The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Fiscal Policy

BILL:	CS/CS/SB 892
INTRODUCER:	Appropriations Committee on Agriculture, Environment, and General Government; Banking and Insurance Committee; and Senator Harrell
SUBJECT:	Dental Insurance Claims
DATE:	February 20, 2024 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Sanders	Betta	AEG	**Fav/CS**
3.	Johnson	Yeatman	FP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 892 revises provisions within the Florida Insurance Code relating to covered dental services, contractual agreements, and dental claims payments by an insurer, prepaid limited health service organization (PLHSO), or a health maintenance organization (HMO). The bill:

- Revises the definition of covered services, and as a result, if an insurer, HMO, or PLHSO denies service due to a contractual limitation (maximum benefits paid prior to the end of the plan year), then the procedure would be considered a non-covered service and the dentist would not be subject to the negotiated rate, and may charge patient a higher rate;
- Prohibits a contract between a dentist and a health insurer, HMO, or PLHSO from limiting the method of claim payments for dental services to credit card payments only;
- Requires a health insurer, PLHSO, or HMO to disclose in writing to a dentist any fees associated with an electronic funds transfer (EFT) and alternative payment methods before the insurer, HMO or PLHSO pays a dentist via EFT;
- Requires a health insurer, PLHSO, or HMO to receive written consent from a dentist prior to employing claim payment through EFT and clarifies the EFT includes, but is not limited to, virtual credit card payment;
- Prohibits an insurer, HMO or PLHSO that pays a claim to a dentist through an automatic clearing house (ACH) from charging a fee solely to transmit the payment unless the dentist has consented to the fee;

- Prohibits an insurer, HMO, or PLHSO from denying the payment of a claim if the procedure was previously authorized by an insurer, HMO, or PLHSO prior to the dentist rendering the service except under the following circumstances:
  - Benefit limitations being reached subsequent to the issuance of the prior authorization;
  - Inadequate documentation submitted by a dentist to support the originally authorized procedures and claim;
  - Subsequent to the issuance of the prior authorization, new procedures are provided to the insured or the insured's condition changes, resulting in the prior authorized procedure not being medically necessary;
  - The claim was denied because another payor is responsible for payment, the dentist has already been paid, the claim was submitted fraudulently, or the prior authorization was based on erroneous information submitted to the insurer, HMO, or PLHSO; or
  - The person receiving the procedure was not eligible to receive the procedure on the date of service and the insurer, HMO, or PLHSO did not know of the ineligibility.

The bill has an indeterminate, likely insignificant impact to state revenues and expenditures. *See* Section V., Fiscal Impact Statement.

II. Present Situation:

Oversight of the Practice of Dentistry in Florida

The Board of Dentistry within the Department of Health (DOH) is the state's regulatory board for the practice of dentistry, dental hygienists, and dental assistants under the Dental Practice Act.[1] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[2]

State Regulation of Health Insurers, Health Maintenance Organizations, and Prepaid Limited Health Service Organizations

The Office of Insurance Regulation (OIR),[3] is responsible for all activities concerning insurers and other risk bearing entities, such as health maintenance organizations (HMOs) or prepaid limited health service organizations, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.[4] To transact business in Florida, a health insurer or other entity subject to regulation by the OIR must obtain a certificate of authority or license from the OIR.[5]

The Agency for Health Care Administration (Agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority from the OIR, an

[1] Section 466.004, F.S.
[2] Section 466.003(3), F.S.
[3] The OIR is a unit under the Financial Services Commission, which is composed of the Governor, the Attorney General, the Chief Financial Officer, and the Commissioner of Agriculture. Commission members serve as the agency head for purposes of rulemaking under ch. 120, F.S. *See* s. 20.121(3), F.S.
[4] Section 20.121(3)(a), F.S.
[5] Sections 624.401 and 641.49, F.S.

