

A bill to be entitled
An act relating to insurance claims payments to health care providers; amending s. 408.7057, F.S.; defining the terms "claim dispute" and "denied prior authorization request"; requiring the Agency for Health Care Administration to establish a program to assist health care providers and health plans in resolving claims of denied prior authorization requests; providing that the program is mandatory; revising the list of claims that are not reviewed by the program; prohibiting respondents from avoiding default by refusing to participate in the review process; requiring health plans to reimburse health care providers' costs in bringing claims under certain circumstances; requiring the agency to adopt rules; amending ss. 627.6131 and 641.315, F.S.; prohibiting contracts between health care providers and health insurers and health maintenance organizations, respectively, from specifying credit card payments to providers as the only acceptable method for payments; authorizing use of electronic funds transfers by health insurers and health maintenance organizations, respectively, for payments to providers under certain circumstances; providing notification requirements; prohibiting health insurers and health maintenance

HB 1023

2026

26 organizations, respectively, from charging fees for
27 automated clearinghouse transfers as claims payments
28 to providers; providing an exception; providing
29 applicability; prohibiting health insurers and health
30 maintenance organizations, respectively, from denying
31 claims subsequently submitted by providers for
32 procedures that were included in prior authorizations;
33 providing exceptions; providing applicability;
34 defining the term "provider"; providing an effective
35 date.

36
37 Be It Enacted by the Legislature of the State of Florida:

38
39 **Section 1. Section 408.7057, Florida Statutes, is amended**
40 **to read:**

41 408.7057 Statewide provider and health plan claim dispute
42 resolution program.—

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

44 (a) "Agency" means the Agency for Health Care
45 Administration.

46 (b) "Claim dispute" may include, but is not limited to, a
47 denied prior authorization request.

48 (c) "Denied prior authorization request" means a
49 determination by a health plan that a request submitted by a
50 provider for prior authorization of a health care service,

51 supply, or medication:

52 1. Has been wholly or partially denied;

53 2. Has not been acted upon within the time limits

54 established by law or contract; or

55 3. Has been approved subject to materially restrictive
56 conditions that prevent the service, supply, or medication from
57 being furnished as clinically indicated.

58 (d) ~~(b)~~ "Health plan" means a health maintenance
59 organization or a prepaid health clinic certified under chapter
60 641, a prepaid health plan authorized under s. 409.912, an
61 exclusive provider organization certified under s. 627.6472, or
62 a major medical expense health insurance policy, as defined in
63 s. 627.643(2) (e), offered by a group or an individual health
64 insurer licensed pursuant to chapter 624, including a preferred
65 provider organization under s. 627.6471.

66 (e) ~~(e)~~ "Resolution organization" means a qualified
67 independent third-party claim-dispute-resolution entity selected
68 by and contracted with the Agency for Health Care
69 Administration.

70 (2) (a) The agency shall establish a program to provide
71 assistance to contracted and noncontracted providers and health
72 plans for resolution of claim disputes that are not resolved by
73 the provider and the health plan. The agency shall contract with
74 a resolution organization to timely review and consider claim
75 disputes submitted by providers and health plans and recommend

76 to the agency an appropriate resolution of those disputes. The
77 agency shall establish by rule jurisdictional amounts and
78 methods of aggregation for claim disputes that may be considered
79 by the resolution organization.

80 (b) The dispute resolution program is a mandatory program,
81 and a provider or health plan may not opt out of the process.
82 The resolution organization shall review claim disputes filed by
83 contracted and noncontracted providers and health plans unless
84 the disputed claim:

85 1. Is related to interest payment;
86 2. Does not meet the jurisdictional amounts or the methods
87 of aggregation established by agency rule, as provided in
88 paragraph (a);
89 3. Is part of an internal grievance in a Medicare managed
90 care organization or a reconsideration appeal through the
91 Medicare appeals process;

92 4. Is related to a health plan that is not regulated by
93 the state;

94 5. Is part of a Medicaid fair hearing pursued under 42
95 C.F.R. ss. 431.220 et seq.;

96 6. Is the specific subject of an existing lawsuit filed
97 ~~basis for an action pending~~ in state or federal court before the
98 ~~submission of the claim to the resolution organization;~~ or

99 7. Is subject to a binding claim-dispute-resolution
100 process provided by contract entered into prior to October 1,

101 2000, between the provider and the managed care organization.

