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: SB 794

INTRODUCER: Senator Bradley

SUBJECT: Mandatory Human Reviews of Insurance Claim Denials

DATE: March 24, 2025 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AEG	
3.			RC	

I. Summary:

SB 794 prohibits an insurer from relying on the decisions of artificial intelligence (AI), a machine learning algorithm, or an automated system as the basis for an insurer to deny a claim. The bill specifies that an insurer's decision to deny a claim must be reviewed, approved, and signed off on by a "qualified human professional," (QHP) that includes, but is not limited to, a supervisor, a claims manager, or a licensed claims adjuster having authority over a claim.

Artificial Intelligence (AI) is a machine-based system that can, for a given set of objectives, generate outputs such as predictions, recommendations, content, or other output influencing decisions made in real or virtual environments.[1] Machine learning algorithm is a field within artificial intelligence that focuses on the ability of computers to learn from the provided date without being explicitly programmed.[2]

The bill requires an insurer to:

- Maintain detailed records of the QHP's review processes that include the name and title of the QHP who reviewed the denial decision, the date and time of the review by the QHP, and the documentation used as the basis for the denial.
- Identify the QHP who reviewed the denial decision, as well as include a statement confirming AI did not serve as the basis for the denial, in all communications relating to a claimant's denied claim.
- Submit periodic compliance reports to the Office of Insurance Regulation (OIR) documenting the steps it has taken to comply with the provisions of this bill.

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[1] National Association of Insurance Commissioners, Model Bulletin, Use of Artificial Intelligence Systems by Insurers, (Dec. 4, 2023), https://content.naic.org/sites/default/files/inline-files/2023-12-4%20Model%20Bulletin_Adopted_0.pdf (last visited Mar. 12, 2025).

[2] *Id.*

Further, the bill authorizes OIR to conduct compliance audits of insurer's denied claims.

In recent years, artificial intelligence systems and machine learning algorithms are being used in many areas of the insurance industry, such as claim management and fraud detection, to achieve greater efficiencies and accuracy. While these tools can improve efficiency, they also raise concerns about inaccuracies and bias in healthcare decision-making. Errors in algorithm-driven denials of care may result in delays in receiving medical necessary care, resulting in adverse health outcomes.

II. Present Situation:

Artificial Intelligence

The term, "artificial intelligence (AI)," is term encompassing a variety of technologies and techniques. AI has been defined in various ways, without consensus on a single definition, in part due to its rapidly changing nature. Multiple definitions for AI are provided in the U.S. Code. For example, in 15 U.S.C. Section 9401(3), AI is defined as:

> a machine-based system that can, for a given set of human-defined objectives, make predictions, recommendations or decisions influencing real or virtual environments. Artificial intelligence systems use machine and human-based inputs to-(A) perceive real and virtual environments; (B) abstract such perceptions into models through analysis in an automated manner; and (C) use model inference to formulate options for information or action.

The application of AI in health care and insurance has become more common due to recent increases in the availability of data and innovations in big data analytical methods.[3] The use of properly trained AI tools may provide many benefits; however, for those benefits to be realized, AI technologies must be trained in data representative of the populations and tasks for which the AI tool is intended.[4]

Commonly referenced techniques to develop AI may include machine learning (ML), deep learning, supervised learning, and reinforcement learning, among others.[5] A notable area of recent advancement has been in generative AI (GenAI), which refers to ML models developed through training on large volumes of data in order to generate content.[6] The underlying models for GenAI tools have been described as "general-purpose AI," meaning they can be adapted to a wide range of downstream tasks.[7] Such advancements, and the wide variety of applications for AI technologies, have renewed debates over appropriate uses and guardrails, including in the areas of health care, education, and national security.[8]

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[3] Congressional Research Services Report R48319, *Artificial Intelligence (AI) in Health Care* (Dec. 30, 2024), Artificial Intelligence (AI) in Health Care | Congress.gov | Library of Congress (last visited Mar. 20, 2025).
[4] *Id.*
[5] Congressional Research Services Report R46795, *Artificial Intelligence: Background, Selected Issues, and Policy Considerations* (May 19, 2021), Artificial Intelligence: Background, Selected Issues, and Policy Considerations | Congress.gov | Library of Congress (last visited Mar. 20, 2022).
[6] *Id.*
[7] *Id.*
[8] *Id.*

