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HEARINGS: No

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CL/JA

§1
Note to §§2-5
§§2,3
C.52:14-17.28f
and 52:14-17.28g
§§4,5
C.52:14-17.46.5a
and
52:14-17.46.5b
§6
C.52:14-17.37b
and Note to
C.52:14-17.46.5

P.L. 2023, CHAPTER 195, *approved December 21, 2023*
Senate Committee Substitute (*Second Reprint*) for
Senate, No. 3756

1 AN ACT concerning the State Health Benefits Program and the
2 School Employees' Health Benefits Program, supplementing
3 P.L.1961, c.49 (C.52:14-17.25 et seq.) and P.L.2007, c.103
4 (C.52:14-17.46.1 et seq.), and repealing section 1 of P.L.2013,
5 c.189 (C.52:14-17.37a).
6

7 **BE IT ENACTED** by the Senate and General Assembly of the State
8 of New Jersey:
9

- 10 1. The Legislature finds and declares that:
11 a. The cost of health care for public employees in the State has
12 been increasing at a pace that will make our current system of
13 health care delivery unsustainable if it continues on its present
14 trajectory.
15 b. As health care costs continue to rise more quickly than the
16 average annual income, those costs displace other priorities for
17 individuals, such as saving for retirement or their children's
18 education, and even discourage people from obtaining
19 recommended health care. The litany of research in this area has
20 demonstrated that action must be taken to reduce costs.
21 c. One way to reduce costs is to increase competition among
22 the third-party administrators that contract with the State to
23 administer the State Health Benefits Program and the School
24 Employees' Health Benefits Program that cover thousands of State,
25 municipal, school district, and related public employees and their
26 dependents.

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 amendments adopted in accordance with Governor's
recommendations December 11, 2023.

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

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

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

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

32

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

36 In addition, as used in this act:

37 "Competitive range" means the group of responsive proposals to a
38 request for proposal that are among the most highly rated proposals
39 ²within a range established by the director in consultation with the
40 commission] as determined by the evaluation committee². The
41 ²[director] commission, or its designee,² shall include an economic
42 component to the established competitive range to ensure the group of
43 responsive proposals deliver competitive pricing beneficial to the
44 ²[plan] State Health Benefits Program and the School Employees'
45 Health Benefits Program².

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

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

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

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

14 “Plan type” means preferred provider organization (PPO), health
15 maintenance organization (HMO), tiered network plan, high-
16 deductible health plan, ²and² Medicare supplemental PPO and HMO
17 ²**[**, and Medicare Advantage plan**]** plans² as those terms may be
18 defined in law.

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

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

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

33
34 3. a. For each plan type offered to eligible employees, early
35 retirees, and ²certain² Medicare retirees, and their dependents, the
36 State Health Benefits Commission ², or its designee,² shall select at
37 least two third-party administrators from among those vendors who
38 submit responsive proposals that are most advantageous to the State,
39 ²price and other factors considered,² provided that, if fewer than two
40 ²**[**qualified**]**² vendors submit responsive proposals within a
41 competitive range established by the ²**[**director in consultation with
42 the commission**]** evaluation committee², the commission ², or its
43 designee,² shall ¹either: (1)¹ select ¹the¹ one qualified vendor ¹;¹ or
44 ¹**[**a solicitation for the plan type may be reissued**]** (2) reissue the
45 solicitation for the plan type in its entirety in an effort to secure at least
46 two third-party administrators¹.

1 b. Unless otherwise limited through the terms of a collective
2 bargaining agreement, State or federal statute, or regulation, an eligible
3 employee, early retiree, and Medicare ²~~retiree~~ retirees not eligible
4 for or enrolled in Medicare Advantage plans² shall have the
5 opportunity, on an annual basis, during the open enrollment period or
6 other applicable enrollment period, to choose a plan from among the
7 plan types the commission has selected.

8 c. The commission ², or its designee,² shall award the contracts for
9 each plan type under subsection a. of this section on the basis of the
10 bid ²~~response~~ responses² that ²~~is~~ are² the most advantageous to
11 the State, which shall consider price, network breadth, member
12 experience, the ability to engage in innovative approaches designed to
13 slow the growth of health care costs, and any other factors that the
14 commission or ²~~their~~ its² designee may deem relevant.

15 d. The commission ², or its designee,² is authorized to award a
16 contract to the vendor with the bid that is most advantageous to the
17 State ², price and other factors considered,² based upon the evaluation
18 factors in subsection c. of this section, and to thereafter award another
19 contract to one or more vendors with bids within the competitive range
20 that can provide a comparable bid price and factors of the first
21 awarded contract.

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

29
30 4. The definitions set forth in section 32 of P.L.2007, c.103
31 (C.52:14-17.46.2) shall be applicable to sections 4 and 5 of this act,
32 P.L. , c. (C.) (pending before the Legislature as this bill).

33 In addition, as used in this act:

34 “Competitive range” means the group of responsive proposals to a
35 request for proposal that are among the most highly rated proposals
36 ²~~within a range established by the director in consultation with the~~
37 ~~commission~~ as determined by the evaluation committee². The
38 ²~~director~~ commission, or its designee,² shall include an economic
39 component to the established competitive range to ensure the group of
40 responsive proposals deliver competitive pricing beneficial to the
41 ²~~plan~~ State Health Benefits Program and the School Employees’
42 Health Benefits Program².

43 ²~~“Director”~~ means the Director of the Division of Pension and
44 Benefits or the director’s designee.]²

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

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

8 “Medicare retiree” means a retired employee of the State or
9 participating employer who is 65 years of age or older, or otherwise
10 qualified to enroll in Medicare due to health status, and is currently
11 enrolled in Medicare. Eligible retirees include those who are enrolled
12 in a self-insured Medicare Supplement plan ²or a fully-insured
13 Medicare Advantage plan².

14 “Plan type” means preferred provider organization (PPO), health
15 maintenance organization (HMO), tiered network plan, high-
16 deductible health plan, ²and² Medicare supplemental PPO and HMO
17 ²or a Medicare Advantage plan² plans² as those terms may be
18 defined in law.

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

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

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

33
34 5. a. For each plan type offered to eligible employees, early
35 retirees, and ²certain² Medicare retirees, and their dependents, the
36 School Employees’ Health Benefits Commission ², or its designee,²
37 shall select at least two third-party administrators from among those
38 vendors who submit responsive proposals that are most advantageous
39 to the State, ²price and other factors considered,² provided that, if
40 fewer than two ²qualified² vendors submit responsive proposals
41 within a competitive range established by the ²director in
42 consultation with the commission² evaluation committee², the
43 commission ², or its designee,² shall ¹either: (1)¹ select ¹the¹ one
44 qualified vendor ¹;¹ or ¹or ¹a solicitation for the plan type may be
45 reissued¹ (2) reissue the solicitation for the plan type in its entirety in
46 an effort to secure at least two third-party administrators¹.

1 b. Unless otherwise limited through the terms of a collective
2 bargaining agreement, State or federal statute, or regulation, an eligible
3 employee, early retiree, and Medicare ²~~retiree~~ retirees not eligible
4 for or enrolled in Medicare Advantage plans² shall have the
5 opportunity, on an annual basis, during the open enrollment period or
6 other applicable enrollment period, to choose a plan from among the
7 plan types the commission has selected.

