The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Banking and Insurance

BILL:	CS/SB 1082
INTRODUCER:	Health Policy Committee and Senator Grall and others
SUBJECT:	Statewide Provider and Health Plan Claim Dispute Resolution Program
DATE:	February 3, 2026 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Ranier	Brown	HP	**Fav/CS**
2.	Johnson	Knudson	BI	**Pre-meeting**
3.			RC	

Please see Section IX. for Additional Information:

PLEASE MAKE SELECTION

I. Summary:

CS/SB 1082 amends the Statewide Provider and Health Plan Dispute Resolution Program under s. 408.7057, F.S. The bill adds two additional matters to the list of health services claims which may not be reviewed by the program. First, it excludes any claim involving emergency care by a licensed hospital if the claim was submitted to the federal independent dispute resolution process and also meets the criteria for the federal process. Second, it excludes any claim by an out-of-network provider if the claim was submitted to the federal independent dispute resolution process and also meets the criteria for the federal process.

By excluding these claims from the state's dispute resolution program, such claims would presumably no longer be excluded from the federal independent dispute review (IDR) program, which provides that the federal IDR process is not available to the disputing parties when there is a "specified state law" for resolving disputed claims.

The bill provides an effective date of July 1, 2026.

II. Present Situation:

Balance Billing and Surprise Billing

In 1999 the Florida Legislature established the Advisory Group on Submission and Payment of Health Claims. The Advisory Group was to review and provide recommendations as to prompt

payment of health insurance claims. The group submitted a report to the Legislature on February 1, 2000.[1]

The report dealt, in part, with concerns as to "balance billing." Balance billing occurs when a health care provider seeks to collect from the member/subscriber of a health plan, the difference between what the provider charges and what is paid by the health plan. The report noted that in 1988, the Legislature passed s. 641.315, F.S., which prohibits a provider of services from billing a member of a health maintenance organization (HMO) for any service that is covered by the HMO. It was further noted that there was some ambiguity whether the prohibition on subscriber billing applied to health care providers who did not have a contract with the HMO; i.e. noncontracted or out-of-network providers.[2]

The report also recognized that the Agency for Health Care Administration (AHCA) had performed an emergency room claims payment survey and that there were some methodology concerns with the survey. It was acknowledged that s. 395.1041, F.S., provides for universal access to hospital emergency departments.[3] In 1986, the U.S. Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA). The EMTALA imposes obligations for hospitals that have Medicare contracts to provide emergency services to all patients who are present at an emergency department. Section 395.1041, F.S., extends such EMTALA obligations to all Florida hospitals with an emergency department.

The report noted some billing code problems with emergency department claims. Also, a concern was recognized that not all providers in the emergency department necessarily had contracts with a patient's HMO for services, e.g. anesthesia, physicians, radiology, and pathology.

The report further noted the Statewide Provider and Subscriber Assistance Program. However, the program only addressed grievances that HMO members had with their HMO and providers within the HMO's provider network. The program was limited to quality of care concerns and did not apply to payment issues. Disputes between the provider, HMO, and members as to payment of claim were not within the jurisdiction of the program.[4]

In 2000, the Legislature adopted ch. 2000-252, Laws of Florida, which addressed many of the concerns raised in the report. In particular, as to the balance billing issues, s. 641.315, F.S., was amended to recognize that a provider who has a contract with an HMO cannot balance bill a member of the HMO. The amendment did not address whether the HMO was liable for non-authorized care such as emergency care and treatment.[5]

Next, the 2000 law created a new s. 641.3154, F.S., which established that if a noncontracted provider follows an HMO's authorization procedures and receives authorization, then the HMO is solely liable for the payment, and the provider may not balance bill the HMO member.

