

VETO MESSAGE: No

GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

Murphy, Colleen. "Arbitration Amended for Law Governing Out-of-Network Medical Costs", New Jersey Law Journal. August 8, 2022

end

P.L. 2022, CHAPTER 74, *approved July 29, 2022*
Senate, No. 1177 (*Second Reprint*)

1 AN ACT revising the out-of-network arbitration process and
2 amending P.L.2018, c.32.

3

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

6

7 1. Section 9 of P.L.2018, c.32 (C.26:2SS-9) is amended to read
8 as follows:

9 9. Notwithstanding any law, rule, or regulation to the contrary:

10 a. With respect to a carrier, if a covered person receives
11 inadvertent out-of-network services, or services at an in-network or
12 out-of-network health care facility on an emergency or urgent basis,
13 the carrier shall ensure that the covered person incurs no greater
14 out-of-pocket costs than the covered person would have incurred
15 with an in-network health care provider for covered services.
16 Pursuant to sections 7 and 8 of this act, the out-of-network provider
17 shall not bill the covered person, except for applicable deductible,
18 copayment, or coinsurance amounts that would apply if the covered
19 person utilized an in-network health care provider for the covered
20 services. In the case of services provided to a member of a self-
21 funded plan that does not elect to be subject to the provisions of this
22 section, the provider shall be permitted to bill the covered person in
23 excess of the applicable deductible, copayment, or coinsurance
24 amounts.

25 b. (1) With respect to inadvertent out-of-network services, or
26 services at an in-network or out-of-network health care facility on
27 an emergency or urgent basis, benefits provided by a carrier that the
28 covered person receives for health care services shall be assigned to
29 the out-of-network health care provider, which shall require no
30 action on the part of the covered person. Once the benefit is
31 assigned as provided in this subsection:

32 (a) any reimbursement paid by the carrier shall be paid directly
33 to the out-of-network provider; and

34 (b) the carrier shall provide the out-of-network provider with a
35 written remittance of payment that specifies the proposed
36 reimbursement and the applicable deductible, copayment, or
37 coinsurance amounts owed by the covered person.

38 (2) An entity providing or administering a self-funded health
39 benefits plan that elects to participate in this section pursuant to
40 subsection d. of this section, shall comply with the provisions of
41 paragraph (1) of this subsection.

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:

¹Senate SCM committee amendments adopted May 16, 2022.

²Assembly AFI committee amendments adopted June 2, 2022.

1 c. If inadvertent out-of-network services or services provided
2 at an in-network or out-of-network health care facility on an
3 emergency or urgent basis are performed in accordance with
4 subsection a. of this section, the out-of-network provider may bill
5 the carrier for the services rendered. The carrier may pay the billed
6 amount or the carrier shall determine within 20 days from the date
7 of the receipt of the claim for the services whether the carrier
8 considers the claim to be excessive, and if so, the carrier shall
9 notify the provider of this determination within 20 days of the
10 receipt of the claim. If the carrier provides this notification, the
11 carrier and the provider shall have ~~30~~ 60 days from the date of
12 this notification to negotiate a settlement. The carrier may attempt
13 to negotiate a final reimbursement amount with the out-of-network
14 health care provider which differs from the amount paid by the
15 carrier pursuant to this subsection. If there is no settlement reached
16 after the ~~30~~ 60 days, the carrier shall pay the provider their final
17 offer for the services. If the carrier and provider cannot agree on the
18 final offer as a reimbursement rate for these services, the carrier,
19 provider, or covered person, as applicable, may initiate binding
20 arbitration within ~~30~~ ²~~90~~ 60² days of the final offer, pursuant
21 to section 10 or 11 of this act. In addition, in the event that
22 arbitration is initiated pursuant to section 10 of this act, the payment
23 shall be subject to the binding arbitration provisions of paragraphs
24 (4) and (5) of subsection b. of section 10 of this act.

25 d. With respect to an entity providing or administering a self-
26 funded health benefits plan and its plan members, this section shall
27 only apply if the plan elects to be subject to the provisions of this
28 section. To elect to be subject to the provisions of this section, the
29 self-funded plan shall provide notice, on an annual basis, to the
30 department, on a form and in a manner prescribed by the
31 department, attesting to the plan's participation and agreeing to be
32 bound by the provisions of this section. The self-funded plan shall
33 amend the employee benefit plan, coverage policies, contracts and
34 any other plan documents to reflect that the benefits of this section
35 shall apply to the plan's members.

