By the Appropriations Committee on Agriculture, Environment, and General Government; the Committee on Banking and Insurance; and Senator Harrell

601-03255-24 2024892c2

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 and obtain a
7 dentist's consent before paying a claim to the dentist
8 through electronic funds transfer; providing that the
9 dentist's consent applies to the dentist's entire
10 practice; prohibiting the insurer and dentist from
11 requiring consent on a patient-by-patient basis;
12 specifying the requirements of a certain notification;
13 prohibiting a health insurer from charging a fee to
14 transmit a payment to a dentist through Automated
15 Clearing House (ACH) transfer unless the dentist has
16 consented to such fee; providing construction;
17 authorizing the Office of Insurance Regulation of the
18 Financial Services Commission to enforce certain
19 provisions; authorizing the commission to adopt rules;
20 prohibiting a health insurer from denying claims for
21 procedures included in a prior authorization;
22 providing exceptions; providing construction;
23 authorizing the office to enforce certain provisions;
24 authorizing the commission to adopt rules; amending s.
25 627.6474, F.S.; revising the definition of the term
26 "covered services"; amending s. 636.032, F.S.;
27 prohibiting a contract between a prepaid limited
28 health service organization and a dentist from
29 containing certain restrictions on payment methods;

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

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59 electronic funds transfer; providing that the
60 dentist’s consent applies to the dentist’s entire
61 practice; prohibiting the health maintenance
62 organization and dentist from requiring consent on a
63 patient-by-patient basis; specifying the requirements
64 of a certain notification; prohibiting a health
65 maintenance organization from charging a fee to
66 transmit a payment to a dentist through ACH transfer
67 unless the dentist has consented to such fee;
68 providing construction; authorizing the office to
69 enforce certain provisions; authorizing the commission
70 to adopt rules; prohibiting a health maintenance
71 organization from denying claims for procedures
72 included in a prior authorization; providing
73 exceptions; providing construction; authorizing the
74 office to enforce certain provisions; authorizing the
75 commission to adopt rules; providing an effective
76 date.
77
78 Be It Enacted by the Legislature of the State of Florida:
79
80 Section 1. Subsections (20) and (21) are added to section
81 627.6131, Florida Statutes, to read:
82 627.6131 Payment of claims.—
83 (20)(a) A contract between a health insurer and a dentist
84 licensed under chapter 466 for the provision of services to an
85 insured may not specify credit card payment as the only
86 acceptable method for payments from the health insurer to the
87 dentist.

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88 (b) When a health insurer employs the method of claims
89 payment to a dentist through electronic funds transfer,
90 including, but not limited to, virtual credit card payment, the
91 health insurer shall notify the dentist as provided in this
92 paragraph and obtain the dentist's consent in writing before
93 employing the electronic funds transfer. The dentist's written
94 consent described in this paragraph applies to the dentist's
95 entire practice. The insurer or dentist may not require that a
96 dentist's consent as described in this paragraph be made on a
97 patient-by-patient basis. The notification provided by the
98 health insurer to the dentist must include all of the following:
99 1. The fees, if any, associated with the electronic funds
100 transfer.
101 2. The available methods of payment of claims by the health
102 insurer, with clear instructions to the dentist on how to select
103 an alternative payment method.
104 (c) A health insurer that pays a claim to a dentist through
105 Automated Clearing House transfer may not charge a fee solely to
106 transmit the payment to the dentist unless the dentist has
107 consented to the fee.
108 (d) This subsection may not be waived, voided, or nullified
109 by contract, and any contractual clause in conflict with this
110 subsection or that purports to waive any requirements of this
111 subsection is null and void.
112 (e) The office has all rights and powers to enforce this
113 subsection as provided by s. 624.307.
114 (f) The commission may adopt rules to implement this
115 subsection.
116 (21)(a) A health insurer may not deny any claim

