SENATE, No. 1944

STATE OF NEW JERSEY

219th LEGISLATURE

INTRODUCED FEBRUARY 25, 2020

Sponsored by:
Senator NIA H. GILL
District 34 (Essex and Passaic)

SYNOPSIS

Requires carriers to disclose selection standards for placement of health care providers in tiered health benefits plan network; establishes oversight monitor to review compliance.

CURRENT VERSION OF TEXT

As introduced.

AN ACT concerning tiered health insurance networks and supplementing P.L.1997, c.192 (C.26:2S-1 et al.).

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

1. a. A carrier that offers a managed care plan that provides for in-network benefits and for a tiered network, shall:

(1) use quality of performance and cost-efficiency measurements as selection standards to determine the placement of health care providers in a tier: and

(2) make written disclosures regarding the selection standards used to determine the placement of health care providers in a tier in accordance with the provisions of this act.

b. For the purposes of this act, "tiered network" means a managed care plan provider network with more than one level or tier of in-network benefits, based on different levels of reimbursement and cost sharing accepted by the health care providers in that network.

2. The carrier shall also comply with the following requirements:

a. With respect to disclosures required pursuant to sections 3, 4 and 5 of this act, provide a description of how individual scores for quality of performance and cost-efficiency are calculated and to the extent the individual scores for quality of performance and cost-efficiency are combined for a total ranking, the proportion of each measure shall be clearly disclosed.

b. In evaluating health care provider performance, the carrier shall seek to achieve the goals of safe, timely, effective, efficient, equitable, and patient-centered care, to the extent possible, and shall seek to include patient experience as a measure of patient-centeredness.

c. In evaluating cost-efficiency performance of a health care provider, the carrier shall use appropriate and comprehensive episode of care software and shall ensure that any appropriate risk adjustment occurs as follows:

(1) in measuring cost-efficiency, the carrier shall compare health care providers within the same specialty within an appropriate geographical market; and

(2) the carrier shall fully disclose the basis and data used, and its relative weight or relevance to the overall evaluation.

d. The carrier shall describe the statistical basis for the number of patients for each disease state or specialty and use accurate, reliable and valid measurements of a health care provider's quality of performance.

e. The carrier shall describe the statistical basis for the number of patient episodes of care and use accurate, reliable and valid

measurements of a health care provider's cost-efficiency performance.

f. In determining a health care provider's performance for quality and cost-efficiency, the carrier shall use appropriate risk adjustment to account for the characteristics of the health care provider's patient population, such as case mix, severity of the patient's condition, co-morbidities, outlier episodes and other factors.

g. In deciding health care provider attribution for quality measurement, the carrier shall determine which health care provider should be held reasonably accountable for a patient's care and shall fully disclose the methodology used for attribution.

h. With respect to any changes in the use of performance quality or cost-efficiency measures, the carrier shall provide to the affected health care providers, at least 45 days before implementing the change, notice of the proposed change, an explanation of and access to data used for a particular health care provider, the methodology and measures used to assess health care providers, and an explanation of a health care provider's right to appeal in accordance with the appeal process provided pursuant to section 5 of this act.

i. With respect to data collection used for the purposes of performance measurements, the carrier shall:

(1) use the most current claims or other data to measure health care provider performance, consistent with the time period needed to attain adequate sample sizes and to comply with the provisions of this act; and

(2) use its best efforts to ensure the data it relies upon is accurate, including a consideration of whether some medical record verification is appropriate and necessary.

j. As part of its reporting to the oversight monitor pursuant to section 3 of this act, the carrier shall provide the oversight monitor with a plan to use aggregated (pooled) data, validated as appropriate, as a supplement to test its own data, in a manner and a time frame to be determined by the Commissioner of Banking and Insurance.

k. The carrier shall cooperate with the oversight monitor in developing standardized quality of performance and cost-efficiency measures.

3. a. The carrier shall disclose to the oversight monitor, appointed to pursuant to section 6 of this act, as to each plan that provides for a tiered network, a description of:

(1) the quality of performance and cost-efficiency measurements used as selection standards to determine the placement of health care providers in a tier;

(2) the data and methodology used to establish the performance measurements;

(3) the formulas or methods used to determine the weight given to any factors used to establish the performance measurements;

(4) the extent to which nationally recognized evidence-based or consensus-based clinical recommendations or guidelines are used to establish the performance measurements;

(5) the extent to which data concerning patient episodes of care is used to establish the performance measurements;

(6) the extent to which patient treatment outcomes or patient satisfaction surveys are used to establish the performance measurements; and

(7) any limitations of the data, methodology, formulas or methods used to establish the performance measurements.

b. The quality of performance measurements used to determine the placement of health care providers in a tier shall be those endorsed by the National Quality Forum, the AQA, or shall be measures based on other bona fide nationally-recognized guidelines.

c. The carrier shall disclose this information in a manner to be determined by the oversight monitor on at least an annual basis and otherwise as frequently as the oversight monitor deems necessary.

