[Second Reprint]

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 3756

STATE OF NEW JERSEY

220th LEGISLATURE

ADOPTED JUNE 12, 2023

Sponsored by:
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District 22 (Middlesex, Somerset and Union)
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District 35 (Bergen and Passaic)

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SYNOPSIS

Permits SHBP and SEHBP to award contracts for more claims administrators for each program plan; requires claims data and trend reports to be provided to certain persons.

CURRENT VERSION OF TEXT

As amended on December 11, 2023 by the Senate pursuant to the Governor's recommendations.

(Sponsorship Updated As Of: 6/30/2023)

AN ACT concerning the State Health Benefits Program and the School Employees' Health Benefits Program, supplementing P.L.1961, c.49 (C.52:14-17.25 et seq.) and P.L.2007, c.103 (C.52:14-17.46.1 et seq.), and repealing section 1 of P.L.2013, c.189 (C.52:14-17.37a).

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

1. The Legislature finds and declares that:

a. The cost of health care for public employees in the State has been increasing at a pace that will make our current system of health care delivery unsustainable if it continues on its present trajectory.

b. As health care costs continue to rise more quickly than the average annual income, those costs displace other priorities for individuals, such as saving for retirement or their children's education, and even discourage people from obtaining recommended health care. The litany of research in this area has demonstrated that action must be taken to reduce costs.

c. One way to reduce costs is to increase competition among the third-party administrators that contract with the State to administer the State Health Benefits Program and the School Employees' Health Benefits Program that cover thousands of State, municipal, school district, and related public employees and their dependents.

d. Permitting these employees to have greater choice in the selection of third-party administrators for their respective health plan will also increase accountability of the administrators and overall performance, quality, and cost by encouraging competition among the third-party administrators.

e. Many federal and State sponsored health plans embrace the use of multiple administrators to ensure sufficient competition not only at the time of bid awards but throughout the life of the contract. For example, use of multiple administrators encourages contracted administrators to compete, on an ongoing basis, for membership by accelerating innovation and by delivering on key measures of success, such as on the ability to manage the rate of health care inflation, network breadth, member experience, and programs to advance health care quality, unit cost discounts, and other cost saving initiatives. Without meaningful competition, the State may have limited ability to determine if best practices are met in the aforementioned areas.

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1]Senate amendments adopted in accordance with Governor's recommendations December 11, 2023.

f. A more competitive procurement process also increases accountability and transparency. Having multiple contract administrators will enable a more accurate comparison to measure relative performance on key metrics pertaining to cost, quality, and experience.

g. For the purpose of reducing health care costs and facilitating greater satisfaction, efficiency, and accountability in the administration of health benefits claims to State employees, their eligible family members, and participating local government and school district employees and their eligible family members, the State of New Jersey deems it fitting and crucial to procure more than one contract administrator for each health benefits plan type offered by the State Health Benefits Program and the School Employees' Health Benefits Program.

2. The definitions set forth in section 2 of P.L.1961, c.49 (C.52:14-17.26) shall be applicable to sections 2 and 3 of this act, P.L. , c. (C.) (pending before the Legislature as this bill).

In addition, as used in this act:

"Competitive range" means the group of responsive proposals to a request for proposal that are among the most highly rated proposals [2][within a range established by the director in consultation with the commission] as determined by the evaluation committee[2]. The [2][director] commission, or its designee,[2] shall include an economic component to the established competitive range to ensure the group of responsive proposals deliver competitive pricing beneficial to the [2][plan] State Health Benefits Program and the School Employees' Health Benefits Program[2].

[2]["Director" means the Director of the Division of Pension and Benefits or the director's designee.][2]

"Early retiree" means a retired employee of the State or participating employer who is retired, under 65 years of age, and not yet eligible to enroll in Medicare.

[2]"Evaluation committee" means a group of individuals assigned, pursuant to section 3 of P.L.2005, c.336 (C.52:34-10.3), to review and evaluate quotes submitted in response to a request for proposal and recommend a contract award.[2]

"Medicare retiree" means a retired employee of the State or participating employer who is 65 years of age or older, or otherwise qualified to enroll in Medicare due to health status, and is currently enrolled in Medicare. Eligible retirees include those who are enrolled in a self-insured Medicare Supplement plan [2][or a fully-insured Medicare Advantage plan][2].

"Plan type" means preferred provider organization (PPO), health maintenance organization (HMO), tiered network plan, high-deductible health plan, [2]and[2] Medicare supplemental PPO and HMO

[2][, and Medicare Advantage plan] plans[2] as those terms may be defined in law.

"Request for proposal" refers to all documents, whether attached or incorporated by reference, used for a publicly advertised procurement process that solicits proposals or offers to provide the goods or services specified therein.

"Responsive proposal" refers to a proposal that is deemed to have adequately addressed all material provisions of a request for proposal's terms and conditions, specifications, and other requirements.