8 c. The commission ², or its designee,² shall award the contracts for
9 each plan type under subsection a. of this section on the basis of the
10 bid ²~~response~~ responses² that ²~~is~~ are² the most advantageous to
11 the State, which shall consider price, network breadth, member
12 experience, the ability to engage in innovative approaches designed to
13 slow the growth of health care costs, and any other factors that the
14 commission or ²~~their~~ its² designee may deem relevant.

15 d. The commission ², or its designee,² is authorized to award a
16 contract to the vendor with the bid that is most advantageous to the
17 State ², price and other factors considered,² based upon the evaluation
18 factors in subsection c. of this section, and to thereafter award another
19 contract to one or more vendors with bids within the competitive range
20 that can provide a comparable bid price and factors of the first
21 awarded contract.

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

29
30 6. a. (1) As soon as is practicable, but not later than 180 days
31 from the effective date of P.L. , c. (C.) (pending before the
32 Legislature as this bill), the Department of the Treasury shall provide,
33 upon request, but not more frequently than ²~~twice~~ once² in a ²~~plan~~
34 year 24-month period², to a participating employer in the State
35 Health Benefits Program or the School Employees Health Benefits
36 Program, a standard report which contains the requesting employer's
37 de-identified aggregate data relating to the use of benefits by their
38 employees ²~~,~~ and² early retirees, ²~~and Medicare retirees,~~²
39 and their dependents, covered under each plan in the program. The report
40 shall include premiums paid by month for each month covered in the
41 report ²~~and~~ . If the participating employer has more than 300
42 employees in the plan, then the report shall include² paid claims by
43 month for the following categories of services: (a) inpatient hospital;
44 (b) outpatient hospital; (c) in network medical; (d) out of network
45 medical; (e) prescription drugs; (f) ²~~medical drugs;~~ (g)² emergency
46 room services; and ²~~(h)~~ (g)² behavioral health, each reported

1 separately. The report shall cover both health and prescription
2 benefits.

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

9 (2) The Department of the Treasury shall provide the reports to a
10 requesting participating employer within ²[30] ²60² days of receipt of
11 such request. ²[For a request submitted on or after April 1st, the
12 report shall contain data from the January 1st through December 31st
13 of the prior year. For a request submitted on or after September 1st,
14 the report shall contain data from June 1st of the prior year through
15 May 31st of the current year. The department shall also provide such
16 reports to a majority representative of public employees for collective
17 negotiations purposes, but only for employers specifically identified as
18 having employees, early retirees, or Medicare retirees, and their
19 dependents, represented by the majority representative.]²

20 b. As soon as practicable, ²[but not later than December 1st of
21 each year,]² the Department of the Treasury shall collect and analyze
22 claims data within the State Health Benefits Program and the School
23 Employees Health Benefits Program to develop, and make publicly
24 available, a claims trend report for each program in the following
25 categories: (1) inpatient hospital; (2) outpatient hospital; (3) in
26 network medical; (4) out of network medical ; (5) prescription drugs;
27 (6) medical drugs; (7) emergency room services; and (8) behavioral
28 health. The claims trend report shall provide the information in
29 segments including active, early retiree, and Medicare retiree for each
30 plan in the State Health Benefits Program, and in the School
31 Employees Health Benefits Program, and in the aggregate for each
32 plan in both programs. The ²[department shall also make the]² report
33 ²shall be made publicly² available ²[on or before December 31st of
34 each year to all majority representatives of public employees for
35 collective negotiations purposes with which the State negotiates. The
36 report shall be posted]² on the Department of the Treasury's website
37 in a prominent and accessible location ²[not later than January 1st of
38 the following calendar year]².

39 ²[Each] The² claims trend report shall be submitted to the
40 Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1),
41 each member of the State Health Benefits Plan Design Committee and
42 of the School Employees' Health Benefits Plan Design Committee,
43 each member of the State Health Benefits Commission and of the
44 School Employees' Health Benefits Commission, and the Governor's
45 Office of Employee Relations.

46 c. No later than 12 months from the effective date of P.L. ,

1 c. (C.) (pending before the Legislature as this bill), the Department
2 of the Treasury shall provide the State Health Benefits Plan Design
3 Committee and the School Employees Health Benefits Plan Design
4 Committee with a feasibility study of strategies to lower the cost of
5 health care service for the participants of the programs. ²【The study
6 shall incorporate opportunities identified in previous management
7 consultant studies, including, but not limited to, changes to the benefit
8 design, spousal surcharges, value based care initiatives, reference-
9 based pricing, out-of-network reimbursements, and prescription drug
10 formulary changes.】² There shall be a review of short-term savings
11 achievable within 3 to 12 months, medium-term savings achievable
12 within 12 to 24 months, and long-term savings achievable after 24
13 months.

14

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

16

17 8. This act shall take effect immediately.

18

19

20

21

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

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 floor amendments adopted June 26, 2023.

² Senate amendments adopted in accordance with Governor's recommendations December 11, 2023.

SENATE, No. 3756

STATE OF NEW JERSEY 220th LEGISLATURE

INTRODUCED MARCH 30, 2023

Sponsored by:

Senator NICHOLAS P. SCUTARI

District 22 (Middlesex, Somerset and Union)

Senator PAUL A. SARLO

District 36 (Bergen and Passaic)

SYNOPSIS

Provides for increased competition to reduce State health care costs; provides member representatives access to claims data to increase transparency and accountability; enables SHBP and SEHBP members to choose claim administrators.

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 3/30/2023)

1 AN ACT concerning the State Health Benefits Program and the
2 School Employees' Health Benefits Program and supplementing
3 P.L.1961, c.49 (C.52:14-17.25 et seq.) and P.L.2007, c.103
4 (C.52:14-17.46.1 et seq.).

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

8
9 1. The Legislature finds and declares that:

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

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

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

25 d. Permitting these employees to have greater choice in the
26 selection of claims administrators for their respective health plan
27 will also increase accountability of the administrators and overall
28 performance, quality, and cost by encouraging competition among
29 the claims administrators.

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

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

1 g. For the purpose of reducing health care costs and facilitating
2 greater satisfaction, efficiency, and accountability in the
3 administration of health benefits claims to State employees, their
4 eligible family members, and participating local government and
5 school district employees and their eligible family members, the
6 State of New Jersey deems it fitting and crucial to procure more
7 than one contract administrator for each health benefits plan type
8 offered by the State Health Benefits Program and the School
9 Employees' Health Benefits Program for implementation in the plan
10 year beginning in January of 2024.

11

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

15 In addition, as used in this act:

16 "Competitive range" means the group of responsive proposals to
17 a request for proposal that are among the most highly rated
18 proposals.

19 "Director" means the Director of the Division of Pension and
20 Benefits or the director's designee.

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

24 "Medicare retiree" means a retired employee of the State or
25 participating employer who is 65 years of age or older, or otherwise
26 qualified to enroll in Medicare due to health status, and is currently
27 enrolled in Medicare. Eligible retirees include those who are
28 enrolled in a Self-insured Medicare Supplement plan or a Fully-
29 Insured Medicare Advantage plan. When relevant, the term
30 Medicare retiree is used to distinguish Medicare Supplement
31 retirees.

