

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 notify a dentist if initiating or changing
7 electronic funds transfer payment methods for dental
8 claims; prohibiting a health insurer from charging a
9 fee to transmit a payment to a dentist through an
10 automated clearinghouse transfer unless the dentist
11 has consented to such fee; authorizing a health
12 insurer to charge certain fees; providing
13 applicability; authorizing the Office of Insurance
14 Regulation of the Financial Services Commission to
15 enforce certain provisions; authorizing the commission
16 to adopt rules; prohibiting a health insurer from
17 denying claims for procedures included in a prior
18 authorization; providing exceptions; providing
19 applicability; authorizing the office to enforce
20 certain provisions; authorizing the commission to
21 adopt rules; amending s. 636.032, F.S.; prohibiting a
22 contract between a prepaid limited health service
23 organization and a dentist from containing certain
24 restrictions on payment methods; requiring a prepaid
25 limited health service organization to notify a

26 | dentist if initiating or changing electronic funds
27 | transfer payment methods for dental claims;
28 | prohibiting a prepaid limited health service
29 | organization from charging a fee to transmit a payment
30 | to a dentist through an automated clearinghouse
31 | transfer unless the dentist has consented to such fee;
32 | authorizing a prepaid limited health service
33 | organization to charge certain fees; providing
34 | applicability; authorizing the office to enforce
35 | certain provisions; authorizing the commission to
36 | adopt rules; amending s. 636.035, F.S.; prohibiting a
37 | prepaid limited health service organization from
38 | denying claims for procedures included in a prior
39 | authorization; providing exceptions; providing
40 | applicability; amending s. 641.315, F.S.; prohibiting
41 | a contract between a health maintenance organization
42 | and a dentist from containing certain restrictions on
43 | payment methods; requiring a health maintenance
44 | organization to notify a dentist if initiating or
45 | changing electronic funds transfer payment methods for
46 | dental claims; prohibiting a health maintenance
47 | organization from charging a fee to transmit a payment
48 | to a dentist through an automated clearinghouse
49 | transfer unless the dentist has consented to such fee;
50 | authorizing a health maintenance organization to

51 charge certain fees; providing applicability;
 52 authorizing the office to enforce certain provisions;
 53 authorizing the commission to adopt rules; prohibiting
 54 a health maintenance organization from denying claims
 55 for procedures included in a prior authorization;
 56 providing exceptions; providing applicability;
 57 authorizing the office to enforce certain provisions;
 58 authorizing the commission to adopt rules; providing
 59 an effective date.

60

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

62

63 Section 1. Subsections (20) and (21) are added to section
 64 627.6131, Florida Statutes, to read:

65 627.6131 Payment of claims.—

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

71 (b) If initiating or changing payments to a dentist using
 72 electronic funds transfer payments, including, but not limited
 73 to, virtual credit card payments, a health insurer shall notify
 74 the dentist in writing of all of the following:

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

76 transfer.

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

80 (c) A health insurer that pays a claim to a dentist
 81 through an automated clearinghouse transfer may not charge a fee
 82 solely to transmit the payment to the dentist unless the dentist
 83 has consented to the fee. A health insurer may charge reasonable
 84 fees for value-added services related to the transfer,
 85 including, but not limited to, transaction management, data
 86 management, and portal services.

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

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

91 (f) The commission may adopt rules to implement this
 92 subsection.

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

98 1. Benefit limitations, such as annual maximums and
 99 frequency limitations not applicable at the time of the prior
 100 authorization, are reached subsequent to issuance of the prior

101 authorization.

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

104 3. 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 no longer be considered medically necessary,
 108 based on the prevailing standard of care.

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

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

117 a. Another payor is responsible for payment.

118 b. The dentist has already been paid for the procedures
 119 identified in the claim.

120 c. The claim was submitted fraudulently, or the prior
 121 authorization was based in whole or material part on erroneous
 122 information provided to the health insurer by the dentist,
 123 patient, or other person not related to the insurer.

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

126 e. The services were provided during the grace period
 127 established under s. 627.608 or applicable federal regulations,
 128 and the health insurer notified the dentist that the patient was
 129 in the grace period when the dentist requested eligibility or
 130 enrollment verification from the health insurer, if such request
 131 was made.

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

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

136 (d) The commission may adopt rules to implement this
 137 subsection.

