# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/CS/HB 1219 Dental Insurance Claims
**SPONSOR(S):** Health & Human Services Committee, Insurance & Banking Subcommittee, Black
**TIED BILLS:** **IDEN./SIM. BILLS:** CS/CS/SB 892

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Insurance & Banking Subcommittee | 17 Y, 0 N, As CS | Herrera | Lloyd |
| 2) Health & Human Services Committee | 19 Y, 0 N, As CS | Lloyd | Calamas |
| 3) Commerce Committee | 16 Y, 0 N | Herrera | Hamon |

## SUMMARY ANALYSIS

Health insurance serves a vital role in protecting individuals from financial hardships caused by accidents, illnesses, or disabilities. Health insurers and health care providers often interact with one another prior to the delivery of care. An initial interaction often involves a provider seeking verification from an insurer that a patient has active insurance coverage.

Dental insurance is subject to regulation by the Office of Insurance Regulation (OIR) and the Department of Financial Services (DFS) for adherence to insurance laws and fair practices and by the Agency for Health Care Administration (AHCA) for quality of care issues.

The federal Patient Protection and Affordable Care Act (Act) also provides consumer protections to those individuals who purchase qualified health plans, and receive a federal premium tax credit towards that coverage. These individuals also are eligible for extended grace periods for non-payment of premiums. Federal regulations require coverage of services during a portion of that grace period.

If patients seek services for which they are not currently covered, the claim may be denied. For example, a patient may seek services prior to that patient's coverage effective date, after coverage terminates, or during grace period when a patient has not yet paid the premium. A provider may have also verified that the patient had coverage, provided services based on that verification, and in some cases, already received payment from the insurer. Retroactive denials can result in the provider or the patient covering the financial costs, despite a verification of eligibility.

The bill regulates dental services claims payment contract terms for insurers, including prepaid limited health service organizations (PLHSOs), preferred provider organizations (PPOs), exclusive provider organizations (EPOs), and health maintenance organizations (HMOs). The bill will:

- Prohibit mandating credit card payments as the sole means of reimbursement for dental services.
- Require written notice by insurers to dental providers of the initiation or change in payment methods or fees for electronic fund transfers.
- Allow the insurer to deny claims if the services were provided during the premium non-payment grace period and the insurer informed the provider of such in response to an eligibility inquiry.
- Establishes criteria for other claims denial under prior authorizations under specific circumstances.
- Mandates OIR enforcement of claims payment provisions.
- Establishes an application date for all contractual changes required by the bill as the date of the next issuance, delivery, or renewal date of the impacted contract.

The bill may have a positive impact on state government revenue and local governments. It has an indeterminate economic impact on the private sector and state government expenditures.

The bill provides an effective date of July 1, 2024.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

### Background

Health Insurance

Health insurance is the insurance of human beings against bodily injury or disablement by accident or sickness, including the expenses associated with such injury, disablement, or sickness.[1] Individuals purchase health insurance coverage with the purpose of managing anticipated expenses related to health and protecting themselves from unexpected medical bills or large health care costs. Many individuals access health care coverage as a benefit of employment where the employer may contribute towards the cost of the employee's coverage while others may purchase coverage directly from an insurance company or from places like the Act's marketplace.[2] Health insurance may be purchased on an individual basis or for an entire family.

*Managed Care*

Managed care is the most common delivery system for medical care today by health insurers.[3] Managed care systems combine the delivery and financing of health care services by limiting the choice of doctors and hospitals.[4] In return for this limited choice, however, medical care is usually less costly to the patient due to lower out of pocket costs and the managed care network's ability to control the cost and utilization of health care services. Some common forms of managed care are preferred provider organizations[5] (PPOs), exclusive provider organizations (EPOs),[6] and health maintenance organizations[7] (HMOs). For services to be covered at the lowest out of pocket cost to the insured, the insured must utilize the managed care plan's network of providers, except in cases of an emergency. Different managed care companies have a variety of network and out of pocket cost arrangements based on an individual's or family's needs.

