

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

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

3

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

6

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

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

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

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

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

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

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

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

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

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

38 [f.] "Evidence of coverage" means any certificate, agreement or
39 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.

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

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

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

11 "National Association of Insurance Commissioners" or "NAIC"
12 means the National Association of Insurance Commissioners, its
13 affiliates, or subsidiaries, or any agency or committee thereof, or any
14 successor organization.

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

16

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

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

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

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

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

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

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

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

6 (4) ~~【All】~~ The form of all contracts or agreements made between
7 any dentist and the dental plan organization;

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

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

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

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

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

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

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

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

41 (13) A description of the procedures and programs to be
42 implemented to achieve an effective dental plan as required in section
43 5 a.(2) of this act; and

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

45 d. The dental plan organization shall pay a fee of ~~【\$100.00】~~
46 \$1,000 to the commissioner, upon filing an application for a certificate

1 of authority.

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

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

7

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

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

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

16

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 c. [A certificate of authority shall expire 1 year following the date
20 of issuance or previous renewal. If the dental plan organization
21 remains in compliance with this act and has paid a renewal fee of
22 \$100.00, its certificate shall be renewed.] (~~Deleted by amendment,~~
23 ~~P.L. c.~~).

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

25

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

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

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

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

38

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

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

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

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

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

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

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

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

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

20 d. Any subsequent change in the evidence of coverage or the
21 amount or percentage of payment which the enrollee is obligated to
22 pay, shall be evidenced in a separate document issued to the enrollee.
23 (cf: P.L.1979, c.478, s.9)

24
25 7. Section 9 of P.L.1999, c.154 (C.17:48D-9.4) is amended to read
26 as follows:

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

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

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

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

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

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

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

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

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

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

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

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

40 (a) the claim is an ineligible claim;

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

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

45 (d) the payer disputes the amount claimed; or

46 (e) the claim requires special treatment that prevents timely

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

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

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

22 (5) If a payer subject to the provisions of P.L.1983, c.320
23 (C.17:33A-1 et seq.) has reason to believe that a claim has been
24 submitted fraudulently, it shall investigate the claim in accordance with
25 its fraud prevention plan established pursuant to section 1 of P.L.1993,
26 c.362 (C.17:33A-15), or refer the claim, together with supporting
27 documentation, to the Office of the Insurance Fraud Prosecutor in the
28 Department of Law and Public Safety established pursuant to section
29 32 of P.L.1998, c.21 (C.17:33A-16).

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

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

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

1 10% per annum.

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

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

8

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

11 10. a. No schedule of [charges] premiums for [enrollee]
12 coverage for dental services, or amendment thereto, may be used by
13 a dental plan organization until a copy of such schedule, or amendment
14 thereto, has been filed with the commissioner. The commissioner may
15 disapprove the schedule of [charges] premiums at any time if he finds
16 that the [charges] premiums are excessive, inadequate or unfairly
17 discriminatory. If the commissioner disapproves the schedule of
18 [charges] premiums he shall notify the dental plan organization within
19 5 days of the date of disapproval and specify in the notice, the reason
20 for his disapproval. A hearing shall be granted within 20 days after a
21 request in writing by the filer. It shall be unlawful for any dental plan
22 organization whose schedule of [charges] premiums has been
23 disapproved to effect any contract or issue any subscription certificate
24 which uses the disapproved schedule of [charges] premiums until a
25 revised schedule of [charges] premiums has been filed.

