[First Reprint]

ASSEMBLY, No. 4820

STATE OF NEW JERSEY

219th LEGISLATURE

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Sponsored by:
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District 6 (Burlington and Camden)
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District 37 (Bergen)

SYNOPSIS

Prohibits carrier from precluding dentist from billing covered person under certain circumstances.

CURRENT VERSION OF TEXT

As reported by the Assembly Financial Institutions and Insurance Committee on June 2, 2021, with amendments.

(Sponsorship Updated As Of: 11/30/2020)

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

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

[1]**[**1. a. A carrier shall not include in an agreement between the carrier and a participating dentist a provision that:

(1) allows the carrier to deny payment to a participating dentist for a procedure performed or for a service provided on behalf of a covered person; and

(2) prohibits the dentist from collecting the amount owed from the covered person for that procedure or service.

b. As used in this section:

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

"Participating dentist" means a dentist who has entered into a contract with a carrier to provide dental services to covered persons for a predetermined fee or set of fees.**]**[1]

[1]1. a. A carrier shall not preclude a participating dentist from billing a covered person for a covered service under a dental plan and collecting payment from the covered person for the covered service if the participating dentist:

(1) notifies the covered person prior to performing the covered service that the dentist may not be paid by the carrier and that the covered person is responsible for payment of the covered service;

(2) provides the covered person an explanation, in writing, of the benefits and material cost differences of suitable alternative options for the service, and that the alternative selected may not be covered by the plan, in advance of it being performed;

(3) obtains the covered person's consent, in writing, to the performance of the service and the participating dentist makes the written consent available to the carrier upon request; and

(4) accepts as payment in full the amount the participating dentist would have accepted from the carrier under the covered person's dental plan, including bundled payments.

A participating dentist that receives payment for a covered service from a covered person that exceeds the amount the participating dentist is obligated to accept under the covered person's dental plan shall refund to the covered person the difference between the amount accepted by the participating dentist

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

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Assembly AFI committee amendments adopted June 2, 2021.

1 from the covered person and the amount the participating dentist is
2 obligated to accept under the covered person's dental plan.
3 b. Notwithstanding the provisions of subsection a. of this
4 section, this act shall not apply in cases where the service
5 performed by the participating dentist is required as a result of a
6 prior service by the dentist that was inconsistent with the quality of
7 care in the practice of dentistry as determined by a licensed dentist,
8 and this act shall not permit billing covered persons for:
9 (1) equipment used by the participating dentist;
10 (2) overhead expenses incurred by the participating dentist; or
11 (3) laboratory costs or other services customarily associated
12 with the performance of covered services unless:
13 (a) the participating dentist receives prior written consent from
14 the covered person in advance of the performance of the service;
15 and
16 (b) the participating dentist has explained, in writing, the
17 benefits and material cost differences of suitable alternative options
18 for the service, and that the alternative selected may not be covered
19 by the plan, in advance of it being performed.
20 c. A carrier shall not maintain a dental plan that:
21 (1) based on the participating dentist's contracted fee for
22 covered services, uses down-coding in a manner that prevents a
23 dental provider from collecting the fee for the actual service
24 performed from either the dental plan or the patient; or
25 (2) uses bundling of covered services in a manner where a
26 procedure is labeled as nonbillable to the patient unless, consistent
27 with quality of care in the practice of dentistry, the procedure may
28 be provided in conjunction with another procedure.
29 d. Nothing in this act shall exempt or limit any dentist from the
30 provisions of the "Insurance Fraud Prevention Act," P.L.1983,
31 c.320 (C.17:33A-1 et seq.).
32 e. As used in this act:
33 "Bundled Payments" means the practice of combining distinct
34 dental procedures or components of a more extensive procedure
35 into one procedure for billing purposes.
36 "Carrier" means an insurance company, health service
37 corporation, hospital service corporation, medical service
38 corporation, dental service corporation, dental plan organization or
39 health maintenance organization authorized to issue dental
40 contracts, policies, or plans in this State.
41 "Covered person" means a person on whose behalf a carrier
42 offering a dental plan is obligated to pay benefits for or provide
43 dental procedures or services pursuant to the plan.
44 "Covered procedure or service" means a dental care procedure or
45 service for which a reimbursement is available under a covered
46 person's dental plan, or for which a reimbursement would be
47 available but for the application of contractual limitations including,
48 but not limited to, deductibles, copayments, coinsurance, waiting

periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation, or services not reimbursable by the carrier due a provision in the dental plan.

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

Dental plan shall not include the following plans, policies, or contracts: accident only, credit disability, long-term care, Medicare supplement coverage; TRICARE supplement coverage, coverage for Medicare services pursuant to a contract with the United States government, the State Medicaid program established pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.), the NJ FamilyCare Program established pursuant to P.L.2005, c.156 (C.30:4J-8 et al.), coverage arising out of a worker's compensation or similar law, the State Health Benefits Program, the School Employees' Health Benefits Program, or a self-insured health benefits plan governed by the provisions of the federal "Employee Retirement Income Security Act of 1974," 29 U.S.C. s.1001 et seq., coverage under a policy of private passenger automobile insurance issued pursuant to P.L.1972, c.70 (C.39:6A-1 et seq.), or hospital confinement indemnity coverage.

"Down-coding" means the adjustment of a claim submitted to a dental plan to a less complex or lower cost procedure code. Down-coding does not include a carrier's adjustment of payment for procedures which were improperly or inaccurately billed.

"Participating dentist" means a dentist who has entered into a contract with a carrier to provide dental services to covered persons for a predetermined fee or set of fees.[1]

2. This act shall take effect on the 90th day next following enactment, and shall apply to dental contracts or plans issued or renewed after the effective date.