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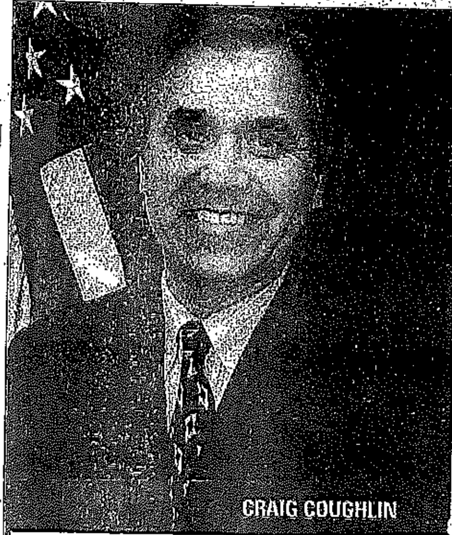
NJ Mulls Arbitration for Disputes Over Out-of-Network Costs

By Michael Booth

New Jersey lawmakers are considering legislation that would establish an arbitration framework to settle disputes between health-care providers and insurance companies when an insured uses an out-of-network provider, either by necessity or by chance.

The two-bill package, recommended for passage Nov. 23 by the Assembly Financial Institutions and Insurance Committee, is designed to prevent patients from being hit with surprise additional costs if they use an out-of-network provider.



CRAIG COUGHLIN

Health-care providers and hospitals are lobbying against the legislative package, arguing that it is far too favorable to insurance carriers and that it would be too difficult for providers to set fair rates for reimbursement.

"This is a significant day for New Jersey health-care consumers," said the committee chairman, Assemblyman Craig Coughlin, D-Middlesex, adding that the legislative package is a "fair and balanced compromise."

"Consumers would be shielded from payment disputes between carriers and providers," said Coughlin, who is a solo practitioner in Fords and is also the chief sponsor of the key bill in the package, A4444, which is called the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act.

The legislation also would impose disclosure requirements on providers and carriers, and would allow for payment disputes to be subject to peer review by panels of experts in a particular field before the disputes go to arbitration.

Lawmakers also are proposing the creation of a "Healthcare Price Index," in which the state Department of Banking and Insurance, in coordination with carriers and providers, would set a price rate out-of-network providers could charge.

That provision was removed from A4444 at the request of health-care providers and was drafted into a second bill, A952, the Health Care Consumer Cost Transparency Act, sponsored by Assemblyman Troy Singleton, D-Burlington.

The chief opponents remain the Medical Society of New Jersey and the New Jersey Hospital Association.

Mishael Azam, the Medical Society's senior manager for legislative affairs, said the arbitration process would be weighted too heavily in the carriers' favor.

Plus, the peer review process would add even more costs to providers, who in many cases would be having to share the costs of both arbitration and peer review in cases in which they may be seeking a relatively small amount of money, he said. And carriers would be allowed to pay less to providers if they are able to threaten providers with mandatory arbitration, Azam argued.

Coughlin disagreed, saying arbitration is the preferred method of settling disputes. And, he said, peer review should be considered to be a process akin to a pretrial conference, where the results could lead to disputes being settled before they're heard by arbitration panels.

Health-care litigator Eric Katz also testified on behalf of the Medical Society.

Katz, of Mazie Slater Katz & Freeman in Roseland, urged the committee to hold off on any attempt to establish a price index or price database.

The U.S. Supreme Court is set to hear arguments Dec. 2 in *Gobeille v. Liberty Mutual Insurance Co.* The state of Vermont enacted a law requiring insurers to report claims data, but the U.S. Court of Appeals for the Second Circuit ruled that the legislation, similar to legislation passed in 11 other states, is preempted by the federal Employee Retirement Income Security Act.

The high court agreed to hear Vermont's appeal.

Katz said lawmakers should wait until the court rules before it enacts similar legislation or sets a price index.

"Take a step back," he said, adding that a decision from the court is expected by next spring.

Katz also argued against mandatory arbitration.

Arbitration is not a fair process, he said.

"It's not quick, and it's not cheap," Katz said.

Providers will not appear before arbitrators as frequently as carriers, and those arbitrators will become much more familiar with those carriers than providers, he said.

"Arbitrators remember who is buttering their bread," Katz said.

The bill would require a health-care provider to furnish a patient with a detailed breakdown of the expected costs at least 30 days prior to the procedure, as well as any related costs. The bill also would require carriers to post updated lists of providers for individual health plans every 20 days.

In addition, the bill would bar providers from waiving deductibles, copayments or coinsurance, or from offering reimbursements to patients. Providers also would be required to provide written notices listing what insurance plans they accept.

The legislation must still be acted on by the full Assembly and Senate, where a similar bill, S20, sponsored by Sen. Joseph Vitale, D-Middesex, is pending action. The bill would also have to be signed into law by Gov. Chris Christie.

The legislation has the backing of the insurance industry and consumer advocacy groups, who argue that controlling out-of-network costs could help reduce premiums. ■

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