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117 subsequently submitted by a dentist licensed under chapter 466
118 for procedures specifically included in a prior authorization
119 unless at least one of the following circumstances applies for
120 each procedure denied:
121 1. Benefit limitations, such as annual maximums and
122 frequency limitations not applicable at the time of the prior
123 authorization, are reached subsequent to issuance of the prior
124 authorization.
125 2. The documentation provided by the person submitting the
126 claim fails to support the claim as originally authorized.
127 3. Subsequent to the issuance of the prior authorization,
128 new procedures are provided to the patient or a change in the
129 condition of the patient occurs such that the prior authorized
130 procedure would no longer be considered medically necessary,
131 based on the prevailing standard of care.
132 4. Subsequent to the issuance of the prior authorization,
133 new procedures are provided to the patient or a change in the
134 patient's condition occurs such that the prior authorized
135 procedure would at that time have required disapproval pursuant
136 to the terms and conditions for coverage under the patient's
137 plan in effect at the time the prior authorization was issued.
138 5. The denial of the claim was due to one of the following:
139 a. Another payor is responsible for payment.
140 b. The dentist has already been paid for the procedures
141 identified in the claim.
142 c. The claim was submitted fraudulently, or the prior
143 authorization was based in whole or material part on erroneous
144 information provided to the health insurer by the dentist,
145 patient, or other person not related to the insurer.

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146 d. The person receiving the procedure was not eligible to
147 receive the procedure on the date of service and the health
148 insurer did not know, and with the exercise of reasonable care
149 could not have known, of his or her ineligibility.
150 (b) This subsection may not be waived, voided, or nullified
151 by contract, and any contractual clause in conflict with this
152 subsection or that purports to waive any requirements of this
153 subsection is null and void.
154 (c) The office has all rights and powers to enforce this
155 subsection as provided by s. 624.307.
156 (d) The commission may adopt rules to implement this
157 subsection.
158 Section 2. Subsection (2) of section 627.6474, Florida
159 Statutes, is amended to read:
160 627.6474 Provider contracts.—
161 (2) A contract between a health insurer and a dentist
162 licensed under chapter 466 for the provision of services to an
163 insured may not contain a provision that requires the dentist to
164 provide services to the insured under such contract at a fee set
165 by the health insurer unless such services are covered services
166 under the applicable contract. As used in this subsection, the
167 term “covered services” means dental care services for which a
168 reimbursement is available under the insured’s contract,
169 notwithstanding ~~or for which a reimbursement would be available~~
170 ~~but for~~ the application of contractual limitations such as
171 deductibles, coinsurance, waiting periods, annual or lifetime
172 maximums, frequency limitations, alternative benefit payments,
173 or any other limitation.
174 Section 3. Section 636.032, Florida Statutes, is amended to

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175 read:
176 636.032 Acceptable payments.—
177 (1) Each prepaid limited health service organization may
178 accept from government agencies, corporations, groups, or
179 individuals payments covering all or part of the cost of
180 contracts entered into between the prepaid limited health
181 service organization and its subscribers.
182 (2)(a) A contract between a prepaid limited health service
183 organization and a dentist licensed under chapter 466 for the
184 provision of services to a subscriber may not specify credit
185 card payment as the only acceptable method for payments from the
186 prepaid limited health service organization to the dentist.
187 (b) When a prepaid limited health service organization
188 employs the method of claims payment to a dentist through
189 electronic funds transfer, including, but not limited to,
190 virtual credit card payment, the prepaid limited health service
191 organization shall notify the dentist as provided in this
192 paragraph and obtain the dentist's consent in writing before
193 employing the electronic funds transfer. The dentist's written
194 consent described in this paragraph applies to the dentist's
195 entire practice. The prepaid limited health service organization
196 or dentist may not require that the dentist's consent as
197 described in this paragraph be made on a patient-by-patient
198 basis. The notification provided by the prepaid limited health
199 service organization to the dentist must include all of the
200 following:
201 1. The fees, if any, that are associated with the
202 electronic funds transfer.
203 2. The available methods of payment of claims by the

