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A bill to be entitled  
An act relating to insurance claims payments to health care providers; creating s. 627.4193, F.S.; providing definitions; prohibiting payment adjudicators from downcoding health care services under certain circumstances; providing exceptions; providing requirements for such exceptions; requiring health insurers to ensure that their downcoding policies are updated and to ensure compliance with specified provisions on downcoding; authorizing investigations and actions against noncompliance; providing certain presumption in favor of physicians' determination regarding patients' diagnoses and service orders; providing calculations of interests on health insurers' nonpayment and underpayment due to downcoding; providing causes of action for health care providers; amending s. 627.42392, F.S.; providing and revising definitions; requiring utilization review entities to establish electronic prior authorizations to accept prior authorization requests; providing requirements for such entities and for prior authorization processes; prohibiting such entities from implementing new requirements, restrictions, and changes; providing exceptions; providing reporting requirements; requiring the Office of Insurance

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26 Regulation to publish a report based on such entities' reports; providing requirements for adverse determinations made by such entities on health care providers' claims; providing a timeframe for such entities' determination on claims; prohibiting prior authorization requirements under certain circumstances; prohibiting prior authorization revocations, limits, conditions, and restrictions under certain circumstances; providing exceptions; providing validity timeframe of prior authorizations under certain circumstances; providing construction; amending ss. 627.6131 and 641.3155, F.S.; providing and revising definitions; revising requirements and timeframes for responses from health insurers and health maintenance organizations, respectively, to submitted claims; revising interests on overdue payments of claims; authorizing health care providers to refuse to participate in internal dispute resolution processes under certain circumstances; prohibiting health insurers and health maintenance organizations, respectively, from retrospectively, rather than retroactively, denying claims because of insured and enrollee ineligibility beyond a specified timeframe; revising such timeframe; revising applicability; providing construction; prohibiting

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51        health insurers and health maintenance organizations,  
52        respectively, from requesting or requiring certain  
53        information from health care providers under certain  
54        circumstances; providing causes of action for health  
55        care providers under certain circumstances; amending  
56        s. 395.1065, F.S.; conforming cross-references;  
57        providing an effective date.

58  
59        Be It Enacted by the Legislature of the State of Florida:

60  
61        **Section 1. Section 627.4193, Florida Statutes, is created  
62 to read:**

63        627.4193 Restrictions on health insurance reimbursement  
64 downcoding.—

65        (1) As used in this section, the term:

66        (a) "Downcode" or "downcoding" means the alteration by a  
67 payment adjudicator of a service code to another service code or  
68 the alteration, addition, or removal by a payment adjudicator of  
69 a modifier, when the changed code or modifier is associated with  
70 a lower payment amount than the service code or modifier billed  
71 by the provider or facility.

72        (b) "Health insurer" means any entity that offers health  
73 insurance coverage, whether through a fully insured plan or  
74 self-insured plan or fund, including, as applicable:

75        1. An authorized health insurer offering health insurance

76 as defined in s. 624.603, as well as any entity that offers a  
77 commercial self-insurance fund as defined in s. 624.462(2) or  
78 group self-insurance fund as described in s. 624.4621.

79 2. A health insurer that is subject to any of the  
80 provisions of this chapter, as well as any entity that offers a  
81 self-insurance plan or a group self-insurance plan.

82 3. A managed care plan as defined in s. 409.962.

83 4. A health maintenance organization as defined in s.  
84 641.19.

85 (c) "Medical record" means the comprehensive collection of  
86 documentation, including clinical notes, diagnostic reports, and  
87 other relevant information, which supports the health care  
88 services provided.

89 (d) "Participation agreement" means a written contract or  
90 agreement between a health insurer and a provider which outlines  
91 the terms and conditions of participation, reimbursement rates,  
92 and other relevant details.

93 (e) "Payment adjudicator" means a health insurer or any  
94 entity that provides, offers to provide, or administers payment  
95 on behalf of a health insurer, as well any pharmacy benefit  
96 manager as defined in s. 624.490(1), and any other individual or  
97 entity that provides, offers to provide, or administers payment  
98 for hospital services, outpatient services, medical services,  
99 prescription drugs, or other health care services, to a person  
100 treated by a health care professional or facility in this state

101 under a policy, plan, or contract.

102 (f) "Provider" means any health care professional,  
103 facility, or entity that submits claims for reimbursement for  
104 covered health care services.

105 (2) Payment adjudicators are prohibited from downcoding a  
106 health care service billed by, or on behalf of, a provider, if  
107 the health care service was ordered by a provider that is in-  
108 network with the applicable health insurer, unless such  
109 downcoding is otherwise expressly permitted under the  
110 participation agreement between the health insurer and the  
111 provider.

112 (3) If downcoding is expressly permitted under the  
113 participation agreement, the payment adjudicator must provide  
114 the following information to the provider before making its  
115 initial payment or notice of denial of payment:

116 (a) A statement indicating that the service code or  
117 modifier billed by the provider or facility is going to be  
118 downcoded.

119 (b) An explanation detailing the reasons for downcoding  
120 the claim. This explanation must include a clear description of  
121 the service codes or modifiers that were altered, added, or  
122 removed, if applicable.

123 (c) The payment amount that the payment adjudicator would  
124 otherwise make if the service code or modifier is not downcoded.

125 (d) A statement that the provider may contest the

126 downcoding of the applicable service code or modifier by filing  
127 a contestation with the payment adjudicator with respect to the  
128 downcoding within 15 days after receipt of the notice of  
129 downcoding.

130 (e) A statement that by contesting the downcoding of the  
131 applicable service code or modifier, the provider does not waive  
132 any of its legal rights and claims against the health insurer or  
133 payment adjudicator to the fullest extent permissible under law.

134 (4) Even if the participation agreement expressly permits  
135 downcoding, a payment adjudicator is prohibited from downcoding  
136 a service without first conducting a review of the associated  
137 medical record to ensure the accuracy of the coding change.

138 (5) A payment adjudicator is prohibited from downcoding  
139 for orders by a licensed nurse.

140 (6) Notwithstanding any provision in this section, a  
141 payment adjudicator that proceeds to downcode a service code or  
142 modifier, regardless of whether such downcoding is contested by  
143 the provider, is solely responsible for any violations of law  
144 associated with such downcoding.

145 (7) Payment adjudicators are required to maintain clear  
146 and accessible downcoding policies on their official website.  
147 These policies must include:

148 (a) An overview of the circumstances under which  
149 downcoding may occur.

150 (b) The process and criteria used for conducting reviews

151 of downcoded claims, including the role of medical record  
152 review.

153 (c) Information about the internal mechanisms for ensuring  
154 consistency and accuracy in downcoding practices.

155 (d) Information regarding the processes for contesting  
156 with the payment adjudicator the downcoding of a service code,  
157 which processes must offer appeal rights for the provider and  
158 the patient, and peer review by a licensed physician before the  
159 downcoding.

160 (8) Health insurers shall ensure that their downcoding  
161 policies are updated as needed to reflect any changes in  
162 regulations, industry standards, or internal procedures.

163 (9) Health insurers shall ensure compliance with this  
164 section and shall develop internal procedures to implement and  
165 adhere to the requirements outlined in this section.

166 (10) Regulatory authorities, including, but not limited  
167 to, the Office of Insurance Regulation, may investigate and take  
168 appropriate actions in cases of noncompliance with this section.

169 (11) When a particular health care service is ordered by a  
170 licensed physician, there shall be a presumption that the  
171 physician determination regarding the diagnosis of the patient  
172 and service order by the physician is correct and sufficient,  
173 absent a coding error which the health insurer must first verify  
174 with the physician before downcoding for such error.

175 (12) If an applicable court, arbitration tribunal, or

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176 other binding legal process determines that a claim was subject  
177 to an inappropriate or impermissible downcoding, whether in  
178 breach of contract, statute, common law, or otherwise, such that  
179 nonpayment or underpayment of the original claim has occurred,  
180 then in accordance with s. 627.6131, interest shall be  
181 calculated upon the full total amount that should have been paid  
182 on the claim as of the applicable time period for payment  
183 specified in s. 627.6131.

184 (13) In the instance of a violation of this section, a  
185 provider shall have a private cause of action to proceed against  
186 the health insurer or payment adjudicator in the applicable  
187 tribunal for the violation.

188 **Section 2. Section 627.42392, Florida Statutes, is amended**  
189 **to read:**

190 627.42392 Prior authorization.—

191 (1) As used in this section, the term:

192 (a) "Adverse determination" means a decision by a health  
193 insurer or utilization review entity that the health care  
194 services rendered, or proposed to be rendered, to a patient are  
195 denied, reduced, or terminated. The term does not include a  
196 decision to deny, reduce, or terminate services that are  
197 determined to have been billed in duplicate bills or that are  
198 confirmed with the provider to have been billed in error.

199 (b) "Electronic prior authorization process" does not  
200 include transmissions through a facsimile machine.

201       (c) "Emergency health care service" means medical  
202 screening, examination, and evaluation by a physician, or, to  
203 the extent permitted by applicable law, by other appropriate  
204 personnel under the supervision of a physician, to determine if  
205 an emergency medical condition exists and, if it does, the care,  
206 treatment, or surgery by a physician necessary to relieve or  
207 eliminate the emergency medical condition, within the service  
208 capability of the facility.

209       (d) "Emergency medical condition" means a medical  
210 condition manifesting itself by acute symptoms of sufficient  
211 severity, including severe pain, such that a prudent layperson  
212 who possesses an average knowledge of health and medicine could  
213 reasonably expect the absence of immediate medical attention to  
214 result in any of the conditions listed in s. 395.002(8).

215       (e) "Health insurer" means any entity that offers health  
216 insurance coverage, whether through a fully insured plan or  
217 self-insured plan or fund, including, as applicable:

218       1. An authorized health insurer offering health insurance  
219 as defined in s. 624.603, as well as any entity that offers a  
220 commercial self-insurance fund as defined in s. 624.462(2) or a  
221 group self-insurance fund as described in s. 624.4621.

222       2. A health insurer that is subject to any of the  
223 provisions of this chapter, as well as any entity that offers a  
224 self-insurance plan or a group self-insurance plan.

