# 17:48D-2

**LEGISLATIVE HISTORY CHECKLIST**
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**LAWS OF**: 2005 **CHAPTER:** 38

**NJSA:** 17:48D-2 (Changes to "Dental Plan Organization Act")

**BILL NO**: S1752 (Substituted for A3455)

**SPONSOR(S)**: Baer and others

**DATE INTRODUCED:** June 24, 2004

**COMMITTEE:** **ASSEMBLY:** Financial Institutions and Insurance
**SENATE:** Commerce

**AMENDED DURING PASSAGE:** Yes

**DATE OF PASSAGE:** **ASSEMBLY:** February 24, 2005

**SENATE:** October 25, 2004

**DATE OF APPROVAL:** March 7, 2005

**FOLLOWING ARE ATTACHED IF AVAILABLE:**

**FINAL TEXT OF BILL** 1st reprint enacted

**S1752**

**SPONSOR'S STATEMENT**: (Begins on page 16 of original bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: Yes

**SENATE**: Yes

**FLOOR AMENDMENT STATEMENT:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

**A3455**

**SPONSOR'S STATEMENT**: (Begins on page 15 of original bill) Yes

**COMMITTEE STATEMENT:** **ASSEMBLY**: Yes

**SENATE:** No

**FLOOR AMENDMENT STATEMENT:** No

**LEGISLATIVE FISCAL ESTIMATE:** No

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| **REPORTS:** | No |
| **HEARINGS** | No |
| **NEWSPAPER ARTICLES:** | No |

IS 3/15/07

P.L. 2005, CHAPTER 38, ***approved March 7, 2005***
Senate, No. 1752 ***(First Reprint)***

**AN ACT** concerning dental plan organizations, amending P.L.1979, c.478 and repealing section 22 thereof.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.1979, c.478 (C.17:48D-2) is amended to read as follows:

2. In this act, unless the context otherwise requires:

"Capitation" means a method of compensation by a dental plan organization to its contracted dentists for dental services and supplies provided to covered persons of the dental plan organization on the basis of a fixed periodic payment per covered person or enrollee;

**[**a.**]** "Commissioner" means the Commissioner of Banking and Insurance;

"Consultant" means a person who holds himself out as an advisor or renders advice on the organization, financing, administration or operation of a dental plan to any employer, union, trust fund or dental plan organization;

"Covered person" means any person eligible to receive covered benefits or services and supplies under the terms of a dental plan;

**[**b.**]** "Dental plan" means any contractual arrangement for dental services **[**provided directly or arranged for or administered directly on a prepaid or postpaid individual or group capitation basis**]** and supplies to covered persons where contracted dentists are compensated by means of capitation, salary or a method authorized, submitted to and approved by the commissioner;

**[**c.**]** "Dental plan organization" or "DPO" means any person who undertakes to provide directly or to arrange for or administer one or more dental plans providing dental services and supplies;

**[**d.**]** "Dental services" means services included in the practice of dentistry as defined in R.S.45:6-19;

**[**e.**]** "Enrollee" means an individual **[**and his dependents who are enrolled in a dental plan organization**]** whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the dental plan, or in the case of an individual contract, the person in whose name the contract is issued;

**[**f.**]** "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee, setting out the dental services and

**EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.**

**Matter underlined thus is new matter.**
**Matter enclosed in superscript numerals has been adopted as follows:**
**[1] Senate SCM committee amendments adopted October 4, 2004.**

supplies to which the enrollee and his dependents [is] are entitled;

[g. "Consultant" means a person who holds himself out as an advisor or renders advice on the organization, financing, administration or operation of a dental plan to any employer, union, trust fund or dental plan organization;]

[h.] "Finder" means a person who brings together a dental plan organization with an employer, union or trust fund for the purpose of establishing a contractual relationship to provide dental services, or facilities or equipment related to the operation of the dental plan or dental plan organization.

"National Association of Insurance Commissioners" or "NAIC" means the National Association of Insurance Commissioners, it's affiliates, or subsidiaries, or any agency or committee thereof, or any successor organization.

(cf: P.L.1983, c.24, s.1)

2. Section 3 of P.L.1979, c.478 (C.17:48D-3) is amended to read as follows:

3. a. No person may establish, operate or administer a dental plan organization, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration in conjunction with any dental plan organization, utilizing in the aggregate the services of more than one full-time equivalent dentist, without obtaining and maintaining a certificate of authority pursuant to this act.

b. Within 90 days after the effective date of this act, every dental plan organization utilizing in the aggregate the services of more than one full-time equivalent dentist shall submit an application for a certificate of authority to the commissioner. A dental plan organization may continue to operate until the commissioner acts upon the application. If the application is denied, the dental plan organization shall be treated as if its certificate of authority has been revoked.

c. An application for a certificate of authority shall be in a form prescribed by the commissioner, shall be verified by an officer or authorized representative of the dental plan organization and shall include the following:

(1) All basic organizational documents of the dental plan organization, such as the articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement or other applicable documents and all amendments to those documents;

(2) The bylaws, rules and regulations or similar documents regulating the conduct or the internal affairs of the dental plan organization;

(3) The names, addresses [and], official positions and a biographical affidavit (NAIC form) of the persons who are responsible

for the conduct of the affairs of the dental plan organization, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers, in the case of a corporation, and the partners or members, in the case of a partnership or association;

(4) **[**All**]** The form of all contracts or agreements made between any dentist and the dental plan organization;

(5) All contracts or agreements made between any person listed in paragraph (3) of this subsection and any dentist, consultant, finder, supplier of administrative services or business manager;

(6) A description of the dental plan organization, its dental plan or plans, facilities and personnel;

(7) The form of the evidence of coverage to be issued to the enrollees;

(8) The form of any group contract which is issued to employers, unions, trustees or others;

(9) A financial statement prepared by an independent certified public accountant, setting forth the applicant's present or anticipated assets, liabilities and sources of funds. The statement shall set forth the terms and conditions of all current liabilities and any outstanding loans made from the funds of the applicant, and shall be attested to by the applicant or an authorized officer thereof. If the commissioner requires an audit of the financial records of the applicant by an independent certified public accountant, the financial statement shall be prepared and certified by the certified public accountant having conducted the audit;

(10) The proposed method of marketing the plan, a financial plan with a 3 year projection of the initial operating results and a statement of the sources of working capital and any other sources of funding. The justifications and assumptions for the marketing and financial plan shall also be disclosed;

(11) A power of attorney duly executed by the dental plan organization, if not domiciled in this State, appointing the commissioner, the commissioner's successors in office and duly authorized deputies as the true and lawful attorney of the dental plan organization in and for this State, upon whom lawful process in any legal action or proceeding against the dental plan organization on a cause of action arising in this State may be served;

(12) A description of the geographic area or areas to be served, by county and zip code (first 3 digits);

(13) A description of the procedures and programs to be implemented to achieve an effective dental plan as required in section 5 a.(2) of this act; and

(14) Such other information as the commissioner may require.

d. The dental plan organization shall pay a fee of **[**$100.00**]** $1,000 to the commissioner, upon filing an application for a certificate

of authority.

e. The commissioner shall act on an application for a certificate of authority within 90 days following receipt of the application [or the operative date of this amendatory and supplementary act, whichever is later].

(cf: P.L.1983, c.24, s.2)

3. Section 4 of P.L.1979, c.478 (C.17:48D-4) is amended to read as follows:

4. [Within 10 days following] Sixty days prior to any significant modification of information submitted with the application for a certificate of authority or a subsequent modification, a dental plan organization shall file notice of the modification with the commissioner.

(cf: P.L.1979, c.478, s.4)

4. Section 5 of P.L.1979, c.478 (C.17:48D-5) is amended to read as follows:

5. a. The commissioner shall issue a certificate of authority if he is satisfied that the following conditions are met:

(1) The persons responsible for conducting the affairs of the dental plan organization are competent and trustworthy and are professionally capable of providing, arranging for or administering the services offered by the plan;

(2) The dental plan organization constitutes an appropriate mechanism to achieve an effective dental plan, as determined by the commissioner;

(3) The dental plan organization has demonstrated the potential to provide dental services in a manner that will assure both availability and accessibility of adequate personnel and facilities;

(4) The dental plan organization has arrangements for an ongoing quality of dental care assurance program;

(5) The dental plan organization has a procedure to establish and maintain uniform systems of cost accounting and reports and audits that meet the requirements of the commissioner;

(6) The dental plan organization is financially responsible and may reasonably be expected to meet its obligations to [enrollees] covered persons. In making this determination the commissioner shall consider:

(a) The financial soundness of the dental plan's arrangements for services and the schedule of [charges] premiums used;

(b) Any arrangement with an insurer or medical or dental service corporation for continuation of coverage in the event of discontinuance of the plan, on an indemnity basis through a group vehicle to the end of the period for which premiums were paid to the discontinued dental plan organization; and

(c) The sufficiency of an agreement with dentists for the provision of dental services;

(7) A general surplus is maintained as required in section 6 of this act;

(8) A contingent surplus is accumulated and maintained as required in section 7 of this act;

(9) The condition or methods of operation of the dental plan organization are not such as would render its operations hazardous to its enrollees or the public; and

(10) The persons responsible for conducting the affairs of the dental plan organization are: (a) of good moral character, and (b) have not been convicted, within 7 years of the filing of the application for a certificate of authority, of a crime listed in N.J.S.2C:41-1 or, at any time, of engaging in a pattern of racketeering activity, as defined in N.J.S.2C:41-1 and 2C:41-2.

b. When the commissioner disapproves an application for a certificate of authority, he shall notify the dental plan organization in writing of the reasons for the disapproval.

c. **[**A certificate of authority shall expire 1 year following the date of issuance or previous renewal. If the dental plan organization remains in compliance with this act and has paid a renewal fee of $100.00, its certificate shall be renewed.**]** (Deleted by amendment, P.L. c. ).

