FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 1449	**COMPANION BILL:** CS/SB 1082 (Grall)
TITLE: Statewide Provider and Health Plan Claim Dispute Resolution Program	**LINKED BILLS:** None
SPONSOR(S): Busatta	**RELATED BILLS:** None

Committee References

Health Care Facilities & Systems
14 Y, 0 N, As CS

➤

Health & Human Services

SUMMARY

Effect of the Bill:
CS/HB 1449 makes a disputed claim ineligible for resolution under the Statewide Provider and Health Plan Claim Dispute Resolution Program when 1) the claimant submits the disputed claim through the federal independent dispute resolution process, 2) the submitted claim meets the criteria for resolution through that process, and 3) the disputed claim relates to services initiated under the federal Emergency Medical Treatment and Active Labor Act, s. 395.1041, F.S., or services rendered by out-of-network providers.

Fiscal or Economic Impact:
None

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

CS/HB 1449 makes a disputed claim ineligible for resolution under the Statewide Provider and Health Plan Claim Dispute Resolution Program (Program) when 1) the claimant submits the disputed claim through the federal independent dispute resolution (IDR) process, 2) the submitted claim meets the criteria for resolution through that process, and 3) the disputed claim relates to services initiated under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) or s. 395.1041, F.S., or to services rendered by out-of-network providers. (Section 1).

If a claimant submits a disputed claim relating to services initiated under EMTALA or s. 395.1041, F.S., or to services rendered by out-of-network providers, through the federal IDR process, and the federal arbitrator deems the claim ineligible for resolution through the federal IDR process, the bill preserves the ability of the claimant to submit the same disputed claim for resolution under the state Program.

According to the Agency for Health Care Administration, the bill addresses the interaction between the federal IDR process and the state Program when a disputed claim involving emergency services or out-of-network providers may appear eligible for review under both frameworks. Under current law, AHCA asserts that this potential overlap makes the appropriate forum for resolving certain disputes unpredictable and lends to a duplication of effort and adjudication.[1]

The bill has an effective date of July 1, 2026. (Section 2).

[1] Agency for Health Care Administration, Agency Bill Analysis for HB 1449 (2026), pp. 3-4 (Jan. 17, 2026) http://abar.laspbs.state.fl.us/ABAR/Attachment.aspx?id=37415 (last visited Feb. 1, 2026).

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Dispute Resolution Programs

Statewide Provider and Health Plan Claim Dispute Resolution Program

Current law prohibits out-of-network health care providers from balance billing[2] members of a preferred provider organization,[3] an exclusive provider organization,[4] a health maintenance organization,[5] or a Medicaid managed care plan[6] for emergency services or for nonemergency services when the nonemergency services are provided at an in-network hospital and the patient had no ability and opportunity to choose an in-network provider. Current law sets standards for determining health plan reimbursement to out-of-network providers in these balancing billing situations and authorizes providers and health plans to resolve disputed claims through a statewide dispute resolution program.[7]

The Agency for Health Care Administration (AHCA) regulates the Statewide Provider and Health Plan Claim Dispute Resolution Program (Program) established in statute, where in-network and out-of-network providers and state-regulated health plans[8] may bring claims disputes before an independent third-party resolution organization contracted by AHCA.[9] Current law requires AHCA's contractor to analyze claim disputes submitted for resolution and to provide recommendations to AHCA on how to resolve these disputes.[10]

The Program provides an optional path to dispute resolution in lieu of formal litigation. However, the Program is mandatory for a provider who contracts with AHCA to participate as a Statewide Medicaid Managed Care plan.[11]