36 (cf: P.L.2018, c.32, s.9)

37

38 2. Section 10 of P.L.2018, c.32 (C.26:2SS-10) is amended to
39 read as follows:

40 10. a. If attempts to negotiate reimbursement for services
41 provided by an out-of-network health care provider, pursuant to
42 subsection c. of section 9 of this act, do not result in a resolution of
43 the payment dispute, and the difference between the carrier's and
44 the provider's final offers is not less than \$1,000, ²for a billed
45 amount of \$2,500 or more and not less than \$500 for a billed
46 amount of less than \$2,500,]² the carrier or out-of-network health

1 care provider may initiate binding arbitration to determine payment
2 for the services.

3 b. The binding arbitration shall adhere to the following
4 requirements:

5 (1) The party requesting arbitration shall notify the other party
6 that arbitration has been initiated and state its final offer before
7 arbitration, which in the case of the carrier shall be the amount paid
8 pursuant to subsection c. of section 9 of this act. In response to this
9 notice, the out-of-network provider shall inform the carrier of its
10 final offer before the arbitration occurs;

11 (2) Arbitration shall be initiated by filing a request with the
12 department;

13 (3) The department shall contract, through the request for
14 proposal process, every three years, with one or more entities that
15 have experience in health care pricing arbitration. ²~~【The arbitrators~~
16 ~~shall be 【American Arbitration Association certified arbitrators】~~
17 ¹~~【certified by the department】~~ American Arbitration Association
18 certified arbitrators¹】². The department may initially utilize the
19 entity engaged under the "Health Claims Authorization, Processing,
20 and Payment Act," P.L.2005, c.352 (C.17B:30-48 et seq.), for
21 arbitration under this act; however, after a period of one year from
22 the effective date of this act, the selection of the arbitration entity
23 shall be through the Request for Proposal process. Claims that are
24 subject to arbitration pursuant to the provisions of this act, which
25 previously would be subject to arbitration pursuant to the "Health
26 Claims Authorization, Processing, and Payment Act," shall instead
27 be subject to this act;

28 (4) The arbitration shall consist of a review of the written
29 submissions by both parties, which shall include the final offer for
30 the payment by the carrier for the out-of-network health care
31 provider's fee made pursuant to subsection c. of section 9 of this act
32 and the final offer by the out-of-network provider for the fee the
33 provider will accept as payment from the carrier; and

34 (5) The arbitrator's decision shall be one of the two amounts
35 submitted by the parties as their final offers and shall be binding on
36 both parties. The decision of the arbitrator shall include detailed
37 written findings and shall be issued within 30 days after the request
38 is filed with the department. The detailed written findings shall be
39 an analysis of the decision including, but not ²【be】² limited to,
40 information concerning any databases, previous awards, or other
41 documentation or arguments that contributed to the arbitrator's
42 decision. The arbitrator's expenses and fees shall be split equally
43 among the parties except in situations in which the arbitrator
44 determines that the payment made by the carrier was not made in
45 good faith, in which case the carrier shall be responsible for all of
46 the arbitrator's expenses and fees. Each party shall be responsible
47 for its own costs and fees, including legal fees if any.

1 c. (1) The amount awarded by the arbitrator that is in excess of
2 any payment already made pursuant to subsection c. of section 9 of
3 this act shall be paid within 20 days of the arbitrator's decision as
4 provided in subsection b. of this section.

5 (2) The interest charges for overdue payments, pursuant to
6 P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the
7 pendency of a decision under subsection b. of this section and any
8 interest required to be paid a provider pursuant to P.L.1999, c.154
9 (C.17B:30-23 et al.) shall not accrue until after 20 days following
10 an arbitrator's decision as provided in subsection b. of this section,
11 but in no circumstances longer than 150 days from the date that the
12 out-of-network provider billed the carrier for services rendered,
13 unless both parties agree to a longer period of time.

14 d. This section shall apply only if the covered person complies
15 with any applicable preauthorization or review requirements of the
16 health benefits plan regarding the determination of medical
17 necessity to access in-network inpatient or outpatient benefits.

18 e. This section shall not apply to a covered person who
19 knowingly, voluntarily, and specifically selected an out-of-network
20 provider for health care services.

21 f. In the event an entity providing or administering a self-
22 funded health benefits plan elects to be subject to the provisions of
23 section 9 of this act, as provided in subsection d. of that section, the
24 provisions of this section shall apply to a self-funded plan in the
25 same manner as the provisions of this section apply to a carrier. If a
26 self-funded plan does not elect to be subject to the provision of
27 section 9 of this act, a member of that plan may initiate binding
28 arbitration as provided in section 11 of this act.

