

1 A bill to be entitled
2 An act relating to dental insurance claims; amending
3 s. 627.6131, F.S.; prohibiting a contract between a
4 health insurer and a dentist from containing certain
5 restrictions on payment methods; requiring a health
6 insurer to make certain notifications before paying a
7 claim to a dentist through electronic funds transfer;
8 prohibiting a health insurer from charging a fee to
9 transmit a payment to a dentist through ACH transfer
10 unless the dentist has consented to such fee;
11 authorizing a health insurer to charge reasonable fees
12 for other value-added services related to the ACH
13 transfer; providing construction; authorizing the
14 Office of Insurance Regulation of the Financial
15 Services Commission to enforce certain provisions;
16 authorizing the commission to adopt rules; prohibiting
17 a health insurer from denying claims for procedures
18 included in a prior authorization; providing
19 exceptions; providing construction; authorizing the
20 office to enforce certain provisions; authorizing the
21 commission to adopt rules; amending s. 627.6474, F.S.;
22 revising the definition of the term "covered
23 services"; amending s. 636.032, F.S.; prohibiting a
24 contract between a prepaid limited health service
25 organization and a dentist from containing certain

26 | restrictions on payment methods; requiring the prepaid
27 | limited health service organization to make certain
28 | notifications before paying a claim to a dentist
29 | through electronic funds transfer; prohibiting a
30 | prepaid limited health service organization from
31 | charging a fee to transmit a payment to a dentist
32 | through ACH transfer unless the dentist has consented
33 | to such fee; authorizing the prepaid limited health
34 | service organization to charge reasonable fees for
35 | other value-added services related to the ACH
36 | transfer; providing construction; authorizing the
37 | office to enforce certain provisions; authorizing the
38 | commission to adopt rules; amending s. 636.035, F.S.;
39 | revising the definition of the term "covered
40 | services"; prohibiting a prepaid limited health
41 | service organization from denying claims for
42 | procedures included in a prior authorization;
43 | providing exceptions; providing construction;
44 | authorizing the office to enforce certain provisions;
45 | authorizing the commission to adopt rules; amending s.
46 | 641.315, F.S.; revising the definition of the term
47 | "covered service"; prohibiting a contract between a
48 | health maintenance organization and a dentist from
49 | containing certain restrictions on payment methods;
50 | requiring the health maintenance organization to make

51 certain notifications before paying a claim to a
52 dentist through electronic funds transfer; prohibiting
53 a health maintenance organization from charging a fee
54 to transmit a payment to a dentist through ACH
55 transfer unless the dentist has consented to such fee;
56 authorizing the health maintenance organization to
57 charge reasonable fees for other value-added services
58 related to the ACH transfer; providing construction;
59 authorizing the office to enforce certain provisions;
60 authorizing the commission to adopt rules; prohibiting
61 a health maintenance organization from denying claims
62 for procedures included in a prior authorization;
63 providing exceptions; providing construction;
64 authorizing the office to enforce certain provisions;
65 authorizing the commission to adopt rules; providing
66 an effective date.

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

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70 Section 1. Subsections (20) and (21) are added to section
71 627.6131, Florida Statutes, to read:

72 627.6131 Payment of claims.—

73 (20) (a) A contract between a health insurer and a dentist
74 licensed under chapter 466 for the provision of services to an
75 insured may not specify credit card payment as the only

76 acceptable method for payments from the health insurer to the
77 dentist.

78 (b) At least 10 days before a health insurer pays a claim
79 to a dentist through electronic funds transfer, including, but
80 not limited to, virtual credit card payments, the health insurer
81 shall notify the dentist in writing of all of the following:

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

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

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

94 (d) This subsection may not be waived, voided, or
95 nullified by contract, and any contractual clause in conflict
96 with this subsection or which purports to waive any requirements
97 of this subsection is null and void.

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

100 (f) The commission may adopt rules to implement this

101 subsection.

102 (21) (a) A health insurer may not deny any claim
103 subsequently submitted by a dentist licensed under chapter 466
104 for procedures specifically included in a prior authorization
105 unless at least one of the following circumstances applies for
106 each procedure denied:

107 1. Benefit limitations, such as annual maximums and
108 frequency limitations not applicable at the time of the prior
109 authorization, are reached subsequent to issuance of the prior
110 authorization.

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

113 3. Subsequent to the issuance of the prior authorization,
114 new procedures are provided to the patient or a change in the
115 condition of the patient occurs such that the prior authorized
116 procedure would no longer be considered medically necessary,
117 based on the prevailing standard of care.

118 4. Subsequent to the issuance of the prior authorization,
119 new procedures are provided to the patient or a change in the
120 patient's condition occurs such that the prior authorized
121 procedure would at that time have required disapproval pursuant
122 to the terms and conditions for coverage under the patient's
123 plan in effect at the time the prior authorization was issued.

