaction fees. These additional items may include services such as assistance with re-associating the EFT file with the ERA file for reconciliation or other purposes, customer service functions, hotline numbers, special reporting or output files, billing services, and eligibility verification processes. Federal regulations prohibit a health plan from requiring a provider to agree to any value-added services as a condition of payment or inclusion of the required reassociation services using the HHS adopted EFT and ERA standards.[48]

If the provider has made a request to a health plan to conduct transactions via EFT and ERA using the adopted standards, and the provider believes that the health plan has not used or complied with those standards or operating rules, or the insurer has required the provider to pay for additional services declined by the provider as a condition of claims payment, the provider may file a complaint against the health plan with the federal Centers for Medicare and Medicaid Services.[49]

Regulation of Physician Practices in Florida

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[50] The MQA works in conjunction with 22 boards and four councils to license and regulate 364 health care professions, including Medical Doctors (allopathic physicians) and Doctors of Osteopathic Medicine (osteopathic physicians).[51] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.[52]

Allopathic Physician Licensure (ch. 458, F.S.)

Chapter 458, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Medicine (allopathic board) in conjunction with DOH. The chapter imposes requirements for licensure examination and licensure by endorsement.

Allopathic Licensure Requirements

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[44] Department of Health and Human Services, *Go to Guidance: Guidance on health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted HIPAA standards for Health Care Electronic Funds Transfer (EFT) and Remittance Advice (ERA) transactions; 45 CFR §§162.1601 and 162.1602(d)*, available at Virtual Credit Cards (VCCs) and Electronic Funds Transfers (EFT) Guidance Letter (last visited March 17, 2025).
[45] *Id.*
[46] *Id.* and 45 CFR §162.925(a)(1).
[47] Department of Health and Human Services, *Go to Guidance: Guidance on health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted HIPAA standards for Health Care Electronic Funds Transfer (EFT) and Remittance Advice (ERA) transactions; 45 CFR §§162.1601 and 162.1602(d)*, available at Virtual Credit Cards (VCCs) and Electronic Funds Transfers (EFT) Guidance Letter (last visited March 17, 2025).
[48] *Id.*
[49] *Id.*
[50] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include physicians among other providers.
[51] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2022-2023*, p. 4, https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/2024.04.15.MQA_AR-FINAL-Tbl-10-REVISED.pdf (last visited March 18, 2025).
[52] S. 456.001(4), F.S.

An individual seeking to be licensed by examination as an allopathic physician must, among other things:

- Complete 2 years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry prior to entering medical school;
- Meet one of the following medical education and postgraduate training requirements:
  - Graduate from an allopathic medical school recognized and approved by an accrediting agency recognized by the U.S. Office of Education or recognized by an appropriate governmental body of a U.S. territorial jurisdiction, and have completed at least one year of approved residency training;
  - Graduate from an allopathic foreign medical school registered with the World Health Organization and certified pursuant to statute as meeting the standards required to accredit U.S. medical schools, and have completed at least one year of approved residency training; or
  - Graduate from an allopathic foreign medical school that has not been certified pursuant to statute; have an active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG),[53] have passed that commission's examination; and have completed an approved residency or fellowship of at least 2 years in one specialty area; and
- Obtain a passing score on:
  - The United States Medical Licensing Examination (USMLE);
  - A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or
  - The Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX), if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the United States or Canada, and has practiced for a period of at least 10 years.[54]

An individual who holds an active license to practice medicine in another jurisdiction may seek licensure by endorsement to practice medicine in Florida.[55] The applicant must meet the same requirements for licensure by examination. To qualify for licensure by endorsement, the applicant must also submit evidence of the licensed active practice of medicine in another jurisdiction for at least 2 of the preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure.

Osteopathic Physician Licensure (ch. 459, F.S.)

Chapter 459, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Osteopathic Medicine (osteopathic board) in conjunction with DOH. The chapter imposes requirements for licensure by examination and licensure by endorsement.

Osteopathic Licensure Requirements

An individual seeking to be licensed as an osteopathic physician must, among other things:[56]

- Graduate from a medical college recognized and approved by the American Osteopathic Association;
- Successfully complete a resident internship of at least 12 months in a hospital approved by the Board of Trustees of the American Osteopathic Association or any other internship approved by the osteopathic board; and

[53] A graduate of a foreign medical school does not need to present an ECFMG certification or pass its exam if the graduate received his or bachelor's degree from an accredited U.S. college or university, studied at a medical school recognized by the World Health Organization, and has completed all but the internship or social service requirements, has passed parts I and II of the National Board Medical Examiners licensing examination or the ECFMG equivalent examination. Section 458.311, F.S.

[54] S. 458.311(1), F.S.

[55] S. 458.313, F.S.

[56] S. 459.0055(1), F.S.

- Obtain a passing score, as established by rule of the osteopathic board, on the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the osteopathic board, no more than five years prior to applying for licensure.[57]

If an applicant for a license to practice osteopathic medicine is licensed in another state, the applicant must have actively practiced osteopathic medicine within the two years prior to applying for licensure in this state.

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Insurance & Banking Subcommittee	15 Y, 0 N	3/20/2025	Hamon	Schenk
Health Care Facilities & Systems Subcommittee				
Commerce Committee				

[57] However, if an applicant has been actively licensed in another state, the initial licensure in the other state must have occurred no more than five years after the applicant obtained the passing score on the licensure examination.