---

[1] Senate Staff Analysis, SB 1508 and 706 and 2234, Apr. 26, 2000, available at: https://www.flsenate.gov/Session/Bill/2000/1508/Analyses/20001508SFP_SB1508.fp.pdf
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*

However, the law was unclear whether the HMO would be liable to noncontracted providers who did not obtain authorization when providing emergency care and treatment.[6]

The 2000 law also adopted a new s. 408.7057, F.S., which created the Statewide Provider and Managed Care Organization Claim Dispute Resolution Program. The program was to be administered by the AHCA and established by January 1, 2001. The AHCA was required to contract with an independent third-party claims dispute resolution organization. The resolution organization would provide assistance and review of claims disputes between providers, both contracted and noncontracted, and managed care organizations. The AHCA was directed to adopt rules for jurisdictional amounts for claims, batching of claims, the process to submit and review claim disputes, and the issuing of recommendations.

Within 30 days of the resolution organization issuing its recommendations, the AHCA is required to issue a final order. The 2000 law also contained a list of claims parameters which were not subject to dispute resolution by the program.[7] It is this last requirement, i.e. the list of exclusions,[8] which is the subject of SB 1082.

In 2002, the Legislature amended s. 408.7057, F.S., to change the name of the program to Statewide Provider and Health Plan Claim Dispute Resolution Program. The scope of managed care plans and insurers who could participate in the program was expanded significantly. There were also timeframes established for various parts of the process, i.e., submittal of the claim, submittal of supporting documentation, and review time by the resolution organization. A default process was provided. The authority was provided to the AHCA to report health plans or health care providers who had a 12-month pattern of noncompliance with Florida's Prompt Pay Law[9] to their applicable licensing or certification entity. Also, if the AHCA issued a final order pursuant to the resolution process, and the final order was not paid or was otherwise violated, then the AHCA is to notify in seven days the appropriate licensing or certification entity of the offender about the offender's noncompliance. Lastly, the AHCA was to directed to annually report to the Governor and Legislature, by February 1 of each year, the number of claims dismissed, defaults issued, and failure to comply with the AHCA's final orders on award amounts.[10]

In 2016, the Legislature again considered the issues of balance billing in a number of different bills. For this round of law making, the issue was referred to as "Surprise Billing." Surprise billing was recognized as patient encounters in which:

- An HMO member or health insurance policy holder utilizes an in-network hospital but is billed by noncontracted providers who provide services at such hospital or are consulted by a network physician. This could happen in the emergency or nonemergency scenario.
- An HMO member or health insurance policy holder receives out-of-network emergency care from an out-of-network hospital.[11]

---

[6] *Id.*
[7] Chapter 2000-252, Laws of Florida, pp 10-12.
[8] Section 408.7057,(2)(b), F.S.
[9] Sections 627.6131 and 641.3155, F.S.
[10] Chapter 2002-389, Laws of Florida, pp 9-12.
[11] House Staff Analysis, HB 221,April 15, 2016, available at: https://www.flsenate.gov/Session/Bill/2016/221/Analyses/h0221z1.IBS.PDF

The Legislature adopted ch. 2016-222, Laws of Florida. The 2016 law required all hospitals to post on their websites those health plans with which they are a contracted network provider. In addition, a hospital was required to deliver a statement to patients that the patient has the obligation to determine which health care providers involved in their care are contracted with the patient's health plan.

Next, the 2016 law recognized that the obligation to provide emergency care is a mandated coverage under Florida law and made changes to ensure such mandated coverage for emergency services covered all types of health plans and insurers, not just HMOs.[12] All providers, whether contracted or noncontracted, who provide emergency services are to be paid by the health plan.[13]

If nonemergency care is provided by an in-network hospital which has noncontracted providers, then for any covered services, the health plan must likewise cover such services.[14] Lastly, the 2016 law provided that any dispute by a nonparticipating provider only has jurisdiction in a court of competent jurisdiction or "through the voluntary dispute resolution process in s. 408.7057, F.S."[15]

Finally, amendments were made to s. 408.7057, F.S., in 2016.[16] A subsection was added for a settlement process. Authorization was provided that the resolution organization could receive witnesses, evidence, and conduct a hearing. *Ex parte* communication with the dispute organization was prohibited. The resolution organization was required to issue a written recommendation with findings of fact, its method of calculating any award, and to indicate what evidence it relied upon. Lastly, jurisdiction was provided to review any final order pursuant to s.120.68, F.S.