---

[2] Balancing bill describes a situation where a health care provider seeks to collect payment from a patient for the difference between the provider's billed charges for a covered service and the amount that health plan paid on the claim.
[3] A preferred provider organization (PPO) contracts with a network of health care providers who participate for an alternative or reduced rate of payment in exchange for a higher volume of patients. PPO policyholders are responsible only for required cost-sharing if covered services are obtained in-network; PPO policyholders may choose to receive services out-of-network, but they are responsible for the outstanding balance to the out-of-network provider after the health plan pays its share. *See* s. 627.6471, F.S.
[4] An exclusive provider organization (EPO) contracts with a network of health care providers where the EPO conditions payment of benefits to the patient, in whole or in part, on the patient's use of the exclusive providers. *See* s. 627.6472, F.S.
[5] A health maintenance organization (HMO) contracts with a network of preferred health care providers to provide services at pre-negotiated rates. *See* s. 641.19, F.S.
[6] Providers agreeing to accept persons with Medicaid must accept Medicaid payment as payment in full. Current law prohibits such providers from balance billing Medicaid enrollees for Medicaid-covered services and goods. *See* s. 409.907(3)(j), F.S.
[7] S. 627.64194, F.S., s. 641.3154, F.S. Notwithstanding the general bill balancing prohibition relating to HMO policyholders, a provider can balance bill an HMO policyholder if that provider's request for prior authorization is denied or if that provider does not request prior authorization in the first instance. s. 641.3154(2), F.S.
[8] Under the Program, state-regulated health plans include health maintenance organizations, prepaid health clinics, prepaid health plans, exclusive provider organizations, and major medical expense health insurance policies (both group and individual) offered by preferred provider organizations. s. 408.7057(1)(b), F.S.
[9] AHCA's current "resolution organization" is Capitol Bridge, LLC. Capitol Bridge, LLC is also a certified independent dispute resolution entity for the federal No Suprises Act process. Centers for Medicare & Medicaid Services, "List of certified independent dispute resolution entities," *U.S. Department of Health* (last updated Jan. 26, 2026) https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list (last visited Jan. 31, 2026); "Capitol Bridge: An Independent Dispute Resolution Entity," https://federalidr.capitolbridge.com/ (last visited Jan. 31, 2026).
[10] S. 408.7057(2)(a), F.S.
[11] Bureau of Health Facility Regulation, "Statewide Provider and Health Plan Claim Dispute Resolution Program FAQ," *Agency for Health Care Administration*, Question 4 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-faq (last visited Feb. 3, 2026).

Claim Submissions

When a claimant (i.e., the provider or health plan that submits a disputed claim for resolution) brings a claim under the Program, AHCA's contracted resolution organization requests that the claimant and the respondent (i.e., the provider or health plan being challenged by the claimant) provide supporting documentation for its position on the dispute claim. Current law requires the both parties to provide supporting documentation within 15 days after receiving such request, unless AHCA's contractor authorizes an extension of time. AHCA's contractor must dismiss the claim if the claimant fails to meet such deadline, and AHCA's contractor must award a default judgment[12] against the respondent if the respondent fails to meet such deadline.[13]

The table below partitions eligible claims from ineligible claims.[14]

Eligible Claims	Ineligible Claims
• Claims disputes for services rendered; • Claims disputes related to payment amounts only; • In-network hospital inpatient claims, aggregated by service type, that are at least $25,000; • Out-of-network hospital inpatient claims, aggregated by service type, that are at least $10,000; • In-network hospital outpatient claims, aggregated by service type, that are at least $10,000; • Out-of-network hospital outpatient claims, aggregated by service type, that are at least $3,000; • Physician professional services claims, aggregated by service type, that are at least $500; or • Rural hospital claims.	• Interest payment disputes; • Claims less than the minimum amounts for a particular service type; • Claims solely related to late payment/processing. • Claims in the Medicare managed organization internal grievance process; • Claims in the Medicare appeals process; • Claims involving a health plan that is not regulated by the state; • Claims involving a Medicaid fair hearing pursued under 42 C.F.R. §§ 431.220 et seq.;[15] • Claims pending in state or federal court; • Claims that did not exhaust an internal dispute resolution process established by contract; or • Claims filed more than 12 months after a provider or health made its final decision with respect to the disputed claim.

Current law requires AHCA to independently evaluate a disputed claim when it has reason to believe that a provider or health plan may have engaged in a pattern of noncompliance with s. 627.6131 and s. 641.3155 during the preceding 12 months. After its independent evaluation, AHCA must report its findings together with substantial evidence to the appropriate licensure or certification entity for the provider or health plan. In addition, current law requires AHCA to prepare an annual report for the Governor and the Legislature which information relating to the claims dismissed, the defaults issued, and the failures to comply with any final orders issued by AHCA through the Program.[16] The table below records claims statistics for the four most recent years.[17]