29 (cf: P.L.2018, c.32, s.10.)
30

31 3. This act shall take effect ²**[immediately]** on the 90th day
32 next following the date of enactment, except that the Commissioner
33 of Banking and Insurance may take such anticipatory administrative
34 action in advance thereof as shall be necessary for the
35 implementation of this act.²
36
37
38
39

40 Revises out-of-network arbitration process.

SENATE, No. 1177

STATE OF NEW JERSEY
220th LEGISLATURE

INTRODUCED JANUARY 31, 2022

Sponsored by:

Senator JOSEPH A. LAGANA

District 38 (Bergen and Passaic)

Senator VIN GOPAL

District 11 (Monmouth)

SYNOPSIS

Revises out-of-network arbitration process.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 2/10/2022)

1 AN ACT revising the out-of-network arbitration process and
2 amending P.L.2018, c.32.

3

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

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7 1. Section 9 of P.L.2018, c.32 (C.26:2SS-9) is amended to read
8 as follows:

9 9. Notwithstanding any law, rule, or regulation to the contrary:

10 a. With respect to a carrier, if a covered person receives
11 inadvertent out-of-network services, or services at an in-network or
12 out-of-network health care facility on an emergency or urgent basis,
13 the carrier shall ensure that the covered person incurs no greater
14 out-of-pocket costs than the covered person would have incurred
15 with an in-network health care provider for covered services.
16 Pursuant to sections 7 and 8 of this act, the out-of-network provider
17 shall not bill the covered person, except for applicable deductible,
18 copayment, or coinsurance amounts that would apply if the covered
19 person utilized an in-network health care provider for the covered
20 services. In the case of services provided to a member of a self-
21 funded plan that does not elect to be subject to the provisions of this
22 section, the provider shall be permitted to bill the covered person in
23 excess of the applicable deductible, copayment, or coinsurance
24 amounts.

25 b. (1) With respect to inadvertent out-of-network services, or
26 services at an in-network or out-of-network health care facility on
27 an emergency or urgent basis, benefits provided by a carrier that the
28 covered person receives for health care services shall be assigned to
29 the out-of-network health care provider, which shall require no
30 action on the part of the covered person. Once the benefit is
31 assigned as provided in this subsection:

32 (a) any reimbursement paid by the carrier shall be paid directly
33 to the out-of-network provider; and

34 (b) the carrier shall provide the out-of-network provider with a
35 written remittance of payment that specifies the proposed
36 reimbursement and the applicable deductible, copayment, or
37 coinsurance amounts owed by the covered person.

38 (2) An entity providing or administering a self-funded health
39 benefits plan that elects to participate in this section pursuant to
40 subsection d. of this section, shall comply with the provisions of
41 paragraph (1) of this subsection.

42 c. If inadvertent out-of-network services or services provided
43 at an in-network or out-of-network health care facility on an
44 emergency or urgent basis are performed in accordance with
45 subsection a. of this section, the out-of-network provider may bill

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Matter underlined thus is new matter.

1 the carrier for the services rendered. The carrier may pay the billed
2 amount or the carrier shall determine within 20 days from the date
3 of the receipt of the claim for the services whether the carrier
4 considers the claim to be excessive, and if so, the carrier shall
5 notify the provider of this determination within 20 days of the
6 receipt of the claim. If the carrier provides this notification, the
7 carrier and the provider shall have ~~【30】~~ 60 days from the date of
8 this notification to negotiate a settlement. The carrier may attempt
9 to negotiate a final reimbursement amount with the out-of-network
10 health care provider which differs from the amount paid by the
11 carrier pursuant to this subsection. If there is no settlement reached
12 after the ~~【30】~~ 60 days, the carrier shall pay the provider their final
13 offer for the services. If the carrier and provider cannot agree on the
14 final offer as a reimbursement rate for these services, the carrier,
15 provider, or covered person, as applicable, may initiate binding
16 arbitration within ~~【30】~~ 90 days of the final offer, pursuant to
17 section 10 or 11 of this act. In addition, in the event that arbitration
18 is initiated pursuant to section 10 of this act, the payment shall be
19 subject to the binding arbitration provisions of paragraphs (4) and
20 (5) of subsection b. of section 10 of this act.

