By Senator Massullo

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A bill to be entitled

An act relating to health insurance claims; amending s. 408.7057, F.S.; defining the term "denied prior authorization request"; expanding the scope of the statewide provider and health plan claim dispute resolution program to include resolution of denied prior authorization requests; providing that participation in the program is mandatory and prohibiting providers and health plans from opting out of the claim dispute resolution process; revising circumstances under which a claim dispute is exempt from the program's claim dispute resolution process; providing that respondents in claim disputes may not avoid imposition of a default by declining to participate in the claim dispute resolution process; providing for reimbursement of reasonable costs to providers if the health plan is determined to be the nonprevailing party in a claim dispute involving a denied prior authorization request; requiring the Agency for Health Care Administration to adopt certain rules; amending ss. 627.6131 and 641.315, F.S.; prohibiting contracts between certain physicians and health insurers and health maintenance organizations, respectively, from specifying credit card payments to physicians as the only acceptable method for payments; authorizing use of electronic funds transfers by health insurers and health maintenance organizations, respectively, for payments to physicians under certain circumstances; providing notification requirements;

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prohibiting health insurers and health maintenance organizations, respectively, from charging fees for automated clearinghouse transfers as claims payments to physicians; providing an exception; providing applicability; prohibiting health insurers and health maintenance organizations, respectively, from denying claims subsequently submitted by physicians for procedures that were included in prior authorizations; providing exceptions; providing applicability; amending ss. 409.967 and 627.64194, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 408.7057, Florida Statutes, is amended to read:

408.7057 Mandatory statewide provider and health plan claim dispute resolution program.—

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

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

(b) "Denied prior authorization request" means, with respect to a request submitted by a provider for prior authorization of a health care service, supply, or medication, a health plan has made a determination that the request is wholly or partially disapproved, has not been acted upon within the time limits established by law or contract, or is approved subject to materially restrictive conditions that prevent the

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service, supply, or medication from being furnished as clinically indicated.

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

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

(2)(a) The agency shall establish a program to provide assistance to contracted and noncontracted providers and health plans for resolution of claim disputes and denied prior authorization requests that are not resolved by the provider and the health plan. The agency shall contract with a resolution organization to timely review and consider claim disputes and denied prior authorization requests submitted by providers and health plans and recommend to the agency an appropriate resolution of those disputes. The agency shall establish by rule jurisdictional amounts and methods of aggregation for claim disputes and denied prior authorization requests that may be considered by the resolution organization.

(b) Participation in the claim dispute resolution program is mandatory, and a provider or health plan may not opt out of the program's claim dispute resolution process. The resolution

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organization shall review all claim disputes filed by contracted and noncontracted providers and health plans unless the disputed claim:

1. Is related to interest payment;

2. Does not meet the jurisdictional amounts or the methods of aggregation established by agency rule, as provided in paragraph (a);

3. Is part of an internal grievance in a Medicare managed care organization or a reconsideration appeal through the Medicare appeals process;

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

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

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

7. Is subject to a binding claim-dispute-resolution process provided by contract entered into before ~~prior to~~ October 1, 2000, between the provider and the managed care organization.

(c) Contracts entered into or renewed on or after October 1, 2000, may require 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.

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

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

(f) The resolution organization shall require the respondent in the claim dispute to submit all documentation in support of its position within 15 days after receiving a request from the resolution organization for supporting documentation. The resolution organization may extend the time if appropriate. Failure to submit the supporting documentation within such time period shall result in a default against the health plan or provider. A respondent may not avoid a default by declining to participate in the claim dispute resolution process set forth in this section. In the event of such a default, the resolution organization shall issue its written recommendation to the agency that a default be entered against the defaulting entity. The written recommendation shall include a recommendation to the agency that the defaulting entity shall pay the entity submitting the claim dispute the full amount of the claim dispute, plus all accrued interest, and shall be considered a nonprevailing party for the purposes of this section.

(g)1. If on an ongoing basis during the preceding 12 months, the agency has reason to believe that a pattern of noncompliance with s. 627.6131 and s. 641.3155 exists on the

part of a particular health plan or provider, the agency shall evaluate the information contained in these cases to determine whether the information evidences a pattern and report its findings, together with substantiating evidence, to the appropriate licensure or certification entity for the health plan or provider.