[12] In the event of default judgment, current law requires the resolution organization to formally recommend to AHCA that a default judgment be entered against the respondent, where the respondent must pay the full amount of the dispute claimed, plus all accrued interest, as the nonprevailing party. S. 408.7057(2)(f), F.S.
[13] S. 408.7057(2), F.S.
[14] S. 408.7057(2), F.S., Rule 59A-12.030, F.A.C.
[15] AHCA or the Department of Children and Families (DCF), as applicable, must grant an opportunity for a Medicaid fair hearing to any individual who requests it because he or she believes the agency has taken an action erroneously, denied his or her claim for eligibility or for covered benefits or services, issued a determination of an individual's liability, or has not acted upon the claim with reasonable promptness. 42 C.F.R. §§ 431.220(a)(1). This federal regulation enumerates other examples of when a hearing is required.
[16] S. 408.7057(2)(g), F.S.
[17] Bureau of Health Facility Regulation, "Statewide Provider and Health Plan Claim Dispute Resolution Program," *Agency for Health Care Administration*, 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. 31, 2026). Select annual reports by year and calculate the raw claim numbers to yield the low, high, and average amounts.

Year	Claim Submissions			Range of Disputed Amounts		
	Eligible	Total	Eligibility Rate	Low End	High End	Average
2022	443	563	78.6%	$539	$1,001,694,838	Not Available
2023	137	296	46.2%	$34	$10,879	$126,397
2024	58	77	75.3%	$800	$924,889	$100,995
2025	125	162	77.1%	$2,936	$10,573,672	$416,397

Recommendation and Final Order

AHCA's contracted resolution organization must issue a recommendation to AHCA within 60 days after receipt of the supporting documentation requested by the claimant and respondent. Current law prohibits AHCA's contracted resolution organization from taking longer than 90 days to review the disputed claim and to submit a recommendation to AHCA.[18] Within 30 days after receipt of the recommended course of action, AHCA must adopt the recommendation as a final order. Current law subjects this final order to judicial review.[19]

Before adjudication of the disputed claim, current law authorizes the claimant and the respondent to settle the disputed claim at any time, for any amount, regardless of whether an offer to settle was already made or rejected.[20]

As the table below depicts, AHCA reports the following case outcomes for the 125 eligible claims filed in 2025.[21]

Case Outcomes (Calendar Year 2025)						
AHCA Decisions			Party Decisions		Judicial Review	
Final Order Award	Dismissal	Under Review	Provider Withdrew	Health Plan Opt-Outs	Final Order Decision Upheld	Final Order Decision Overturned
43	2	20	5	51	4	0

As the table above shows, health plans opted-out of the claims dispute resolution process in 51 of 125 disputed claim cases, which represents 40.8% of case outcomes for 2025. Most of the opt-outs came from Florida Blue, Humana Health Plan, and United Healthcare of Florida.[22]

In 2025, the average final order award was $198,879. The highest award was $2,299,056 and the lowest was $4,657.

AHCA must notify the appropriate health care licensure or certification entity within 7 days of a violation of a final order issued under the Program.[23]

[18] S. 408.7057(3), F.S.
[19] S. 408.7057(4), F.S., *see* s. 120.68, F.S.
[20] S. 408.7057(2)(h), F.S.
[21] Bureau of Health Facility Regulation, "Statewide Provider and Health Plan Claim Dispute Resolution Program: 2025 Annual Report," Agency for Health Care Administration, (Feb. 2026) https://ahca.myflorida.com/content/download/28078/file/2026%20-%20Annual%20Report.pdf (last visited Feb. 1, 2026).
[22] *Id.*
[23] S. 408.7057(5), F.S.

Federal Independent Dispute Resolution Process

The No Suprises Act[24] (NSA) established a federal independent dispute resolution (IDR) process to resolve payment disputes between providers and private health insurers regarding certain out-of-network items or services furnished during surprise billing circumstances. A surprise billing circumstance is where an individual receives large, unexpected medical bills when they are unknowingly, and potentially unavoidably, treated by out-of-network providers.[25]

