By Senator Harrell

31-00805-23 2023834__

1 A bill to be entitled
2 An act relating to dental payments under health
3 insurance plans; amending s. 627.6131, F.S.;
4 prohibiting certain restrictions on payment methods by
5 individual health insurers to dentists; providing
6 requirements if certain payment methods are initiated
7 or changed; prohibiting fees for payment transmittals;
8 providing exceptions; requiring enforcement by the
9 Financial Services Commission; prohibiting insurers
10 from denying certain claims submitted by dentists
11 except under specified circumstances; providing
12 construction; amending s. 627.6474, F.S.; revising the
13 definition of the term "covered services"; creating s.
14 627.65772, F.S.; prohibiting certain restrictions on
15 payment methods by group health insurers to dentists;
16 providing requirements if certain payment methods are
17 initiated or changed; prohibiting fees for payment
18 transmittals; providing exceptions; requiring
19 enforcement by the commission; prohibiting insurers
20 from denying certain claims submitted by dentists
21 except under specified circumstances; providing
22 construction; amending s. 636.035, F.S.; revising the
23 definition of the term "covered services"; prohibiting
24 certain restrictions on payment methods by prepaid
25 limited health service organizations to dentists;
26 providing requirements if certain payment methods are
27 initiated or changed; prohibiting fees for payment
28 transmittals; providing exceptions; requiring
29 enforcement by the commission; prohibiting such

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30 organizations from denying certain claims submitted by
31 dentists except under specified circumstances;
32 providing construction; amending s. 641.315, F.S.;
33 prohibiting certain restrictions on payment methods by
34 health maintenance organizations to dentists;
35 providing requirements if certain payment methods are
36 initiated or changed; prohibiting fees for payment
37 transmittals; providing exceptions; requiring
38 enforcement by the commission; prohibiting such
39 organizations from denying certain claims submitted by
40 dentists except under specified circumstances;
41 providing construction; providing an effective date.
42
43 Be It Enacted by the Legislature of the State of Florida:
44
45 Section 1. Subsections (20) and (21) are added to section
46 627.6131, Florida Statutes, to read:
47 627.6131 Payment of claims.—
48 (20)(a) A contract between a health insurer and a dentist
49 licensed under chapter 466 for the provision of dental services
50 to an insured may not contain restrictions by the health insurer
51 or its contracted vendor on methods of payment by the health
52 insurer or its contracted vendor to the dentist in which the
53 only acceptable payment method is by credit card.
54 (b)1. If initiating or changing payment methods to a
55 dentist to payments made by electronic funds transfers,
56 including virtual credit card payments, a health insurer under
57 its dental benefit plan or a health insurer's contracted vendor
58 must:

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59 a. Notify the dentist if any fees are associated with a
60 particular payment method.
61 b. Advise the dentist of the available payment methods and
62 provide clear instructions to the dentist as to how to select an
63 alternative payment method.
64 2. If initiating or changing payments to a dentist to
65 payments made through the Automated Clearing House Network, as
66 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health
67 insurer under its dental benefit plan or a health insurer's
68 contracted vendor may not charge a fee solely to transmit the
69 payment to the dentist, unless the dentist has consented to the
70 fee. However, a dentist's agent may charge the dentist
71 reasonable fees when transmitting an Automated Clearing House
72 Network payment related to transaction management, data
73 management, portal services, and other value-added services in
74 addition to the bank transmittal.
75 (c) The provisions of this subsection may not be waived by
76 contract. A contractual clause that is in conflict with this
77 subsection or that purports to waive any requirement of this
78 subsection is void.
79 (d) The commission shall enforce this subsection.
80 (21)(a) A health insurer providing coverage for dental
81 services may not deny a claim submitted by a dentist licensed
82 under chapter 466 for a procedure specifically included in a
83 prior authorization unless at least one of the following
84 circumstances applies:
85 1. Benefit limitations such as annual maximums and
86 frequency limitations not applicable at the time of the prior
87 authorization are reached due to use after issuance of the prior