21 d. With respect to an entity providing or administering a self-
22 funded health benefits plan and its plan members, this section shall
23 only apply if the plan elects to be subject to the provisions of this
24 section. To elect to be subject to the provisions of this section, the
25 self-funded plan shall provide notice, on an annual basis, to the
26 department, on a form and in a manner prescribed by the
27 department, attesting to the plan's participation and agreeing to be
28 bound by the provisions of this section. The self-funded plan shall
29 amend the employee benefit plan, coverage policies, contracts and
30 any other plan documents to reflect that the benefits of this section
31 shall apply to the plan's members.

32 (cf: P.L.2018, c.32, s.9)

33

34 2. Section 10 of P.L.2018, c.32 (C.26:2SS-10) is amended to
35 read as follows:

36 10. a. If attempts to negotiate reimbursement for services
37 provided by an out-of-network health care provider, pursuant to
38 subsection c. of section 9 of this act, do not result in a resolution of
39 the payment dispute, and the difference between the carrier's and
40 the provider's final offers is not less than \$1,000, for a billed amount
41 of \$2,500 or more and not less than \$500 for a billed amount of less
42 than \$2,500, the carrier or out-of-network health care provider may
43 initiate binding arbitration to determine payment for the services.

44 b. The binding arbitration shall adhere to the following
45 requirements:

46 (1) The party requesting arbitration shall notify the other party
47 that arbitration has been initiated and state its final offer before
48 arbitration, which in the case of the carrier shall be the amount paid

1 pursuant to subsection c. of section 9 of this act. In response to this
2 notice, the out-of-network provider shall inform the carrier of its
3 final offer before the arbitration occurs;

4 (2) Arbitration shall be initiated by filing a request with the
5 department;

6 (3) The department shall contract, through the request for
7 proposal process, every three years, with one or more entities that
8 have experience in health care pricing arbitration. The arbitrators
9 shall be **【American Arbitration Association certified arbitrators】**
10 certified by the department. The department may initially utilize
11 the entity engaged under the "Health Claims Authorization,
12 Processing, and Payment Act," P.L.2005, c.352 (C.17B:30-48 et
13 seq.), for arbitration under this act; however, after a period of one
14 year from the effective date of this act, the selection of the
15 arbitration entity shall be through the Request for Proposal process.
16 Claims that are subject to arbitration pursuant to the provisions of
17 this act, which previously would be subject to arbitration pursuant
18 to the "Health Claims Authorization, Processing, and Payment Act,"
19 shall instead be subject to this act;

20 (4) The arbitration shall consist of a review of the written
21 submissions by both parties, which shall include the final offer for
22 the payment by the carrier for the out-of-network health care
23 provider's fee made pursuant to subsection c. of section 9 of this act
24 and the final offer by the out-of-network provider for the fee the
25 provider will accept as payment from the carrier; and

26 (5) The arbitrator's decision shall be one of the two amounts
27 submitted by the parties as their final offers and shall be binding on
28 both parties. The decision of the arbitrator shall include detailed
29 written findings and shall be issued within 30 days after the request
30 is filed with the department. The detailed written findings shall be an
31 analysis of the decision including, but not be limited to, information
32 concerning any databases, previous awards, or other documentation or
33 arguments that contributed to the arbitrator's decision. The
34 arbitrator's expenses and fees shall be split equally among the
35 parties except in situations in which the arbitrator determines that
36 the payment made by the carrier was not made in good faith, in
37 which case the carrier shall be responsible for all of the arbitrator's
38 expenses and fees. Each party shall be responsible for its own costs
39 and fees, including legal fees if any.

40 c. (1) The amount awarded by the arbitrator that is in excess of
41 any payment already made pursuant to subsection c. of section 9 of
42 this act shall be paid within 20 days of the arbitrator's decision as
43 provided in subsection b. of this section.

44 (2) The interest charges for overdue payments, pursuant to
45 P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the
46 pendency of a decision under subsection b. of this section and any
47 interest required to be paid a provider pursuant to P.L.1999, c.154
48 (C.17B:30-23 et al.) shall not accrue until after 20 days following

1 an arbitrator's decision as provided in subsection b. of this section,
2 but in no circumstances longer than 150 days from the date that the
3 out-of-network provider billed the carrier for services rendered,
4 unless both parties agree to a longer period of time.

5 d. This section shall apply only if the covered person complies
6 with any applicable preauthorization or review requirements of the
7 health benefits plan regarding the determination of medical
8 necessity to access in-network inpatient or outpatient benefits.

9 e. This section shall not apply to a covered person who
10 knowingly, voluntarily, and specifically selected an out-of-network
11 provider for health care services.