225       3. A managed care plan as defined in s. 409.962.

226       4. A health maintenance organization as defined in s.  
227 641.19.

228       (f) "Prior authorization" means the process by which  
229 utilization review entities determine the medical necessity or  
230 medical appropriateness of otherwise covered health care  
231 services before the rendering of such health care services. The  
232 term also includes any requirement by a health insurer or  
233 utilization review entity that an enrollee or health care  
234 provider notify the health insurer or utilization review entity  
235 before the provision of a health care service.

236       (g) "Urgent health care service" means a health care  
237 service that, if the timeframe for making a nonexpedited prior  
238 authorization is applied, could, in the opinion of a physician  
239 with knowledge of the patient's medical condition:

240       1. Seriously jeopardize the life or health of the patient  
241 or the ability of the patient to regain maximum function; or  
242       2. Subject the patient to severe pain that cannot be  
243 adequately managed without the care, treatment, or prescription  
244 drugs that are the subject of the prior authorization request.

245       (h) "Utilization review activity" means any activity  
246 prospective to, concurrent with, or retrospective to, the  
247 provision of a nonemergency health care service, to determine  
248 whether payment shall be made in full or shall be subject to an  
249 adverse determination. Utilization review activity is  
250 prohibited:

251       1. To the extent restricted or prohibited by an agreement  
252       with a health care provider;

253       2. For an emergency health care service; or

254       3. For a service provided to a patient who is experiencing  
255       an emergency medical condition.

256       (i) "Utilization review entity" means an entity permitted  
257       under the applicable agreement with a health care provider or  
258       otherwise permitted by a provider that does not have such an  
259       agreement to perform utilization review activities or upon whose  
260       behalf utilization review activities are performed, including,  
261       as applicable:

262       1. An authorized health insurer offering health insurance  
263       as defined in s. 624.603, as well as any entity that offers a  
264       commercial self-insurance fund as defined in s. 624.462(2) or  
265       group self-insurance fund as described in s. 624.4621.

266       2. A health insurer that is subject to any of the  
267       provisions of this chapter, as well as any entity that offers a  
268       self-insurance plan or a group self-insurance plan.

269       3. A managed care plan as defined in s. 409.962.

270       4. A health maintenance organization as defined in s.

271       641.19.

272       5. A pharmacy benefit manager as defined in s. 624.490(1).

273       6. Any other individual or entity that provides, offers to  
274       provide, or administers payment for hospital services,  
275       outpatient services, medical services, prescription drugs, or

276 other health care services to a person treated by a health care  
277 professional or facility in this state under a policy, plan,  
278 contract, or fund "health insurer" means an authorized insurer  
279 offering health insurance as defined in s. 624.603, a managed  
280 care plan as defined in s. 409.962(10), or a health maintenance  
281 organization as defined in s. 641.19(12).

282 (2) Notwithstanding any other provision of law, a  
283 utilization review entity that effective January 1, 2017, or six  
284 (6) months after the effective date of the rule adopting the  
285 prior authorization form, whichever is later, a health insurer,  
286 or a pharmacy benefits manager on behalf of the health insurer,  
287 which does not provide an electronic prior authorization process  
288 for use by its contracted providers, shall only use the prior  
289 authorization form that has been approved by the Financial  
290 Services Commission for granting a prior authorization for a  
291 medical procedure, course of treatment, or prescription drug  
292 benefit. Such form shall be no longer than may not exceed two  
293 pages in length, excluding any instructions or guiding  
294 documentation, and must include all clinical documentation  
295 necessary for the utilization review entity ~~health insurer~~ to  
296 make a decision. At a minimum, the form must include: (1)  
297 sufficient patient information to identify the member, date of  
298 birth, full name, and Health Plan ID number; (2) provider name,  
299 address and phone number; (3) the medical procedure, course of  
300 treatment, or prescription drug benefit being requested,

301 including the medical reason therefor, and all services tried  
302 and failed; (4) any laboratory documentation required; and (5)  
303 an attestation that all information provided is true and  
304 accurate.

305 (3) The Financial Services Commission in consultation with  
306 the Agency for Health Care Administration shall adopt by rule  
307 guidelines for all prior authorization forms which ensure the  
308 general uniformity of such forms.

309 (4) A utilization review entity must establish and offer a  
310 secure, interactive online electronic prior authorization to  
311 accept electronic prior authorization requests. The process of  
312 electronic prior authorization must allow a person seeking a  
313 prior authorization the ability to upload documentation if such  
314 documentation is required by the utilization review entity to  
315 adjudicate the prior authorization request. Once a provider  
316 grants a health insurer access to a patient's electronic medical  
317 record, the provider shall be deemed to have supplied all  
318 information necessary for prior authorization of the health care  
319 service, including, without limitation, all information that is  
320 reasonably required by the health insurer, other than for an  
321 emergency health care service or for a service provided to a  
322 patient who is experiencing an emergency medical condition, in  
323 advance of the provision of service, and the health insurer  
324 asserts is missing as of the date of such service. Additional  
325 information or documentation, regardless of whether the

326 utilization review entity requests any additional information,  
327 shall be deemed unnecessary, and deemed not required, for prior  
328 authorization of the health care service, and any request for  
329 additional information or any position of the utilization review  
330 entity or any third party acting on behalf of the utilization  
331 review entity regarding any lack of information from the  
332 provider is prohibited from being used to deny, pend, or delay  
333 prior authorization of the health care service.

334 (5)(4) Electronic prior authorization approvals do not  
335 preclude benefit verification or medical review by the health  
336 insurer under either the medical or pharmacy benefits.

337 (6) A utilization review entity's prior authorization  
338 process is prohibited from requiring information that is not  
339 needed to make a determination or facilitate a determination of  
340 medical necessity of the requested medical procedure, course of  
341 treatment, or prescription drug benefit.

342 (7) A utilization review entity shall disclose all of its  
343 prior authorization requirements and restrictions, including any  
344 written clinical criteria, in a publicly accessible manner on  
345 its website. This information shall be explained in detail and  
346 in clear and ordinary terms.

347 (8) A utilization review entity is prohibited from  
348 implementing any new requirements or restrictions and from  
349 making changes to existing requirements or restrictions on  
350 obtaining prior authorization unless:

351        (a) The changes have been available on a publicly  
352        accessible website for at least 60 days before they are  
353        implemented;

354        (b) Policyholders and health care providers who are  
355        affected by the new requirements and restrictions or changes to  
356        the requirements and restrictions are provided with a written  
357        notice of the changes at least 60 days before they are  
358        implemented, with such notice being delivered electronically or  
359        by other means as agreed to by the policyholder or the health  
360        care provider; and

361        (c) All applicable amendments to a provider's agreement  
362        with the applicable health insurer or utilization review entity  
363        have been obtained and memorialized in a mutually agreed-upon  
364        writing before such implementation.

365        (9) (a) Utilization review entities shall, by March 31 of  
366        each year, submit a report to the Office of Insurance Regulation  
367        with the following data elements for the prior calendar year:

368        1. A list of all items and services requiring prior  
369        authorization.

370        2. The percentage of standard prior authorization requests  
371        approved by the utilization review entity and aggregated by item  
372        or service.

373        3. The percentage of standard prior authorization requests  
374        denied by the utilization review entity aggregated by item or  
375        service.

376       4. The percentage of standard prior authorization requests  
377       approved by the utilization review entity after appeal by item  
378       or service.

379       5. The percentage of prior authorization where the  
380       timeframe for review was extended and request approved by item  
381       or service.

382       6. The percentage of expedited prior authorization  
383       requests approved by the utilization review entity by item or  
384       service.

385       7. The percentage of expedited prior authorization  
386       requests denied by the utilization review entity by item or  
387       service.

388       8. The percentage of expedited prior authorization  
389       requests approved by the utilization review entity after appeal  
390       by item or service.

391       9. The average and median time between submission of a  
392       request for prior authorization and the utilization review  
393       entity's decision for standard prior authorizations by item or  
394       service.

395       10. The average and median time between submission of a  
396       request for prior authorization and the utilization review  
397       entity's decision for expedited prior authorizations by item or  
398       service.

399       (b) The Office of Insurance Regulation shall, by July 1 of  
400       each year, publish a report on its website detailing the

401 information in paragraph (a) submitted by utilization review  
402 entities.

403 (10) Utilization review entities must ensure that all  
404 adverse determinations are made by a physician licensed under  
405 chapter 458 or chapter 459. The physician must:

406 (a) Possess a current and valid nonrestricted license to  
407 practice medicine in this state;

408 (b) Be of the same specialty as the physician who  
409 typically manages the medical condition or disease, or provides  
410 the health care service involved in the request;

411 (c) Have at least 5 years of experience treating patients  
412 with the medical condition or disease for which the health care  
413 service is being requested; and

414 (d) Not have any direct or indirect financial arrangement  
415 with the utilization review entity that rewards or incentivizes,  
416 financially or otherwise, such physician in any way relating to  
417 adverse determinations.

418 (11) Notice of an adverse determination shall be provided  
419 by electronic mail to the health care provider that initiated  
420 the prior authorization and to the patient. Notice required  
421 under this subsection must include:

422 (a) The name, title, e-mail address, and telephone number  
423 of the physician responsible for making the adverse  
424 determination.

425 (b) The written clinical criteria, if any, and any

426 internal rule, guideline, or protocol on which the utilization  
427 review entity relied when making the adverse determination and  
428 how those provisions apply to the patient's specific medical  
429 circumstance.

430 (c) Information for the patient and the patient's health  
431 care provider which describes the procedure through which the  
432 patient or health care provider may request a copy of any report  
433 developed by personnel performing the review that led to the  
434 adverse determination.

435 (d) Information that explains to the patient and the  
436 patient's health care provider how to appeal the adverse  
437 determination.

438 (12) If a utilization review entity requires prior  
439 authorization of a nonurgent health care service, the  
440 utilization review entity shall grant a prior authorization or  
441 make an adverse determination and notify the patient and the  
442 patient's health care provider of the decision within 72 hours  
443 after obtaining all necessary information to grant the prior  
444 authorization or make the adverse determination. For purposes of  
445 this subsection, the term "necessary information" includes the  
446 results of any face-to-face clinical evaluation or second  
447 opinion that may be required.

