**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

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| BILL: | SB 892 |
| INTRODUCER: | Senator Harrell |
| SUBJECT: | Dental Insurance Claims |
| DATE: | February 5, 2024 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Johnson | Knudson | BI | **Pre-meeting** |
| 2. | | | AEG | |
| 3. | | | FP | |

## I. Summary:


SB 892 revises provisions within the Florida Insurance Code relating to covered dental services, contractual agreements, and dental claims payments by an insurer, prepaid limited health service organization (PLHSO), or a health maintenance organization (HMO). The bill provides the following changes:

- Revises the definition of covered services, and as a result, if an insurer, HMO, or PLHSO denies service due to a contractual limitation (maximum benefits paid prior to the end of the plan year), then the procedure would be considered a non-covered service and the dentist would not be subject to the negotiated rate, and may charge patient a higher rate.
- Prohibits a contract between a dentist and a health insurer, HMO or PLHSO from limiting the method of claim payments for dental services to credit card payments only.
- Requires a health insurer, PLHSO, or HMO to disclose in writing to a dentist any fees associated with an electronic funds transfer (EFT) and alternative payment methods at least 10 days before the insurer, HMO or PLHSO pays a dentist via EFT.
- Prohibits an insurer, HMO or PLHSO that pays a claim to a dentist through Automatic Clearing House (ACH) from charging a fee solely to transmit the payment unless the dentist has consented to the fee.
- Authorizes an insurer, HMO, or PLHSO to impose reasonable fees for other value-added services related to an ACH transfer.
- Limits circumstances in which an insurer, HMO, or PLHSO may deny the payment of a claim if the procedure was previously authorized by an insurer, HMO, or PLHSO prior to the dentist rendering the service. These circumstances include:
  - Benefit limitations being reached subsequent to the issuance of the prior authorization.
  - Inadequate documentation submitted by a dentist to support the originally authorized procedures and claim.
  - Changes in the insured's condition or new procedures are provided to the insured subsequent to the issuance of the prior authorization.

- The denial of the dental service claim was due another payor being responsible for payment or the dentist has already been paid for the procedures identified in the claim.
- The person receiving the procedure was not eligible to receive the procedure on the date of service and the insurer, HMO, or PLHSO did not know of the ineligibility.

The fiscal impact of the bill on State Group Insurance is unknown.

## II. Present Situation:

### State Regulation of Insurance

The Office of Insurance Regulation (OIR),[1] is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[2] To transact business in Florida, a health insurer or HMO must obtain a certificate of authority from the OIR.[3] The Agency for Health Administration (Agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the Agency.[4] As part of the certification process used by the Agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[5]

***Statutory Cost Containment Requirements***

Insurers or HMOs use many cost containment and utilization review strategies to manage medical and drug spending and patient safety. For example, insurers or HMOs may place utilization management requirements on the use of certain medical treatments or drugs on their formulary.

Section 627.4234, F.S., requires a health insurance policy or health care services plan, which provides medical, hospital, or surgical expense coverage delivered or issued for delivery in this state to contain one or more of the following procedures or provisions to contain health insurance costs or mitigate cost increases:

- Coinsurance.
- Deductible amounts.
- Utilization review.
- Audits of provider bills to verify that services and supplies billed were furnished and that proper charges were made.
- Scheduled benefits.
- Benefits for preadmission testing.

[1] The OIR is a unit under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. Commission members serve as the agency head for purposes of rulemaking under ch. 120, F.S. See s. 20.121(3), F.S.
[2] Section 20.121(3)(a), F.S.
[3] Sections 624.401 and 641.49, F.S.
[4] Section 641.495, F.S.
[5] *Id.*

- Any lawful measure or combination of measures for which the insurer provides to the office information demonstrating that the measure or combination of measures is reasonably expected to have an effect toward containing health insurance costs or cost increases.