12 f. In the event an entity providing or administering a self-
13 funded health benefits plan elects to be subject to the provisions of
14 section 9 of this act, as provided in subsection d. of that section, the
15 provisions of this section shall apply to a self-funded plan in the
16 same manner as the provisions of this section apply to a carrier. If a
17 self-funded plan does not elect to be subject to the provision of
18 section 9 of this act, a member of that plan may initiate binding
19 arbitration as provided in section 11 of this act.

20 (cf: P.L.2018, c.32, s.10.)

21

22 3. This act shall take effect immediately.

23

24

25

STATEMENT

26

27 This bill amends the “Out-of-network Consumer Protection,
28 Transparency, Cost Containment and Accountability Act” to revise
29 certain aspects of the arbitration processes established in that act for
30 claims involving health insurance carriers subject to the provisions
31 of the act.

32 The bill extends the amount of time that the insurance carrier and
33 healthcare provider have to negotiate a settlement in the event of an
34 inadvertent use of out-of-network services from 30 to 60 days, and
35 extends the deadline for the carrier, provider, or covered person to
36 initiate binding arbitration in the event of a failure to reach a
37 settlement from within 30 days of the final offer to within 90 days
38 of the final offer. The bill provides that, in order for binding
39 arbitration to be initiated, the difference between a carrier’s and
40 provider’s final offers be \$1,000 or higher for a billed amount of
41 \$2,500 or more or \$500 or higher for a billed amount of less than
42 \$2,500.

43 The bill changes the certification requirement for arbitrators
44 from a certification from the American Arbitration Association to a
45 certification from the Department of Banking and Insurance.

46 Finally, the bill requires an arbitrator to include detailed written
47 findings with each decision. The detailed written findings are to be
48 an analysis of the decision including, but not be limited to,

- 1 information concerning any databases, previous awards, or other
- 2 documentation or arguments that contributed to the arbitrator's
- 3 decision.

SENATE COMMERCE COMMITTEE

STATEMENT TO

SENATE, No. 1177

with committee amendments

STATE OF NEW JERSEY

DATED: MAY 16, 2022

The Senate Commerce Committee reports favorably Senate Bill No. 1177, with committee amendments.

As amended, this bill amends the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” to revise certain aspects of the arbitration processes established in that act for claims involving health insurance carriers subject to the provisions of the act.

The bill extends the amount of time that the insurance carrier and healthcare provider have to negotiate a settlement in the event of an inadvertent use of out-of-network services from 30 to 60 days, and extends the deadline for the carrier, provider, or covered person to initiate binding arbitration in the event of a failure to reach a settlement from within 30 days of the final offer to within 90 days of the final offer. The bill provides that, in order for binding arbitration to be initiated, the difference between a carrier’s and provider’s final offers be \$1,000 or higher for a billed amount of \$2,500 or more or \$500 or higher for a billed amount of less than \$2,500.

Finally, the bill requires an arbitrator to include detailed written findings with each decision. The detailed written findings are to be an analysis of the decision including, but not be limited to, information concerning any databases, previous awards, or other documentation or arguments that contributed to the arbitrator’s decision.

COMMITTEE AMENDMENTS

The committee amended the bill to remove a provision requiring arbitrators to be certified by the Department of Banking and Insurance; thereby preserving the requirement under current law that arbitrators be certified by the American Arbitration Association.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE
COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 1177

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 2, 2022

The Assembly Financial Institutions and Insurance Committee reports favorably Senate Bill No. 1177 (1R) with committee amendments.

As amended, this bill amends the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” to revise certain aspects of the arbitration processes established in that act for claims involving health insurance carriers subject to the provisions of the act.

The bill extends the amount of time that the insurance carrier and healthcare provider have to negotiate a settlement in the event of an inadvertent use of out-of-network services from 30 to 60 days, and extends the deadline for the carrier, provider, or covered person to initiate binding arbitration in the event of a failure to reach a settlement from within 30 days of the final offer to within 60 days of the final offer.

Finally, the bill requires an arbitrator to include detailed written findings with each decision. The detailed written findings are to be an analysis of the decision including, but not be limited to, information concerning any databases, previous awards, or other documentation or arguments that contributed to the arbitrator’s decision.

As amended and reported by the committee, Senate Bill No. 1177 (1R) is identical to Assembly Bill No. 4032, as also amended and reported by the committee.