448 (13) A utilization review entity shall grant an expedited  
449 prior authorization or make an expedited adverse determination  
450 concerning an urgent health care service and notify the patient

451 and the patient's health care provider of such expedited prior  
452 authorization or adverse determination no later than 24 hours  
453 after receiving all information needed to complete the review of  
454 the requested urgent health care service.

455 (14) (a) A utilization review entity is prohibited from  
456 requiring prior authorization for:

457 1. Prehospital transportation;  
458 2. Provision of an emergency health care service; or  
459 3. Provision of a service to a patient who is experiencing  
460 an emergency medical condition.

461 (b) A utilization review entity is prohibited from  
462 conducting utilization review activity, and from making any  
463 adverse determinations, to the extent restricted or prohibited  
464 by an agreement with a health care provider. A utilization  
465 review entity is prohibited from performing any utilization  
466 review activity, and from making any adverse determinations,  
467 with respect to:

468 1. An emergency health care service; or  
469 2. A service provided to a patient who experiences an  
470 emergency medical condition.

471 (15) A utilization review entity is prohibited from  
472 requiring prior authorization, and from making any adverse  
473 determinations, for the provision of medications for opioid use  
474 disorder. For purposes of this subsection, the term "medications  
475 for opioid use disorder" means the use of medications, commonly

476 prescribed in combination with counseling and behavioral  
477 therapies, to provide a comprehensive approach to the treatment  
478 of opioid use disorder. FDA-approved medications used to treat  
479 opioid addiction include, but are not limited to, methadone,  
480 buprenorphine, alone or in combination with naloxone, and  
481 extended-release injectable naltrexone. Types of behavioral  
482 therapies include, but are not limited to, individual therapy,  
483 group counseling, family behavior therapy, motivational  
484 incentives, and other modalities.

485 (16) A utilization review entity is prohibited from  
486 revoking, limiting, conditioning, or restricting a prior  
487 authorization if care is provided within 45 business days after  
488 the date the health care provider receives the prior  
489 authorization. A utilization review entity must pay, or cause  
490 payment to be made to, the health care provider, without any  
491 prepayment review or prepayment audit before such payment, at  
492 the contracted payment rate for a health care service provided  
493 by the health care provider per the prior authorization, unless:

494 (a) The health care provider knowingly and materially  
495 misrepresented the health care service in the prior  
496 authorization request with the specific intent to deceive and  
497 obtain an unlawful payment from the utilization review entity;

498 (b) The health care service was no longer a covered  
499 benefit, and medical necessity did not constitute a basis for  
500 such noncovered benefit status, on the day the health care

501 service was provided, and the utilization review entity notified  
502 the health care provider in writing of these facts before the  
503 health care service being provided;

504 (c) The authorized service was never performed; or  
505 (d) The patient was no longer enrolled under the  
506 applicable health plan and, on that basis, was not eligible for  
507 health care coverage from the applicable health insurer or self-  
508 insured plan on the day the care was provided, and the  
509 utilization review entity notified the health care provider in  
510 writing of these facts before the health care service being  
511 provided.

512 (17) If a utilization review entity requires a prior  
513 authorization for a health care service for the treatment of a  
514 chronic or long-term care condition, the prior authorization  
515 shall remain valid for the length of the treatment and the  
516 utilization review entity is prohibited from requiring the  
517 patient to obtain a prior authorization again for the health  
518 care service.

519 (18) A utilization review entity is prohibited from  
520 imposing an additional prior authorization requirement with  
521 respect to a surgical or otherwise invasive procedure, or any  
522 item furnished as part of the surgical or invasive procedure, if  
523 the procedure or item is furnished during the perioperative  
524 period of another procedure for which prior authorization was  
525 granted by the health insurer.

526        (19) If there is a change in coverage or approval criteria  
527        for a previously authorized health care service, the change in  
528        coverage or approval criteria is prohibited from adversely  
529        affecting an enrollee who received prior authorization before  
530        the effective date of the change for the remainder of the  
531        enrollee's plan year.

532        (20) A utilization review entity shall continue to honor a  
533        prior authorization it has granted to an enrollee when the  
534        enrollee changes products under the same health insurer.

535        (21) Any failure by a utilization review entity to comply  
536        with the deadlines and other requirements specified in this  
537        section shall result in any health care services subject to  
538        review to be automatically deemed authorized by the utilization  
539        review entity.

540        (22) Except as otherwise provided in paragraphs (16) (a) -  
541        (d), prior authorization constitutes a conclusive determination  
542        of the medical necessity of the authorized health care service  
543        and an irrevocable obligation to pay for such authorized health  
544        care service.

545        (23) (a) This section prohibits an agreement with a health  
546        care provider to restrict, limit, prohibit, or substitute a  
547        utilization review activity or prior authorization.

548        (b) Nothing in this section shall be construed to:

549        1. Limit in any way the restrictions or prohibitions on  
550        adverse determinations under an agreement with a health care

551 provider, nor to imply permission for, or applicability of,  
552 adverse determinations for emergency health care services.

553 2. Restrict, limit, or prohibit in any way prior  
554 authorizations under an agreement between a provider and a  
555 utilization review entity, nor to restrict, limit, or prohibit a  
556 provider's rights to contest, reject, or oppose any prior  
557 authorization activities.

558 (24) In the instance of a violation of this section, a  
559 provider shall have a private cause of action to proceed against  
560 the health insurer or utilization review entity in the  
561 applicable tribunal for the violation.

562 **Section 3. Section 627.6131, Florida Statutes, is amended**  
563 **to read:**

564 627.6131 Prompt payment of claims.—

565 (1) The contract shall include the following provision:  
566 "Time of Payment of Claims: After receiving written proof of  
567 loss, the health insurer shall will pay monthly all claims.  
568 Claims benefits then due for ....(type of benefit).... Benefits  
569 for any other loss covered by this policy shall will be paid as  
570 soon as the health insurer receives proper written proof."

571 (2) As used in this section, the term:

572 (a) "Claim" for a noninstitutional provider means a paper  
573 HCFA 1500 claim form, or its successor, or an electronic billing  
574 instrument submitted to the health insurer's designated location  
575 that consists of the ANSI ASC X12N 837P standard HCFA-1500 data

576 set, or its successor, that has all mandatory entries for a  
577 physician licensed under chapter 458, chapter 459, chapter 460,  
578 chapter 461, or chapter 463, or psychologists licensed under  
579 chapter 490 or any appropriate billing instrument as designated  
580 by the provider that has all mandatory entries for any other  
581 noninstitutional provider. For institutional providers, "claim"  
582 means a paper CMS-1450 claim form or its successor, or an  
583 electronic billing instrument submitted to the health insurer's  
584 designated location that consists of the ANSI ASC X12N 837I  
585 standard UB-92 data set, or its successor, with entries stated  
586 as mandatory by the National Uniform Billing Committee.

587 (b) "Clean claim" means a completed form, or completed  
588 electronic billing instrument, containing all information  
589 required under the applicable form or electronic billing  
590 instrument, as well as information reasonably required by the  
591 health insurer, other than for emergency services and care as  
592 defined in s. 395.002(9), in advance of the provision of service  
593 by the health insurer to substantiate the claim.

594 (c) "Electronic medical record" means the digital record  
595 of a patient's information that may be accessed through  
596 electronic means, via portal or other method of electronic  
597 access, which may include information regarding the patient's  
598 medical history, medical condition, medical treatment,  
599 laboratory results, diagnostic reports, and clinical notes.

600 (d) "Emergency health care services" has the same meaning

601 as "emergency services and care" as defined in s. 395.002(9).

602 (e) "Health insurer" means any entity that offers health  
603 insurance coverage, whether through a fully insured plan or a  
604 self-insured plan or fund, including, as applicable:

605 1. An authorized health insurer offering health insurance  
606 as defined in s. 624.603, as well as any entity that offers a  
607 commercial self-insurance fund as defined in s. 624.462(2) or a  
608 group self-insurance fund as described in s. 624.4621.

609 2. A health insurer that is subject to any of the  
610 provisions of this chapter, as well as any entity that offers a  
611 self-insurance plan or a group self-insurance plan.

612 (f) "Insured ineligibility" means that the insured was no  
613 longer enrolled in the health plan at the time of receiving the  
614 applicable service.

615 (g) "Overpayment" means payment made upon a claim that is:  
616 1. Billed in error;  
617 2. A duplicate claim; or  
618 3. Billed for a service rendered to a patient in spite of  
619 insured ineligibility.

620  
621 A request for overpayment is limited to a billing error,  
622 duplicate bill, or insured ineligibility.

623 (3) All claims for payment or overpayment, whether  
624 electronic or nonelectronic:

625 (a) Are considered received on the date the claim is

626 received by the health insurer at its designated claims-receipt  
627 location or the date the ~~claim for~~ overpayment claim is received  
628 by the provider at its designated location.

629 (b) As to providers' claims for payment, must be mailed or  
630 electronically transferred to the primary health insurer within  
631 6 months after the following have occurred:

632 1. Discharge for inpatient services or the date of service  
633 for outpatient services; and

634 2. The provider has been furnished with the correct name  
635 and address of the patient's health insurer.

636

637 All providers' claims for payment, whether electronic or  
638 nonelectronic, must be mailed or electronically transferred to  
639 the secondary health insurer within 45 90 days after final  
640 determination by the primary health insurer. A provider's claim  
641 is considered submitted on the date it is electronically  
642 transferred or mailed.

643 (c) Must not duplicate a claim previously submitted unless  
644 it is determined that the original claim was not received or is  
645 otherwise lost.

646 (4) For all electronically submitted claims, a health  
647 insurer shall:

648 (a) Within 24 hours after the beginning of the next  
649 business day after receipt of the claim, provide to the  
650 electronic source submitting the claim an electronic

651 acknowledgment of the receipt of the claim, accompanied by a  
652 statement indicating the health insurer's position as to whether  
653 the claim is a clean claim or is missing any information that is  
654 required under the applicable electronic billing instrument, as  
655 described in paragraph (2)(a), or that was reasonably required  
656 by the health insurer, other than for emergency health care  
657 services, in advance of the provision of service to substantiate  
658 to the electronic source submitting the claim, and the health  
659 insurer asserts is missing as of the date of service.