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204 prepaid limited health service organization, with clear
205 instructions to the dentist on how to select an alternative
206 payment method.
207 (c) A prepaid limited health service organization that pays
208 a claim to a dentist through Automatic Clearing House transfer
209 may not charge a fee solely to transmit the payment to the
210 dentist unless the dentist has consented to the fee.
211 (d) This subsection may not be waived, voided, or nullified
212 by contract, and any contractual clause in conflict with this
213 subsection or that purports to waive any requirements of this
214 subsection is null and void.
215 (e) The office has all rights and powers to enforce this
216 subsection as provided by s. 624.307.
217 (f) The commission may adopt rules to implement this
218 subsection.
219 Section 4. Subsection (13) of section 636.035, Florida
220 Statutes, is amended, and subsection (15) is added to that
221 section, to read:
222 636.035 Provider arrangements.—
223 (13) A contract between a prepaid limited health service
224 organization and a dentist licensed under chapter 466 for the
225 provision of services to a subscriber of the prepaid limited
226 health service organization may not contain a provision that
227 requires the dentist to provide services to the subscriber of
228 the prepaid limited health service organization at a fee set by
229 the prepaid limited health service organization unless such
230 services are covered services under the applicable contract. As
231 used in this subsection, the term "covered services" means
232 dental care services for which a reimbursement is available

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233 under the subscriber's contract, notwithstanding ~~or for which a~~
234 ~~reimbursement would be available but for~~ the application of
235 contractual limitations such as deductibles, coinsurance,
236 waiting periods, annual or lifetime maximums, frequency
237 limitations, alternative benefit payments, or any other
238 limitation.
239 (15)(a) A prepaid limited health service organization may
240 not deny any claim subsequently submitted by a dentist licensed
241 under chapter 466 for procedures specifically included in a
242 prior authorization unless at least one of the following
243 circumstances applies for each procedure denied:
244 1. Benefit limitations, such as annual maximums and
245 frequency limitations not applicable at the time of the prior
246 authorization, are reached subsequent to issuance of the prior
247 authorization.
248 2. The documentation provided by the person submitting the
249 claim fails to support the claim as originally authorized.
250 3. Subsequent to the issuance of the prior authorization,
251 new procedures are provided to the patient or a change in the
252 condition of the patient occurs such that the prior authorized
253 procedure would no longer be considered medically necessary,
254 based on the prevailing standard of care.
255 4. Subsequent to the issuance of the prior authorization,
256 new procedures are provided to the patient or a change in the
257 patient's condition occurs such that the prior authorized
258 procedure would at that time have required disapproval pursuant
259 to the terms and conditions for coverage under the patient's
260 plan in effect at the time the prior authorization was issued.
261 5. The denial of the dental service claim was due to one of

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262 the following:
263 a. Another payor is responsible for payment.
264 b. The dentist has already been paid for the procedures
265 identified in the claim.
266 c. The claim was submitted fraudulently, or the prior
267 authorization was based in whole or material part on erroneous
268 information provided to the prepaid limited health service
269 organization by the dentist, patient, or other person not
270 related to the organization.
271 d. The person receiving the procedure was not eligible to
272 receive the procedure on the date of service and the prepaid
273 limited health service organization did not know, and with the
274 exercise of reasonable care could not have known, of his or her
275 ineligibility.
276 (b) This subsection may not be waived, voided, or nullified
277 by contract, and any contractual clause in conflict with this
278 subsection or that purports to waive any requirements of this
279 subsection is null and void.
280 (c) The office has all rights and powers to enforce this
281 subsection as provided by s. 624.307.
282 (d) The commission may adopt rules to implement this
283 subsection.
284 Section 5. Subsection (11) of section 641.315, Florida
285 Statutes, is amended, and subsections (13) and (14) are added to
286 that section, to read:
287 641.315 Provider contracts.—
288 (11) A contract between a health maintenance organization
289 and a dentist licensed under chapter 466 for the provision of
290 services to a subscriber of the health maintenance organization