102 (c) Contracts entered into or renewed on or after October
103 1, 2000, may require exhaustion of an internal dispute-
104 resolution process as a prerequisite to the submission of a
105 claim by a provider or a health plan to the resolution
106 organization.

107 (d) A contracted or noncontracted provider or health plan
108 may not file a claim dispute with the resolution organization
109 more than 12 months after a final determination has been made on
110 a claim by a health plan or provider.

111 (e) The resolution organization shall require the health
112 plan or provider submitting the claim dispute to submit any
113 supporting documentation to the resolution organization within
114 15 days after receipt by the health plan or provider of a
115 request from the resolution organization for documentation in
116 support of the claim dispute. The resolution organization may
117 extend the time if appropriate. Failure to submit the supporting
118 documentation within such time period shall result in the
119 dismissal of the submitted claim dispute.

120 (f) The resolution organization shall require the
121 respondent in the claim dispute to submit all documentation in
122 support of its position within 15 days after receiving a request
123 from the resolution organization for supporting documentation.
124 The resolution organization may extend the time if appropriate.
125 Failure to submit the supporting documentation within such time

HB 1023

2026

126 period shall result in a default against the health plan or
127 provider. The respondent may not avoid default by declining to
128 participate in the review process provided in this section. In
129 the event of such a default, the resolution organization shall
130 issue its written recommendation to the agency that a default be
131 entered against the defaulting entity. The written
132 recommendation shall include a recommendation to the agency that
133 the defaulting entity shall pay the entity submitting the claim
134 dispute the full amount of the claim dispute, plus all accrued
135 interest, and shall be considered a nonprevailing party for the
136 purposes of this section.

137 (g)1. If on an ongoing basis during the preceding 12
138 months, the agency has reason to believe that a pattern of
139 noncompliance with s. 627.6131 and s. 641.3155 exists on the
140 part of a particular health plan or provider, the agency shall
141 evaluate the information contained in these cases to determine
142 whether the information evidences a pattern and report its
143 findings, together with substantiating evidence, to the
144 appropriate licensure or certification entity for the health
145 plan or provider.

146 2. In addition, the agency shall prepare a report to the
147 Governor and the Legislature by February 1 of each year,
148 enumerating: claims dismissed; defaults issued; and failures to
149 comply with agency final orders issued under this section.

150 (h) Either the contracted or noncontracted provider or the

151 health plan may make an offer to settle the claim dispute when
152 it submits a request for a claim dispute and supporting
153 documentation. The offer to settle the claim dispute must state
154 its total amount, and the party to whom it is directed has 15
155 days to accept the offer once it is received. If the party
156 receiving the offer does not accept the offer and the final
157 order amount is more than 90 percent or less than 110 percent of
158 the offer amount, the party receiving the offer must pay the
159 final order amount to the offering party and is deemed a
160 nonprevailing party for purposes of this section. The amount of
161 an offer made by a contracted or noncontracted provider to
162 settle an alleged underpayment by the health plan must be
163 greater than 110 percent of the reimbursement amount the
164 provider received. The amount of an offer made by a health plan
165 to settle an alleged overpayment to the provider must be less
166 than 90 percent of the alleged overpayment amount by the health
167 plan. Both parties may agree to settle the disputed claim at any
168 time, for any amount, regardless of whether an offer to settle
169 was made or rejected.