32 "Plan type" means preferred provider organization, health
33 maintenance organization, tiered network plan, high-deductible
34 health plan, Medicare supplemental PPO and HMO, and Medicare
35 Advantage plan.

36 "Prevailing wage" means the wage rates and fringe benefits for
37 service employees found prevailing in the locality as determined by
38 the Department of Labor and Workforce Development or contained
39 in a predecessor contractor's collective bargaining agreements.

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

44 "Responsive proposal" refers to a proposal that is deemed to
45 have adequately addressed all material provisions of an RFP's terms
46 and conditions, specifications, and other requirements.

1 3. a. For each plan type offered to eligible employees, early
2 retirees, and Medicare retirees, and their dependents, the State
3 Health Benefits Commission shall select at least two qualified
4 vendors for claims administration services, provided that, if fewer
5 than two qualified vendors in response to an RFP issued on behalf
6 of the commission submit responsive proposals within a
7 competitive range established by the director in consultation with
8 the commission, the commission shall have the authority to either
9 select one qualified vendor or reissue a solicitation for the plan
10 type.

11 b. Each eligible employee, early retiree, and Medicare retiree
12 shall have the opportunity, on an annual basis, during the open
13 enrollment period or other applicable enrollment period, to choose a
14 plan from among the plans the commission has selected pursuant to
15 subsection a. of this section.

16 c. The commission shall award the contracts for each plan type
17 under subsection a. of this section on the basis of the bid response
18 that is the most advantageous to the State, which shall consider
19 price, network breadth, member experience, and the ability to
20 engage in innovation designed to slow health care cost growth.
21 The commission shall also consider as positive factors for any
22 bidder the percentage of employees who will perform the work
23 under the contract who (1) will perform those services in-State, and
24 (2) will be compensated at least a prevailing wage and afforded
25 health benefits under a health benefits plan authorized pursuant to
26 State or federal law.

27 d. The commission is authorized to award a contract to the
28 bidder who presented the bid that is most advantageous to the State
29 based upon an evaluation of factors in subsection c. of this section,
30 and to thereafter award another contract to one or more bidders
31 within the competitive range that can provide a comparable bid
32 price and performance to the first awarded contract.

33

34 4. a. The State Health Benefits Program shall provide to a plan
35 sponsor of a public employer that participates in the State Health
36 Benefits Program, at no cost and upon request not more than once
37 in each calendar year, aggregated and de-identified claims
38 experience data for the applicable group of public employees,
39 provided that any disclosure of aggregate data shall be done in a
40 manner that complies with the federal Health Insurance Portability
41 and Accountability Act of 1996, Pub.L.104-191, and any other
42 applicable federal and state privacy protection laws and related
43 regulations.

44 b. The director, in consultation with the commission, shall
45 establish a standard format for the report to be provided in
46 compliance with subsection a. of this section. The report shall be
47 provided in electronic format within 90 days of receipt of the
48 written request.

1 5. The definitions set forth in section 32 of P.L.2007, c.103
2 (C.52:14-17.46.2) shall be applicable to sections 5 to 7 of this act,
3 P.L. , c. (C.) (pending before the Legislature as this bill).

4 In addition, as used in this act:

5 “Competitive range” means the group of responsive proposals to
6 a request for proposal that are among the most highly rated
7 proposals.

8 “Director” means the Director of the Division of Pension and
9 Benefits or the director’s designee.

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

13 “Medicare retiree” means a retired employee of the State or
14 participating employer who is 65 years of age or older, or otherwise
15 qualified to enroll in Medicare due to health status, and is currently
16 enrolled in Medicare. Eligible retirees include those who are
17 enrolled in a Self-insured Medicare Supplement plan or a Fully-
18 Insured Medicare Advantage plan. When relevant, the term
19 Medicare retiree is used to distinguish Medicare Supplement
20 retirees.

21 “Plan type” means preferred provider organization, health
22 maintenance organization, tiered network plan, high-deductible
23 health plan, Medicare supplemental PPO and HMO, and Medicare
24 Advantage plan.

25 “Prevailing wage” means the wage rates and fringe benefits for
26 service employees found prevailing in the locality as determined by
27 the Department of Labor and Workforce Development or contained
28 in a predecessor contractor’s collective bargaining agreements.

29 “Request for Proposal” or “RFP” refers to all documents,
30 whether attached or incorporated by reference, used for a publicly
31 advertised procurement process that solicits proposals or offers to
32 provide the goods or services specified therein.

33 “Responsive proposal” refers to a proposal that is deemed to
34 have adequately addressed all material provisions of an RFP’s terms
35 and conditions, specifications, and other requirements.

36

37 6. a. For each plan type offered to eligible employees, early
38 retirees, and Medicare retirees, and their dependents, the School
39 Employees’ Health Benefits Commission shall select at least two
40 qualified vendors for claims administration services, provided that,
41 if fewer than two qualified vendors in response to an RFP issued on
42 behalf of the commission submit responsive proposals within a
43 competitive range established by the director in consultation with
44 the commission, the commission shall have the authority to either
45 select one qualified vendor or reissue a solicitation for the plan
46 type.

1 b. Each eligible employee, early retiree, and Medicare retiree
2 shall have the opportunity, on an annual basis, during the open
3 enrollment period or other applicable enrollment period, to choose a
4 plan from among the plans the commission has selected pursuant to
5 subsection a. of this section.

6 c. The commission shall award the contracts for each plan type
7 under subsection a. of this section on the basis of the bid response
8 that is the most advantageous to the State, which shall consider
9 price, network breadth, member experience, and the ability to
10 engage in innovation designed to slow health care cost growth.
11 The commission shall also consider as positive factors for any
12 bidder the percentage of employees who will perform the work
13 under the contract who (1) will perform those services in-State, and
14 (2) will be compensated at least a prevailing wage and afforded
15 health benefits under a health benefits plan authorized pursuant to
16 State or federal law.

17 d. The commission is authorized to award a contract to the
18 bidder who presented the bid that is most advantageous to the State
19 based upon an evaluation of factors in subsection c. of this section,
20 and to thereafter award another contract to one or more bidders
21 within the competitive range that can provide a comparable bid
22 price and performance to the first awarded contract.

23

24 7. a. The School Employees' Health Benefits Program shall
25 provide to a plan sponsor of a public employer that participates in
26 the School Employees' Health Benefits Program, at no cost and
27 upon request not more than once in each calendar year, aggregated
28 and de-identified claims experience data for the applicable group of
29 public employees, provided that any disclosure of aggregate data
30 shall be done in a manner that complies with the federal Health
31 Insurance Portability and Accountability Act of 1996, Pub.L.104-
32 191, and any other applicable federal and state privacy protection
33 laws and related regulations.

34 b. The director, in consultation with the commission, shall
35 establish a standard format for the report to be provided in
36 compliance with subsection a. of this section. The report shall be
37 provided in electronic format within 90 days of receipt of the
38 written request.

39

40 8. This act shall take effect immediately.

41

42

43

STATEMENT

44

45 This bill allows for the State Health Benefits Program (SHBP)
46 and the School Employees' Health Benefits Program (SEHBP) to

S3756 SCUTAR, SARLO

7

1 select more than one claims administrator in order to increase
2 competition and lower costs in the long term.

