

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

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

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

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59 containing certain restrictions on payment methods;  
60 requiring the health maintenance organization to make  
61 certain notifications and obtain a dentist's consent  
62 before paying a claim to the dentist through  
63 electronic funds transfer; providing that the  
64 dentist's consent applies to the dentist's entire  
65 practice; requiring the dentist's consent to bear the  
66 signature of the dentist; specifying the form of such  
67 signature; prohibiting the health maintenance  
68 organization and dentist from requiring consent on a  
69 patient-by-patient basis; specifying the requirements  
70 of a certain notification; prohibiting a health  
71 maintenance organization from charging a fee to  
72 transmit a payment to a dentist through ACH transfer  
73 unless the dentist has consented to such fee;  
74 providing construction; authorizing the office to  
75 enforce certain provisions; authorizing the commission  
76 to adopt rules; prohibiting a health maintenance  
77 organization from denying claims for procedures  
78 included in a prior authorization; providing  
79 exceptions; providing construction; authorizing the  
80 office to enforce certain provisions; authorizing the  
81 commission to adopt rules; providing an effective  
82 date.

83

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

85

86 Section 1. Subsections (20) and (21) are added to section  
87 627.6131, Florida Statutes, to read:

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88           627.6131 Payment of claims.—

89           (20) (a) A contract between a health insurer and a dentist  
90 licensed under chapter 466 for the provision of services to an  
91 insured may not specify credit card payment as the only  
92 acceptable method for payments from the health insurer to the  
93 dentist.

94           (b) When a health insurer employs the method of claims  
95 payment to a dentist through electronic funds transfer,  
96 including, but not limited to, virtual credit card payment, the  
97 health insurer shall notify the dentist as provided in this  
98 paragraph and obtain the dentist's consent in writing before  
99 employing the electronic funds transfer. The dentist's written  
100 consent described in this paragraph applies to the dentist's  
101 entire practice. For purposes of this paragraph, the dentist's  
102 written consent, which may be given through e-mail, must bear  
103 the signature of the dentist. Such signature includes an  
104 electronic or digital signature if the form of signature is  
105 recognized as a valid signature under applicable federal law or  
106 state contract law or an act that demonstrates express consent,  
107 including, but not limited to, checking a box indicating  
108 consent. The insurer or dentist may not require that a dentist's  
109 consent as described in this paragraph be made on a patient-by-  
110 patient basis. The notification provided by the health insurer  
111 to the dentist must include all of the following:

112           1. The fees, if any, associated with the electronic funds  
113 transfer.

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

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117 (c) A health insurer that pays a claim to a dentist through  
118 Automated Clearing House transfer may not charge a fee solely to  
119 transmit the payment to the dentist unless the dentist has  
120 consented to the fee.

121 (d) This subsection may not be waived, voided, or nullified  
122 by contract, and any contractual clause in conflict with this  
123 subsection or that purports to waive any requirements of this  
124 subsection is null and void.

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

127 (f) The commission may adopt rules to implement this  
128 subsection.

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

134 1. Benefit limitations, such as annual maximums and  
135 frequency limitations not applicable at the time of the prior  
136 authorization, are reached subsequent to issuance of the prior  
137 authorization.

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

140 3. Subsequent to the issuance of the prior authorization,  
141 new procedures are provided to the patient or a change in the  
142 condition of the patient occurs such that the prior authorized  
143 procedure would no longer be considered medically necessary,  
144 based on the prevailing standard of care.

145 4. Subsequent to the issuance of the prior authorization,

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146 new procedures are provided to the patient or a change in the  
147 patient's condition occurs such that the prior authorized  
148 procedure would at that time have required disapproval pursuant  
149 to the terms and conditions for coverage under the patient's  
150 plan in effect at the time the prior authorization was issued.

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

152 a. Another payor is responsible for payment.

153 b. The dentist has already been paid for the procedures  
154 identified in the claim.

155 c. The claim was submitted fraudulently, or the prior  
156 authorization was based in whole or material part on erroneous  
157 information provided to the health insurer by the dentist,  
158 patient, or other person not related to the insurer.

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

163 (b) This subsection may not be waived, voided, or nullified  
164 by contract, and any contractual clause in conflict with this  
165 subsection or that purports to waive any requirements of this  
166 subsection is null and void.

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

169 (d) The commission may adopt rules to implement this  
170 subsection.

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

173 627.6474 Provider contracts.—

174 (2) A contract between a health insurer and a dentist

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175 licensed under chapter 466 for the provision of services to an  
176 insured may not contain a provision that requires the dentist to  
177 provide services to the insured under such contract at a fee set  
178 by the health insurer unless such services are covered services  
179 under the applicable contract. As used in this subsection, the  
180 term "covered services" means dental care services for which a  
181 reimbursement is available under the insured's contract,  
182 notwithstanding ~~or for which a reimbursement would be available~~  
183 ~~but for~~ the application of contractual limitations such as  
184 deductibles, coinsurance, waiting periods, annual or lifetime  
185 maximums, frequency limitations, alternative benefit payments,  
186 or any other limitation.

