

By Senator Harrell

31-00708-24

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1                                   A bill to be entitled  
2       An act relating to dental insurance claims; amending  
3       s. 627.6131, F.S.; prohibiting a contract between a  
4       health insurer and a dentist from containing certain  
5       restrictions on payment methods; requiring a health  
6       insurer to make certain notifications before paying a  
7       claim to a dentist through electronic funds transfer;  
8       prohibiting a health insurer from charging a fee to  
9       transmit a payment to a dentist through ACH transfer  
10      unless the dentist has consented to such fee;  
11      authorizing a health insurer to charge reasonable fees  
12      for other value-added services related to the ACH  
13      transfer; providing construction; authorizing the  
14      Office of Insurance Regulation of the Financial  
15      Services Commission to enforce certain provisions;  
16      authorizing the commission to adopt rules; prohibiting  
17      a health insurer from denying claims for procedures  
18      included in a prior authorization; providing  
19      exceptions; providing construction; authorizing the  
20      office to enforce certain provisions; authorizing the  
21      commission to adopt rules; amending s. 627.6474, F.S.;  
22      revising the definition of the term "covered  
23      services"; amending s. 636.032, F.S.; prohibiting a  
24      contract between a prepaid limited health service  
25      organization and a dentist from containing certain  
26      restrictions on payment methods; requiring the prepaid  
27      limited health service organization to make certain  
28      notifications before paying a claim to a dentist  
29      through electronic funds transfer; prohibiting a

31-00708-24

2024892\_\_

30 prepaid limited health service organization from  
31 charging a fee to transmit a payment to a dentist  
32 through ACH transfer unless the dentist has consented  
33 to such fee; authorizing the prepaid limited health  
34 service organization to charge reasonable fees for  
35 other value-added services related to the ACH  
36 transfer; providing construction; authorizing the  
37 office to enforce certain provisions; authorizing the  
38 commission to adopt rules; amending s. 636.035, F.S.;  
39 revising the definition of the term "covered  
40 services"; prohibiting a prepaid limited health  
41 service organization from denying claims for  
42 procedures included in a prior authorization;  
43 providing exceptions; providing construction;  
44 authorizing the office to enforce certain provisions;  
45 authorizing the commission to adopt rules; amending s.  
46 641.315, F.S.; revising the definition of the term  
47 "covered service"; prohibiting a contract between a  
48 health maintenance organization and a dentist from  
49 containing certain restrictions on payment methods;  
50 requiring the health maintenance organization to make  
51 certain notifications before paying a claim to a  
52 dentist through electronic funds transfer; prohibiting  
53 a health maintenance organization from charging a fee  
54 to transmit a payment to a dentist through ACH  
55 transfer unless the dentist has consented to such fee;  
56 authorizing the health maintenance organization to  
57 charge reasonable fees for other value-added services  
58 related to the ACH transfer; providing construction;

31-00708-24

2024892\_\_

59 authorizing the office to enforce certain provisions;  
60 authorizing the commission to adopt rules; prohibiting  
61 a health maintenance organization from denying claims  
62 for procedures included in a prior authorization;  
63 providing exceptions; providing construction;  
64 authorizing the office to enforce certain provisions;  
65 authorizing the commission to adopt rules; providing  
66 an effective date.

67

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

69

70 Section 1. Subsections (20) and (21) are added to section  
71 627.6131, Florida Statutes, to read:

72 627.6131 Payment of claims.—

73 (20) (a) A contract between a health insurer and a dentist  
74 licensed under chapter 466 for the provision of services to an  
75 insured may not specify credit card payment as the only  
76 acceptable method for payments from the health insurer to the  
77 dentist.

78 (b) At least 10 days before a health insurer pays a claim  
79 to a dentist through electronic funds transfer, including, but  
80 not limited to, virtual credit card payments, the health insurer  
81 shall notify the dentist in writing of all of the following:

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

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

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

31-00708-24

2024892\_\_

88 Automated Clearing House (ACH) transfer may not charge a fee  
89 solely to transmit the payment to the dentist unless the dentist  
90 has consented to the fee. A health insurer may charge reasonable  
91 fees for other value-added services related to the ACH transfer,  
92 including, but not limited to, transaction management, data  
93 management, and portal services.