(cf: P.L.1983, c.24, s.3)

5. Section 8 of P.L.1979, c.478 (C.17:48D-8) is amended to read as follows:

8. a. Any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization shall be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.

b. Each dentist employed by a dental plan organization shall be insured against professional liability or malpractice by an insurer licensed to conduct business in this State for such minimum amounts as shall be determined by the commissioner.

(cf: P.L.1979, c.478, s.8)

6. Section 9 of P.L.1979, c.478 (C.17:48D-9) is amended to read as follows:

9. a. An enrollee shall be entitled to receive evidence of coverage or a certificate indicating specifically the nature and extent of coverage, and evidence of the total amount or percentage of payment, if any, which the enrollee is obligated to pay for dental services. If an individual enrollee obtains coverage through an insurance policy or through a contract issued by a medical or dental service corporation,

whether by option or otherwise, the insurer or medical or dental service corporation shall issue the evidence of coverage. Otherwise, the dental plan organization shall issue the evidence of coverage.

b. No evidence of coverage or amendment thereto shall be issued or delivered to any person until a copy of the form of evidence of coverage or amendment thereto has been filed with the commissioner.

c. Evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

(1) The dental services and the insurance or other benefits, if any, to which **[**enrollees**]** covered persons are entitled;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any charge, deductible or co-payment feature;

(3) Where and in what manner information is available as to how services may be obtained; and

(4) A clear and understandable description of the dental plan organization's method for resolving **[**enrollees'**]** covered persons' complaints.

d. Any subsequent change in the evidence of coverage or the amount or percentage of payment which the enrollee is obligated to pay, shall be evidenced in a separate document issued to the enrollee.

(cf: P.L.1979, c.478, s.9)

7. Section 9 of P.L.1999, c.154 (C.17:48D-9.4) is amended to read as follows:

9. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a dental plan organization, its subsidiary or its covered **[**enrollees**]** persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization or a subsidiary that

processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization shall require that health care providers file all claims for payment for dental services. A covered person who receives dental services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a dental plan organization or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by **[**an enrollee**]** a covered person or that **[**enrollee's**]** covered person's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;

(d) the payer has no reason to believe that the claim has been submitted fraudulently; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

(a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely

payments from being made on the claim under the terms of the contract, the payer shall notify the [enrollee] covered person, or that [enrollee's] covered person's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or [enrollee] covered person, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of

10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by [an enrollee] a covered person for payment of benefits under an insured dental plan organization contract for which the financial obligation for the payment of a claim under the contract rests upon the dental plan organization.

(cf: P.L.1999, c.154, s.9)

8. Section 10 of P.L.1979, c.478 (C.17:48D-10) is amended to read as follows:

10. a. No schedule of [charges] premiums for [enrollee] coverage for dental services, or amendment thereto, may be used by a dental plan organization until a copy of such schedule, or amendment thereto, has been filed with the commissioner. The commissioner may disapprove the schedule of [charges] premiums at any time if he finds that the [charges] premiums are excessive, inadequate or unfairly discriminatory. If the commissioner disapproves the schedule of [charges] premiums he shall notify the dental plan organization within 5 days of the date of disapproval and specify in the notice, the reason for his disapproval. A hearing shall be granted within 20 days after a request in writing by the filer. It shall be unlawful for any dental plan organization whose schedule of [charges] premiums has been disapproved to effect any contract or issue any subscription certificate which uses the disapproved schedule of [charges] premiums until a revised schedule of [charges] premiums has been filed.

b. [Charges] Premiums shall be established in accordance with actuarial principles, but [charges] premiums applicable to [an enrollee] a covered person shall not be individually determined based on the status of his health.

(cf: P.L.1979, c.478, s.10)

9. Section 11 of P.L.1979, c.478 (C.17:48D-11) is amended to read as follows:

11. a. The commissioner or his designee may, as often as he may reasonably determine, investigate the business and examine the books, accounts, records and files of every dental plan organization. For that purpose the commissioner or his designee shall have reasonably free access to the offices and places of business, books, accounts, papers, records and files of all dental plan organizations. A dental plan organization shall keep and use in its business such books, accounts and records as will enable the commissioner to determine whether the dental plan organization is complying with the provisions of this act and with the rules and regulations promulgated pursuant to it. A dental plan organization shall preserve its books, accounts and records for at least [3] 7 years; except that preservation by photographic

reproduction or records in photographic form shall constitute compliance with this act.

b. For the purpose of the examination, the commissioner may, within the limits of funds appropriated for such purpose, contract with such persons as he may deem advisable to conduct the same or assist therein.

c. At the discretion of the commissioner, the Commissioner of Health and Senior Services and the New Jersey State Board of Dentistry may participate in the investigations and examinations described in this section to verify the existence of an effective dental plan.

d. The expenses incurred in making any examination pursuant to this section **[**up to $1,000.00 annually,**]** shall be assessed against and paid by the dental plan organization so examined. A dental plan organization having direct premiums written in this State of less than **1[**$1,000,000**]** $2,000,000**1** in any calendar year shall be subject to a limited scope examination with expenses for that examination not to exceed **1[**$10,000**]** $5,000**1**. Upon written notice by the commissioner of the total amount of an assessment, a dental plan organization shall become liable for and shall pay the assessment to the commissioner.

(cf: P.L.1979, c.478, s.11)

10. Section 12 of P.L.1979, c.478 (C.17:48D-12) is amended to read as follows:

12. a. A dental plan organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints initiated by **[**enrollees**]** covered persons concerning dental plan services. The dental plan organization shall maintain records of all written complaints initiated by **[**enrollees**]** covered persons.

b. The commissioner may examine the complaint system and if he determines that the system is not adequate he may require a revision of the complaint system.

(cf: P.L.1979, c.478, s.12)

11. Section 13 of P.L.1979, c.478 (C.17:48D-13) is amended to read as follows:

13. a. Every dental plan organization annually on or before March 1 shall file with the commissioner a report covering its activities for the preceding calendar year.

b. The reports shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the dental plan organization, prepared **[**by an independent certified public accountant**]** **1**by an independent certified public accountant**1** and attested to by an officer of the dental plan organization, which statement shall include full disclosure of all

assets and liabilities of the dental plan organization, the terms and conditions thereof, and the sources and disposition of all funds [. If the dental plan organization's records have been audited by an independent certified public accountant, the financial statement shall be certified by the certified public accountant having conducted the audit]1. If the dental plan organization's records have been audited by an independent certified public accountant, the financial statement shall be certified by the certified public accountant having conducted the audit1;

(2) Any significant modification of information submitted with the application for a certificate of authority;

(3) The number of persons who became [enrollees] covered persons during the year, the number of [enrollees] covered persons as of the end of the year and the number of enrollments terminated during the year;

(4) A description of the [enrollees] covered persons complaint system, including the procedures of the complaint system, the total number of written complaints handled through the system, a summary of causes underlying the complaints filed, and the number, amount and disposition of malpractice claims settled during the year by the dental plan organization and any of the dentists used by it; and

(5) Any other information relating to the performance of the dental plan organization as required by the commissioner.

1[c. Audited financial statements of the dental plan organization's records certified by the certified public accountant having conducted the audit, shall be filed with the commissioner annually on or before June 1.]1

(cf: P.L.1983, c.24, s.4)

12. Section 14 of P.L.1979, c.478 (C.17:48D-14) is amended to read as follows:

14. [A dental plan organization shall not use more than 30% of its gross contract and certificate income in the first year of operation, 25% in the second year of operation and 20% in any subsequent year for general expenses, acquisition expenses and miscellaneous taxes, licenses and fees.]

At least 70 percent of every dental plan organization's earned premium in the first year of operation, 75 percent in the second year, and 80 percent in all subsequent years shall be used for payments to 1[contracted]1 dentists for dental services and supplies provided to covered persons.

(cf: P.L.1979, c.478, s.14)

13. Section 15 of P.L.1979, c.478 (C.17:48D-15) is amended to read as follows:

15. a. No dental plan organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a dental plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a person who does not possess special knowledge regarding dental plan coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to **[**an enrollee**]** a covered person of, or person considering enrollment in, a dental plan, if the benefit or advantage or absence of exclusion, limitation, or disadvantage does not in fact exist;

(3) Evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography, format and language, may cause a person who does not possess special knowledge regarding dental plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the dental plan organization issuing the evidence of coverage does not regularly make available for **[**enrollees**]** persons covered under such evidence of coverage.

b. The unfair trade practice provisions contained in chapter 30 of Title 17B of the New Jersey Statutes shall apply to dental plan organizations, dental plans and evidences of coverage, except to the extent that the commissioner determines that the nature of dental plan organizations, dental plans and evidences of coverage render these sections clearly inappropriate.

c. No dental plan organization, unless licensed as an insurer, may use in its name, evidence of coverage or literature any of the words "insurance," "assurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurer licensed to do business in this State.

The provisions of this subsection shall be enforced by the Division of Consumer Affairs in the Department of Law and Public Safety and, where applicable, the commissioner. Nothing in this act shall limit the powers of the Attorney General and the procedures with respect to consumer fraud in P.L.1960, c.39 (C.56:8-1 et seq.).