No Suprise Billing for Patients

Emergency Services

The NSA requires health plans to cover emergency services[26] furnished by out-of-network health care providers without the need for any prior authorization determination and in a manner that does not impose any limitation on out-of-network coverage that is more restrictive than in-network coverage limitations. The NSA also creates cost-sharing[27] parity between in-network and out-of-network providers for emergency services rendered, meaning the plan beneficiary does not pay an out-of-network provider more than he or she would for an in-network provider. Cost-sharing for emergency services rendered by out-of-network providers counts towards the plan beneficiary's in-network deductible or out-of-pocket maximums as applicable.[28]

Certain Non-Emergency Services

The NSA requires health plans to cover non-emergency services furnished by out-of-network providers at in-network hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers, and other facilities designated by the federal government in a manner that does not impose any limitation on out-of-network coverage that is more restrictive than in-network coverage limitations. The NSA also creates cost-sharing parity between in-network and out-of-network providers for such services, meaning the plan beneficiary does not pay an out-of-network provider more than he or she would for an in-network provider. Cost-sharing for non-emergency services rendered by out-of-network providers at in-network facilities counts towards the plan beneficiary's in-network deductible or out-of-pocket maximums as applicable.[29]

Federal IDR Process

Certification and Selection of IDR Entity

When a provider and a health plan have a disputed claim that they could not resolve during a voluntary negotiation period, the NSA authorizes the provider or health plan to initiate the federal IDR process.[30] The Centers for Medicare & Medicaid Services (CMS) certifies IDR entities to serve as arbitrators; CMS may only certify entities that have sufficient medical and legal expertise and sufficient staffing to make determinations on a timely basis and do not pose a conflict of interest to the claimant or the respondent.[31] CMS currently certifies 16 IDR entities.[32]

---

[24] Consolidated Appropriations Act, P.L. 116-260 (Dec. 27, 2020), 134 Stat. 1182, Division BB, Title I, Sec. 101-118. Codified at 42 U.S.C. § 300gg-111.
[25] Ryan Russo and Wen Shen, "No Surprises Act (NSA) Independent Dispute Resolution (IDR) Process Data Analysis for 2024," *Congressional Research Service*, pp. 1 (Nov. 26, 2025) https://www.congress.gov/crs-product/R48738 (last visited Feb. 1, 2026).
[26] Under the NSA, emergency services consist of a medical screening examination for an emergency medical condition that is within the capability of the emergency department of a hospital or of an independent free-standing emergency department, as applicable and further medical examination and stabilizing treatment within the capabilities of the staff and facilities available. 42 U.S.C. § 300gg-111(3).
[27] Cost-sharing includes copayments, coinsurance, and deductibles. 42 U.S.C. § 300gg-111(a)(3)(L).
[28] 42 U.S.C. § 300gg-111(a)(1).
[29] 42 U.S.C. § 300gg-111(b).
[30] 42 U.S.C. § 300gg-111(c).
[31] 42 U.S.C. § 300gg-111(c). Claimants and respondents may petition CMS to deny or revoke certification of an IDR entity. 42 U.S.C. § 300gg-111(c)(4).

The NSA permits a claimant and respondent to jointly select a certified IDR entity; however, if they cannot agree on a certified IDR entity within 3 business days of initiating the federal IDR process, the NSA requires CMS to select the presiding certified IDR entity.[33]

Baseball-Style Arbitration

The federal IDR process resolves disputed claims with "baseball-style arbitration,"[34] where an arbitrator must choose either the claimant's offer or the respondent's offer. To choose between the offers, the certified IDR entity must consider:

- the "qualifying payment amounts"[35] for the services furnished which are comparable to the same service furnished within the same geographic region;
- the provider's level of training, experience, and performance measures;
- the provider's market share;
- the acuity of the individual receiving the service or the complexity of providing the service;
- the provider's teaching status, case mix, and scope of services; and
- demonstrations of good faith efforts (or the lack thereof) to contract for in-network status.[36]

The certified IDR entity may not consider usual and customary charges or public payor reimbursement rates.[37]

Under the NSA, the arbitrator's determination is binding upon the claimant and the respondent unless the claim itself is fraudulent or there is evidence of misrepresentation of facts presented to the arbitrator involving such claim. The NSA also exempts the arbitrator's determination from judicial review in most cases.[38] In November 2025, the United States Court of Appeals for the Eleventh Circuit observed, in dicta, that the process of baseball-style arbitration may incentivize both the claimant and the respondent "to eschew extreme offers that the arbitrator would be more likely to reject."[39]

Before the certified IDR entity issues a determination, the NSA authorizes the claimant and respondent to continue negotiations and to settle a disputed claim privately, subject to compensating the certified IDR entity for professional services rendered.[40]

---

[32] Centers for Medicare & Medicaid Services, "List of certified independent dispute resolution entities," *U.S. Department of Health & Human Services* (last updated Jan. 26, 2026) https://www.cms.gov/nosurprises/help-resolve-payment-disputes/certified-idre-list (last visited Jan. 31, 2026).

