By the Committee on Banking and Insurance; and Senator Harrell

597-03028-24 2024892c1

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 providing construction; authorizing the Office of
12 Insurance Regulation of the Financial Services
13 Commission to enforce certain provisions; authorizing
14 the commission to adopt rules; prohibiting a health
15 insurer from denying claims for procedures included in
16 a prior authorization; providing exceptions; providing
17 construction; authorizing the office to enforce
18 certain provisions; authorizing the commission to
19 adopt rules; amending s. 627.6474, F.S.; revising the
20 definition of the term "covered services"; amending s.
21 636.032, F.S.; prohibiting a contract between a
22 prepaid limited health service organization and a
23 dentist from containing certain restrictions on
24 payment methods; requiring the prepaid limited health
25 service organization to make certain notifications
26 before paying a claim to a dentist through electronic
27 funds transfer; prohibiting a prepaid limited health
28 service organization from charging a fee to transmit a
29 payment to a dentist through ACH transfer unless the

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

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

61

62 Section 1. Subsections (20) and (21) are added to section
63 627.6131, Florida Statutes, to read:
64 627.6131 Payment of claims.—
65 (20)(a) A contract between a health insurer and a dentist
66 licensed under chapter 466 for the provision of services to an
67 insured may not specify credit card payment as the only
68 acceptable method for payments from the health insurer to the
69 dentist.
70 (b) At least 10 days before a health insurer pays a claim
71 to a dentist through electronic funds transfer, including, but
72 not limited to, virtual credit card payments, the health insurer
73 shall notify the dentist in writing of all of the following:
74 1. The fees, if any, associated with the electronic funds
75 transfer.
76 2. The available methods of payment of claims by the health
77 insurer, with clear instructions to the dentist on how to select
78 an alternative payment method.
79 (c) A health insurer that pays a claim to a dentist through
80 Automated Clearing House (ACH) transfer may not charge a fee
81 solely to transmit the payment to the dentist unless the dentist
82 has consented to the fee.
83 (d) This subsection may not be waived, voided, or nullified
84 by contract, and any contractual clause in conflict with this
85 subsection or that purports to waive any requirements of this
86 subsection is null and void.
87 (e) The office has all rights and powers to enforce this

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88 subsection as provided by s. 624.307.
89 (f) The commission may adopt rules to implement this
90 subsection.
91 (21)(a) A health insurer may not deny any claim
92 subsequently submitted by a dentist licensed under chapter 466
93 for procedures specifically included in a prior authorization
94 unless at least one of the following circumstances applies for
95 each procedure denied:
96 1. Benefit limitations, such as annual maximums and
97 frequency limitations not applicable at the time of the prior
98 authorization, are reached subsequent to issuance of the prior
99 authorization.
100 2. The documentation provided by the person submitting the
101 claim fails to support the claim as originally authorized.
102 3. Subsequent to the issuance of the prior authorization,
103 new procedures are provided to the patient or a change in the
104 condition of the patient occurs such that the prior authorized
105 procedure would no longer be considered medically necessary,
106 based on the prevailing standard of care.
107 4. Subsequent to the issuance of the prior authorization,
108 new procedures are provided to the patient or a change in the
109 patient’s condition occurs such that the prior authorized
110 procedure would at that time have required disapproval pursuant
111 to the terms and conditions for coverage under the patient’s
112 plan in effect at the time the prior authorization was issued.
113 5. The denial of the claim was due to one of the following:
114 a. Another payor is responsible for payment.
115 b. The dentist has already been paid for the procedures
116 identified in the claim.

117 c. The claim was submitted fraudulently, or the prior
118 authorization was based in whole or material part on erroneous
119 information provided to the health insurer by the dentist,
120 patient, or other person not related to the insurer.
121 d. The person receiving the procedure was not eligible to
122 receive the procedure on the date of service and the health
123 insurer did not know, and with the exercise of reasonable care
124 could not have known, of his or her ineligibility.
125 (b) This subsection may not be waived, voided, or nullified
126 by contract, and any contractual clause in conflict with this
127 subsection or that purports to waive any requirements of this
128 subsection is null and void.
129 (c) The office has all rights and powers to enforce this
130 subsection as provided by s. 624.307.
131 (d) The commission may adopt rules to implement this
132 subsection.
133 Section 2. Subsection (2) of section 627.6474, Florida
134 Statutes, is amended to read:
135 627.6474 Provider contracts.—
136 (2) A contract between a health insurer and a dentist
137 licensed under chapter 466 for the provision of services to an
138 insured may not contain a provision that requires the dentist to
139 provide services to the insured under such contract at a fee set
140 by the health insurer unless such services are covered services
141 under the applicable contract. As used in this subsection, the
142 term “covered services” means dental care services for which a
143 reimbursement is available under the insured’s contract,
144 notwithstanding ~~or for which a reimbursement would be available~~
145 ~~but for~~ the application of contractual limitations such as