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

(h) Either the contracted or noncontracted provider or the health plan may make an offer to settle the claim dispute when it submits a request for a claim dispute and supporting documentation. The offer to settle the claim dispute must state its total amount, and the party to whom it is directed has 15 days to accept the offer once it is received. If the party receiving the offer does not accept the offer and the final order amount is more than 90 percent or less than 110 percent of the offer amount, the party receiving the offer must pay the final order amount to the offering party and is deemed a nonprevailing party for purposes of this section. The amount of an offer made by a contracted or noncontracted provider to settle an alleged underpayment by the health plan must be greater than 110 percent of the reimbursement amount the provider received. The amount of an offer made by a health plan to settle an alleged overpayment to the provider must be less than 90 percent of the alleged overpayment amount by the health plan. Both parties may agree to settle the disputed claim at any time, for any amount, regardless of whether an offer to settle

was made or rejected.

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

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

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

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

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

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

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

(4) Within 30 days after receipt of the recommendation of

the resolution organization, the agency shall adopt the recommendation as a final order. The final order is subject to judicial review pursuant to s. 120.68.

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

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

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

(8) The agency may adopt rules to administer this section.

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

627.6131 Payment of claims.—

(20)(a) A contract between a health insurer and a dentist licensed under chapter 466 or a physician licensed under chapter 458 or chapter 459 for the provision of services to an insured

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may not specify credit card payment as the only acceptable method for payments from the health insurer to the dentist or physician.

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

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

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

(c) A health insurer that pays a claim to a dentist or

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physician through automated clearinghouse transfer may not charge a fee solely to transmit the payment to the dentist or physician unless the dentist or physician has consented to the fee.

(d) This subsection applies to all contracts:

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

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

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

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

(21)(a) A health insurer may not deny any claim subsequently submitted by a dentist licensed under chapter 466 or a physician licensed under chapter 458 or chapter 459 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

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

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

3. Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary,

based on the prevailing standard of care.

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

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

a. Another payor is responsible for payment.

b. The dentist or physician has already been paid for the procedures identified in the claim.

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

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

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

(b) This subsection applies to all contracts:

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

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

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

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

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

641.315 Provider contracts.—

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 or a physician licensed under chapter 458 or chapter 459 for the provision of services to a subscriber of the health maintenance organization may not specify credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist or physician.

(b) When a health maintenance organization employs the method of claims payment to a dentist or physician through electronic funds transfer, including, but not limited to, virtual credit card payment, the health maintenance organization shall notify the dentist or physician as provided in this paragraph and obtain the dentist's or physician's consent before employing the electronic funds transfer. The dentist's or physician's consent described in this paragraph applies to the dentist's or physician's entire practice. For the purpose of this paragraph, the dentist's or physician's consent, which may be given through e-mail, must bear the signature of the dentist or physician. Such signature includes an electronic or digital signature if the form of signature is recognized as a valid signature under applicable federal law or state contract law or an act that demonstrates express consent, including, but not

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limited to, checking a box indicating consent. The health maintenance organization or the dentist or physician may not require that a dentist's or physician's consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the health maintenance organization to the dentist or physician must include all of the following:

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

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

(c) A health maintenance organization that pays a claim to a dentist or physician through automated clearing house transfer may not charge a fee solely to transmit the payment to the dentist or physician unless the dentist or physician has consented to the fee.

(d) This subsection applies to all contracts:

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

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

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

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

(14)(a) A health maintenance organization may not deny any claim subsequently submitted by a dentist licensed under chapter

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466 or a physician licensed under chapter 458 or chapter 459 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

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

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

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

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

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

a. Another payor is responsible for payment.

b. The dentist or physician has already been paid for the procedures identified in the claim.

c. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided to the health maintenance organization by the dentist or physician, patient, or other person not related

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to the organization.

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

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

(b) This subsection applies to all contracts:

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

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

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

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

Section 4. Paragraph (n) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(n) *Provider dispute resolution.*—Disputes between a plan

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and a provider must ~~may~~ be resolved as described in s. 408.7057.

Section 5. Subsection (6) of section 627.64194, Florida Statutes, is amended to read:

627.64194 Coverage requirements for services provided by nonparticipating providers; payment collection limitations.—

(6) Any dispute with regard to the reimbursement to the nonparticipating provider of emergency or nonemergency services as provided in subsection (4) shall be resolved in a court of competent jurisdiction or through the mandatory ~~voluntary~~ dispute resolution process in s. 408.7057.

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

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