[First Reprint]

ASSEMBLY, No. 3246

STATE OF NEW JERSEY

220th LEGISLATURE

INTRODUCED MARCH 7, 2022

Sponsored by:
Assemblywoman PAMELA R. LAMPITT
District 6 (Burlington and Camden)
Assemblyman GARY S. SCHAER
District 36 (Bergen and Passaic)
Assemblywoman CAROL A. MURPHY
District 7 (Burlington)

Co-Sponsored by:
Assemblyman Conaway

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 December 11, 2023, with amendments.

(Sponsorship Updated As Of: 11/20/2023)

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. a. A carrier shall not [1]⟦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⟧ include in an agreement between the carrier and a participating dentist a provision that prohibits a participating dentist from collecting an amount owed from a covered person for a covered procedure or service[1] if the participating dentist:

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

(2) provides the covered person an explanation, in writing, of the benefits and material cost differences of suitable alternative options for the [1]covered procedure or[1] 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 [1]covered procedure or[1] 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 [1]⟦bundled payments⟧ bundling pursuant to this act[1].

A participating dentist that receives payment for a covered [1]procedure or[1] 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 from the covered person and the amount the participating dentist is obligated to accept under the covered person's dental plan.

b. Notwithstanding the provisions of subsection a. of this section, this act shall not apply in cases where the service performed by the participating dentist is required as a result of a prior service by the dentist that was inconsistent with the quality of care in the practice of dentistry as determined by a licensed dentist, and this act shall not permit billing covered persons for:

(1) equipment used by the participating dentist;

(2) overhead expenses incurred by the participating dentist; [1]⟦or⟧[1]

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 December 11, 2023.

(3) [1]other costs of services or supplies rendered that are covered, or for which benefits are payable, under the covered person's dental plan, except for copayment, coinsurance, or deductible amounts set forth in the dental plan; or

(4)[1] laboratory costs or other services customarily associated with the performance of covered services unless:

(a) the participating dentist receives prior written consent from the covered person in advance of the performance of the service; and

(b) the participating dentist has explained, in writing, 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.

c. A carrier shall not [1]**[**maintain a dental plan that:

(1) based on the participating dentist's contracted fee for covered services, uses down-coding in a manner that prevents a dental provider from collecting the fee for the actual service performed from either the dental plan or the patient; or

(2) uses bundling of covered services in a manner where a procedure is labeled as nonbillable to the patient unless, consistent with quality of care in the practice of dentistry, the procedure may be provided in conjunction with another procedure.**]** change a dentist's submitted procedure codes through down-coding or bundling unless the carrier undertakes a professional review of the submitted charges and supporting clinical information and determines that the original coding was incorrect, fragmented, or un-bundled as:

(1) provided for in the Current Dental Terminology Code of Dental Procedures and Nomenclature; or

(2) consistent with the generally acceptable standards of care in the practice of dentistry.[1]

d. [1]Notwithstanding any other provision of this act or any other law to the contrary, a carrier may base its benefit reimbursement on a lower acceptable cost procedure, material, or test where an alternative, and less costly, means is available and generally accepted for purposes of benefit payment, and based on the participation agreement between the carrier and the participating dentist. However, nothing in this act shall preclude a carrier from covering procedures or services that are actually performed by a participating dentist, per its network provider agreement, and are otherwise eligible for benefit.

e.[1] Nothing in this act shall exempt or limit any dentist from the provisions of the "Insurance Fraud Prevention Act," P.L.1983, c.320 (C.17:33A-1 et seq.).

[1]**[**e.**]** f.[1] As used in this act:

[1]**[**"Bundled Payments"**]** "Bundling"[1] means the practice of combining distinct dental procedures or components of a more extensive procedure into one procedure for billing purposes[1], but does not include the denial or adjustment of claims for covered services in accordance with the covered person's dental plan[1].

"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, policies, or plans in this State.

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

"Covered procedure or service" means a dental care procedure or service [1]⟦for⟧ that is consistent with generally acceptable standards of care in the practice of dentistry, and[1] which [1]⟦a reimbursement is available⟧ the carrier has determined to be reimbursable[1] under a covered person's dental plan, or for which reimbursement would be available but for the application of [1]⟦contractual limitations including, but not limited to,⟧[1] deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, [1]or[1] alternative benefit payments[1]⟦, or any other limitation, or services not reimbursable by the carrier due a provision in the dental plan⟧[1].

"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 [1], or the denial or adjustment of claims for covered services in accordance with the covered person's dental plan[1].

"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.

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.