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 Rules

BILL:	CS/CS/SB 1808
INTRODUCER:	Rules Committee; Health Policy Committee and Senator Burton
SUBJECT:	Refund of Overpayments Made by Patients
DATE:	April 17, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.	Gerbrandt	McKnight	AHS	**Favorable**
3.	Smith	Yeatman	RC	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 1808 requires health care practitioners, facilities, providers, and anyone who accepts payment from insurance for services rendered by health care practitioners, to refund any overpayment made by the patient no later than 30 days after determining that the patient made an overpayment.

Under the bill, if a health care practitioner fails to timely refund an overpayment after he or she determines that an overpayment was made, the failure constitutes grounds for disciplinary action by the applicable board, or the Department of Health if there is no board.

Under the bill, if a facility or provider licensed by the Agency for Health Care Administration fails to timely refund an overpayment, the agency may impose an administrative penalty of up to $500 on the licensee.

The bill's requirement to timely refund such an overpayment does not apply to overpayments made to providers by health insurers and health maintenance organizations, and the bill instead defers to existing law for such cases.

The bill has an indeterminate yet significant negative impact on state expenditures. **See Section V., Fiscal Impact Statement.**

The bill takes effect January 1, 2026.

II. Present Situation:

Overpayments in Health Care

Circumstances such as miscalculations, duplicate payments, insurance coverage adjustments, and coding errors can create occasional overpayments by patients to health care providers. When this occurs, it is legally required[1] for the provider to return any excess funds to the patient, although there is no statutory requirement that the overpayment be refunded by a certain date.

For example, the following situations could lead to a health care provider collecting an overpayment and subsequently refunding the overpayment to the patient:

Excess Patient Responsibility Collected

In some instances, a patient's insurance benefits or deductibles may be miscalculated by either the patient or the health care provider. For example, a clinic might initially collect a copayment or deductible based on an estimate of services rendered. When the insurance claim is later processed, the insurer might pay more than anticipated, resulting in an overpayment on the patient's account. In such cases, the provider is obligated to refund the excess amount to the patient.

Duplicate Payments

Occasionally, patients or their family members may inadvertently make multiple payments for the same service. This situation can occur when payment is mailed, then followed by an electronic payment or when two different individuals in a household pay the same bill. Once the provider's accounting or billing system detects that the patient's account has been paid more than once for the same service, they may issue a refund of the additional payment.

Insurance Reconciliation Adjustments

After claims are submitted to an insurance company, subsequent policy adjustments or retroactive changes to coverage may alter the final bill. For instance, if an insurance company conducts an internal audit and determines that a greater portion of the claim should have been covered, they might send an additional reimbursement to the provider. This supplemental payment can create a credit on the patient's account, thereby necessitating a refund of any previously collected balance from the patient.

Billing or Coding Errors

In rare circumstances, mistakes in billing codes or modifiers lead to inaccurate charges on a patient's account. Such coding discrepancies may not be apparent until the insurance company or the provider's billing department conducts a review. Upon identifying a coding error, such as a charge for a service that was not actually performed, the provider corrects the billing statement and may refund any overpayment to the patient.

[1] A court order would be required to mandate that a patient's overpayment be refunded to the patient. In common law, restitution for an overpayment aims to prevent unjust enrichment by restoring the claimant to their original position, requiring the recipient to return the benefit received, typically money, due to a mistake or other legal basis. *See also* the Florida Deceptive and Unfair Trade Practices Act in part II of ch. 501. F.S.

Coordination of Benefits Between Multiple Insurers

Patients sometimes have two or more sources of insurance coverage (e.g., primary and secondary insurance plans). If both insurers remit payment and inadvertently exceed the cost of the service, the health care provider may receive funds beyond what is contractually called for. Once this overage is discovered, the overpayment may be refunded directly to the patient or appropriately adjusted between the insurers.

State Regulation of Insurance

The Office of Insurance Regulation (OIR)[2] is responsible for all activities concerning health maintenance organizations (HMOs), health insurers, and other risk-bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[3] To transact business in Florida, a health insurer or HMO must obtain a certificate of authority from the OIR.[4] The Agency for Health Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA.[5] As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[6]

Payment of Health Insurer and HMO Claims

The Florida Insurance Code[7] prescribes the rights and responsibilities of health care providers, health insurers, and HMOs for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131, 627.662, and 641.3155, F.S., respectively.[8] The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs to use for the payment or denial of the claims.