(cf: P.L.1979, c.478, s.15)

14. Section 16 of P.L.1979, c.478 (C.17:48D-16) is amended to read as follows:

16. a. The commissioner may suspend or revoke any certificate of authority issued to a dental plan organization pursuant to this act, if he finds that any of the following conditions exist:

(1) The dental plan organization is operating in a manner significantly contrary to that described in sections 3 and 4 of this act;

(2) The dental plan organization issues an evidence of coverage which does not comply with the requirements of section 9 of this act;

(3) The dental plan organization does not provide or arrange for an effective dental plan, as determined by the commissioner;

(4) The dental plan organization can no longer be expected to meet its obligations to **[**enrollees**]** covered persons;

(5) The dental plan organization, or any authorized person on its behalf, has advertised or merchandised its services in an untrue or misleading manner;

(6) The dental plan organization has failed to comply with this act or any rules and regulations promulgated thereunder;

(7) Any person responsible for conducting the affairs of the dental plan organization is: (a) not of good moral character, or (b) has been convicted, within 7 years of the filing of the application for a certificate of authority, of a crime listed in N.J.S.2C:41-1 or, at any time, of engaging in a pattern of racketeering activity, as defined in N.J.S.2C:41-1 and 2C:41-2.

b. When the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the dental plan organization in writing, specifically stating the grounds for suspension or revocation. A hearing on the matter shall be granted by the commissioner within 20 days after a request in writing by the dental plan organization. After the hearing, or upon failure of the dental plan organization to appear at the hearing, the commissioner shall take action on his findings.

c. If the commissioner suspends the certificate of authority, the dental plan organization shall not accept any additional **[**enrollees**]** covered persons, except newborn children, new employees and new dependents of current employees, or engage in any advertising or solicitation during the period of the suspension.

d. If the commissioner revokes the certificate of authority, the dental plan organization shall proceed to dissolve its structure immediately following the effective date of the order of revocation, and shall conduct no further business, except as may be essential to the orderly conclusion of the affairs of the dental plan organization. The commissioner by written order, however, may permit such further operation of the dental plan organization as he finds to be in the best interest of **[**enrollees**]** covered persons to the end that **[**enrollees**]** covered persons shall be afforded the greatest practical opportunity to

obtain continuing dental plan coverage.

e. Notwithstanding the provisions of subsections c. and d. of this section, a dental plan organization which has had its certificate of authority suspended or revoked, or has suffered an adverse decision by the commissioner, shall be entitled to a hearing pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

(cf: P.L.1983, c.24, s.5)

15. Section 18 of PL.1979, c.478 (C.17:48D-18) is amended to read as follows:

18. Any dental plan organization which violates any provisions of this act, or neglects, fails or refuses to comply with any of the requirements of this act shall be liable for a civil penalty of not less than $500.00 nor more than $10,000.00 for each violation. The failure to file an annual report and the failure to reply promptly in writing to inquiries of the commissioner may result in an administrative penalty in an amount not less than $50 nor more than $500 for each day that the dental plan organization fails to file that reports or response. The penalty may be sued for and recovered by the commissioner in a summary proceeding pursuant to the "Penalty Enforcement Law of 1999" **[**(N.J.S.2A:58-1 et seq.)**]** P.L.1999, c.274 (C.2A:58-10 et seq.).

A purposeful or knowing misstatement or omission of material fact required to be supplied to the commissioner is a crime of the fourth degree.

(cf: P.L.1983, c.24, s.6)

16. Section 21 of P.L.1979, c.478 (C.17:48D-21) is amended to read:

21. Data or information pertaining to the diagnosis, treatment or health of any **[**enrollee**]** covered person obtained by the dental plan organization from the **[**enrollee**]** covered person or any dentist shall be confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this act, or upon the express consent of the **[**enrollee**]** covered person, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between the **[**enrollee**]** covered person and the dental plan organization wherein the data or information is pertinent. A dental plan organization shall be entitled to claim any statutory privileges against such disclosure which the dentist who furnished the information to the dental organization is entitled to claim.

(cf: P.L.1979, c.478, s.21)

17. Section 22 of P.L.1979, c.478 (C.17:48D-22) is repealed.

18. This act shall take effect immediately.

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Makes various revisions to the "Dental Plan Organization Act."

# SENATE, No. 1752

# STATE OF NEW JERSEY

## 211th LEGISLATURE

INTRODUCED JUNE 24, 2004

**Sponsored by:**
**Senator BYRON M. BAER**
**District 37 (Bergen)**

**SYNOPSIS**

Makes various revisions to the "Dental Plan Organization Act."

**CURRENT VERSION OF TEXT**

As introduced.

**AN ACT** concerning dental plan organizations, amending P.L.1979, c.478 and repealing section 22 thereof.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.1979, c.478 (C.17:48D-2) is amended to read as follows:

2. In this act, unless the context otherwise requires:

"Capitation" means a method of compensation by a dental plan organization to its contracted dentists for dental services and supplies provided to covered persons of the dental plan organization on the basis of a fixed periodic payment per covered person or enrollee;

**[**a.**]** "Commissioner" means the Commissioner of Banking and Insurance;

"Consultant" means a person who holds himself out as an advisor or renders advice on the organization, financing, administration or operation of a dental plan to any employer, union, trust fund or dental plan organization;

"Covered person" means any person eligible to receive covered benefits or services and supplies under the terms of a dental plan;

**[**b.**]** "Dental plan" means any contractual arrangement for dental services **[**provided directly or arranged for or administered directly on a prepaid or postpaid individual or group capitation basis**]** and supplies to covered persons where contracted dentists are compensated by means of capitation, salary or a method authorized, submitted to and approved by the commissioner;

**[**c.**]** "Dental plan organization" or "DPO" means any person who undertakes to provide directly or to arrange for or administer one or more dental plans providing dental services and supplies;

**[**d.**]** "Dental services" means services included in the practice of dentistry as defined in R.S. 45:6-19;

**[**e.**]** "Enrollee" means an individual **[**and his dependents who are enrolled in a dental plan organization**]** whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the dental plan, or in the case of an individual contract, the person in whose name the contract is issued;

**[**f.**]** "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee, setting out the dental services and supplies to which the enrollee and his dependents **[**is**]** are entitled;

**[**g. "Consultant" means a person who holds himself out as an advisor or renders advice on the organization, financing,

**EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.**

**Matter underlined thus is new matter.**

administration or operation of a dental plan to any employer, union, trust fund or dental plan organization;**]**

**[**h.**]** "Finder" means a person who brings together a dental plan organization with an employer, union or trust fund for the purpose of establishing a contractual relationship to provide dental services, or facilities or equipment related to the operation of the dental plan or dental plan organization.

"National Association of Insurance Commissioners" or "NAIC" means the National Association of Insurance Commissioners, it's affiliates, or subsidiaries, or any agency or committee thereof, or any successor organization.

(cf: P.L.1983, c.24, s.1)

2. Section 3 of P.L.1979, c.478 (C.17:48D-3) is amended to read as follows:

3. a. No person may establish, operate or administer a dental plan organization, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration in conjunction with any dental plan organization, utilizing in the aggregate the services of more than one full-time equivalent dentist, without obtaining and maintaining a certificate of authority pursuant to this act.

b. Within 90 days after the effective date of this act, every dental plan organization utilizing in the aggregate the services of more than one full-time equivalent dentist shall submit an application for a certificate of authority to the commissioner. A dental plan organization may continue to operate until the commissioner acts upon the application. If the application is denied, the dental plan organization shall be treated as if its certificate of authority has been revoked.

c. An application for a certificate of authority shall be in a form prescribed by the commissioner, shall be verified by an officer or authorized representative of the dental plan organization and shall include the following:

(1) All basic organizational documents of the dental plan organization, such as the articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement or other applicable documents and all amendments to those documents;

(2) The bylaws, rules and regulations or similar documents regulating the conduct or the internal affairs of the dental plan organization;

(3) The names, addresses **[**and**]**, official positions and a biographical affidavit (NAIC form) of the persons who are responsible for the conduct of the affairs of the dental plan organization, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal

officers, in the case of a corporation, and the partners or members, in the case of a partnership or association;

(4) **[**All**]** The form of all contracts or agreements made between any dentist and the dental plan organization;

(5) All contracts or agreements made between any person listed in paragraph (3) of this subsection and any dentist, consultant, finder, supplier of administrative services or business manager;

(6) A description of the dental plan organization, its dental plan or plans, facilities and personnel;

(7) The form of the evidence of coverage to be issued to the enrollees;

(8) The form of any group contract which is issued to employers, unions, trustees or others;

(9) A financial statement prepared by an independent certified public accountant, setting forth the applicant's present or anticipated assets, liabilities and sources of funds. The statement shall set forth the terms and conditions of all current liabilities and any outstanding loans made from the funds of the applicant, and shall be attested to by the applicant or an authorized officer thereof. If the commissioner requires an audit of the financial records of the applicant by an independent certified public accountant, the financial statement shall be prepared and certified by the certified public accountant having conducted the audit;

(10) The proposed method of marketing the plan, a financial plan with a 3 year projection of the initial operating results and a statement of the sources of working capital and any other sources of funding. The justifications and assumptions for the marketing and financial plan shall also be disclosed;

(11) A power of attorney duly executed by the dental plan organization, if not domiciled in this State, appointing the commissioner, the commissioner's successors in office and duly authorized deputies as the true and lawful attorney of the dental plan organization in and for this State, upon whom lawful process in any legal action or proceeding against the dental plan organization on a cause of action arising in this State may be served;

(12) A description of the geographic area or areas to be served, by county and zip code (first 3 digits);

(13) A description of the procedures and programs to be implemented to achieve an effective dental plan as required in section 5 a.(2) of this act; and

(14) Such other information as the commissioner may require.

d. The dental plan organization shall pay a fee of **[**$100.00**]** $1,000 to the commissioner, upon filing an application for a certificate of authority.

e. The commissioner shall act on an application for a certificate of authority within 90 days following receipt of the application **[**or the

operative date of this amendatory and supplementary act, whichever is later**]**.
(cf: P.L.1983, c.24, s.2)