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88 authorization.
89 2. If, after issuance of the prior authorization, a new
90 procedure is provided to the patient or a change in the
91 condition of the patient occurs such that the prior authorized
92 procedure would:
93 a. No longer be considered medically necessary, based on
94 the prevailing standard of care; or
95 b. At the time of the use of the procedure, require denial
96 of authorization under the terms and conditions for coverage
97 under the patient's plan in effect at the time the prior
98 authorization was used.
99 3. The patient receiving the procedure was not eligible to
100 receive the procedure on the date of service, and the dentist
101 did not know, and with the exercise of reasonable care could not
102 have known, of the patient's eligibility status.
103 4. Another payer is responsible for the payment.
104 5. The dentist has already been paid for the procedure
105 identified on the claim.
106 6. The documentation for the claim provided by the person
107 submitting the claim clearly fails to support the claim as
108 originally authorized.
109 7. The claim was submitted fraudulently, or the prior
110 authorization was based in whole or material part on erroneous
111 information provided by the dentist, the patient, or any other
112 person not related to the health insurer.
113 (b) The provisions of this subsection may not be waived by
114 contract. A contractual clause that is in conflict with this
115 subsection or that purports to waive any requirement of this
116 subsection is void.

117 Section 2. Subsection (2) of section 627.6474, Florida
118 Statutes, is amended to read:
119 627.6474 Provider contracts.—
120 (2) A contract between a health insurer and a dentist
121 licensed under chapter 466 for the provision of services to an
122 insured may not contain a provision that requires the dentist to
123 provide services to the insured under such contract at a fee set
124 by the health insurer unless such services are covered services
125 under the applicable contract. As used in this subsection, the
126 term "covered services" means dental care services for which a
127 reimbursement is available under the insured's contract,
128 notwithstanding ~~or for which a reimbursement would be available~~
129 ~~but for~~ the application of contractual limitations such as
130 deductibles, coinsurance, waiting periods, annual or lifetime
131 maximums, frequency limitations, alternative benefit payments,
132 or any other limitation.
133 Section 3. Section 627.65772, Florida Statutes, is created
134 to read:
135 627.65772 Payment methods for dental services; claim
136 payment denials.—
137 (1)(a) A contract between a health insurer and a dentist
138 licensed under chapter 466 for the provision of dental services
139 to an insured may not contain restrictions by the health insurer
140 or its contracted vendor on methods of payment by the health
141 insurer or its contracted vendor to the dentist in which the
142 only acceptable payment method is by credit card.
143 (b)1. If initiating or changing payment methods to a
144 dentist to payments made by electronic funds transfers,
145 including virtual credit card payments, a health insurer under

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146 its dental benefit plan or a health insurer’s contracted vendor
147 must:
148 a. Notify the dentist if any fees are associated with a
149 particular payment method.
150 b. Advise the dentist of the available payment methods and
151 provide clear instructions to the dentist as to how to select an
152 alternative payment method.
153 2. If initiating or changing payments to a dentist to
154 payments made through the Automated Clearing House Network, as
155 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health
156 insurer under its dental benefit plan or a health insurer’s
157 contracted vendor may not charge a fee solely to transmit the
158 payment to the dentist, unless the dentist has consented to the
159 fee. However, a dentist’s agent may charge the dentist
160 reasonable fees when transmitting an Automated Clearing House
161 Network payment related to transaction management, data
162 management, portal services, and other value-added services in
163 addition to the bank transmittal.
164 (c) The commission shall enforce this subsection.
165 (2) A health insurer providing coverage for dental services
166 may not deny a claim submitted by a dentist licensed under
167 chapter 466 for a procedure specifically included in a prior
168 authorization unless at least one of the following circumstances
169 applies:
170 (a) Benefit limitations such as annual maximums and
171 frequency limitations not applicable at the time of the prior
172 authorization are reached due to use after issuance of the prior
173 authorization.
174 (b) If, after issuance of the prior authorization, a new

175 procedure is provided to the patient or a change in the
176 condition of the patient occurs such that the prior authorized
177 procedure would:
178 1. No longer be considered medically necessary, based on
179 the prevailing standard of care; or
180 2. At the time of the use of the procedure, require denial
181 of authorization pursuant to the terms and conditions for
182 coverage under the patient’s plan in effect at the time the
183 prior authorization was used.
184 (c) The patient receiving the procedure was not eligible to
185 receive the procedure on the date of service, and the dentist
186 did not know, and with the exercise of reasonable care could not
187 have known, of the patient’s eligibility status.
188 (d) Another payer is responsible for the payment.
189 (e) The dentist has already been paid for the procedure
190 identified on the claim.
191 (f) The documentation for the claim provided by the person
192 submitting the claim clearly fails to support the claim as
193 originally authorized.
194 (g) The claim was submitted fraudulently, or the prior
195 authorization was based in whole or material part on erroneous
196 information provided by the dentist, the patient, or any other
197 person not related to the health insurer.
198 (3) The provisions of this section may not be waived by
199 contract. A contractual clause that is in conflict with this
200 section or that purports to waive any requirement of this
201 section is void.
202 Section 4. Subsection (13) of section 636.035, Florida
203 Statutes, is amended, and subsections (15) and (16) are added to