660 (b) Within 15 20 days after receipt of the claim, pay the  
661 claim or notify a provider or designee if a claim is denied or  
662 contested. Notice of the health insurer's action on the claim  
663 and payment of the claim is considered to be made on the date  
664 the notice or payment was received by the provider mailed or  
665 electronically transferred.

666 (c)1. Notification of the health insurer's determination  
667 of a contested claim must be accompanied by an itemized list of  
668 any additional information that is required under the applicable  
669 billing instrument, as described in paragraph (2)(a), or that  
670 was reasonably required by the health insurer, other than for  
671 emergency health care services, in advance of the provision of  
672 service to substantiate the claim, and the health insurer  
673 asserts is missing as of the date of such service ~~or documents~~  
674 ~~the insurer can reasonably determine are necessary to process~~  
675 ~~the claim.~~

676        2. A provider must submit the additional information or  
677 documentation, as specified on the itemized list, within 30 ~~35~~  
678 days after receipt of the notification of contestation unless,  
679 within the 30-day period, the provider notifies the health  
680 insurer of the provider's position that a clean claim has been  
681 submitted. Additional information is considered submitted on the  
682 date it is electronically transferred or mailed. The health  
683 insurer is prohibited from requesting ~~may not request~~ duplicate  
684 documents.

685        (d) For purposes of this subsection, electronic means of  
686 transmission of claims, notices, documents, forms, and payments  
687 shall be used to the greatest extent possible by the health  
688 insurer and the provider.

689        (e) A claim that was contested by the health insurer must  
690 be paid or denied within 30 ~~90~~ days after receipt of the  
691 additional information requested ~~claim~~. Failure to pay or deny a  
692 claim within 90 ~~120~~ days after receipt of the claim, regardless  
693 of whether contested by the health insurer, creates an  
694 uncontestable obligation to pay the claim as submitted by the  
695 provider.

696        (5) For all nonelectronically submitted claims, a health  
697 insurer shall:

698        (a) Within 15 days following receipt of the claim  
699 ~~Effective November 1, 2003, provide to the provider or its~~  
700 designee:

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701       1. An acknowledgment of receipt of the claim, accompanied  
702 by a statement indicating the health insurer's position as to  
703 whether the claim is a clean claim or the claim is missing any  
704 information that is required under the applicable paper billing  
705 form, as described in paragraph (2)(a), or that was reasonably  
706 required by the health insurer, other than for emergency health  
707 care services, in advance of the provision of service to  
708 substantiate the claim, and the health insurer asserts is  
709 missing as of the date of service; or

710       2. ~~within 15 days after receipt of the claim to the~~  
711 ~~provider or provide a provider within 15 days after receipt with~~  
712 ~~Electronic access to the status of the a submitted claim, which~~  
713 ~~status must indicate the health insurer's position as to whether~~  
714 ~~the claim is a clean claim or missing any information described~~  
715 ~~in subparagraph 1.~~

716       (b) Within 30 40 days after receipt of the claim, pay the  
717 claim or notify a provider or designee if a claim is denied or  
718 contested. Notice of the health insurer's action on the claim  
719 and payment of the claim is considered to be made on the date  
720 the notice or payment was received by the provider mailed or  
721 electronically transferred.

722       (c)1. Notification of the health insurer's determination  
723 of a contested claim must be accompanied by an itemized list of  
724 any additional information that is required under the applicable  
725 form or billing instrument, as described in paragraph (2)(a), or

726 that was reasonably required by the health insurer, other than  
727 for emergency health care services, in advance of the provision  
728 of service to substantiate the claim, and the health insurer  
729 asserts is missing as of the date of such service or documents  
730 the insurer can reasonably determine are necessary to process  
731 the claim.

732 2. A provider must submit the additional information or  
733 documentation, as specified on the itemized list, within 30 ~~35~~  
734 days after receipt of the notification of contestation unless,  
735 within the 30-day period, the provider notifies the health  
736 insurer of its position that a clean claim has been submitted.  
737 Additional information is considered submitted on the date it is  
738 electronically transferred or mailed. The health insurer is  
739 prohibited from requesting ~~may not request~~ duplicate documents.

740 (d) For purposes of this subsection, electronic means of  
741 transmission of claims, notices, documents, forms, and payments  
742 shall be used to the greatest extent possible by the health  
743 insurer and the provider.

744 (e) A claim that was contested by the health insurer must  
745 be paid or denied within 30 ~~120~~ days after receipt of the  
746 additional information requested ~~claim~~. Failure to pay or deny a  
747 claim within 90 ~~140~~ days after receipt of the claim, regardless  
748 of whether contested by the health insurer, creates an  
749 uncontestable obligation to pay the claim as submitted by the  
750 provider.

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751        (6) Regardless of whether a claim has been submitted  
752        electronically or nonelectronically, and notwithstanding any  
753        other provision of this section to the contrary:

754        (a) Once a provider grants a health insurer access to a  
755        patient's electronic medical record, the provider shall be  
756        deemed to have supplied all information necessary to pay the  
757        claim, including, without limitation, all information that is  
758        required under the applicable billing instrument and that was  
759        reasonably required by the health insurer, other than for  
760        emergency health care services, in advance of the provision of  
761        service to substantiate the claim. Additional information or  
762        documentation, regardless of whether the health insurer requests  
763        any additional information, shall be deemed unnecessary, and  
764        deemed not required for payment of the claim, and any request  
765        for additional information, and any position of the health  
766        insurer or any third party acting on behalf of the health  
767        insurer regarding any lack of information from the provider, is  
768        prohibited from being used to deny, reduce, offset, withhold,  
769        pend, or delay payment of the claim.

770        (b) For instances in which notice of access to the  
771        electronic medical record has been provided to the health  
772        insurer, the claim must be paid or denied within 30 days of such  
773        notice to the health insurer. Failure to pay or deny a claim,  
774        for which the health insurer has been provided notice of access  
775        to the electronic medical record within 75 days after receipt of

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776 such notice creates an uncontestable obligation to pay the claim  
777 as submitted by the provider.

778 (7)(6) If a health insurer determines that it has made an  
779 overpayment to a provider for services rendered to an insured,  
780 the health insurer must make an overpayment a claim for such  
781 overpayment to the provider's designated location. A health  
782 insurer that makes an overpayment a claim ~~for overpayment~~ to a  
783 provider under this section shall give the provider a written or  
784 electronic statement specifying the basis for the retrospective  
785 ~~retroactive~~ denial or payment adjustment. The health insurer  
786 must also identify the claim or claims, or portion thereof, as  
787 to which the health insurer alleges overpayment claim; and the  
788 specific invoice number submitted with or on the claim portion  
789 ~~thereof, for which a claim for overpayment is submitted. Except~~  
790 ~~as provided in subparagraph (a).3, there shall be no denial,~~  
791 ~~reduction, offset, withholding, pending, or delay of payment, or~~  
792 ~~other negative impact, regardless of whether by the health~~  
793 ~~insurer or any third party acting on behalf of such health~~  
794 ~~insurer, on payment of any other claim of the provider on the~~  
795 ~~basis of the overpayment allegation.~~

796 (a) If an overpayment determination is the result of  
797 retrospective retroactive review or retrospective audit ~~of~~  
798 ~~coverage decisions or payment levels not related to fraud~~, a  
799 health insurer shall adhere to the following procedures:

800 1. All overpayment claims ~~for overpayment~~ must be received

801 by the submitted to a provider within 18 30 months after the  
802 health insurer's payment of the claim. A provider must pay,  
803 deny, or contest the health insurer's ~~claim for~~ overpayment  
804 claim within 40 days after the receipt of the overpayment claim.  
805 All contested overpayment claims ~~for overpayment~~ must be paid or  
806 denied within 120 days after receipt of the overpayment claim.  
807 Failure to pay or deny an overpayment ~~and~~ claim within 140 days  
808 after receipt creates an uncontestable obligation to pay the  
809 overpayment claim.

810 2. A provider that denies or contests a health insurer's  
811 overpayment claim ~~for overpayment~~ or any portion of an  
812 overpayment ~~a~~ claim shall notify the health insurer, in writing,  
813 within 40 35 days after the provider receives the overpayment  
814 claim that such overpayment ~~the~~ claim ~~for overpayment~~ is  
815 contested or denied. The notice that the overpayment claim ~~for~~  
816 ~~overpayment~~ is denied or contested must identify the denied or  
817 contested portion of the overpayment claim and the specific  
818 reason for contesting or denying the overpayment claim and, if  
819 contested, must include a request for additional information. If  
820 the health insurer submits additional information, the health  
821 insurer must, within 35 days after receipt of the request, mail  
822 or electronically transfer the information to the provider. The  
823 provider shall pay or deny the overpayment claim ~~for overpayment~~  
824 within 45 days after receipt of the information. The notice from  
825 the provider regarding denial or contestation of the overpayment

826 claim is considered made on the date the notice is mailed or  
827 electronically transferred by the provider.

828 3. The health insurer is prohibited from denying,  
829 reducing, offsetting, withholding, pending, or delaying ~~may not~~  
830 ~~reduce~~ payment to the provider for other services unless the  
831 provider agrees to the denial, reduction, offset, withholding,  
832 pending, or delay of payment in writing or fails to respond to  
833 the health insurer's overpayment claim as required by this  
834 paragraph.

835 4. Payment of an overpayment claim is considered made on  
836 the date the payment was mailed or electronically transferred.  
837 An overdue payment of a claim bears simple interest at the rate  
838 of 12 percent per year. Interest on an overdue payment for an  
839 overpayment ~~a~~ claim ~~for an overpayment~~ begins to accrue when the  
840 overpayment claim should have been paid, denied, or contested.

841 (b) An overpayment ~~A~~ claim is prohibited for overpayment  
842 ~~shall not be permitted~~ beyond 18 30 months after the health  
843 insurer's payment of a claim, except that overpayment claims ~~for~~  
844 ~~overpayment~~ may be sought beyond that time from providers  
845 convicted of fraud pursuant to s. 817.234.

