

By Senator Harrell

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1                                   A bill to be entitled  
2       An act relating to health insurance claims; amending  
3       s. 627.6131, F.S.; prohibiting a contract between a  
4       health insurer and a physician from containing certain  
5       restrictions on payment methods; requiring a health  
6       insurer to make certain notifications and obtain a  
7       physician's consent before paying a claim to the  
8       physician through electronic funds transfer; providing  
9       that the physician's consent applies to the  
10      physician's entire practice; requiring the physician's  
11      consent to bear the signature of the physician;  
12      prohibiting the physician from requiring consent on a  
13      patient-by-patient basis; prohibiting a health insurer  
14      from charging a fee to transmit a payment to a  
15      physician through Automated Clearing House (ACH)  
16      transfer unless the physician has consented to such  
17      fee; revising applicability; providing applicability;  
18      prohibiting a health insurer from denying a certain  
19      claims submitted by a physician; amending s. 641.315,  
20      F.S.; prohibiting a contract between a health  
21      maintenance organization and a physician from  
22      containing certain restrictions on payment methods;  
23      requiring the health maintenance organization to make  
24      certain notifications and obtain a physician's consent  
25      before paying a claim to the physician through  
26      electronic funds transfer; providing that the  
27      physician's consent applies to the physician's entire  
28      practice; requiring the physician's consent to bear  
29      the signature of the physician; prohibiting the

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30 physician from requiring consent on a patient-by-  
31 patient basis; prohibiting a health maintenance  
32 organization from charging a fee to transmit a payment  
33 to a physician through ACH transfer unless the  
34 physician has consented to such fee; revising  
35 applicability; providing applicability; prohibiting a  
36 health maintenance organization from denying certain  
37 claims submitted by a physician; providing an  
38 effective date.

39  
40 Be It Enacted by the Legislature of the State of Florida:

41  
42 Section 1. Paragraphs (a) through (d) of subsection (20)  
43 and paragraphs (a) and (b) of subsection (21) of section  
44 627.6131, Florida Statutes, are amended to read:

45 627.6131 Payment of claims.—

46 (20) (a) A contract between a health insurer and a dentist  
47 licensed under chapter 466 or a physician licensed under chapter  
48 458 or chapter 459 for the provision of services to an insured  
49 may not specify credit card payment as the only acceptable  
50 method for payments from the health insurer to the dentist or  
51 physician.

52 (b) When a health insurer employs the method of claims  
53 payment to a dentist or physician through electronic funds  
54 transfer, including, but not limited to, virtual credit card  
55 payment, the health insurer shall notify the dentist or  
56 physician as provided in this paragraph and obtain the dentist's  
57 or physician's consent before employing the electronic funds  
58 transfer. The dentist's or physician's consent described in this

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59 paragraph applies to the dentist's or physician's entire  
60 practice. For the purpose of this paragraph, the dentist's or  
61 physician's consent, which may be given through e-mail, must  
62 bear the signature of the dentist or physician. Such signature  
63 includes an electronic or digital signature if the form of  
64 signature is recognized as a valid signature under applicable  
65 federal law or state contract law or an act that demonstrates  
66 express consent, including, but not limited to, checking a box  
67 indicating consent. The insurer, physician, or dentist may not  
68 require that a dentist's or physician's consent as described in  
69 this paragraph be made on a patient-by-patient basis. The  
70 notification provided by the health insurer to the dentist or  
71 physician must include all of the following:

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

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

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

81 (d) For contracts entered into between an insurer and a  
82 dentist, this subsection applies to contracts delivered, issued,  
83 or renewed on or after January 1, 2025. For contracts entered  
84 into between an insurer and a physician, this subsection applies  
85 to contracts delivered, issued, or renewed on or after January  
86 1, 2026.

87 (21) (a) A health insurer may not deny any claim

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88 subsequently submitted by a dentist licensed under chapter 466  
89 or a physician licensed under chapter 458 or chapter 459 for  
90 procedures specifically included in a prior authorization unless  
91 at least one of the following circumstances applies for each  
92 procedure denied:

93 1. Benefit limitations, such as annual maximums and  
94 frequency limitations not applicable at the time of the prior  
95 authorization, are reached subsequent to issuance of the prior  
96 authorization.

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

99 3. Subsequent to the issuance of the prior authorization,  
100 new procedures are provided to the patient or a change in the  
101 condition of the patient occurs such that the prior authorized  
102 procedure would no longer be considered medically necessary,  
103 based on the prevailing standard of care.