170 (3) The agency shall adopt rules to establish a process to
171 be used by the resolution organization in considering claim
172 disputes submitted by a provider or health plan which must
173 include:

174 (a) That the resolution organization review and consider
175 all documentation submitted by both the health plan and the

HB 1023

2026

176 provider;

177 (b) That the resolution organization's recommendation make
178 findings of fact;

179 (c) That either party may request that the resolution
180 organization conduct an evidentiary hearing in which both sides
181 can present evidence and examine witnesses, and for which the
182 cost of the hearing is equally shared by the parties;

183 (d) That the resolution organization may not communicate
184 ex parte with either the health plan or the provider during the
185 dispute resolution;

186 (e) That the resolution organization's written
187 recommendation, including findings of fact relating to the
188 calculation under s. 641.513(5) for the recommended amount due
189 for the disputed claim, include any evidence relied upon; and

190 (f) That the resolution organization issue a written
191 recommendation to the agency within 60 days after the requested
192 information is received by the resolution organization within
193 the timeframes specified by the resolution organization. In no
194 event shall the review time exceed 90 days following receipt of
195 the initial claim dispute submission by the resolution
196 organization.

197 (4) Within 30 days after receipt of the recommendation of
198 the resolution organization, the agency shall adopt the
199 recommendation as a final order. The final order is subject to
200 judicial review pursuant to s. 120.68.

HB 1023

2026

201 (5) The agency shall notify within 7 days the appropriate
202 licensure or certification entity whenever there is a violation
203 of a final order issued by the agency pursuant to this section.

204 (6) The entity that does not prevail in the agency's order
205 must pay a review cost to the review organization, as determined
206 by agency rule. Such rule must provide for an apportionment of
207 the review fee in any case in which both parties prevail in
208 part. If the nonprevailing party fails to pay the ordered review
209 cost within 35 days after the agency's order, the nonpaying
210 party is subject to a penalty of not more than \$500 per day
211 until the penalty is paid.

212 (7) If a claim dispute under this section involves a
213 denied prior authorization request and the health plan is
214 determined to be the nonprevailing party, the health plan shall
215 reimburse the provider for the provider's reasonable costs
216 incurred in bringing the claim, including any filing fees and
217 administrative costs assessed by the agency or its designee. The
218 agency shall adopt rules to specify allowable costs and
219 procedures for cost recovery under this subsection.

220 (8)-(7) The agency may adopt rules to administer this
221 section.

222 **Section 2. Subsections (20) and (21) of section 627.6131,
223 Florida Statutes, are amended to read:**

224 627.6131 Payment of claims.—

225 (20) (a) A contract between a health insurer and a dentist

226 licensed under chapter 466 or a provider for the provision of
227 services to an insured may not specify credit card payment as
228 the only acceptable method for payments from the health insurer
229 to the dentist or provider.

230 (b) When a health insurer employs the method of claims
231 payment to a dentist or provider through electronic funds
232 transfer, including, but not limited to, virtual credit card
233 payment, the health insurer shall notify the dentist or provider
234 as provided in this paragraph and obtain the dentist's or
235 provider's consent before employing the electronic funds
236 transfer. The dentist's or provider's consent described in this
237 paragraph applies to the dentist's or provider's entire
238 practice. For the purpose of this paragraph, the dentist's or
239 provider's consent, which may be given through e-mail, must bear
240 the signature of the dentist or provider. Such signature
241 includes an electronic or digital signature if the form of
242 signature is recognized as a valid signature under applicable
243 federal law or state contract law or an act that demonstrates
244 express consent, including, but not limited to, checking a box
245 indicating consent. The health insurer or the dentist or
246 provider may not require that a dentist's or provider's consent
247 as described in this paragraph be made on a patient-by-patient
248 basis. The notification provided by the health insurer to the
249 dentist or provider must include all of the following:

250 1. The fees, if any, associated with the electronic funds

251 transfer.

252 2. The available methods of payment of claims by the
253 health insurer, with clear instructions to the dentist or
254 provider on how to select an alternative payment method.