*Office of Insurance Regulation*

The Office of Insurance Regulation (OIR) regulates specified insurance products, insurers and other risk bearing entities in Florida, as well as licensing, rates, policy forms, market conduct, claims, issuances of certificates of authority, solvency, viatical statements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[8] .The OIR is also authorized to conduct market conduct examinations to determine compliance with applicable provisions of the Insurance Code.[9] For managed care entities to receive a license from OIR, the entity must meet financial guidelines, benefits, and policy standards as established under ch. 690.154, F.A.C.

*The Agency for Health Care Administration*

[1] S. 624.603, F.S.
[2] *See* Healthcare.gov, *How to apply and enroll, Apply for Health Insurance | HealthCare.gov* (last visited Feb. 12, 2024).
[3] Florida Department of Financial Services, *Health Insurance and Health Maintenance Organizations, A Guide for Consumers,* available at: https://www.myfloridacfo.com/docs-sf/consumer-services-libraries/ (last visited Jan. 26, 2024).
[4] *Id*.
[5] S. 627.6471, F.S.
[6] S. 627.6472, F.S.
[7] Part I of ch. 641, F.S.
[8] S. 20.121(3)(a), F.S.
[9] The Code is comprised of chs. 624-632, 634-636, 641, 642, 648, and 651, F.S. *See* S. 624.3161, F.S.

The Agency for Health Care Administration (AHCA) is the chief health policy and planning entity for the state,[10] and regulates the quality of care provided by managed care organizations under ch. 408, F.S.

*Health Maintenance Organizations*

Health Maintenance Organizations (HMOs) operate within a regulatory framework dually overseen by the OIR and AHCA. To offer a commercial health insurance plan in Florida, an HMO must obtain a license from the OIR[11] and a Certificate of Authority from AHCA. An HMO is also required to become accredited by one of the state's approved organizations: National Committee for Quality Assurance, National Association for Ambulatory Health Care, and American Accreditation HealthCare Commission.[12] Certificates of authority are granted by AHCA, if found to be compliant with the certification process, on a county by county basis or for a portion of a county.[13]

Most managed care enrollment in Florida is through an HMO. For the last quarterly submission to AHCA in September 2023, Florida HMOs reported over 8.2 million enrollees as shown in the table below.[14]

| HMO Enrollment | |
|---|---|
| **Group Type** | **Third Qtr 2023** |
| Small Group | 203,821 |
| Large Group | 476,358 |
| Individual | 1,909,616 |
| Other | 8,559 |
| Healthy Kids | 109,385 |
| Medicaid | 3,763,314 |
| Medicare | 1,763,708 |
| Federal Employees | 6,207 |
| **GRAND TOTAL:** | **8,240,968** |

These plans provide comprehensive healthcare services to members for a fixed monthly premium.[15] Members typically select a primary care physician from within the HMO's network, who serves as the main point of contact for all healthcare needs and referrals to specialists.[16] HMOs maintain networks of healthcare providers, including primary care physicians, specialists, hospitals, and other healthcare facilities.[17] Members are generally required to receive care from within the HMO's network, with exceptions for emergencies or authorized out-of-network care, for services to be covered.[18]

[10] AHCA, *About the Agency for Health Care Administration*, https://ahca.myflorida.com/about-the-agency-for-health-care-administration (last visited Jan. 26, 2024).
[11] S. 641.21(1), F.S.
[12] Agency for Health Care Administration, *Health Care Provider Certificate Process,* *Health Care Provider Certificate Process (myflorida.com)* (last visited Feb. 13, 2024).
[13] Id.
[14] Florida Office of Insurance Regulation, *Managed Care Report: Quarterly Data Summary as of September 30, 2023,* *managed-care-report-2023-q3-15dec2023.pdf (floir.com)* (last visited Feb. 13, 2024).
[15] Medicare, What's an HMO? https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Jan. 26, 2024).
[16] *Id*.
[17] S. 641.19(12), F.S.
[18] Medicare, *What's an HMO?*, https://www.medicare.gov/health-drug-plans/health-plans/. (last visited Jan. 26, 2024).