HMO must receive a Health Care Provider Certificate from the Agency.[6] As part of the certification process used by the Agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[7]

Dental Plans

An individual or group health dental plan is considered a product within the accident and health line of business.[8] A dental plan provides benefits for routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw.[9]

According to the OIR, there are plans on the federal exchange that offer dental coverage for either an adult or child or both embedded in a policy or contract. There are plans on the exchange that offer standalone dental coverage, and such coverage may vary by county. Typically, insurers and HMOs submit rate filings for policies or contracts in June and finalize such filings by August for the following calendar plan year.[10]

Oversight of Health Insurer Contracts with Dentists

A contract between a health insurer and a dentist licensed under chapter 466, F.S., for the provision of services to an insured of the health insurer may not contain a provision that requires the dentist to provide services to the insured of the health insurer at a fee set by the health insurer unless such services are covered services under the applicable contract.[11] The term "covered services" means dental care services for which a reimbursement is available under the insured's policy, 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.[12]

Oversight of HMO Contracts with Dentists

A contract between an HMO and a dentist licensed under chapter 466, F.S., for the provision of services to a subscriber of the HMO may not contain a provision that requires the dentist to provide services to the subscriber of the health maintenance organization at a fee set by the health maintenance organization unless such services are covered services under the applicable contract.[13] 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,

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[6] Section 641.495, F.S.
[7] *Id.*
[8] Pursuant to s. 624.603, F.S., health insurance is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers' compensation coverages, except as provided in s. 624.406(4), F.S.
[9] Office of Insurance Regulation, Accident and Health, Year-to-Date Rate Change Report (Jan. 31, 2024). ytd-rate-changes-as-of-january-2024.pdf (floir.com) (last visited Feb. 15, 2024).
[10] Correspondence with Kevin Jacobs, Deputy Chief of Staff, Office of Insurance Regulation (Feb. 2, 2024). (On file with Senate Banking and Insurance Committee.)
[11] Section 6217.6474, F.S.
[12] *Id.*
[13] Section 641.315(11), F.S.

annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.[14]

Oversight of Prepaid Limited Health Service Organizations

A PLHSO is any entity which, in return for a prepayment, provides limited health services to enrollees through an exclusive panel of providers.[15] Pursuant to s. 636.003, F.S., a PLHSO provides the following limited health services:

- Ambulance services;
- Dental care services;
- Vision care services;
- Mental health services;
- Substance abuse services;
- Chiropractic services;
- Podiatric care services; and pharmaceutical services.

The PLHSOs and their arrangements or contracts with providers are governed by s. 636.035, F.S., and are regulated by the OIR. A contract between a PLHSO and a dentist licensed under ch. 466, F.S., for the provision of services to a subscriber of the PHLSO, may not contain a provision that requires the dentist to provide services to the subscriber of the prepaid limited health service organization at a fee set by the PLHSO unless such services are covered services under the applicable contract. As used in subsection (7), 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.

Payment of Claims

The Florida Insurance Code prescribes rights and responsibilities of health care providers, health insurers, and HMOs for the payment of claims. Florida's prompt payment laws govern payment of provider claims submitted to insurers and HMOs, including Medicaid managed care plans, in accordance with ss. 627.6131, 627.662, and 641.3155, F.S., respectively. 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 organizations, and specified contracts. The law prescribes a protocol for specified providers to use for the submission of their claims to an insurer or HMO, as well as a statutory process for insurers or HMOs to use for the payment or denial of the claims.

Denial of Claims

Coverage for medical services can be denied before or after the service has been provided, through denial of preauthorization requests, through denial of claims for payment, or a retroactive denial of payment. As a condition for coverage of some services, providers or insureds are required to request authorization prior to the provision of the procedure. The full

[14] *Id.*
[15] Section 636.003(7), F.S.

claim or certain lines of the claim may be denied, such as a surgery with charges for multiple procedures and supplies.

There are many possible reasons for claim denials.[16] Claims may be denied due to an incorrect diagnosis code, incomplete claim submission, or the submission of a duplicate claim. Eligibility issues can cause claims to be denied. For example, a claim may be submitted for a service provided prior to an individual's effective date of coverage or after it has been terminated. Finally, claim denials can occur when a determination is made that the service provided was not covered or it was not medically necessary. Denied claims[17] may be appealed.

After an insurer or HMO pays a claim, the insurer or HMO may conduct a claims audit to verify claims were paid appropriately and accurately. Such an audit can be triggered by a variety of reasons.[18] Some of these situations include new billing guidelines have been established by regulators; the provider has made significant changes to the original bill, such as the diagnosis of the patient; the plan is notified that the enrollee's coverage is terminated due to non-payment of premiums; or the plan is notified that the enrollee has other health insurance coverage. After the audit, an insurer or HMO may retrospectively deny a claim for a preauthorized service and try to recoup the payment from the provider. Reasons for the retroactive denial may include fraud, submission of incomplete or inaccurate information; nonpayment of premiums; exhaustion of benefits; coordination of benefits; or if the individual was not enrolled or eligible for coverage at the time services were rendered.[19] As a result, an insurer or HMO may try to recoup payment from a provider by retroactively denying a previously paid claim.