3 This bill also requires that SHBP and SEHBP provide, upon
4 request, aggregated and de-identified claims data to the plan
5 sponsor of a public employer that participates in the respective
6 program in order to increase transparency within the administration
7 of these health care plans.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR SENATE, No. 3756

STATE OF NEW JERSEY

DATED: JUNE 12, 2023

The Senate Budget and Appropriations Committee reports favorably a Senate Committee Substitute for Senate Bill No. 3756.

This substitute bill allows for the State Health Benefits Program (SHBP) and the School Employees Health Benefits Program (SEHBP) to select more than one claims administrator for each plan in the program offered to employees, early retirees, and Medicare retirees, and their dependents, in order to increase competition and lower costs in the long term.

This bill requires the State Health Benefits Commission and the School Employees' Health Benefits Commission to choose at least two third-party administrators from among submitted responsive proposals within a competitive range. The commissions are required to award the contracts based on which responsive proposal within the competitive range is the most advantageous to the State based on relevant factors including 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 may deem relevant. The commissions are authorized to award a contract to the vendor with the bid that is most advantageous to the State based upon the evaluation factors, 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.

Five years following the effective date of this bill, the Director of the Division of Pensions and Benefits will conduct a study on the impact of this bill and will include a recommendation to maintain, modify, or otherwise terminate the contracting provisions of the bill. The director will provide a copy of the study to the Legislature upon completion.

The bill requires the Department of the Treasury to provide, upon request, but not more frequently than twice in a plan year, 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, early retirees, and Medicare retirees, and their dependents, covered under the plans in the

program. The report will include premiums paid by month for each month covered in the report and 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) medical drugs; (g) emergency room services; and (h) behavioral health, each reported separately. The report shall cover both health and prescription benefits.

The report will also provide for a listing of de-identified claims within each plan of both programs, 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 will cover both health and prescription benefits.

The Department of the Treasury will provide the reports to a requesting participating employer within 30 days of receipt of such request.

Not later than December 1st of each year, the Department of the Treasury will 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 will 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 department will also make the report available 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 will be posted on the Department of the Treasury's website in a prominent and accessible location not later than January 1st of the following calendar year.

Each claims trend report shall be submitted to the Legislature, 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.

No later than 12 months from the effective date of the bill, the Department of the Treasury will 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. The study will 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. There will 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.

FISCAL IMPACT:

The Office of Legislative Services (OLS) estimates that requiring the State Health Benefits Commission and the School Employees' Health Benefits Commission to contract with multiple claims administrators for each plan offered by the State Health Benefits Program and the School Employees' Health Benefits Program and requiring the programs to annually provide certain claims data to participating plan sponsors will potentially reduce combined State and local expenditures by five to 20 percent, or \$319 million to \$1.3 billion, given certain assumptions.

At present, there is insufficient information to determine the degree to which increased competition among State Health Benefits and School Employees' Health Benefits claims administrators will lower health care expenditures. If the assumptions behind the analysis change, the OLS' estimates will also shift.

LEGISLATIVE FISCAL ESTIMATE
SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 3756
STATE OF NEW JERSEY
220th LEGISLATURE

DATED: JUNE 23, 2023

SUMMARY

- 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.
- Type of Impact:** Expenditure impact on State General Fund and local government and school district funds.
- Agencies Affected:** Division of Pensions and Benefits in the Department of the Treasury; certain local governments and school districts participating in SHBP and SEBHP.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State	Indeterminate
Local	Indeterminate
School District	Indeterminate
Total	Indeterminate

- The Office of Legislative Services (OLS) finds that the fiscal estimate depends on whether additional vendors bidding on the contract to be a third-party administrator for the State Health Benefits Program and the School Employees’ Health Benefits Program have the ability to affect costs because the State self-insures for the provision of health care benefits to public employees who are enrolled in the programs and because State law and State policy determine health benefits coverage, not the insurance carrier.
- The OLS concludes that the insurance carriers competing for the State and school health benefits business are competing to administer the plans, not to insure the plans.
- If the State were to contract with more than one third-party administrator, the State would have to pay for more than one administrative services contract, which would result in higher costs unless competitive differences in the vendor bids including employee-per month rates, the

number of employees enrolled in the vendors' plans, other administrative cost differentiating items, and separately the contractual provider reimbursement rates can result in overall lower costs.

- The OLS notes that the move to contract with one third-party administrator each for active health care benefits (2019) and retiree post-retirement medical benefits (2018) resulted in \$30.9 million in third-party administrator savings.

BILL DESCRIPTION

This bill would require the State Health Benefits Commission and the School Employees' Health Benefits Commission to contract with at least two third-party administrators who submit responsive proposals to provide administrative services for the health benefit plans offered to State Health Benefits Program and School Employees' Health Benefits Program employees and retirees unless only one vendor submits a responsive proposal. The bill would also require the Department of the Treasury to furnish de-identified aggregate claims experience data for participating employers in the State Health Benefits and School Employees' Health Benefits programs to such participating employers annually. The department will also make claims trend reports containing certain categories of information publicly available for each program and to all majority representatives of public employees for collective negotiation purposes with the State annually. Finally, the bill requires the department to provide a feasibility study of strategies to lower the cost of health care service for the participants of the programs to the State Health Benefits Plan Design Committee and the School Employees' Plan Design Committee no later than one year after the effective date of the bill.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS finds that the fiscal estimate depends on whether additional vendors bidding on the contract to be a third-party administrator for the State Health Benefits Program and the School Employees' Health Benefits Program have the ability to affect costs because the State self-insures for the provision of health care benefits to public employees who are enrolled in the programs and because State law and State policy determine health benefits coverage, not the insurance carrier. A self-insured health plan is coverage offered by an employer in which the employer takes on the risk providing coverage, instead of purchasing coverage from an insurance company. Self-insured coverage means that the employer pays for enrollees' medical care directly. Fully insured coverage means that health insurance is being purchased from an insurance company by an employer and the insurance company will be the entity responsible for paying for medical care.

Under current law, the State Health Benefits Commission and the School Employees' Health Benefits Commission negotiate with and arrange for the purchase, from licensed carriers, of

contracts providing hospital, surgical, obstetrical, and other covered health care services and benefits covering employees of the State, participating local governments and school districts and their dependents. In addition, the State Health Benefits Commission and the School Employees' Health Benefits Commission have the authority to establish rules and regulations for the administration of the programs. Furthermore, the State Health Benefits and the School Employees' Health Benefits Plan Design Committees have the responsibility for and authority over the various plans and components of those plans, including medical benefits, prescription benefits, dental, vision and any other healthcare benefits, offered and administered by the programs. Finally, the committees have the authority to create, modify, or terminate any plan or component at their sole discretion.

The State actuary projects plan year costs published annually in Rate Renewal reports, which identify trends, project costs, and establish rates for each plan and plan type offered. Plan design committees monitor, review, and analyze plan performance and, if necessary, recommend plan design changes to control costs, as evidenced by the annual resolutions adopted intended to control costs. Approved rates and plan designs are adopted by the commissions.

Administrative Services Only Fee

Vendors bid, in a competitive bidding process, to secure an administrative services contract as a third-party administrator with the State to provide the healthcare plans at the approved rates. Third-party administrators are paid on the basis of an "administrative services only fee." The fee is the only compensation due to the vendor under the contract unless otherwise mutually agreed to by the vendor and the State contract manager. The vendor's monthly compensation is a function of the vendor's fee multiplied by the number of participating public subscribers during the applicable month.