Florida law, under ch. 641, F.S., provides various consumer protections, including guaranteed access to emergency services, coverage for essential health benefits[19] mandated by the Act,[20] and the right to appeal coverage decisions made by the HMO.[21]

*Prepaid Limited Health Service Organizations*

Prepaid limited health service organizations (PLHSOs) provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment authorized under ch. 636, F.S. Limited health services include:

- Ambulance;
- Dental;
- Vision;
- Mental health;
- Substance abuse;
- Chiropractic;
- Podiatric; and
- Pharmaceutical.

Provider arrangements for PLHSOs are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

*Preferred Provider Organizations*

Authorized under ch. 627, F.S., a preferred provider organization (PPO) includes those licensed health insurers who have contracted with providers or a group of providers, directly or indirectly for an alternative or reduced rate of payment to provide a list of covered services to policyholders under the insurer's plan.[22] A PPO provider must distribute to its policyholders a list of preferred providers and make the list available on its website. Insureds have a choice of who may provide their services, but usually pay a lower deductible and less other out of pockets costs if they choose a preferred provider.[23]

*Exclusive Provider Organizations*

Exclusive provider organizations (EPOs) are another form of managed care that is also dually regulated by the OIR and the AHCA. Regulated under chapter 627, F.S., an EPO is a group of providers who have signed written contracts with an insurer to provide services to the insured's subscribers. Before the EPO can issue a policy; however, the AHCA must issue a Certificate of Authority which specifically includes approval of the EPO's plan of operation. In addition to a plan of operation, an EPO must maintain a quality assurance program and the ability to resolve complaints and grievances from its subscribers.[24]

*Dental Insurance Plans*

[19] Under the Patient Protection and Affordable Care Act, all non-grandfathered plans in the non-group and small group private health insurance markets must offer a core package of health insurance services known as the essential health benefits (EHBs). While not specifying the details of these benefits and services, there are ten general categories including coverage for pediatric dental services. Adult dental benefits are not an essential health benefit. *See Essential Health Benefits,* Healthcare.gov, *Find out what Marketplace health insurance plans cover | HealthCare.gov* (last visited Feb. 13, 2024).
[20] Patient Protection and Affordable Care Act, (March 23, 2010), P.L. 111-141, as amended.
[21] Consumer Services, *Health Insurance & HMO Overview*, https://www.myfloridacfo.com/division/consumers/understanding-insurance/health-insurance-and-hmo-overview (last visited Feb. 12, 2024).
[22] S. 627.6471, F.S.
[23] *Supra,* note 30.
[24] Agency for Health Care Administration, *Exclusive Provider Organizations (EPOs), Exclusive Provider Organizations (EPOs) (myflorida.com)* (last visited Feb. 12, 2024).

Dental insurance is a contract with an insurance company which provides benefits that can help lower the costs of dental treatment.[25] In exchange for a premium paid, dental insurance typically covers the cost of preventive care, such as routine cleanings and check-ups, but other care such as restorative treatments like fillings and extractions is usually covered at lower percentage rates, such as 80 percent, requiring higher out of pocket costs by the patient.[26] Some plans may also offer coverage for more extensive procedures like root canals, crowns, and orthodontic treatment, although coverage levels and limitations can vary widely depending on the specific plan.[27] Many dental plans may also impose an annual benefit maximum (dollar amount).

Consumers in Florida have the option to purchase dental insurance plans on the individual market or through group plans offered by employers, other organizations, or on the Act's marketplace.[28] An Act's dental plan cannot be purchased separately; it can only be purchased if a health plan is bought at the same time.[29] Some of the marketplace plans offer health plans which include dental benefits under a single premium amount. For children aged 18 or younger, dental coverage is an essential health benefit and therefore, dental coverage must be available either as part of the health plan or offered as a separate plan. While dental coverage must be available to children, it is not required that it be purchased.[30]

The availability and cost of dental insurance coverage can vary depending on factors such as age, location, and the extent of coverage desired.[31] In addition to traditional dental insurance plans, some employees may also have access to dental discount plans, health reimbursement accounts, flexible spending accounts, or health savings accounts (HSAs) that can help employees save for major and minor dental expenses and offset the cost of dental care.[32] Some of these options allow employees to deposit funds pre-tax through pay-roll deductions to potentially receive a tax break on predictable out of pocket costs.