187 Section 3. Section 636.032, Florida Statutes, is amended to  
188 read:

189 636.032 Acceptable payments.—

190 (1) Each prepaid limited health service organization may  
191 accept from government agencies, corporations, groups, or  
192 individuals payments covering all or part of the cost of  
193 contracts entered into between the prepaid limited health  
194 service organization and its subscribers.

195 (2) (a) A contract between a prepaid limited health service  
196 organization and a dentist licensed under chapter 466 for the  
197 provision of services to a subscriber may not specify credit  
198 card payment as the only acceptable method for payments from the  
199 prepaid limited health service organization to the dentist.

200 (b) When a prepaid limited health service organization  
201 employs the method of claims payment to a dentist through  
202 electronic funds transfer, including, but not limited to,  
203 virtual credit card payment, the prepaid limited health service

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204 organization shall notify the dentist as provided in this  
205 paragraph and obtain the dentist's consent in writing before  
206 employing the electronic funds transfer. The dentist's written  
207 consent described in this paragraph applies to the dentist's  
208 entire practice. For purposes of this paragraph, the dentist's  
209 written consent, which may be given through e-mail, must bear  
210 the signature of the dentist. Such signature includes an  
211 electronic or digital signature if the form of signature is  
212 recognized as a valid signature under applicable federal law or  
213 state contract law or an act that demonstrates express consent,  
214 including, but not limited to, checking a box indicating  
215 consent. The prepaid limited health service organization or  
216 dentist may not require that the dentist's consent as described  
217 in this paragraph be made on a patient-by-patient basis. The  
218 notification provided by the prepaid limited health service  
219 organization to the dentist must include all of the following:

220 1. The fees, if any, that are associated with the  
221 electronic funds transfer.

222 2. The available methods of payment of claims by the  
223 prepaid limited health service organization, with clear  
224 instructions to the dentist on how to select an alternative  
225 payment method.

226 (c) A prepaid limited health service organization that pays  
227 a claim to a dentist through Automatic Clearing House transfer  
228 may not charge a fee solely to transmit the payment to the  
229 dentist unless the dentist has consented to the fee.

230 (d) This subsection may not be waived, voided, or nullified  
231 by contract, and any contractual clause in conflict with this  
232 subsection or that purports to waive any requirements of this

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233 subsection is null and void.

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

236 (f) The commission may adopt rules to implement this  
237 subsection.

238 Section 4. Subsection (13) of section 636.035, Florida  
239 Statutes, is amended, and subsection (15) is added to that  
240 section, to read:

241 636.035 Provider arrangements.—

242 (13) A contract between a prepaid limited health service  
243 organization and a dentist licensed under chapter 466 for the  
244 provision of services to a subscriber of the prepaid limited  
245 health service organization may not contain a provision that  
246 requires the dentist to provide services to the subscriber of  
247 the prepaid limited health service organization at a fee set by  
248 the prepaid limited health service organization unless such  
249 services are covered services under the applicable contract. As  
250 used in this subsection, the term "covered services" means  
251 dental care services for which a reimbursement is available  
252 under the subscriber's contract, notwithstanding ~~or for which a~~  
253 ~~reimbursement would be available but for~~ the application of  
254 contractual limitations such as deductibles, coinsurance,  
255 waiting periods, annual or lifetime maximums, frequency  
256 limitations, alternative benefit payments, or any other  
257 limitation.

258 (15) (a) A prepaid limited health service organization may  
259 not deny any claim subsequently submitted by a dentist licensed  
260 under chapter 466 for procedures specifically included in a  
261 prior authorization unless at least one of the following

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262 circumstances applies for each procedure denied:

263 1. Benefit limitations, such as annual maximums and  
264 frequency limitations not applicable at the time of the prior  
265 authorization, are reached subsequent to issuance of the prior  
266 authorization.

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

269 3. Subsequent to the issuance of the prior authorization,  
270 new procedures are provided to the patient or a change in the  
271 condition of the patient occurs such that the prior authorized  
272 procedure would no longer be considered medically necessary,  
273 based on the prevailing standard of care.

274 4. Subsequent to the issuance of the prior authorization,  
275 new procedures are provided to the patient or a change in the  
276 patient's condition occurs such that the prior authorized  
277 procedure would at that time have required disapproval pursuant  
278 to the terms and conditions for coverage under the patient's  
279 plan in effect at the time the prior authorization was issued.

280 5. The denial of the dental service claim was due to one of  
281 the following:

282 a. Another payor is responsible for payment.

283 b. The dentist has already been paid for the procedures  
284 identified in the claim.

