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BANKING AND INSURANCE

DIVISION OF INSURANCE

Dental Services

Proposed Readoption with Amendments: N.J.A.C. 11:10

Proposed Repeals: N.J.A.C. 11:10-1.13 and 11:10 Appendices A and B

Authorized By: Thomas B. Considine, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15(e), 17:48D-1 et seq., 17B:26-44.4 et seq., 17:48C-18.1 et seq. and 17B:27-51.10a et seq.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2011-012.

Submit comments by March 19, 2011 to:

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The agency proposal follows:

Summary

Pursuant to the sunset provisions of N.J.S.A. 52:14B-5.1c, the Department of Banking and Insurance (Department) proposes to readopt N.J.A.C. 11:10, Dental Services, scheduled to expire on June 5, 2011.

Subchapter 1 of N.J.A.C. 11:10 implements the Dental Plan Organization Act, N.J.S.A. 17:48D-1 et seq. (the Act), which regulates persons and corporations offering plans for the prepayment or postpayment of dental services. The Act provides for the licensing and supervision of dental plan organizations (DPOs) to protect enrollees of the plans and to assure that the services contracted for are actually delivered.

P.L. 2005, c. 38, was approved March 7, 2005, and made several amendments to the Act, all of which were effective on that date. Generally, the amendments updated many of the Act's provisions and subjected DPOs to the same level of oversight by the Department as other types of health insurers. More specifically, the amendments included permitting DPOs to compensate contracted dentists by means other than capitation; removing, with certain exceptions, the $1,000 cap on the fee that the Department may assess a DPO for performing a financial condition examination; revising the maximum administrative expense ratio to a minimum medical loss ratio; permitting the assessment of civil monetary penalties for a DPO's failure to file an annual report or timely respond to Department inquiries; eliminating the DPO certificate of authority renewal requirement; and increasing the DPO records retention requirement from three to seven years. These revisions to the Act necessitated the Department's proposing several amendments to Subchapter 1 of Chapter 10, which are contained in this proposal. The Department is also proposing other amendments that

are consistent with the legislative intent of the statutory amendments to subject dental plan organizations to the same level of oversight and review by the Department as other types of health insurers. The Department is further proposing some "housekeeping" amendments that clarify the existing rules. The Department has reviewed the rules at N.J.A.C. 11:10 and, with the exception of the proposed amendments described below, has determined the existing rules to be necessary, reasonable and proper for the purposes for which they were originally promulgated.

Subchapter 1 sets forth certain standards and procedures designed to effectuate the purposes of the Act. The rules at Subchapter 1 contain requirements for a DPO to obtain and maintain a certificate of authority, including criteria for written agreements with dentists and for evidence of coverage and group contract forms; financial reporting; general surplus, expense limitation and fidelity bond and malpractice insurance requirements; enrollee complaint procedures; and standards for schedules of charges. The Department is proposing to amend N.J.A.C. 11:10-1.1 and 1.2 to reflect the statutory change permitting DPOs to compensate contracted dentists by means other than capitation, and by changing references to "enrollees" to "covered persons." The Department is revising several of the definitions of terms used in the chapter at N.J.A.C. 11:10-1.3 to conform to the amended statutory definitions, and to include additional terms used in the chapter. A definition of "alternative payment" is being added because the amended statute permits dentists to be compensated by means other than capitation. The definition of "capitation" is being revised to reflect the definition in the amended statute, that is, “capitation” means a method of

compensation by a DPO to its contracted dentists for dental services and supplies provided to covered persons of the DPO on the basis of a fixed periodic payment per covered person or enrollee. Definitions for "consultant," "covered person," and "dental plan" are being added to mirror those definitions in the amended statute. The definition of "Dental Plan Organization" is being revised to conform to the definition in the amended statute, that is, “dental plan organization” means any person who undertakes to provide directly or to arrange for or administer one or more dental plans providing dental services and supplies. Definitions of "enrollee," "finder" and "National Association of Insurance Commissioners" are being added, which conform to the amended statutory definitions of those terms. The definition of "fee-for-service" is being amended to use include the term "enrollee" as used in the amended statute rather than "insured (or subscriber)." The definitions of "One Full-Time Equivalent Dentist" and "Supplemental Dental Plan" are being revised to include the more accurate term "covered person" rather than the terms "enrollees" or "enrollees and dependents combined." The definitions of "postpaid capitation" and "prepaid capitation" are being deleted as no longer necessary.

The Department is proposing several amendments to the general rules section at N.J.A.C. 11:10-1.4. N.J.A.C. 11:10-1.4(a) is being amended to clarify that a certificate of authority must be obtained to operate as a DPO, to include a link to the Department's website and the Department's address for obtaining an application for a certificate of authority, and to delete the requirement that a request for an application must be in writing. N.J.A.C. 11:10-1.4(b) is being revised to conform to the statutory

amendments by requiring a DPO to provide 60 days' notice to the Department of any significant modification of information that was submitted with an application, or that was submitted following submission of the initial application. The Department is also adding "changes to provider agreements" to the list of examples of significant modifications requiring such notice. A new subsection at N.J.A.C. 11:10-1.4(d) sets forth standards and procedures for a DPO to obtain Department approval of an alternative payment methodology it intends to use for its contracted dentists. Existing subsection (d) is being recodified as subsection (e), and amended to require the submission of three copies of a request for approval of a specialist pool or an alternative payment methodology. The Department is adding a new subsection at N.J.A.C. 11:10-1.4(f) requiring DPOs to report to the Department any finder's fee payments within 30 days of using or employing the finder. A new N.J.A.C. 11:10-1.4(g) is being added, which permits a DPO's certificate of authority to automatically renew each year so long as the DPO continues to comply with the rules in this chapter.