AI technologies, including GenAI tools, have many potential benefits, such as accelerating and providing insights into data processing, augmenting human decision making, and optimizing performance for complex systems and tasks.[9] However, AI systems may perpetuate or amplify biases in the datasets on which they are trained; may not yet be able to fully explain their decision making; and often depend on such vast amounts of data and other resources that they are not widely accessible for research, development, and commercialization beyond a handful of technology companies.[10]

The Office of Insurance Regulation

The Office of Insurance Regulation (OIR),[11] is responsible for all activities concerning health maintenance organizations (HMOs), life and health insurers, property and casualty 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.[12] To transact business in Florida, an insurer must meet certain requirements and obtain a certificate of authority from the OIR.[13]

Cost Containment and Utilization Management

Insurers use various tools to contain costs. For example, health insurers are statutorily required to implement procedures to contain costs or mitigate cost increases, such as utilization reviews, audits of provider bills, and any other lawful measure or combination of measures for which the insurer submits to the OIR information demonstrating that the measure or combination of measures is reasonably expected to have an effect toward containing health insurance costs or cost increases.[14] An HMO may establish a utilization management program.[15]

HMOs are required to implement an internal quality assurance program. The program includes:
- A written statement of goals and objectives which stress health outcomes as the principal criteria for the evaluation of the quality of care rendered to subscribers;
- A written statement describing how state-of-the-art methodology has been incorporated into an ongoing system for monitoring care, which is individual case oriented and, when implemented, can provide interpretation and analysis of patterns of care rendered to individual patients by individual providers;
- Written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided;

[99] *Id.*
[10] *Id.*
[11] 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.
[12] Section 20.121(3)(a), F.S.
[13] Section
s 624.401 and 641.49, F.S.
[14] Section 627.4234, F.S.
[15] *Id.*

- A written plan for providing review of physicians and other licensed medical providers which includes ongoing review within the organization.[16]

Workers' compensation carriers are required to conduct utilization reviews, and must review all claims submitted by health care providers in order to identify overutilization of medical services and disallow overutilization.[17] A utilization review is the evaluation of the appropriateness of both the level and the quality of health care and health services provided to a patient, including, but not limited to, evaluation of the appropriateness of treatment, hospitalization, or office visits based on medically accepted standards.[18]

Pharmaceutical and Therapeutic Committees[19]

Each health insurer or HMO offering comprehensive major medical policies or contracts must have a pharmacy and therapeutics committee (committee) that has members that represent a sufficient number of clinical specialties to adequately meet the needs of enrollees. The committee must:

- Develop and document procedures to ensure appropriate drug review and inclusion.
- Must base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other such information as it determines appropriate.
- Review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.

Denial of Claims by a Health Insurer or HMO

The Florida Insurance Code[20] 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. 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 and the appeal process for denied claims.

An HMO must ensure that only physicians licensed under ch. 458 or 459, F.S., may render an adverse determination regarding a service provided by a physician licensed in this state.[21] An HMO must submit to the treating provider and the subscriber written notification regarding the organization's adverse determination within 2 working days after the subscriber or provider is notified of the adverse determination.[22] The written notification must include the utilization review criteria or benefits provisions used in the adverse determination, identify the physician who rendered the adverse determination, and be signed by an authorized representative of the

[16] Section 641.51, F.S.
[17] Section 440.13(3) and (6), F.S.
[18] Section 440.13(1)(s), F.S.
[19] 45 CFR s. 156.122.
[20] Pursuant to s. 624.01, F.S., chs. 624-632, 634, 635, 636, 641, 642, 648, and 651 constitute the "Florida Insurance Code."
[21] *Id.*
[22] *Id.*

organization or the physician who rendered the adverse determination.[23] The organization must include with the notification of an adverse determination information concerning the appeal process for adverse determinations.

Coverage for medical services can be denied before or after the service has been provided, through denial of preauthorization requests, through denial of claims for payment, or a retroactive denial of payment. As a condition for coverage of some services, providers or insureds are required to request authorization prior to providing or receiving the service. The full claim or certain lines of the claim may be denied, such as a surgery with charges for multiple procedures and supplies.