104 4. Subsequent to the issuance of the prior authorization,  
105 new procedures are provided to the patient or a change in the  
106 patient's condition occurs such that the prior authorized  
107 procedure would at that time have required disapproval pursuant  
108 to the terms and conditions for coverage under the patient's  
109 plan in effect at the time the prior authorization was issued.

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

111 a. Another payor is responsible for payment.

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

114 c. The claim was submitted fraudulently, or the prior  
115 authorization was based in whole or material part on erroneous  
116 information provided to the health insurer by the dentist,

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

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

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

126 (b) For contracts entered into between an insurer and a  
127 dentist, this subsection applies to all contracts delivered,  
128 issued, or renewed on or after January 1, 2025. For contracts  
129 entered into between an insurer and a physician, this subsection  
130 applies to contracts delivered, issued, or renewed on or after  
131 January 1, 2026.

132 Section 2. Paragraphs (a) through (d) of subsection (13)  
133 and paragraphs (a) and (b) of subsection (14) of section  
134 641.315, Florida Statutes, are amended to read:

135 641.315 Provider contracts.—

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

143 (b) When a health maintenance organization employs the  
144 method of claims payment to a dentist or physician through  
145 electronic funds transfer, including, but not limited to,

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146 virtual credit card payment, the health maintenance organization  
147 shall notify the dentist or physician as provided in this  
148 paragraph and obtain the dentist's or physician's consent before  
149 employing the electronic funds transfer. The dentist's or  
150 physician's consent described in this paragraph applies to the  
151 dentist's or physician's entire practice. For the purpose of  
152 this paragraph, the dentist's or physician's consent, which may  
153 be given through e-mail, must bear the signature of the dentist  
154 or physician. Such signature includes an electronic or digital  
155 signature if the form of signature is recognized as a valid  
156 signature under applicable federal law or state contract law or  
157 an act that demonstrates express consent, including, but not  
158 limited to, checking a box indicating consent. The health  
159 maintenance organization or dentist or physician may not require  
160 that a dentist's or physician's consent as described in this  
161 paragraph be made on a patient-by-patient basis. The  
162 notification provided by the health maintenance organization to  
163 the dentist or physician must include all of the following:

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

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

169 (c) A health maintenance organization that pays a claim to  
170 a dentist or physician through Automated Clearing House transfer  
171 may not charge a fee solely to transmit the payment to the  
172 dentist or physician unless the dentist or physician has  
173 consented to the fee.

174 (d) For contracts entered into between an insurer and a

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175 dentist, this subsection applies to contracts delivered, issued,  
176 or renewed on or after January 1, 2025. For contracts entered  
177 into between an insurer and a physician, this subsection applies  
178 to contracts delivered, issued, or renewed on or after January  
179 1, 2026.

180 (14) (a) A health maintenance organization may not deny any  
181 claim subsequently submitted by a dentist licensed under chapter  
182 466 or a physician licensed under chapter 458 or chapter 459 for  
183 procedures specifically included in a prior authorization unless  
184 at least one of the following circumstances applies for each  
185 procedure denied:

186 1. Benefit limitations, such as annual maximums and  
187 frequency limitations not applicable at the time of the prior  
188 authorization, are reached subsequent to issuance of the prior  
189 authorization.

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

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

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

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

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- 204 a. Another payor is responsible for payment.
- 205 b. The dentist or physician has already been paid for the  
206 procedures identified in the claim.
- 207 c. The claim was submitted fraudulently, or the prior  
208 authorization was based in whole or material part on erroneous  
209 information provided to the health maintenance organization by  
210 the dentist, physician, patient, or other person not related to  
211 the organization.
- 212 d. The person receiving the procedure was not eligible to  
213 receive the procedure on the date of service.
- 214 e. The services were provided during the grace period  
215 established under s. 627.608 or applicable federal regulations,  
216 and the ~~dental~~ insurer notified the dentist or physician  
217 ~~provider~~ that the patient was in the grace period when the  
218 provider requested eligibility or enrollment verification from  
219 the ~~dental~~ insurer, if such request was made.
- 220 (b) For contracts entered into between an insurer and a  
221 dentist, this subsection applies to all contracts delivered,  
222 issued, or renewed on or after January 1, 2025. For contracts  
223 entered into between an insurer and a physician, this subsection  
224 applies to contracts delivered, issued, or renewed on or after  
225 January 1, 2026.
- 226 Section 3. This act shall take effect July 1, 2025.