Group Health Plans Retroactive Termination of Coverage

Retroactive termination of insurance coverage to an earlier date due to an employee's discharge is an increasing problem for some providers and consumers. Some plans may allow an employer to cancel coverage of an employee retroactively more than 90 days post termination. Other plans will accept retroactive terminations for up to the preceding three months, if the plan has not paid any claims for the insurer or HMO during that period. If claims have been paid within the previous 60 days, the coverage termination date may be established as of the end of the month in which services were rendered.

When a provider is notified of a retroactive termination, the provider may have already verified that the insured or subscriber was covered, rendered services in reliance and expectation of payment, and even received payment. Retroactive terminations often result in the provider or the consumer bearing the loss, despite the verified eligibility.

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[16] KFF (a/k/a Kaiser Family Foundation), Private Insurance, *Claims Denials and Appeals in ACA Marketplace Plans in 2021* (Feb. 9, 2023), https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/ (last visited Feb. 8, 2024).
[17] U.S. Department of Health and Human Services, HealthCare.gov, Health Insurance Marketplace, *Appealing a health plan decision*, https://www.healthcare.gov/appeal-insurance-company-decision/ (last visited Feb. 8, 2024).
[18] LW Consulting, Inc., *10 Factors that Could Trigger an Audit of Your Medical Records*, https://lw-consult.com/10-factors-that-could-trigger-an-audit-of-your-medical-records/ (last visited Feb. 8, 2024).
[19] Health First Health Plans, *Provider Directory* (July 19, 2022), https://hf.org/sites/default/files/2022-09/hfhp_indiv_directory.pdf (last visited Feb. 8, 2024).

Federal Subsidized Individual Policies or Contracts and Grace Periods

The federal Patient Protection and Affordable Care Act (PPACA)[20] guarantees access to coverage and mandates certain essential health benefits, including pediatric dental coverage,[21] and other requirements. 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 (QHPs) on a state or federal exchange (exchange).[22] For plan year 2024, Florida enrollees accounted for about 20 percent (4,211,902 individuals) of the 21.2 million total individuals) enrolled through the state and federal exchanges.[23] For plan year 2023, approximately 3,108,149 Floridians enrolled, and about 97 percent received tax credits.[24]

Under PPACA, insurers and HMOs must provide a grace period[25] of at least three consecutive months[26] before cancelling the policy or contract of a federally subsidized enrollee who is delinquent if the enrollee previously paid one-month's premium. During the grace period, the insurer or HMO must pay all appropriate claims for services provided during the first month of the grace period. For the second and third months, an insurer may pend claims. Insurers or HMOs must notify providers that may be affected that an enrollee has lapsed in his or her payment of premiums and there is a possibility the insurer or HMO may deny the payment of claims incurred during the second and third months.[27]

If the insured or subscriber resolves all outstanding premium payments by the end of the grace period, then the pended claims would be paid as appropriate. If not, the claims for the second and third month would be denied. If coverage is terminated, the termination date is the last day of the first month of the grace period and the insurer may not recoup any payment for claims made during the first month of the grace period. At the end of grace period, the provider may seek payment for the medical services the insurer denied for months two and three. According to a

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[20] *The Patient Protection and Affordable Care Act* (PPACA) (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.

[21] Dental coverage is an essential health benefit for children under age 18, and must be available for a child either as part of a health plan or as a separate dental plan. *See* U.S. Department of Health and Human Services, HealthCare.gov, *Health benefits & coverage, Dental Coverage in the Marketplace*, https://www.healthcare.gov/coverage/dental-coverage/ (last visited Feb. 8, 2024).

[22] 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 for their family size. *See* Internal Revenue Service, *Questions and Answers on the Premium Tax Credit*, https://www.irs.gov/affordable-care-act/individuals-and-families/questions-and-answers-on-the-premium-tax-credit (last visited Feb. 8, 2024).