What is Included in the Administrative Only Fee?

In the responses to the OLS FY 2019-2020 Discussion Points regarding third-party administrator fees, the Division of Pensions and Benefits clarified administrative services only fees. "The fees paid by the State Health Benefits Program and the School Employees Health Benefits Program to the third-party administrators include fees for general administration, claim administration, network management, medical management (precertification, concurrent review, discharge planning, case management), and disease management (coronary artery disease, heart failure, COPD, asthma, chronic kidney disease, diabetes, etc.). Administrative services only fees are paid on an "employee-per-month rate." In addition, the State Health Benefits Program and the School Employees Health Benefits Program pay third-party administrators for a number of other administrative services including: a 24-hour nurse line, which aids in reducing non-emergent use of the emergency room; radiology management which directs members to the most cost effective radiology service settings; pain management to reduce misuse of pain management services; medical supply drug management services to guide injectable drug administration to the most economic and clinically appropriate site of services; care coordination assistance to physician group partners to manage better patient care to avoid acute episodes; and wellness program support."

The Size of the Administrative Services Only Fee

In the responses the division provided a chart of the administrative service only fees paid to the third-party administrators of the programs. At that time, of the actuarially equivalent 14 plans offered by Aetna and the 13 plans offered by Horizon to active employees of State and local governments and school districts, 83.4 percent of enrolled members (190,911 individuals) were enrolled in Horizon plans. Out of the nine actuarially equivalent plans offered by both Aetna and Horizon to State and local government and school district retirees 70 percent of the retired member population were enrolled in Aetna plans.

Administrative Services Only Fees PY 2015 to 2018				
Fiscal Year	Aetna (\$)		Horizon (\$)	
	ASO Fees	Other Fees	ASO Fees	Other Fees
2015	\$ 21,495,374	\$ 855,659	\$ 96,284,366	\$ 29,639,998
2016	\$ 20,764,220	\$ 770,867	\$ 95,094,475	\$ 31,322,864
2017	\$ 21,434,003	\$ 992,131	\$ 82,933,366	\$ 33,012,000
2018	\$ 20,470,857	\$ 973,224	\$ 83,441,811	\$ 49,424,212

Subsequently, the State contracted with Aetna (2018) to administer the retiree plans and with Horizon (2019) for the active employee plans, saving \$30.9 million in third-party administrative fees as given in FY 2022 responses to OLS budget questions.

Provider Reimbursement Rates

Current law requires the contract or contracts purchased by the commissions to base reimbursement and payments on reasonable and customary charges, meaning charges based upon the 90th percentile of the usual, customary, and reasonable fee schedule determined by the Health Insurance Association of America or a similar nationally recognized database of prevailing health care charges and must reflect the cost of the benefits provided based on principles which in the judgment of the commission are actuarially sound.

The rates charged are determined by the carrier on accepted group rating principles with due regard to the experience, both past and contemplated, under the contract, but within reasonable and customary charges. Differences in contracted provider reimbursement rates would be limited by the association’s fee schedule and judgement of the commission.

Summary

In summary, the OLS concludes that the insurance carriers competing for the State and school health benefits business are competing to administer the plans, not to insure the plans. Nevertheless, differences in vendor bids affecting the cost to the State can include the “employee per month rate” charged by the carrier to administer the plans, other administrative services, and separately the effect on plan costs resulting from any slight differences in the contracted provider reimbursement rates paid to doctors for their services based on the carrier’s network.

If the State were to contract with more than one third-party administrator, the State would have to pay for more than one administrative services contract, which would result in higher costs unless competitive differences in the vendor bids including employee-per month rates, the number of employees enrolled in the vendors’ plans, other administrative cost differentiating items, and separately the contractual provider reimbursement rates can result in overall lower costs.

FE to SCS for S3756

5

Section: Legislative Budget and Finance Office
Analyst: Kim Clemmensen
Assistant Legislative Budget and Finance Officer
Approved: Thomas Koenig
Legislative Budget and Finance Officer

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 3756

with Senate Floor Amendments
(Proposed by Senator SCUTARI)

ADOPTED: JUNE 26, 2023

The bill currently provides that, if less than two qualified vendors submit responsive proposals within a competitive range, the State Health Benefits Commission or the School Employees' Health Benefits Commission must either: (1) select the one qualified vendor; or (2) reissue the solicitation for the plan type.

These floor amendments clarify that when reissuing the solicitation, the commission must reissue the solicitation for the plan type in its entirety in an effort to secure at least two third-party administrators.

These floor amendments make this bill identical to Assembly Bill No. 5363 ACS.

ASSEMBLY, No. 5363

STATE OF NEW JERSEY 220th LEGISLATURE

INTRODUCED MAY 8, 2023

Sponsored by:

Assemblyman GARY S. SCHAER

District 36 (Bergen and Passaic)

SYNOPSIS

Provides for increased competition to reduce State health care costs; provides member representatives access to claims data to increase transparency and accountability; enables SHBP and SEHBP members to choose claim administrators.

CURRENT VERSION OF TEXT

As introduced.



1 AN ACT concerning the State Health Benefits Program and the
2 School Employees' Health Benefits Program and supplementing
3 P.L.1961, c.49 (C.52:14-17.25 et seq.) and P.L.2007, c.103
4 (C.52:14-17.46.1 et seq.).

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

8
9 1. The Legislature finds and declares that:

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

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

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

25 d. Permitting these employees to have greater choice in the
26 selection of claims administrators for their respective health plan
27 will also increase accountability of the administrators and overall
28 performance, quality, and cost by encouraging competition among
29 the claims administrators.

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

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

47 g. For the purpose of reducing health care costs and facilitating
48 greater satisfaction, efficiency, and accountability in the
49 administration of health benefits claims to State employees, their

1 eligible family members, and participating local government and
2 school district employees and their eligible family members, the
3 State of New Jersey deems it fitting and crucial to procure more
4 than one contract administrator for each health benefits plan type
5 offered by the State Health Benefits Program and the School
6 Employees' Health Benefits Program for implementation in the plan
7 year beginning in January of 2024.

8

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

12 In addition, as used in this act:

13 "Competitive range" means the group of responsive proposals to
14 a request for proposal that are among the most highly rated
15 proposals.

16 "Director" means the Director of the Division of Pension and
17 Benefits or the director's designee.

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

21 "Medicare retiree" means a retired employee of the State or
22 participating employer who is 65 years of age or older, or otherwise
23 qualified to enroll in Medicare due to health status, and is currently
24 enrolled in Medicare. Eligible retirees include those who are
25 enrolled in a Self-insured Medicare Supplement plan or a Fully-
26 Insured Medicare Advantage plan. When relevant, the term
27 Medicare retiree is used to distinguish Medicare Supplement
28 retirees.

29 "Plan type" means preferred provider organization, health
30 maintenance organization, tiered network plan, high-deductible
31 health plan, Medicare supplemental PPO and HMO, and Medicare
32 Advantage plan.

33 "Prevailing wage" means the wage rates and fringe benefits for
34 service employees found prevailing in the locality as determined by
35 the Department of Labor and Workforce Development or contained
36 in a predecessor contractor's collective bargaining agreements.