255 (c) A health insurer that pays a claim to a dentist or
256 provider through automated clearinghouse transfer may not charge
257 a fee solely to transmit the payment to the dentist or provider
258 unless the dentist or provider has consented to the fee.

259 (d) This subsection applies to all contracts:

260 1. Between a health insurer and a dentist which are
261 delivered, issued, or renewed on or after January 1, 2025.

262 2. Between a health insurer and a provider which are
263 delivered, issued, or renewed on or after January 1, 2027.

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

266 (f) The commission may adopt rules to implement this
267 subsection.

268 (g) As used in this subsection, the term "provider" has
269 the same meaning as the term "health care provider" in s.
270 381.00321(1).

271 (21) (a) A health insurer may not deny any claim
272 subsequently submitted by a dentist licensed under chapter 466
273 or a provider for procedures specifically included in a prior
274 authorization unless at least one of the following circumstances
275 applies for each procedure denied:

276 1. Benefit limitations, such as annual maximums and
277 frequency limitations not applicable at the time of the prior
278 authorization, are reached subsequent to issuance of the prior
279 authorization.

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

282 3. Subsequent to the issuance of the prior authorization,
283 new procedures are provided to the patient or a change in the
284 condition of the patient occurs such that the prior authorized
285 procedure would no longer be considered medically necessary,
286 based on the prevailing standard of care.

287 4. Subsequent to the issuance of the prior authorization,
288 new procedures are provided to the patient or a change in the
289 patient's condition occurs such that the prior authorized
290 procedure would at that time have required disapproval pursuant
291 to the terms and conditions for coverage under the patient's
292 plan in effect at the time the prior authorization was issued.

293 5. The denial of the claim was due to one of the
294 following:

295 a. Another payor is responsible for payment.
296 b. The dentist or provider has already been paid for the
297 procedures identified in the claim.

298 c. The claim was submitted fraudulently, or the prior
299 authorization was based in whole or material part on erroneous
300 information provided to the health insurer by the dentist or

301 provider, patient, or other person not related to the insurer.

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

304 e. The services were provided during the grace period
305 established under s. 627.608 or applicable federal regulations,
306 and the ~~dental~~ insurer notified the dentist or provider that the
307 patient was in the grace period when the dentist or provider
308 requested eligibility or enrollment verification from the ~~dental~~
309 insurer, if such request was made.

310 (b) This subsection applies to all contracts:

311 1. Between a health insurer and a dentist which are
312 delivered, issued, or renewed on or after January 1, 2025.

313 2. Between a health insurer and a provider which are
314 delivered, issued, or renewed on or after January 1, 2027.

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

317 (d) The commission may adopt rules to implement this
318 subsection.

319 (e) As used in this subsection, the term "provider" has
320 the same meaning as the term "health care provider" in s.
321 381.00321(1).

322 **Section 3. Subsections (13) and (14) of section 641.315,**
323 **Florida Statutes, are amended to read:**

324 641.315 Provider contracts.—

325 (13) (a) A contract between a health maintenance

326 organization and a dentist licensed under chapter 466 or a
327 provider for the provision of services to a subscriber of the
328 health maintenance organization may not specify credit card
329 payment as the only acceptable method for payments from the
330 health maintenance organization to the dentist or provider.

331 (b) When a health maintenance organization employs the
332 method of claims payment to a dentist or provider through
333 electronic funds transfer, including, but not limited to,
334 virtual credit card payment, the health maintenance organization
335 shall notify the dentist or provider as provided in this
336 paragraph and obtain the dentist's or provider's consent before
337 employing the electronic funds transfer. The dentist's or
338 provider's consent described in this paragraph applies to the
339 dentist's or provider's entire practice. For the purpose of this
340 paragraph, the dentist's or provider's consent, which may be
341 given through e-mail, must bear the signature of the dentist or
342 provider. Such signature includes an electronic or digital
343 signature if the form of signature is recognized as a valid
344 signature under applicable federal law or state contract law or
345 an act that demonstrates express consent, including, but not
346 limited to, checking a box indicating consent. The health
347 maintenance organization or the dentist or provider may not
348 require that a dentist's or provider's consent as described in
349 this paragraph be made on a patient-by-patient basis. The
350 notification provided by the health maintenance organization to

351 the dentist or provider must include all of the following:

352 1. The fees, if any, that are associated with the
353 electronic funds transfer.