COMMITTEE AMENDMENTS:

The committee amended the bill to:

(1) extend the deadline under current law for the carrier, provider, or covered person to initiate binding arbitration in the event of a failure to reach a settlement from within 30 days of the final offer to within 60 days of the final offer, rather than 90 days as it was originally amended in the bill;

(2) remove from the bill a provision that, in order for binding arbitration to be initiated, the difference between a carrier's and provider's final offers be \$1,000 or higher for a billed amount of \$2,500 or more or \$500 or higher for a billed amount of less than \$2,500, thereby leaving current law intact;

(3) remove requirements in the bill and existing under current law requiring arbitrators to be certified; and

(4) stipulate that the bill take effect on the 90 day next following the date of enactment rather than immediately.

ASSEMBLY, No. 4032

STATE OF NEW JERSEY 220th LEGISLATURE

INTRODUCED MAY 16, 2022

Sponsored by:

Assemblyman CRAIG J. COUGHLIN

District 19 (Middlesex)

SYNOPSIS

Revises out-of-network arbitration process.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT revising the out-of-network arbitration process and
2 amending P.L.2018, c.32.

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4 **BE IT ENACTED** by the Senate and General Assembly of the State
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14 of-pocket costs than the covered person would have incurred with an
15 in-network health care provider for covered services. Pursuant to
16 sections 7 and 8 of this act, the out-of-network provider shall not bill
17 the covered person, except for applicable deductible, copayment, or
18 coinsurance amounts that would apply if the covered person utilized
19 an in-network health care provider for the covered services. In the
20 case of services provided to a member of a self-funded plan that does
21 not elect to be subject to the provisions of this section, the provider
22 shall be permitted to bill the covered person in excess of the
23 applicable deductible, copayment, or coinsurance amounts.

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28 the out-of-network health care provider, which shall require no action
29 on the part of the covered person. Once the benefit is assigned as
30 provided in this subsection:

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32 to the out-of-network provider; and

33 (b) the carrier shall provide the out-of-network provider with a
34 written remittance of payment that specifies the proposed
35 reimbursement and the applicable deductible, copayment, or
36 coinsurance amounts owed by the covered person.

37 (2) An entity providing or administering a self-funded health
38 benefits plan that elects to participate in this section pursuant to
39 subsection d. of this section, shall comply with the provisions of
40 paragraph (1) of this subsection.

41 c. If inadvertent out-of-network services or services provided at
42 an in-network or out-of-network health care facility on an emergency
43 or urgent basis are performed in accordance with subsection a. of this
44 section, the out-of-network provider may bill the carrier for the
45 services rendered. The carrier may pay the billed amount or the
46 carrier shall determine within 20 days from the date of the receipt of

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not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 the claim for the services whether the carrier considers the claim to
2 be excessive, and if so, the carrier shall notify the provider of this
3 determination within 20 days of the receipt of the claim. If the carrier
4 provides this notification, the carrier and the provider shall have **[30]**
5 60 days from the date of this notification to negotiate a settlement.
6 The carrier may attempt to negotiate a final reimbursement amount
7 with the out-of-network health care provider which differs from the
8 amount paid by the carrier pursuant to this subsection. If there is no
9 settlement reached after the **[30]** 60 days, the carrier shall pay the
10 provider their final offer for the services. If the carrier and provider
11 cannot agree on the final offer as a reimbursement rate for these
12 services, the carrier, provider, or covered person, as applicable, may
13 initiate binding arbitration within **[30]** 90 days of the final offer,
14 pursuant to section 10 or 11 of this act. In addition, in the event that
15 arbitration is initiated pursuant to section 10 of this act, the payment
16 shall be subject to the binding arbitration provisions of paragraphs
17 (4) and (5) of subsection b. of section 10 of this act.

18 d. With respect to an entity providing or administering a self-
19 funded health benefits plan and its plan members, this section shall
20 only apply if the plan elects to be subject to the provisions of this
21 section. To elect to be subject to the provisions of this section, the
22 self-funded plan shall provide notice, on an annual basis, to the
23 department, on a form and in a manner prescribed by the department,
24 attesting to the plan's participation and agreeing to be bound by the
25 provisions of this section. The self-funded plan shall amend the
26 employee benefit plan, coverage policies, contracts and any other
27 plan documents to reflect that the benefits of this section shall apply
28 to the plan's members.