**Denial of Claims**

Coverage for medical services can be denied before or after the service has been provided, through denial of preauthorization requests, through denial of claims for payment, or a retroactive denial of payment. As a condition for coverage of some services, providers or insureds are required to request authorization prior to the provision of the procedure. The full claim or certain lines of the claim may be denied, such as a surgery with charges for multiple procedures and supplies.

There are many possible reasons for claim denials.[6] Claims may be denied due to an incorrect diagnosis code, incomplete claim submission, or the submission of a duplicate claim. Eligibility issues can cause claims to be denied. For example, a claim may be submitted for a service provided prior to an individual's effective date of coverage or after it has been terminated. Finally, claim denials can occur when a determination is made that the service provided was not covered or it was not medically necessary. Denied claims[7] may be appealed.

After an insurer or HMO pays a claim, the insurer or HMO may conduct a claims audit to verify claims were paid appropriately and accurately. Such an audit can be triggered by a variety of reasons.[8] Some of these situations include new billing guidelines have been established by regulators; the provider has made significant changes to the original bill, such as the diagnosis of the patient; the plan is notified that the enrollee's coverage is terminated due to non-payment of premiums; or the plan is notified that the enrollee has other health insurance coverage. After the audit, an insurer or HMO may retrospectively deny a claim for a preauthorized service and try to recoup the payment from the provider. Reasons for the retroactive denial may include fraud, submission of incomplete or inaccurate information; nonpayment of premiums; exhaustion of benefits; coordination of benefits; or if the individual was not enrolled or eligible for coverage at the time services were rendered.[9] As a result, an insurer or HMO may try to recoup payment from a provider by retroactively denying a previously paid claim.

***Group Health Plans Retroactive Termination of Coverage***

Retroactive termination of insurance coverage to an earlier date due to an employee's discharge is an increasing problem for some providers and consumers. Some plans may allow an employer to cancel coverage of an employee retroactively more than 90 days post termination. Other plans will accept retroactive terminations for up to the preceding three months, if the plan has not paid any claims for the insurer or HMO during that period. If claims have been paid within the previous 60 days, the coverage termination date may be established as of the end of the month in which services were rendered.

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[6] Claims Denials and Appeals in ACA Marketplace Plans in 2021 | KFF (Feb. 9, 2023) (last visited Jan. 31, 2024).
[7] How to appeal an insurance company decision | HealthCare.gov (last visited Jan. 20, 2024).
[8] 10 Factors that Could Trigger an Audit of Your Medical Records | LW Consulting, Inc. (lw-consult.com) (last visited Jan. 30, 2024).
[9] Microsoft Word - Brevard_Indian River County Auth List_4-16 (hf.org) (last visited Jan. 30, 2024).

When a provider is notified of a retroactive termination, the provider may have already verified that the insured or subscriber was covered, rendered services in reliance and expectation of payment, and even received payment. Retroactive terminations often result in the provider or the consumer bearing the loss, despite the verified eligibility.

***Federal Subsidized Individual Policies or Contracts and Grace Periods***

The federal Patient Protection and Affordable Care Act (PPACA)[10] guarantees access to coverage and mandates certain essential health benefits, including pediatric dental coverage,[11] and other requirements. To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and moderate-income individuals to purchase qualified health plans (QHPs) on a state or federal exchange.[12] For plan year 2024, Florida enrollees accounted for about 20 percent (4,211,902 individuals) of the 21.2 million total individuals) enrolled through the state and federal exchanges.[13] For plan year 2023, approximately 3,108,149 Floridians enrolled, and about 97 percent received tax credits.[14]

Under PPACA, insurers and HMOs must provide a grace period[15] of at least three consecutive months[16] before cancelling the policy or contract of a federally subsidized enrollee who is delinquent if the enrollee previously paid 1-month's premium. During the grace period, the insurer or HMO must pay all appropriate claims for services provided during the first month of the grace period. For the second and third months, an insurer may pend claims. Insurers or HMOs must notify providers that may be affected that an enrollee has lapsed in his or her payment of premiums and there is a possibility the insurer or HMO may deny the payment of claims incurred during the second and third months.[17]

If the insured or subscriber resolves all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third month would be denied. If coverage is terminated, the termination date is the last day of the first month of the grace period and the insurer may not recoup any payment for claims made during the first month of the grace period. At the end of grace period, the provider may seek payment for the medical services the insurer denied for months two and three. According to a

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[10] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended several provisions of the PPACA, was enacted on March 30, 2010.

