A bill to be entitled

An act relating to dental payments under health insurance plans; amending s. 627.6131, F.S.; prohibiting certain restrictions on payment methods by individual health insurers to dentists; providing requirements if certain payment methods are initiated or changed; prohibiting fees for payment transmittals; providing exceptions; prohibiting waivers; requiring enforcement; prohibiting denials of certain claims under specified circumstances; providing exceptions; amending s. 627.6474, F.S.; revising the definition of the term "covered services"; creating s. 627.65772, F.S.; prohibiting certain restrictions on payment methods by group health insurers to dentists; providing requirements if certain payment methods are initiated or changed; prohibiting fees for payment transmittals; providing exceptions; requiring enforcement of violations; prohibiting denials of certain claims under specified circumstances; providing exceptions; prohibiting waivers; amending s. 636.035, F.S.; revising the definition of the term "covered services"; prohibiting certain restrictions on payment methods by prepaid limited health service organizations to dentists; providing requirements if certain payment methods are initiated or changed;

prohibiting fees for payment transmittals; providing exceptions; prohibiting waivers; requiring enforcement; prohibiting denials of certain claims under specified circumstances; providing exceptions; amending s. 641.315, F.S.; prohibiting certain restrictions on payment methods by health maintenance organizations to dentists; providing requirements if certain payment methods are initiated or changed; prohibiting fees for payment transmittals; providing exceptions; prohibiting waivers; requiring enforcement; prohibiting denials of certain claims under specified circumstances; providing exceptions; providing an effective date.

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

Section 1. Subsections (20) and (21) are added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

(20)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of dental services to an insured may not contain restrictions by the health insurer or its contracted vendor on methods of payment by the health insurer or its contracted vendor to the dentist in which the only acceptable payment method is by credit card.

(b)1. If initiating or changing payment methods to a dentist to payments by electronic funds transfers, including virtual credit card payments, a health insurer under its dental benefit plan or a health insurer's contracted vendor must:

a. Notify the dentist if any fees are associated with a particular payment method.

b. Advise the dentist of the available payment methods and provide clear instructions to the dentist as to how to select an alternative payment method.

2. If initiating or changing payments to a dentist to payments through the Automated Clearing House network, as provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health insurer under its dental benefit plan or a health insurer's contracted vendor may not charge a fee solely to transmit the payment to the dentist, unless the dentist has consented to the fee. However, a dentist's agent may charge the dentist reasonable fees when transmitting an Automated Clearing House network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

(c) The provisions of this subsection may not be waived by contract. A contractual clause that is in conflict with this subsection or that purports to waive any requirement of this subsection is void.

(d) The commission shall enforce this subsection.

(21)(a) A health insurer providing coverage for dental services may not deny a claim submitted by a dentist licensed under chapter 466 for a procedure specifically included in a prior authorization unless at least one of the following circumstances applies:

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

2. If, after issuance of the prior authorization, a new procedure is provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would:

a. No longer be considered medically necessary, based on the prevailing standard of care; or

b. At the time of the use of the procedure, require denial of authorization under the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.

3. The patient receiving the procedure was not eligible to receive the procedure on the date of service, and the dentist did not know, and with the exercise of reasonable care could not have known, of the patient's eligibility status.

4. Another payer is responsible for the payment.

5. The dentist has already been paid for the procedure

identified on the claim.

6. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized.

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

(b) The provisions of this subsection may not be waived by contract. A contractual clause that is in conflict with this subsection or that purports to waive any requirement of this subsection is void.

Section 2. Subsection (2) of section 627.6474, Florida Statutes, is amended to read:

627.6474 Provider contracts.—

(2) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of services to an insured may not contain a provision that requires the dentist to provide services to the insured under such contract at a fee set by the health insurer unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the insured's contract, excluding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as

deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

Section 3. Section 627.65772, Florida Statutes, is created to read:

627.65772 Payment methods for dental services; claim payment denials.—

(1)(a) A contract between a health insurer and a dentist licensed under chapter 466 for the provision of dental services to an insured may not contain restrictions by the health insurer or its contracted vendor on methods of payment by the health insurer or its contracted vendor to the dentist in which the only acceptable payment method is by credit card.

(b)1. If initiating or changing payment methods to a dentist to payments by electronic funds transfers, including virtual credit card payments, a health insurer under its dental benefit plan or a health insurer's contracted vendor must:

a. Notify the dentist if any fees are associated with a particular payment method.

b. Advise the dentist of the available payment methods and provide clear instructions to the dentist as to how to select an alternative payment method.

2. If initiating or changing payments to a dentist to payments through the Automated Clearing House network, as provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health

insurer under its dental benefit plan or a health insurer's contracted vendor may not charge a fee solely to transmit the payment to the dentist, unless the dentist has consented to the fee. However, a dentist's agent may charge the dentist reasonable fees when transmitting an Automated Clearing House network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

(c) The commission shall enforce this subsection.

(2) A health insurer providing coverage for dental services may not deny a claim submitted by a dentist licensed under chapter 466 for a procedure specifically included in a prior authorization unless at least one of the following circumstances applies:

(a) Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to use after issuance of the prior authorization.

(b) If, after issuance of the prior authorization, a new procedure is provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would:

1. No longer be considered medically necessary, based on the prevailing standard of care; or

2. At the time of the use of the procedure, require denial

of authorization pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.