There are many possible reasons for claim denials. Claims may be denied due to an incorrect diagnosis code, incomplete claim submission, or the submission of a duplicate claim. Eligibility issues can cause claims to be denied. For example, a claim may be submitted for a service provided prior to an individual's effective date of coverage or after it has been terminated. Finally, claim denials can occur when a determination is made that the service provided was not covered or it was not medically necessary.

Regulation of Adjusters by the Department of Financial Services

The Department of Financial Services is responsible for the regulation of insurance agents and adjusters.[24] Chapter 626, F.S., regulates insurance field representatives and operations. Part VI of the chapter governs insurance adjusters.[25] Current law provides the following five adjuster licenses: an all-lines adjuster, temporary license all-lines adjuster, public adjuster, public adjuster apprentice, and catastrophe or emergency adjuster.[26] A licensed all-lines adjuster may be appointed as an independent adjuster, or company employee adjuster, but not concurrently as both.[27] An all-lines adjuster means a person who acts on behalf of an insurer to determine the amount of and settle a claim (adjust).[28] An "independent adjuster" is defined as a person who is licensed as an all-lines adjuster and who is self-appointed or works for an independent adjusting firm to adjust claims.[29] A "company adjuster" is defined as a person who is licensed as an all-lines adjuster and who is appointed and employed by an insurer to adjust claims.[30]

[23] *Id.*
[24] The Chief Financial Officer (CFO) serves as the head of the Department of Financial Services, and is the chief fiscal officer of the state is responsible for settling approving accounts against the state and keeping all state funds and securities (s. 17.001, F.S.). See ch. 17, F.S., for additional duties of the CFO.
[25] Section 626.852, F.S., provides this part does not apply to life insurance or annuity contracts.
[26] Section 626.859. F.S.
[27] Section 626.864, F.S.
[28] Section 626.8548, F.S.
[29] Section 626.855, F.S.
[30] Section 626.856, F.S.

Federal and Other State's Oversight of AI an Insurance Practices

Department of Health and Human Services

In 2022, the Office of Inspector General of the U.S. Department of Health and Human Services issued a report regrading denials of prior authorization requests.[31] The report noted that, although Medicare Advantage Organizations (MAOs) approve the vast majority of requests for services and payment, they issue millions of denials each year, and CMS's annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment. As enrollment in Medicare Advantage continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have access to medically necessary covered services and that providers are reimbursed appropriately.

The report determined that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. The MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. MAOs denied prior authorization and payment requests that met Medicare coverage rules by:

- Using MAO clinical criteria that are not contained in Medicare coverage rules;
- Requesting unnecessary documentation; and
- Making manual review errors and system errors.

The report found that among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules. Further, the report found that among payment requests that MAOs denied, 18 percent met Medicare coverage rules and MAO billing rules.

In response to these findings, the Department of Health and Human Services adopted rules in 2023. The rules provide that a Medicare Advantage organization must ensure that they are making medical necessity determinations based on the circumstances of the specific individual, as outlined at 45 CFR s 422.101(c), as opposed to using an algorithm or software that doesn't account for an individual's circumstances.[32] When a MAO is making a coverage determination on a Medicare covered item or service with fully established coverage criteria, the MAO cannot deny coverage of the item or service on the basis of internal, proprietary, or external clinical criteria that are not found in Traditional Medicare coverage policies.[33] MAOs must comply with 45 CFR s. 422.566(d), which requires that a denial based on a medical necessity determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care that is appropriate for the service at issue.[34]

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[31] U.S. Department of Health and Human Services, Office of Inspector General Report in Brief (Apr. 2022) Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care" (OEI-09-18-00260) (last visited Mar. 20, 2025).
[32] 88 FR 22190 (Apr. 4, 2023). Federal Register :: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (last visited Mar. 20, 2025).
[33] *Id.*
[34] Id.

