26:25-26 to 26:25-28

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2014 **CHAPTER:** 70

NJSA: 26:25-26 to 26:25-28 (Prohibits insurers from setting prices for non-covered dental services)

BILL NO: S2164 (Substituted for A3411)

SPONSOR(S) Gill and others

DATE INTRODUCED: June 9, 2014

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

SENATE: Commerce

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** October 16, 2014

SENATE: September 22, 2014

DATE OF APPROVAL: November 28, 2014

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (First reprint enacted)

S2164

SPONSOR'S STATEMENT: (Begins on page 2 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

A3411

SPONSOR'S STATEMENT: (Begins on page 2 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes

SENATE: No

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: No

(continued)

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: No

FOLLOWING WERE PRINTED:
To check for circulating copies, contact New Jersey State Government Publications at the State Library (609) 278-2640 ext.103 or mailto:refdesk@njstatelib.org

REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: No

LAW/RWH

§§1-3 -
C.26:2S-26 to
26:2S-28
§4 - Note

P.L.2014, CHAPTER 70, ***approved November 28, 2014***
Senate, No. 2164 ***(First Reprint)***

AN ACT concerning certain dental benefit plans and supplementing P.L.1997, c.192 (C:26:2S-1 et seq.).

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

1. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, dental service corporation, dental plan organization, or health maintenance organization, authorized to issue dental plans in this State.

"Covered person" means a person on whose behalf a carrier offering a dental plan is obligated to pay benefits [1]for[1] or provide [1]dental[1] services pursuant to the plan.

"Covered service" means a dental care service [1]**[**provided to a covered person under a dental plan for which the carrier is obligated to pay benefits or provide services**]** for which a reimbursement is available under a covered person's dental plan, or for which a reimbursement would be available but for the application of contractual limitations including, but not limited to, deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation, or services not reimbursable due to the dentist's failure to comply with a provision of the dentist's participating provider agreement or the dental plan[1].

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a [1]**[**dental**]**[1] carrier [1]either on a stand-alone basis or as part of other coverage including, but not limited to, health benefits coverage[1].

2. Notwithstanding section 22 of P.L.1993, c.162 (C.17B:27A-54) or any other law or regulation to the contrary, a contract between a carrier and a dentist to provide covered services shall not require, directly or indirectly, that a dentist provide services to a covered person at a fee set by, or at a fee subject to the approval of,

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is 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 September 15, 2014.

1 the carrier unless the dental services are a covered service under the
2 person's dental plan.
3
4 3. The Commissioner of Banking and Insurance shall
5 promulgate rules and regulations pursuant to the "Administrative
6 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to
7 effectuate the purposes of this act.
8
9 4. This act shall take effect immediately and shall apply to
10 contracts entered into or renewed on or after the effective date of
11 this act.
12
13
14 ---
15
16 Prohibits insurers from setting prices for non-covered dental
17 services.

SENATE, No. 2164

STATE OF NEW JERSEY

216th LEGISLATURE

INTRODUCED JUNE 9, 2014

Sponsored by:
Senator NIA H. GILL
District 34 (Essex and Passaic)

SYNOPSIS

Prohibits insurers from setting prices for non-covered dental services.

CURRENT VERSION OF TEXT

As introduced.

1 **AN ACT** concerning certain dental benefit plans and supplementing
2 P.L.1997, c.192 (C:26:2S-1 et seq.).
3
4 **BE IT ENACTED** *by the Senate and General Assembly of the State*
5 *of New Jersey:*
6
7 1. As used in this act:
8 "Carrier" means an insurance company, health service
9 corporation, hospital service corporation, medical service
10 corporation, dental service corporation, dental plan organization, or
11 health maintenance organization, authorized to issue dental plans in
12 this State.
13 "Covered person" means a person on whose behalf a carrier
14 offering a dental plan is obligated to pay benefits or provide
15 services pursuant to the plan.
16 "Covered service" means a dental care service provided to a
17 covered person under a dental plan for which the carrier is obligated
18 to pay benefits or provide services.
19 "Dental plan" means a benefits plan which pays or provides
20 dental expense benefits for covered services and is delivered or
21 issued for delivery in this State by or through a dental carrier.
22
23 2. Notwithstanding section 22 of P.L.1993, c.162 (C.17B:27A-
24 54) or any other law or regulation to the contrary, a contract
25 between a carrier and a dentist to provide covered services shall not
26 require, directly or indirectly, that a dentist provide services to a
27 covered person at a fee set by, or at a fee subject to the approval of,
28 the carrier unless the dental services are a covered service under the
29 person's dental plan.
30
31 3. The Commissioner of Banking and Insurance shall
32 promulgate rules and regulations pursuant to the "Administrative
33 Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to
34 effectuate the purposes of this act.
35
36 4. This act shall take effect immediately and shall apply to
37 contracts entered into or renewed on or after the effective date of
38 this act.
39
40 STATEMENT
41
42 This bill prohibits dental carriers from requiring, directly or
43 indirectly, that a dentist provide services to a covered person at a
44 fee set by, or at a fee subject to the approval of, the carrier unless
45 the dental services are a covered service under the person's dental
46 plan.
47 This bill is, in part, a response to the decision in New Jersey
48 Dental Ass'n v. Metropolitan Life Ins. Co., 424 N.J. Super. 160