In 2022, the Legislature expanded the scope of the dispute resolution process to pharmacies.[17]

Statewide Provider and Health Plan Claim Dispute Resolution Program

The AHCA has been administering the program for approximately 25 years and has developed a website for access to the program.[18] The dispute resolution entity is Capitol Bridge, LLC.[19] Rule 59A-12.030, F.A.C. has been published as to the program's administration. The rule provides the following categories of claims which are to be submitted:

- Hospital inpatient services claims.

[12] Chapter 2016-222, Laws of Florida, pp 6- 8.
[13] *Id*.
[14] Sections 627.64194(3) and 641.3154, F.S.
[15] Section 627.64193(6), F.S. It is unclear whether such jurisdictional requirement applies to HMOs.
[16] *Id* at Section 7, (pages 3-5)
[17] Agency for Health Care Administration, Statewide Provider and Health Plan Claim Dispute Program, 2024 Annual Report; page 1, available at: https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/commercial-managed-care/statewide-provider-and-health-plan-claim-dispute-resolution-program (last visited Jan. 23, 2026)
[18] Available at: https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/commercial-managed-care/statewide-provider-and-health-plan-claim-dispute-resolution-program (last visited Jan. 23, 2026)
[19] Capitol Bridge, LLC is also a certified independent dispute resolution entity for the federal No Surprises Act process. *See:* https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list (last visited Jan. 23, 2026)

- Hospital outpatient services claims.
- Professional services claims.

Pursuant to s. 408.7057, F.S., and the rule, a claim is not eligible for the program if the claim:

- Is related to interest payment;
- Does not meet the following jurisdictional amounts[20];
  - Hospital inpatient claims: a total amount of $25,000 + for health plan contracted hospitals and $10,000 +for non-contracted hospitals
  - Hospital outpatient claims: a total amount of $10,000 +for health plan contracted hospitals, and $3,000 + for non-contracted hospitals
  - Professional Services: a minimum amount of $500 +
- Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;
- Is related to a health plan that is not regulated by the state;
- Is part of a Medicaid fair hearing pursued under 42 C.F.R. ss. 431.220 et seq;
- Is the basis for an action pending in state or federal court;
- Is subject to a binding claim-dispute-resolution process provided by contract entered into prior to October 1, 2000, between the provider and the managed care organization;
- Arises under a contract that requires exhaustion of an internal dispute-resolution process as a prerequisite to the submission of a claim by a provider or a health plan to the resolution organization; or
- Is a disputed claim which is more than 12 months after a final determination has been made on a claim by a health plan or provider.

The annual reports which the AHCA has submitted to the Legislature contain the following statistics.[21]

Year	Number of Claims Submitted	Number of Claims Deemed Eligible	Claims Range
2025	162	125	$2,936.13 to $10,573,672.15
2024	77	58	$396.45 to $22,379,900.00
2023	296	137	$34.44 to $10,879.6660
2022	563	443	$539.17 to $1,001,694,838.00
2021	111	73	$893.19 to $2,320399.58

Federal No Surprises Act Independent Resolution Process (IDR)

The federal government has been likewise active in legislating in this area. In 1986, the genesis of this legislative matter commenced with the adoption of Emergency Medical Treatment and

[20] Claims can be aggregated to reach these jurisdictional amounts. Rule, 59A-12.030(5)(c), F.A.C. Rural hospitals are exempt from such aggregation requirement. Rule, 59A-12.030(5)(d), F.A.C.