29 (cf: PL.2018, c.32, s.9)

30

31 2. Section 10 of P.L.2018, c.32 (C.26:2SS-10) is amended to
32 read as follows:

33 10. a. If attempts to negotiate reimbursement for services
34 provided by an out-of-network health care provider, pursuant to
35 subsection c. of section 9 of this act, do not result in a resolution of
36 the payment dispute, and the difference between the carrier's and the
37 provider's final offers is not less than \$1,000, for a billed amount of
38 \$2,500 or more and not less than \$500 for a billed amount of less than
39 \$2,500, the carrier or out-of-network health care provider may initiate
40 binding arbitration to determine payment for the services.

41 b. The binding arbitration shall adhere to the following
42 requirements:

43 (1) The party requesting arbitration shall notify the other party
44 that arbitration has been initiated and state its final offer before
45 arbitration, which in the case of the carrier shall be the amount paid
46 pursuant to subsection c. of section 9 of this act. In response to this
47 notice, the out-of-network provider shall inform the carrier of its final
48 offer before the arbitration occurs;

1 (2) Arbitration shall be initiated by filing a request with the
2 department;

3 (3) The department shall contract, through the request for
4 proposal process, every three years, with one or more entities that
5 have experience in health care pricing arbitration. The arbitrators
6 shall be **[American Arbitration Association certified arbitrators]**
7 certified by the department. The department may initially utilize the
8 entity engaged under the "Health Claims Authorization, Processing,
9 and Payment Act," P.L.2005, c.352 (C.17B:30-48 et seq.), for
10 arbitration under this act; however, after a period of one year from
11 the effective date of this act, the selection of the arbitration entity
12 shall be through the Request for Proposal process. Claims that are
13 subject to arbitration pursuant to the provisions of this act, which
14 previously would be subject to arbitration pursuant to the "Health
15 Claims Authorization, Processing, and Payment Act," shall instead
16 be subject to this act;

17 (4) The arbitration shall consist of a review of the written
18 submissions by both parties, which shall include the final offer for
19 the payment by the carrier for the out-of-network health care
20 provider's fee made pursuant to subsection c. of section 9 of this act
21 and the final offer by the out-of-network provider for the fee the
22 provider will accept as payment from the carrier; and

23 (5) The arbitrator's decision shall be one of the two amounts
24 submitted by the parties as their final offers and shall be binding on
25 both parties. The decision of the arbitrator shall include detailed
26 written findings and shall be issued within 30 days after the request
27 is filed with the department. The detailed written findings shall be an
28 analysis of the decision including, but not be limited to, information
29 concerning any databases, previous awards, or other documentation or
30 arguments that contributed to the arbitrator's decision.The arbitrator's
31 expenses and fees shall be split equally among the parties except in
32 situations in which the arbitrator determines that the payment made
33 by the carrier was not made in good faith, in which case the carrier
34 shall be responsible for all of the arbitrator's expenses and fees. Each
35 party shall be responsible for its own costs and fees, including legal
36 fees if any.

37 c. (1) The amount awarded by the arbitrator that is in excess of
38 any payment already made pursuant to subsection c. of section 9 of
39 this act shall be paid within 20 days of the arbitrator's decision as
40 provided in subsection b. of this section.

41 (2) The interest charges for overdue payments, pursuant to
42 P.L.1999, c.154 (C.17B:30-23 et al.), shall not apply during the
43 pendency of a decision under subsection b. of this section and any
44 interest required to be paid a provider pursuant to P.L.1999, c.154
45 (C.17B:30-23 et al.) shall not accrue until after 20 days following an
46 arbitrator's decision as provided in subsection b. of this section, but
47 in no circumstances longer than 150 days from the date that the out-

1 of-network provider billed the carrier for services rendered, unless
2 both parties agree to a longer period of time.

3 d. This section shall apply only if the covered person complies
4 with any applicable preauthorization or review requirements of the
5 health benefits plan regarding the determination of medical necessity
6 to access in-network inpatient or outpatient benefits.

7 e. This section shall not apply to a covered person who
8 knowingly, voluntarily, and specifically selected an out-of-network
9 provider for health care services.

10 f. In the event an entity providing or administering a self-funded
11 health benefits plan elects to be subject to the provisions of section 9
12 of this act, as provided in subsection d. of that section, the provisions
13 of this section shall apply to a self-funded plan in the same manner
14 as the provisions of this section apply to a carrier. If a self-funded
15 plan does not elect to be subject to the provision of section 9 of this
16 act, a member of that plan may initiate binding arbitration as provided
17 in section 11 of this act.

18 (cf: P.L.2018, c.32, s.10.)

19

20 3. This act shall take effect immediately.

