ASSEMBLY, No. 5872

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED JUNE 14, 2021

Sponsored by:
Assemblywoman ELIANA PINTOR MARIN
District 29 (Essex)

SYNOPSIS

Requires SHBP and SEHBP to implement referenced based pricing program and bundled payment program.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning health care benefits for public employees and retirees, amending P.L.1961, c.49 and P.L.2007, c.103, and supplementing Title 52 of the Revised Statutes.

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

1. Section 5 of P.L.1961, c.49 (C.52:14-17.29) is amended to read as follows:

5. (A) The contract or contracts purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall provide separate coverages or policies as follows:

(1) Basic benefits which shall include:

(a) Hospital benefits, including outpatient;

(b) Surgical benefits;

(c) Inpatient medical benefits;

(d) Obstetrical benefits; and

(e) Services rendered by an extended care facility or by a home health agency and for specified medical care visits by a physician during an eligible period of such services, without regard to whether the patient has been hospitalized, to the extent and subject to the conditions and limitations agreed to by the commission and the carrier or carriers.

Basic benefits shall be substantially equivalent to those available on a group remittance basis to employees of the State and their dependents under the subscription contracts of the New Jersey "Blue Cross" and "Blue Shield" Plans. Such basic benefits shall include benefits for:

(i) Additional days of inpatient medical service;

(ii) Surgery elsewhere than in a hospital;

(iii) X-ray, radioactive isotope therapy and pathology services;

(iv) Physical therapy services;

(v) Radium or radon therapy services;

and the extended basic benefits shall be subject to the same conditions and limitations, applicable to such benefits, as are set forth in "Extended Outpatient Hospital Benefits Rider," Form 1500, 71(9-66), and in "Extended Benefit Rider" (as amended), Form MS 7050J(9-66) issued by the New Jersey "Blue Cross" and "Blue Shield" Plans, respectively, and as the same may be amended or superseded, subject to filing by the Commissioner of Banking and Insurance; and

(2) Major medical expense benefits which shall provide benefit payments for reasonable and necessary eligible medical expenses for hospitalization, surgery, medical treatment and other related services and supplies to the extent they are not covered by basic benefits. The

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 <u>thus</u> is new matter.

commission may, by regulation, determine what types of services and supplies shall be included as "eligible medical services" under the major medical expense benefits coverage as well as those which shall be excluded from or limited under such coverage. Benefit payments for major medical expense benefits shall be equal to a percentage of the reasonable charges for eligible medical services incurred by a covered employee or an employee's covered dependent, during a calendar year as exceed a deductible for such calendar year of $100.00 subject to the maximums hereinafter provided and to the other terms and conditions authorized by this act. The percentage shall be 80% of the first $2,000.00 of charges for eligible medical services incurred subsequent to satisfaction of the deductible and 100% thereafter. There shall be a separate deductible for each calendar year for (a) each enrolled employee and (b) all enrolled dependents of such employee. Not more than $1,000,000.00 shall be paid for major medical expense benefits with respect to any one person for the entire period of such person's coverage under the plan, whether continuous or interrupted except that this maximum may be reapplied to a covered person in amounts not to exceed $2,000.00 a year. Maximums of $10,000.00 per calendar year and $20,000.00 for the entire period of the person's coverage under the plan shall apply to eligible expenses incurred because of mental illness or functional nervous disorders, and such may be reapplied to a covered person, except as provided in P.L.1999, c.441 (C.52:14-17.29d et al.). The same provisions shall apply for retired employees and their dependents. Under the conditions agreed upon by the commission and the carriers as set forth in the contract, the deductible for a calendar year may be satisfied in whole or in part by eligible charges incurred during the last three months of the prior calendar year.

Any service determined by regulation of the commission to be an "eligible medical service" under the major medical expense benefits coverage which is performed by a duly licensed practicing psychologist within the lawful scope of his practice shall be recognized for reimbursement under the same conditions as would apply were such service performed by a physician.

(B) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include coverage for services and benefits that are at a level that is equal to or exceeds the level of services and benefits set forth in this subsection, provided that such services and benefits shall include only those that are eligible medical services and not those deemed experimental, investigative or otherwise not eligible medical services. The determination of whether services or benefits are eligible medical services shall be made by the commission consistent with the best interests of the State and participating employers, employees, and dependents. The following list of services is not intended to be exclusive or to require that any limits or exclusions be exceeded.