3. Section 4 of P.L.1979, c.478 (C.17:48D-4) is amended to read as follows:

4. **[**Within 10 days following**]** Sixty days prior to any significant modification of information submitted with the application for a certificate of authority or a subsequent modification, a dental plan organization shall file notice of the modification with the commissioner.
(cf: P.L.1979, c.478, s.4)

4. Section 5 of P.L.1979, c.478 (C.17:48D-5) is amended to read as follows:

5. a. The commissioner shall issue a certificate of authority if he is satisfied that the following conditions are met:

(1) The persons responsible for conducting the affairs of the dental plan organization are competent and trustworthy and are professionally capable of providing, arranging for or administering the services offered by the plan;

(2) The dental plan organization constitutes an appropriate mechanism to achieve an effective dental plan, as determined by the commissioner;

(3) The dental plan organization has demonstrated the potential to provide dental services in a manner that will assure both availability and accessibility of adequate personnel and facilities;

(4) The dental plan organization has arrangements for an ongoing quality of dental care assurance program;

(5) The dental plan organization has a procedure to establish and maintain uniform systems of cost accounting and reports and audits that meet the requirements of the commissioner;

(6) The dental plan organization is financially responsible and may reasonably be expected to meet its obligations to **[**enrollees**]** covered persons. In making this determination the commissioner shall consider:

(a) The financial soundness of the dental plan's arrangements for services and the schedule of **[**charges**]** premiums used;

(b) Any arrangement with an insurer or medical or dental service corporation for continuation of coverage in the event of discontinuance of the plan, on an indemnity basis through a group vehicle to the end of the period for which premiums were paid to the discontinued dental plan organization; and

(c) The sufficiency of an agreement with dentists for the provision of dental services;

(7) A general surplus is maintained as required in section 6 of this act;

(8) A contingent surplus is accumulated and maintained as required in section 7 of this act;

(9) The condition or methods of operation of the dental plan organization are not such as would render its operations hazardous to its enrollees or the public; and

(10) The persons responsible for conducting the affairs of the dental plan organization are: (a) of good moral character, and (b) have not been convicted, within 7 years of the filing of the application for a certificate of authority, of a crime listed in N.J.S.2C:41-1 or, at any time, of engaging in a pattern of racketeering activity, as defined in N.J.S.2C:41-1 and 2C:41-2.

b. When the commissioner disapproves an application for a certificate of authority, he shall notify the dental plan organization in writing of the reasons for the disapproval.

c. **[**A certificate of authority shall expire 1 year following the date of issuance or previous renewal. If the dental plan organization remains in compliance with this act and has paid a renewal fee of $100.00, its certificate shall be renewed.**]** (Deleted by amendment, P.L. c. ).

(cf: P.L.1983, c.24, s.3)

5. Section 8 of P.L.1979, c.478 (C.17:48D-8) is amended to read as follows:

8. a. Any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization shall be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.

b. Each dentist employed by a dental plan organization shall be insured against professional liability or malpractice by an insurer licensed to conduct business in this State for such minimum amounts as shall be determined by the commissioner.

(cf: P.L.1979, c.478, s.8)

6. Section 9 of P.L.1979, c.478 (C.17:48D-9) is amended to read as follows:

9. a. An enrollee shall be entitled to receive evidence of coverage or a certificate indicating specifically the nature and extent of coverage, and evidence of the total amount or percentage of payment, if any, which the enrollee is obligated to pay for dental services. If an individual enrollee obtains coverage through an insurance policy or through a contract issued by a medical or dental service corporation, whether by option or otherwise, the insurer or medical or dental service corporation shall issue the evidence of coverage. Otherwise,

the dental plan organization shall issue the evidence of coverage.

b. No evidence of coverage or amendment thereto shall be issued or delivered to any person until a copy of the form of evidence of coverage or amendment thereto has been filed with the commissioner.

c. Evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

(1) The dental services and the insurance or other benefits, if any, to which **[**enrollees**]** covered persons are entitled;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any charge, deductible or co-payment feature;

(3) Where and in what manner information is available as to how services may be obtained; and

(4) A clear and understandable description of the dental plan organization's method for resolving **[**enrollees'**]** covered persons' complaints.

d. Any subsequent change in the evidence of coverage or the amount or percentage of payment which the enrollee is obligated to pay, shall be evidenced in a separate document issued to the enrollee.

(cf: P.L.1979, c.478, s.9)

7. Section 9 of P.L.1999, c.154 (C.17:48D-9.4) is amended to read as follows:

9. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a dental plan organization, its subsidiary or its covered **[**enrollees**]** persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in

connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization shall require that health care providers file all claims for payment for dental services. A covered person who receives dental services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a dental plan organization or its agent, hereinafter the payer, shall remit payment for every insured claim submitted by **[**an enrollee**]** a covered person or that **[**enrollee's**]** covered person's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;

(d) the payer has no reason to believe that the claim has been submitted fraudulently; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

(a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the **[**enrollee**]** covered person, or that

**[**enrollee's**]** covered person's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or **[**enrollee**]** covered person, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a

claim by [an enrollee] a covered person for payment of benefits under an insured dental plan organization contract for which the financial obligation for the payment of a claim under the contract rests upon the dental plan organization.
(cf: P.L.1999, c.154, s.9)

8. Section 10 of P.L.1979, c.478 (C.17:48D-10) is amended to read as follows:

10. a. No schedule of [charges] premiums for [enrollee] coverage for dental services, or amendment thereto, may be used by a dental plan organization until a copy of such schedule, or amendment thereto, has been filed with the commissioner. The commissioner may disapprove the schedule of [charges] premiums at any time if he finds that the [charges] premiums are excessive, inadequate or unfairly discriminatory. If the commissioner disapproves the schedule of [charges] premiums he shall notify the dental plan organization within 5 days of the date of disapproval and specify in the notice, the reason for his disapproval. A hearing shall be granted within 20 days after a request in writing by the filer. It shall be unlawful for any dental plan organization whose schedule of [charges] premiums has been disapproved to effect any contract or issue any subscription certificate which uses the disapproved schedule of [charges] premiums until a revised schedule of [charges] premiums has been filed.

b. [Charges] Premiums shall be established in accordance with actuarial principles, but [charges] premiums applicable to [an enrollee] a covered person shall not be individually determined based on the status of his health.
(cf: P.L.1979, c.478, s.10)

9. Section 11 of P.L.1979, c.478 (C.17:48D-11) is amended to read as follows:

11. a. The commissioner or his designee may, as often as he may reasonably determine, investigate the business and examine the books, accounts, records and files of every dental plan organization. For that purpose the commissioner or his designee shall have reasonably free access to the offices and places of business, books, accounts, papers, records and files of all dental plan organizations. A dental plan organization shall keep and use in its business such books, accounts and records as will enable the commissioner to determine whether the dental plan organization is complying with the provisions of this act and with the rules and regulations promulgated pursuant to it. A dental plan organization shall preserve its books, accounts and records for at least 3 years; except that preservation by photographic reproduction or records in photographic form shall constitute compliance with this act.

b. For the purpose of the examination, the commissioner may, within the limits of funds appropriated for such purpose, contract with such persons as he may deem advisable to conduct the same or assist therein.

c. At the discretion of the commissioner, the Commissioner of Health and Senior Services and the New Jersey State Board of Dentistry may participate in the investigations and examinations described in this section to verify the existence of an effective dental plan.

d. The expenses incurred in making any examination pursuant to this section **[**up to $1,000.00 annually,**]** shall be assessed against and paid by the dental plan organization so examined. A dental plan organization having direct premiums written in this State of less than $1,000,000 in any calendar year shall be subject to a limited scope examination with expenses for that examination not to exceed $10,000. Upon written notice by the commissioner of the total amount of an assessment, a dental plan organization shall become liable for and shall pay the assessment to the commissioner.

(cf: P.L.1979, c.478, s.11)

10. Section 12 of P.L.1979, c.478 (C.17:48D-12) is amended to read as follows:

12. a. A dental plan organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints initiated by **[**enrollees**]** covered persons concerning dental plan services. The dental plan organization shall maintain records of all written complaints initiated by **[**enrollees**]** covered persons.

b. The commissioner may examine the complaint system and if he determines that the system is not adequate he may require a revision of the complaint system.

(cf: P.L.1979, c.478, s.12)

11. Section 13 of P.L.1979, c.478 (C.17:48D-13) is amended to read as follows:

13. a. Every dental plan organization annually on or before March 1 shall file with the commissioner a report covering its activities for the preceding calendar year.

b. The reports shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the dental plan organization, prepared **[**by an independent certified public accountant**]** and attested to by an officer of the dental plan organization, which statement shall include full disclosure of all assets and liabilities of the dental plan organization, the terms and conditions thereof, and the sources and disposition of all funds **[**. If the dental plan organization's records

have been audited by an independent certified public accountant, the financial statement shall be certified by the certified public accountant having conducted the audit**]** ;

(2) Any significant modification of information submitted with the application for a certificate of authority;

(3) The number of persons who became **[**enrollees**]** covered persons during the year, the number of **[**enrollees**]** covered persons as of the end of the year and the number of enrollments terminated during the year;

(4) A description of the **[**enrollees**]** covered persons complaint system, including the procedures of the complaint system, the total number of written complaints handled through the system, a summary of causes underlying the complaints filed, and the number, amount and disposition of malpractice claims settled during the year by the dental plan organization and any of the dentists used by it; and

(5) Any other information relating to the performance of the dental plan organization as required by the commissioner.

c. Audited financial statements of the dental plan organization's records certified by the certified public accountant having conducted the audit, shall be filed with the commissioner annually on or before June 1.

(cf: P.L.1983, c.24, s.4)

12. Section 14 of P.L.1979, c.478 (C.17:48D-14) is amended to read as follows:

14. **[**A dental plan organization shall not use more than 30% of its gross contract and certificate income in the first year of operation, 25% in the second year of operation and 20% in any subsequent year for general expenses, acquisition expenses and miscellaneous taxes, licenses and fees.**]**

At least 70 percent of every dental plan organization's earned premium in the first year of operation, 75 percent in the second year, and 80 percent in all subsequent years shall be used for payments to contracted dentists for dental services and supplies provided to covered persons.