846 (8)(7) Payment of a claim is considered made on the date  
847 the payment was mailed or electronically transferred. An overdue  
848 payment of a claim bears simple interest of 15 12 percent per  
849 year, to be calculated upon the full total amount that should  
850 have been paid on the claim within the applicable time period

851 specified in this section. If an applicable court, arbitration  
852 tribunal, or other binding legal process determines that a claim  
853 that was paid at a lesser amount should have been paid at a full  
854 total amount, whether under a breach of contract legal claim, a  
855 legal claim under a statutory private cause of action, or other  
856 basis, the 15 percent per year interest shall be calculated upon  
857 the full total amount, rather than upon the difference between  
858 the full total amount and the amount that was actually paid. If  
859 an applicable court, arbitration tribunal, or other binding  
860 legal process determines that a claim was subject to an  
861 inappropriate or impermissible denial or partial denial, whether  
862 in a breach of contract, statute, common law, or otherwise,  
863 interest shall be calculated upon the full total amount that  
864 should have been paid on the claim within the applicable time  
865 period for payment specified in this section, and the act of  
866 denial or partial denial shall be deemed not to have in any way  
867 tolled the time period for such payment. Interest on the full  
868 total amount that should have been paid on the claim within the  
869 applicable time period specified in this section ~~an overdue~~  
870 ~~payment for a claim or for any portion of a claim~~ begins to  
871 accrue when the claim should have been paid, denied, or  
872 ~~contested~~. The interest must be paid along with, and in addition  
873 to, the payment for the satisfaction of the full total amount of  
874 the claim, as determined by an applicable court, arbitration  
875 tribunal, or other binding legal process is payable with the

876 ~~payment of the claim.~~

877 (9) ~~(8)~~ For all contracts entered into or renewed on or  
878 after October 1, 2002, a health insurer's internal dispute  
879 resolution process related to a denied claim not under active  
880 review by a mediator, arbitrator, or third-party dispute entity  
881 must be finalized within 60 days after the receipt of the  
882 provider's request for review or appeal. Notwithstanding any  
883 provision of this section to the contrary, when the provider and  
884 health insurer disagree as to interpretation of contractual or  
885 statutory language, the provider is not required to participate  
886 in the health insurer's internal dispute resolution process.

887 (10) ~~(9)~~ A provider or any representative of a provider,  
888 regardless of whether the provider is under contract with the  
889 health insurer, is prohibited from collecting or attempting ~~may~~  
890 ~~not collect or attempt~~ to collect money from, maintaining  
891 ~~maintain~~ any action at law against, or reporting ~~report~~ to a  
892 credit agency an insured for payment of covered services for  
893 which the health insurer contested or denied the provider's  
894 claim. This prohibition applies during the pendency of any claim  
895 for payment made by the provider to the health insurer for  
896 payment of the services or internal dispute resolution process  
897 to determine whether the health insurer is liable for the  
898 services. For a claim, this pendency applies from the date the  
899 claim or a portion of the claim is denied to the date of the  
900 completion of the health insurer's internal dispute resolution

901 process, not to exceed 60 days. This subsection does not  
902 prohibit the collection by the provider of copayments,  
903 coinsurance, or deductible amounts due the provider.

904 ~~(10) The provisions of this section may not be waived,  
905 voided, or nullified by contract.~~

906 (11) A health insurer is prohibited from retrospectively  
907 denying ~~may not retroactively~~ deny a claim because of insured  
908 ineligibility more than 90 days ~~1 year~~ after the date of payment  
909 of the claim.

910 (12) A health insurer shall pay a contracted primary care  
911 or admitting physician, pursuant to such physician's contract,  
912 for providing inpatient services in a contracted hospital to an  
913 insured if such services are determined by such physician ~~the~~  
914 ~~health insurer~~ to be medically necessary and, regardless of the  
915 health plan's determination of medical necessity, are otherwise  
916 covered services under the health insurer's contract with the  
917 contract holder.

918 (13) Upon written notification by an insured, a health ~~an~~  
919 insurer shall investigate any claim of improper billing of the  
920 insured by a physician, hospital, or other health care provider  
921 for a health care service alleged to not actually have been  
922 received. The health insurer shall determine if the insured  
923 actually received the applicable service ~~was properly billed for~~  
924 ~~only those procedures and services that the insured actually~~  
925 ~~received.~~ If the health insurer determines that the insured did

926 not actually receive the applicable service has been improperly  
927 billed, the health insurer shall notify the insured and the  
928 provider of its findings and shall reduce the amount of payment  
929 to the provider by the amount for the service that was not  
930 actually received determined to be improperly billed. If a  
931 reduction is made due to such notification by the insured, the  
932 insurer shall pay to the insured 20 percent of the amount of the  
933 reduction up to \$500.

934 (14) A permissible error ratio of 5 percent is established  
935 for health insurer's claims payment violations of paragraphs  
936 (4) (a), (b), (c), and (e) and (5) (a), (b), (c), and (e). If the  
937 error ratio of a particular health insurer does not exceed the  
938 permissible error ratio of 5 percent for an audit period, no  
939 fine shall be assessed for the noted claims violations for the  
940 audit period. The error ratio shall be determined by dividing  
941 the number of claims with violations found on a statistically  
942 valid sample of claims for the audit period by the total number  
943 of claims in the sample. If the error ratio exceeds the  
944 permissible error ratio of 5 percent, a fine may be assessed  
945 according to s. 624.4211 for those claims payment violations  
946 which exceed the error ratio. Notwithstanding the provisions of  
947 this section, the office may fine a health insurer for claims  
948 payment violations of paragraphs (4) (e) and (5) (e) which create  
949 an uncontestable obligation to pay the claim as submitted by the  
950 provider. The office shall refrain from imposing a not fine upon

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951 a health insurer ~~insurers~~ for violations which the office  
952 determines were due to circumstances beyond the health insurer's  
953 control.

954 (15) This section is applicable only to a major medical  
955 expense health insurance policy as defined in s. 627.643(2)(e)  
956 offered by a group or an individual health insurer licensed  
957 under pursuant to chapter 624, including a preferred provider  
958 policy under s. 627.6471 and an exclusive provider organization  
959 under s. 627.6472 or a group or individual insurance contract  
960 that only provides direct payments to dentists for enumerated  
961 dental services, or other health insurance coverage, policy, or  
962 fund, regardless of whether fully insured or self-insured,  
963 offered or administered by a health insurer.

964 (16) Notwithstanding paragraph (4)(b), where an electronic  
965 pharmacy claim is submitted to a pharmacy benefits manager  
966 acting on behalf of a health insurer, the pharmacy benefits  
967 manager shall, within 30 days of receipt of the claim, pay the  
968 claim or notify a provider or designee if a claim is denied or  
969 contested. Notice of the health insurer's action on the claim  
970 and payment of the claim is considered to be made on the date  
971 the notice or payment was received by the provider mailed or  
972 electronically transferred.

973 (17) Notwithstanding paragraph (5)(a), effective November  
974 1, 2003, where a nonelectronic pharmacy claim is submitted to a  
975 pharmacy benefits manager acting on behalf of a health insurer,

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976 the pharmacy benefits manager shall provide acknowledgment of  
977 receipt of the claim within 30 days after receipt of the claim  
978 to the provider or provide a provider within 30 days after  
979 receipt with electronic access to the status of a submitted  
980 claim.

981 (18) Notwithstanding the 18-month ~~30-month~~ period provided  
982 in subsection (7) ~~(6)~~, all overpayment claims ~~for overpayment~~  
983 submitted to a provider licensed under chapter 395, chapter 458,  
984 chapter 459, chapter 460, chapter 461, chapter 463, chapter 466,  
985 or chapter 490 must be submitted to the provider within 12  
986 months after the health insurer's payment of the claim. An  
987 overpayment ~~A~~ claim to a provider licensed under chapter 395,  
988 chapter 458, chapter 459, chapter 460, chapter 461, chapter 463,  
989 chapter 466, or chapter 490 is prohibited ~~for overpayment~~ may  
990 ~~not be permitted~~ beyond 12 months after the health insurer's  
991 payment of a claim, except that overpayment claims ~~for~~  
992 ~~overpayment~~ may be sought beyond that time from providers  
993 convicted of fraud pursuant to s. 817.234.

994 (19) Notwithstanding any other provision of this section,  
995 all claims for underpayment from a provider licensed under  
996 chapter 395, chapter 458, chapter 459, chapter 460, chapter 461,  
997 or chapter 466 must be submitted to the health insurer within 12  
998 months after the health insurer's payment of the claim. A claim  
999 for underpayment by a provider licensed under chapter 395,  
1000 chapter 458, chapter 459, chapter 460, chapter 461, or chapter

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1001 466 is prohibited ~~may not be permitted~~ beyond 12 months after  
1002 the health insurer's payment of a claim.

1003 (20) Nothing in this section shall be interpreted to  
1004 limit, restrict, or negatively impact any legal claim by a  
1005 provider or health insurer for breach of contract, statutory or  
1006 regulatory violation, or a common-law cause of action, nor to  
1007 shorten or otherwise negatively impact the statute of  
1008 limitations timeframe for bringing any such legal claim.

1009 (21) A health insurer is prohibited from requesting  
1010 information from a contracted or noncontracted provider which  
1011 does not apply to the medical condition at issue for the  
1012 purposes of adjudicating a clean claim.

1013 (22) A health insurer is prohibited from requesting a  
1014 contracted or noncontracted provider to resubmit claim  
1015 information that the contracted or noncontracted provider can  
1016 document it has already provided to the health insurer or that  
1017 is contained inside the electronic medical record to which the  
1018 health insurer has been provided access.

1019 (23) Notwithstanding any other provision of this section  
1020 to the contrary, a health insurer is prohibited from requiring  
1021 any information from a provider before the provision of  
1022 emergency health care services as a condition of payment of a  
1023 claim, as a basis for denying, delaying, offsetting,  
1024 withholding, or reducing payment of a claim, or in contesting  
1025 whether the claim is a clean claim.