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

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

31

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

34 11. a. The commissioner or his designee may, as often as he may
35 reasonably determine, investigate the business and examine the books,
36 accounts, records and files of every dental plan organization. For that
37 purpose the commissioner or his designee shall have reasonably free
38 access to the offices and places of business, books, accounts, papers,
39 records and files of all dental plan organizations. A dental plan
40 organization shall keep and use in its business such books, accounts
41 and records as will enable the commissioner to determine whether the
42 dental plan organization is complying with the provisions of this act
43 and with the rules and regulations promulgated pursuant to it. A
44 dental plan organization shall preserve its books, accounts and records
45 for at least ¹[3] ¹7 years; except that preservation by photographic

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

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

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

12 d. The expenses incurred in making any examination pursuant to
13 this section [up to \$1,000.00 annually,] shall be assessed against and
14 paid by the dental plan organization so examined. A dental plan
15 organization having direct premiums written in this State of less than
16 ¹[\$1,000,000] \$2,000,000¹ in any calendar year shall be subject to a
17 limited scope examination with expenses for that examination not to
18 exceed ¹[\$10,000] \$5,000¹. Upon written notice by the commissioner
19 of the total amount of an assessment, a dental plan organization shall
20 become liable for and shall pay the assessment to the commissioner.
21 (cf: P.L.1979, c.478, s.11)

22

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

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

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

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

35

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

38 13. a. Every dental plan organization annually on or before March
39 1 shall file with the commissioner a report covering its activities for
40 the preceding calendar year.

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

43 (1) A financial statement of the dental plan organization, prepared
44 [by an independent certified public accountant] ¹by an independent
45 certified public accountant¹ and attested to by an officer of the dental
46 plan organization, which statement shall include full disclosure of all

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

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

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

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

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

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

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

29
30 12. Section 14 of P.L.1979, c.478 (C.17:48D-14) is amended to
31 read as follows:

32 14. [A dental plan organization shall not use more than 30% of its
33 gross contract and certificate income in the first year of operation,
34 25% in the second year of operation and 20% in any subsequent year
35 for general expenses, acquisition expenses and miscellaneous taxes,
36 licenses and fees.]

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

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

43
44 13. Section 15 of P.L.1979, c.478 (C.17:48D-15) is amended to
45 read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 obtain continuing dental plan coverage.

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

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

9

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

12 18. Any dental plan organization which violates any provisions of
13 this act, or neglects, fails or refuses to comply with any of the
14 requirements of this act shall be liable for a civil penalty of not less
15 than \$500.00 nor more than \$10,000.00 for each violation. The failure
16 to file an annual report and the failure to reply promptly in writing to
17 inquiries of the commissioner may result in an administrative penalty
18 in an amount not less than \$50 nor more than \$500 for each day that
19 the dental plan organization fails to file that reports or response. The
20 penalty may be sued for and recovered by the commissioner in a
21 summary proceeding pursuant to the "Penalty Enforcement Law of
22 1999" [(N.J.S.2A:58-1 et seq.)] P.L.1999, c.274 (C.2A:58-10 et
23 seq.).

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

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

28

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

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

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

45

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

1 18. This act shall take effect immediately.

2

3

4

5

6 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.



S1752 BAER

2

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

3

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

6

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

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

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

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

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

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

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

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

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

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

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

41 [g.] "Consultant" means a person who holds himself out as an
42 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.

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

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

8 "National Association of Insurance Commissioners" or "NAIC"
9 means the National Association of Insurance Commissioners, its
10 affiliates, or subsidiaries, or any agency or committee thereof, or any
11 successor organization.

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

13

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

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

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

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

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

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

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

S1752 BAER

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

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

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

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

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

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

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

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

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

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

38 (13) A description of the procedures and programs to be
39 implemented to achieve an effective dental plan as required in section
40 5 a.(2) of this act; and

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

42 d. The dental plan organization shall pay a fee of ~~[\$100.00]~~
43 \$1,000 to the commissioner, upon filing an application for a certificate
44 of authority.

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

1 operative date of this amendatory and supplementary act, whichever
2 is later].

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

4

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

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

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

13

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 c. [A certificate of authority shall expire 1 year following the date
18 of issuance or previous renewal. If the dental plan organization
19 remains in compliance with this act and has paid a renewal fee of
20 \$100.00, its certificate shall be renewed.] (Deleted by amendment,
21 P.L. c.).

