ASSEMBLY RESOLUTION No. 74

STATE OF NEW JERSEY

INTRODUCED MARCH 25, 1996

By Assemblymen DORIA and DiGAETANO

AN ASSEMBLY RESOLUTION directing the Assembly Policy and Regulatory Oversight Committee to investigate certain actions of the Department of Insurance, the Market Transition Facility, and certain insurers and servicing carriers with respect to the payment procedures for all claims including medical expense benefits.

WHEREAS, The "Fair Automobile Insurance Reform Act of 1990," P.L.1990, c.8 (17:33B-1 et seq.), hereinafter, the "FAIR Act," significantly revised the law regarding the use of medical fee schedules for the reimbursement of health care providers providing services or equipment to persons covered for medical expense benefits by automobile insurers under personal injury protection coverage; and

WHEREAS, The Commissioner of Insurance is directed to promulgate those fee schedules on the basis of the type of service provided and to incorporate the reasonable and prevailing fees of 75% of the practitioners within a given region; and

WHEREAS, Under the FAIR Act reforms, a health care provider may not demand or request any payment from any person in excess of those provided by the medical fee schedules, nor is any person liable to a health care provider for any amount of money in excess of that permitted by the medical fee schedules for treatment of injuries sustained in an automobile accident; and

WHEREAS, The intent of these reforms was to reduce the arbitrary determinations of insurance companies and Market Transition Facility (MTF) servicing carriers in paying medical expense benefits claims by providing uniform fee schedules which establish ceilings on the maximum insurance reimbursement for medical treatment that is rendered as the result of an accident, thereby controlling costs; and

WHEREAS, The intent was not to prohibit providers from raising their fees to reflect their operating costs; and

WHEREAS, The commissioner has no statutory authority to prohibit providers from raising their usual or customary fees or to determine the appropriate level of health care fees that providers may generally charge; and

WHEREAS, The Commissioner of Insurance is thus obligated to ensure that health care providers are paid an amount for services rendered to persons

entitled to medical expense benefits based on the lower of the medical fee schedule rate or the provider's usual, customary and reasonable fee; and

WHEREAS, Conversely, the only fee that an insurance company or servicing carrier is permitted to pay is the lower of either the individual provider's usual, customary and reasonable fee or that which the medical fee schedule allows; and

WHEREAS, The arbitrary determination by certain insurance companies and servicing carriers as to what were considered usual, customary and reasonable fees prior to the enactment of the FAIR Act was problematic and guided the Legislature to direct the commissioner to establish medical fee schedules based on the prevailing fees of 75% of the practitioners within a given region; and

WHEREAS, It has been alleged that certain insurance companies and servicing carriers have attempted to circumvent the law with respect to the proper payment of health care provider fees, by making partial payment of fees or paying arbitrary fees in various manners that are inconsistent with the directives and intent of the FAIR Act reforms; and

WHEREAS, A provider is prohibited under the law from obtaining the balance of the bill from the patient and therefore has no recourse with respect to recouping moneys that may properly be due him; and

WHEREAS, Despite the directives of section 5 of the original "no-fault law," P.L.1972, c.70 (C.39:6A-5), with respect to prompt payment of medical expense benefits claims, it has been alleged that certain automobile insurance companies and servicing carriers have engaged in the use of "stalling" tactics, such as losing files and ignoring claimant and provider telephone calls, which have resulted in a pattern of consistently late claims payments; and

WHEREAS, Such actions are not consistent with the legislative intent of these provisions and have caused thousands of health care providers to be illegally underpaid or paid late, which, in turn, has placed certain health care providers in precarious financial positions; and

WHEREAS, The public health and welfare is therefore being jeopardized, because the uncertainty of receiving payment has forced many health care providers to refuse to treat patients injured in accidents and covered by certain automobile insurance companies and MTF servicing carriers; and

WHEREAS, There are serious questions with respect to whether the Department of Insurance has properly exercised its duties and responsibilities to protect the public welfare in this regard; now, therefore,

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

1. The Assembly Policy and Regulatory Oversight Committee is directed to undertake a thorough inquiry into the actions of the New Jersey Department

of Insurance and the Market Transition Facility (MTF) with respect to their administration and enforcement of the law concerning medical fee schedules and the prompt payment of medical expense benefits. The committee is further directed to review payment procedures for all claims, actions and practices of certain automobile insurance companies and MTF servicing carriers with respect to the payment of medical expense benefits.

2. For purposes of carrying out its charge under this resolution, the committee shall have all the powers conferred pursuant to Chapter 13 of Title 52 of the Revised Statutes.

3. The committee shall be entitled to call to its assistance and avail itself of the services of the employees of the State of New Jersey, or any political subdivision of the State or any agency thereof, as may be required and as may be available for that purpose, and to employ stenographic and clerical assistants and incur traveling and other expenses as may be deemed necessary, in order to perform the duties provided herein, and within the limit of funds appropriated or otherwise made available for that purpose.

4. The committee shall report its findings and recommendations, including any legislative proposals, to the General Assembly no later than January 1998.

STATEMENT

This Assembly Resolution directs the Assembly Policy and Regulatory Oversight Committee to investigate actions of the Department of Insurance, the Market Transition Facility, and certain insurers and servicing carriers respecting payment procedures for all claims, including, but not limited to, medical expense benefits.

According to the resolution, the Department of Insurance has proceeded without statutory authority and in a manner inconsistent with the "Fair Automobile Insurance Reform Act of 1990," P.L.1990, c.8 (C.17:33B-1 et seq.), to prohibit health care providers from raising their fees to reflect operating costs.

The resolution also states that certain insurers and servicing carriers have engaged in "stalling tactics" contrary to provisions for the prompt payment of medical expense benefits claims in the "no-fault law." P.L.1972, c.70 (C.39:6A-5).

Under the resolution, the Assembly Policy and Regulatory Oversight Committee would be accorded the investigatory powers of Chapter 13 of Title 52 of the Revised Statutes, including the power to subpoena and compel witnesses, and would be required to report its findings and recommendations,

including any legislative proposals, to the General Assembly no later than January 9, 1998.

Directs Assembly Policy and Regulatory Oversight Committee to investigate certain actions and practices with respect to medical expense benefits payments.