"Third-party administrator" means a vendor that conducts claims administration, network management, claims processing, or other related services for an organization contracted by the State to provide health care services and benefits. [2][For purposes of Medicare Advantage plans, the term third-party administrator shall include carriers contracted by the State to offer Medicare Advantage plans to eligible retirees.][2]

3. a. For each plan type offered to eligible employees, early retirees, and [2]certain[2] Medicare retirees, and their dependents, the State Health Benefits Commission [2], or its designee,[2] shall select at least two third-party administrators from among those vendors who submit responsive proposals that are most advantageous to the State, [2]price and other factors considered,[2] provided that, if fewer than two [2][qualified][2] vendors submit responsive proposals within a competitive range established by the [2][director in consultation with the commission] evaluation committee[2], the commission [2], or its designee,[2] shall [1]either: (1)[1] select [1]the[1] one qualified vendor [1];[1] or [1][a solicitation for the plan type may be reissued] (2) reissue the solicitation for the plan type in its entirety in an effort to secure at least two third-party administrators[1].

b. Unless otherwise limited through the terms of a collective bargaining agreement, State or federal statute, or regulation, an eligible employee, early retiree, and Medicare [2][retiree] retirees not eligible for or enrolled in Medicare Advantage plans[2] shall have the opportunity, on an annual basis, during the open enrollment period or other applicable enrollment period, to choose a plan from among the plan types the commission has selected.

c. The commission [2], or its designee,[2] shall award the contracts for each plan type under subsection a. of this section on the basis of the bid [2][response] responses[2] that [2][is] are[2] the most advantageous to the State, which shall consider price, network breadth, member experience, the ability to engage in innovative approaches designed to slow the growth of health care costs, and any other factors that the commission or [2][their] its[2] designee may deem relevant.

d. The commission [2], or its designee,[2] is authorized to award a contract to the vendor with the bid that is most advantageous to the

State [2], price and other factors considered,[2] based upon the evaluation factors in subsection c. of this section, and to thereafter award another contract to one or more vendors with bids within the competitive range that can provide a comparable bid price and factors of the first awarded contract.

[2][e. After five years following the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), the director shall conduct a study on the impact of this section and shall include a recommendation to maintain, modify, or otherwise terminate this section. The director shall provide a copy of the study to the Legislature upon completion pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1).][2]

4. The definitions set forth in section 32 of P.L.2007, c.103 (C.52:14-17.46.2) shall be applicable to sections 4 and 5 of this act, P.L. , c. (C.) (pending before the Legislature as this bill).

In addition, as used in this act:

"Competitive range" means the group of responsive proposals to a request for proposal that are among the most highly rated proposals [2][within a range established by the director in consultation with the commission] as determined by the evaluation committee[2]. The [2][director] commission, or its designee,[2] shall include an economic component to the established competitive range to ensure the group of responsive proposals deliver competitive pricing beneficial to the [2][plan] State Health Benefits Program and the School Employees' Health Benefits Program[2].

[2]["Director" means the Director of the Division of Pension and Benefits or the director's designee.][2]

"Early retiree" means a retired employee of the State or participating employer who is retired, under 65 years of age, and not yet eligible to enroll in Medicare.

[2]"Evaluation committee" means a group of individuals assigned, pursuant to section 3 of P.L.2005, c.336 (C.52:34-10.3), to review and evaluate quotes submitted in response to a request for proposal and recommend a contract award.[2]

"Medicare retiree" means a retired employee of the State or participating employer who is 65 years of age or older, or otherwise qualified to enroll in Medicare due to health status, and is currently enrolled in Medicare. Eligible retirees include those who are enrolled in a self-insured Medicare Supplement plan [2][or a fully-insured Medicare Advantage plan][2].

"Plan type" means preferred provider organization (PPO), health maintenance organization (HMO), tiered network plan, high-deductible health plan, [2]and[2] Medicare supplemental PPO and HMO [2][, and Medicare Advantage plan] plans[2] as those terms may be defined in law.

"Request for proposal" refers to all documents, whether attached or incorporated by reference, used for a publicly advertised procurement process that solicits proposals or offers to provide the goods or services specified therein.

"Responsive proposal" refers to a proposal that is deemed to have adequately addressed all material provisions of a request for proposal's terms and conditions, specifications, and other requirements.

"Third-party administrator" means a vendor that conducts claims administration, network management, claims processing, or other related services for an organization contracted by the State to provide health care services and benefits. [2][For purposes of Medicare Advantage plans, the term third-party administrator shall include carriers contracted by the State to offer Medicare Advantage plans to eligible retirees.][2]

5. a. For each plan type offered to eligible employees, early retirees, and [2]certain[2] Medicare retirees, and their dependents, the School Employees' Health Benefits Commission [2], or its designee,[2] shall select at least two third-party administrators from among those vendors who submit responsive proposals that are most advantageous to the State, [2]price and other factors considered,[2] provided that, if fewer than two [2][qualified][2] vendors submit responsive proposals within a competitive range established by the [2][director in consultation with the commission] evaluation committee[2], the commission [2], or its designee,[2] shall [1]either: (1)[1] select [1]the[1] one qualified vendor [1];[1] or [1][a solicitation for the plan type may be reissued] (2) reissue the solicitation for the plan type in its entirety in an effort to secure at least two third-party administrators[1].