Covered services shall include:

(1) Physician services, including:

(a) Inpatient services, including:

(i) medical care including consultations;

(ii) surgical services and services related thereto; and

(iii) obstetrical services including normal delivery, cesarean section, and abortion.

(b) Outpatient/out-of-hospital services, including:

(i) office visits for covered services and care;

(ii) allergy testing and related diagnostic/therapy services;

(iii) dialysis center care;

(iv) maternity care;

(v) well child care;

(vi) child immunizations/lead screening;

(vii) routine adult physicals including pap, mammography, and prostate examinations; and

(viii) annual routine obstetrical/gynecological exam.

(2) Hospital services, both inpatient and outpatient, including:

(a) room and board;

(b) intensive care and other required levels of care;

(c) semi-private room;

(d) therapy and diagnostic services;

(e) surgical services or facilities and treatment related thereto;

(f) nursing care;

(g) necessary supplies, medicines, and equipment for care; and

(h) maternity care and related services.

(3) Other facility and services, including:

(a) approved treatment centers for medical emergency/accidental injury;

(b) approved surgical center;

(c) hospice;

(d) chemotherapy;

(e) diagnostic x-ray and lab tests;

(f) ambulance;

(g) durable medical equipment;

(h) prosthetic devices;

(i) foot orthotics;

(j) diabetic supplies and education; and

(k) oxygen and oxygen administration.

(4) All services for which coverage is required pursuant to P.L.1961, c.49 (C.52:14-17.25 et seq.), as amended and supplemented. Benefits under the contract or contracts purchased as authorized by the State Health Benefits Program shall include those for mental health services subject to limits and exclusions consistent with the provisions of the New Jersey State Health Benefits Program Act.

(5) After the effective date of P.L. , c. (pending before the Legislature as this bill), the contract or contracts purchased by the

commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall allow the commission to contract with a healthcare marketplace vendor, that shall not be the carrier or carriers contracted with pursuant to subsection b. of section 4 of P.L. 1961, c. 49 (C.52:14-17.28) . The healthcare marketplace vendor shall establish a Bundled Payment Program through which the contracted healthcare marketplace vendor shall contract with high quality providers to accept a global negotiated payment of a predetermined amount for all services provided during an episode of care by a designated group of providers, including both hospital and post-acute services. The payment methodology for the episode of care shall be developed through administrative action by the Division of Pensions and Benefits with the healthcare marketplace vendor utilizing metric based allowable amounts. A contract for the services of a healthcare marketplace vendor to establish a Bundled Payment Program may be procured in accordance with section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

(6) After the effective date of P.L. , c. (pending before the Legislature as this bill), the contract or contracts purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall allow the commission to engage in a program whereby the payment methodology for certain elective medical procedures, developed through administrative action by the Division of Pensions and Benefits, utilizes a metric based allowable amount for such elective medical procedures.

(7) As used in this subsection:

"Elective medical procedure" means any nonemergency care that can be scheduled at least 24 hours prior to the service without posing a significant threat to the patient's health or well-being.

"Episode of care" includes all physician, inpatient, and outpatient care that the patient received in the course of being treated for the specific condition or medical event.

"Metric based allowable amount" means a maximum, uniformly-applied amount payable for an elective medical procedure, based on an external price that is deemed reasonable and selected by the payer and set by utilizing a claim pricing approach grounded in analysis of an objective value for medical services, which may include Medicare pricing, the provider's reported costs, average wholesale price, and third party databases.

(C) The contract or contracts purchased by the commission pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall include the following provisions regarding reimbursements and payments:

(1) In the successor plan, the co-payment for doctor's office visits shall be $10 per visit with a maximum out-of-pocket of $400 per individual and $1,000 per family for in-network services for each calendar year. The out-of-network deductible shall be $100 per individual and $250 per family for each calendar year, and the

participant shall receive reimbursement for out-of-network charges at the rate of 80% of reasonable and customary charges, provided that the out-of-pocket maximum shall not exceed $2,000 per individual and $5,000 per family for each calendar year.