[33] 42 U.S.C. § 300gg-111(c)(4).

[34] In professional baseball, an eligible baseball player may invoke the salary arbitration process to negotiate a competitive, merit-based salary with his baseball team for the upcoming season. A player does this when he cannot reach a voluntary agreement with his team during the offseason. An arbitration panel considers the player's proposed salary and the team's proposed salary based on certain criteria and chooses one of those offers. The arbitration panel's selection is final and binding on both the player and the team. "Glossary: Salary Arbitration and Arbitration Eligibility," *Major League Baseball* https://www.mlb.com/glossary/transactions/salary-arbitration (last visited Feb. 2, 2026).

[35] The qualifying payment amount is the amount that a health plan recognizes as the median of in-network rates for emergency services furnished by a provider within a geographic region, indexed annually for inflation. 42 U.S.C. § 300gg-111(3)(E).

[36] 42 U.S.C. § 300gg-111(c)(5)(C).

[37] 42 U.S.C. § 300gg-111(c)(5)(D).

[38] 42 U.S.C. §§ 300gg-111(c)(5)(E)(i). The NSA authorizes a federal district court to vacate an arbitrator's determination in cases where the award was procured by corruption, fraud, or undue means; in cases where there was evidence of partiality or corruption by one or more arbitrators; in cases where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy, or of any other misbehavior by which the rights of any party have been prejudiced; or in cases where the arbitrators exceeded their powers, or so imperfectly executed them that a mutual, final, and definite award upon the subject matter submitted was not made. 9 U.S.C. § 10(a). *See Reach Air Medical Servs., LLC v. Kaiser Foundation Health Plan, Inc.*, 160 F.4th 1110, 1116 (11th Cir. 2025).

[39] *See Reach Air Medical Servs.*, 160 F.4th at 1124.

[40] 42 U.S.C. § 300gg-111(c)(2).

As of July 2025, CMS reports 96.5% of all federal IDR disputes submitted since the beginning of the program in 2022 have either been resolved or are less than 30 business days old.[41] Certified IDR entities closed 1,349,343 disputes nationwide within the first six months of 2025, approximately a 48% increase from the last six months of 2024 (911,088 determinations). They also rendered 1,082,247 payment determinations within the same timeframe, approximately a 55% increase from the last six months of 2024.[42]

Interaction between Federal and State Claim Disputes Programs

In June 2021, CMS asked each state, among other questions, whether it would direct all balance billing claims disputes through the federal IDR process or whether it has its own state resolution process and a specified state law[43] to handle certain balance billing claims disputes. In January 2022, CMS informed Florida that its specified state law applies to determine out-of-network rates and claim dispute payment amounts above certain threshold amounts. The federal IDR process applies to out-of-network rates and claims dispute payment amounts below Florida's specified state law thresholds and to all out-of-network air ambulance service rates.[44]

Since the Florida Program and the federal IDR process partition different classes of disputed claims into exclusive spheres of jurisdiction, providers and health plans must understand the nuances of both state and federal alternative dispute resolution programs.[45] CMS asserts that the primary cause of dispute processing delays in the federal IDR process continues to be the complexity of determining whether disputes are eligible for federal IDR.[46]

Emergency Stabilizing Treatment

The Emergency Medical Treatment and Active Labor Act (EMTALA)[47] requires Medicare-participating hospitals that offer emergency services to medically screen and to provide further medical examination and necessary stabilization treatment within the capabilities of the staff and facilities available at the hospital to any person who asks for help and who presents with an emergency medical condition.[48] A hospital may not transfer an individual who has not been stabilized[49] unless the hospital satisfies stringent requirements before facilitating an appropriate transfer.[50]

---

[41] Centers for Medicare & Medicaid Services, "Fact Sheet: Clearing the Independent Dispute Resolution Backlog," *U.S. Department of Health & Human Services*, (Sept. 2025) https://www.cms.gov/files/document/fact-sheet-clearing-independent-dispute-resolution-backlog.pdf (last visited Jan. 31, 2026).