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146 deductibles, coinsurance, waiting periods, annual or lifetime
147 maximums, frequency limitations, alternative benefit payments,
148 or any other limitation.
149 Section 3. Section 636.032, Florida Statutes, is amended to
150 read:
151 636.032 Acceptable payments.—
152 (1) Each prepaid limited health service organization may
153 accept from government agencies, corporations, groups, or
154 individuals payments covering all or part of the cost of
155 contracts entered into between the prepaid limited health
156 service organization and its subscribers.
157 (2)(a) A contract between a prepaid limited health service
158 organization and a dentist licensed under chapter 466 for the
159 provision of services to a subscriber may not specify credit
160 card payment as the only acceptable method for payments from the
161 prepaid limited health service organization to the dentist.
162 (b) At least 10 days before a limited health service
163 organization pays a claim to a dentist through electronic funds
164 transfer, including, but not limited to, virtual credit card
165 payments, the prepaid limited health service organization shall
166 notify the dentist in writing of all of the following:
167 1. The fees, if any, that are associated with the
168 electronic funds transfer.
169 2. The available methods of payment of claims by the
170 prepaid limited health service organization, with clear
171 instructions to the dentist on how to select an alternative
172 payment method.
173 (c) A prepaid limited health service organization that pays
174 a claim to a dentist through Automatic Clearing House (ACH)

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175 transfer may not charge a fee solely to transmit the payment to
176 the dentist unless the dentist has consented to the fee.
177 (d) This subsection may not be waived, voided, or nullified
178 by contract, and any contractual clause in conflict with this
179 subsection or that purports to waive any requirements of this
180 subsection is null and void.
181 (e) The office has all rights and powers to enforce this
182 subsection as provided by s. 624.307.
183 (f) The commission may adopt rules to implement this
184 subsection.
185 Section 4. Subsection (13) of section 636.035, Florida
186 Statutes, is amended, and subsection (15) is added to that
187 section, to read:
188 636.035 Provider arrangements.—
189 (13) A contract between a prepaid limited health service
190 organization and a dentist licensed under chapter 466 for the
191 provision of services to a subscriber of the prepaid limited
192 health service organization may not contain a provision that
193 requires the dentist to provide services to the subscriber of
194 the prepaid limited health service organization at a fee set by
195 the prepaid limited health service organization unless such
196 services are covered services under the applicable contract. As
197 used in this subsection, the term "covered services" means
198 dental care services for which a reimbursement is available
199 under the subscriber's contract, notwithstanding ~~or for which a~~
200 ~~reimbursement would be available but for~~ the application of
201 contractual limitations such as deductibles, coinsurance,
202 waiting periods, annual or lifetime maximums, frequency
203 limitations, alternative benefit payments, or any other

204 limitation.

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

210 1. Benefit limitations, such as annual maximums and
211 frequency limitations not applicable at the time of the prior
212 authorization, are reached subsequent to issuance of the prior
213 authorization.

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

216 3. Subsequent to the issuance of the prior authorization,
217 new procedures are provided to the patient or a change in the
218 condition of the patient occurs such that the prior authorized
219 procedure would no longer be considered medically necessary,
220 based on the prevailing standard of care.

221 4. Subsequent to the issuance of the prior authorization,
222 new procedures are provided to the patient or a change in the
223 patient’s condition occurs such that the prior authorized
224 procedure would at that time have required disapproval pursuant
225 to the terms and conditions for coverage under the patient’s
226 plan in effect at the time the prior authorization was issued.

227 5. The denial of the dental service claim was due to one of
228 the following:

229 a. Another payor is responsible for payment.

230 b. The dentist has already been paid for the procedures
231 identified in the claim.

