

1                                   A bill to be entitled  
 2           An act relating to insurance claims payments to  
 3           physicians; amending ss. 627.6131 and 641.315, F.S.;  
 4           prohibiting contracts between certain physicians and  
 5           health insurers and health maintenance organizations,  
 6           respectively, from specifying credit card payments to  
 7           physicians as the only acceptable method for payments;  
 8           authorizing use of electronic funds transfers by  
 9           health insurers and health maintenance organizations,  
 10          respectively, for payments to physicians under certain  
 11          circumstances; providing notification requirements;  
 12          prohibiting health insurers and health maintenance  
 13          organizations, respectively, from charging fees for  
 14          automated clearinghouse transfers as claims payments  
 15          to physicians; providing an exception; providing  
 16          applicability; prohibiting health insurers and health  
 17          maintenance organizations, respectively, from denying  
 18          claims subsequently submitted by physicians for  
 19          procedures that were included in prior authorizations;  
 20          providing exceptions; providing applicability;  
 21          providing an effective date.

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 23   Be It Enacted by the Legislature of the State of Florida:  
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25                   **Section 1. Subsections (20) and (21) of section 627.6131,**

26 **Florida Statutes, are amended to read:**

27 627.6131 Payment of claims.—

28 (20) (a) A contract between a health insurer and a dentist  
29 licensed under chapter 466 or a physician licensed under chapter  
30 458 or chapter 459 for the provision of services to an insured  
31 may not specify credit card payment as the only acceptable  
32 method for payments from the health insurer to the dentist or  
33 physician.

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

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

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

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

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

64 (d) This subsection applies to all contracts:

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

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

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

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

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

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

79 |       1. Benefit limitations, such as annual maximums and  
80 | frequency limitations not applicable at the time of the prior  
81 | authorization, are reached subsequent to issuance of the prior  
82 | authorization.

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

85 |       3. Subsequent to the issuance of the prior authorization,  
86 | new procedures are provided to the patient or a change in the  
87 | condition of the patient occurs such that the prior authorized  
88 | procedure would no longer be considered medically necessary,  
89 | based on the prevailing standard of care.

90 |       4. Subsequent to the issuance of the prior authorization,  
91 | new procedures are provided to the patient or a change in the  
92 | patient's condition occurs such that the prior authorized  
93 | procedure would at that time have required disapproval pursuant  
94 | to the terms and conditions for coverage under the patient's  
95 | plan in effect at the time the prior authorization was issued.

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

98 |           a. Another payor is responsible for payment.

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

HB 1231

2025

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

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

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

114 (b) This subsection applies to all contracts:

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

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

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

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

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

125 641.315 Provider contracts.—

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

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

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

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

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

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

165 (d) This subsection applies to all contracts:

166 1. Between a health maintenance organization and a dentist  
167 which are delivered, issued, or renewed on or after January 1,  
168 2025.

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

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

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

176 (14) (a) A health maintenance organization may not deny any  
177 claim subsequently submitted by a dentist licensed under chapter  
178 466 or a physician licensed under chapter 458 or chapter 459 for  
179 procedures specifically included in a prior authorization unless  
180 at least one of the following circumstances applies for each  
181 procedure denied:

182 1. Benefit limitations, such as annual maximums and  
183 frequency limitations not applicable at the time of the prior  
184 authorization, are reached subsequent to issuance of the prior  
185 authorization.

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

188 3. Subsequent to the issuance of the prior authorization,  
189 new procedures are provided to the patient or a change in the  
190 condition of the patient occurs such that the prior authorized  
191 procedure would no longer be considered medically necessary,  
192 based on the prevailing standard of care.

193 4. Subsequent to the issuance of the prior authorization,  
194 new procedures are provided to the patient or a change in the  
195 patient's condition occurs such that the prior authorized  
196 procedure would at that time have required disapproval pursuant  
197 to the terms and conditions for coverage under the patient's  
198 plan in effect at the time the prior authorization was issued.

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



HB 1231

2025

- 201 a. Another payor is responsible for payment.
- 202 b. The dentist or physician has already been paid for the  
203 procedures identified in the claim.
- 204 c. The claim was submitted fraudulently, or the prior  
205 authorization was based in whole or material part on erroneous  
206 information provided to the health maintenance organization by  
207 the dentist or physician, patient, or other person not related  
208 to the organization.
- 209 d. The person receiving the procedure was not eligible to  
210 receive the procedure on the date of service.
- 211 e. The services were provided during the grace period  
212 established under s. 627.608 or applicable federal regulations,  
213 and the ~~dental~~ insurer notified the dentist or physician  
214 ~~provider~~ that the patient was in the grace period when the  
215 dentist or physician provider requested eligibility or  
216 enrollment verification from the ~~dental~~ insurer, if such request  
217 was made.
- 218 (b) This subsection applies to all contracts:
- 219 1. Between a health maintenance organization and a dentist  
220 which are delivered, issued, or renewed on or after January 1,  
221 2025.
- 222 2. Between a health maintenance organization and a  
223 physician which are delivered, issued, or renewed on or after  
224 January 1, 2026.
- 225 (c) The office has all rights and powers to enforce this

HB 1231

2025

226 subsection as provided by s. 624.307.

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

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