b. Unless otherwise limited through the terms of a collective bargaining agreement, State or federal statute, or regulation, an eligible employee, early retiree, and Medicare [2][retiree] retirees not eligible for or enrolled in Medicare Advantage plans[2] shall have the opportunity, on an annual basis, during the open enrollment period or other applicable enrollment period, to choose a plan from among the plan types the commission has selected.

c. The commission [2], or its designee,[2] shall award the contracts for each plan type under subsection a. of this section on the basis of the bid [2][response] responses[2] that [2][is] are[2] the most advantageous to the State, which shall consider price, network breadth, member experience, the ability to engage in innovative approaches designed to slow the growth of health care costs, and any other factors that the commission or [2][their] its[2] designee may deem relevant.

d. The commission [2], or its designee,[2] is authorized to award a contract to the vendor with the bid that is most advantageous to the State [2], price and other factors considered,[2] based upon the evaluation factors in subsection c. of this section, and to thereafter award another

contract to one or more vendors with bids within the competitive range that can provide a comparable bid price and factors of the first awarded contract.

[2]e. After five years following the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), the director shall conduct a study on the impact of this section and shall include a recommendation to maintain, modify, or otherwise terminate this section. The director shall provide a copy of the study to the Legislature upon completion pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1).]2

6. a. (1) As soon as is practicable, but not later than 180 days from the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), the Department of the Treasury shall provide, upon request, but not more frequently than [2]twice] once[2] in a [2]plan year] 24-month period[2], to a participating employer in the State Health Benefits Program or the School Employees Health Benefits Program, a standard report which contains the requesting employer's de-identified aggregate data relating to the use of benefits by their employees [2],] and[2] early retirees, [2]and Medicare retirees,][2] and their dependents, covered under each plan in the program. The report shall include premiums paid by month for each month covered in the report [2]and] . If the participating employer has more than 300 employees in the plan, then the report shall include[2] paid claims by month for the following categories of services: (a) inpatient hospital; (b) outpatient hospital; (c) in network medical; (d) out of network medical; (e) prescription drugs; (f) [2]medical drugs; (g)][2] emergency room services; and [2](h)] (g)[2] behavioral health, each reported separately. The report shall cover both health and prescription benefits.

The report shall also provide for a listing of de-identified claims within each plan of both the State Health Benefits Program and the School Employees Health Benefits Program, without reference to a specific employer participating in the programs, in excess of $50,000 that were paid in any of the months covered by the report. The report shall cover both health and prescription benefits.

(2) The Department of the Treasury shall provide the reports to a requesting participating employer within [2]30] 60[2] days of receipt of such request. [2]For a request submitted on or after April 1st, the report shall contain data from the January1st through December 31st of the prior year. For a request submitted on or after September 1st, the report shall contain data from June 1st of the prior year through May 31st of the current year. The department shall also provide such reports to a majority representative of public employees for collective negotiations purposes, but only for employers specifically identified as having employees, early retirees, or Medicare retirees, and their dependents, represented by the majority representative.]2

b. As soon as practicable, [2]⟦but not later than December 1st of each year,⟧[2] the Department of the Treasury shall collect and analyze claims data within the State Health Benefits Program and the School Employees Health Benefits Program to develop, and make publicly available, a claims trend report for each program in the following categories: (1) inpatient hospital; (2) outpatient hospital; (3) in network medical; (4) out of network medical ; (5) prescription drugs; (6) medical drugs; (7) emergency room services; and (8) behavioral health. The claims trend report shall provide the information in segments including active, early retiree, and Medicare retiree for each plan in the State Health Benefits Program, and in the School Employees Health Benefits Program, and in the aggregate for each plan in both programs. The [2]⟦department shall also make the⟧[2] report [2]shall be made publicly[2] available [2]⟦on or before December 31st of each year to all majority representatives of public employees for collective negotiations purposes with which the State negotiates. The report shall be posted⟧[2] on the Department of the Treasury's website in a prominent and accessible location [2]⟦not later than January 1st of the following calendar year⟧[2].

[2]⟦Each⟧ The[2] claims trend report shall be submitted to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), each member of the State Health Benefits Plan Design Committee and of the School Employees' Health Benefits Plan Design Committee, each member of the State Health Benefits Commission and of the School Employees' Health Benefits Commission, and the Governor's Office of Employee Relations.

c. No later than 12 months from the effective date of P.L. , c. (C.) (pending before the Legislature as this bill), the Department of the Treasury shall provide the State Health Benefits Plan Design Committee and the School Employees Health Benefits Plan Design Committee with a feasibility study of strategies to lower the cost of health care service for the participants of the programs. [2]⟦The study shall incorporate opportunities identified in previous management consultant studies, including, but not limited to, changes to the benefit design, spousal surcharges, value based care initiatives, reference-based pricing, out-of-network reimbursements, and prescription drug formulary changes.⟧[2] There shall be a review of short-term savings achievable within 3 to 12 months, medium-term savings achievable within 12 to 24 months, and long-term savings achievable after 24 months.

7. Section 1 of P.L.2013, c.189 (C.52:14-17.37a) is repealed.

8. This act shall take effect immediately.