(2) In the State managed care plan that is required to be included in a contract entered into pursuant to subsection c. of section 4 of P.L.1961, c.49 (C.52:14-17.28), the co-payment for doctor's office visits shall be $15 per visit. The participant shall receive reimbursement for out-of-network charges at the rate of 70% of reasonable and customary charges. The in-network and out-of-network limits, exclusions, maximums, and deductibles shall be substantially equivalent to those in the NJ PLUS plan in effect on June 30, 2007, with adjustments to that plan pursuant to a binding collective negotiations agreement or pursuant to action by the commission, in its sole discretion, to apply such adjustments to State employees for whom there is no majority representative for collective negotiations purposes.

(3) "Reasonable and customary charges" means charges based upon the 90th percentile of the usual, customary, and reasonable (UCR) fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges.

(D) Benefits under the contract or contracts purchased as authorized by this act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

Benefits under the contract or contracts purchased as authorized by this act shall include those for the treatment of alcoholism where such treatment is prescribed by a physician and shall also include treatment while confined in or as an outpatient of a licensed hospital or residential treatment program which meets minimum standards of care equivalent to those prescribed by the Joint Commission on Hospital Accreditation. No benefits shall be provided beyond those stipulated in the contracts held by the State Health Benefits Commission.

(E) The rates charged for any contract purchased under the authority of this act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

(F) The initial term of any contract purchased by the commission under the authority of this act shall be for such period to which the commission and the carrier may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

(G) A contract purchased by the commission pursuant to subsection b. of section 4 of P.L.1961, c.49 (C.52:14-17.28) shall contain a provision that if basic benefits or major medical expense benefits of an employee or of an eligible dependent under the contract, after having been in effect for at least one month in the case of basic benefits or at least three months in the case of major medical expense benefits, is terminated, other than by voluntary cancellation of enrollment, there shall be a 31-day period following the effective date of termination during which such employee or dependent may exercise the option to convert, without evidence of good health, to converted coverage issued by the carriers on a direct payment basis. Such converted coverage shall include benefits of the type classified as "basic benefits" or "major medical expense benefits" in subsection (A) hereof and shall be equivalent to the benefits which had been provided when the person was covered as an employee. The provision shall further stipulate that the employee or dependent exercising the option to convert shall pay the full periodic charges for the converted coverage which shall be subject to such terms and conditions as are normally prescribed by the carrier for this type of coverage.

(H) The commission may purchase a contract or contracts to provide drug prescription and other health care benefits or authorize the purchase of a contract or contracts to provide drug prescription and other health care benefits as may be required to implement a duly executed collective negotiations agreement or as may be required to implement a determination by a public employer to provide such benefit or benefits to employees not included in collective negotiations units.

(I) The commission shall take action as necessary, in cooperation with the School Employees' Health Benefits Commission established pursuant to section 33 of P.L.2007, c.103 (C.52:14-17.46.3), to effectuate the purposes of the School Employees' Health Benefits Program Act as provided in sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11) and to enable the School Employees' Health Benefits Commission to begin providing coverage to participants pursuant to the School Employees' Health Benefits Program Act as of July 1, 2008.

(J) Beginning January 1, 2012, the State Health Benefits Plan Design Committee shall provide to employees the option to select one of at least three levels of coverage each for family, individual, individual and spouse, and individual and dependent, or equivalent

categories, for each plan offered by the program differentiated by out of pocket costs to employees including co-payments and deductibles. Notwithstanding any other provision of law to the contrary, the committee shall have the sole discretion to set the amounts for maximums, co-pays, deductibles, and other such participant costs for all plans in the program. The committee shall also provide for a high deductible health plan that conforms with Internal Revenue Code Section 223.

There shall be appropriated annually for each State fiscal year, through the annual appropriations act, such amounts as shall be necessary as funding by the State as an employer, or as otherwise required, with regard to employees or retirees who have enrolled in a high deductible health plan that conforms with Internal Revenue Code Section 223.