The Department is proposing several amendments to N.J.A.C. 11:10-1.5, which addresses DPO agreements with dentists. References throughout the section to "enrollees" have been changed to "covered persons." At N.J.A.C. 11:10-1.5(b), the Department is changing the current requirement that DPOs file with the Commissioner a copy of all provider agreements to require filing only a form of the provider agreement(s). The Department is also deleting the language at subsection (b) that permits a DPO to use a provider agreement or amendment to an agreement 60 days after filing unless the Department determines that the agreement or amendment is

financially insufficient for the DPO's provision of dental services, thereby requiring the Department to notify the DPO of any insufficiency in a provider agreement or amendment. This subsection is also being amended to include minor changes to the submission requirements of provider agreements and amendments.

A new subsection (c) requires each page of a provider agreement or amendment to contain a contract form identifier and the effective date of the form or amendment.

Existing N.J.A.C. 11:10-1.5(c), which contains the items that must be included in a provider agreement, is being recodified as subsection (d) and contains several amendments. These proposed amendments are consistent with the legislative intent of the statutory amendments to subject DPOs to the same level of oversight and review by the Department as other types of health insurers, and with the Department's rules at N.J.A.C. 11:24, 11:24A and 11:24B regarding agreements between providers and other types of health insurers. The agreements must include the capitation schedule; the method for calculating any alternative payment; and a provision addressing a provider's right to receive at least annually a periodic accounting of disbursements from the specialist pool, and/or the alternative payment methodology to the provider, including the method of calculation. This subsection also includes the statutory requirement at N.J.S.A. 45:9-19.17 that dentists maintain malpractice insurance of at least $1,000,000 per occurrence and $3,000,000 in the aggregate per year. Provider agreements are also being required to include not only the date and term of the agreement, but also a provision specifying the right of either party to terminate the agreement by providing at least 90 days written notice. Other new requirements include that agreements contain

a hold harmless provision prohibiting providers from obtaining payment from covered persons for any costs of covered services or supplies, except for allowable copayments, coinsurance or deductibles, as well as provisions addressing payment of claims pursuant to N.J.A.C. 11:22. A new subsection (e) includes the Department's address for submission of written agreements and amendments.

N.J.A.C. 11:10-1.6, Evidence of coverage and group contracts, is being amended to clarify its terms and to require that DPOs issue evidence of coverage forms to enrollees within 60 days of the effective date of coverage or a change in coverage. Several changes are being made to subsection (f), which sets forth the conditions under which a DPO is permitted to use coordination of benefits provisions. A reference to non-duplication of benefits provisions is being deleted because subsection (g) prohibits the use of such provisions. Some terms used in this subsection are being revised to conform to terms used in the revised statute, such as changing "enrollee" to "covered person." At recodified paragraph (f)2, "coordination of benefits" was added to identify the name of the rule cited in that paragraph. Existing paragraphs (f)2 and 4 are being deleted because they are inconsistent with the coordination of benefits rule, N.J.A.C. 11:4-28. Paragraph (f)2 sets forth a condition that the provisions are not operative with respect to dental plans provided by another DPO, and paragraph (f)4 sets forth a condition that the funds recovered as a result of these provisions are credited directly against the charges payable by the group for the plan's services. Existing subsection (i), which requires dentists to cover dental services exclusively on a capitation basis, is being deleted to reflect the statutory change permitting other methods of payment.

Proposed subsection (i) (current subsection (j)) is being revised to replace the word "should" with "shall" because N.J.S.A. 56:12 -2 requires that all evidences of coverage be written in a simple, clear, understandable and easily readable manner. A new subsection (j) provides the Department address for the submission of evidences of coverage and group contracts and amendments.

The Department is amending the DPO financial reporting provisions at N.J.A.C. 11:10-1.7. Subsection (a) is being amended to require DPOs to submit to the Department the DPO Supplement to the Quarterly Report and the DPO Supplement to the Annual Report. This subsection also provides the Department's website addresses that contain instructions for filing these reports. In accordance with N.J.S.A. 17:48D-5, new subsection (g) requires DPOs to maintain an arrangement on an indemnity basis for continuation of coverage if a dental plan is discontinued. A new subsection (h) permits the Commissioner to conduct examinations of DPOs, requires DPOs to make their books and records available for such an examination, and requires DPOs to maintain their financial records for at least seven years. This subsection further permits the Commissioner to employ additional personnel for such examinations, and requires DPOs to bear the reasonable cost of such examinations. Consistent with the statutory amendments, this subsection places a cap on such examination costs of $5,000 for DPOs with less than $2,000,000 in direct written premium in any calendar year.