(cf: P.L.1979, c.478, s.14)

13. Section 15 of P.L.1979, c.478 (C.17:48D-15) is amended to read as follows:

15. a. No dental plan organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a

dental plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a person who does not possess special knowledge regarding dental plan coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to **[**an enrollee**]** a covered person of, or person considering enrollment in, a dental plan, if the benefit or advantage or absence of exclusion, limitation, or disadvantage does not in fact exist;

(3) Evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography, format and language, may cause a person who does not possess special knowledge regarding dental plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the dental plan organization issuing the evidence of coverage does not regularly make available for **[**enrollees**]** persons covered under such evidence of coverage.

b. The unfair trade practice provisions contained in chapter 30 of Title 17B of the New Jersey Statutes shall apply to dental plan organizations, dental plans and evidences of coverage, except to the extent that the commissioner determines that the nature of dental plan organizations, dental plans and evidences of coverage render these sections clearly inappropriate.

c. No dental plan organization, unless licensed as an insurer, may use in its name, evidence of coverage or literature any of the words "insurance," "assurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurer licensed to do business in this State.

The provisions of this subsection shall be enforced by the Division of Consumer Affairs in the Department of Law and Public Safety and, where applicable, the commissioner. Nothing in this act shall limit the powers of the Attorney General and the procedures with respect to consumer fraud in P.L.1960, c.39 (C.56:8-1 et seq.).

(cf: P.L.1979, c.478, s.15)

14. Section 16 of P.L.1979, c.478 (C.17:48D-16) is amended to read as follows:

16. a. The commissioner may suspend or revoke any certificate of authority issued to a dental plan organization pursuant to this act, if he finds that any of the following conditions exist:

(1) The dental plan organization is operating in a manner significantly contrary to that described in sections 3 and 4 of this act;

(2) The dental plan organization issues an evidence of coverage which does not comply with the requirements of section 9 of this act;

(3) The dental plan organization does not provide or arrange for an effective dental plan, as determined by the commissioner;

(4) The dental plan organization can no longer be expected to meet its obligations to **[**enrollees**]** covered persons;

(5) The dental plan organization, or any authorized person on its behalf, has advertised or merchandised its services in an untrue or misleading manner;

(6) The dental plan organization has failed to comply with this act or any rules and regulations promulgated thereunder;

(7) Any person responsible for conducting the affairs of the dental plan organization is: (a) not of good moral character, or (b) has been convicted, within 7 years of the filing of the application for a certificate of authority, of a crime listed in N.J.S. 2C:41-1 or, at any time, of engaging in a pattern of racketeering activity, as defined in N.J.S.2C:41-1 and 2C:41-2.

b. When the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the dental plan organization in writing, specifically stating the grounds for suspension or revocation. A hearing on the matter shall be granted by the commissioner within 20 days after a request in writing by the dental plan organization. After the hearing, or upon failure of the dental plan organization to appear at the hearing, the commissioner shall take action on his findings.

c. If the commissioner suspends the certificate of authority, the dental plan organization shall not accept any additional **[**enrollees**]** covered persons, except newborn children, new employees and new dependents of current employees, or engage in any advertising or solicitation during the period of the suspension.

d. If the commissioner revokes the certificate of authority, the dental plan organization shall proceed to dissolve its structure immediately following the effective date of the order of revocation, and shall conduct no further business, except as may be essential to the orderly conclusion of the affairs of the dental plan organization. The commissioner by written order, however, may permit such further operation of the dental plan organization as he finds to be in the best interest of **[**enrollees**]** covered persons to the end that **[**enrollees**]** covered persons shall be afforded the greatest practical opportunity to obtain continuing dental plan coverage.

e. Notwithstanding the provisions of subsections c. and d. of this section, a dental plan organization which has had its certificate of authority suspended or revoked, or has suffered an adverse decision

by the commissioner, shall be entitled to a hearing pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).
(cf: P.L.1983, c.24, s.5)

15. Section 18 of PL.1979, c.478 (C.17:48D-18) is amended to read as follows:

18. Any dental plan organization which violates any provisions of this act, or neglects, fails or refuses to comply with any of the requirements of this act shall be liable for a civil penalty of not less than $500.00 nor more than $10,000.00 for each violation. The failure to file an annual report and the failure to reply promptly in writing to inquiries of the commissioner may result in an administrative penalty in an amount not less than $50 nor more than $500 for each day that the dental plan organization fails to file that reports or response. The penalty may be sued for and recovered by the commissioner in a summary proceeding pursuant to the "Penalty Enforcement Law of 1999" **[**(N.J.S.2A:58-1 et seq.)**]** P.L.1999, c.274 (C.2A:58-10 et seq.).

A purposeful or knowing misstatement or omission of material fact required to be supplied to the commissioner is a crime of the fourth degree.
(cf: P.L.1983, c.24, s.6)

16. Section 21 of P.L.1979, c.478 (C.17:48D-21) is amended to read:

21. Data or information pertaining to the diagnosis, treatment or health of any **[**enrollee**]** covered person obtained by the dental plan organization from the **[**enrollee**]** covered person or any dentist shall be confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this act, or upon the express consent of the **[**enrollee**]** covered person, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between the **[**enrollee**]** covered person and the dental plan organization wherein the data or information is pertinent. A dental plan organization shall be entitled to claim any statutory privileges against such disclosure which the dentist who furnished the information to the dental organization is entitled to claim.
(cf: P.L.1979, c.478, s.21)

17. Section 22 of P.L.1979, c.478 (C.17:48D-22) is repealed.

18. This act shall take effect immediately.

STATEMENT

This bill makes various revisions to the "Dental Plan Organization Act," in order to update certain of its provisions, especially with respect to financial examinations of dental plan organizations (DPOs) conducted by the Department of Banking and Insurance. These revisions establish that DPOs are subject to the same level of departmental oversight and review as other types of health insurers, generally.

Specifically, the bill requires the filing of an annual audited financial statement by a DPO, certified by the certified public accountant having conducted the audit. In addition, the bill provides that a DPO include in its annual report filed with the department, a financial statement prepared and attested to by an officer of the DPO. Previously, the DPO was required to have its financial statement prepared and attested to by an independent certified public accountant. This process will not be necessary with the new requirement of submission of the annual audited financial statement.

The bill also deletes the $1,000 cap the department may currently assess a DPO for performing a financial examination, and instead provides that the department may assess a DPO for the full expense incurred in conducting a financial examination. However, the bill also provides that a dental plan organization with direct written premiums written in this State of less than $1,000,000 in any calendar year is subject to a limited scope examination with expenses for that examination not to exceed $10,000.

In addition, the bill provides for the assessment of civil monetary penalties for failure of a DPO to file an annual report or respond in a timely manner to inquiries from the department. The penalty amount shall not be less than $50 nor more than $500 for each day that the DPO fails to comply.

The bill requires any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization to be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.

Finally, other technical revisions are included in the bill.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

[First Reprint]

**SENATE, No. 1752**

# STATE OF NEW JERSEY

DATED: DECEMBER 2, 2004

The Assembly Financial Institutions and Insurance Committee reports favorably Senate Bill No. 1752 (1R).

This bill revises the "Dental Plan Organization Act" generally, to update certain of its provisions and subject dental plan organizations (DPOs) to the same level of oversight by the Department of Banking and Insurance and review as other types of health insurers.

The bill eliminates the $1,000 cap the department may currently assess a DPO for performing a financial examination, and instead provides that the department may assess a DPO for the full expense incurred in conducting a financial examination. However, the bill also provides that a dental plan organization with direct written premiums written in this State of less than $2,000,000 in any calendar year is subject to a limited scope examination, with expenses for that examination not to exceed $5,000. Under the current law, the threshold for a limited scope examination is $1,000,000, with expenses for the examination not to exceed $10,000.

In addition, the bill provides for the assessment of administrative penalties in addition to the civil monetary penalties in the current act, for the failure of a DPO to file an annual report or respond in a timely manner to inquiries from the department. The administrative penalties shall be not be less than $50 nor more than $500 for each day that the DPO fails to comply.

The bill also requires retention of DPO records for seven years, rather than the current three.

The bill requires any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization to be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.

SENATE COMMERCE COMMITTEE

STATEMENT TO

# SENATE, No. 1752

with committee amendments

# STATE OF NEW JERSEY

DATED: OCTOBER 4, 2004

The Senate Commerce Committee reports favorably, and with committee amendments, Senate Bill No. 1752.

As amended by the committee, this bill revises the "Dental Plan Organization Act" generally, to update certain of its provisions and subject dental plan organizations (DPOs) to the same level of oversight by the Department of Banking and Insurance and review as other types of health insurers.

The bill deletes the $1,000 cap the department may currently assess a DPO for performing a financial examination, and instead provides that the department may assess a DPO for the full expense incurred in conducting a financial examination. However, the bill also provides that a dental plan organization with direct written premiums written in this State of less than $2,000,000 in any calendar year is subject to a limited scope examination, with expenses for that examination not to exceed $5,000.

In addition, the bill provides for the assessment of civil monetary penalties for the failure of a DPO to file an annual report or respond in a timely manner to inquiries from the department. The penalty shall be not be less than $50 nor more than $500 for each day that the DPO fails to comply.

The bill also requires retention of DPO records for seven years, rather than the current three.

The bill requires any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization to be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.