1026        (24) In an instance of a violation of this section, a  
1027 provider shall have a private cause of action to proceed against  
1028 the health insurer in the applicable tribunal for the violation.

1029        (25) ~~(20)~~(a) A contract between a health insurer and a  
1030 dentist licensed under chapter 466 for the provision of services  
1031 to an insured is prohibited from specifying ~~may not specify~~  
1032 credit card payment as the only acceptable method for payments  
1033 from the health insurer to the dentist.

1034        (b) When a health insurer employs the method of claims  
1035 payment to a dentist through electronic funds transfer,  
1036 including, but not limited to, virtual credit card payment, the  
1037 health insurer shall notify the dentist as provided in this  
1038 paragraph and obtain the dentist's consent before employing the  
1039 electronic funds transfer. The dentist's consent described in  
1040 this paragraph applies to the dentist's entire practice. For the  
1041 purpose of this paragraph, the dentist's consent, which may be  
1042 given through e-mail, must bear the signature of the dentist.  
1043 Such signature includes an electronic or digital signature if  
1044 the form of signature is recognized as a valid signature under  
1045 applicable federal law or state contract law or an act that  
1046 demonstrates express consent, including, but not limited to,  
1047 checking a box indicating consent. The health insurer or dentist  
1048 is prohibited from requiring ~~may not require~~ that a dentist's  
1049 consent as described in this paragraph be made on a patient-by-  
1050 patient basis. The notification provided by the health insurer

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1051 to the dentist must include all of the following:

1052 1. The fees, if any, associated with the electronic funds  
1053 transfer.

1054 2. The available methods of payment of claims by the  
1055 health insurer, with clear instructions to the dentist on how to  
1056 select an alternative payment method.

1057 (c) A health insurer that pays a claim to a dentist  
1058 through automated clearinghouse transfer is prohibited from  
1059 charging ~~may not charge~~ a fee solely to transmit the payment to  
1060 the dentist unless the dentist has consented to the fee.

1061 (d) This subsection applies to contracts delivered,  
1062 issued, or renewed on or after January 1, 2025.

1063 (e) The office has all rights and powers to enforce this  
1064 subsection as provided by s. 624.307.

1065 (f) The commission may adopt rules to implement this  
1066 subsection.

1067 (26) ~~(21)~~ (a) A health insurer is prohibited from denying  
1068 ~~may not deny~~ any claim subsequently submitted by a dentist  
1069 licensed under chapter 466 for procedures specifically included  
1070 in a prior authorization unless at least one of the following  
1071 circumstances applies for each procedure denied:

1072 1. Benefit limitations, such as annual maximums and  
1073 frequency limitations not applicable at the time of the prior  
1074 authorization, are reached subsequent to issuance of the prior  
1075 authorization.

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1076        2. The documentation provided by the person submitting the  
1077 claim fails to support the claim as originally authorized.

1078        3. Subsequent to the issuance of the prior authorization,  
1079 new procedures are provided to the patient or a change in the  
1080 condition of the patient occurs such that the prior authorized  
1081 procedure would no longer be considered medically necessary,  
1082 based on the prevailing standard of care.

1083        4. Subsequent to the issuance of the prior authorization,  
1084 new procedures are provided to the patient or a change in the  
1085 patient's condition occurs such that the prior authorized  
1086 procedure would at that time have required disapproval pursuant  
1087 to the terms and conditions for coverage under the patient's  
1088 plan in effect at the time the prior authorization was issued.

1089        5. The denial of the claim was due to one of the  
1090 following:

1091            a. Another payor is responsible for payment.

1092            b. The dentist has already been paid for the procedures  
1093 identified in the claim.

1094            c. The claim was submitted fraudulently, or the prior  
1095 authorization was based in whole or material part on erroneous  
1096 information provided to the health insurer by the dentist,  
1097 patient, or other person not related to the health insurer.

1098            d. The person receiving the procedure was not eligible to  
1099 receive the procedure on the date of service.

1100            e. The services were provided during the grace period

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1101 established under s. 627.608 or applicable federal regulations,  
1102 and the dental insurer notified the provider that the patient  
1103 was in the grace period when the provider requested eligibility  
1104 or enrollment verification from the dental insurer, if such  
1105 request was made.

1106 (b) This subsection applies to all contracts delivered,  
1107 issued, or renewed on or after January 1, 2025.

1108 (c) The office has all rights and powers to enforce this  
1109 subsection as provided by s. 624.307.

1110 (d) The commission may adopt rules to implement this  
1111 subsection.

1112 **Section 4. Section 641.3155, Florida Statutes, is amended**  
1113 **to read:**

1114 641.3155 Prompt payment of claims.—

1115 (1) As used in this section, the term:

1116 (a) "Claim" for a noninstitutional provider means a paper  
1117 HCFA 1500 claim form, or its successor, or an electronic billing  
1118 instrument submitted to the health maintenance organization's  
1119 designated location that consists of the ANSI ASC X12N 837P  
1120 standard HCFA 1500 data set, or its successor, that has all  
1121 mandatory entries for a physician licensed under chapter 458,  
1122 chapter 459, chapter 460, chapter 461, or chapter 463, or  
1123 psychologists licensed under chapter 490 or any appropriate  
1124 billing instrument as designated by the provider that has all  
1125 mandatory entries for any other noninstitutional provider. For

1126 institutional providers, "claim" means a paper CMS-1450 claim  
1127 form, or its successor, or an electronic billing instrument  
1128 submitted to the health maintenance organization's designated  
1129 location that consists of the ANSI ASC X12N 837I standard UB-92  
1130 data set or its successor with entries stated as mandatory by  
1131 the National Uniform Billing Committee.

1132 (b) "Clean claim" means a completed form, or completed  
1133 electronic billing instrument, containing all information  
1134 required under the applicable form or electronic billing  
1135 instrument, as well as information reasonably required by the  
1136 health maintenance organization, other than for emergency  
1137 services and care as defined in s. 641.19, in advance of the  
1138 provision of service by the health maintenance organization to  
1139 substantiate the claim.

1140 (c) "Electronic medical record" means the digital record  
1141 of a patient's information that may be accessed through  
1142 electronic means, via portal or other method of electronic  
1143 access, which may include information regarding the patient's  
1144 medical history, medical condition, medical treatment,  
1145 laboratory results, diagnostic reports, and clinical notes.

1146 (d) "Emergency health care service" has the same meaning  
1147 as "emergency services and care" as defined in s. 641.19.

1148 (e) "Enrollee ineligibility" means that the enrollee was  
1149 no longer enrolled in the health maintenance organization at the  
1150 time of receiving the applicable service.

1151 (f) "Overpayment" means payment made upon a claim that is:

1152 1. Billed in error;

1153 2. A duplicate claim; or

1154 3. Billed for a service rendered to a patient in spite of  
1155 enrollee ineligibility.

1156

1157 A request for overpayment is limited to a billing error,  
1158 duplicate bill, or enrollee ineligibility.

1159 (2) All claims for payment or overpayment, whether  
1160 electronic or nonelectronic:

1161 (a) Are considered received on the date the claim is  
1162 received by the health maintenance organization at its  
1163 designated claims-receipt location or the date the overpayment a  
1164 claim ~~for overpayment~~ is received by the provider at its  
1165 designated location.

1166 (b) As to providers' claims for payment, must be mailed or  
1167 electronically transferred to the primary organization within 6  
1168 months after the following have occurred:

1169 1. Discharge for inpatient services or the date of service  
1170 for outpatient services; and

1171 2. The provider has been furnished with the correct name  
1172 and address of the patient's health maintenance organization.

1173

1174 All providers' claims for payment, whether electronic or  
1175 nonelectronic, must be mailed or electronically transferred to

1176 the secondary organization within 45 90 days after final  
1177 determination by the primary organization. A provider's claim is  
1178 considered submitted on the date it is electronically  
1179 transferred or mailed.

1180 (c) Must not duplicate a claim previously submitted unless  
1181 it is determined that the original claim was not received or is  
1182 otherwise lost.

1183 (3) For all electronically submitted claims, a health  
1184 maintenance organization shall:

1185 (a) Within 24 hours after the beginning of the next  
1186 business day after receipt of the claim, provide to the  
1187 electronic source submitting the claim an electronic  
1188 acknowledgment of the receipt of the claim, accompanied by a  
1189 statement indicating the health maintenance organization's  
1190 position as to whether the claim is a clean claim or whether the  
1191 claim is missing any information that is required under the  
1192 applicable electronic billing instrument described in paragraph  
1193 (1) (a) or that was reasonably required by the health maintenance  
1194 organization, other than for emergency health care services, in  
1195 advance of the provision of service to substantiate to the  
1196 electronic source submitting the claim, and the health  
1197 maintenance organization asserts is missing as of the date of  
1198 service.

1199 (b) Within 15 20 days after receipt of the claim, pay the  
1200 claim or notify a provider or designee if a claim is denied or

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1201 contested. Notice of the health maintenance organization's  
1202 action on the claim and payment of the claim is considered to be  
1203 made on the date the notice or payment was received by the  
1204 provider mailed or electronically transferred.

1205 (c)1. Notification of the health maintenance  
1206 organization's determination of a contested claim must be  
1207 accompanied by an itemized list of any additional information  
1208 required under the applicable billing instrument described in  
1209 paragraph (1) (a) or that was reasonably required by the health  
1210 maintenance organization, other than for emergency health care  
1211 services, in advance of the provision of service to substantiate  
1212 the claim, and the health maintenance organization asserts is  
1213 missing as of the date of such service or documents the insurer  
1214 can reasonably determine are necessary to process the claim.

1215 2. A provider must submit the additional information or  
1216 documentation, as specified on the itemized list, within 30 35  
1217 days after receipt of the notification of contestation unless,  
1218 within the 30-day period, the provider notifies the health  
1219 maintenance organization of the provider's position that a clean  
1220 claim has been submitted. Additional information is considered  
1221 submitted on the date it is electronically transferred or  
1222 mailed. The health maintenance organization is prohibited from  
1223 requesting may not request duplicate documents.

