COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	____	(Y/N)
ADOPTED AS AMENDED	____	(Y/N)
ADOPTED W/O OBJECTION	____	(Y/N)
FAILED TO ADOPT	____	(Y/N)
WITHDRAWN	____	(Y/N)
OTHER		

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Black offered the following:

Amendment (with title amendment)

Remove lines 62-339 and insert:

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

627.6131 Payment of claims.—

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

(b) If initiating or changing payments to a dentist using electronic funds transfer payments, including but not limited

to, virtual credit card payments, a health insurer shall:

1. Notify the dentist in writing of the fees, if any, associated with the electronic funds transfer.

2. Notify the dentist in writing of the available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method, if any.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health insurer may charge reasonable fees for value-added services related to the ACH transfer, including but not limited to, transaction management, data management, and portal services.

(d) This subsection applies to contracts delivered, issued, or renewed on or after January 1, 2025.

(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 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 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,

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 provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(b) This subsection applies to all contracts delivered, issued, or renewed on or after January 1, 2025.

(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. Section 636.032, Florida Statutes, is amended to read:

636.032 Acceptable payments.—

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

(2)(a) A contract between a prepaid limited health service organization and a dentist licensed under chapter 466 for the

provision of services to a subscriber may not require credit card payment as the only acceptable method for payments from the prepaid limited health service organization to the dentist.

(b) If initiating or changing payments to a dentist using electronic funds transfer payments, including but not limited to, virtual credit card payments, a health insurer shall:

1. Notify the dentist in writing of the fees, if any, associated with the electronic funds transfer.

2. Notify the dentist in writing of the available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method, if any.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health insurer may charge reasonable fees for value-added services related to the ACH transfer, including but not limited to, transaction management, data management, and portal services.

(d) This subsection applies to contracts delivered, issued, or renewed on or after January 1, 2025.

(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.

Section 3. Subsection (15) is added to section 636.035, Florida Statutes, to read:

(15)(a) A prepaid limited health service organization may not deny any claim subsequently submitted by a dentist licensed under chapter 466 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 dental service claim was due to one

of the following:

a. Another payor is responsible for payment.

b. The dentist 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 prepaid limited health service organization by the dentist, 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. 636.016 or applicable federal regulations, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(d) This paragraph applies to contracts delivered, issued, or renewed on or after January 1, 2025

Section 4. Subsections (13) and (14) of section 641.315, Florida Statutes, are added to read:

641.315 Provider contracts.—

(13)(a) A contract between a health maintenance organization and a dentist licensed under chapter 466 for the provision of services to a subscriber of the health maintenance

organization may not require credit card payment as the only acceptable method for payments from the health maintenance organization to the dentist.

(b) If initiating or changing payments to a dentist using electronic funds transfer payments, including but not limited to, virtual credit card payments, a health insurer shall:

1. Notify the dentist in writing of the fees, if any, associated with the electronic funds transfer.

2. Notify the dentist in writing of the available methods of payment of claims by the health insurer, with clear instructions to the dentist on how to select an alternative payment method, if any.

(c) A health insurer that pays a claim to a dentist through Automated Clearing House (ACH) transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health insurer may charge reasonable fees for value-added services related to the ACH transfer, including but not limited to, transaction management, data management, and portal services.

(d) This subsection applies to all contracts delivered, issued, or renewed on or after January 1, 2025.

(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 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 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, 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. 641.31 or applicable federal regulations, and the dental insurer notified the provider that the patient was in the grace period when the provider requested eligibility or enrollment verification from the dental insurer, if such request was made.

(b) This subsection applies to all contracts delivered, issued, or renewed, on or after January 1, 2025.

T I T L E A M E N D M E N T

Remove lines 19-41 and insert:

amending s. 636.032, F.S.; prohibiting a contract between a prepaid limited health service organization and a dentist from containing certain restrictions on payment methods; requiring the prepaid limited health service organization to make certain

notifications before paying a claim to a dentist through electronic funds transfer; prohibiting a prepaid limited health service organization from charging a fee to transmit a payment to a dentist through ACH transfer unless the dentist has consented to such fee; providing construction; providing an effective date for contractual changes; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; amending s. 636.035, F.S.; prohibiting a prepaid limited health service organization from denying claims for procedures included in a prior authorization; providing exceptions; providing construction; authorizing the office to enforce certain provisions; providing an effective date for contractual changes; authorizing the commission to adopt rules; amending s. 641.315, F.S.; prohibiting