21

22

23

STATEMENT

24

25 This bill amends the “Out-of-network Consumer Protection,
26 Transparency, Cost Containment and Accountability Act” to revise
27 certain aspects of the arbitration processes established in that act for
28 claims involving health insurance carriers subject to the provisions
29 of the act.

30 The bill extends the amount of time that the insurance carrier and
31 healthcare provider have to negotiate a settlement in the event of an
32 inadvertent use of out-of-network services from 30 to 60 days, and
33 extends the deadline for the carrier, provider, or covered person to
34 initiate binding arbitration in the event of a failure to reach a
35 settlement from within 30 days of the final offer to within 90 days of
36 the final offer. The bill provides that, in order for binding arbitration
37 to be initiated, the difference between a carrier’s and provider’s final
38 offers be \$1,000 or higher for a billed amount of \$2,500 or more or
39 \$500 or higher for a billed amount of less than \$2,500.

40 The bill changes the certification requirement for arbitrators from
41 a certification from the American Arbitration Association to a
42 certification from the Department of Banking and Insurance.

43 Finally, the bill requires an arbitrator to include detailed written
44 findings with each decision. The detailed written findings are to be
45 an analysis of the decision including, but not be limited to,
46 information concerning any databases, previous awards, or other
47 documentation or arguments that contributed to the arbitrator’s
48 decision.

ASSEMBLY FINANCIAL INSTITUTIONS AND INSURANCE
COMMITTEE

STATEMENT TO
ASSEMBLY, No. 4032

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 2, 2022

The Assembly Financial Institutions and Insurance Committee reports favorably and with committee amendments Assembly Bill No. 4032.

As amended, this bill amends the “Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act” to revise certain aspects of the arbitration processes established in that act for claims involving health insurance carriers subject to the provisions of the act.

The bill extends the amount of time that the insurance carrier and healthcare provider have to negotiate a settlement in the event of an inadvertent use of out-of-network services from 30 to 60 days, and extends the deadline for the carrier, provider, or covered person to initiate binding arbitration in the event of a failure to reach a settlement from within 30 days of the final offer to within 60 days of the final offer.

Finally, the bill requires an arbitrator to include detailed written findings with each decision. The detailed written findings are to be an analysis of the decision including, but not be limited to, information concerning any databases, previous awards, or other documentation or arguments that contributed to the arbitrator’s decision.

As amended and reported by the committee, Assembly Bill No. 4032 is identical to Senate Bill No. 1177 (1R), as also amended and reported by the committee.

COMMITTEE AMENDMENTS:

The committee amended the bill to:

(1) extend the deadline under current law for the carrier, provider, or covered person to initiate binding arbitration in the event of a failure to reach a settlement from within 30 days of the final offer to within 60 days of the final offer, rather than 90 days as it was originally amended in the bill;

(2) remove from the bill a provision that, in order for binding arbitration to be initiated, the difference between a carrier’s and provider’s final offers be \$1,000 or higher for a billed amount of

\$2,500 or more or \$500 or higher for a billed amount of less than \$2,500, thereby leaving current law intact;

(3) remove requirements in the bill and existing under current law requiring arbitrators to be certified; and

(4) stipulate that the bill take effect on the 90 day next following the date of enactment rather than immediately.

Governor Murphy Takes Action on Legislation

07/29/2022

TRENTON – Today, Governor Phil Murphy signed the following bills into law:

S-144/A-2159 (Diegnan, Beach/Egan, Danielsen, Park) - Establishes “COVID-19 Frontline Healthcare Worker Memorial Commission.”

S-1177/A-4032 (Lagana, Gopal/Coughlin) - Revises out-of-network arbitration process

S-2677/A-4068 (Pou/Wimberly, Sumter, Reynolds-Jackson) - Amends requirements for certain mixed use parking projects undertaken by municipal redevelopers under Economic Redevelopment and Growth Grant program; increases total available tax credits by \$25 million

A-1797/S-1906 (DeAngelo, Dancer, Dunn/Diegnan, Greenstein) - Clarifies that member of SPRS may receive accidental disability benefit under certain circumstances.

A3110/S2049 (Jasey, Benson, Reynolds-Jackson/Codey, Schepisi) - Establishes minimum Medicaid reimbursement rates for brain injury services.

A-3898/S-2522 (Pintor Marin, Space/Ruiz) - Makes FY2022 supplemental appropriation of \$3 million for mosquito control.

A-4193/S-2759 (Greenwald/Singleton) - Adjusts municipal ballot question for amusement games for future elections and repeals section of law creating office of Amusement Games Control Commissioner