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

23

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

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

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

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

36

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

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

1 the dental plan organization shall issue the evidence of coverage.

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

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

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

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

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

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

18 d. Any subsequent change in the evidence of coverage or the
19 amount or percentage of payment which the enrollee is obligated to
20 pay, shall be evidenced in a separate document issued to the enrollee.
21 (cf: P.L.1979, c.478, s.9)

22

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

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

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

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

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

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

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

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

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

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

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

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

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

38 (a) the claim is an ineligible claim;

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

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

43 (d) the payer disputes the amount claimed; or

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

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

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

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

20 (5) If a payer subject to the provisions of P.L.1983, c.320
21 (C.17:33A-1 et seq.) has reason to believe that a claim has been
22 submitted fraudulently, it shall investigate the claim in accordance with
23 its fraud prevention plan established pursuant to section 1 of P.L.1993,
24 c.362 (C.17:33A-15), or refer the claim, together with supporting
25 documentation, to the Office of the Insurance Fraud Prosecutor in the
26 Department of Law and Public Safety established pursuant to section
27 32 of P.L.1998, c.21 (C.17:33A-16).

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

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

44 (7) An overdue payment shall bear simple interest at the rate of
45 10% per annum.

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

1 claim by [an enrollee] a covered person for payment of benefits under
2 an insured dental plan organization contract for which the financial
3 obligation for the payment of a claim under the contract rests upon the
4 dental plan organization.

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

6

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

9 10. a. No schedule of [charges] premiums for [enrollee]
10 coverage for dental services, or amendment thereto, may be used by
11 a dental plan organization until a copy of such schedule, or amendment
12 thereto, has been filed with the commissioner. The commissioner may
13 disapprove the schedule of [charges] premiums at any time if he finds
14 that the [charges] premiums are excessive, inadequate or unfairly
15 discriminatory. If the commissioner disapproves the schedule of
16 [charges] premiums he shall notify the dental plan organization within
17 5 days of the date of disapproval and specify in the notice, the reason
18 for his disapproval. A hearing shall be granted within 20 days after a
19 request in writing by the filer. It shall be unlawful for any dental plan
20 organization whose schedule of [charges] premiums has been
21 disapproved to effect any contract or issue any subscription certificate
22 which uses the disapproved schedule of [charges] premiums until a
23 revised schedule of [charges] premiums has been filed.

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

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

29

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

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

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

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

10 d. The expenses incurred in making any examination pursuant to
11 this section [up to \$1,000.00 annually,] shall be assessed against and
12 paid by the dental plan organization so examined. A dental plan
13 organization having direct premiums written in this State of less than
14 \$1,000,000 in any calendar year shall be subject to a limited scope
15 examination with expenses for that examination not to exceed
16 \$10,000. Upon written notice by the commissioner of the total
17 amount of an assessment, a dental plan organization shall become
18 liable for and shall pay the assessment to the commissioner.

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

20
21 10. Section 12 of P.L.1979, c.478 (C.17:48D-12) is amended to
22 read as follows:

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

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

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

33
34 11. Section 13 of P.L.1979, c.478 (C.17:48D-13) is amended to
35 read as follows:

36 13. a. Every dental plan organization annually on or before March
37 1 shall file with the commissioner a report covering its activities for
38 the preceding calendar year.

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

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

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

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

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

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

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

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

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

23

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

26 14. [A dental plan organization shall not use more than 30% of its
27 gross contract and certificate income in the first year of operation,
28 25% in the second year of operation and 20% in any subsequent year
29 for general expenses, acquisition expenses and miscellaneous taxes,
30 licenses and fees.]