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291 may not contain a provision that requires the dentist to provide
292 services to the subscriber of the health maintenance
293 organization at a fee set by the health maintenance organization
294 unless such services are covered services under the applicable
295 contract. As used in this subsection, the term “covered
296 services” means dental care services for which a reimbursement
297 is available under the subscriber’s contract, notwithstanding ~~or~~
298 ~~for which a reimbursement would be available but for~~ the
299 application of contractual limitations such as deductibles,
300 coinsurance, waiting periods, annual or lifetime maximums,
301 frequency limitations, alternative benefit payments, or any
302 other limitation.
303 (13)(a) A contract between a health maintenance
304 organization and a dentist licensed under chapter 466 for the
305 provision of services to a subscriber of the health maintenance
306 organization may not specify credit card payment as the only
307 acceptable method for payments from the health maintenance
308 organization to the dentist.
309 (b) When a health maintenance organization employs the
310 method of claims payment to a dentist through electronic funds
311 transfer, including, but not limited to, virtual credit card
312 payment, the health maintenance organization shall notify the
313 dentist as provided in this paragraph and obtain the dentist’s
314 consent in writing before employing the electronic funds
315 transfer. The dentist’s written consent described in this
316 paragraph applies to the dentist’s entire practice. The health
317 maintenance organization or dentist may not require a dentist’s
318 consent as described in this paragraph be made on a patient-by-
319 patient basis. The notification provided by the health

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320 maintenance organization to the dentist must include all of the
321 following:
322 1. The fees, if any, that are associated with the
323 electronic funds transfer.
324 2. The available methods of payment of claims by the health
325 maintenance organization, with clear instructions to the dentist
326 on how to select an alternative payment method.
327 (c) A health maintenance organization that pays a claim to
328 a dentist through Automated Clearing House transfer may not
329 charge a fee solely to transmit the payment to the dentist
330 unless the dentist has consented to the fee.
331 (d) This subsection may not be waived, voided, or nullified
332 by contract, and any contractual clause in conflict with this
333 subsection or which purports to waive any requirements of this
334 subsection is null and void.
335 (e) The office has all rights and powers to enforce this
336 subsection as provided by s. 624.307.
337 (f) The commission may adopt rules to implement this
338 subsection.
339 (14)(a) A health maintenance organization may not deny any
340 claim subsequently submitted by a dentist licensed under chapter
341 466 for procedures specifically included in a prior
342 authorization unless at least one of the following circumstances
343 applies for each procedure denied:
344 1. Benefit limitations, such as annual maximums and
345 frequency limitations not applicable at the time of the prior
346 authorization, are reached subsequent to issuance of the prior
347 authorization.
348 2. The documentation provided by the person submitting the

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349 claim fails to support the claim as originally authorized.
350 3. Subsequent to the issuance of the prior authorization,
351 new procedures are provided to the patient or a change in the
352 condition of the patient occurs such that the prior authorized
353 procedure would no longer be considered medically necessary,
354 based on the prevailing standard of care.
355 4. Subsequent to the issuance of the prior authorization,
356 new procedures are provided to the patient or a change in the
357 patient's condition occurs such that the prior authorized
358 procedure would at that time have required disapproval pursuant
359 to the terms and conditions for coverage under the patient's
360 plan in effect at the time the prior authorization was issued.
361 5. The denial of the claim was due to one of the following:
362 a. Another payor is responsible for payment.
363 b. The dentist has already been paid for the procedures
364 identified in the claim.
365 c. The claim was submitted fraudulently, or the prior
366 authorization was based in whole or material part on erroneous
367 information provided to the health maintenance organization by
368 the dentist, patient, or other person not related to the
369 organization.
370 d. The person receiving the procedure was not eligible to
371 receive the procedure on the date of service and the health
372 maintenance organization did not know, and with the exercise of
373 reasonable care could not have known, of his or her
374 ineligibility.
375 (b) The subsection may not be waived, voided, or nullified
376 by contract, and any contractual clause in conflict with this
377 subsection or which purports to waive any requirements of this

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378 subsection is null and void.

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

380 subsection as provided by s. 624.307.

381 (d) The commission may adopt rules to implement this

382 subsection.

383 Section 6. This act shall take effect December 1, 2024.

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