[21] The annual reports are available at: https://ahca.myflorida.com/health-quality-assurance/bureau-of-health-facility-regulation/certificate-of-need-and-commercial-managed-care-unit/commercial-managed-care/statewide-provider-and-health-plan-claim-dispute-resolution-program (last visited Jan. 23, 2026)

Active Labor Act (EMTALA).[22] The EMTALA requires hospitals that participate in the Medicare program, and which offer emergency services must provide medical screening and stabilization to any person who presents with an emergency medical condition or active labor, regardless of the ability to pay or payor source. Florida adopted a very similar requirement in s. 395.1041, F.S., but extended it to all hospitals as a condition of licensure. The AHCA has the full range of administrative remedies and sanctions for any violation, from licensure revocation to fines up to $10,000 per violation.[23] Criminal sanctions can be imposed against hospital administrative or medical staff for violations.[24] In addition, physicians licensed under ch. 458 or 459, F.S., who violate the statute can be fined.[25] Lastly, a private cause of action can be asserted against a hospital or licensed physician who violates the statute.[26]

Numerous disputes between health plans and insurers, and hospitals or health care providers have been filed as to the payment of claims for patients who presented to noncontracted hospitals and providers. Florida law was at the forefront of resolving the issue of payment liability for such patients. Florida holds the patient harmless and requires the hospital or health care provider to either resort to a suit in court or dispute resolution through the Statewide Provider and Health Plan Claim Dispute Resolution Program.[27]

The federal government, in 2010, began legislating on these topics with adoption of the Patient Protection and Affordable Care Act (ACA).[28] The ACA provided, in part, that health plans, if they offered any coverage for emergency benefits, could not require prior authorization nor the use of only contracted providers for emergency services.[29] However, the ACA did not prohibit balance billing. Rather, it provides for a cost sharing requirement by the patient, and a minimum rate that health plans are to reimburse noncontracted providers.[30] Yet, the ACA provides that such cost sharing requirements do not apply if state law prohibits balance billing or the plan is contractually liable for the payment.[31]

The federal government again addressed these issues in 2020 with the adoption of the "No Surprises Act" (NSA).[32] This was a comprehensive approach by Congress as to the patient, provider, and payor issues concerning surprise billing for emergency services. The NSA covers situations where a patient receives an unexpected medical bill from a noncontracted provider

[22] 42 U.S.C. §1395dd.; see also Centers for Medicare & Medicaid Services, Emergency Medical Treatment & Labor Act (EMTALA), http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/emtala/ (last visited Jan. 23, 2026)
[23] Section 395.1041(5)(a), F.S.
[24] Section 395.1041(5)(c), F.S.
[25] Section 395.1041(5)(e), F.S.
[26] Section 395.1041(5)(b), F.S.
[27] Sections 627.64194 and 641.3154, F.S.
[28] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, H.R. 3590, 11th Cong. (March 23, 2010). On March 30, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010; 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92, and 300gg–111 through 300gg–139.
[29] 42 C.F.R. § 147.138(b)
[30] 42 C.F.R. § 147.138(b)(3)
[31] House Staff Analysis, HB 221, April 15, 2016.
[32] PL 116-260, December 27, 2020, 134 Stat 1182, Consolidated Appropriations Act, 2021, Division BB - Title I sections 101 through 118; 42 U.S.C. § 300gg-111.

without having had a chance to select a contracted provider, e.g. medical emergency.[33] Federal protections are now provided for patients against surprise billing, and a patient has to only pay the same co-pays or coinsurance amount as if they had presented to a contracted provider.[34]

Providers and health plan payment disputes were also addressed by the NSA. A health plan is required to pay the amount determined by a "specified state law" or, if there is no specified state law, the amount they negotiate, or as determined by an "independent dispute review" (IDR) program set forth in federal rule. The health plan must make a payment within 30 days of receiving a claim from a noncontracted provider or deny the claim. If either party disputes the payment amount or denial of claim, the party must notify the other party that they want to negotiate. The parties have 30 business days to openly negotiate. If, after this 30-day period, the parties are unable to agree, they then can submit the claims to the federal IDR.[35] A determination is made by a certified IDR entity. The determination is binding on the parties and is subject to judicial review in very limited circumstances.[36]

The federal IDR recently has commenced activity. There are 15 entities certified for accepting disputes.[37] At the start of 2025, there were more than 600,000 disputes awaiting determination.[38] The IDR at times receives over 200,000 disputes a month for resolution.[39] Nevertheless, 90 percent of all disputes submitted have been resolved.[40] The program will be adding more certified IDR entities and updating its web portal to streamline operations.[41]