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

41 "Responsive proposal" refers to a proposal that is deemed to
42 have adequately addressed all material provisions of an RFP's terms
43 and conditions, specifications, and other requirements.

44

45 3. a. For each plan type offered to eligible employees, early
46 retirees, and Medicare retirees, and their dependents, the State
47 Health Benefits Commission shall select at least two qualified
48 vendors for claims administration services, provided that, if fewer
49 than two qualified vendors in response to an RFP issued on behalf

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1 of the commission submit responsive proposals within a
2 competitive range established by the director in consultation with
3 the commission, the commission shall have the authority to either
4 select one qualified vendor or reissue a solicitation for the plan
5 type.

6 b. Each eligible employee, early retiree, and Medicare retiree
7 shall have the opportunity, on an annual basis, during the open
8 enrollment period or other applicable enrollment period, to choose a
9 plan from among the plans the commission has selected pursuant to
10 subsection a. of this section.

11 c. The commission shall award the contracts for each plan type
12 under subsection a. of this section on the basis of the bid response
13 that is the most advantageous to the State, which shall consider
14 price, network breadth, member experience, and the ability to
15 engage in innovation designed to slow health care cost growth.
16 The commission shall also consider as positive factors for any
17 bidder the percentage of employees who will perform the work
18 under the contract who (1) will perform those services in-State, and
19 (2) will be compensated at least a prevailing wage and afforded
20 health benefits under a health benefits plan authorized pursuant to
21 State or federal law.

22 d. The commission is authorized to award a contract to the
23 bidder who presented the bid that is most advantageous to the State
24 based upon an evaluation of factors in subsection c. of this section,
25 and to thereafter award another contract to one or more bidders
26 within the competitive range that can provide a comparable bid
27 price and performance to the first awarded contract.

28
29 4. a. The State Health Benefits Program shall provide to a plan
30 sponsor of a public employer that participates in the State Health
31 Benefits Program, at no cost and upon request not more than once
32 in each calendar year, aggregated and de-identified claims
33 experience data for the applicable group of public employees,
34 provided that any disclosure of aggregate data shall be done in a
35 manner that complies with the federal Health Insurance Portability
36 and Accountability Act of 1996, Pub.L.104-191, and any other
37 applicable federal and state privacy protection laws and related
38 regulations.

39 b. The director, in consultation with the commission, shall
40 establish a standard format for the report to be provided in
41 compliance with subsection a. of this section. The report shall be
42 provided in electronic format within 90 days of receipt of the
43 written request.

44
45 5. The definitions set forth in section 32 of P.L.2007, c.103
46 (C.52:14-17.46.2) shall be applicable to sections 5 to 7 of this act,
47 P.L. , c. (C.) (pending before the Legislature as this bill).

48 In addition, as used in this act:

1 “Competitive range” means the group of responsive proposals to
2 a request for proposal that are among the most highly rated
3 proposals.

4 “Director” means the Director of the Division of Pension and
5 Benefits or the director’s designee.

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

9 “Medicare retiree” means a retired employee of the State or
10 participating employer who is 65 years of age or older, or otherwise
11 qualified to enroll in Medicare due to health status, and is currently
12 enrolled in Medicare. Eligible retirees include those who are
13 enrolled in a Self-insured Medicare Supplement plan or a Fully-
14 Insured Medicare Advantage plan. When relevant, the term
15 Medicare retiree is used to distinguish Medicare Supplement
16 retirees.

17 “Plan type” means preferred provider organization, health
18 maintenance organization, tiered network plan, high-deductible
19 health plan, Medicare supplemental PPO and HMO, and Medicare
20 Advantage plan.

21 “Prevailing wage” means the wage rates and fringe benefits for
22 service employees found prevailing in the locality as determined by
23 the Department of Labor and Workforce Development or contained
24 in a predecessor contractor’s collective bargaining agreements.

25 “Request for Proposal” or “RFP” refers to all documents,
26 whether attached or incorporated by reference, used for a publicly
27 advertised procurement process that solicits proposals or offers to
28 provide the goods or services specified therein.

29 “Responsive proposal” refers to a proposal that is deemed to
30 have adequately addressed all material provisions of an RFP’s terms
31 and conditions, specifications, and other requirements.

32

33 6. a. For each plan type offered to eligible employees, early
34 retirees, and Medicare retirees, and their dependents, the School
35 Employees’ Health Benefits Commission shall select at least two
36 qualified vendors for claims administration services, provided that,
37 if fewer than two qualified vendors in response to an RFP issued on
38 behalf of the commission submit responsive proposals within a
39 competitive range established by the director in consultation with
40 the commission, the commission shall have the authority to either
41 select one qualified vendor or reissue a solicitation for the plan
42 type.

43 b. Each eligible employee, early retiree, and Medicare retiree
44 shall have the opportunity, on an annual basis, during the open
45 enrollment period or other applicable enrollment period, to choose a
46 plan from among the plans the commission has selected pursuant to
47 subsection a. of this section.

48 c. The commission shall award the contracts for each plan type
49 under subsection a. of this section on the basis of the bid response

1 that is the most advantageous to the State, which shall consider
2 price, network breadth, member experience, and the ability to
3 engage in innovation designed to slow health care cost growth.
4 The commission shall also consider as positive factors for any
5 bidder the percentage of employees who will perform the work
6 under the contract who (1) will perform those services in-State, and
7 (2) will be compensated at least a prevailing wage and afforded
8 health benefits under a health benefits plan authorized pursuant to
9 State or federal law.

10 d. The commission is authorized to award a contract to the
11 bidder who presented the bid that is most advantageous to the State
12 based upon an evaluation of factors in subsection c. of this section,
13 and to thereafter award another contract to one or more bidders
14 within the competitive range that can provide a comparable bid
15 price and performance to the first awarded contract.

16
17 7. a. The School Employees' Health Benefits Program shall
18 provide to a plan sponsor of a public employer that participates in
19 the School Employees' Health Benefits Program, at no cost and
20 upon request not more than once in each calendar year, aggregated
21 and de-identified claims experience data for the applicable group of
22 public employees, provided that any disclosure of aggregate data
23 shall be done in a manner that complies with the federal Health
24 Insurance Portability and Accountability Act of 1996, Pub.L.104-
25 191, and any other applicable federal and state privacy protection
26 laws and related regulations.

27 b. The director, in consultation with the commission, shall
28 establish a standard format for the report to be provided in
29 compliance with subsection a. of this section. The report shall be
30 provided in electronic format within 90 days of receipt of the
31 written request.

32
33 8. This act shall take effect immediately.

34
35
36 STATEMENT

37
38 This bill allows for the State Health Benefits Program (SHBP)
39 and the School Employees' Health Benefits Program (SEHBP) to
40 select more than one claims administrator in order to increase
41 competition and lower costs in the long term.

42 This bill also requires that SHBP and SEHBP provide, upon
43 request, aggregated and de-identified claims data to the plan
44 sponsor of a public employer that participates in the respective
45 program in order to increase transparency within the administration
46 of these health care plans.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 5363

STATE OF NEW JERSEY

DATED: JUNE 22, 2023

The Assembly Appropriations Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 5363.