Generally, if a health insurer or HMO determines it has made an overpayment to a provider, the insurer's or HMO's claim for the overpayment must be submitted to the provider within 30 months after the applicable payment by the insurer or HMO.[9] A provider must pay, deny, or contest the claim for overpayment of a health insurer or HMO within 40 days after receiving the claim.

---

[2] The OIR is a unit under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. Commission members serve as the agency head for purposes of rulemaking under ch. 120, F.S. See s. 20.121(3), F.S.
[3] Section 20.121(3)(a), F.S.
[4] Sections 624.401 and 641.49, F.S.
[5] Section 641.495, F.S.
[6] *Id.*
[7] Pursuant to s. 624.01, F.S., chs. 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code."
[8] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S.
[9] Section 627.6131(6), F.S., and s. 641.3155(5) F.S., for HMO provision.

All contested claims for overpayment must be paid or denied within 120 days after the provider's receipt of the claim.[10] Failure to pay or deny the claim of overpayment within 140 days after receipt creates an uncontestable obligation by the provider to pay the claim.[11] A claim for overpayment is not permitted beyond 30 months after the health insurer's or HMO's applicable payment to the provider, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.[12]

Section 627.6131(18), F.S., provides an exception to the period of 30 months for an insurer to submit a claim for overpayment to a provider. Section 641.3155(16), F.S., provides the same requirements for an HMO. All claims for overpayment submitted to a provider licensed under chs. 458 (medical practice), 459 (osteopathic medicine), 460 (chiropractic medicine), 461 (podiatric medicine), or 466 (dentistry), F.S., must be submitted to the provider within 12 months – not 30 months – after the health insurer's or HMO's applicable payment to the provider. A claim for overpayment may not be permitted after 12 months except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to s. 817.234, F.S.

Agency for Health Care Administration; Health Care Licensing Procedures Act

As of February 21, 2025, the Agency for Health Care Administration (AHCA) regulates 49,823 health care providers.[13] The Health Care Licensing Procedures Act[14] (Act) provides a streamlined and consistent set of basic licensing requirements for health care providers that are licensed, registered, or certified by the AHCA, including all of the following:[15]

- Laboratories authorized to perform testing under the Drug-Free Workplace Act, as provided under ss. 112.0455 and 440.102, F.S.
- Birth centers, as provided under ch. 383, F.S.
- Abortion clinics, as provided under ch. 390, F.S.
- Crisis stabilization units, as provided under parts I and IV of ch. 394, F.S.
- Short-term residential treatment facilities, as provided under parts I and IV of ch. 394, F.S.
- Residential treatment facilities, as provided under part IV of ch. 394, F.S.
- Residential treatment centers for children and adolescents, as provided under part IV of ch. 394, F.S.
- Hospitals, as provided under part I of ch. 395, F.S.
- Ambulatory surgical centers, as provided under part I of ch. 395, F.S.

[10] Section 627.6131(6), F.S., and s. 641.3155(5) F.S., for HMO provision.
[11] *Id.*
[12] *Id.*
[13] Agency for Health Care Administration, Senate Bill 786 Legislative Analysis (Feb. 19, 2025) (on file with the Senate Committee on Health Policy).
[14] Chapter 408, Part II, F.S. *See also* s. 408.801(1), F.S.
[15] Section 408.801(2), F.S. The act applies to following providers: laboratories authorized to perform testing under the Drug-Free Workplace Act, birth centers, abortion clinics, crisis stabilization units, short-term residential treatment facilities, residential treatment facilities, residential treatment centers for children and adolescents, hospitals, ambulatory surgical centers, nursing homes, assisted living facilities, home health agencies, nurse registries, companion services or homemaker services providers, adult day care centers, hospices, adult family-care homes, homes for special services, transitional living facilities, prescribed pediatric extended care centers, home medical equipment providers, intermediate care facilities for persons with developmental disabilities, health care services pools, health care clinics, organ tissue and eye procurement organizations.

- Nursing homes, as provided under part II of ch. 400, F.S.
- Assisted living facilities, as provided under part I of ch. 429, F.S.
- Home health agencies, as provided under part III of ch. 400, F.S.
- Nurse registries, as provided under part III of ch. 400, F.S.
- Companion services or homemaker services providers, as provided under part III of ch. 400, F.S.
- Adult day care centers, as provided under part III of ch. 429, F.S.
- Hospices, as provided under part IV of ch. 400, F.S.
- Adult family-care homes, as provided under part II of ch. 429, F.S.
- Homes for special services, as provided under part V of ch. 400, F.S.
- Transitional living facilities, as provided under part XI of ch. 400, F.S.
- Prescribed pediatric extended care centers, as provided under part VI of ch. 400, F.S.
- Home medical equipment providers, as provided under part VII of ch. 400, F.S.
- Intermediate care facilities for persons with developmental disabilities, as provided under part VIII of ch. 400, F.S.
- Health care services pools, as provided under part IX of ch. 400, F.S.
- Health care clinics, as provided under part X of ch. 400, F.S.
- Organ, tissue, and eye procurement organizations, as provided under part V of ch. 765, F.S.