N.J.A.C. 11:10-1.9, Expense limitation, is being amended to change references to "gross contract and certificate income" and "charges" to "premium" to comply with the terminology used in the statutory amendments. Also, the term "New Jersey premium"

is replacing "gross contract and certificate income" at N.J.A.C. 11:10-1.9(a)1 because the amended statute uses the term "premium." The Department specifies "New Jersey premium" because some DPOs are not domiciled in New Jersey and/or write premiums in other states, which was not the case when the Department originally adopted these rules. The Department is clarifying that it only has the authority to require those DPOs to meet New Jersey's expense limitation requirements for those DPOs' New Jersey premium. In that same paragraph, the Department is inserting the word "calendar" before “year” to clarify the expense limitation requirements to be met. This section already conforms to the statutory amendments' use of a minimum medical loss ratio requirement rather than the maximum administrative expense ratio contained in the original statute. Subsection (e), addressing gross contract and certificate income, is being deleted, and the existing subsection (f) is being recodified as subsection (e).

N.J.A.C. 11:10-1.10 is being amended to require DPOs to respond to complaints from covered persons within 30 days after receipt rather than 15 working days, and to respond to any Department inquiry within that same timeframe. The Department is also deleting subsection (c), which required DPOs to furnish an appropriate reply to communications other than those mentioned in subsections (a) and (b) within 15 working days.

N.J.A.C. 11:10-1.11, Fidelity bonds and malpractice insurance, is being amended to conform to the statutory amendments by permitting DPOs to maintain crime insurance or its equivalent as an alternative to a fidelity bond on each director, officer,

partner or employee who receives, collects, reimburses or invests moneys in connection with the activities of the DPO.

The section heading of N.J.A.C. 11:10-1.12 is being changed to "Schedule of premiums" rather than "Schedule of charges" consistent with the statutory amendments, and references throughout the section have been changed. Subsection (a) is being amended to require that a DPO file a schedule of premiums with the Commissioner at least annually. Consistent with the authority granted to the Commissioner by the Act, language is also being added to this subsection permitting the Commissioner to disapprove a schedule of premiums at any time if the premiums provided thereunder are excessive, inadequate, or unfairly discriminatory. The subsection is being further revised to indicate that the Commissioner may disapprove a schedule of premiums if the filing does not substantially comply with the requirements of N.J.A.C. 11:10-1.12. Existing subsections (b) through (f), addressing schedules of charges, are being deleted and replaced with new subsections (b) through (f) addressing premium filing requirements, including requirements for a supplemental dental plan.

N.J.A.C. 11:10-1.13, addressing renewal of a DPO's certificate of authority, is being deleted consistent with the statutory amendments eliminating the one-year certificate of authority expiration requirement. Existing N.J.A.C. 11:10-1.14 and 1.15 are being recodified as N.J.A.C. 11:10-1.13 and 1.14. Chapter Appendices A, the Certificate of Authority Renewal form, and B, the DPO Certificate of Authority Renewal

Request Form, referenced in N.J.A.C. 11:10-1.13 are accordingly also proposed for repeal.

Subchapter 2 of N.J.A.C. 11:10 implements 1983 amendments to the Act that prohibited employers from requiring employees to use the services of dentists selected by them (closed panel dental plan arrangements), and to permit selection of an alternative form of dental care. The rules contain notification requirements concerning alternative dental care aimed at employers and the health insurers, DPOs and dental service corporations that issue dental plans.

A 60-day comment period is provided for this notice of proposal, and therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The rules proposed for readoption with amendments and repeals will continue to have a favorable impact on consumers. Readoption of the existing rules will ensure that the protections they afford the consuming public will continue. Some of the proposed amendments will provide additional protections to consumers, thereby enhancing the favorable impact. One such amendment requires that provider agreements include a hold harmless provision that would prohibit a provider from billing or otherwise pursuing payment from a covered person for the costs of covered services or supplies other than allowable copayment, coinsurance or deductible amounts. Also, DPOs must maintain an arrangement with an insurer or medical or dental service corporation that would continue coverage of a covered person if a plan is discontinued.

Readoption of the existing rules will also continue to provide certain protections to consumers concerning alternative dental coverage.

The existing rules have established a system of oversight of DPOs that continually monitors their financial arrangements and practices, as well as their provision of dental care services. Readoption of these rules will have a favorable impact on DPOs in that they will serve to ensure that DPOs intending to continue operating maintain the high standards required by these rules, including those addressing eligibility for obtaining a certificate of authority, agreements with dentists, and financial requirements. Some of the proposed amendments will additionally favorably impact DPOs. The amendment eliminating the necessity for DPOs to annually renew their certificates of authority so long as they remain compliant with the requirements of this chapter will favorably impact DPOs.

Some of the proposed amendments will also favorably impact dentists. The amendments eliminating the requirement that dentists be reimbursed on only a capitated basis, and requiring that DPOs obtain Department approval of an alternate payment methodology, will benefit dental providers.

Economic Impact

The rules proposed for readoption with amendments and repeals will continue to impose certain financial and reporting requirements on DPOs, some of which have been in place since these rules were originally promulgated, and others that were subsequently adopted, including financial reporting and surplus requirements. Some of the Department's proposed amendments impose additional or more stringent

requirements on DPOs; however, many of these requirements merely conform the Department's rules with the statutory amendments enacted in 2005 or with other existing statutes. DPOs will need to obtain Department approval of an alternate payment methodology for reimbursing dental providers. The amendments permit the Commissioner to conduct a financial examination of a DPO, and the DPO must bear the reasonable cost of the examination. DPOs with less than $2,000,000 in direct premiums written in this State in any calendar year are subject to a limited scope examination not to exceed $5,000 in cost. DPOs must report to the Department any finder's fees they have paid. The amendments also require DPOs to file at least annually with the Department a schedule of premiums, as well as any new or revised schedule. DPOs must also submit to the Department provider agreements and amendments, evidences of coverage and group contracts and amendments. DPOs are also being required to submit to the Department supplemental quarterly and annual financial reports. The Department does not believe, however, that the cost associated with these requirements will necessarily have an unfavorable impact on DPOs. Rather, the costs are a necessary part of doing business in this State in order that the Department may continue its regulatory oversight of DPOs to further ensure their financial solvency and eliminate any fraud or abuse that may exist.