The committee amended the bill to provide that DPOs with direct written premiums of $2,000,000 would be subject to a limited scope examination, and to limit expenses charged by the department for a limited scope examination of such a DPO to $5,000. As the bill originally provided, such limited scope examinations applied to DPOs with direct written premiums of $1,000,000 and expenses for such examinations were limited to $10,000. The amendments also require

retention of records for seven years, rather than three years, as the law currently requires.

The amendments also delete certain of the bill's revisions to the law relative to the financial reporting requirements and thereby preserve the *status quo* under the law in that regard. As introduced, the bill required the filing of an annual audited financial statement by a DPO annually on or before June 1, certified by the certified public accountant having conducted the audit. In addition, the bill provided that a DPO include, in its annual report filed with the department, a financial statement prepared and attested to by an officer of the DPO. As amended, a financial statement prepared and attested to by an independent certified public accountant shall be filed as part of its annual report to the department. If the DPO's records have been audited by a certified public accountant, the financial statement shall be certified by the certified public accountant having conducted the audit.

# ASSEMBLY, No. 3455

# STATE OF NEW JERSEY

## 211th LEGISLATURE

INTRODUCED NOVEMBER 4, 2004

**Sponsored by:**
**Assemblyman JOHN F. MCKEON**
**District 27 (Essex)**
**Assemblyman NEIL M. COHEN**
**District 20 (Union)**

**SYNOPSIS**

Makes various revisions to the "Dental Plan Organization Act."

**CURRENT VERSION OF TEXT**

As introduced.

**AN ACT** concerning dental plan organizations, amending P.L.1979, c.478 and repealing section 22 thereof.

**BE IT ENACTED** *by the Senate and General Assembly of the State of New Jersey:*

1. Section 2 of P.L.1979, c.478 (C.17:48D-2) is amended to read as follows:

2. In this act, unless the context otherwise requires:

"Capitation" means a method of compensation by a dental plan organization to its contracted dentists for dental services and supplies provided to covered persons of the dental plan organization on the basis of a fixed periodic payment per covered person or enrollee;

**[**a.**]** "Commissioner" means the Commissioner of Banking and Insurance;

"Consultant" means a person who holds himself out as an advisor or renders advice on the organization, financing, administration or operation of a dental plan to any employer, union, trust fund or dental plan organization;

"Covered person" means any person eligible to receive covered benefits or services and supplies under the terms of a dental plan;

**[**b.**]** "Dental plan" means any contractual arrangement for dental services **[**provided directly or arranged for or administered directly on a prepaid or postpaid individual or group capitation basis**]** and supplies to covered persons where contracted dentists are compensated by means of capitation, salary or a method authorized, submitted to and approved by the commissioner;

**[**c.**]** "Dental plan organization" or "DPO" means any person who undertakes to provide directly or to arrange for or administer one or more dental plans providing dental services and supplies;

**[**d.**]** "Dental services" means services included in the practice of dentistry as defined in R.S.45:6-19;

**[**e.**]** "Enrollee" means an individual **[**and his dependents who are enrolled in a dental plan organization**]** whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the dental plan, or in the case of an individual contract, the person in whose name the contract is issued;

**[**f.**]** "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee, setting out the dental services and supplies to which the enrollee and his dependents **[**is**]** are entitled;

**[**g. "Consultant" means a person who holds himself out as an advisor or renders advice on the organization, financing, administration or operation of a dental plan to any employer, union, trust fund or dental plan organization;**]**

**[**h.**]** "Finder" means a person who brings together a dental plan

**EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and intended to be omitted in the law.**

**Matter underlined thus is new matter.**

organization with an employer, union or trust fund for the purpose of establishing a contractual relationship to provide dental services, or facilities or equipment related to the operation of the dental plan or dental plan organization.

"National Association of Insurance Commissioners" or "NAIC" means the National Association of Insurance Commissioners, it's affiliates, or subsidiaries, or any agency or committee thereof, or any successor organization.

(cf: P.L.1983, c.24, s.1)

2. Section 3 of P.L.1979, c.478 (C.17:48D-3) is amended to read as follows:

3. a. No person may establish, operate or administer a dental plan organization, or sell or offer to sell, or solicit offers to purchase, or receive advance or periodic consideration in conjunction with any dental plan organization, utilizing in the aggregate the services of more than one full-time equivalent dentist, without obtaining and maintaining a certificate of authority pursuant to this act.

b. Within 90 days after the effective date of this act, every dental plan organization utilizing in the aggregate the services of more than one full-time equivalent dentist shall submit an application for a certificate of authority to the commissioner. A dental plan organization may continue to operate until the commissioner acts upon the application. If the application is denied, the dental plan organization shall be treated as if its certificate of authority has been revoked.

c. An application for a certificate of authority shall be in a form prescribed by the commissioner, shall be verified by an officer or authorized representative of the dental plan organization and shall include the following:

(1) All basic organizational documents of the dental plan organization, such as the articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement or other applicable documents and all amendments to those documents;

(2) The bylaws, rules and regulations or similar documents regulating the conduct or the internal affairs of the dental plan organization;

(3) The names, addresses **[**and**]**, official positions and a biographical affidavit (NAIC form) of the persons who are responsible for the conduct of the affairs of the dental plan organization, including all members of the board of directors, board of trustees, executive committee or other governing board or committee, the principal officers, in the case of a corporation, and the partners or members, in the case of a partnership or association;

(4) **[**All**]** The form of all contracts or agreements made between any dentist and the dental plan organization;

(5) All contracts or agreements made between any person listed in

paragraph (3) of this subsection and any dentist, consultant, finder, supplier of administrative services or business manager;

(6) A description of the dental plan organization, its dental plan or plans, facilities and personnel;

(7) The form of the evidence of coverage to be issued to the enrollees;

(8) The form of any group contract which is issued to employers, unions, trustees or others;

(9) A financial statement prepared by an independent certified public accountant, setting forth the applicant's present or anticipated assets, liabilities and sources of funds. The statement shall set forth the terms and conditions of all current liabilities and any outstanding loans made from the funds of the applicant, and shall be attested to by the applicant or an authorized officer thereof. If the commissioner requires an audit of the financial records of the applicant by an independent certified public accountant, the financial statement shall be prepared and certified by the certified public accountant having conducted the audit;

(10) The proposed method of marketing the plan, a financial plan with a 3 year projection of the initial operating results and a statement of the sources of working capital and any other sources of funding. The justifications and assumptions for the marketing and financial plan shall also be disclosed;

(11) A power of attorney duly executed by the dental plan organization, if not domiciled in this State, appointing the commissioner, the commissioner's successors in office and duly authorized deputies as the true and lawful attorney of the dental plan organization in and for this State, upon whom lawful process in any legal action or proceeding against the dental plan organization on a cause of action arising in this State may be served;

(12) A description of the geographic area or areas to be served, by county and zip code (first 3 digits);

(13) A description of the procedures and programs to be implemented to achieve an effective dental plan as required in section 5 a.(2) of this act; and

(14) Such other information as the commissioner may require.

d. The dental plan organization shall pay a fee of **[**$100.00**]** $1,000 to the commissioner, upon filing an application for a certificate of authority.

e. The commissioner shall act on an application for a certificate of authority within 90 days following receipt of the application **[**or the operative date of this amendatory and supplementary act, whichever is later**]**.

(cf: P.L.1983, c.24, s.2)

3. Section 4 of P.L.1979, c.478 (C.17:48D-4) is amended to read as follows:

4. **[**Within 10 days following**]** Sixty days prior to any significant modification of information submitted with the application for a certificate of authority or a subsequent modification, a dental plan organization shall file

notice of the modification with the commissioner.
(cf: P.L.1979, c.478, s.4)

4. Section 5 of P.L.1979, c.478 (C.17:48D-5) is amended to read as follows:

5. a. The commissioner shall issue a certificate of authority if he is satisfied that the following conditions are met:

(1) The persons responsible for conducting the affairs of the dental plan organization are competent and trustworthy and are professionally capable of providing, arranging for or administering the services offered by the plan;

(2) The dental plan organization constitutes an appropriate mechanism to achieve an effective dental plan, as determined by the commissioner;

(3) The dental plan organization has demonstrated the potential to provide dental services in a manner that will assure both availability and accessibility of adequate personnel and facilities;

(4) The dental plan organization has arrangements for an ongoing quality of dental care assurance program;

(5) The dental plan organization has a procedure to establish and maintain uniform systems of cost accounting and reports and audits that meet the requirements of the commissioner;

(6) The dental plan organization is financially responsible and may reasonably be expected to meet its obligations to **[**enrollees**]** covered persons. In making this determination the commissioner shall consider:

(a) The financial soundness of the dental plan's arrangements for services and the schedule of **[**charges**]** premiums used;

(b) Any arrangement with an insurer or medical or dental service corporation for continuation of coverage in the event of discontinuance of the plan, on an indemnity basis through a group vehicle to the end of the period for which premiums were paid to the discontinued dental plan organization; and

(c) The sufficiency of an agreement with dentists for the provision of dental services;

(7) A general surplus is maintained as required in section 6 of this act;

(8) A contingent surplus is accumulated and maintained as required in section 7 of this act;

(9) The condition or methods of operation of the dental plan organization are not such as would render its operations hazardous to its enrollees or the public; and

(10) The persons responsible for conducting the affairs of the dental plan organization are: (a) of good moral character, and (b) have not been convicted, within 7 years of the filing of the application for a certificate of authority, of a crime listed in N.J.S.2C:41-1 or, at any time, of engaging in a pattern of racketeering activity, as defined in N.J.S.2C:41-1 and 2C:41-2.

b. When the commissioner disapproves an application for a certificate of

authority, he shall notify the dental plan organization in writing of the reasons for the disapproval.

c. **[**A certificate of authority shall expire 1 year following the date of issuance or previous renewal. If the dental plan organization remains in compliance with this act and has paid a renewal fee of $100.00, its certificate shall be renewed.**]**(Deleted by amendment, P.L. c. ).