The Act is intended to minimize confusion, standardize terminology, and include issues that are not otherwise addressed in state law pertaining to specific providers.[16] Among other things, it provides certain minimum licensure requirements with which applicants and licensees must comply in order to obtain and maintain a license.[17]

The Department of Health

The Legislature created the Department of Health (DOH) to protect and promote the health of all residents and visitors in the state.[18] The DOH is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[19] and professions within the DOH.[20] The health care practitioners licensed by the DOH include the following:

- Acupuncturists;[21]
- Allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants;[22]
- Osteopathic physicians, physician assistants, and anesthesiologist assistants;[23]
- Chiropractic physicians and physician assistants;[24]

[16] Section 408.801(2), F.S.
[17] *See* generally s. 408.810, F.S.
[18] Section 20.43(1), F.S.
[19] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH MQA.
[20] Section 20.43(3)(g), F.S.
[21] Chapter 457, F.S.
[22] Chapter 458, F.S.
[23] Chapter 459, F.S.
[24] Chapter 460, F.S.

- Podiatric physicians;[25]
- Naturopathic physicians;[26]
- Optometrists;[27]
- Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses, and certified nursing assistants;[28]
- Pharmacists, pharmacy interns, and pharmacy technicians;[29]
- Dentists, dental hygienists, and dental laboratories;[30]
- Midwives;[31]
- Speech and language pathologists;[32]
- Audiologists;[33]
- Occupational therapists and occupational therapy assistants;[34]
- Respiratory therapists;[35]
- Dieticians and nutritionists;[36]
- Athletic trainers;[37]
- Orthotists, prosthetists, and pedorthists;[38]
- Electrologists;[39]
- Massage therapists;[40]
- Clinical laboratory personnel;[41]
- Medical physicists;[42]
- Genetic counselors;[43]
- Opticians;[44]
- Hearing aid specialists;[45]
- Physical therapists;[46]
- Psychologists and school psychologists;[47] and

[25] Chapter 461, F.S.
[26] Chapter 462, F.S.
[27] Chapter 463, F.S.
[28] Chapter 464, F.S.
[29] Chapter 465, F.S.
[30] Chapter 466, F.S.
[31] Chapter 467, F.S.
[32] Part I, ch. 468, F.S.
[33] *Id.*
[34] Part III, ch. 468, F.S.
[35] Part V, ch. 468, F.S.
[36] Part X, ch. 468, F.S.
[37] Part XIII, ch. 468, F.S.
[38] Part XIV, ch. 468, F.S.
[39] Chapter 478, F.S.
[40] Chapter 480, F.S.
[41] Part I, ch. 483, F.S.
[42] Part II, ch. 483, F.S.
[43] Part III, ch. 483, F.S.
[44] Part I, ch. 484, F.S.
[45] Part II, ch. 484, F.S.
[46] Chapter 486, F.S.
[47] Chapter 490, F.S.

- Clinical social workers, mental health counselors, and marriage and family therapists.[48]

Disciplinary Proceeding under Chapters 456 and 120, F.S.

Section 456.072, F.S., enumerates at least 45 specific acts that constitute grounds for disciplinary action against licensed health care practitioners in Florida. In addition, each health care practitioner's respective practice act contains specific statutory provisions on prohibited acts, disciplinary actions, grounds for discipline, and actions by the applicable board.

The DOH, on behalf of the boards, investigates any complaint that is filed against a health care practitioner if the complaint is:
- In writing;
- Signed by the complainant;[49] and
- Legally sufficient.[50]

A complaint is legally sufficient if it contains allegations of ultimate facts that, if true, show that a regulated practitioner has violated:
- Chapter 456, F.S.;
- His or her practice act; or
- A rule of his or her board or the DOH.[51]