204 that section, to read:
205 636.035 Provider arrangements.—
206 (13) A contract between a prepaid limited health service
207 organization and a dentist licensed under chapter 466 for the
208 provision of services to a subscriber of the prepaid limited
209 health service organization may not contain a provision that
210 requires the dentist to provide services to the subscriber of
211 the prepaid limited health service organization at a fee set by
212 the prepaid limited health service organization unless such
213 services are covered services under the applicable contract. As
214 used in this subsection, the term “covered services” means
215 dental care services for which a reimbursement is available
216 under the subscriber’s contract, notwithstanding ~~or for which a~~
217 ~~reimbursement would be available but for~~ the application of
218 contractual limitations such as deductibles, coinsurance,
219 waiting periods, annual or lifetime maximums, frequency
220 limitations, alternative benefit payments, or any other
221 limitation.
222 (15)(a) A contract between a prepaid limited health service
223 organization and a dentist licensed under chapter 466 for the
224 provision of dental services to a subscriber may not contain
225 restrictions by the prepaid limited health service organization
226 or its contracted vendor on methods of payment by the prepaid
227 limited health service organization or its contracted vendor to
228 the dentist in which the only acceptable payment method is by
229 credit card.
230 (b)1. If initiating or changing payments to a dentist to
231 payments made by electronic funds transfers, including virtual
232 credit card payments, a prepaid limited health service

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233 organization under its dental benefit plan or a prepaid limited
234 health service organization's contracted vendor must:
235 a. Notify the dentist if any fees are associated with a
236 particular payment method.
237 b. Advise the dentist of the available payment methods and
238 provide clear instructions to the dentist as to how to select an
239 alternative payment method.
240 2. If initiating or changing payments to a dentist to
241 payments made through the Automated Clearing House Network, as
242 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a prepaid
243 limited health service organization under its dental benefit
244 plan or a prepaid limited health service organization's
245 contracted vendor may not charge a fee solely to transmit the
246 payment to the dentist, unless the dentist has consented to the
247 fee. However, a dentist's agent may charge the dentist
248 reasonable fees when transmitting an Automated Clearing House
249 Network payment related to transaction management, data
250 management, portal services, and other value-added services in
251 addition to the bank transmittal.
252 (c) The provisions of this subsection may not be waived by
253 contract. A contractual clause that is in conflict with this
254 subsection or that purports to waive any requirement of this
255 subsection is void.
256 (d) The commission shall enforce this subsection.
257 (16)(a) A prepaid limited health service organization
258 providing coverage for dental services may not deny a claim
259 submitted by a dentist licensed under chapter 466 for a
260 procedure specifically included in a prior authorization unless
261 at least one of the following circumstances applies:

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262 1. Benefit limitations such as annual maximums and
263 frequency limitations not applicable at the time of the prior
264 authorization are reached due to use after issuance of the prior
265 authorization.
266 2. If, after issuance of the prior authorization, a new
267 procedure is provided to the patient or a change in the
268 condition of the patient occurs such that the prior authorized
269 procedure would:
270 a. No longer be considered medically necessary, based on
271 the prevailing standard of care; or
272 b. At the time of the use of the procedure, require denial
273 of authorization pursuant to the terms and conditions for
274 coverage under the patient's plan in effect at the time the
275 prior authorization was used.
276 3. The patient receiving the procedure was not eligible to
277 receive the procedure on the date of service, and the dentist
278 did not know, and with the exercise of reasonable care could not
279 have known, of the patient's eligibility status.
280 4. Another payer is responsible for the payment.
281 5. The dentist has already been paid for the procedure
282 identified on the claim.
283 6. The documentation for the claim provided by the person
284 submitting the claim clearly fails to support the claim as
285 originally authorized.
286 7. The claim was submitted fraudulently, or the prior
287 authorization was based in whole or material part on erroneous
288 information provided by the dentist, the patient, or any other
289 person not related to the prepaid limited health service
290 organization.