State Adoption of the National Association of Insurance Commissioners' Model Bulletin - Use of Artificial Intelligence Systems by Insurers

In December 2023, the National Association of Insurance Commissioners (NAIC)[35] issued a model bulletin, *Use of Artificial Intelligence Systems by Insurer,* [36] which has been adopted by 23 states.[37] Further, four states have issued specific regulations or guidance to the industry.[38] The goal of the bulletin is to ensure that the insurers are aware of their state's expectation as to how AI systems will be governed and managed and recommends the kinds of information and documents their state would expect an insurer to produce when requested. The bulletin relies upon NAIC referenced adopted model laws and regulations, such as the Unfair Trade Practices Model Act, Unfair Claims Settlement Practices Model Act, Corporate Governance Annual Disclosure Model Act, the Property and Casualty Model Rating Law, and the Market Conduct Surveillance Model Law.[39] As of February 1, 2025, Florida has not adopted the NAIC bulletin.

California

In 2024, California enacted legislation to ensure that decisions about medical care are made by licensed health care providers, not solely by artificial intelligence algorithms used by health insurers.[40] Effective January 1, 2025, any denial, delay, or modification of care based on medical necessity must be reviewed and decided by a licensed physician or qualified health care provider with expertise in the specific medical issues.[41] The law also creates standards for companies using AI in their utilization review processes.[42]

In 2022, California's Insurance Commissioner (commissioner) issued a bulletin[43] reminding the insurance industry that they must avoid bias or discrimination that may result from the use of artificial intelligence when marketing, rating, underwriting, processing claims or investigating suspected fraud relating to an insurance transaction. The commissioner noted that the greater use by the insurance industry of artificial intelligence, algorithms, and other data collection models has resulted in an increase in consumer complaints relating to unfair discrimination in California and elsewhere.

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[35] The National Association of Insurance Commissioners is a voluntary association of insurance regulators from all 50 states. The NAIC coordinates regulation and examination of multistate insurers, provides a forum for addressing major insurance issues, and promotes uniform model laws among the states. The NAIC accreditation is a certification that a state insurance regulator is fulfilling legal, financial, and organizational standards.

[36] National Association of Insurance Commissioners, NAIC MODEL BULLETIN: USE OF ARTIFICIAL INTELLIGENCE SYSTEMS BY INSURERS (Dec. 4, 2023) (last visited Mar. 17, 2025).

[37] National Association of Insurance Commissioners (NAIC), Implementation of NAIC Bulletin: Use of Artificial Intelligence Systems by Insurers (Mar. 3, 2025) IMPLEMENTATION of NAIC MODEL BULLETIN (last visited Mar. 17, 2025)

[38] *Id.*

[39] *Id.*

[40] Senate Bill No. 1120 (Chapter 879), The Physicians Make Decisions Act, https://sd13.senate.ca.gov/ (last visited Mar. 17, 2025).

[41] *Id.*

[42] *Id.*

[43] California Insurance Commissioner Ricardo, Allegations of Racial Bias and Unfair Discrimination in Marketing, Rating, Underwriting, and Claims Practices by the Insurance Industry, Bulletin 2022-5 (June 30, 2022), BULLETIN 2022-5 Allegations of Racial Bias and Unfair Discrimination in Marketing, Rating, Underwriting, and Claims Practices by the Insurance Industry (last visited March 17, 2025).

The commissioner advises that, before utilizing any data collection method, fraud algorithm, rating/underwriting or marketing tool, insurers and licensees must conduct their own due diligence to ensure full compliance with all applicable laws. These laws include, but are not limited to, laws prohibiting discrimination with regard to insurance rate making,[44] laws prohibiting discrimination in claims handling practices,[45] laws prohibiting discrimination when accepting insurance applications,[46] and laws prohibiting discrimination when canceling or nonrenewing insurance policies.[47] Additionally, insurers and licensees must provide transparency by informing consumers of the specific reasons for any adverse underwriting decisions.[48]

Colorado[49]

In 2023, the Division of Insurance (Division) issued a regulation that establishes the governance and risk management requirements for life insurers that use external consumer data and information sources (ECDIS), as well as algorithms and predictive models that use ECDIS. Life insurers that use ECDIS, as well as algorithms and predictive models that use ECDIS in any insurance practice, must establish a risk-based governance and risk management framework that facilitates and supports policies, procedures, systems, and controls designed to determine whether the use of such ECDIS, algorithms, and predictive models potentially result in unfair discrimination with respect to race and remediate unfair discrimination, if detected. The regulation imposes compliance reporting requirements on insurers.