The Consumer Services Unit, within the DOH, receives the complaints and refers them to the closest Investigative Services Unit (ISU) office. The ISU investigates complaints against health care practitioners.[52] Complaints that present an immediate threat to public safety are given priority; however, all complaints are investigated as timely as possible. When the complaint is assigned to an investigator, the complainant will be contacted and given the opportunity to provide additional information. A thorough investigation will be conducted. The steps taken in the investigation are determined by the specifics of the allegations, but generally include the following:
- Obtaining medical records, documents, and evidence;
- Locating and interviewing the complainant, the patient, the subject, and any witnesses; and
- Drafting and serving subpoenas for necessary information.[53]

[48] Chapter 491, F.S.
[49] Section 456.073(1), F.S. The DOH may also investigate an anonymous complaint, or that of a confidential informant, if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the DOH has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.
[50] *Id.*
[51] *Id.*
[52] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services*, *available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited March 14, 2025).
[53] *Id.*

The ISU includes a staff of professional investigators and senior pharmacists who conduct interviews, collect documents and evidence, prepare investigative reports for the Prosecution Services Unit (PSU), and serve subpoenas and official orders for the DOH.[54]

The PSU is responsible for providing legal services to the DOH in the regulation of all health care boards and councils.[55] The PSU will review the investigative file and report from ISU and recommend a course of action to the State Surgeon General (when an immediate threat to the health, safety, and welfare of the people of Florida exists), the appropriate board's probable cause panel, or the DOH, if there is no board, which may include:

- Having the file reviewed by an expert;
- Issuing a closing order (CO);
- Filing an administrative complaint (AC); or
- Issuing an emergency order (ERO or ESO).[56]

If the ISU investigative file received by the PSU does not pose an immediate threat to the health, safety, and welfare of the people of Florida, then the PSU attorneys review the file and determine, first, whether expert witness review is required and, then, whether to recommend to the board's probable cause panel:

- A CO;
- An AC; or
- A Letter of Guidance (LOG).[57,58]

A CO is recommended if the investigation and/or the expert opinion does not support the allegation(s). The subject and the complainant are notified of the results. The complainant may appeal the decision within sixty (60) days of notification by providing additional information for consideration. Cases closed with no finding of probable cause are confidential and are not available through a public records request.[59]

An AC is recommended when the investigation and/or the expert opinion supports the allegation(s). The subject is entitled to a copy of the complete case file prior to the probable cause panel meeting. When an AC is filed with the agency clerk, at the DOH, the subject has the right to choose one of the following options:

- *An Administrative Hearing Involving Disputed Issues of Material Fact* – The subject disputes the facts in the AC and elects to have a hearing before the Division of Administrative Hearings (DOAH). If this occurs, all parties may be asked to testify and the administrative

[54] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited March 14, 2025).
[55] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Prosecution Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited March 14, 2025).
[56] *Id.*
[57] Section 456.073(2), F.S. The DOH may recommend a LOG in lieu of finding probable cause if the subject has not previously been issued a LOG for a related offense.
[58] *Id.*
[59] *Supra* note 57.

law judge will issue a recommended order that will then go to the board or the DOH for final agency action.

- *A Settlement/Stipulation/Consent Agreement* – The subject enters into an agreement to be presented before the board or the DOH. Terms of this agreement may impose penalties negotiated between the subject or the subject's attorney and the DOH's attorney.
- *A Hearing Not Involving Disputed Issues of Material Fact* – The subject of the AC does not dispute the facts. The subject elects to be heard before the board or the DOH. At that time, the subject will be permitted to give oral and/or written evidence in mitigation or in opposition to the recommended action by the DOH.
- *Voluntary Relinquishment of License* – The subject of the AC may elect to surrender his or her license and to cease practice.[60]

Final DOH action, including all of the above, as well as cases where the subject has failed to respond to an AC, are presented before the applicable board, or the DOH if there is no board. The subject may be required to appear. The complainant is notified of the date and location of the hearing and may attend. If the subject is entitled to, and does, appeal the final decision, PSU defends the final order before the appropriate appellate court.[61]

When the applicable board, or the DOH if there is no board, finds a person guilty, it may enter an order imposing a penalty listed in s. 456.072(2), F.S., which includes revocation, suspension, and restriction of license, administrative fines not to exceed $10,000 per offense, reprimand, probation, corrective action, and remedial education. It must also consider what sanctions are necessary to protect the public or compensate the patient.

III. Effect of Proposed Changes:

Section 1 creates s. 408.812, F.S., to require an Agency for Health Care Administration (AHCA) licensee[62] who tenders charges for reimbursement to refund to the patient the amount of any overpayment no later than 30 days after the date that the licensee determines that such overpayment was made. For purposes of this section of statute, the bill defines the term "tenders charges for reimbursement" to mean the licensee files a claim for reimbursement with any government-sponsored program (including Medicaid, Medicare, and Tricare) or private health insurer or health maintenance organization for services rendered to the patient.