291 (b) The provisions of this subsection may not be waived by
292 contract. A contractual clause that is in conflict with this
293 subsection or that purports to waive any requirement of this
294 subsection is void.
295 Section 5. Subsection (11) of section 641.315, Florida
296 Statutes, is amended, and subsections (13) and (14) are added to
297 that section, to read:
298 641.315 Provider contracts.—
299 (11) A contract between a health maintenance organization
300 and a dentist licensed under chapter 466 for the provision of
301 services to a subscriber of the health maintenance organization
302 may not contain a provision that requires the dentist to provide
303 services to the subscriber of the health maintenance
304 organization at a fee set by the health maintenance organization
305 unless such services are covered services under the applicable
306 contract. As used in this subsection, the term "covered
307 services" means dental care services for which a reimbursement
308 is available under the subscriber's contract, notwithstanding ~~or~~
309 ~~for which a reimbursement would be available but for~~ the
310 application of contractual limitations such as deductibles,
311 coinsurance, waiting periods, annual or lifetime maximums,
312 frequency limitations, alternative benefit payments, or any
313 other limitation.
314 (13)(a) A contract between a health maintenance
315 organization and a dentist licensed under chapter 466 for the
316 provision of dental services to a subscriber of the health
317 maintenance organization may not contain restrictions by the
318 health maintenance organization or its contracted vendor on
319 methods of payment by the health maintenance organization or its

320 contracted vendor to the dentist in which the only acceptable
321 payment method is by credit card.
322 1. If initiating or changing payments to a dentist to
323 payments made by electronic funds transfers, including virtual
324 credit card payments, a health maintenance organization under
325 its dental benefit plan or a health maintenance organization's
326 contracted vendor must:
327 a. Notify the dentist if any fees are associated with a
328 particular payment method.
329 b. Advise the dentist of the available payment methods and
330 provide clear instructions to the dentist as to how to select an
331 alternative payment method.
332 2. If initiating or changing payments to a dentist to
333 payments made through the Automated Clearing House Network, as
334 provided under 45 C.F.R. ss. 162.1601 and 162.1602, a health
335 maintenance organization under its dental benefit plan or
336 through a contracted vendor may not charge a fee solely to
337 transmit the payment to the dentist, unless the dentist has
338 consented to the fee. However, a dentist's agent may charge the
339 dentist reasonable fees when transmitting an Automated Clearing
340 House Network payment related to transaction management, data
341 management, portal services, and other value-added services in
342 addition to the bank transmittal.
343 (b) The provisions of this subsection may not be waived by
344 contract. A contractual clause that is in conflict with this
345 subsection or that purports to waive any requirement of this
346 subsection is void.
347 (c) The commission shall enforce this subsection.
348 (14)(a) A health maintenance organization providing

349 coverage for dental services may not deny a claim submitted by a
350 dentist licensed under chapter 466 for a procedure specifically
351 included in a prior authorization unless at least one of the
352 following circumstances applies:
353 1. Benefit limitations such as annual maximums and
354 frequency limitations not applicable at the time of the prior
355 authorization are reached due to use after issuance of the prior
356 authorization.
357 2. If, after issuance of the prior authorization, a new
358 procedure is provided to the patient or a change in the
359 condition of the patient occurs such that the prior authorized
360 procedure would:
361 a. No longer be considered medically necessary, based on
362 the prevailing standard of care; or
363 b. At the time of the use of the procedure, require denial
364 of authorization pursuant to the terms and conditions for
365 coverage under the patient’s plan in effect at the time the
366 prior authorization was used.
367 3. The patient receiving the procedure was not eligible to
368 receive the procedure on the date of service, and the dentist
369 did not know, and with the exercise of reasonable care could not
370 have known, of the patient’s eligibility status.
371 4. Another payer is responsible for the payment.
372 5. The dentist has already been paid for the procedure
373 identified on the claim.
374 6. The documentation for the claim provided by the person
375 submitting the claim clearly fails to support the claim as
376 originally authorized.
377 7. The claim was submitted fraudulently, or the prior

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378 authorization was based in whole or material part on erroneous
379 information provided by the dentist, the patient, or any other
380 person not related to the health maintenance organization.
381 (b) The provisions of this subsection may not be waived by
382 contract. A contractual clause that is in conflict with this
383 subsection or that purports to waive any requirement of this
384 subsection is void.
385 Section 6. This act shall take effect July 1, 2023.

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