[23] U.S. Centers for Medicare and Medicaid Services, *Marketplace 2024 Open Enrollment Period Report: Final National Snapshot* (Jan. 24, 2024), https://www.cms.gov/newsroom/fact-sheets/marketplace-2024-open-enrollment-period-report-final-national-snapshot (last visited Feb. 8, 2024).

[24] U.S. Centers for Medicare and Medicaid Services, *Effectuated Enrollment: Early 2023 Snapshot and Full Year 2022 Average* (March 2023), https://www.cms.gov/files/document/early-2023-and-full-year-2022-effectuated-enrollment-report.pdf (last visited Feb. 8, 2024).

[25] Example of grace period: Premium is not paid in May. Premium payments are made in June and July. Grace period would end July 31. Coverage would be cancelled retroactively to the last day of May. *See* U.S. Centers for Medicare and Medicaid Services, How to apply & enroll, *Premium payments, grace periods, & losing coverage*, https://www.healthcare.gov/apply-and-enroll/health-insurance-grace-period/ (last visited Feb. 8, 2024).

[26] 45 C.F.R. s. 155.430.

[27] 45 C.F.R. s. 156.270.

2014 survey, 48 percent of the providers not participating with any PPACA exchange products cited concerns about assuming financial liability during the grace period as a reason for their decision.[28]

Grace Periods for Policies or Contracts without a Federal Subsidy

The federal regulation governing grace periods for federally subsidized[29] policies or contracts does not affect policies or contracts of individuals who are not enrolled in an exchange QHP or who are enrolled in an exchange QHP and do not receive a subsidy. The grace period for these individual policies or contracts remain at the length required under Florida law,[30] which varies by the duration of the premium payment interval. During the grace period, the policy or contract stays in force. The policy is in force during the grace period, thus the insurer or HMO must affirm that an individual is insured, even when the payment is late and remains unpaid during the grace period. 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 retroactively deny any claims incurred during the grace period.

Division of State Group Insurance

Under the authority of s. 110.123, F.S., the Department of Management Services (DMS), through the Division of State Group Insurance (DSGI), administers the state group health insurance program under a cafeteria plan consistent with s. 125, Internal Revenue Code. To administer the state group health insurance program, the DMS contracts with third party administrators for self-insured health plans and insured (HMOs), as well as a pharmacy benefits manager for the state employees' self-insured prescription drug program pursuant to s. 110.12315, F.S. The 2024 State Group Insurance Program offers dental plans that cover various types of benefits and services, some plans have annual deductibles, and some plans have annual maximum benefits.[31]

Virtual Credit Card Payments and Fees

March 2022 Federal Guidance Letter[32]

[28] Tracy Gnadinger, Health Affairs, *Health Policy Brief: The Ninety-Day Grace Period*, (Oct. 16, 2014) *available at* http://healthaffairs.org/blog/2014/10/17/health-policy-brief-the-ninety-day-grace-period/ (last viewed Feb. 8, 2024).
[29] 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 for their family size. Questions and answers on the Premium Tax Credit | Internal Revenue Service (irs.gov) (Feb. 9, 2024) (last visited Feb. 19,, 2024).
[30] Sections 627.608 and 641.31(15), F.S. The grace period of an individual policy must be a minimum of seven 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. *See also* Section 627.6645, F.S.
[31] Department of Management Services, Division of State Group Insurance 2024 Dental_Plan Comparison https://dms-media.ccplatform.net/content/download/160521/file/2024_Dental_Plan_Comparison(Final).pdf
[32] Department of Health and Human Services, Guidance Letter 2022-04 - Health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for Health Care Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA) transactions; 45 Code of Federal Regulations (CFR) ss. 162.1601 and 162.1602(d) FAQs (Mar. 22, 2022) (last visited Feb. 19, 2024).

In lieu of sending paper checks or paying health care claims using electronic funds transfer, some health plans (insurers, HMOs, or PLHSO) pay claims by sending providers a single use credit card number. Providers must manually enter virtual credit cards (VCC) into their point-of-sale (POS) processing terminals to receive payments from the card processing networks. Card processing networks typically charge a fees of a percent value of each payment. When processing various electronic payment methods, health plans often engage with business associates or vendors to conduct transactions, or parts thereof, on their behalf.