The bill's requirement for timely refund of an overpayment would not apply to overpayments made to providers by commercial health insurers subject to s. 627.6131, F.S., or to health maintenance organizations subject to s. 641.3155, F.S.

A licensee's violation of this new section would be subject to an administrative fine under s. 408.813, as amended in section 2 of the bill.

---

[60] Chapter 478, F.S.

[61] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited March 14, 2025).

[62] *See* "Agency for Health Care Administration; Health Care Licensing Procedures Act" under "Present Situation" in this Bill Analysis for a list of practitioners who would be required to follow new s. 408.812, F.S.

Section 2 amends s. 408.813, F.S., to add a violation of s. 408.812, F.S., as created in section 1 of the bill, to a list of unclassified violations,[63] for which the AHCA could impose an administrative fine of up to $500.

Section 3 creates s. 456.0625, F.S., to require a health care practitioner[64] who tenders charges for reimbursement, or any billing department, management company, or group practice that accepts payment for services rendered by the health care practitioner, to refund the amount of any overpayment made by a patient no later than 30 days after the date that the health care practitioner determines that the overpayment was made. For purposes of this section of statute, the bill defines the term "tenders charges for reimbursement" to mean that the health care practitioner, department, company, or practice files a claim for reimbursement with any government-sponsored program (including Medicaid, Medicare, and Tricare) or private health insurer or health maintenance organization for services rendered to the patient.

The bill's requirement for timely refund of an overpayment would not apply to overpayments made to providers by commercial health insurers subject to s. 627.6131, F.S., or to health maintenance organizations subject to s. 641.3155, F.S.

A violation of s. 456.0625, F.S., would constitute grounds for disciplinary action under the practitioner's practice act and under s. 456.072, F.S., as amended in section 4 of the bill.

Section 4 amends s. 456.072(1), F.S., to add failure to comply with s. 456.0625, F.S., as created in section 3 of the bill, to the list of grounds for discipline. If the applicable board, or the Department of Health, when there is no board, finds any person guilty of this new ground for discipline, it may discipline the health care practitioner with disciplinary actions specified in s. 456.072(2), F.S.

The bill takes effect January 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[63] An unclassified violation is a violation listed in s. 408.813, F.S., which is not designated as a class I, class II, class III, or class IV violation.

[64] *See* "The Department of Health" under "Present Situation" in this Bill Analysis for a list of practitioners who would be required to follow new s. 456.0625, F.S.

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:

This bill may result in a loss of improper revenue for providers who fail to check for or refund overpayments.

C. Government Sector Impact:

The Department of Health (DOH) reports that the bill may create a workload demand on the department requiring additional staff. Such demand would depend on the volume of complaints filed against health care practitioners under the bill's new requirements. Whether such volume materializes is indeterminant. The DOH estimates the need for two expert witnesses to calculate medical billing overpayments and to provide medical expertise at an annual cost of $83,530.[65]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill creates the following sections of the Florida Statutes: 408.812 and 456.0625.

The bill substantially amends the following sections of the Florida Statutes: 408.13 and 456.072.

[65] Department of Health, Senate Bill 1808 Legislative Analysis (Mar. 14, 2025) (on file with the Senate Committee on Health Policy).

IX. Additional Information:

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

CS/CS by Rules on April 15, 2025:
The bill requires a health care practitioner who tenders charges for reimbursement, or any billing department, management company, or group practice that accepts payment for services rendered by the health care practitioner, to refund the amount of any overpayment made by a patient no later than 30 days after the date that the health care practitioner determines that the overpayment was made. The CS/CS clarifies that the determination of whether an overpayment was made is to be made by the health care practitioner.

CS by Health Policy on March 18, 2025:
The CS expands the number of parties subject to the bill's 30-day requirement to include the Agency for Health Care Administration (AHCA) licensees, all health care practitioners regulated by the Department of Health (DOH), and anyone who accepts payment from insurance for services rendered by health care practitioners, including billing department, management companies, or group practices. Such parties must refund any overpayment made by the patient no later than 30 days after determining that the patient made an overpayment. The CS defines the term "tenders charges for reimbursement." The CS authorizes the AHCA to impose a fine of up to $500 on a licensee who violates the 30-day refund requirement. The CS also removes a provision in the underlying bill extending rulemaking authority to the DOH.

B. Amendments:

None.