Dentists entering into agreements with DPOs to provide dental services will continue to experience a favorable economic impact from the readoption of this chapter's existing rules and the proposed amendments, including those addressing

written agreements with dentists and the DPO's financial reporting and surplus requirements.

Federal Standards Statement

A Federal standards analysis is not required because the rules proposed for readoption and the proposed amendments and repeals are not subject to any Federal requirements.

Jobs Impact

The Department does not anticipate that the rules proposed for readoption with amendments and repeals will result in the generation or loss of jobs.

Agriculture Industry Impact

Pursuant to N.J.S.A. 4:1C-10.3, the Right to Farm Act, and N.J.S.A. 52:14B-4(a)(2) of the Administrative Procedure Act, the Department does not expect any impact on the agriculture industry from the rules proposed for readoption with amendments and repeals.

Regulatory Flexibility Analysis

Some of the DPOs presently authorized to operate in New Jersey and that will be affected by the rules proposed for readoption and the proposed amendments and repeals may be small businesses as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules proposed for readoption and the proposed amendments impose certain reporting, recordkeeping and other compliance requirements on DPOs, including submitting applications to obtain a certificate of authority, filing quarterly and supplemental financial reports, filing all written

agreements with dentists, filing all applications for approval of specialist pools, obtaining approval of an alternate payment methodology, filing a schedule of premiums, reporting all finder's fees, filing all evidences of coverage and group contracts, and subjecting DPOs to financial examinations.

The Department does not believe that these rules as originally adopted, or as being proposed for amendment, require DPOs to obtain professional services in order to comply with the rules. Any professional services that a DPO might need to engage in order to comply with this chapter are of such a nature that such services should already be available to the DPOs as a matter of their daily operations. Additionally, some of the proposed amendments will to some extent alleviate the compliance burden imposed by these rules, such as annually renewing certificates of authority, submitting written requests for forms required to obtain a certificate of authority, filing all provider agreements and amendments with the Department, and responding to covered person complaints within 15 days.

The requirements contained in these rules and the proposed amendments are necessary to carry out the purposes of the Act (that is, to protect consumers and prevent fraud and abuse within the marketplace). Nevertheless, pursuant to the statutory amendments, these proposed amendments make an exception for DPOs with less than $2,000,000 direct premium written in this State in any calendar year as far as costs for financial examinations are concerned. The proposed amendments subject those DPOs to a limited scope financial examination, the costs of which are not to exceed $5,000. Other than this one exception, the Department does not believe that

small businesses can be exempt from the requirements of these rules proposed for readoption or the proposed amendments.

Smart Growth Impact

The rules proposed for readoption with amendments and repeals have no impact on the achievement of smart growth and the implementation of the State Development and Redevelopment Plan.

Housing Affordability Impact

The Department does not expect the rules proposed for readoption with amendments and repeals to have any impact on housing affordability because the rules proposed for readoption with amendments and repeals address the supervision of DPOs to ensure the protection of their enrollees.

Smart Growth Development Impact

The Department does not expect the rules proposed for readoption with amendments and repeals to evoke a change in the housing production in Planning Areas 1 and 2 or within the designated centers under the State Development and Redevelopment Plan in New Jersey because the rules proposed for readoption with amendments and repeals address the supervision of DPOs to ensure the protection of their enrollees.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:10.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:10-1.13 and 11:10 Appendices A and B.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. DENTAL PLAN ORGANIZATIONS

11:10-1.1 Purpose

(a) The Dental Plan Organization Act (N.J.S.A. 17:48D-1 et seq.) regulates persons and corporations which offer plans [for the prepayment or postpayment] **for the provision** of dental services **on other than a pure fee-for-service basis**. The Act provides for the licensing and supervision of dental plan organizations to protect [enrollees] **covered persons** of the plan and to assure that the services contracted for are actually delivered.

(b) (No change.)

11:10-1.2 Scope and application

(a) This subchapter applies to dental plan organizations as defined in N.J.S.A. 17:48D-2c and N.J.A.C. 11:10-1.3. Such organizations may offer group and individual dental plans on [a prepaid and postpaid capitation] **other than a pure fee-for-service** basis.

(b) If the dental plan organization utilizes more than one full-time equivalent dentist to serve dental plan [enrollees] **covered persons**, it is subject to the Act and this subchapter.

(c) An individual dentist in solo practice [who capitates his services] is not required to comply with the Act or this subchapter.

(d) – (f) (No change.)

11:10-1.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Alternative payment" means a type of payment to a DPO contracted dentist based upon a payment methodology approved by the Department.