This substitute bill allows for the State Health Benefits Program (SHBP) and the School Employees Health Benefits Program (SEHBP) to select more than one claims administrator for each plan in the program offered to employees, early retirees, and Medicare retirees, and their dependents, in order to increase competition and lower costs in the long term.

This bill requires the State Health Benefits Commission and the School Employees' Health Benefits Commission to choose at least two third-party administrators from among submitted responsive proposals within a competitive range. The commissions are required to award the contracts based on which responsive proposal within the competitive range is the most advantageous to the State based on relevant factors including 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 may deem relevant. The commissions are authorized to award a contract to the vendor with the bid that is most advantageous to the State based upon the evaluation factors, 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.

Five years following the effective date of this bill, the Director of the Division of Pensions and Benefits will conduct a study on the impact of this bill and will include a recommendation to maintain, modify, or otherwise terminate the contracting provisions of the bill. The director will provide a copy of the study to the Legislature upon completion.

The bill requires the Department of the Treasury to provide, upon request, but not more frequently than twice in a plan year, 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, early retirees, and Medicare retirees, and their dependents, covered under the plans in the

program. The report will include premiums paid by month for each month covered in the report and 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) medical drugs; (g) emergency room services; and (h) behavioral health, each reported separately. The report shall cover both health and prescription benefits.

The report will also provide for a listing of de-identified claims within each plan of both programs, 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 will cover both health and prescription benefits.

The Department of the Treasury will provide the reports to a requesting participating employer within 30 days of receipt of such request.

Not later than December 1st of each year, the Department of the Treasury will 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 will 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 department will also make the report available 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 will be posted on the Department of the Treasury's website in a prominent and accessible location not later than January 1st of the following calendar year.

Each claims trend report shall be submitted to the Legislature, 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.

No later than 12 months from the effective date of the bill, the Department of the Treasury will 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. The study will 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. There will 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.

This substitute will be identical to the Senate Committee Substitute for Senate Bill No. 3756.

FISCAL IMPACT

Fiscal information for this bill is currently unavailable.

SENATE COMMITTEE SUBSTITUTE FOR
SENATE BILL NO. 3756
(First Reprint)

To the Senate:

Pursuant to Article V, Section I, Paragraph 14 of the New Jersey Constitution, I am returning Senate Committee Substitute for Senate Bill No. 3756 (First Reprint) with my recommendations for reconsideration.

Senate Committee Substitute for Senate Bill No. 3756 (First Reprint) requires the State Health Benefits Commission ("SHBC") and the School Employees' Health Benefits Commission ("SEHBC") (collectively "Commissions") to contract with at least two third-party administrators to provide administrative services for each plan type offered to State Health Benefits Program ("SHBP") and School Employees' Health Benefits Program ("SEHBP") employees and retirees. The SHBC and SEHBC are required to award the contracts based on which responsive proposals within a competitive range are the most advantageous to the State utilizing factors outlined in the bill. The bill also requires the Department of the Treasury ("Treasury") to provide claims data to employers participating in the SHBP and SEHBP, publish claims trend reports for each program, and provide a feasibility study to the SHBP and SEHBP Plan Design Committees assessing strategies to lower the cost of health care services.

Current law directs the SHBC and the SEHBC to negotiate contracts arranging for the purchase of hospital, surgical, obstetrical, and other covered health care services and benefits covering employees of the State, participating local governments and school districts, and their dependents. The SHBC and SEHBC are empowered to request that the Division of Purchase and Property ("DPP") in Treasury contract on the Commissions' behalf for medical benefit services. In such instances, the procurement rules, policies, and procedures of the DPP govern. Operating pursuant to

the Commissions' authority to delegate the procurement of medical benefit services, the DPP posted a bid solicitation to solicit quotes from qualified bidders to provide claims administration, care management, and other services for the medical plans of the SHBP and the SEHBP on July 5, 2023.

I commend the sponsors of this legislation for seeking creative solutions to keep health benefits costs in check. In light of the Legislature's clear desire for the State to award more than one third-party administrator contract, as evidenced by this bill, the DPP revised its bid solicitation on August 15, 2023, to state that it is the intent of the State to award two or more contracts to responsible bidders whose quotes responsive to the bid solicitation are most advantageous to the State, following consideration of price and other factors. Consequently, the primary goal of this legislation is already incorporated into the DPP's bid solicitation. Therefore, to ensure that no unnecessary delays are inured in the procurement process, I am recommending several amendments to the bill to better align its language with the DPP's bid solicitation and the State's procurement laws. My recommended changes will also ensure that some of the bill's more onerous reporting requirements do not undermine our shared goal of reducing health care costs and facilitating greater satisfaction, efficiency, and accountability in the administration of health benefits claims to State employees, participating local government and school district employees, and their dependents.

My proposed changes include revising language to account for the fact that the procurement of a third-party administrator has been delegated by the SHBC and SEHBC to the DPP, better aligning the bill's definitions section with the definitions in current law and the bid solicitation, and ensuring that one bid solicitation can cover plans issued under both the SHBP and SEHBP. Moreover, my proposed amendments remove references to fully insured Medicare

Advantage plans, which fall outside the scope of the current bid solicitation as these plans do not utilize the services of a third-party administrator.

Among my recommended amendments are slight modifications to the reporting requirements set forth in the bill. These changes will help ensure that the State remains in compliance with the federal Health Insurance Portability and Accountability Act of 1996. The changes will also help provide realistic expectations for the reporting requirements placed on Treasury by aligning deadlines set forth in the legislation with how the State actually receives claims data from its vendors.

To be clear, my recommended revisions maintain the bill's overarching goal of having a more competitive procurement process by using multiple contract administrators for each plan type. Moreover, my recommended amendments leave largely intact the legislation's robust reporting requirements to ensure accountability and transparency to help shine light on key performance metrics that tend to impact the cost of health benefits for the State, local employers, and employees. The changes I am recommending further these goals while accounting for existing federal and State laws and regulations governing the procurement process and the protection of confidential patient information.

Therefore, I herewith return Senate Committee Substitute for Senate Bill No. 3756 (First Reprint) and recommend that it be amended as follows:

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| <u>Page 3, Section 2, Lines 22-23:</u> | Delete "within a range established by the director in consultation with the commission" and insert "as determined by the evaluation committee" |
| <u>Page 3, Section 2, Line 23:</u> | Delete "director" and insert "commission, or its designee," |
| <u>Page 3, Section 2, Line 26:</u> | Delete "plan" and insert "State Health Benefits Program and the School Employees' Health Benefits Program" |
| <u>Page 3, Section 2, Lines 27-28:</u> | Delete in their entirety |