*Insurer Contracts with Dentists*

A contract between an insurer and dentist licensed under ch. 466, F.S., for the provision of services to a subscriber of the HMO, PPO, PLHSO, or other insurer may not require the dentist to provide services to the subscriber of the HMO at a fee set by the HMO unless such services are covered services under the applicable contract.[33] The term "covered services" means dental care services for which a reimbursement is available under the subscriber's contract, or for which a reimbursement would be available but for the application of contractual limitations, such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.[34] Currently, if an insured patient exhausts his benefits or reaches a limitation, but the contract is still active, the dental patient is entitled to pay the price negotiated between the plan and the dental provider for that covered service, not a fee unilaterally set by the dental provider.

*Health Insurance Contracts*

All health insurance policies issued in the state of Florida, with the exception of certain self-insured policies,[35] must meet certain requirements that are detailed throughout the Florida Insurance Code. At a minimum, insurance policies must specify premium rates, services covered, and effective dates.

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[25] Humana, *What is dental insurance?"* *How Does Dental Insurance Work? | Humana* (last visited Feb. 12, 2024).
[26] HealthPartners, *What Does Dental Insurance Cover?*, https://www.healthpartners.com/blog/what-does-dental-insurance-cover/ (last visited Jan. 26, 2024).
[27] *Id*.
[28] Health Care, *Dental Coverage in the Marketplace*, https://www.healthcare.gov/coverage/dental-coverage/ (last visited Feb. 12, 2024).
[29] *Id.*
[30] *Id.*
[31] *Id*.
[32] MyBenefits, *Health Savings Account*, https://www.mybenefits.myflorida.com/health/savings_and_spending_accounts (last visited Jan. 26, 2024).
[33] S. 641.315(11), F.S.
[34] S. 641.315(11), F.S.
[35] The Employment Retirement Security Act of 1974 (ERISA). 29 U.S.C. ch 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida.

Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.[36]

*Non-Payment of Premiums*

Responsibilities of insured patients are also reflected in insurance contracts. Contracts set premium payment schedules and require that payments must be made in a timely fashion. In cases where this requirement is not met, any health insurer or HMO may cancel coverage for nonpayment of premiums after a statutory grace period.[37]

Before cancellation can occur, however, covered patients are protected by grace periods that extend the time frame in which premium payments may be submitted. A grace period is a period of time following the due date of a premium payment in which the insurance policy remains in force, even if the premium payment has not been made. The grace periods for policies or contracts issued in Florida are set in the Insurance Code,[38] and vary based on the premium payment schedule.

Pursuant to ss. 627.608 and 641.31, F.S., insurance policies and health maintenance contracts stay in force during grace periods. If the insurer or HMO does not receive the full payment of the premium by the end of the grace period, coverage terminates as of the grace period start date and the insurer or HMO may deny any medical claims incurred during the grace period. When a claim is denied at a later date, it is referred to as a retroactive denial.

The Insurance Code is silent on whether the insurer or HMO may advise a health care provider that a patient has not paid the applicable premium, and that the policy or health maintenance contract may be terminated in the future, possibly resulting in a retroactive claim denial.

*Prompt Payment*

Current law governs prompt payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, under ss. 627.6131 and 641.3155, F.S., respectively.[39] These provisions detail the rights and responsibilities of insurers, HMOs, and providers for the payment of medical claims. The statutes provide a process and timeline for providers to pay, deny, or contest the claim, and also prohibit an insurer or HMO from retroactively denying a claim because of the ineligibility of an insured or subscriber more than one year after the date the claim is paid.[40]

Federal Patient Protection and Affordable Care Act

The Act introduced a set of claims-related requirements for insurers offering plans through the federally-facilitated and state-based insurance exchanges. The Act guarantees access to coverage and mandates certain essential health benefits, among other directives.[41] To address affordability issues, federal premium tax credits and cost-sharing subsidies are available to assist eligible low and moderate-income individuals to purchase qualified health plans on a state or federal exchange.[42]