[11] Dental coverage is an essential health benefit for children under age 18, and must be available for a child either as part of a health plan or as a separate dental plan. https://www.healthcare.gov/coverage/dental-coverage/ (last visited Jan. 30, 2024).

[12] In general, individuals and families may be eligible for the premium tax credit if their household income for the year is at least 100 percent but no more than 400 percent of the federal poverty line for their family size. https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last viewed Feb. 24, 2024).

[13] Centers for Medicare and Medicaid Services, Marketplace 2024 Open Enrollment Period Report: Final National Snapshot (Jan. 24, 2024) Marketplace 2024 Open Enrollment Period Report: Final National Snapshot | CMS

[14] Centers for Medicare and Medicaid Services, Effectuated Enrollment: Early 2023 Snapshot and Full Year 2022 Average (March 2023) https://www.cms.gov/files/document/early-2023-and-full-year-2022-effectuated-enrollment-report.pdf (last visited Feb. 1, 2024).

[15] Example of grace period: Premium is not paid in May. Premium payments are made in June and July. Grace period would end July 31. Coverage would be cancelled retroactively to the last day of May. See https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/ (last viewed Mar. 9, 2017).

[16] 45 C.F.R. s. 155.430.

[17] 45 C.F.R. s. 156.270.

2014 survey, 48 percent of the providers not participating with any PPACA exchange products cited concerns about assuming financial liability during the grace period as a reason for their decision.[18]

According to the OIR, there are plans on the Exchange that offer dental coverage for either an adult or child or both embedded in a policy or contract. There are plans on the Exchange that offer standalone dental coverage, and such coverage may vary by county. Typically, insurers and HMOs submit rate filings for policies or contracts in June and finalize such filings by August for the following calendar plan year.[19]

***Grace Periods for Policies or Contracts without a Federal Subsidy***

The federal regulation governing grace periods for federally subsidized policies or contracts does not affect policies or contracts of individuals who are not enrolled in an exchange QHP or who are enrolled in an exchange QHP and do not receive a subsidy. The grace period for these individual policies or contracts remain at the length required under Florida law,[20] 14 which varies by the duration of the premium payment interval. During the grace period, the policy or contract stays in force. The policy is in force during the grace period, thus the insurer or HMO must affirm that an individual is insured, even when the payment is late and remains unpaid during the grace period. If the insurer or HMO does not receive the full payment of the premium by the end of the grace period, coverage terminates as of the grace period start date and the insurer or HMO may retroactively deny any claims incurred during the grace period.

***Oversight of HMO Contracts with Dentists***

A contract between an HMO and a dentist licensed under chapter 466, F.S., for the provision of services to a subscriber of the HMO 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.[21] The term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, 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.[22]

***Oversight of Prepaid Limited Health Services Organizations (PLHSOs) Contracts with Dentists***

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[18] Tracy Gnadinger, Health Policy Brief: The Ninety-Day Grace Period, (Oct. 16, 2014) *available at* http://healthaffairs.org/blog/2014/10/17/health-policy-brief-the-ninety-day-grace-period/ (last viewed Jan. 31, 2024).

[19] Correspondence with K. Jacobs, Deputy Chief of Staff, OIR (Feb. 2, 2024). On file with Senate Banking and Insurance Committee.