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

126 a. Another payor is responsible for payment.
 127 b. The dentist has already been paid for the procedures
 128 identified in the claim.
 129 c. The claim was submitted fraudulently, or the prior
 130 authorization was based in whole or material part on erroneous
 131 information provided to the health insurer by the dentist,
 132 patient, or other person not related to the insurer.
 133 d. The person receiving the procedure was not eligible to
 134 receive the procedure on the date of service and the health
 135 insurer did not know, and with the exercise of reasonable care
 136 could not have known, of his or her ineligibility.
 137 (b) This subsection may not be waived, voided, or
 138 nullified by contract, and any contractual clause in conflict
 139 with this subsection or which purports to waive any requirements
 140 of this subsection is null and void.
 141 (c) The office has all rights and powers to enforce this
 142 subsection as provided by s. 624.307.
 143 (d) The commission may adopt rules to implement this
 144 subsection.
 145 Section 2. Subsection (2) of section 627.6474, Florida
 146 Statutes, is amended to read:
 147 627.6474 Provider contracts.—
 148 (2) A contract between a health insurer and a dentist
 149 licensed under chapter 466 for the provision of services to an
 150 insured may not contain a provision that requires the dentist to

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151 provide services to the insured under such contract at a fee set
152 by the health insurer unless such services are covered services
153 under the applicable contract. As used in this subsection, the
154 term "covered services" means dental care services for which a
155 reimbursement is available under the insured's contract,
156 ~~notwithstanding or for which a reimbursement would be available~~
157 ~~but for~~ the application of contractual limitations, such as
158 deductibles, coinsurance, waiting periods, annual or lifetime
159 maximums, frequency limitations, alternative benefit payments,
160 or any other limitation.

161 Section 3. Section 636.032, Florida Statutes, is amended
162 to read:

163 636.032 Acceptable payments.—

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

169 (2)(a) A contract between a prepaid limited health service
170 organization and a dentist licensed under chapter 466 for the
171 provision of services to a subscriber may not specify credit
172 card payment as the only acceptable method for payments from the
173 prepaid limited health service organization to the dentist.

174 (b) At least 10 days before a limited health service
175 organization pays a claim to a dentist through electronic funds

176 transfer, including, but not limited to, virtual credit card
177 payments, the prepaid limited health service organization shall
178 notify the dentist in writing of all of the following:

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

181 2. The available methods of payment of claims by the
182 prepaid limited health service organization, with clear
183 instructions to the dentist on how to select an alternative
184 payment method.

185 (c) A prepaid limited health service organization that
186 pays a claim to a dentist through Automatic Clearing House (ACH)
187 transfer may not charge a fee solely to transmit the payment to
188 the dentist unless the dentist has consented to the fee. A
189 prepaid limited health service organization may charge
190 reasonable fees for other value-added services related to the
191 ACH transfer, including, but not limited to, transaction
192 management, data management, and portal services.

193 (d) This subsection may not be waived, voided, or
194 nullified by contract, and any contractual clause in conflict
195 with this subsection or which purports to waive any requirements
196 of this subsection is null and void.

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

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

201 Section 4. Subsection (13) of section 636.035, Florida
 202 Statutes, is amended, and subsection (15) is added to that
 203 section, to read:

204 636.035 Provider arrangements.—

205 (13) A contract between a prepaid limited health service
 206 organization and a dentist licensed under chapter 466 for the
 207 provision of services to a subscriber of the prepaid limited
 208 health service organization may not contain a provision that
 209 requires the dentist to provide services to the subscriber of
 210 the prepaid limited health service organization at a fee set by
 211 the prepaid limited health service organization unless such
 212 services are covered services under the applicable contract. As
 213 used in this subsection, the term "covered services" means
 214 dental care services for which a reimbursement is available
 215 under the subscriber's contract, notwithstanding ~~or for which a~~
 216 ~~reimbursement would be available but for~~ the application of
 217 contractual limitations such as deductibles, coinsurance,
 218 waiting periods, annual or lifetime maximums, frequency
 219 limitations, alternative benefit payments, or any other
 220 limitation.

221 (15) (a) A prepaid limited health service organization may
 222 not deny any claim subsequently submitted by a dentist licensed
 223 under chapter 466 for procedures specifically included in a
 224 prior authorization unless at least one of the following
 225 circumstances applies for each procedure denied:

226 1. Benefit limitations, such as annual maximums and
227 frequency limitations not applicable at the time of the prior
228 authorization, are reached subsequent to issuance of the prior
229 authorization.

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

232 3. Subsequent to the issuance of the prior authorization,
233 new procedures are provided to the patient or a change in the
234 condition of the patient occurs such that the prior authorized
235 procedure would no longer be considered medically necessary,
236 based on the prevailing standard of care.