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[36] S. 627.413(1)(d), F.S.
[37] SS. 627.6043(1) and 641.3108(2), F.S.
[38] SS. 627.608 and 641.31(15), F.S.; The grace period of an individual policy must be a minimum of 7 days for weekly premium; 10 days for a monthly premium; and 31 days for all other periods. The grace period of a HMO contract must be at least 10 days. For group policies, if cancellation is due to nonpayment of premium, the insurer may not retroactively cancel the policy to a date prior to the date that notice of cancellation was provided to the policyholder unless the insurer mails notice of cancellation to the policyholder prior to 45 days after the date the premium was due. Such notice must be mailed to the policyholder's last address as shown by the records of the insurer and may provide for a retroactive date of cancellation no earlier than midnight of the date that the premium was due.
[39] The prompt pay provisions apply to HMO contracts and major medical policies offered by individual and group insurers licensed under ch. 624, F.S., including preferred provider policies and an exclusive provider organization, and individual and group contracts that only provide direct payments to dentists.
[40] SS. 627.6131(11) and 641.3155(10), F.S.
[41] The Patient Protection and Affordable Care Act (Pub. Law No. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. Law No. 111–152), which amended several provisions of the PPACA, was enacted on March 30, 2010. Together these two Acts are known as PPACA.
[42] In general, individuals and families may be eligible for the premium tax credit if their household income for the year is at least 100 percent but no more than 400 percent of the federal poverty line (FPL) for their family size. For residents of one of the 48 contiguous

According to the 2023 Market Report by the Florida Health Insurance Advisory Board, total enrollment in Florida's commercial health insurance market is 4,671,680 individuals which represents an increase of over eight percent from the prior year.[43] The largest group in this market has individual coverage, over 2.9 million Floridians, an increase of 16 percent over 2022, and the vast majority of this coverage has been purchased through the ACA marketplace.[44] For the 2024 Open Enrollment period, Florida's total number of ACA marketplace plan selections from new and continuing consumers was 4,211,902 plan selections, the highest number of selection among all states, federal or state based exchanges.[45]

*Non-Payment of Premiums – Federal Law*

All qualified health plans (QHPs)[46] in the ACA marketplace are required to establish standard policies for the termination of enrollees due to the non-payment of premiums. The policy must be applied uniformly to enrollees in similar situations.[47] If an enrollee is delinquent with a premium payment, the QHP must notify the enrollee of the delinquency promptly and without undue delay, within 10 business days of the date from which the insurer should have discovered the delinquency.[48]

Individual health insurance plans purchased via the exchanges with a federal premium tax credit are not subject to the grace periods in Florida law. Instead, the Act requires insurers and HMOs to provide subscribers in these plans, a grace period of at least three consecutive months before cancelling the policy or contract if the enrollee previously paid at least a binder payment or the first month's premium payment.[49] The binder payment is due no earlier than the coverage effective date and no later than 30 calendar days from the coverage effective date.[50]

During the first month of the grace period, the insurer must pay all appropriate claims for services provided.[51] During the grace period, the insurer must also notify the Department of Health and Human Services (HHS) of the non-payment and notify providers of the possibility for denied claims when an enrollee is in the second and third months of a grace period.[52] For the second and third months, an insurer may pend claims and then must notify affected providers that an enrollee has lapsed in his or her payment of premiums and there is a possibility the insurer may deny the payment of claims incurred during the second and third months.[53]

Payment Methods for Health Care Claims

In March 2022, HHS issued guidance for covered entities[54] on the payment of health care claims by health plans through the use of virtual credit cards (VCC) and whether these transactions met the federal regulatory standards for electronic transactions. In model legislation, the National Council of

states or Washington, D.C., 100 percent of the FPL for a family of 4 is $31,200; at 400 percent of the FPL for a family of 4 is $124,800. *See* U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *HHS Poverty Guidelines for 2024*, available at: detailed-guidelines-2024.pdf (hhs.gov) (last visited Feb. 12, 2024).

[43] Florida Health Insurance Advisory Board, *2023 Market Report, fhiab-2023-market-report---adopted-(12-15-23).pdf (floir.com)* (last visited Feb. 13, 2024).

[44] *Id.*

[45] Centers for Medicare and Medicaid Services, *Marketplace 2024 Open Enrollment Period Report: Final National Snapshot (January 24, 2024)*, available at Marketplace 2024 Open Enrollment Period Report: Final National Snapshot | CMS (last visited Feb. 13, 2024).