[20] Sections 627.608 and 641.31(15), F.S. The grace period of an individual policy must be a minimum of 7 days for weekly premium; 10 days for a monthly premium; and 31 days for all other periods. The grace period of a HMO contract must be at least 10 days. For group policies, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due. [Section 627.6645, F.S.].

[21] Section 641.315(11), F.S.

[22] *Id.*

Pursuant to Part I of ch. 636, F.S., the OIR regulates PLHSOs. A PLHSO is any entity which, in return for a prepayment, provides limited health services to enrollees through an exclusive panel of providers.[23] Prepaid limited health service organization does not include:

- An entity otherwise authorized pursuant to the laws of this state to indemnify for any limited health service;
- A provider or entity when providing limited health services pursuant to a contract with a prepaid limited health service organization, an HMO, a health insurer, or a self-insurance plan; or
- Any person who is licensed pursuant to part II of ch. 636, F.S., as a discount plan organization.[24]

A PLHSO provides the following limited health services:

- Ambulance services;
- Dental care services;
- Vision care services;
- Mental health services;
- Substance abuse services;
- Chiropractic services;
- Podiatric care services; and pharmaceutical services.[25]

The PLHSO arrangements or contracts with providers PLHSOs are governed by s. 636.035, F.S. A contract between a PLHSO and a dentist licensed under chapter 466, F.S., for the provision of services to a subscriber of the PHLSO, 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 PLHSO unless such services are covered services under the applicable contract. As used in subsection (7), the term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, 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.

***Prompt Payment of Health Insurer and HMO Claims***

The Florida Insurance Code prescribes rights and responsibilities of health care providers, health insurers, and HMOs for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131, 627.662, and 641.3155, F.S., respectively.[26] The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs to use for the payment or denial of the claims.

[23] Section 636.003(7), F.S.
[24] *Id.*
[25] Section 636.003(5), F.S.
[26] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organizations, and specified contracts.

**Division of State Group Insurance**

Under the authority of s. 110.123, F.S., the Department of Management Services, through the Division of State Group Insurance, administers the state group health insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the state group health insurance program, DMS contracts with third party administrators for self-insured health plans and insured (HMOs), as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S.

**Oversight of the Practice of Dentistry in Florida**

The Board of Dentistry (BOD) within the Department of Health is the state's regulatory board for the practice of dentistry, dental hygienists, and dental assistants under the Dental Practice Act.[27] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[28]

**Credit Virtual Card Payments and Fees Imposed on Dentists[29]**

According to the American Dental Association (ADA), dental insurance companies and third party administrators may pay dental offices with a credit or debit card instead of a traditional check. Many companies provide virtual credit card services and offer a virtual stored-value debit card program designed specifically for claims payments. Generally, the cards are delivered to the dental office either by fax or email. Then, the dental office processes the payment by entering the card number, security code, expiration date and amount.

The ADA notes that companies may market the quicker reimbursement as a benefit for dentists to use the credit/virtual card; however, dentists may incur a higher processing fee for virtual cards than a traditional debit or credit card transaction. The ADA suggests that a dental office can request to opt out of using the card and instead receive a paper check as payment for services rendered. The ADA suggests that a dental office may need to contact the card issuing company and not necessarily the dental plan to resolve this payment issue.

A representative of the Florida Dental Association noted that 21 states have enacted legislation to address credit or virtual card payments.[30]

## III. Effect of Proposed Changes:

**Credit Card Payments and Fees (Sections 1, 3, and 5)**
The bill prohibits a health insurer, HMO or PLHSO from specifying credit card payment as the only acceptable method for payments to the dentist. The bill requires a health insurer, HMO or PLHSO to provide a written notice to the dentist at least 10 days before the payment of a claim

[27] Section 466.004, F.S.
[28] Section 466.003(3), F.S.
[29] Credit Virtual Card Payment (ada.org) (2021) (last visited Jan. 31, 2024).
[30] Correspondence from Joe Ann Hart, (Feb. 1, 2024) on file with Senate Banking and Insurance Committee. See also ADA Dental Insurance Reform Virtual Credit Cards Dental Insurance Reform, Virtual Credit Cards, and State Law. (2021) (last visited Jan. 31, 2024).

to a dentist through electronic funds transfer, including but not limited to, virtual credit card payments the following information:

- The fee, if any, associated with the electronic funds transfer.
- The available methods of payment of claims by the health insurer, HMO or PLHSO including instructions to the dentist on how to select an alternative payment.