354 2. The available methods of payment of claims by the
355 health maintenance organization, with clear instructions to the
356 dentist or provider on how to select an alternative payment
357 method.

358 (c) A health maintenance organization that pays a claim to
359 a dentist or provider through automated clearinghouse ~~Clearing~~
360 ~~House~~ transfer may not charge a fee solely to transmit the
361 payment to the dentist or provider unless the dentist or
362 provider has consented to the fee.

363 (d) This subsection applies to all contracts:

364 1. Between a health maintenance organization and a dentist
365 which are delivered, issued, or renewed on or after January 1,
366 2025.

367 2. Between a health maintenance organization and a
368 provider which are delivered, issued, or renewed on or after
369 January 1, 2027.

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

372 (f) The commission may adopt rules to implement this
373 subsection.

374 (g) As used in this subsection, the term "provider" has
375 the same meaning as the term "health care provider" in s.

376 381.00321(1).

377 (14) (a) A health maintenance organization may not deny any
378 claim subsequently submitted by a dentist licensed under chapter
379 466 or a provider licensed for procedures specifically included
380 in a prior authorization unless at least one of the following
381 circumstances applies for each procedure denied:

382 1. Benefit limitations, such as annual maximums and
383 frequency limitations not applicable at the time of the prior
384 authorization, are reached subsequent to issuance of the prior
385 authorization.

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

388 3. Subsequent to the issuance of the prior authorization,
389 new procedures are provided to the patient or a change in the
390 condition of the patient occurs such that the prior authorized
391 procedure would no longer be considered medically necessary,
392 based on the prevailing standard of care.

393 4. Subsequent to the issuance of the prior authorization,
394 new procedures are provided to the patient or a change in the
395 patient's condition occurs such that the prior authorized
396 procedure would at that time have required disapproval pursuant
397 to the terms and conditions for coverage under the patient's
398 plan in effect at the time the prior authorization was issued.

399 5. The denial of the claim was due to one of the
400 following:

401 a. Another payor is responsible for payment.

402 b. The dentist or provider has already been paid for the

403 procedures identified in the claim.

404 c. The claim was submitted fraudulently, or the prior

405 authorization was based in whole or material part on erroneous

406 information provided to the health maintenance organization by

407 the dentist or provider, patient, or other person not related to

408 the organization.

409 d. The person receiving the procedure was not eligible to

410 receive the procedure on the date of service.

411 e. The services were provided during the grace period

412 established under s. 627.608 or applicable federal regulations,

413 and the health maintenance organization dental insurer notified

414 the dentist or provider that the patient was in the grace period

415 when the dentist or provider requested eligibility or enrollment

416 verification from the health maintenance organization dental

417 insurer, if such request was made.

418 (b) This subsection applies to all contracts:

419 1. Between a health maintenance organization and a dentist

420 which are delivered, issued, or renewed on or after January 1,

421 2025.

422 2. Between a health maintenance organization and a

423 provider which are delivered, issued, or renewed on or after

424 January 1, 2027.

425 (c) The office has all rights and powers to enforce this

HB 1023

2026

426 subsection as provided by s. 624.307.

427 (d) The commission may adopt rules to implement this
428 subsection.

429 (e) As used in this subsection, the term "provider" has
430 the same meaning as the term "health care provider" in s.
431 381.00321(1).

432 **Section 4.** This act shall take effect July 1, 2026.