[46] A "qualified health plan" is a plan that has been certified to meet the minimum standards of participation under 45 CFR §156.200 and is recognized as a QHP by the exchanges through which the plan is offered. Those standards include compliance with Exchange process and procedures, benefit design standards, licensure compliance in state where products are sold, in good standing in states where licensed products are sold, implementation of a quality improvement strategy or strategies consistent with the Act's goals, payment of applicable user fees, and compliance with reinsurance, risk corridors, and risk adjustment requirements.

[47] 45 CFR §156.270(c).

[48] 45 CFR §156.270 (f).

[49] 45 CFR §156.270(d).

[50] Centers for Medicare and Medicaid Services, *Health Plan Coverage Effectuation Webinar Training: Payment, Grace Periods, and Termination (Navigator Training materials – January 2024),* available at Health Plan Coverage Effectuation_Webinar_Jan_2024 (cms.gov) (last visited Feb. 12, 2024).

[51] 45 CFR §156.270(d)(1).

[52] 45 CFR §156.270(d).

[53] 45 CFR §156.270(d)(3).

[54] A "covered entity" is defined at 45 CFR §160.103, as a health plan, a health plan clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a transaction.

Insurance Legislators has defined VCCs as an online credit card payment where no physical card is present and the number expires upon use at a credit card terminal or internet portal.[55] Instead of sending a paper check or an electronic payment transmission, some health plans have paid providers by sending these single use credit cards requiring the provider to then manually enter VCC numbers in order to receive payment. A transaction fee is incurred for each payment processed. For ACH transaction, the fee per item is based on volume, and can average in 2024 around $0.35.[56] For transactions by VCC, fees have been quoted as high as five percent.[57] HHS guidance concluded that payment by VCC was permitted; however, to meet the standards, the health plans must maintain certain privacy and confidentiality and transaction standards, including a one-to-one relationship between each electronic remittance advice (ERA) and electronic funds transfer (EFT).[58] Once a plan submits a payment using the required standard with the specifications, any intermediaries acting on behalf of the health plan, including health care clearinghouses, financial institutions, and payment vendors, cannot alter, amend, or omit any information.[59]

Federal regulations also require that if a health plan pays providers via a VCC, the provider must be able to continue to request payments via EFT through the Automated Clearinghouse (ACH) Network using regulatory and ERA transaction standards, and the health plan is required to comply with those requests.[60] When a provider makes this request, the health plan must comply, regardless of whether the provider is in the plan's network or not or otherwise not affiliated with the plan.[61]

Many VCC vendors offer additional or value added services directly or through business associates to dental providers for additional fees above the transaction fees. These additional items may include services such as assistance with re-associating the EFT file with the ERA file for reconciliation or other purposes, customer service functions, hotline numbers, special reporting or output files, billing services, and eligibility verification processes. Federal regulations prohibit a health plan from requiring a provider to agree to any value added services as a condition of payment or inclusion of the required reassociation services using the HHS adopted EFT and ERA standards.[62]

If the provider has made a request to a health plan to conduct transactions via EFT and ERA using the adopted standards, and the provider believes that the health plan has not used or complied with those standards or operating rules, or the insurer has required the provider to pay for additional services declined by the provider as a condition of claims payment, the provider may file a complaint against the health plan with the federal Centers for Medicare and Medicaid Services.[63]

**Regulation of Dentists**

Dentists are licensed by the Board of Dentistry within the Department of Health under ch. 466, F.S. A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[64] Dentists may delegate certain tasks[65] to dental hygienists and dental assistants, but a patient's "dentist of record" retains primary responsibility for all dental treatment on the patient.[66]