1 (App. Div. 2012). In that decision, the court held that the "selective
2 contracting law," section 22 of P.L.1993, c.162 (C.17B:27A-54),
3 authorized the Department of Banking and Insurance to issue
4 regulations that allow managed care plans to negotiate the fees paid
5 by their insureds to in-network providers for dental services that are
6 not covered under the dental benefits plan. This bill would overturn
7 that part of the decision and the effect of those regulations by
8 prohibiting carriers from setting fees paid by their insureds for
9 services that are not covered services under the insured's dental
10 plan.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 2164

with committee amendments

STATE OF NEW JERSEY

DATED: SEPTEMBER 15, 2014

The Senate Commerce Committee reports favorably and with committee amendments Senate Bill No. 2164.

This bill, as amended, prohibits carriers from requiring, directly or indirectly, that a dentist provide services to a covered person at a fee set by, or at a fee subject to the approval of, the carrier unless the dental services are a covered service under the person's dental plan.

This bill is, in part, a response to the decision in New Jersey Dental Ass'n v. Metropolitan Life Ins. Co., 424 N.J. Super. 160 (App. Div. 2012). In that decision, the court held that the "selective contracting law," section 22 of P.L.1993, c.162 (C.17B:27A-54), authorized the Department of Banking and Insurance to issue regulations that allow managed care plans to negotiate the fees paid by their insureds to in-network providers for dental services that are not covered under the dental benefits plan. This bill would overturn that part of the decision and the effect of those regulations by prohibiting carriers from setting fees paid by their insureds for services that are not covered services under the insured's dental plan.

Committee Amendments:

The committee amended the bill to:

- revise the definition of "covered service" to mean a dental care service for which a reimbursement is available under a covered person's dental plan, or for which a reimbursement would be available but for the application of contractual limitations including, but not limited to, deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation, or services not reimbursable due to the dentist's failure to comply with a provision of the dentist's participating provider agreement or the dental plan.

- clarify that the bill applies to benefits plans which pay or provide dental expense benefits for covered services on a stand-alone basis or as part of other coverage including, but not limited to, health benefits coverage.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

[First Reprint]
SENATE, No. 2164

STATE OF NEW JERSEY

DATED: OCTOBER 2, 2014

The Assembly Financial Institutions and Insurance Committee reports favorably Senate Bill No. 2164 (1R).

This bill prohibits carriers from requiring, directly or indirectly, that a dentist provide services to a covered person at a fee set by, or at a fee subject to the approval of, the carrier unless the dental services are a covered service under the person's dental plan.

This bill is, in part, a response to the decision in New Jersey Dental Ass'n v. Metropolitan Life Ins. Co., 424 N.J. Super. 160 (App. Div. 2012). In that decision, the court held that the "selective contracting law," section 22 of P.L.1993, c.162 (C.17B:27A-54), authorized the Department of Banking and Insurance to issue regulations that allow managed care plans to negotiate the fees paid by their insureds to in-network providers for dental services that are not covered under the dental benefits plan. This bill would overturn that part of the decision and the effect of those regulations by prohibiting carriers from setting fees paid by their insureds for services that are not covered services under the insured's dental plan.

As reported, this bill is identical to Assembly Bill No. 3411, as amended and also reported by the committee.