94 (d) This subsection may not be waived, voided, or nullified  
95 by contract, and any contractual clause in conflict with this  
96 subsection or which purports to waive any requirements of this  
97 subsection is null and void.

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

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

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

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

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

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

31-00708-24

2024892\_\_

117 based on the prevailing standard of care.

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

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

125 a. Another payor is responsible for payment.

126 b. The dentist has already been paid for the procedures  
127 identified in the claim.

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

132 d. The person receiving the procedure was not eligible to  
133 receive the procedure on the date of service and the health  
134 insurer did not know, and with the exercise of reasonable care  
135 could not have known, of his or her ineligibility.

136 (b) This subsection may not be waived, voided, or nullified  
137 by contract, and any contractual clause in conflict with this  
138 subsection or which purports to waive any requirements of this  
139 subsection is null and void.

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

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

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

31-00708-24

2024892\_\_

146 627.6474 Provider contracts.—

147 (2) A contract between a health insurer and a dentist  
148 licensed under chapter 466 for the provision of services to an  
149 insured may not contain a provision that requires the dentist to  
150 provide services to the insured under such contract at a fee set  
151 by the health insurer unless such services are covered services  
152 under the applicable contract. As used in this subsection, the  
153 term "covered services" means dental care services for which a  
154 reimbursement is available under the insured's contract,  
155 notwithstanding ~~or for which a reimbursement would be available~~  
156 ~~but for~~ the application of contractual limitations, such as  
157 deductibles, coinsurance, waiting periods, annual or lifetime  
158 maximums, frequency limitations, alternative benefit payments,  
159 or any other limitation.

160 Section 3. Section 636.032, Florida Statutes, is amended to  
161 read:

162 636.032 Acceptable payments.—

163 (1) Each prepaid limited health service organization may  
164 accept from government agencies, corporations, groups, or  
165 individuals payments covering all or part of the cost of  
166 contracts entered into between the prepaid limited health  
167 service organization and its subscribers.

168 (2) (a) A contract between a prepaid limited health service  
169 organization and a dentist licensed under chapter 466 for the  
170 provision of services to a subscriber may not specify credit  
171 card payment as the only acceptable method for payments from the  
172 prepaid limited health service organization to the dentist.

173 (b) At least 10 days before a limited health service  
174 organization pays a claim to a dentist through electronic funds

31-00708-24

2024892\_\_

175 transfer, including, but not limited to, virtual credit card  
176 payments, the prepaid limited health service organization shall  
177 notify the dentist in writing of all of the following:

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

180 2. The available methods of payment of claims by the  
181 prepaid limited health service organization, with clear  
182 instructions to the dentist on how to select an alternative  
183 payment method.

184 (c) A prepaid limited health service organization that pays  
185 a claim to a dentist through Automatic Clearing House (ACH)  
186 transfer may not charge a fee solely to transmit the payment to  
187 the dentist unless the dentist has consented to the fee. A  
188 prepaid limited health service organization may charge  
189 reasonable fees for other value-added services related to the  
190 ACH transfer, including, but not limited to, transaction  
191 management, data management, and portal services.

192 (d) This subsection may not be waived, voided, or nullified  
193 by contract, and any contractual clause in conflict with this  
194 subsection or which purports to waive any requirements of this  
195 subsection is null and void.

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

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

200 Section 4. Subsection (13) of section 636.035, Florida  
201 Statutes, is amended, and subsection (15) is added to that  
202 section, to read:

203 636.035 Provider arrangements.—

31-00708-24

2024892\_\_

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

220 (15) (a) A prepaid limited health service organization may  
221 not deny any claim subsequently submitted by a dentist licensed  
222 under chapter 466 for procedures specifically included in a  
223 prior authorization unless at least one of the following  
224 circumstances applies for each procedure denied:

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

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

231 3. Subsequent to the issuance of the prior authorization,  
232 new procedures are provided to the patient or a change in the



31-00708-24

2024892\_\_

233 condition of the patient occurs such that the prior authorized  
234 procedure would no longer be considered medically necessary,  
235 based on the prevailing standard of care.