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[55] National Council of Insurance Legislators, *NCOIL Adopts Transparency in Dental Benefits Contracting Model Act (December 27, 2020)*, available at Transparency-in-Dental-Benefits-2020_final.pdf (ncoil.org) (last visited Feb. 15, 2024).
[56] The Federal Reserve, *FedACH Services 2024 Fee Schedule*, available at https://www.frbservices.org/resources/fees/ach-2024 (last visited Feb. 15. 2024).
[57] Cezary Podkul, *The Hidden Fee Costing Doctors Millions Every Year,* ProPublica (August 14, 2023), available at https://www.propublica.org/article/the-hidden-fee-costing-doctors-millions-every-year (last visited Feb. 15, 2024).
[58] Department of Health and Human Services, *Go to Guidance: Guidance on health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted HIPAA standards for Health Care Electronic Funds Transfer (EFT) and Remittance Advice (ERA) transactions; 45 CFR §§162.1601 and 162.1602(d),* available at Virtual Credit Cards (VCCs) and Electronic Funds Transfers (EFT) Guidance Letter (cms.gov) (last visited Feb. 12, 2024).
[59] *Id.*
[60] *Id.* and 45 CFR §162.925(a)(1).
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] S. 466.003(2)-(3), F.S.
[65] S. 466.024, F.S.
[66] S. 466.018, F.S.

Any person wishing to practice dentistry must meet specified requirements and apply to the Department of Health (DOH) for licensure. Applicants must sit for and pass three examinations prior to licensure:[67]

- The National Board of Dental Examiners dental examination (NBDE);
- A practical examination, which is the American Dental Licensing Examination developed by the American Board of Dental Examiners, Inc.;[68] and
- A written examination on Florida laws and rules regulating the practice of dentistry and dental hygiene.

To qualify to take the Florida dental licensure examination, an applicant must be 18 years of age or older, be a graduate of a dental school accredited by the American Dental Association or be a student in the final year of a program at an accredited institution, and have successfully completed the NBDE dental examination.[69]

Once licensed, dentists must maintain professional liability insurance or provide proof of financial responsibility of an equal amount. If the dentist obtains professional liability insurance, the coverage must be at least $100,000 per claim, with a minimum annual aggregate of at least $300,000.[70] Alternatively, a dentist may maintain an unexpired, irrevocable letter of credit in the amount of $100,000 per claim, with a minimum aggregate availability of credit of at least $300,000.[71] The professional liability insurance must provide coverage for the actions of any dental hygienist supervised by the dentist.[72] However, a dentist may be exempt from maintaining professional liability insurance if he or she:[73]

- Practices exclusively for the federal government or the State of Florida or its agencies or subdivisions;
- Is not practicing in this state;
- Practices only in conjunction with his or her teaching duties at an accredited school of dentistry or in its main teaching hospitals; or
- Demonstrates to the Board that he or she has no malpractice exposure in this state.

There are currently 17,193 dentists with active licenses to practice in Florida,[74] and 41 out-of-state registered telehealth dentists.[75]

**Effects of the Bill**

The bill regulates contracts between dental providers and insurers, including HMOs, PPOs, EPOs, and PLHSOs.

*Regulation of Payment Methods*

The bill prohibits health insurers under chs. 627, 636, and 641, F.S., from requiring reimbursement of claims through credit card payments as the only acceptable method of payment in a contract with a dentist licensed under ch. 466, F.S. Currently, state law is silent on acceptable forms of payment between a health plan and a provider in a private contract; however federal law has established specific standards for covered entities, which includes both the plan and the provider, as to how such transaction must be carried out, and what privacy and security specifications apply to the information involved. Federal regulations have also prohibited covered entities from exclusively requiring payment

[67] S. 466.006, F.S.
[68] Rule 64B5-2.013, F.A.C.
[69] S. 466.006(2), F.S.
[70] Rule 64B5-17.011(1), F.A.C.
[71] Rule 64B5-17.011(2), F.A.C.
[72] Rule 64B5-17.011(4), F.A.C.
[73] Rule 64B5-17.011(3), F.A.C.
[74] *See*, Department of Health *License Verification* web search. Available at https://mqa-internet.doh.state.fl.us/MQASearchServices/HealthCareProviders (last visited Jan. 26, 2024).
[75] *Id*.

via VCCs, and require that a health plan honor a provider's request for payment via the ACH and EFT process.

If initiating or changing the payment method to the dental provider using the EFT process, including but not limited to VCCs, the bill establishes a requirement for these insurers to provide written notice to dentists outlining any associated fees, and presenting alternative payment methods with clear instructions for how to select an alternative method of payment, if any.