1224 (d) For purposes of this subsection, electronic means of  
1225 transmission of claims, notices, documents, forms, and payment

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1226 shall be used to the greatest extent possible by the health  
1227 maintenance organization and the provider.

1228 (e) A claim that was contested by the health maintenance  
1229 organization must be paid or denied within 30 ~~90~~ days after  
1230 receipt of the additional information requested ~~claim~~. Failure  
1231 to pay or deny a claim within 90 ~~120~~ days after receipt of the  
1232 claim, regardless of whether contested by the health maintenance  
1233 organization, creates an uncontestable obligation to pay the  
1234 claim.

1235 (4) For all nonelectronically submitted claims, a health  
1236 maintenance organization shall:

1237 (a) Within 15 days following receipt of the claim  
1238 ~~Effective November 1, 2003, provide to the provider, or~~  
1239 designee, who submitted the claim:

1240 1. An acknowledgment of receipt of the claim, accompanied  
1241 by a statement indicating the health maintenance organization's  
1242 position as to whether the claim is a clean claim or the claim  
1243 is missing any information that is required under the applicable  
1244 paper billing form, as described in paragraph (1)(a), or that  
1245 was reasonably required by the health maintenance organization,  
1246 other than for emergency health care services, in advance of the  
1247 provision of service to substantiate the claim, and the health  
1248 maintenance organization asserts is missing as of the date of  
1249 service; or

1250 2. within 15 days after receipt of the claim to the

1251 provider or designee or provide a provider or designee within 15  
1252 days after receipt with Electronic access to the status of the a  
1253 submitted claim, which status must indicate the health  
1254 maintenance organization's position as to whether the claim is a  
1255 clean claim or missing any information described in subparagraph  
1256 1.

1257 (b) Within 30 40 days after receipt of the claim, pay the  
1258 claim or notify a provider or designee if a claim is denied or  
1259 contested. Notice of the health maintenance organization's  
1260 action on the claim and payment of the claim is considered to be  
1261 made on the date the notice or payment was received by the  
1262 provider mailed or electronically transferred.

1263 (c) 1. Notification of the health maintenance  
1264 organization's determination of a contested claim must be  
1265 accompanied by an itemized list of any additional information  
1266 required under the applicable form or billing instrument  
1267 described in paragraph (1)(a), or that was reasonably required  
1268 by the health maintenance organization, other than for emergency  
1269 health care services, in advance of the provision of service to  
1270 substantiate the claim, and the health maintenance organization  
1271 asserts is missing as of the date of such service or documents  
1272 the organization can reasonably determine are necessary to  
1273 process the claim.

1274 2. A provider must submit the additional information or  
1275 documentation, as specified on the itemized list, within 30 35

1276 days after receipt of the notification of contestation unless,  
1277 within the 30-day period, the provider notifies the health  
1278 maintenance organization of the provider's position that a clean  
1279 claim has been submitted. Additional information is considered  
1280 submitted on the date it is electronically transferred or  
1281 mailed. The health maintenance organization is prohibited from  
1282 requesting ~~may not request~~ duplicate documents.

1283 (d) For purposes of this subsection, electronic means of  
1284 transmission of claims, notices, documents, forms, and payments  
1285 shall be used to the greatest extent possible by the health  
1286 maintenance organization and the provider.

1287 (e) A claim that was contested by the health maintenance  
1288 organization must be paid or denied within 30 ~~120~~ days after  
1289 receipt of the additional information requested ~~claim~~. Failure  
1290 to pay or deny a claim within 90 ~~140~~ days after receipt of the  
1291 claim, regardless of whether contested by the health maintenance  
1292 organization, creates an uncontestable obligation to pay the  
1293 claim as submitted by the provider.

1294 (5) Regardless of whether a claim has been submitted  
1295 electronically or nonelectronically, and notwithstanding any  
1296 other provision of this section to the contrary:

1297 (a) Once a provider grants a health maintenance  
1298 organization access to a patient's electronic medical record,  
1299 the provider shall be deemed to have supplied all information  
1300 necessary to pay the claim, including, without limitation, all

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1301 information that is required under the applicable billing  
1302 instrument and that was reasonably required by the health  
1303 maintenance organization, other than for emergency health care  
1304 services, in advance of the provision of service to substantiate  
1305 the claim. Additional information or documentation, regardless  
1306 of whether the health maintenance organization requests any  
1307 additional information, shall be deemed unnecessary, and deemed  
1308 not required for payment of the claim, and any request for  
1309 additional information, and any position of the health  
1310 maintenance organization or any third party acting on behalf of  
1311 the health maintenance organization regarding any lack of  
1312 information from the provider, is prohibited from being used to  
1313 deny, reduce, offset, withhold, pend, or delay payment of the  
1314 claim.

1315 (b) For instances in which notice of access to the  
1316 electronic medical record has been provided to the health  
1317 maintenance organization, the claim must be paid or denied  
1318 within 30 days of such notice to the health maintenance  
1319 organization. Failure to pay or deny a claim, for which the  
1320 health maintenance organization has been provided notice of  
1321 access to the electronic medical record within 75 days after  
1322 receipt of such notice creates an uncontestable obligation to  
1323 pay the claim as submitted by the provider.

1324 (6)-(5) If a health maintenance organization determines  
1325 that it has made an overpayment to a provider for services

1326 rendered to an enrollee ~~a subscriber~~, the health maintenance  
1327 organization must make an overpayment ~~a~~ claim for such  
1328 overpayment to the provider's designated location. A health  
1329 maintenance organization that makes an overpayment ~~a~~ claim ~~for~~  
1330 ~~overpayment~~ to a provider under this section shall give the  
1331 provider a written or electronic statement specifying the basis  
1332 for the retrospective ~~retroactive~~ denial or payment adjustment.  
1333 The health maintenance organization must also identify the claim  
1334 or claims, or ~~overpayment~~ ~~claim~~ portion thereof, as to which the  
1335 health maintenance organization alleges overpayment; and the  
1336 specific invoice number submitted with or on the claim, as well  
1337 as the specific line items on the bill that are subject to the  
1338 overpayment claim for which a claim for overpayment is  
1339 submitted. Except as provided in subparagraph (a)3., there shall  
1340 be no denial, reduction, offset, withholding, pending, or delay  
1341 of payment, or other negative impact, regardless of whether by  
1342 the health maintenance organization or any third party acting on  
1343 behalf of such health maintenance organization, on payment of  
1344 any other claim of the provider on the basis of the overpayment  
1345 allegation.

1346 (a) If an overpayment determination is the result of  
1347 retrospective ~~retroactive~~ review or retrospective audit ~~of~~  
1348 ~~coverage decisions or payment levels not related to fraud~~, a  
1349 health maintenance organization shall adhere to the following  
1350 procedures:

1351        1. All overpayment claims ~~for overpayment~~ must be received  
1352 ~~by the~~ ~~submitted to a~~ provider within 18 30 months after the  
1353 health maintenance organization's payment of the claim. A  
1354 provider must pay, deny, or contest the health maintenance  
1355 organization's overpayment claim ~~for overpayment~~ within 40 days  
1356 after the receipt of the overpayment claim. All contested  
1357 overpayment claims ~~for overpayment~~ must be paid or denied within  
1358 120 days after receipt of the overpayment claim. Failure to pay  
1359 or deny an overpayment ~~and~~ claim within 140 days after receipt  
1360 creates an uncontestable obligation to pay the overpayment  
1361 claim.

1362        2. A provider that denies or contests a health maintenance  
1363 organization's overpayment claim ~~for overpayment~~ or any portion  
1364 of an overpayment ~~a~~ claim shall notify the health maintenance  
1365 organization, in writing, within 40 35 days after the provider  
1366 receives the overpayment claim that the overpayment claim ~~for~~  
1367 ~~overpayment~~ is contested or denied. The notice that the  
1368 overpayment claim ~~for overpayment~~ is denied or contested must  
1369 identify the denied or contested portion of the claim and the  
1370 specific reason for contesting or denying the overpayment claim  
1371 and, if contested, must include a request for additional  
1372 information. If the health maintenance organization submits  
1373 additional information, the health maintenance organization  
1374 must, within 35 days after receipt of the request, mail or  
1375 electronically transfer the information to the provider. The

1376 provider shall pay or deny the overpayment claim ~~for overpayment~~  
1377 within 45 days after receipt of the information. The notice from  
1378 the provider regarding denial or contestation of the overpayment  
1379 claim is considered made on the date the notice is mailed or  
1380 electronically transferred by the provider.

1381 3. The health maintenance organization is prohibited from  
1382 denying, reducing, offsetting, withholding, pending, or delaying  
1383 ~~may not reduce~~ payment to the provider for other services unless  
1384 the provider agrees to the denial, reduction, offset,  
1385 withholding, pending, or delay of payment in writing or fails to  
1386 respond to the health maintenance organization's overpayment  
1387 claim as required by this paragraph.

1388 4. Payment of an overpayment claim is considered made on  
1389 the date the payment was mailed or electronically transferred.  
1390 An overdue payment of a claim bears simple interest at the rate  
1391 of 12 percent per year. Interest on an overdue payment for an  
1392 overpayment ~~a claim for an overpayment payment~~ begins to accrue  
1393 when the overpayment claim should have been paid, ~~denied, or~~  
1394 ~~contested~~.

1395 (b) An overpayment ~~A~~ claim is prohibited for overpayment  
1396 ~~shall not be permitted~~ beyond 18 ~~30~~ months after the health  
1397 maintenance organization's payment of a claim, except that  
1398 overpayment claims ~~for overpayment~~ may be sought beyond that  
1399 time from providers convicted of fraud pursuant to s. 817.234.