"Capitation" means a method of compensation by a DPO to its [participating primary dentists for services and supplies provided to members of the DPO on the basis of a fixed payment per member, together with such additional types of payments as are specifically approved by the Department as appropriate to recruit new participating dentists, recruit or retain participating dentists in underserved areas and/or eliminate disincentives for participating primary dentists to render quality dental care to members and to its participating specialist dentists for services and supplies provided to members of the DPO on the basis of either a fixed payment per member or a contractual fee schedule from an approved specialist pool. A plan that employs dentists whose salaries are paid by the DPO shall be considered a capitated plan.] **contracted dentists for dental services and supplies provided to covered persons of the DPO on the basis of a fixed periodic payment per covered person or enrollee.**

. . .

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

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

"Dental plan" means any contractual arrangement for dental services and supplies to covered persons where contracted dentists are compensated by means of capitation, salary or a method authorized, submitted to and approved by the Commissioner.

"Dental [Plan Organization] **plan organization**" or "DPO" means [a direct provider of dental services compensated on a prepaid or postpaid capitation basis, which provides such services to either individuals or groups. The provision of such services by the DPO is deemed to be a "non-delegable" duty. An arrangement whereby dental services are provided indirectly through "independent contractors" is not considered a DPO. An arrangement whereby compensation to dentists for dental services is provided exclusively on a fee-for-service basis is not considered a DPO. An arrangement whereby dental services are provided by entering into an agreement with providers, or by employing dentists, where the dentists agree to treat enrollees of the plan in their private offices or a central facility, is considered a DPO.] **any person who undertakes to provide directly or to arrange for or administer one or more dental plans providing dental services and supplies.**

. . .

“Enrollee” means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the dental plan, or in the case of an individual contract, the person in whose name the contract is issued.

"Fee-for-service" is a reimbursement arrangement in which the amount reimbursed for dental services is paid either to an [insured (or subscriber)] **enrollee** or to a provider of services and the amount is determined on the basis of the dental procedure performed and/or the amount charged by the dentist for the procedure. An example of a fee-for-service plan is one covering or indemnifying the services provided by dentists on the basis of a schedule of fees or percentage reimbursement of the fee charged, under which the dentist does not share in the "volume of service" risk assumed by the DPO.

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

“National Association of Insurance Commissioners” or “NAIC” means the National Association of Insurance Commissioners, its affiliates, subsidiaries, any agency or committee thereof, or any successor organization.

"One [Full-Time Equivalent Dentist] **full-time equivalent dentist**" means one dentist working full time or an aggregation of hours spent by more than one dentist on DPO [enrollees] **covered person** so as to equal a 40-hour week. A full-time general practitioner can serve a group of at least 1,500 [enrollees and dependents combined] **covered persons**. This number could vary by specialty and service performed; for example, an orthodontist may serve a smaller number of patients than a general practitioner.

["Postpaid capitation" means an arrangement whereby the primary dentist providing services is compensated by an annual distribution of the excess in a specialist pool in addition to the prepaid capitation.

"Prepaid capitation" means an arrangement whereby the dentist providing services is compensated through capitation on the basis of the presence of an enrollee regardless of whether services are provided.]

. . .

"Specialist pool" means a portion of the premium that is set aside to cover the cost of specialist services not provided by the primary care dentist and not paid on a [prepaid] capitation basis.

"Supplemental [Dental Plan] **dental plan**" means an arrangement in which a dentist or group of dentists agrees to relieve patients of paying any patient charges or copayments associated with dental insurance or other dental coverage for a predetermined fee. Supplemental dental plan also means an arrangement which covers

less than 50 percent of [an enrollee's] **a covered person's** dental expenses regardless of whether the enrollee has other coverage.

11:10-1.4 General rules

(a) **Any person desiring to establish, operate or administer a dental plan organization shall apply to the Commissioner for a certificate of authority.** [To obtain an] **An** application for a certificate of authority as a dental plan organization [, a written request for the appropriate forms must be submitted to the Commissioner.] **is available on the Department's website at www.state.nj.us/dobi/division_insurance/managedcare/dpo_app.pdf or can be obtained from:**

New Jersey Department of Banking and Insurance

Valuation Bureau

Life and Health Division

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

Phone: 609-292-5427

[Applicants shall complete and return the forms with the supporting documents requested by the Department.]

(b) [The notice of] **Following the issuance of a Certificate of Authority, the DPO shall notify the Department in writing 60 days prior to any** significant

modification of information submitted with the application**, or subsequently submitted,** [required by N.J.S.A. 17:48D-4] **and** shall include the document being modified and an explanation of the modification. Examples of modifications which are considered significant include, but are not limited to:

1. - 3. (No change.)

4. Adjustments to financial statements; [and]

5. A change in ownership[.]**; and**

6. Changes to provider agreements.

(c) (No change.)

(d) A DPO shall file for approval with the Department an alternative payment methodology prior to use. The alternative payment methodology shall be deemed approved 30 days after filing unless disapproved in writing by the Commissioner within that timeframe. All alternative payment methodologies shall include the following:

1. A clear explanation of the methodology and numerical examples illustrating how the methodology will operate; and

2. An explanation of the appropriateness of the payment methodology to recruit new dentists, retain contracted dentists in underserved areas and/or eliminate disincentives for contracted dentists to render quality dental care to covered persons of the DPO.

[(d) A] **(e) Three copies of a** request for approval of a specialist pool **or alternative payment methodology** shall be submitted to the Department at the following address:

Chief[, Managed Care Bureau] **Actuary**

Office of Life and Health

New Jersey Department of Banking and Insurance

20 West State Street

PO Box 325

Trenton, NJ 08625-0325

(f) Every DPO shall report to the Commissioner the name and address of, and the amount of any fee paid to, a finder within 30 days of the use or employment of the finder.