*Claims Denial*

Under the bill, an insurer may not deny any claim submitted by a dentist licensed under ch. 466, F.S., for procedures specifically included in a prior authorization, unless:

- Benefit limitations were reached subsequent to the issuance of the prior authorization;
- Inadequate documentation was submitted to support the originally authorized claim;
- Changes in the patient's condition or provision of new procedures post-authorization rendered the prior authorized procedure medically unnecessary;
- Changes in the patient's condition or provision of new procedures would have required disapproval under the terms and conditions of the patient's plan at the time of prior authorization;
- Services were provided during the grace period established under an applicable federal or state law or regulation, 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 a request was made; or
- Responsibility for the claim belonged to another payor for payment, prior payment was already made to the dentist for the procedures in question, request was a fraudulent claim submission, or patient shown as ineligible at the time of service.

Existing state law does not establish which party is responsible for claims incurred when verification of eligibility or prior authorization is received by a dental provider for a specific service from an insurer, the service is provided, and afterwards, the claim is denied because the patient was not covered at the time of service. The patient may not have been covered for a variety of reasons, such as a timing difference between when the dental provider's office called to verify eligibility and received a prior authorization for the service, or the patient may have been in the premium grace period.

The bill limits the circumstances in which a claim could be denied to situations when benefits were exhausted, the service was no longer medically necessary, there are clinical issues, suspicion of fraud, or the services were provided during a grace period and the insurer notified the provider when the provider sought verification of the patient's eligibility or enrollment. In cases where prior authorization was granted, the patient had not exceeded his or her benefits, and the covered services were still medically necessary, the claim could not be denied.

*Compliance*

The bill is applicable to contracts delivered, issued, or renewed on or after January 1, 2025.

The bill authorizes OIR to enforce its provisions, and authorizes the FSC to adopt rules for implementation.

The bill provides an effective date of July 1, 2024.

B. SECTION DIRECTORY:

**Section 1**: Amends s. 627.6131, F.S., relating to payment of claims.

**Section 2:** Amends s. 636.032, F.S., relating to acceptable payments.

**Section 3:** Amends s. 636.035, F.S., relating to provider arrangements.

**Section 4:** Amends s. 641.315, F.S., relating to provider contracts.

**Section 5:** Provides an effective date of July 1, 2024.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None. The Division of State Group Insurance within the Department of Management Services asserts that the bill will not increase costs for the state employee group health plan.[76]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The bill may negatively impact local government expenditures through potential increases in premium costs, resulting from any additional payments for dental claims which would have been previously denied but for which denial is prohibited by the bill, and from increased administrative costs. The amount of impact, if any, depends on the level of coverage and the practices of each dental plan.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have a negative economic impact on the insurance industry, depending on the amount and type of claims denial activity in which they engage, and also due to increased administrative costs. The bill may have a positive economic impact on dental care providers, which may experience increased revenue under the bill's claims payment regulations.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

[76] Email correspondence with Jake Holmgreen, Department of Management Services, Jan. 29, 2024, on file with the Health and Human Services Committee.

The bill provides sufficient rulemaking authority to the FSC to implement its provisions. OIR has sufficient rulemaking authority under current law to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On February 1, 2024, the Insurance & Banking Subcommittee considered the bill, adopted an amendment, reported the bill favorably as a committee substitute. The amendment removed a proposed authorization for health insurers to charge a fee for value-added services related to ACH transfers.

On February 15, 2024, the Health and Human Services Committee considered the bill, adopted an amendment, and reported the bill favorably as a committee substitute. The amendment:

- Removed a provision allowing dental providers to establish alternative fee schedules for covered services once an insured individual reaches certain contractual limitations.
- Permitted the charging of reasonable fees for value added services related to ACH transactions if the dental provider has consented to those fees.
- Modified the application date for contractual changes required by the bill to the date of the next issuance, delivery, or renewal and removes current contract nullification language.
- Removed the bill's insurer knowledge and reasonable care requirement related to the authority to deny a claim due to patient's ineligibility on the procedure date.
- Allows for a claim denial if the services were provided during the premium non-payment grace period and the insurer informed the provider of such in response to an eligibility inquiry.

The analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.