<u>Page 3, Section 2, Line 31:</u>	After "Medicare." insert "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."
<u>Page 3, Section 2, Lines 36-37:</u>	Delete "or a fully-insured Medicare Advantage plan"
<u>Page 3, Section 2, Line 40:</u>	After "plan," insert "and"
<u>Page 3, Section 2, Lines 40-41:</u>	Delete ", and Medicare Advantage plan" and insert "plans"
<u>Page 4, Section 2, Line 6:</u>	Delete "For purposes of Medicare"
<u>Page 4, Section 2, Lines 7-9:</u>	Delete in their entirety
<u>Page 4, Section 3, Line 12:</u>	Before "Medicare" insert "certain"
<u>Page 4, Section 3, Line 13:</u>	After "Commission" insert ", or its designee,"
<u>Page 4, Section 3, Line 15:</u>	After "State," insert "price and other factors considered,"
<u>Page 4, Section 3, Line 16:</u>	Delete "qualified"
<u>Page 4, Section 3, Lines 17-18:</u>	Delete "director in consultation with the commission" and insert "evaluation committee"
<u>Page 4, Section 3, Line 18:</u>	After "commission" insert ", or its designee,"
<u>Page 4, Section 3, Line 25:</u>	After "Medicare" delete "retiree" and insert "retirees not eligible for or enrolled in Medicare Advantage plans"
<u>Page 4, Section 3, Line 29:</u>	After "commission" insert ", or its designee,"
<u>Page 4, Section 3, Line 30:</u>	Delete "response" and insert "responses"
<u>Page 4, Section 3, Line 31:</u>	Delete "is" and insert "are"
<u>Page 4, Section 3, Line 34:</u>	Delete "their" and insert "its"
<u>Page 4, Section 3, Line 36:</u>	After "commission" insert ", or its designee,"
<u>Page 4, Section 3, Line 37:</u>	After "State" insert ", price and other factors considered,"
<u>Page 4, Section 3, Lines 42-48:</u>	Delete in their entirety
<u>Page 5, Section 4, Lines 7-8:</u>	Delete "within a range established by the director in consultation with the

commission" and insert "as determined by the evaluation committee"

Page 5, Section 4, Line 8: Delete "director" and insert "commission, or its designee,"

Page 5, Section 4, Line 11: Delete "plan" and insert "State Health Benefits Program and the School Employees' Health Benefits Program"

Page 5, Section 4, Lines 12-13: Delete in their entirety

Page 5, Section 4, Line 16: After "Medicare." Insert
 ""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."

Page 5, Section 4, Lines 21-22: Delete "or a fully-insured Medicare Advantage plan"

Page 5, Section 4, Line 25: After "plan," insert "and"

Page 5, Section 4, Lines 25-26: Delete ", and Medicare Advantage plan" and insert "plans"

Page 5, Section 4, Line 38: Delete "For purposes of Medicare"

Page 5, Section 4, Lines 39-41: Delete in their entirety

Page 5, Section 5, Line 44: Before "Medicare" insert "certain"

Page 5, Section 5, Line 45: After "Commission" insert ", or its designee,"

Page 5, Section 5, Line 47: After "State," insert "price and other factors considered,"

Page 5, Section 5, Line 48: Delete "qualified"

Page 6, Section 5, Line 2: Delete "director in consultation with the commission" and insert "evaluation committee"

Page 6, Section 5, Line 2: After "commission" insert ", or its designee,"

Page 6, Section 5, Line 9: After "Medicare" delete "retiree" and insert "retirees not eligible for or enrolled in Medicare Advantage plans"

Page 6, Section 5, Line 13: After "commission" insert ", or its designee,"

Page 6, Section 5, Line 14: Delete "response" and insert "responses"

Page 6, Section 5, Line 15: Delete "is" and insert "are"

Page 6, Section 5, Line 18: Delete "their" and insert "its"

Page 6, Section 5, Line 20: After "commission" insert ", or its designee,"

Page 6, Section 5, Line 21: After "State" insert ", price and other factors considered,"

Page 6, Section 5, Lines 26-32: Delete in their entirety

Page 6, Section 6, Line 37: Delete "twice" and insert "once"

Page 6, Section 6, Lines 37-38: Delete "plan year" and insert "24-month period"

Page 6, Section 6, Line 42: After "employees" delete ",," and insert "and"

Page 6, Section 6, Line 42: Delete "and Medicare retirees,"

Page 6, Section 6, Line 45: Delete "and" and insert ". If the participating employer has more than 300 employees in the plan, then the report shall include"

Page 6, Section 6, Line 48: Delete "medical drugs; (g)"

Page 6, Section 6, Line 48: Delete "(h)" and insert "(g)"

Page 7, Section 6, Line 10: Delete "30" and insert "60"

Page 7, Section 6, Line 11: Delete "For a request submitted on or after April 1st, the"

Page 7, Section 6, Lines 12-20: Delete in their entirety

Page 7, Section 6, Lines 21-22: Delete "but not later than December 1st of each year,"

Page 7, Section 6, Lines 33-34: Delete "department shall also make the"

Page 7, Section 6, Line 34: After "report" insert "shall be made publicly"

Page 7, Section 6, Line 34: Delete "on or before December 31st of each"

Page 7, Section 6, Lines 35-36: Delete in their entirety

Page 7, Section 6, Line 37: Delete "The report shall be posted"

Page 7, Section 6, Lines 38-39: Delete "not later than January 1st of the following calendar year"

Page 7, Section 6, Line 40: Delete "Each" and insert "The"

Page 8, Section 6, Line 7: Delete "The study shall incorporate opportunities identified in"

Page 8, Section 6, Lines 8-10: Delete in their entirety

Page 8, Section 6, Line 11: Delete "reimbursements, and prescription drug formulary changes."

[seal]

Respectfully,
/s/ Philip D. Murphy
Governor

Attest:
/s/ Parimal Garg
Chief Counsel to the Governor

Governor Murphy Takes Action on Legislation

12/21/2023

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

SCS for S-524wGR/ACS for A-1700 (Ruiz, Cunningham/Quijano, Mukherji, Atkins) - Creates Mental Health Diversion Program to divert eligible persons away from criminal justice system and into appropriate case management and mental health services

S-2818wGR/A-4394 (Turner/Kennedy) - Establishes "Working Group to Study Pricing of Motor Fuels by Retail Dealers"

SCS for S-2848wGR/A-4328 (Smith, Greenstein/DeAngelo, Karabinchak) - Revises criteria for remote net metering program established by BPU

S-3011/A-4800 (Scutari/Murphy, McKeon, Mukherji) - Concerns use of ignition interlock devices for drunk driving offenses

S-3044wGR/A-4716 (Diegnan, Greenstein/Stanley, Benson, Mukherji) - Makes supplemental appropriation of \$15 million to DEP for implementation of Electric School Bus Program

S-3153wGR/A-4548 (Codey/Kennedy, Haider, Stanley) - Authorizes schools to receive certain food waste from other schools, and provides exemption to such receiving schools for certain DEP permits, under certain conditions

S-3480wGR/A-5137 (Vitale, Pou/McKeon, Park, Murphy) – "The Small Business Health Insurance Affordability Act"; revises certain requirements for individual and small employer health benefits plans

SCS for -3756wGR/ACS for A-5363 (Scutari, Sarlo/Schaer, Wimberly) - 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

S-3839wGR/A-4061 (Greenstein, Steinhardt/Mukherji, Wirths, Space) - Requires Commissioner of Corrections to institute 10-minute shift overlap in State correctional facilities; appropriates \$13 million

S-4011wGR/A-5650 (Ruiz/Coughlin, Pintor Marin, Wimberly) - Modifies New Jersey Community-Anchored Development Program

A-5549/S-3960 (Lopez, Benson, McKnight/Vitale) - Extends eligibility for certain individuals for emergency assistance

ACS for A-5757/S-4127 (Conaway, Speight, Sumter/Gopal) - Extends certain pay parity regarding telemedicine and telehealth for one year