(g) A DPO that has not had its certificate of authority suspended or revoked shall automatically renew each year while in compliance with this subchapter.

11:10-1.5 Written agreements with dentists

(a) Every DPO shall enter into a written agreement with each dentist who will be providing dental services for plan [enrollees] **covered persons**, unless the dentist is employed by the DPO.

(b) DPOs shall file with the Commissioner at least 60 days prior to the planned date of use a copy of [all written agreements with dentists] **the form(s) of their**

provider agreement(s) and any amendments thereto. [A written] **The** agreement or amendment [to a written agreement] may be used 60 days after filing unless the [Commissioner has determined that the agreement or amendment is not sufficient financially for the DPO's provision of dental services. The] Department [shall notify] **notifies** the DPO in writing within 60 days of filing of any insufficiency in the agreement or amendment. Submissions of amended forms shall include two copies of the revised or amended form(s) [or page(s) only, if practicable]. One copy shall be marked to show [the changes from the prior] **all additions or deletions to the previously** approved form, and one copy shall be **an** unmarked **final version of the form**.

(c) Agreements and amendments shall include a contract form identifier on each page of the contract and/or amendment. The effective date of the form or amendment shall be part of the contract form identifier.

[(c)] **(d)** Agreements with dentists shall include:

1. The amount and method of compensation and the service**s and supplies** to be provided**, including:**

i. The capitation payment schedule;

ii. The method for calculating alternative payment, if applicable; and

iii. A provision stating the right of each provider to receive a periodic accounting (no less frequently than annually) of disbursements

from the specialist pool, and/or the alternative payment methodology to the provider, including the method of calculation;

2. The minimum number of hours per week which the dentist must make available for the treatment of plan [enrollees] **covered persons** or a statement that an appointment must be granted to [an enrollee] **a covered person** within 10 working days of the date of request;

3. - 4. (No change.)

5. [The requirements for malpractice insurance coverage] **A requirement for the dentist to maintain malpractice insurance coverage in an amount no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year**;

6. [The] **A provision specifying the** date and term of the agreement **, including the right of either party to terminate the agreement by providing written notice at least 90 days prior to the date of termination**;

7. With respect to primary dentists, a provision that a referral from the primary dentist or DPO is required for the provision of non-emergency specialty care by a specialist who is to be paid from the specialist pool; [and]

8. With respect to specialists who are to be paid from the specialist pool, a provision that a referral from a primary dentist or DPO is required to obtain payment for the provision of specialty care except in an emergency[.]**;**

9. A hold harmless provision prohibiting the provider from billing or otherwise pursuing payment from a covered person for the costs of

covered services or supplies, except for allowable copayment, coinsurance or deductible amounts, regardless of whether the provider agrees with the amount paid or to be paid, for the services or supplies rendered; and

10. Provisions concerning payment of claims pursuant to N.J.A.C. 11:22.

[(d)] **(e)** (No change in text.)

(f) The written agreements and amendments shall be sent to:

Chief, Health Insurance Bureau

Office of Life and Health

New Jersey Department of Banking and Insurance

20 West State Street

P.O. Box 325

Trenton, NJ 08625-0325

11:10-1.6 Evidence of coverage and group contracts

(a) The DPO shall prepare and issue the evidence of coverage form to each enrollee **within 60 days of the effective date of coverage or of a change in coverage**. Covered groups may distribute the forms to [its members] **covered persons** on behalf of the DPO.

(b) – (e) (No change.)

(f) Coordination of benefits [and non-duplication of benefits] provisions, which limit payment to 100 percent of allowable expenses when more than one dental plan

covers [an enrollee, are not permitted in an evidence of coverage or group contract issued by a DPO unless] **a covered person, are permitted only if all of** the following conditions are met:

1. [Enrollees] **Covered persons** are covered under a group, not an individual contract;

[2. The provisions are not operative with respect to dental plans provided by another DPO;]

[3.] **2.** The DPO follows the **coordination of benefits** rules set forth at N.J.A.C. 11:4-28; **and**

[4. The funds recovered as a result of these provisions are credited directly against the charges payable by the group for the plan's services; and]

[5.] **3.** (No change in text.)

(g) – (h) (No change.)

[(i) No DPO may cover dental services exclusively on a fee-for-service, expense incurred or indemnity basis. A DPO shall offer primary dental services directly (that is, not on an indemnity, expense incurred or fee-for-service basis), and may do so only on a capitation basis. A DPO may also arrange for the provision of dental services on a fee-for-service, expense incurred or indemnity basis by purchasing coverage or such service from a duly authorized insurer, or a hospital, medical, dental or health service corporation. Specialists may be paid on a contractual fee-for-service basis when such payments are made from a specialist pool approved by the Department.]

[(j)] **(i)** An evidence of coverage issued to a non-group enrollee is subject to the plain language requirements of N.J.S.A. 56:12-1 et seq. All evidences of coverage, including those issued to [enrollees] **covered persons** of a group, [should] **shall** be written in a simple, clear, understandable and easily readable [way] **manner**. In writing an evidence of coverage form to be issued to an enrollee of a group, a DPO may use the guidelines set forth in N.J.S.A. 56:12-10 to assure compliance with this subsection.