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

242 5. The denial of the dental service claim was due to one of  
243 the following:

244 a. Another payor is responsible for payment.

245 b. The dentist has already been paid for the procedures  
246 identified in the claim.

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

252 d. The person receiving the procedure was not eligible to  
253 receive the procedure on the date of service and the prepaid  
254 limited health service organization did not know, and with the  
255 exercise of reasonable care could not have known, of his or her  
256 ineligibility.

257 (b) This subsection may not be waived, voided, or nullified  
258 by contract, and any contractual clause in conflict with this  
259 subsection or which purports to waive any requirements of this  
260 subsection is null and void.

261 (c) The office has all rights and powers to enforce this

31-00708-24

2024892\_\_

262 subsection as provided by s. 624.307.

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

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

268 641.315 Provider contracts.—

269 (11) A contract between a health maintenance organization  
270 and a dentist licensed under chapter 466 for the provision of  
271 services to a subscriber of the health maintenance organization  
272 may not contain a provision that requires the dentist to provide  
273 services to the subscriber of the health maintenance  
274 organization at a fee set by the health maintenance organization  
275 unless such services are covered services under the applicable  
276 contract. As used in this subsection, the term "covered  
277 services" means dental care services for which a reimbursement  
278 is available under the subscriber's contract, notwithstanding ~~or~~  
279 ~~for which a reimbursement would be available but for the~~  
280 application of contractual limitations such as deductibles,  
281 coinsurance, waiting periods, annual or lifetime maximums,  
282 frequency limitations, alternative benefit payments, or any  
283 other limitation.

284 (13) (a) A contract between a health maintenance  
285 organization and a dentist licensed under chapter 466 for the  
286 provision of services to a subscriber of the health maintenance  
287 organization may not specify credit card payment as the only  
288 acceptable method for payments from the health maintenance  
289 organization to the dentist.

290 (b) At least 10 days before a health maintenance

31-00708-24

2024892\_\_

291 organization pays a claim to a dentist through electronic funds  
292 transfer, including, but not limited to, virtual credit card  
293 payments, the health maintenance organization shall notify the  
294 dentist in writing of all of the following:

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

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

300 (c) A health maintenance organization that pays a claim to  
301 a dentist through Automated Clearing House (ACH) transfer may  
302 not charge a fee solely to transmit the payment to the dentist  
303 unless the dentist has consented to the fee. A health  
304 maintenance organization may charge reasonable fees for other  
305 value-added services related to the ACH transfer, including, but  
306 not limited to, transaction management, data management, and  
307 portal services.

308 (d) This subsection may not be waived, voided, or nullified  
309 by contract, and any contractual clause in conflict with this  
310 subsection or which purports to waive any requirements of this  
311 subsection is null and void.

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

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

316 (14) (a) A health maintenance organization may not deny any  
317 claim subsequently submitted by a dentist licensed under chapter  
318 466 for procedures specifically included in a prior  
319 authorization unless at least one of the following circumstances

31-00708-24

2024892\_\_

320 applies for each procedure denied:

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

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

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

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

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

339 a. Another payor is responsible for payment.

340 b. The dentist has already been paid for the procedures  
341 identified in the claim.

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

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

31-00708-24

2024892\_\_

349 maintenance organization did not know, and with the exercise of  
350 reasonable care could not have known, of his or her  
351 ineligibility.

352 (b) The subsection may not be waived, voided, or nullified  
353 by contract, and any contractual clause in conflict with this  
354 subsection or which purports to waive any requirements of this  
355 subsection is null and void.

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

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

360 Section 6. This act shall take effect July 1, 2024.