(c) The patient receiving the procedure was not eligible to receive the procedure on the date of service, and the dentist did not know, and with the exercise of reasonable care could not have known, of the patient's eligibility status.

(d) Another payer is responsible for the payment.

(e) The dentist has already been paid for the procedure identified on the claim.

(f) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized.

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

(3) The provisions of this section may not be waived by contract. A contractual clause that is in conflict with this section or that purports to waive any requirement of this section is void.

Section 4. Subsection (13) of section 636.035, Florida Statutes, is amended, and subsections (15) and (16) are added to that section, to read:

636.035 Provider arrangements.—

(13) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the prepaid limited health service organization may not contain a provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the prepaid limited health service organization unless such services are covered services under the applicable contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, excluding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(15)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the provision of dental services to a subscriber may not contain restrictions by the prepaid limited health service organization or its contracted vendor on methods of payment by the prepaid limited health service organization or its contracted vendor to the dentist in which the only acceptable payment method is by credit card.

(b)1. If initiating or changing payments to a dentist to

payments by electronic funds transfers, including virtual credit card payments, a prepaid limited health service organization under its dental benefit plan or a prepaid limited health service organization's contracted vendor must:

a. Notify the dentist if any fees are associated with a particular payment method.

b. Advise the dentist of the available payment methods and provide clear instructions to the dentist as to how to select an alternative payment method.

2. If initiating or changing payments to a dentist to payments through the Automated Clearing House network, as provided under 45 C.F.R. ss. 162.1601 and 162.1602, a prepaid limited health service organization under its dental benefit plan or a prepaid limited health service organization's contracted vendor may not charge a fee solely to transmit the payment to the dentist, unless the dentist has consented to the fee. However, a dentist's agent may charge the dentist reasonable fees when transmitting an Automated Clearing House network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

(c) The provisions of this subsection may not be waived by contract. A contractual clause that is in conflict with this subsection or that purports to waive any requirement of this subsection is void.

(d) The commission shall enforce this subsection.

(16)(a) A prepaid limited health service organization providing coverage for dental services may not deny a claim submitted by a dentist licensed under chapter 466 for a procedure specifically included in a prior authorization unless at least one of the following circumstances applies:

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

2. If, after issuance of the prior authorization, a new procedure is provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would:

a. No longer be considered medically necessary, based on the prevailing standard of care; or

b. At the time of the use of the procedure, require denial of authorization pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.

3. The patient receiving the procedure was not eligible to receive the procedure on the date of service, and the dentist did not know, and with the exercise of reasonable care could not have known, of the patient's eligibility status.

4. Another payer is responsible for the payment.

5. The dentist has already been paid for the procedure identified on the claim.

6. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized.

7. The claim was submitted fraudulently, or the prior authorization was based in whole or material part on erroneous information provided by the dentist, the patient, or any other person not related to the prepaid limited health service organization.

(b) The provisions of this subsection may not be waived by contract. A contractual clause that is in conflict with this subsection or that purports to waive any requirement of this subsection is void.

Section 5. Subsection (11) of section 641.315, Florida Statutes, is amended, and subsections (13) and (14) are added to that section, to read:

641.315 Provider contracts.—

(11) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance organization may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable

contract. As used in this subsection, the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, excluding ~~or for which a reimbursement would be available but for~~ the application of contractual limitations such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of dental services to a subscriber of the health maintenance organization may not contain restrictions by the health maintenance organization or its contracted vendor on methods of payment by the health maintenance organization or its contracted vendor to the dentist in which the only acceptable payment method is by credit card.

1. If initiating or changing payments to a dentist to payments by electronic funds transfers, including virtual credit card payments, a health maintenance organization under its dental benefit plan or a health maintenance organization's contracted vendor must:

a. Notify the dentist if any fees are associated with a particular payment method.

b. Advise the dentist of the available payment methods and provide clear instructions to the dentist as to how to select an

alternative payment method.

2. If initiating or changing payments to a dentist to payments through the Automated Clearing House network, as provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health maintenance organization under its dental benefit plan or through a contracted vendor may not charge a fee solely to transmit the payment to the dentist, unless the dentist has consented to the fee. However, a dentist's agent may charge the dentist reasonable fees when transmitting an Automated Clearing House network payment related to transaction management, data management, portal services, and other value-added services in addition to the bank transmittal.

(b) The provisions of this subsection may not be waived by contract. A contractual clause that is in conflict with this subsection or that purports to waive any requirement of this subsection is void.

(c) The commission shall enforce this subsection.

(14)(a) A health maintenance organization providing coverage for dental services may not deny a claim submitted by a dentist licensed under chapter 466 for a procedure specifically included in a prior authorization unless at least one of the following circumstances applies:

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

authorization.

2. If, after issuance of the prior authorization, a new procedure is provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would:

a. No longer be considered medically necessary, based on the prevailing standard of care; or

b. At the time of the use of the procedure, require denial of authorization pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.

3. The patient receiving the procedure was not eligible to receive the procedure on the date of service, and the dentist did not know, and with the exercise of reasonable care could not have known, of the patient's eligibility status.

4. Another payer is responsible for the payment.

5. The dentist has already been paid for the procedure identified on the claim.

6. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized.

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

(b) The provisions of this subsection may not be waived by contract. A contractual clause that is in conflict with this subsection or that purports to waive any requirement of this subsection is void.

Section 6. This act shall take effect July 1, 2023.