(j) Evidences of coverage and group contracts, including amendments, shall be submitted to:

Chief, Health Insurance Bureau

Office of Life and Health

New Jersey Department of Banking and Insurance

P.O. Box 325

20 West State Street

Trenton, NJ 08625-0325

11:10-1.7 Financial reporting

(a) Every DPO shall submit a quarterly report **and the DPO Supplement to the Quarterly Report** [of its activities] for each of the first three calendar quarters ending March, June and September within 45 days of the end of each quarter [on a form prescribed by the Commissioner to the addresses set forth in (e) below]. **Every DPO shall also submit the DPO Supplement to the Annual Report.**

Instructions for the filing of quarterly reports and copies of the DPO Supplements to the Quarterly and Annual Report forms are available on the Department's website at www.state.nj.us/dobi/division_insurance/managedcare/dpoqtrsup.pdf and www.state.nj.us/dobi/division_insurance/managedcare/dpoannsup.pdf.

(b) – (f) (No change.)

(g) In the event of discontinuance of the plan, every DPO shall maintain an arrangement with an insurer or medical or dental service corporation for continuation of coverage on an indemnity basis through a group policy to the end of the period for which premiums were paid to the discontinued dental plan organization.

(h) The Commissioner may, upon reasonable notice, conduct an examination of a DPO as often as he or she deems necessary. A DPO shall make its books and records available for examination by the Commissioner, and maintain its records for at least seven years.

1. The Commissioner may employ such persons to conduct or assist in conducting the examination as he or she may deem advisable.

2. The DPO shall bear the reasonable cost of the examination. A DPO having direct premiums written in this State of less than $2,000,000 in any calendar year shall be subject to a limited scope examination, and expenses for such examination shall not exceed $5,000.

11:10-1.9 Expense limitation

(a) To achieve compliance with the expense limits set forth in N.J.S.A. 17:48D-14, every DPO shall:

1. Use at least 70 percent of its [gross contract and certificate income] **New Jersey premium** in the first **calendar** year of operation, 75 percent in the second **calendar** year, and 80 percent in all subsequent **calendar** years for the direct provision of professional dental services to [enrollees] **covered persons**;

2. Set its per [enrollee] **covered person** retention in conformity with the statutory limits in constructing its schedule of [charges] **premiums**.

(b) Expenditures for the direct provision of professional dental services are, in general, that portion of the DPO's total expenses which would exist if the DPO were simply a dental practice and if [enrollees] **covered persons** were the patients of that practice. Monies paid to dentists for their time, for the cost of their assistants, hygienists, and other support personnel, for their laboratory costs, malpractice insurance, and for all other necessary costs of offices and equipment which are not required for the non-dental care delivery activities of a DPO are examples of such dental expenditures.

(c) (No change.)

(d) [Gross contract and certificate income] **Premium** not needed for the direct provision of dental care shall be considered as retention and will be subject to the limitations of N.J.S.A. 17:48D-14. Two examples of items of retention are profits and marketing costs.

[(e) Copayment income shall not be considered gross contract and certificate income in determining compliance with the expense limitations unless the DPO providers are employees or associates of the DPO. The costs of providing the dental services to which the copayments apply shall be included with other dental service costs. For the purpose of this subsection, copayment income means the fees that a DPO collects for the portion of the dental services which is not covered under the dental plan contract.]

[(f)] **(e)** (No change in text.)

11:10-1.10 Complaints and other communications

(a) Complaint systems required of every DPO (see N.J.S.A. 17:48D-12) shall provide that a written response shall be furnished to the [enrollee] **covered person** within [15 working] **30** days after its receipt of a written complaint. The DPO's response shall, based on the information available to it at the time of response, be complete and accurate.

(b) Every DPO shall, based on the information available to it, provide the Department with a complete and accurate written response to any inquiry from the Department within [15 working] **30** days after its receipt of such inquiry.

[(c) Every DPO shall furnish an appropriate reply to all other communications which reasonably suggest that a response is expected within 15 working days of receipt.]

[(d)] **(c)** (No change in text.)

11:10-1.11 Fidelity bonds**, crime** and malpractice insurance

(a) The minimum amount of the fidelity bond**, or crime insurance or its equivalent,** on each director, officer, partner or employee of the DPO [required by N.J.S.A. 17:48D-8] **who receives, collects, reimburses or invests moneys in connection with the activities of the organization** shall be $50,000.

1. Every DPO shall increase the bond amount**, or its equivalent,** as appropriate whenever its risk of loss for individual employee theft is greater than $50,000.

2. The fidelity bond **or insurance policy** shall name the DPO and the State of New Jersey as dual obligees **or the State of New Jersey as an additional insured, as appropriate**.

(b) All dentists serving [enrollees] **covered persons** of a DPO shall be insured against professional liability or for malpractice in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

(c) The fidelity bond **or alternate insurance coverage** and the malpractice policy shall be obtained only from insurers which are authorized to conduct business in New Jersey.

11:10-1.12 Schedule of [charges] **premiums**

(a) **A DPO shall file a schedule of premiums at least annually.** Every new or revised schedule of [charges must] **premiums shall** be filed with the Commissioner at least 60 days prior to [its effective date] **the effective date of coverage using**

that schedule of premiums. **The Commissioner may disapprove a schedule of premiums at any time if the premiums provided thereunder are excessive, inadequate, or unfairly discriminatory, or if the filing does not substantially comply with the requirements of this section**. A DPO shall not use a schedule of [charges] **premiums** which has **not** been **filed, or which has been** disapproved by the Commissioner.