232 c. The claim was submitted fraudulently, or the prior

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233 authorization was based in whole or material part on erroneous
234 information provided to the prepaid limited health service
235 organization by the dentist, patient, or other person not
236 related to the organization.
237 d. The person receiving the procedure was not eligible to
238 receive the procedure on the date of service and the prepaid
239 limited health service organization did not know, and with the
240 exercise of reasonable care could not have known, of his or her
241 ineligibility.
242 (b) This subsection may not be waived, voided, or nullified
243 by contract, and any contractual clause in conflict with this
244 subsection or that purports to waive any requirements of this
245 subsection is null and void.
246 (c) The office has all rights and powers to enforce this
247 subsection as provided by s. 624.307.
248 (d) The commission may adopt rules to implement this
249 subsection.
250 Section 5. Subsection (11) of section 641.315, Florida
251 Statutes, is amended, and subsections (13) and (14) are added to
252 that section, to read:
253 641.315 Provider contracts.—
254 (11) A contract between a health maintenance organization
255 and a dentist licensed under chapter 466 for the provision of
256 services to a subscriber of the health maintenance organization
257 may not contain a provision that requires the dentist to provide
258 services to the subscriber of the health maintenance
259 organization at a fee set by the health maintenance organization
260 unless such services are covered services under the applicable
261 contract. As used in this subsection, the term "covered

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262 services” means dental care services for which a reimbursement
263 is available under the subscriber’s contract, notwithstanding ~~or~~
264 ~~for which a reimbursement would be available but for~~ the
265 application of contractual limitations such as deductibles,
266 coinsurance, waiting periods, annual or lifetime maximums,
267 frequency limitations, alternative benefit payments, or any
268 other limitation.
269 (13)(a) A contract between a health maintenance
270 organization and a dentist licensed under chapter 466 for the
271 provision of services to a subscriber of the health maintenance
272 organization may not specify credit card payment as the only
273 acceptable method for payments from the health maintenance
274 organization to the dentist.
275 (b) At least 10 days before a health maintenance
276 organization pays a claim to a dentist through electronic funds
277 transfer, including, but not limited to, virtual credit card
278 payments, the health maintenance organization shall notify the
279 dentist in writing of all of the following:
280 1. The fees, if any, that are associated with the
281 electronic funds transfer.
282 2. The available methods of payment of claims by the health
283 maintenance organization, with clear instructions to the dentist
284 on how to select an alternative payment method.
285 (c) A health maintenance organization that pays a claim to
286 a dentist through Automated Clearing House (ACH) transfer may
287 not charge a fee solely to transmit the payment to the dentist
288 unless the dentist has consented to the fee.
289 (d) This subsection may not be waived, voided, or nullified
290 by contract, and any contractual clause in conflict with this

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291 subsection or which purports to waive any requirements of this
292 subsection is null and void.
293 (e) The office has all rights and powers to enforce this
294 subsection as provided by s. 624.307.
295 (f) The commission may adopt rules to implement this
296 subsection.
297 (14)(a) A health maintenance organization may not deny any
298 claim subsequently submitted by a dentist licensed under chapter
299 466 for procedures specifically included in a prior
300 authorization unless at least one of the following circumstances
301 applies for each procedure denied:
302 1. Benefit limitations, such as annual maximums and
303 frequency limitations not applicable at the time of the prior
304 authorization, are reached subsequent to issuance of the prior
305 authorization.
306 2. The documentation provided by the person submitting the
307 claim fails to support the claim as originally authorized.
308 3. Subsequent to the issuance of the prior authorization,
309 new procedures are provided to the patient or a change in the
310 condition of the patient occurs such that the prior authorized
311 procedure would no longer be considered medically necessary,
312 based on the prevailing standard of care.
313 4. Subsequent to the issuance of the prior authorization,
314 new procedures are provided to the patient or a change in the
315 patient’s condition occurs such that the prior authorized
316 procedure would at that time have required disapproval pursuant
317 to the terms and conditions for coverage under the patient’s
318 plan in effect at the time the prior authorization was issued.
319 5. The denial of the claim was due to one of the following:

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320 a. Another payor is responsible for payment.
321 b. The dentist has already been paid for the procedures
322 identified in the claim.
323 c. The claim was submitted fraudulently, or the prior
324 authorization was based in whole or material part on erroneous
325 information provided to the health maintenance organization by
326 the dentist, patient, or other person not related to the
327 organization.
328 d. The person receiving the procedure was not eligible to
329 receive the procedure on the date of service and the health
330 maintenance organization did not know, and with the exercise of
331 reasonable care could not have known, of his or her
332 ineligibility.
333 (b) The subsection may not be waived, voided, or nullified
334 by contract, and any contractual clause in conflict with this
335 subsection or which purports to waive any requirements of this
336 subsection is null and void.
337 (c) The office has all rights and powers to enforce this
338 subsection as provided by s. 624.307.
339 (d) The commission may adopt rules to implement this
340 subsection.
341 Section 6. This act shall take effect July 1, 2024.