A bill to be entitled

An act relating to insurance claims payments to physicians; amending ss. 627.6131 and 641.315, F.S.; prohibiting contracts between certain physicians and health insurers and health maintenance organizations, respectively, from specifying credit card payments to physicians as the only acceptable method for payments; authorizing use of electronic funds transfers by health insurers and health maintenance organizations, respectively, for payments to physicians under certain circumstances; providing notification requirements; prohibiting health insurers and health maintenance organizations, respectively, from charging fees for automated clearinghouse transfers as claims payments to physicians; providing an exception; providing applicability; prohibiting health insurers and health maintenance organizations, respectively, from denying claims subsequently submitted by physicians for procedures that were included in prior authorizations; providing exceptions; providing applicability; providing an effective date.

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

Section 1. Subsections (20) and (21) of section 627.6131,

Florida Statutes, are amended to read:

627.6131 Payment of claims.—

(20)(a) A contract between a health insurer and a dentist licensed under chapter 466 or a physician licensed under chapter 458 or chapter 459 for the provision of services to an insured may not specify credit card payment as the only acceptable method for payments from the health insurer to the dentist or physician.

(b) When a health insurer employs the method of claims payment to a dentist or physician through electronic funds transfer, including, but not limited to, virtual credit card payment, the health insurer shall notify the dentist or physician as provided in this paragraph and obtain the dentist's or physician's consent before employing the electronic funds transfer. The dentist's or physician's consent described in this paragraph applies to the dentist's or physician's entire practice. For the purpose of this paragraph, the dentist's or physician's consent, which may be given through e-mail, must bear the signature of the dentist or physician. Such signature includes an electronic or digital signature if the form of signature is recognized as a valid signature under applicable federal law or state contract law or an act that demonstrates express consent, including, but not limited to, checking a box indicating consent. The health insurer or the dentist or physician may not require that a dentist's or physician's

consent as described in this paragraph be made on a patient-by-patient basis. The notification provided by the health insurer to the dentist or physician must include all of the following:

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

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

(c) A health insurer that pays a claim to a dentist or physician through automated clearinghouse transfer may not charge a fee solely to transmit the payment to the dentist or physician unless the dentist or physician has consented to the fee.

(d) This subsection applies to all contracts:

1. Between a health insurer and a dentist which are delivered, issued, or renewed on or after January 1, 2025.

2. Between a health insurer and a physician which are delivered, issued, or renewed on or after January 1, 2026.

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

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

(21)(a) A health insurer may not deny any claim subsequently submitted by a dentist licensed under chapter 466 or a physician licensed under chapter 458 or chapter 459 for

procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. 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.

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

3. 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.

4. 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.

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

a. Another payor is responsible for payment.

b. The dentist or physician has already been paid for the procedures identified in the claim.

c. 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 or physician, patient, or other person not related to the insurer.

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

e. The services were provided during the grace period established under s. 627.608 or applicable federal regulations, and the ~~dental~~ insurer notified the dentist or physician ~~provider~~ that the patient was in the grace period when the dentist or physician ~~provider~~ requested eligibility or enrollment verification from the ~~dental~~ insurer, if such request was made.

(b) This subsection applies to all contracts:

1. Between a health insurer and a dentist which are delivered, issued, or renewed on or after January 1, 2025.

2. Between a health insurer and a physician which are delivered, issued, or renewed on or after January 1, 2026.

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

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

Section 2. Subsections (13) and (14) of section 641.315, Florida Statutes, are amended to read:

641.315 Provider contracts.—

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 or a physician licensed under chapter 458 or chapter 459 for the provision of services to a subscriber of the health maintenance organization may not specify credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist or physician.

(b) When a health maintenance organization employs the method of claims payment to a dentist or physician through electronic funds transfer, including, but not limited to, virtual credit card payment, the health maintenance organization shall notify the dentist or physician as provided in this paragraph and obtain the dentist's or physician's consent before employing the electronic funds transfer. The dentist's or physician's consent described in this paragraph applies to the dentist's or physician's entire practice. For the purpose of this paragraph, the dentist's or physician's consent, which may be given through e-mail, must bear the signature of the dentist or physician. Such signature includes an electronic or digital signature if the form of signature is recognized as a valid signature under applicable federal law or state contract law or an act that demonstrates express consent, including, but not limited to, checking a box indicating consent. The health maintenance organization or the dentist or physician may not require that a dentist's or physician's consent as described in

this paragraph be made on a patient-by-patient basis. The notification provided by the health maintenance organization to the dentist or physician must include all of the following:

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

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

(c) A health maintenance organization that pays a claim to a dentist or physician through automated clearing house transfer may not charge a fee solely to transmit the payment to the dentist or physician unless the dentist or physician has consented to the fee.

(d) This subsection applies to all contracts:

1. Between a health maintenance organization and a dentist which are delivered, issued, or renewed on or after January 1, 2025.

2. Between a health maintenance organization and a physician which are delivered, issued, or renewed on or after January 1, 2026.

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

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

(14)(a) A health maintenance organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 or a physician licensed under chapter 458 or chapter 459 for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. 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.

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

3. 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.

4. 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.

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

a. Another payor is responsible for payment.

b. The dentist or physician has already been paid for the procedures identified in the claim.

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

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

e. The services were provided during the grace period established under s. 627.608 or applicable federal regulations, and the ~~dental~~ insurer notified the dentist or physician ~~provider~~ that the patient was in the grace period when the dentist or physician ~~provider~~ requested eligibility or enrollment verification from the ~~dental~~ insurer, if such request was made.

(b) This subsection applies to all contracts:

1. Between a health maintenance organization and a dentist which are delivered, issued, or renewed on or after January 1, 2025.

2. Between a health maintenance organization and a physician which are delivered, issued, or renewed on or after January 1, 2026.

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

subsection as provided by s. 624.307.

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

Section 3. This act shall take effect July 1, 2025.