[42] Centers for Medicare & Medicaid Services, "Supplemental Background on Federal Independent Dispute Resolution Public Use Files: January 1, 2025 – June 30, 2025," *U.S. Department of Health & Human Services* (Jan. 21, 2026) https://www.cms.gov/files/document/federal-idr-supplemental-background-2025-q1-2025-q2.pdf (last visited Feb. 2, 2026).

[43] Under the NSA, a "specified state law" means a state law that providers for a method of determining the total amount payable under a state-regulated health plan in the case of a beneficiary receiving services from OON provider. 42 U.S.C. § 300gg-111(a)(3)(I). Florida's "specified state law" is AHCA Rule 59A-12.030, F.A.C.

[44] Centers for Medicare & Medicaid Services, "Consolidated Appropriations Act Enforcement Letter to Florida," *U.S. Department of Health 7 Human Services* (Jan. 28, 2022) https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/caa-enforcement-letters-florida.pdf (last visited Feb. 2, 2026).

[45] *See* Centers for Medicare & Medicaid Services, "Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process," *U.S. Department of Health & Human Services*, (last updated Jan. 13, 2023) https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf (last visited Feb. 2, 2026). At the time of the 2023 update, CMS identified 20 other states that used a bifurcated process to claims dispute resolution.

[46] Centers for Medicare & Medicaid Services, "Supplemental Background on Federal Independent Dispute Resolution Public Use Files: January 1, 2025 – June 30, 2025," *U.S. Department of Health & Human Services*, pp. 3 (Jan. 21, 2026) https://www.cms.gov/files/document/federal-idr-supplemental-background-2025-q1-2025-q2.pdf (last visited Feb. 2, 2026).

[47] 42 U.S.C. § 1395dd.

[48] Under EMTALA, an "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is have contractions, an emergency medical condition means that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child. 42 U.S.C. § 1395dd(e)(1).

[49] Under EMTALA, "stabilized" means that the patient is not likely to experience, within reasonable medical probability, a material deterioration of the emergency medical condition from or during a transfer. 42 U.S.C. § 1395dd(e)(3).

[50] 42 U.S.C. § 1395dd(c).

EMTALA prohibits Medicare-participating hospitals with specialized capabilities or facilities (e.g., burn units, shock-trauma units, neonatal intensive care units) from refusing to accept an appropriate transfer of an individual.[51] EMTALA prohibits Medicare-participating hospitals from delaying the provision of emergency services in order to inquire about the individual's method of payment or insurance status.[52] EMTALA violations are punishable by civil monetary penalties and are further enforceable through private causes of action.[53]

EMTALA expressly does not preempt any state or local law requirement, except to the extent that the state or local law requirement directly conflicts with EMTALA.[54] Florida has a similar law to EMTALA codified at s. 395.1041, F.S., with the principal difference being that the state's emergency medical treatment law applies to all general hospitals in the state with emergency departments and all rural emergency hospitals[55] in the state as a condition of licensure.[56]

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Care Facilities & Systems Subcommittee	14 Y, 0 N, As CS	2/5/2026	Lloyd	DesRochers
THE CHANGES ADOPTED BY THE COMMITTEE:	Makes certain disputed claims submitted through the federal IDR process which meet the criteria for resolution through that process ineligible for claims dispute resolution under the Statewide Provider and Health Plan Claim Dispute Resolution Program.			
Health & Human Services Committee				

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.

---

[51] 42 U.S.C. § 1395dd(g).
[52] 42 U.S.C. § 1395dd(h).
[53] 42 U.S.C. § 1395dd(d).
[54] 42 U.S.C. § 1395dd(f).
[55] Under s. 395.1041, F.S., a rural hospital means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:
- the sole provider within a county with a population density of no greater than 100 persons per square mile;
- an acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;
- a hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;
- a hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database located in AHCA's Florida Center for Health Information and Transparency; or
- A critical access hospital.

[56] *See* s. 395.1041(5), F.S.