1400 (7)-(6) Payment of a claim is considered made on the date

1401 the payment was mailed or electronically transferred to the  
1402 provider. An overdue payment of a claim bears simple interest of  
1403 15 12 percent per year, to be calculated upon the full total  
1404 amount that should have been paid on the claim within the  
1405 applicable time period specified in this section. If an  
1406 applicable court, arbitration tribunal, or other binding legal  
1407 process determines that a claim that was paid at a lesser amount  
1408 should have been paid at a full total amount, whether under a  
1409 breach of contract legal claim, a legal claim under a statutory  
1410 private cause of action, or other basis, the 15 percent per year  
1411 interest shall be calculated upon the full total amount, rather  
1412 than upon the difference between the full total amount and the  
1413 amount that was actually paid. If an applicable court,  
1414 arbitration tribunal, or other binding legal process determines  
1415 that a claim was subject to an inappropriate or impermissible  
1416 denial or partial denial, whether in a breach of contract,  
1417 statute, common law, or otherwise, interest shall be calculated  
1418 upon the full total amount that should have been paid on the  
1419 claim within the applicable time period for payment specified in  
1420 this section, and the act of denial or partial denial shall be  
1421 deemed not to have in any way tolled the time period for such  
1422 payment. Interest on the full total amount that should have been  
1423 paid on the claim within the applicable time period specified in  
1424 this section an overdue payment for a claim or for any portion  
1425 of a claim begins to accrue when the claim should have been

1426 paid, ~~denied, or contested.~~ The interest must be paid along  
1427 with, and in addition to, the payment for the satisfaction of  
1428 the full total amount of the claim, as determined by an  
1429 applicable court, arbitration tribunal, or other binding legal  
1430 process is payable with the payment of the claim.

1431 (8)~~(7)~~ For all contracts entered into or renewed on or  
1432 after October 1, 2002, a health maintenance organization's  
1433 internal dispute resolution process related to a denied claim  
1434 not under active review by a mediator, arbitrator, or third-  
1435 party dispute entity must be finalized within 60 days after the  
1436 receipt of the provider's request for review or appeal.

1437 Notwithstanding any provision of this section to the contrary,  
1438 if the provider and health maintenance organization disagree as  
1439 to the interpretation of contractual or statutory language, the  
1440 provider is not required to participate in the health  
1441 maintenance organization's internal dispute resolution process.

1442 (9)~~(8)~~ A provider or any representative of a provider,  
1443 regardless of whether the provider is under contract with the  
1444 health maintenance organization, is prohibited from collecting  
1445 or attempting ~~may not collect or attempt~~ to collect money from,  
1446 maintaining ~~maintain~~ any action at law against, or reporting  
1447 ~~report~~ to a credit agency an enrollee ~~a subscriber~~ for payment  
1448 of covered services for which the health maintenance  
1449 organization contested or denied the provider's claim. This  
1450 prohibition applies during the pendency of any claim for payment

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1451 made by the provider to the health maintenance organization for  
1452 payment of the services or internal dispute resolution process  
1453 to determine whether the health maintenance organization is  
1454 liable for the services. For a claim, this pendency applies from  
1455 the date the claim or a portion of the claim is denied to the  
1456 date of the completion of the health maintenance organization's  
1457 internal dispute resolution process, not to exceed 60 days. This  
1458 subsection does not prohibit collection by the provider of  
1459 copayments, coinsurance, or deductible amounts due the provider.

1460 ~~(9) The provisions of this section may not be waived,  
1461 voided, or nullified by contract.~~

1462 (10) A health maintenance organization is prohibited from  
1463 retrospectively denying ~~may not retroactively deny~~ a claim  
1464 because of enrollee subscriber ineligibility more than 90 days ~~1~~  
1465 ~~year~~ after the date of payment of the claim.

1466 (11) A health maintenance organization shall pay a  
1467 contracted primary care or admitting physician, pursuant to such  
1468 physician's contract, for providing inpatient services in a  
1469 contracted hospital to an enrollee a subscriber if such services  
1470 are determined by the primary care physician or admitting  
1471 physician ~~health maintenance organization~~ to be medically  
1472 necessary and such services are covered services under the  
1473 health maintenance organization's contract with the contract  
1474 holder.

1475 (12) A permissible error ratio of 5 percent is established

1476 for health maintenance organizations' claims payment violations  
1477 of paragraphs (3)(a), (b), (c), and (e) and (4)(a), (b), (c),  
1478 and (e). If the error ratio of a particular health maintenance  
1479 organization ~~insurer~~ does not exceed the permissible error ratio  
1480 of 5 percent for an audit period, no fine shall be assessed for  
1481 the noted claims violations for the audit period. The error  
1482 ratio shall be determined by dividing the number of claims with  
1483 violations found on a statistically valid sample of claims for  
1484 the audit period by the total number of claims in the sample. If  
1485 the error ratio exceeds the permissible error ratio of 5  
1486 percent, a fine may be assessed according to s. 624.4211 for  
1487 those claims payment violations which exceed the error ratio.  
1488 Notwithstanding the provisions of this section, the office may  
1489 fine a health maintenance organization for claims payment  
1490 violations of paragraphs (3)(e) and (4)(e) which create an  
1491 uncontestable obligation to pay the claim as submitted by the  
1492 provider. The office shall refrain from imposing a not fine upon  
1493 a health maintenance organization organizations for violations  
1494 which the office determines were due to circumstances beyond the  
1495 organization's control.

1496 (13) This section shall apply to all claims or any portion  
1497 of a claim submitted for payment for services provided to an  
1498 enrollee by a health maintenance organization subscriber under a  
1499 health maintenance organization plan, or submitted for payment  
1500 for services provided to an enrollee under a self-insured plan

1501 or fund, or fully-insured plan or fund, offered by a person or  
1502 entity, when a health maintenance organization is involved in  
1503 the administration, or claims-processing activities, relating to  
1504 such plan or fund subscriber contract to the organization for  
1505 payment.

1506 (14) Notwithstanding paragraph (3) (b), where an electronic  
1507 pharmacy claim is submitted to a pharmacy benefits manager  
1508 acting on behalf of a health maintenance organization, the  
1509 pharmacy benefits manager shall, within 30 days after ~~of~~ receipt  
1510 of the claim, pay the claim or notify a provider or designee if  
1511 a claim is denied or contested. Notice of the health maintenance  
1512 organization's action on the claim and payment of the claim is  
1513 considered to be made on the date the notice or payment was  
1514 received by the provider mailed or electronically transferred.

1515 (15) Notwithstanding paragraph (4) (a), effective November  
1516 1, 2003, where a nonelectronic pharmacy claim is submitted to a  
1517 pharmacy benefits manager acting on behalf of a health  
1518 maintenance organization, the pharmacy benefits manager shall  
1519 provide acknowledgment of receipt of the claim within 30 days  
1520 after receipt of the claim to the provider or provide a provider  
1521 within 30 days after receipt with electronic access to the  
1522 status of a submitted claim.

1523 (16) Notwithstanding the 18-month ~~30-month~~ period provided  
1524 in subsection (6) ~~(5)~~, all claims for overpayment submitted to a  
1525 provider licensed under chapter 395, chapter 458, chapter 459,

1526 chapter 460, chapter 461, chapter 463, chapter 466, or chapter  
1527 490 must be submitted to the provider within 12 months after the  
1528 health maintenance organization's payment of the claim. An  
1529 overpayment A claim to a provider licensed under chapter 395,  
1530 458, chapter 459, chapter 460, chapter 461, chapter 463, chapter  
1531 466, or chapter 490 is prohibited for overpayment may not be  
1532 permitted beyond 12 months after the health maintenance  
1533 organization's payment of a claim, except that claims for  
1534 overpayment may be sought beyond that time from providers  
1535 convicted of fraud pursuant to s. 817.234.

1536 (17) Notwithstanding any other provision of this section,  
1537 all claims for underpayment from a provider licensed under  
1538 chapter 395, chapter 458, chapter 459, chapter 460, chapter 461,  
1539 or chapter 466 must be submitted to the health maintenance  
1540 organization within 12 months after the health maintenance  
1541 organization's payment of the claim. A claim for underpayment by  
1542 a provider licensed under chapter 395, 458, chapter 459, chapter  
1543 460, chapter 461, or chapter 466 is prohibited may not be  
1544 permitted beyond 12 months after the health maintenance  
1545 organization's payment of a claim.

1546 (18) Nothing in this section shall be interpreted to  
1547 limit, restrict, or negatively impact any legal claim by a  
1548 provider or health maintenance organization for breach of  
1549 contract, statutory or regulatory violation, or a common-law  
1550 cause of action, nor to shorten or otherwise negatively impact

1551 the statute of limitations timeframe for bringing any such legal  
1552 claim.

1553 (19) A health insurer is prohibited from requesting  
1554 information from a contracted or noncontracted provider which  
1555 does not apply to the medical condition at issue for the  
1556 purposes of adjudicating a clean claim.

1557 (20) A health maintenance organization is prohibited from  
1558 requesting a contracted or noncontracted provider to resubmit  
1559 claim information that the contracted or noncontracted provider  
1560 can document it has already provided to the health maintenance  
1561 organization or that is contained inside the electronic medical  
1562 record to which the health maintenance organization has been  
1563 provided access.

1564 (21) Notwithstanding any other provision of this section  
1565 to the contrary, a health maintenance organization is prohibited  
1566 from requiring any information from a provider before the  
1567 provision of emergency health care services as a condition of  
1568 payment of a claim, as a basis for denying, delaying,  
1569 offsetting, withholding, or reducing payment of a claim, or in  
1570 contesting whether the claim is a clean claim.

1571 (22) In an instance of a violation of this section, a  
1572 provider shall have a private cause of action to proceed against  
1573 the health maintenance organization in the applicable tribunal  
1574 for the violation.

1575 **Section 5. Paragraph (c) of subsection (2) of section**

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1576 **395.1065, Florida Statutes, is amended to read:**

1577       395.1065 Criminal and administrative penalties;

1578 moratorium.—

1579 (2)

1580       (c) The agency may impose an administrative fine for the  
1581 violation of s. 641.3154 or, if sufficient claims due to a  
1582 provider from a health maintenance organization do not exist to  
1583 enable the take-back of an overpayment, as provided under s.  
1584 641.3155(6) ~~s. 641.3155(5)~~, for the violation of s. 641.3155(5)  
1585 ~~s. 641.3155(5)~~. The administrative fine for a violation cited in  
1586 this paragraph shall be in the amounts specified in s.  
1587 641.52(5), and the provisions of paragraph (a) do not apply.

1588       **Section 6.** This act shall take effect July 1, 2026.