Further, the bill:

- Prohibits a health insurer, HMO or PLHSO that pays a claim to a dentist through an Automated Clearing House (ACH) transfer to charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee.
- Allows a health insurer, HMO or PLHSO to charge reasonable fees for other value-added services related to the ACH transfer, including transaction management, data management, and portal services.
- Provides that these provisions may not be waived, voided, or nullified by contract.
- Authorizes the OIR to enforce these provisions pursuant to their general powers provided in s. 624.307, F.S.
- Authorizes the Financial Services Commission to adopt rules.

**Limitations on Insurers, HMOs, or PLHSOs Denying Payment of Claims for Procedures Included in Prior Authorizations (Sections 1, 4, and 5)**

The bill prohibits an insurer, HMO or PLHSO from denying any claim subsequently submitted by a dentist for procedures that were included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

- 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.
- The documentation provided by the person submitting the claim fails to support the claim as originally authorized.
- 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.
- 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.
- The denial of the claim was due to one of the following:
  - Another payor is responsible for payment.
  - The dentist has already been paid for the procedures identified in the claim.
  - 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, patient, or other person not related to the insurer.
  - The person receiving the procedure was not eligible to receive the procedure on the date of service and the health insurer did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

Further, the bill provides that these provisions may not be waived, voided, or nullified by contract. The bill authorizes the OIR to enforce these provisions pursuant to their general powers provided in s. 624.307, F.S., and authorizes the Financial Services Commission to adopt rules.

**Provider Contracts and Covered Services (Sections 2, 4, and 5)**

The bill revises the definition of covered services to mean dental care services for which a reimbursement is available under the contract or agreement of the insurer, HMO or PLHSO, notwithstanding the application of contractual limitations, such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation. As a result, if an insured or subscriber reaches their benefit limits prior to the end of plan year, the dentist is not required to bill the insured or subscriber at the negotiated rate. The dentist may charge a higher rate.

**Effective Date (Section 6)**

Provides the bill is effective July 1, 2024.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Dentists may experience savings in fees if they may opt out of the payment of claims by credit cards. Further, dentists may realize additional revenues if an insurer, HMO or PLHSO is limited in their ability to subsequently deny claims that they previously authorized. The impact on insurers, HMOs or PLHSOs is indeterminate.

Insureds or subscribers that have exhausted their dental policy limits prior to the end of the policy or contract period may not be able to obtain additional services at the negotiated rate if the dentist chooses to use a higher rate.

Federal regulations govern the grace period and payment of claims of individuals receiving federally subsidized products on the exchange. This bill would not apply to such claims.

The provisions of the bill would not apply to ERISA (Federal Employee Retirement Income Security Act of 1974)[31]22 self-insured plans. ERISA preempts the regulation of such plans by the state.

C. Government Sector Impact:

The fiscal impact of the bill on State Group Insurance is unknown.

## VI. Technical Deficiencies:

The bill allows a health insurer, PLHSO, or HMO to charge reasonable fees for other value-added services related to the ACH transfer, including transaction management, data management, and portal services. The term, "reasonable fees," is not defined.

## VII. Related Issues:

None.

## VIII. Statutes Affected:

This bill substantially amends sections 627.6131, 627.6474, 636.032, 636.035, and 641.315 of the Florida Statutes.

## IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

[31] 29 U.S.C. 1001 *et seq*. (19740.

B. Amendments:

None.