237 4. Subsequent to the issuance of the prior authorization,
238 new procedures are provided to the patient or a change in the
239 patient's condition occurs such that the prior authorized
240 procedure would at that time have required disapproval pursuant
241 to the terms and conditions for coverage under the patient's
242 plan in effect at the time the prior authorization was issued.

243 5. The denial of the dental service claim was due to one
244 of the following:

245 a. Another payor is responsible for payment.

246 b. The dentist has already been paid for the procedures
247 identified in the claim.

248 c. The claim was submitted fraudulently, or the prior
249 authorization was based in whole or material part on erroneous
250 information provided to the prepaid limited health service

251 organization by the dentist, patient, or other person not
252 related to the organization.

253 d. The person receiving the procedure was not eligible to
254 receive the procedure on the date of service and the prepaid
255 limited health service organization did not know, and with the
256 exercise of reasonable care could not have known, of his or her
257 ineligibility.

258 (b) This subsection may not be waived, voided, or
259 nullified by contract, and any contractual clause in conflict
260 with this subsection or which purports to waive any requirements
261 of this subsection is null and void.

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

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

266 Section 5. Subsection (11) of section 641.315, Florida
267 Statutes, is amended, and subsections (13) and (14) are added to
268 that section, to read:

269 641.315 Provider contracts.—

270 (11) A contract between a health maintenance organization
271 and a dentist licensed under chapter 466 for the provision of
272 services to a subscriber of the health maintenance organization
273 may not contain a provision that requires the dentist to provide
274 services to the subscriber of the health maintenance
275 organization at a fee set by the health maintenance organization

276 unless such services are covered services under the applicable
 277 contract. As used in this subsection, the term "covered
 278 services" means dental care services for which a reimbursement
 279 is available under the subscriber's contract, notwithstanding ~~or~~
 280 ~~for which a reimbursement would be available but for the~~
 281 application of contractual limitations such as deductibles,
 282 coinsurance, waiting periods, annual or lifetime maximums,
 283 frequency limitations, alternative benefit payments, or any
 284 other limitation.

285 (13) (a) A contract between a health maintenance
 286 organization and a dentist licensed under chapter 466 for the
 287 provision of services to a subscriber of the health maintenance
 288 organization may not specify credit card payment as the only
 289 acceptable method for payments from the health maintenance
 290 organization to the dentist.

291 (b) At least 10 days before a health maintenance
 292 organization pays a claim to a dentist through electronic funds
 293 transfer, including, but not limited to, virtual credit card
 294 payments, the health maintenance organization shall notify the
 295 dentist in writing of all of the following:

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

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

301 (c) A health maintenance organization that pays a claim to
 302 a dentist through Automated Clearing House (ACH) transfer may
 303 not charge a fee solely to transmit the payment to the dentist
 304 unless the dentist has consented to the fee. A health
 305 maintenance organization may charge reasonable fees for other
 306 value-added services related to the ACH transfer, including, but
 307 not limited to, transaction management, data management, and
 308 portal services.

309 (d) This subsection may not be waived, voided, or
 310 nullified by contract, and any contractual clause in conflict
 311 with this subsection or which purports to waive any requirements
 312 of this subsection is null and void.

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

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

317 (14) (a) A health maintenance organization may not deny any
 318 claim subsequently submitted by a dentist licensed under chapter
 319 466 for procedures specifically included in a prior
 320 authorization unless at least one of the following circumstances
 321 applies for each procedure denied:

322 1. Benefit limitations, such as annual maximums and
 323 frequency limitations not applicable at the time of the prior
 324 authorization, are reached subsequent to issuance of the prior
 325 authorization.

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

328 3. Subsequent to the issuance of the prior authorization,
329 new procedures are provided to the patient or a change in the
330 condition of the patient occurs such that the prior authorized
331 procedure would no longer be considered medically necessary,
332 based on the prevailing standard of care.

333 4. Subsequent to the issuance of the prior authorization,
334 new procedures are provided to the patient or a change in the
335 patient's condition occurs such that the prior authorized
336 procedure would at that time have required disapproval pursuant
337 to the terms and conditions for coverage under the patient's
338 plan in effect at the time the prior authorization was issued.

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

341 a. Another payor is responsible for payment.

342 b. The dentist has already been paid for the procedures
343 identified in the claim.

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

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

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351 maintenance organization did not know, and with the exercise of
352 reasonable care could not have known, of his or her
353 ineligibility.

354 (b) The subsection may not be waived, voided, or nullified
355 by contract, and any contractual clause in conflict with this
356 subsection or which purports to waive any requirements of this
357 subsection is null and void.

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

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

362 Section 6. This act shall take effect July 1, 2024.