A bill to be entitled

An act relating to dental insurance claims; amending s. 627.6131, F.S.; prohibiting a contract between a health insurer and a dentist from containing certain restrictions on payment methods; requiring a health insurer to notify a dentist if initiating or changing electronic funds transfer payment methods for dental claims; prohibiting a health insurer from charging a fee to transmit a payment to a dentist through an automated clearinghouse transfer unless the dentist has consented to such fee; authorizing a health insurer to charge certain fees; providing applicability; authorizing the Office of Insurance Regulation of the Financial Services Commission to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health insurer from denying claims for procedures included in a prior authorization; providing exceptions; providing applicability; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; 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 a prepaid limited health service organization to notify a

dentist if initiating or changing electronic funds transfer payment methods for dental claims; prohibiting a prepaid limited health service organization from charging a fee to transmit a payment to a dentist through an automated clearinghouse transfer unless the dentist has consented to such fee; authorizing a prepaid limited health service organization to charge certain fees; providing applicability; 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 applicability; amending s. 641.315, F.S.; prohibiting a contract between a health maintenance organization and a dentist from containing certain restrictions on payment methods; requiring a health maintenance organization to notify a dentist if initiating or changing electronic funds transfer payment methods for dental claims; prohibiting a health maintenance organization from charging a fee to transmit a payment to a dentist through an automated clearinghouse transfer unless the dentist has consented to such fee; authorizing a health maintenance organization to

charge certain fees; providing applicability; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; prohibiting a health maintenance organization from denying claims for procedures included in a prior authorization; providing exceptions; providing applicability; authorizing the office to enforce certain provisions; authorizing the commission to adopt rules; providing an effective date.

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

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 notify the dentist in writing of all of the following:

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

transfer.

2. 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 an automated clearinghouse 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 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 patient's condition 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 health insurer notified the dentist that the patient was in the grace period when the dentist requested eligibility or enrollment verification from the health insurer, if such request was made.

(b) This subsection applies to 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 prepaid limited health service organization shall notify the dentist in writing of all of the following:

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

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

(c) A prepaid limited health service organization that pays a claim to a dentist through an automated clearinghouse transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A prepaid limited health service organization may charge reasonable fees for value-added services related to the 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:

636.035 Provider arrangements.—

(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 patient's condition 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 prepaid limited health service organization notified the dentist that the patient was in the grace period when the dentist requested eligibility or enrollment verification from the prepaid limited health service organization, if such request was made.

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

Section 4. Subsections (13) and (14) are added to section 641.315, Florida Statutes, 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 maintenance organization shall notify the dentist in writing of all of the following:

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

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

(c) A health maintenance organization that pays a claim to a dentist through an automated clearinghouse transfer may not charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee. A health maintenance organization may charge reasonable fees for value-added services related to the 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.

(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 patient's condition 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 health maintenance organization notified the dentist that the patient was in the grace period when the dentist requested eligibility or enrollment verification from the health maintenance organization, if such request was made.

(b) This subsection applies to 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 5. This act shall take effect July 1, 2024.