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

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

37

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

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

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

1 dental plan;

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

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

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

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

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

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

39

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

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

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

- 1 (2) The dental plan organization issues an evidence of coverage
2 which does not comply with the requirements of section 9 of this act;
- 3 (3) The dental plan organization does not provide or arrange for
4 an effective dental plan, as determined by the commissioner;
- 5 (4) The dental plan organization can no longer be expected to meet
6 its obligations to [enrollees] covered persons;
- 7 (5) The dental plan organization, or any authorized person on its
8 behalf, has advertised or merchandised its services in an untrue or
9 misleading manner;
- 10 (6) The dental plan organization has failed to comply with this act
11 or any rules and regulations promulgated thereunder;
- 12 (7) Any person responsible for conducting the affairs of the dental
13 plan organization is: (a) not of good moral character, or (b) has been
14 convicted, within 7 years of the filing of the application for a
15 certificate of authority, of a crime listed in N.J.S. 2C:41-1 or, at any
16 time, of engaging in a pattern of racketeering activity, as defined in
17 N.J.S.2C:41-1 and 2C:41-2.
- 18 b. When the commissioner has cause to believe that grounds for the
19 suspension or revocation of a certificate of authority exist, he shall
20 notify the dental plan organization in writing, specifically stating the
21 grounds for suspension or revocation. A hearing on the matter shall
22 be granted by the commissioner within 20 days after a request in
23 writing by the dental plan organization. After the hearing, or upon
24 failure of the dental plan organization to appear at the hearing, the
25 commissioner shall take action on his findings.
- 26 c. If the commissioner suspends the certificate of authority, the
27 dental plan organization shall not accept any additional [enrollees]
28 covered persons, except newborn children, new employees and new
29 dependents of current employees, or engage in any advertising or
30 solicitation during the period of the suspension.
- 31 d. If the commissioner revokes the certificate of authority, the
32 dental plan organization shall proceed to dissolve its structure
33 immediately following the effective date of the order of revocation,
34 and shall conduct no further business, except as may be essential to the
35 orderly conclusion of the affairs of the dental plan organization. The
36 commissioner by written order, however, may permit such further
37 operation of the dental plan organization as he finds to be in the best
38 interest of [enrollees] covered persons to the end that [enrollees]
39 covered persons shall be afforded the greatest practical opportunity to
40 obtain continuing dental plan coverage.
- 41 e. Notwithstanding the provisions of subsections c. and d. of this
42 section, a dental plan organization which has had its certificate of
43 authority suspended or revoked, or has suffered an adverse decision

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

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

5
6 15. Section 18 of PL.1979, c.478 (C.17:48D-18) is amended to
7 read as follows:

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

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

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

24
25 16. Section 21 of P.L.1979, c.478 (C.17:48D-21) is amended to
26 read:

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

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

41
42 17. Section 22 of P.L.1979, c.478 (C.17:48D-22) is repealed.

43
44 18. This act shall take effect immediately.

1 STATEMENT

2

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

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

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

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

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

37 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.



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

3

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

6

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

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

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

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

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

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

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

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

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

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

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

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

40 [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.

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

5 "National Association of Insurance Commissioners" or "NAIC" means the
6 National Association of Insurance Commissioners, its affiliates, or
7 subsidiaries, or any agency or committee thereof, or any successor
8 organization.

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

10

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 (10) The proposed method of marketing the plan, a financial plan with a
18 3 year projection of the initial operating results and a statement of the sources
19 of working capital and any other sources of funding. The justifications and
20 assumptions for the marketing and financial plan shall also be disclosed;

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

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

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

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

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

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

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

38

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

41 4. ~~【Within 10 days following】~~ Sixty days prior to any significant
42 modification of information submitted with the application for a certificate of
43 authority or a subsequent modification, a dental plan organization shall file

1 notice of the modification with the commissioner.