A significant part of the workload of the federal IDR process is determining if a dispute is eligible for determination. In approximately 45 percent of the cases, the non-initiating party challenges the eligibility.[42, 43] Even if not challenged, the IDR entity must still review and

---

[33] Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties October 2022, page 4, available at: https://www.cms.gov/files/document/federal-independent-dispute-resolution-guidance-disputing-parties.pdf
[34] *Id.*
[35] Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties, October 2022, page 4.
[36] 42 U.S.C.A. § 300gg-111(c)(5)(E)
[37] Centers for Medicare & Medicaid Services, Fact Sheet: Clearing the Independent Dispute Resolution Backlog, September 2025, available at: https://www.cms.gov/files/document/fact-sheet-clearing-independent-dispute-resolution-backlog.pdf
[38] *Id.*
[39] Centers for Medicare & Medicaid Services, Independent Dispute Resolution Reports, available at: https://www.cms.gov/nosurprises/policies-and-resources/reports (last visited Jan. 23, 2026)
[40] Centers for Medicare & Medicaid Services, Fact Sheet: Clearing the Independent Dispute Resolution Backlog, September 2025
[41] *Id*.
[42] Supplemental Background on Federal Independent Dispute Resolution Public Use Files January 1, 2024 – June 30, 2024, available at: https://www.cms.gov/files/document/supplemental-background-federal-idr-puf-january-1-june-30-2024-march-18-2025.pdf
[43] There has been litigation concerning the question of eligibility at both the state and federal levels. In the State of Florida, the case of *Blue Cross Blue Shield of Fla., Inc. v. Outpatient Surgery Ctr. of St. Augustine*, 66 So. 3d 952(Fla. 1st DCA 2011), raised the question of whether a non-initiating could opt-out of the State IDR. It was held that a non-initiating party could "opt out" at any time before fact finding, by filing a complaint in court. *Id*. There was a dissent that questioned whether the statutes truly allow opting out. At the federal level, there has been a significant amount of recent litigation by health plans asserting that providers are using the federal IDR to flood the plans with claims that are ineligible and are getting improper IDR awards. Anthem sues 11 Prime hospitals, alleges $15M in fraudulent No Surprises Act awards, January 7, 2026. *See:* https://www.beckerspayer.com/legal/anthem-sues-11-prime-hospitals-alleges-15m-in-fraudulent-no-surprises-act-awards/ (last visited Jan. 23, 2026)

determine eligibility of a claim.[44] The volume of claims found ineligible has ranged between 18 percent and 22 percent.[45]

One basis for ineligibility is that a state law establishes the method for determining the dispute.[46] The federal IDR Process is not available to the disputing parties when there is a "specified state law." The NSA defines "specified state law" as follows.[47]

> The term "specified State law" means, with respect to a State, an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a State law that provides for a method for determining the total amount payable under such a plan, coverage, or issuer, respectively (to the extent such State law applies to such plan, coverage, or issuer, subject to section 1144 of Title 29) in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such a nonparticipating provider or nonparticipating emergency facility.

Pursuant to 45 CFR 149.620(h), the U.S. Department of Health and Human Services will defer to a state's patient-provider dispute resolution process if the state has a state law that meets the following minimum requirements with respect to the item or service for which payment is in dispute:

- Payment determinations made through the state process are binding, unless the provider, facility, or provider of air ambulance services offers for the uninsured (or self-pay) individual to pay a lower payment amount than the determination amount;
- The dispute resolution process takes into consideration a good faith estimate, that meets the minimum standards established in 45 CFR 149.610, provided by the provider, facility, or provider of air ambulance services to the uninsured (or self-pay) individual;
- If the state charges a fee to uninsured (or self-pay) individuals to participate in the patient-provider dispute resolution process, the fee must be equal to or less than the federal administrative fee; and
- The state must have in place a conflict-of-interest standard that, at a minimum, meets the requirements at 45 CFR 149.620(d) and (e).