(cf: P.L.1983, c.24, s.3)

5. Section 8 of P.L.1979, c.478 (C.17:48D-8) is amended to read as follows:

8. a. Any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization shall be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.

b. Each dentist employed by a dental plan organization shall be insured against professional liability or malpractice by an insurer licensed to conduct business in this State for such minimum amounts as shall be determined by the commissioner.

(cf: P.L.1979, c.478, s.8)

6. Section 9 of P.L.1979, c.478 (C.17:48D-9) is amended to read as follows:

9. a. An enrollee shall be entitled to receive evidence of coverage or a certificate indicating specifically the nature and extent of coverage, and evidence of the total amount or percentage of payment, if any, which the enrollee is obligated to pay for dental services. If an individual enrollee obtains coverage through an insurance policy or through a contract issued by a medical or dental service corporation, whether by option or otherwise, the insurer or medical or dental service corporation shall issue the evidence of coverage. Otherwise, the dental plan organization shall issue the evidence of coverage.

b. No evidence of coverage or amendment thereto shall be issued or delivered to any person until a copy of the form of evidence of coverage or amendment thereto has been filed with the commissioner.

c. Evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate, of:

(1) The dental services and the insurance or other benefits, if any, to which **[**enrollees**]** covered persons are entitled;

(2) Any limitations on the services, kind of services, benefits, or kind of benefits to be provided, including any charge, deductible or co-payment feature;

(3) Where and in what manner information is available as to how services

may be obtained; and

(4) A clear and understandable description of the dental plan organization's method for resolving [enrollees'] covered persons' complaints.

d. Any subsequent change in the evidence of coverage or the amount or percentage of payment which the enrollee is obligated to pay, shall be evidenced in a separate document issued to the enrollee.

(cf: P.L.1979, c.478, s.9)

7. Section 9 of P.L.1999, c.154 (C.17:48D-9.4) is amended to read as follows:

9. a. Within 180 days of the adoption of a timetable for implementation pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization, or a subsidiary that processes health care benefits claims as a third party administrator, shall demonstrate to the satisfaction of the Commissioner of Banking and Insurance that it will adopt and implement all of the standards to receive and transmit health care transactions electronically, according to the corresponding timetable, and otherwise comply with the provisions of this section, as a condition of its continued authorization to do business in this State.

The Commissioner of Banking and Insurance may grant extensions or waivers of the implementation requirement when it has been demonstrated to the commissioner's satisfaction that compliance with the timetable for implementation will result in an undue hardship to a dental plan organization, its subsidiary or its covered [enrollees] persons.

b. Within 12 months of the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization or a subsidiary that processes health care benefits claims as a third party administrator shall use the standard health care enrollment and claim forms in connection with all group and individual contracts issued, delivered, executed or renewed in this State.

c. Twelve months after the adoption of regulations establishing standard health care enrollment and claim forms by the Commissioner of Banking and Insurance pursuant to section 1 of P.L.1999, c.154 (C.17B:30-23), a dental plan organization shall require that health care providers file all claims for payment for dental services. A covered person who receives dental services shall not be required to submit a claim for payment, but notwithstanding the provisions of this subsection to the contrary, a covered person shall be permitted to submit a claim on his own behalf, at the covered person's option. All claims shall be filed using the standard health care claim form applicable to the contract.

d. (1) Effective 180 days after the effective date of P.L.1999, c.154, a dental plan organization or its agent, hereinafter the payer, shall remit payment

for every insured claim submitted by [an enrollee] a covered person or that [enrollee's] covered person's agent or assignee if the contract provides for assignment of benefits, no later than the 30th calendar day following receipt of the claim by the payer or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means, if:

(a) the claim is an eligible claim for a health care service provided by an eligible health care provider to a covered person under the contract;

(b) the claim has no material defect or impropriety, including, but not limited to, any lack of required substantiating documentation or incorrect coding;

(c) there is no dispute regarding the amount claimed;

(d) the payer has no reason to believe that the claim has been submitted fraudulently; and

(e) the claim requires no special treatment that prevents timely payments from being made on the claim under the terms of the contract.

(2) If all or a portion of the claim is denied by the payer because:

(a) the claim is an ineligible claim;

(b) the claim submission is incomplete because the required substantiating documentation has not been submitted to the payer;

(c) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;

(d) the payer disputes the amount claimed; or

(e) the claim requires special treatment that prevents timely payments from being made on the claim under the terms of the contract, the payer shall notify the [enrollee] covered person, or that [enrollee's] covered person's agent or assignee if the contract provides for assignment of benefits, in writing or by electronic means, as appropriate, within 30 days, of the following: if all or a portion of the claim is denied, all the reasons for the denial; if the claim lacks the required substantiating documentation, including incorrect coding, a statement as to what substantiating documentation or other information is required to complete adjudication of the claim; if the amount of the claim is disputed, a statement that it is disputed; and if the claim requires special treatment that prevents timely payments from being made, a statement of the special treatment to which the claim is subject.

(3) Any portion of a claim that meets the criteria established in paragraph (1) of this subsection shall be paid by the payer in accordance with the time limit established in paragraph (1) of this subsection.

(4) A payer shall acknowledge receipt of a claim submitted by electronic means from a health care provider or [enrollee] covered person, no later than two working days following receipt of the transmission of the claim.

(5) If a payer subject to the provisions of P.L.1983, c.320 (C.17:33A-1 et seq.) has reason to believe that a claim has been submitted fraudulently, it shall investigate the claim in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or refer the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

(6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this subsection shall be deemed to be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, following receipt by the payer of a claim submitted by electronic means and on or before the 40th calendar day following receipt of a claim submitted by other than electronic means.

In the event payment is withheld on all or a portion of a claim by a payer pursuant to subparagraph (b) of paragraph (2) of this subsection, the claims payment shall be overdue if not remitted to the claimant or his agent by the payer on or before the 30th calendar day or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and the 40th calendar day for claims submitted by other than electronic means, following receipt by the payer of the required documentation or modification of an initial submission.

(7) An overdue payment shall bear simple interest at the rate of 10% per annum.

e. As used in this subsection, "insured claim" or "claim" means a claim by **[**an enrollee**]** a covered person for payment of benefits under an insured dental plan organization contract for which the financial obligation for the payment of a claim under the contract rests upon the dental plan organization.

(cf: P.L.1999, c.154, s.9)

8. Section 10 of P.L.1979, c.478 (C.17:48D-10) is amended to read as follows:

10. a. No schedule of **[**charges**]** premiums for **[**enrollee**]** coverage for dental services, or amendment thereto, may be used by a dental plan organization until a copy of such schedule, or amendment thereto, has been filed with the commissioner. The commissioner may disapprove the schedule of **[**charges**]** premiums at any time if he finds that the **[**charges**]** premiums are excessive, inadequate or unfairly discriminatory. If the commissioner disapproves the schedule of **[**charges**]** premiums he shall notify the dental plan organization within 5 days of the date of disapproval and specify in the notice, the reason for his disapproval. A hearing shall be granted within 20 days after a request in writing by the filer. It shall be unlawful for any dental plan organization whose schedule of **[**charges**]** premiums has been disapproved

to effect any contract or issue any subscription certificate which uses the disapproved schedule of **[**charges**]** premiums until a revised schedule of **[**charges**]** premiums has been filed.

b. **[**Charges**]** Premiums shall be established in accordance with actuarial principles, but **[**charges**]** premiums applicable to **[**an enrollee**]** a covered person shall not be individually determined based on the status of his health.
(cf: P.L.1979, c.478, s.10)

9. Section 11 of P.L.1979, c.478 (C.17:48D-11) is amended to read as follows:

11. a. The commissioner or his designee may, as often as he may reasonably determine, investigate the business and examine the books, accounts, records and files of every dental plan organization. For that purpose the commissioner or his designee shall have reasonably free access to the offices and places of business, books, accounts, papers, records and files of all dental plan organizations. A dental plan organization shall keep and use in its business such books, accounts and records as will enable the commissioner to determine whether the dental plan organization is complying with the provisions of this act and with the rules and regulations promulgated pursuant to it. A dental plan organization shall preserve its books, accounts and records for at least **[**3**]** 7 years; except that preservation by photographic reproduction or records in photographic form shall constitute compliance with this act.

b. For the purpose of the examination, the commissioner may, within the limits of funds appropriated for such purpose, contract with such persons as he may deem advisable to conduct the same or assist therein.

c. At the discretion of the commissioner, the Commissioner of Health and Senior Services and the New Jersey State Board of Dentistry may participate in the investigations and examinations described in this section to verify the existence of an effective dental plan.

d. The expenses incurred in making any examination pursuant to this section **[**up to $1,000.00 annually,**]**shall be assessed against and paid by the dental plan organization so examined. A dental plan organization having direct premiums written in this State of less than $2,000,000 in any calendar year shall be subject to a limited scope examination with expenses for that examination not to exceed $5,000. Upon written notice by the commissioner of the total amount of an assessment, a dental plan organization shall become liable for and shall pay the assessment to the commissioner.
(cf: P.L.1979, c.478, s.11)

10. Section 12 of P.L.1979, c.478 (C.17:48D-12) is amended to read as follows:

12. a. A dental plan organization shall establish and maintain a complaint

system to provide reasonable procedures for the resolution of written complaints initiated by [enrollees] covered persons concerning dental plan services. The dental plan organization shall maintain records of all written complaints initiated by [enrollees] covered persons.

b. The commissioner may examine the complaint system and if he determines that the system is not adequate he may require a revision of the complaint system.