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

3

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 c. [A certificate of authority shall expire 1 year following the date of
4 issuance or previous renewal. If the dental plan organization remains in
5 compliance with this act and has paid a renewal fee of \$100.00, its certificate
6 shall be renewed.](Deleted by amendment, P.L. c.).
7 (cf: P.L.1983, c.24, s.3)

8

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

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

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

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

21

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

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

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

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

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

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

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

1 may be obtained; and

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

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

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

8

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

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

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

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

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

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

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

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

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

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

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

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

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

20 (a) the claim is an ineligible claim;

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

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

25 (d) the payer disputes the amount claimed; or

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

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

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

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

8 (6) Payment of an eligible claim pursuant to paragraphs (1) and (3) of this
9 subsection shall be deemed to be overdue if not remitted to the claimant or his
10 agent by the payer on or before the 30th calendar day or the time limit
11 established by the Medicare program, whichever is earlier, following receipt
12 by the payer of a claim submitted by electronic means and on or before the
13 40th calendar day following receipt of a claim submitted by other than
14 electronic means.

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

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

25 e. As used in this subsection, "insured claim" or "claim" means a claim by
26 [an enrollee] a covered person for payment of benefits under an insured
27 dental plan organization contract for which the financial obligation for the
28 payment of a claim under the contract rests upon the dental plan organization.
29 (cf: P.L.1999, c.154, s.9)

30
31 8. Section 10 of P.L.1979, c.478 (C.17:48D-10) is amended to read as
32 follows:

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

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

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

8

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

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

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

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

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

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

40

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

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

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

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

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

9

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

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

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

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

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

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

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

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

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

39

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

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

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

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

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

8

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

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

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

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

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

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

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

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

2 The provisions of this subsection shall be enforced by the Division of
3 Consumer Affairs in the Department of Law and Public Safety and, where
4 applicable, the commissioner. Nothing in this act shall limit the powers of the
5 Attorney General and the procedures with respect to consumer fraud in
6 P.L.1960, c.39 (C.56:8-1 et seq.).
7 (cf: P.L.1979, c.478, s.15)

8

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

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

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

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

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

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

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

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

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

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

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

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

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

9 e. Notwithstanding the provisions of subsections c. and d. of this section,
10 a dental plan organization which has had its certificate of authority suspended
11 or revoked, or has suffered an adverse decision by the commissioner, shall be
12 entitled to a hearing pursuant to the "Administrative Procedure Act,"
13 P.L.1968, c.410 (C.52:14B-1 et seq.).
14 (cf: P.L.1983, c.24, s.5)

15

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

18 18. Any dental plan organization which violates any provisions of this act,
19 or neglects, fails or refuses to comply with any of the requirements of this act
20 shall be liable for a civil penalty of not less than \$500.00 nor more than
21 \$10,000.00 for each violation. The failure to file an annual report and the
22 failure to reply promptly in writing to inquiries of the commissioner may result
23 in an administrative penalty in an amount not less than \$50 nor more than \$500
24 for each day that the dental plan organization fails to file that reports or
25 response. The penalty may be sued for and recovered by the commissioner
26 in a summary proceeding pursuant to the "Penalty Enforcement Law of
27 1999" [(N.J.S.2A:58-1 et seq.)] P.L.1999, c.274 (C.2A:58-10 et seq.).

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

31

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

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

1 organization is entitled to claim.

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

3

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

5

6 18. This act shall take effect immediately.

7

8

9

STATEMENT

10

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

15 The bill eliminates the \$1,000 cap the department may currently assess a
16 DPO for performing a financial examination, and instead provides that the
17 department may assess a DPO for the full expense incurred in conducting a
18 financial examination. However, the bill also provides that a dental plan
19 organization with direct written premiums written in this State of less than
20 \$2,000,000 in any calendar year is subject to a limited scope examination,
21 with expenses for that examination not to exceed \$5,000.

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

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

28 The bill requires any director, officer, employee or partner of a dental plan
29 organization who receives, collects, reimburses or invests moneys in
30 connection with the activities of the organization to be bonded for his fidelity,
31 or maintain crime insurance or its equivalent, in an amount which shall be
32 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.