[(b) All filings of charges must include sufficient information to enable the Commissioner to determine whether the charges are not excessive, inadequate or unfairly discriminatory. All details, used in the development of rates, must accompany the filing, including:

1. Actuarial principles;

2. Assumptions and methods of calculation; and

3. Method of development of the dental portion of the charges.

i. Development shall be based upon actual utilization of the DPO, or on comparable experience if the DPO does not yet have adequate utilization. Included in this development shall be projections based on trends observed within the DPO, the profession of dentistry or the overall economy.

(c) Every filing of a schedule of charges shall include projections of the following information:

1. The schedule of charges to be used by the DPO during the period that the charges are to be effective;

2. The portion of the charge to be used for the direct provision of professional dental services to enrollees (N.J.A.C. 11:10-1.9(b) and (c)), including the contribution to the specialist pool where applicable;

3. The portion of the charges to be used for retention (N.J.A.C. 11:10-1.9(d)), except for the items of retention referred to in (c)4 below; and

4. Anticipated profits and losses, surplus additions and reductions, each of which shall be itemized separately.

(d) Every filing of a revised schedule of charges shall include the information required by (a) through (c) above, the percentage increase or decrease requested and the prior experience under the old rates itemized as described in (c) above.

(e) A schedule of charges, in addition to meeting any other requirements imposed by statute or regulation, must meet the following criteria:

1. The ratio of retention to the charge falls within the limitations set forth by N.J.S.A. 17:48D-14; and,

2. The portion of charges intended for professional dental services meets the standards prescribed by N.J.A.C. 11:10-1.9(a)1.

(f) A schedule of charges for a supplemental dental plan is also subject to (a) through (e) above. In determining whether such charges comply with (a) through (e) above, the Department shall consider whether the charges for a supplemental dental plan are proportionately equivalent to the charges for a dental plan providing greater benefits. For example, charges for a supplemental dental plan covering 20 percent of

dental expenses must be no more than one-fifth of the charges for a plan covering 100 percent of these dental expenses.]

(b) Every filing shall include all information to determine premiums, including the following:

1. A plan schedule and rate manual containing the following:

i. The rating period for which the filing is effective;

ii. A description of the plan of benefits, including deductibles, copays, and limits for each type of covered service;

iii. The basic premium or rate for each plan of benefits;

iv. The coverage period, if any, for which guaranteed premiums are guaranteed;

v. The numerical value of any classification factors used in the determination of premiums for a group, including age, gender, location, industry, prior coverage, and group size;

vi. A description of the rating methodology which will allow the determination of the premium for any group from group-specific information and the information in (b)1i, ii and iv above;

vii. A detailed example calculation of the premium for a sample group, giving all necessary group-specific information and using the methodology described in (b)1v above;

viii. An example that includes a sample of the rate proposal format using the sample premiums; and

ix. For a revision filing, the date and effective period of the filing that is being revised;

2. An actuarial memorandum containing the methods and assumptions used in determining the premiums, including:

i. Recent claim cost experience and the source of that experience. This shall include the actual experience of the DPO, unless such experience is inadequate for rate determination;

ii. Trend assumptions for claim costs and the source of the trend assumptions;

iii. The portion of the premium to be used for the direct provision of professional dental services to enrollees, including capitation and other compensation (N.J.A.C 11:10-1.9(b) and (d));

iv. The portion of the premium used for retention (N.J.A.C. 11:10-1.9(d)) exclusive of profit and surplus charges (see (b)2v below);

v. The portion of the premium used for profits, contingencies, or contributions to surplus; and

vi. For a filing of revised premiums, the percentage increase in rates from the previous filing; and

3. An actuarial certification that the premiums are intended to meet the requirements of N.J.S.A. 17:48D-14 and N.J.A.C. 11:10-1.9(a)1.

(c) A single case rate filing shall contain, in place of the rate manual and plan schedule, a statement of the rates and a comparison of those rates

to the rates that would be attained by the rate methodology described in (b)1v above. The actuarial memorandum shall discuss the basis for the rates in the single case filing, including competitive considerations or producer concessions. The actuarial certification shall state that the premiums are not discriminatory in violation of N.J.S.A. 17B:30-12d.9 and that the premiums do not include an illegal rebate or inducement in violation of N.J.S.A. 17B:30-13.

(d) All actuarial memoranda and actuarial certifications shall be deemed to contain proprietary and confidential information.

(e) A schedule of premiums for a supplemental dental plan is also subject to (a) through (d) above. In determining whether such premiums comply with (a) through (d) above, the Department shall consider whether the premiums for a supplemental dental plan are proportionately equivalent to the premiums for a dental plan providing greater benefits. For example, the premium for a supplemental dental plan covering 20 percent of dental expenses must be no more than one-fifth of the premium for a plan covering 100 percent of these dental expenses.

(f) Rate filings shall be submitted to:

DPO Rate Filings, Life & Health Actuarial

New Jersey Dept. of Banking and Insurance

PO Box 325

20 West State Street

Trenton NJ 08625

Recodify existing N.J.A.C. 11:10-1.14 and 1.15 as **1.13 and 1.14** (No change in text.)