New York[50]

In 2024, the Department of Financial Services (Department) issued a circular letter to insurers and health maintenance organizations entitled, *Use of Artificial Intelligence Systems and External Consumer Data and Information Sources in Insurance Underwriting and Pricing*. The purpose of this circular letter is to identify the Department's expectations that all insurers authorized to write insurance in New York State, HMOs, and other specified regulated entities (collectively, "insurers") develop and manage their use of ECDIS, AIS, and other predictive models in underwriting and pricing insurance policies and annuity contracts.

The circular notes that the use of ECDIS and artificial intelligence systems (AIS) can benefit insurers and consumers alike by simplifying and expediting insurance underwriting and pricing processes, and potentially result in more accurate underwriting and pricing of insurance. At the same time, ECDIS may reflect systemic biases, and its use raises significant concerns about the potential for unfair adverse effects or discriminatory decision-making. ECDIS also may have

[44] See Cal. Ins. Code ss. 679.71, 679.72, 790.03(f), 1861.02, 1861.03, 1861.05, 11735, and Title 10 California Code of Regulations 2632.4.
[45] See e.g. Cal. Ins. Code ss790.03 and Title 10 California Code of Regulations s. 2695.7.
[46] See, e.g., Cal. Ins. Code sections 679.71, 679.72, and 10140.
[47] See, e.g., Cal. Ins. Code sections 679.71 and 10140.
[48] See, e.g., Cal. Ins. Code section 791.10.
[49] Governance And Risk Management Framework Requirements for Life Insurers' Use Of External Consumer Data and Information Sources, Algorithms, And Predictive Models, (Nov. 14, 2023) 3 CCR 702-10, Code of Colorado Regulations (last visited Mar. 17, 2025).
[50] Department of Financial Services, Use of Artificial Intelligence Systems and External Consumer Data and Information Sources in Insurance Underwriting and Pricing (July 11, 2024) Insurance Circular Letter No. 7 (2024): Use of Artificial Intelligence Systems and External Consumer Data and Information Sources in Insurance Underwriting and Pricing | Department of Financial Services (last visited Mar. 17, 2025).

variable accuracy and reliability and may come from entities that are not subject to regulatory oversight and consumer protections. Furthermore, the self-learning behavior that may be present in AIS increases the risks of inaccurate, arbitrary, capricious, or unfairly discriminatory outcomes that may disproportionately affect vulnerable communities and individuals or otherwise undermine the insurance marketplace. It is critical that insurers that utilize such technologies establish a proper governance and risk management framework to mitigate the potential harm to consumers and comply with all relevant legal obligations. Insurers are required to adopt written policies, procedures, and documentation relating to their development and management of ECDIS or AIS.

If an insurer is using ECDIS or AIS, the notice to the insured or potential insured, or medical professional designee, should disclose: (1) whether the insurer uses AIS in its underwriting or pricing process; (2) whether the insurer uses data about the person obtained from external vendors; and (3) that such person has the right to request information about the specific data that resulted in the underwriting or pricing decision, including contact information for making such request. In the event of an adverse underwriting decision the reason or reasons provided to the insured or potential insured, or a medical professional designee, should include details about all information the insurer based any adverse underwriting decision, including the source of the specific information the insurer based its adverse underwriting or pricing decision.

***Texas*[51]**

In 2020, The Commissioner of the Department of Insurance (Department) issued a bulletin regarding insurers' use of third-party data. The bulletin reminds all regulated entities, their agents, and their representatives that they are responsible for the accuracy of the data used in rating, underwriting, and claims handling – even if the data is provided by a third party. The obligations of regulated entities are set out in several Texas Insurance Code provisions. This bulletin does not create a new legal duty, obligation, or standard of care. The bulletin states that the Department may pursue enforcement action against an insurer if its use of inaccurate data harms policyholders. Insurers are encouraged to provide policyholders with a way to review and correct data being used by the insurer.