(cf: P.L.2011, c.78, s.47)

2. Section 35 of P.L.2007, c.103 (C.52:14-17.46.5) is amended to read as follows:

35. a. The commission shall negotiate with and arrange for the purchase, on such terms as it deems in the best interests of the State, participating employers and those persons covered hereunder from carriers licensed to operate in the State or in other jurisdictions, as appropriate, contracts providing benefits required by the School Employees' Health Benefits Program Act, as specified in section 36 of P.L.2007, c.103 (C.52:14-17.46.6), or such benefits as the commission may determine to provide, so long as such modification of benefits is in the best interests of the State, participating employers and those persons covered hereunder, and is consistent with the provisions of section 40 of that act (C.52:14-17.46.10). The commission shall have authority to execute all documents pertaining thereto for and on behalf of the State. The commission shall not enter into a contract under the School Employees' Health Benefits Program Act, unless the benefits provided thereunder are equal to or exceed the standards specified in section 36 of that act, or as such standards are modified pursuant to section 40 of that act.

b. The rates charged for any contract purchased under the authority of the School Employees' Health Benefits Program Act shall reasonably and equitably reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound. The rates charged shall be determined based upon accepted group rating principles with due regard to the experience, both past and contemplated, under the contract. The commission shall have the right to particularize subgroups for experience purposes and rates. No increase in rates shall be retroactive.

c. The commission shall be authorized to accept an assignment of contract rights from or enter into an agreement, contract, memorandum of understanding or other terms with the State Health

Benefits Commission to ensure that coverage for eligible employees, retirees and dependents under the School Employees' Health Benefits Program whose benefits had been provided through the State Health Benefits Program is continued without interruption. The transition provided for in this subsection shall occur within one year of the effective date of the School Employees' Health Benefits Program Act, sections 31 through 41 of P.L.2007, c.103 (C.52:14-17.46.1 through C.52:14-17.46.11).

d. Benefits under the contract or contracts purchased as authorized by the School Employees' Health Benefits Program Act may be subject to such limitations, exclusions, or waiting periods as the commission finds to be necessary or desirable to avoid inequity, unnecessary utilization, duplication of services or benefits otherwise available, including coverage afforded under the laws of the United States, such as the federal Medicare program, or for other reasons.

e. The initial term of any contract purchased by the commission under the authority of the School Employees' Health Benefits Program Act shall be for such period to which the commission and the carrier may agree, but permission may be made for automatic renewal in the absence of notice of termination by the commission. Subsequent terms for which any contract may be renewed as herein provided shall each be limited to a period not to exceed one year.

f. Any carrier with which the commission contracts for the provision of hospital, surgical, obstetrical, and other covered health care services and benefits pursuant to this section shall provide to the third-party medical claims reviewer, procured pursuant to section 2 of P.L.2019, c.143 (C.52:14-17.30b), information in that carrier's provider network contracts, such as claims information and contractual discounts provided thereunder, that are applicable to a health benefits plan offered under the School Employees' Health Benefits Program.

Documents, materials and other information in the possession or control of the State, or the third-party medical claims reviewer, that are obtained or created by, or disclosed to, the State or any other person pursuant to this subsection shall be recognized by this State as being proprietary and containing trade secrets. All such documents, materials or other information shall be confidential by law and privileged, and shall not be subject to P.L.1963, c.71 (C.47:1A-1 et seq.); except that the State is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commission's or third-party medical claims reviewer's official duties. The State and the third-party medical claims reviewer shall not disclose, sell, or transfer the documents, materials or other information without the prior written consent of the carrier. This subsection shall not be construed as pertaining to medical claims data.

g. A contract entered into with a carrier pursuant to this section shall include therein the State's existing right to withhold payment for administrative services or to pursue any other remedy deemed appropriate by the State Treasurer if the carrier is found by the State upon information provided by the third-party medical claims reviewer to have committed errors resulting in a loss to the State in a quantity or value, or both, beyond a certain threshold, as shall be provided in the contract or by rules promulgated by the State Treasurer. The contract shall permit the State to recover any loss resulting from errors identified by the third-party medical claims reviewer.

h. Information provided to or obtained by the third-party medical claims reviewer shall be delivered, received, maintained, and reviewed in a manner and shall contain only material consistent with the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191. To the extent necessary in accordance therewith, a carrier shall ensure that information provided to the medical claims reviewer is attendant to only persons who are participants in the School Employees' Health Benefits Program.