CMS will review changes to the state process on an annual basis (or at other times if CMS receives information from the state that would indicate the state process no longer meets the minimum federal requirements) to ensure the state process continues to meet or exceed the minimum federal standards. [48]

---

[44] Federal Independent Dispute Resolution Process –Status Update, April 27, 2023, available at: https://www.cms.gov/files/document/federal-idr-processstatus-update-april-2023.pdf
[45] Supplemental Background on Federal Independent Dispute Resolution Public Use Files January 1, 2024 – June 30, 2024.
[46] Federal Independent Dispute Resolution (IDR) Process Guidance for Disputing Parties October 2022, page 6.
[47] 42 U.S.C.A. § 300gg-111(3)(I)
[48] *See:* CMS Letter, (Jan. 28, 2022), available at: https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/caa-enforcement-letters-florida.pdf

Florida has confirmed the fact that it has the requisite "specified state law" for resolving disputed claims. In June 2021, the federal Centers for Medicare & Medicaid Services (CMS) sent a written survey to the State of Florida as to the state's assessment of which provisions of the NSA it will enforce with state laws.[49]

In answering whether the State has the authority and intended to enforce its laws as to out-of-network rates and the resolution of such claims, the AHCA, the Florida Office of Insurance Regulation, and the Department of Health stated that ss. 408.7057, 627.42397, 627.64194(4), 627.64194(6), 641.513(5), and 641.514, F.S., and Rule 59A-12.030, F.A.C., would apply.[50] Specifically, the state will determine the out-of-network rate with respect to items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Florida, as well as a claim dispute payment amounts pertaining to health maintenance organizations that are above the claim threshold described in Rule 59A-12.030, F.A.C, and by nonparticipating providers or nonparticipating emergency facilities.[51]

Claims under the jurisdictional amounts set forth in Rule 59A-12.030, F.A.C are subject to the federal IDR process. Further, the federal IDR process applies for purposes of determining the out-of-network rate with respect to services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in Florida by nonparticipating providers of air ambulance services.[52] In regard to patient-provider disputes, the federal patient-provider dispute process applies for determining the amount an uninsured (or self-pay) individual must pay a provider.[53]

The CMS has published a "Chart for Determining Applicability for Federal Independent Dispute Resolution (IDR) Process."[54] The chart indicates for which states the federal IDR process does not apply to claims. Disputes that have the requisite nexus with the State of Florida, along with 20 other states, are listed as not being available for the federal IDR.[55]

III. Effect of Proposed Changes:

Section 1 amends s. 408.7057(2)(b), F.S., to add to the current list of claims which are not to be reviewed by the Florida dispute resolution program. Added claims to be excluded are:

- Service for emergency services provided under EMTALA, i.e. 42 U.S.C. s. 1395dd, or s. 395.1041, F.S., and have been submitted to the federal independent dispute resolution process, while also meeting the criteria for the federal process.
- Services rendered by out-of-network providers and have been submitted to the federal independent dispute resolution process, while also meeting the criteria for the federal process.

[49] *Id* at page 5.
[50] *Id* at page 5.
[51] *Id* at page 5.
[52] *Id* at page 5.
[53] *Id* at page 5.
[54] *See:* https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/consolidated-appropriations-act-2021-caa (last visited Jan. 23, 2026)
[55] To change this designation, the State of Florida would have to apply to CMS and comply with the No Surprises Act regulations found at 45 C.F.R. Part 149. Under CS/SB 1082, Florida claims could be eligible to file in either the Federal or State IDR process.

By excluding these claims from the state's dispute resolution program, such claims would presumably no longer be excluded from the federal independent dispute program, which provides that the federal IDR process is not available to the disputing parties when there is a "specified state law" for resolving disputed claims.

Section 2 provides for an effective date of July 1, 2026.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 408.7057 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

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

CS by Health Policy on January 26, 2026:
The committee substitute alters the underlying bill's criteria for claims to be excluded from the state's claim dispute resolution program by providing that such claims are excluded from the state process if they have been submitted to the federal dispute resolution process and meet the criteria for the federal process. The underlying bill omits the latter condition.

B. Amendments:

None.