Litigation Relating to AI Use and Insurer Claim Denials

In recent years, the adoption of AI has posed new risks, particularly in the area of disclosure and regulation. In 2022, State Farm Insurance State Farm was sued in the U.S. District Court for the Northern District of Illinois over claims that its AI system discriminates against Black customers.[52] The class-action suit claims State Farm's algorithms are biased against African American names. The complaint cited a study of 800 black and white homeowners with State Farm policies that found discrepancies in the way their claims are handled and how many delays they faced.[53]

[51] Texas Department of Insurance, Commissioner's Bulletin #B-0036-20 (Sept. 30, 2020), B-0036-20 (last visited Mar. 17, 2025).
[52] OECD.AI Policy Observatory, Lawsuits in the United States point to a need for AI risk management systems (May 16, 2023), State Farm was sued (last visited Mar. 21, 2025).
[53] New York Times, New Suit Uses Data to Back Racial Bias Claims Against State Farm, (Dec. 14, 2022) New Suit Uses Data to Back Racial Bias Claims Against State Farm - The New York Times (last visited Mar. 20, 2025).

In July 2022, a class action lawsuit was brought against Cigna in the U.S. District Court for the Eastern District of California over allegations that an AI algorithm it uses to screen claims was faulty and that Cigna also denied claims without having a human review them.[54] Subsequently, in July 2023, a lawsuit was filed in California against Cigna in Kisting-Leung v. Cigna Corporation alleging an "illegal scheme to scheme to systematically, wrongfully and automatically deny its insureds the thorough, individualized physician review of claims guaranteed to them by California law."[55]

In 2024, a lawsuit was filed in Minnesota that alleges United Healthcare illegally deployed AI in place of licensed medical professionals to deny coverage owed to elderly patients under Medicare Advantage plans.[56]

III. Effect of Proposed Changes:

Section 1 creates s. 627.4263, to require that an insurer's decision to deny a claim must be reviewed, approved, and signed off on by a qualified human professional. to define the term, "qualified human professional," to include, but not limited to, a supervisor, a claims manager, or a licensed claims adjuster having authority over a claim.

The section provides that artificial intelligence, a machine learning algorithm, or an automated system may not serve as the basis for determining whether to deny a claim.

An insurer must maintain detailed records of the human review process for all denied claims, including:

- The name and title of the qualified human professional who reviewed the denial decision.
- The date and time of the review by the qualified human professional.
- Documentation of the basis for the denial, including any supplemental information provided by automated tools.

An insurer is required to provide the following information in all denial communications to a claimant:

- Identification of the qualified human professional who reviewed the denial decision.
- A written statement affirming that artificial intelligence, a machine learning algorithm, or an automated system did not serve as the basis for the determining whether to deny a claim.

Further, an insurer is required to submit periodic compliance reports to the Office of Insurance Regulation (OIR) detailing the steps taken to comply with the provisions of the bill.

The OIR is authorized to audit claim denials to verify compliance with the provisions of the bill.

Section 2 provides the bill takes effect July 1, 2025.

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[54] Medical Economics, Cigna using AI to reject claims, lawsuit charges (Aug. 7, 2023) Cigna using AI to reject claims, lawsuit charges (last visited Mar. 20, 2025).
[55] Kisting-Leung_20230724_COMPLAINT.pdf
[56] The Estate of Lokken v. UnitedHealth Grp., 23-cv-3514 (JRT/DJF) | Casetext Search + Citator

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:

Insurers may incur indeterminate administrative costs associated with the development of internal procedures for compliance with these provisions related to reporting, record maintenance, and OIR examinations.

C. Government Sector Impact:

Indeterminate. The Office of Insurance Regulation is authorized to examine claim denials to verify insurer compliance with the provisions of the bill.

VI. Technical Deficiencies:

The bill amends Part II of ch. 627, F.S., relating to the regulation of insurers; however, the bill does not amend Part I of ch. 641, F.S., relating to the regulation of health maintenance organizations, Part II of ch. 641, F.S., relating to prepaid health clinics, or ch. 632, F.S., relating to fraternal benefit associations.

The terms, artificial intelligence or a machine learning algorithm, are used in the bill but are not defined.

VII. Related Issues:

The bill requires a qualified human professional (QHP) to review, approve, and sign off on an insurer's claim denial. The bill does not specify whether the QHP is required to provide an electronic or written signature. Typically, claims systems record the initials or log in for the person who approves a claims transaction,[57] which could be subject to an examination by the OIR.

The bill does not provide the Financial Services Commission with authority to adopt forms or rules to implement the provisions of the bill.

VIII. Statutes Affected:

This bill creates section 627.4263 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

[57] Office of Insurance Regulation, Legislative Analysis of SB 794 (Mar. 11, 2025).