A health care electronic funds transfer (EFT) is the transmission of any of the following from a health plan to a provider:

- Payment;
- Information about the transfer of funds; or
- Payment processing information.[33]

Wire transfer, VCC, and the Automated Clearing House (ACH) Network are types of electronic payment delivery methods. The U.S. Department of Health and Human Services (HHS) has only adopted standards[34] that apply to EFT transmissions through the ACH Network. The Department of Health and Human Services has not promulgated Health Insurance Portability and Accountability Act (HIPAA) rules governing claims payments made with VCCs. Therefore, HHS does not regulate common business practices associated with VCC payments, including fees assessed by health plans or credit card networks for VCC payments.

July 2022 Federal Guidance Letter[35]

The HHS states that the act of charging fees, in and of itself, for EFT and electronic remittance advice transactions is not prohibited under HIPPA. The guidance letter also notes that HIPAA does not require a health plan to comply with a provider's request for health care payments via paper check. The only payment method that HIPAA regulations require health plans to provide, when requested by a provider to do so, is EFT through the ACH Network.

Virtual Credit Card Fees

The American Dental Association (ADA) notes virtual credit card companies may market the quicker reimbursement as a benefit for dentists to use the credit/virtual card; however, dentists may incur a higher processing fee for virtual credit cards than a traditional debit or credit card transaction.[36] The ADA suggests that a dental office can request to opt out of using the card and

[33] 45 C.F.R. s. 162.1601. The preamble to the interim rule with comment period provides that the health care EFT standards do not apply to claim payments made via EFT outside of the ACH Network. Health plans are not required to send health care EFT through the ACH Network. A health plan may decide to transmit a health care EFT via FEdwire or via a payment card network.

[34] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also defines requirements for the privacy and security of protected health information. https://aspe.hhs.gov/reports/health-insurance-portability-accountability-act-1996 (last visited Feb. 19, 2024).

[35] Department of Health and Human Services, Guidance Letter 2022-04 - Health plans' payment of health care claims using Virtual Credit Cards (VCCs) and adopted Health Insurance Portability and Accountability Act of 1996 (HIPAA) standards for Health Care Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA) transactions; 45 Code of Federal Regulations (CFR) §§ 162.1601 and 162.1602(d) FAQs (July 14, 2022) (last visited Feb. 19, 2022).

[36] American Dental Association, *Credit/Virtual Card Payment (2021)*, https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/practice/dental-

instead receive a paper check as payment for services rendered.[37] The ADA suggests that a dental office may need to contact the card issuing company and not necessarily the dental plan to resolve this payment issue.[38]

Transparency in Dental Benefits Contracting Model Act

The National Council of Insurance Legislators (NCOIL) is a legislative organization comprised principally of legislators serving on state insurance and financial institutions committees around the nation. The NCOIL writes model laws in insurance, works to both preserve the state jurisdiction over insurance as established by the McCarran-Ferguson Act 74 years ago, and to serve as an educational forum for public policy makers and interested parties. Founded in 1969, NCOIL works to assert the prerogative of legislators in making state policy when it comes to insurance and educate state legislators on current and perennial insurance issues.[39]

On December 12, 2020 the Executive Committee of the National Council on Insurance Legislators adopted the Transparency in Dental Benefits Contracting Model Act.[40] Provisions in the Model Act include prior authorizations payments and virtual credit card claim payment and transaction fee options and regulations.[41] A representative of the Florida Dental Association noted that 21 states have enacted legislation to address credit or virtual card payments.[42]

III. Effect of Proposed Changes:

Credit Card Payments and Fees (Sections 1, 3, and 5)

Section 1 amends s. 627.6131, F.S., relating to claims; **Section 3** amends s. 636.032, F.S., relating to acceptable payments; and, **Section 5** amends s. 641.315, F.S., relating to provider contracts.

The bill prohibits a health insurer, health maintenance organization (HMO) or prepaid limited health service organization (PLHSO) from specifying credit card payment as the only acceptable method for payments to the dentist. The bill requires a health insurer, HMO or PLHSO to provide a written notice to the dentist and obtain written consent from the dentist before the payment of a claim to a dentist through electronic funds transfer, including but not limited to, virtual credit card payments the following information:

- The fee, if any, associated with the electronic funds transfer; and

insurance/ada_credit_virtual_card_payment.pdf?rev=36fd0dc0475a41eba0446a1b1f67cbfc&hash=833CFBB660D3A5232CF8FB0F851A17A2 (last visited Feb. 9, 2024).

[37] *Id*.

[38] *Id*.

[39] History & Purpose - NCOIL (last visited Feb. 15, 2024).