285 c. The claim was submitted fraudulently, or the prior  
286 authorization was based in whole or material part on erroneous  
287 information provided to the prepaid limited health service  
288 organization by the dentist, patient, or other person not  
289 related to the organization.

290 d. The person receiving the procedure was not eligible to

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291 receive the procedure on the date of service and the prepaid  
292 limited health service organization did not know, and with the  
293 exercise of reasonable care could not have known, of his or her  
294 ineligibility.

295 (b) This subsection may not be waived, voided, or nullified  
296 by contract, and any contractual clause in conflict with this  
297 subsection or that purports to waive any requirements of this  
298 subsection is null and void.

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

301 (d) The commission may adopt rules to implement this  
302 subsection.

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

306 641.315 Provider contracts.—

307 (11) A contract between a health maintenance organization  
308 and a dentist licensed under chapter 466 for the provision of  
309 services to a subscriber of the health maintenance organization  
310 may not contain a provision that requires the dentist to provide  
311 services to the subscriber of the health maintenance  
312 organization at a fee set by the health maintenance organization  
313 unless such services are covered services under the applicable  
314 contract. As used in this subsection, the term "covered  
315 services" means dental care services for which a reimbursement  
316 is available under the subscriber's contract, notwithstanding ~~or~~  
317 ~~for which a reimbursement would be available but for the~~  
318 application of contractual limitations such as deductibles,  
319 coinsurance, waiting periods, annual or lifetime maximums,

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320 frequency limitations, alternative benefit payments, or any  
321 other limitation.

322 (13) (a) A contract between a health maintenance  
323 organization and a dentist licensed under chapter 466 for the  
324 provision of services to a subscriber of the health maintenance  
325 organization may not specify credit card payment as the only  
326 acceptable method for payments from the health maintenance  
327 organization to the dentist.

328 (b) When a health maintenance organization employs the  
329 method of claims payment to a dentist through electronic funds  
330 transfer, including, but not limited to, virtual credit card  
331 payment, the health maintenance organization shall notify the  
332 dentist as provided in this paragraph and obtain the dentist's  
333 consent in writing before employing the electronic funds  
334 transfer. The dentist's written consent described in this  
335 paragraph applies to the dentist's entire practice. For purposes  
336 of this paragraph, the dentist's written consent, which may be  
337 given through e-mail, must bear the signature of the dentist.  
338 Such signature includes an electronic or digital signature if  
339 the form of signature is recognized as a valid signature under  
340 applicable federal law or state contract law or an act that  
341 demonstrates express consent, including, but not limited to,  
342 checking a box indicating consent. The health maintenance  
343 organization or dentist may not require a dentist's consent as  
344 described in this paragraph be made on a patient-by-patient  
345 basis. The notification provided by the health maintenance  
346 organization to the dentist must include all of the following:

347 1. The fees, if any, that are associated with the  
348 electronic funds transfer.

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

352       (c) A health maintenance organization that pays a claim to  
353 a dentist through Automated Clearing House transfer may not  
354 charge a fee solely to transmit the payment to the dentist  
355 unless the dentist has consented to the fee.

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

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

362       (f) The commission may adopt rules to implement this  
363 subsection.

364       (14) (a) A health maintenance organization may not deny any  
365 claim subsequently submitted by a dentist licensed under chapter  
366 466 for procedures specifically included in a prior  
367 authorization unless at least one of the following circumstances  
368 applies for each procedure denied:

369       1. Benefit limitations, such as annual maximums and  
370 frequency limitations not applicable at the time of the prior  
371 authorization, are reached subsequent to issuance of the prior  
372 authorization.

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

375       3. Subsequent to the issuance of the prior authorization,  
376 new procedures are provided to the patient or a change in the  
377 condition of the patient occurs such that the prior authorized

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378 procedure would no longer be considered medically necessary,  
379 based on the prevailing standard of care.

380 4. Subsequent to the issuance of the prior authorization,  
381 new procedures are provided to the patient or a change in the  
382 patient's condition occurs such that the prior authorized  
383 procedure would at that time have required disapproval pursuant  
384 to the terms and conditions for coverage under the patient's  
385 plan in effect at the time the prior authorization was issued.

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

387 a. Another payor is responsible for payment.

388 b. The dentist has already been paid for the procedures  
389 identified in the claim.

390 c. The claim was submitted fraudulently, or the prior  
391 authorization was based in whole or material part on erroneous  
392 information provided to the health maintenance organization by  
393 the dentist, patient, or other person not related to the  
394 organization.

395 d. The person receiving the procedure was not eligible to  
396 receive the procedure on the date of service and the health  
397 maintenance organization did not know, and with the exercise of  
398 reasonable care could not have known, of his or her  
399 ineligibility.

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

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

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

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407 subsection.

408 Section 6. This act shall take effect January 1, 2025.