ASSEMBLY, No. 3411

STATE OF NEW JERSEY

216th LEGISLATURE

INTRODUCED JUNE 16, 2014

Sponsored by:
Assemblywoman PAMELA R. LAMPITT
District 6 (Burlington and Camden)
Assemblyman JOSEPH A. LAGANA
District 38 (Bergen and Passaic)
Assemblywoman NANCY J. PINKIN
District 18 (Middlesex)
Assemblyman HERB CONAWAY, JR.
District 7 (Burlington)

SYNOPSIS

Prohibits insurers from setting prices for non-covered dental services.

CURRENT VERSION OF TEXT

As introduced.

(Sponsorship Updated As Of: 9/30/2014)

AN ACT concerning certain dental benefit plans and supplementing P.L.1997, c.192 (C:26:2S-1 et seq.).

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

1. As used in this act:

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation, dental service corporation, dental plan organization, or health maintenance organization, authorized to issue dental plans in this State.

"Covered person" means a person on whose behalf a carrier offering a dental plan is obligated to pay benefits or provide services pursuant to the plan.

"Covered service" means a dental care service provided to a covered person under a dental plan for which the carrier is obligated to pay benefits or provide services.

"Dental plan" means a benefits plan which pays or provides dental expense benefits for covered services and is delivered or issued for delivery in this State by or through a dental carrier.

2. Notwithstanding section 22 of P.L.1993, c.162 (C.17B:27A-54) or any other law or regulation to the contrary, a contract between a carrier and a dentist to provide covered services shall not require, directly or indirectly, that a dentist provide services to a covered person at a fee set by, or at a fee subject to the approval of, the carrier unless the dental services are a covered service under the person's dental plan.

3. The Commissioner of Banking and Insurance shall promulgate rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) necessary to effectuate the purposes of this act.

4. This act shall take effect immediately and shall apply to contracts entered into or renewed on or after the effective date of this act.

STATEMENT

This bill prohibits dental carriers from requiring, directly or indirectly, that a dentist provide services to a covered person at a fee set by, or at a fee subject to the approval of, the carrier unless the dental services are a covered service under the person's dental plan.

1 This bill is, in part, a response to the decision in New Jersey
2 Dental Ass'n v. Metropolitan Life Ins. Co., 424 N.J. Super. 160
3 (App. Div. 2012). In that decision, the court held that the "selective
4 contracting law," section 22 of P.L.1993, c.162 (C.17B:27A-54),
5 authorized the Department of Banking and Insurance to issue
6 regulations that allow managed care plans to negotiate the fees paid
7 by their insureds to in-network providers for dental services that are
8 not covered under the dental benefits plan. This bill would overturn
9 that part of the decision and the effect of those regulations by
10 prohibiting carriers from setting fees paid by their insureds for
11 services that are not covered services under the insured's dental
12 plan.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE

STATEMENT TO

ASSEMBLY, No. 3411

with committee amendments

STATE OF NEW JERSEY

DATED: OCTOBER 2, 2014

The Assembly Financial Institutions and Insurance Committee reports favorably and with committee amendments Assembly Bill No. 3411.

This bill, as amended, prohibits carriers from requiring, directly or indirectly, that a dentist provide services to a covered person at a fee set by, or at a fee subject to the approval of, the carrier unless the dental services are a covered service under the person's dental plan.

This bill is, in part, a response to the decision in New Jersey Dental Ass'n v. Metropolitan Life Ins. Co., 424 N.J. Super. 160 (App. Div. 2012). In that decision, the court held that the "selective contracting law," section 22 of P.L.1993, c.162 (C.17B:27A-54), authorized the Department of Banking and Insurance to issue regulations that allow managed care plans to negotiate the fees paid by their insureds to in-network providers for dental services that are not covered under the dental benefits plan. This bill would overturn that part of the decision and the effect of those regulations by prohibiting carriers from setting fees paid by their insureds for services that are not covered services under the insured's dental plan.

As amended and reported, this bill is identical to Senate Bill No. 2164 (1R), as also reported by the committee.

COMMITTEE AMENDMENTS:

The committee amended the bill to:

-revise the definition of "covered service" to mean a dental care service for which a reimbursement is available under a covered person's dental plan, or for which a reimbursement would be available but for the application of contractual limitations including, but not limited to, deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation, or services not reimbursable due to the dentist's failure to comply with a provision of the dentist's participating provider agreement or the dental plan.

-clarify that the bill applies to benefits plans which pay or provide dental expense benefits for covered services on a stand-alone basis or as part of other coverage including, but limited to, health benefits coverage.