[40] Dental-Model-Adopted-12-12-20.pdf (ncoil.org) (last visited Feb. 15, 2024).

[41] *Id*.

[42] Correspondence from Joe Ann Hart, Florida Dental Association (Feb. 1, 2024). There are 21 states that have passed laws related to virtual credit card fees (*Alabama, Arizona, Colorado, Connecticut, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maryland, Missouri, Nebraska, New Mexico, North Carolina, Oklahoma, Oregon, South Dakota, Texas, Utah, and Vermont*) (on file with Senate Banking and Insurance Committee). *See also* American Dental Association, Dental Insurance Reform, Virtual Credit Cards, *Virtual Credit Card – Claim Payment Restrictions, State Law* (2021), https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/practice/dental-insurance/ada_dental_insurance_reform_virtual_credit_cards.pdf (last visited Feb. 9, 2024).

- The available methods of payment of claims by the health insurer, HMO or PLHSO including instructions to the dentist on how to select an alternative payment.

Further, the bill:
- Prohibits a health insurer, HMO or PLHSO that pays a claim to a dentist through an Automated Clearing House (ACH) transfer to charge a fee solely to transmit the payment to the dentist unless the dentist has consented to the fee;
- Provides that these provisions may not be waived, voided, or nullified by contract;
- Authorizes the OIR to enforce these provisions pursuant to their general powers provided in s. 624.307, F.S.; and
- Authorizes the Financial Services Commission to adopt rules.

Limitations on Insurers, HMOs, or PLHSOs Denying Payment of Claims for Procedures Included in Prior Authorizations (Sections 1, 4, and 5)

Section 1 amends s. 627.6131, F.S., relating to claims; **Section 4** amends s. 636.035, F.S., relating to provider arrangements; and **Section 5** amends, s. 641.315, F.S., relating to provider contracts.

The bill prohibits an insurer, HMO or PLHSO from denying any claim subsequently submitted by a dentist for procedures that were included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:
- 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;
- The documentation provided by the person submitting the claim fails to support the claim as originally authorized;
- Subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;
- 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; and
- The denial of the claim was due to one of the following:
  - Another payor is responsible for payment;
  - The dentist has already been paid for the procedures identified in the claim;
  - 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; and
  - The person receiving the procedure was not eligible to receive the procedure on the date of service and the health insurer did not know, and with the exercise of reasonable care could not have known, of his or her ineligibility.

Further, the bill provides these provisions may not be waived, voided, or nullified by contract. Furthermore, any contractual clause in conflict with these provisions or that purports to waive

any requirements of these provisions is null and void. The bill authorizes the Office of Insurance Regulation (OIR) to enforce these provisions pursuant to their general powers provided in s. 624.307, F.S., and authorizes the Financial Services Commission to adopt rules.

Provider Contracts and Covered Services (Sections 2, 4, and 5)

Section 2 amends s. 627.6474, F.S., relating to provider contracts; **Section 4** amends s. 636.035, F.S., relating to provider arrangements; and **Section 5** amends, s. 641.315, F.S., relating to provider contracts.

The bill revises the definition of covered services to mean dental care services for which a reimbursement is available under the contract or agreement of the insurer, HMO or PLHSO, notwithstanding the application of contractual limitations, such as deductibles, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation. As a result, if an insured or subscriber reaches their benefit limits prior to the end of plan year, the dentist is not required to bill the insured or subscriber at the negotiated rate. The dentist may charge a higher rate.

Effective Date (Section 6)

Provides the bill is effective December 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

To the extent the bill applies to contracts and insurance policies entered into or renewed before the effective date of December 1, 2024, the bill could impair those contracts. Article I, s. 10 of the United States Constitution prohibits state legislatures from enacting laws impairing the obligation of contracts. The severity of the impairment is a key issue when evaluating whether a state law impairs a contract. In *Exxon Corp. v Eagerton*, 462 U.S. 176 (1983), the Supreme Court suggested it would uphold legislation that

imposes a generally applicable rule of conduct designed to advance a broad societal interest that only incidentally disrupts existing contractual relationships.