i. After the effective date of P.L. , c. (pending before the Legislature as this bill), the contract or contracts purchased by the commission to provide a health care benefits plan shall allow the commission to contract with a healthcare marketplace vendor The healthcare marketplace vendor shall establish a Bundled Payment Program through which the contracted healthcare marketplace vendor shall contract with high quality providers to accept a global negotiated payment of a predetermined amount for all services provided during an episode of care by a designated group of providers, including both hospital and post-acute services. The payment methodology for the episode of care shall be developed through administrative action by the Division of Pensions and Benefits with the healthcare marketplace vendor utilizing metric based allowable amounts. A contract for the services of a healthcare marketplace vendor to establish a Bundled Payment Program may be procured in accordance with section 3 of P.L. , c. (C.) (pending before the Legislature as this bill).

j. After the effective date of P.L. , c. (pending before the Legislature as this bill), a contract to provide any health care benefit plan shall allow the commission to engage in a program whereby the payment methodology for certain elective medical procedures, developed through administrative action by the Division of Pensions and Benefits, utilizes a metric based allowable amount for such elective medical procedures.

k. As used in this section:

“Elective medical procedure” means any nonemergency care that can be scheduled at least 24 hours prior to the service without posing a significant threat to the patient’s health or well-being.

"Episode of care" includes all physician, inpatient, and outpatient care that the patient received in the course of being treated for the specific condition or medical event.

"Metric based allowable amount" means a maximum, uniformly-applied amount payable for an elective medical procedure, based on an external price that is deemed reasonable and selected by the payer and set by utilizing a claim pricing approach grounded in analysis of an objective value for medical services, which may include Medicare pricing, the provider's reported costs, average wholesale price, and third party databases.

(cf: P.L.2019, c.143, s.5)

3. (New section) a. Notwithstanding the provisions of any other law to the contrary, a contract for the services of a healthcare marketplace vendor to establish a Bundled Payment Program for the State Health Benefits Program or the School Employees' Health Benefits Program shall be procured in an expedited process.

b. Notwithstanding the provisions of any other law to the contrary, for the purpose of expediting the procurement of a healthcare marketplace vendor, the following provisions shall apply as modifications to law or regulation that may interfere with the expedited procurement:

(1) the timeframes for challenging the specifications shall be modified as determined by the Division of Pensions and Benefits;

(2) in lieu of advertising in accordance with sections 2, 3, and 4 of P.L.1954, c. 48 (C.52:34-7, C.52:34-8, and C.52:34-9), the division shall advertise the request for proposals for the above services and any addenda thereto on the division's website;

(3) the period of time that the State Comptroller has to review the request for proposals for compliance with applicable public contracting laws, rules, and regulations, pursuant to section 10 of P.L.2007, c.52 (C.52:15C-10), shall be 10 business days or less if practicable, as determined by the State Comptroller; and

(4) the timeframes for submission under section 4 of P.L.2012, c.25 (C.52:32-58) and section 1 of P.L.1977, c.33 (C.52:25-24.2) shall be extended to prior to the issuance of a Notice of Intent to Award.

c. The Division of Pensions and Benefits may, to the extent necessary, waive or modify any other law or regulation that may interfere with the expeditious procurement of a healthcare marketplace vendor to establish a Bundled Payment Program.

4. (New section) Notwithstanding the provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to the contrary, the Director of the Division of Pensions and Benefits in the Department of the Treasury may adopt, immediately,

upon filing with the Office of Administrative Law, regulations that the director determines to be necessary to implement the provisions of this act . The regulations shall be effective for a period not to exceed 365 days from the date of the filing. The director shall thereafter amend, adopt, or readopt the regulations in accordance with the requirements of P.L.1968, c.410 (C.52:14B-1 et seq.).

5. This act shall take effect immediately and apply to plan years beginning on and after January 1, 2021.

STATEMENT

The Governor's Fiscal Year 2022 budget recommendations include the enactment of legislation to require the State Health Benefits Commission and School Employees' Health Benefit Commission to implement a referenced based pricing program for certain elective medical procedures and a bundled payment program. This bill authorizes the commissions to implement both programs.