138 Section 2. Section 636.032, Florida Statutes, is amended
 139 to read:

140 636.032 Acceptable payments.—

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

146 (2) (a) A contract between a prepaid limited health service
 147 organization and a dentist licensed under chapter 466 for the
 148 provision of services to a subscriber may not require credit
 149 card payment as the only acceptable method for payments from the
 150 prepaid limited health service organization to the dentist.

151 (b) If initiating or changing payments to a dentist using
152 electronic funds transfer payments, including, but not limited
153 to, virtual credit card payments, a prepaid limited health
154 service organization shall notify the dentist in writing of all
155 of the following:

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

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

162 (c) A prepaid limited health service organization that
163 pays a claim to a dentist through an automated clearinghouse
164 transfer may not charge a fee solely to transmit the payment to
165 the dentist unless the dentist has consented to the fee. A
166 prepaid limited health service organization may charge
167 reasonable fees for value-added services related to the
168 transfer, including, but not limited to, transaction management,
169 data management, and portal services.

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

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

174 (f) The commission may adopt rules to implement this
175 subsection.

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

178 636.035 Provider arrangements.—

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

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

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

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

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

201 5. The denial of the dental service claim was due to one
 202 of the following:

203 a. Another payor is responsible for payment.

204 b. The dentist has already been paid for the procedures
 205 identified in the claim.

206 c. The claim was submitted fraudulently, or the prior
 207 authorization was based in whole or material part on erroneous
 208 information provided to the prepaid limited health service
 209 organization by the dentist, patient, or other person not
 210 related to the organization.

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

213 e. The services were provided during the grace period
 214 established under s. 636.016 or applicable federal regulations,
 215 and the prepaid limited health service organization notified the
 216 dentist that the patient was in the grace period when the
 217 dentist requested eligibility or enrollment verification from
 218 the prepaid limited health service organization, if such request
 219 was made.

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

222 Section 4. Subsections (13) and (14) are added to section
 223 641.315, Florida Statutes, to read:

224 641.315 Provider contracts.—

225 (13) (a) A contract between a health maintenance

226 organization and a dentist licensed under chapter 466 for the
227 provision of services to a subscriber of the health maintenance
228 organization may not require credit card payment as the only
229 acceptable method for payments from the health maintenance
230 organization to the dentist.

231 (b) If initiating or changing payments to a dentist using
232 electronic funds transfer payments, including, but not limited
233 to, virtual credit card payments, a health maintenance
234 organization shall notify the dentist in writing of all of the
235 following:

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

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

241 (c) A health maintenance organization that pays a claim to
242 a dentist through an automated clearinghouse transfer may not
243 charge a fee solely to transmit the payment to the dentist
244 unless the dentist has consented to the fee. A health
245 maintenance organization may charge reasonable fees for value-
246 added services related to the transfer, including, but not
247 limited to, transaction management, data management, and portal
248 services.

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

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

253 (f) The commission may adopt rules to implement this
254 subsection.

255 (14) (a) A health maintenance organization may not deny any
256 claim subsequently submitted by a dentist licensed under chapter
257 466 for procedures specifically included in a prior
258 authorization unless at least one of the following circumstances
259 applies for each procedure denied:

260 1. Benefit limitations, such as annual maximums and
261 frequency limitations not applicable at the time of the prior
262 authorization, are reached subsequent to issuance of the prior
263 authorization.

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

266 3. Subsequent to the issuance of the prior authorization,
267 new procedures are provided to the patient or a change in the
268 patient's condition occurs such that the prior authorized
269 procedure would no longer be considered medically necessary,
270 based on the prevailing standard of care.

271 4. Subsequent to the issuance of the prior authorization,
272 new procedures are provided to the patient or a change in the
273 patient's condition occurs such that the prior authorized
274 procedure would at that time have required disapproval pursuant
275 to the terms and conditions for coverage under the patient's

276 plan in effect at the time the prior authorization was issued.

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

279 a. Another payor is responsible for payment.

280 b. The dentist has already been paid for the procedures
281 identified in the claim.

282 c. The claim was submitted fraudulently, or the prior
283 authorization was based in whole or material part on erroneous
284 information provided to the health maintenance organization by
285 the dentist, patient, or other person not related to the
286 organization.

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

289 e. The services were provided during the grace period
290 established under s. 641.31 or applicable federal regulations,
291 and the health maintenance organization notified the dentist
292 that the patient was in the grace period when the dentist
293 requested eligibility or enrollment verification from the health
294 maintenance organization, if such request was made.

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

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

299 (d) The commission may adopt rules to implement this
300 subsection.

CS/CS/HB 1219

2024

301 | Section 5. This act shall take effect July 1, 2024. |