While Florida courts have historically strictly applied this restriction, they have exempted laws when they find there is an overriding public necessity for the state to exercise its police powers. This exception extends to laws that are "reasonable and necessary to serve an important public purpose,"[43] to include protecting the public's health, safety or welfare. For a statute to offend the constitutional prohibition against impairment of contract, the statute must have the effect of changing substantive rights of the parties to an existing contract. Any retroactive application of a statute affecting substantive contractual rights would be constitutionally suspect. Historically, both the state and federal courts have attempted to find a rational and defensible compromise between individual rights and public welfare when laws are enacted that may impair existing contracts. The balancing process focuses on whether "the nature and extent of the impairment is constitutionally tolerable in light of the importance of the state's objective, or whether it unreasonably intrudes into the parties' bargain to a degree greater than is necessary to achieve that objective."[44]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Dentists may experience savings in fees if they opt out of the payment of claims by credit cards. Further, dentists may realize additional revenues if an insurer, health maintenance organization (HMO) or prepaid limited health service organization (PLHSO) is limited in their ability to subsequently deny claims they previously authorized.

The impact on insurers, HMOs or PLHSOs is indeterminate. While the bill establishes specific criteria for claims denial and service coverage, which could improve clarity for providers, compliance may result in costs. These costs include investments in systems and staff training by insurers, PLHSOs, and HMOs to ensure compliance.

Insureds or subscribers that have exhausted their dental policy limits prior to the end of the policy or contract period will be negatively impacted in circumstances where they cannot obtain additional services at the negotiated rate and the dentist chooses to use a higher rate.

Federal regulations govern the grace period and payment of claims of individuals receiving federally subsidized products on the exchange. This bill would not apply to such claims.

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[43] *Searcy, Denney, Scarola, Barnhart & Shipley, Etc. v. State*, 209 So. 3d 1181 (Fla. 2017) at 1192 (quoting Pomponio, *Pomponio v. Claridge of Pompano Condominium*, 378 So. 2d 774 (Fla. 1980))
[44] *Id.*

The provisions of the bill would not apply to ERISA (Federal Employee Retirement Income Security Act of 1974)[45] self-insured plans. ERISA preempts the regulation of such plans by the state.

C. Government Sector Impact:

The bill has an indeterminate, likely insignificant impact to state revenues and expenditures. The Office of Insurance Regulation (OIR) estimates the bill could increase enforcement action which would necessitate recurring funds of $30,000 to upgrade positions in OIR's Legal and Market Regulations offices.[46] This can be handled within existing resources.

If the provisions lead to an increase in appeals or legal challenges related to denied claims, it could necessitate additional resources for adjudication processes, potentially adding to state expenditures.

The bill does not impact the Division of State Group Insurance, as there is no expansion of services within the bill.[47] However, an increase in premium costs for state agencies who provide primary dental coverage, resulting from reimbursement requirements stipulated in the bill, could adversely affect state government expenditures.

VI. Technical Deficiencies:

The effective date of the bill is December 1, 2024. Typically, health insurers and HMOs file rates with the Office of Insurance Regulation (OIR) in June for the next calendar year and finalize the rates around August. The Division of State Group Insurance plan year is also on a calendar year basis.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 627.6131, 627.6474, 636.032, 636.035, and 641.315.

[45] 29 U.S.C. 1001 *et seq*. (1974).
[46] Office of Insurance Regulation, *Senate Bill Agency Legislative Analysis of SB 892* (Jan. 11, 2024) (on file with the Senate Committee on Agriculture, Environment, and General Government).
[47] Email from Jake Holmgreen, Deputy Legislative Affairs Director, Florida Department of Management Services to Eric Lloyd, Policy Chief, House Subcommittee on Insurance and Banking (Jan. 29, 2024) (on file with the Senate Appropriations Committee on Agriculture, Environment, and General Government).

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Appropriations Committee on Agriculture, Environment, and General Government on February 12, 2024:
The committee substitute :

- Clarifies a health insurer, prepaid limited health service organization (PLHSO), or health maintenance organization (HMO) who uses electronic funds transfers (EFT) to pay claims, must notify the dentist of such practice and must obtain written consent from the dentist or dental practice prior to using EFT;
- Clarifies EFT includes, but is not limited to virtual credit card payments; and
- Revises the effective date to December 1, 2024.

CS by Banking and Insurance Feb. 5, 2024:
The committee substitute eliminates a provision in the bill that would authorize a health insurer, a prepaid limited health service organization or a health maintenance organization to charge a reasonable fee for other value-added services related to automatic clearing house (ACH) transfers.

B. Amendments:

None.