(cf: P.L.1979, c.478, s.12)

11. Section 13 of P.L.1979, c.478 (C.17:48D-13) is amended to read as follows:

13. a. Every dental plan organization annually on or before March 1 shall file with the commissioner a report covering its activities for the preceding calendar year.

b. The reports shall be on forms prescribed by the commissioner and shall include:

(1) A financial statement of the dental plan organization, prepared by an independent certified public accountant and attested to by an officer of the dental plan organization, which statement shall include full disclosure of all assets and liabilities of the dental plan organization, the terms and conditions thereof, and the sources and disposition of all funds. If the dental plan organization's records have been audited by an independent certified public accountant, the financial statement shall be certified by the certified public accountant having conducted the audit;

(2) Any significant modification of information submitted with the application for a certificate of authority;

(3) The number of persons who became [enrollees] covered persons during the year, the number of [enrollees] covered persons as of the end of the year and the number of enrollments terminated during the year;

(4) A description of the [enrollees] covered persons complaint system, including the procedures of the complaint system, the total number of written complaints handled through the system, a summary of causes underlying the complaints filed, and the number, amount and disposition of malpractice claims settled during the year by the dental plan organization and any of the dentists used by it; and

(5) Any other information relating to the performance of the dental plan organization as required by the commissioner.

(cf: P.L.1983, c.24, s.4)

12. Section 14 of P.L.1979, c.478 (C.17:48D-14) is amended to read as follows:

14. [A dental plan organization shall not use more than 30% of its gross contract and certificate income in the first year of operation, 25% in the

second year of operation and 20% in any subsequent year for general expenses, acquisition expenses and miscellaneous taxes, licenses and fees.**]**

At least 70 percent of every dental plan organization's earned premium in the first year of operation, 75 percent in the second year, and 80 percent in all subsequent years shall be used for payments to dentists for dental services and supplies provided to covered persons.

(cf: P.L.1979, c.478, s.14)

13. Section 15 of P.L.1979, c.478 (C.17:48D-15) is amended to read as follows:

15. a. No dental plan organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

(1) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a dental plan;

(2) A statement or item of information shall be deemed to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a person who does not possess special knowledge regarding dental plan coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to **[**an enrollee**]** a covered person of, or person considering enrollment in, a dental plan, if the benefit or advantage or absence of exclusion, limitation, or disadvantage does not in fact exist;

(3) Evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole, and with consideration given to typography, format and language, may cause a person who does not possess special knowledge regarding dental plans and evidences of coverage therefor, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the dental plan organization issuing the evidence of coverage does not regularly make available for **[**enrollees**]** persons covered under such evidence of coverage.

b. The unfair trade practice provisions contained in chapter 30 of Title 17B of the New Jersey Statutes shall apply to dental plan organizations, dental plans and evidences of coverage, except to the extent that the commissioner determines that the nature of dental plan organizations, dental plans and evidences of coverage render these sections clearly inappropriate.

c. No dental plan organization, unless licensed as an insurer, may use in its name, evidence of coverage or literature any of the words "insurance," "assurance," "casualty," "surety," "mutual" or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name

or description of any insurer licensed to do business in this State.

The provisions of this subsection shall be enforced by the Division of Consumer Affairs in the Department of Law and Public Safety and, where applicable, the commissioner. Nothing in this act shall limit the powers of the Attorney General and the procedures with respect to consumer fraud in P.L.1960, c.39 (C.56:8-1 et seq.).

(cf: P.L.1979, c.478, s.15)

14. Section 16 of P.L.1979, c.478 (C.17:48D-16) is amended to read as follows:

16. a. The commissioner may suspend or revoke any certificate of authority issued to a dental plan organization pursuant to this act, if he finds that any of the following conditions exist:

(1) The dental plan organization is operating in a manner significantly contrary to that described in sections 3 and 4 of this act;

(2) The dental plan organization issues an evidence of coverage which does not comply with the requirements of section 9 of this act;

(3) The dental plan organization does not provide or arrange for an effective dental plan, as determined by the commissioner;

(4) The dental plan organization can no longer be expected to meet its obligations to **[**enrollees**]** <u>covered persons</u>;

(5) The dental plan organization, or any authorized person on its behalf, has advertised or merchandised its services in an untrue or misleading manner;

(6) The dental plan organization has failed to comply with this act or any rules and regulations promulgated thereunder;

(7) Any person responsible for conducting the affairs of the dental plan organization is: (a) not of good moral character, or (b) has been convicted, within 7 years of the filing of the application for a certificate of authority, of a crime listed in N.J.S.2C:41-1 or, at any time, of engaging in a pattern of racketeering activity, as defined in N.J.S.2C:41-1 and 2C:41-2.

b. When the commissioner has cause to believe that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the dental plan organization in writing, specifically stating the grounds for suspension or revocation. A hearing on the matter shall be granted by the commissioner within 20 days after a request in writing by the dental plan organization. After the hearing, or upon failure of the dental plan organization to appear at the hearing, the commissioner shall take action on his findings.

c. If the commissioner suspends the certificate of authority, the dental plan organization shall not accept any additional **[**enrollees**]** <u>covered persons, except newborn children, new employees and new dependents of current employees,</u> or engage in any advertising or solicitation during the period of the suspension.

d. If the commissioner revokes the certificate of authority, the dental plan

organization shall proceed to dissolve its structure immediately following the effective date of the order of revocation, and shall conduct no further business, except as may be essential to the orderly conclusion of the affairs of the dental plan organization. The commissioner by written order, however, may permit such further operation of the dental plan organization as he finds to be in the best interest of **[**enrollees**]** covered persons to the end that **[**enrollees**]** covered persons shall be afforded the greatest practical opportunity to obtain continuing dental plan coverage.

e. Notwithstanding the provisions of subsections c. and d. of this section, a dental plan organization which has had its certificate of authority suspended or revoked, or has suffered an adverse decision by the commissioner, shall be entitled to a hearing pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).

(cf: P.L.1983, c.24, s.5)

15. Section 18 of PL.1979, c.478 (C.17:48D-18) is amended to read as follows:

18. Any dental plan organization which violates any provisions of this act, or neglects, fails or refuses to comply with any of the requirements of this act shall be liable for a civil penalty of not less than $500.00 nor more than $10,000.00 for each violation. The failure to file an annual report and the failure to reply promptly in writing to inquiries of the commissioner may result in an administrative penalty in an amount not less than $50 nor more than $500 for each day that the dental plan organization fails to file that reports or response. The penalty may be sued for and recovered by the commissioner in a summary proceeding pursuant to the "Penalty Enforcement Law of 1999"**[**(N.J.S.2A:58-1 et seq.)**]**P.L.1999, c.274 (C.2A:58-10 et seq.).

A purposeful or knowing misstatement or omission of material fact required to be supplied to the commissioner is a crime of the fourth degree.

(cf: P.L.1983, c.24, s.6)

16. Section 21 of P.L.1979, c.478 (C.17:48D-21) is amended to read:

21. Data or information pertaining to the diagnosis, treatment or health of any **[**enrollee**]** covered person obtained by the dental plan organization from the **[**enrollee**]** covered person or any dentist shall be confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this act, or upon the express consent of the **[**enrollee**]** covered person, or pursuant to statute or court order for the production of evidence or the discovery thereof, or in the event of claim or litigation between the **[**enrollee**]** covered person and the dental plan organization wherein the data or information is pertinent. A dental plan organization shall be entitled to claim any statutory privileges against such disclosure which the dentist who furnished the information to the dental

organization is entitled to claim.
(cf: P.L.1979, c.478, s.21)

17. Section 22 of P.L.1979, c.478 (C.17:48D-22) is repealed.

18. This act shall take effect immediately.

STATEMENT

This bill revises the "Dental Plan Organization Act" generally, to update certain of its provisions and subject dental plan organizations (DPOs) to the same level of oversight and review by the Department of Banking and Insurance as other types of health insurers.

The bill eliminates the $1,000 cap the department may currently assess a DPO for performing a financial examination, and instead provides that the department may assess a DPO for the full expense incurred in conducting a financial examination. However, the bill also provides that a dental plan organization with direct written premiums written in this State of less than $2,000,000 in any calendar year is subject to a limited scope examination, with expenses for that examination not to exceed $5,000.

In addition, the bill provides for the assessment of civil monetary penalties for the failure of a DPO to file an annual report or respond in a timely manner to inquiries from the department. The penalty shall not be less than $50 nor more than $500 for each day that the DPO fails to comply.

The bill also requires retention of DPO records for seven years, rather than the current three.

The bill requires any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization to be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

# ASSEMBLY, No. 3455

# STATE OF NEW JERSEY

DATED: DECEMBER 2, 2004

The Assembly Financial Institutions and Insurance Committee reports favorably Assembly Bill No. 3455.

This bill revises the "Dental Plan Organization Act" generally, to update certain of its provisions and subject dental plan organizations (DPOs) to the same level of oversight and review by the Department of Banking and Insurance as other types of health insurers.

The bill eliminates the $1,000 cap the department may currently assess a DPO for performing a financial examination, and instead provides that the department may assess a DPO for the full expense incurred in conducting a financial examination. However, the bill also provides that a dental plan organization with direct written premiums written in this State of less than $2,000,000 in any calendar year is subject to a limited scope examination, with expenses for that examination not to exceed $5,000. Under the current law, the threshold for a limited scope examination is $1,000,000 with expenses for the examination not to exceed $10,000.

In addition, the bill provides for the assessment of administrative penalties, in addition to the civil monetary penalties in the current act, for the failure of a DPO to file an annual report or respond in a timely manner to inquiries from the department. The administrative penalties shall not be less than $50 nor more than $500 for each day that the DPO fails to comply.

The bill also requires retention of DPO records for seven years, rather than the current three.

The bill requires any director, officer, employee or partner of a dental plan organization who receives, collects, reimburses or invests moneys in connection with the activities of the organization to be bonded for his fidelity, or maintain crime insurance or its equivalent, in an amount which shall be determined by the commissioner.