4. a. A carrier shall disclose to consumers, as to each plan that provides for a tiered network:

(1) the names of each health care provider in the network and the tier in which the provider is placed;

(2) a summary of the information regarding performance measurements required to be disclosed to the oversight monitor pursuant to section 3 of this act, which shall include information on how performance measurements are used as selection standards to determine the placement of health care providers in a tier;

(3) a notice that the health care provider performance measurements are only a guide to choosing a health care provider and that consumers should confer with their primary care physician before selecting other health care providers;

(4) any limitations of the data, methodology, or performance measurements used by the carrier, and that the performance measurements may have a risk of error and should not be used as the sole basis for selecting another health care provider; and

(5) information on how a consumer can register a complaint with the carrier and the oversight monitor with respect to any aspect of a health care provider's placement in a tier or any disclosure required pursuant to this section.

b. The carrier shall disclose this information on its website and in accordance with any other requirements to be determined by the oversight monitor.

5. a. A carrier shall disclose to a health care provider, as to each plan that provides for a tiered network:

(1) the information provided to the oversight monitor concerning quality of performance and cost-efficiency measurements used as selection standards to determine the placement of health care providers in a tier, as required pursuant to section 3 of this act;

(2) a notice that a health care provider has a right to seek review from, and provide additional information to, the carrier with respect to any quality of performance and cost-efficiency measurements used as selection standards to determine the placement of the health care provider in a tier, and the data, methodology, formulas or methods used to establish the performance measurements, and to request the carrier to correct errors and to consider additional information; and

(3) a notice that a health care provider has a right to appeal the carrier's placement of the health care provider in a tier, through an appeal process that shall be developed by the Commissioner of Banking and Insurance.

b. The carrier shall disclose this information in a manner to be determined by the oversight monitor on at least an annual basis and otherwise as frequently as the oversight monitor deems necessary.

6. a. The Commissioner of Banking and Insurance shall appoint, and contract with, an independent, nationally recognized standard-setting organization as an oversight monitor to review and evaluate the disclosure processes required to be maintained by carriers pursuant to this act. The commissioner shall select a non-profit organization that is tax exempt pursuant to 29 U.S.C. s.501(3) of the Internal Revenue Code of 1986 and that has experience in the processes and methodologies used in health care provider performance measurement systems and in monitoring those systems.

b. The contract shall provide that the oversight monitor shall:

(1) review and evaluate on an ongoing basis each carrier's disclosures pursuant to this act and report to the commissioner on the extent to which each carrier has complied with the disclosure requirements; and

(2) in consultation with the commissioner, develop a process to review and evaluate consumer complaints related to the placement of a health care provider in a tier or any disclosure required pursuant to the provisions of this act.

7. The Commissioner of Banking and Insurance shall apply, and periodically revise as necessary, an annual surcharge on all health benefits plans in the State that offer a tiered network plan, to pay for the costs that the department incurs in entering into the contract with the oversight monitor and any other administrative and operational costs as the commissioner deems necessary to effectuate the purposes of this act.

8. If any person violates any provision of this act, the Commissioner of Banking and Insurance shall have the authority to assess penalties and take any other action provided for in section 16 of P.L.1997, c.192 (C.26:2S-16).

9. This act shall take effect on the 90th day next following enactment.

STATEMENT

This bill supplements the "Health Care Quality Act" to require health insurance carriers to disclose selection standards for placement of health care providers in tiered health benefits plan networks and provides for the appointment of an oversight monitor to review compliance with the bill's requirements. With respect to those various selection standards and other data, the bill provides guidelines and details as to how those standards and data shall be calculated. For the purposes of the bill, "tiered network" means a managed care plan provider network with more than one level or tier of in-network benefits, based on different levels of reimbursement and cost sharing accepted by the health care providers in that network.

The bill requires the carrier to disclose to the oversight monitor, as to each plan that provides for a tiered network, a description of:

(1) any quality of performance and cost-efficiency measurements used as selection standards to determine the placement of health care providers in a tier;

(2) the data and methodology used to establish the performance measurements;

(3) the formulas or methods used to determine the weight given to any factors used to establish the performance measurements;

(4) the extent to which nationally recognized evidence-based or consensus-based clinical recommendations or guidelines are used to establish the performance measurements;

(5) the extent to which data concerning patient episodes of care is used to establish the performance measurements;

(6) the extent to which patient treatment outcomes or patient satisfaction surveys are used to establish the performance measurements; and

(7) any limitations of the data, methodology, formulas or methods used to establish the performance measurements.

The carrier shall disclose this information in a manner to be determined by the oversight monitor and on at least an annual basis and otherwise as frequently as the oversight monitor deems necessary.

The bill further requires a carrier to disclose to consumers, as to each plan that provides for a tiered network:

(1) the names of each health care provider in the network and the tier in which the provider is placed;

(2) a summary of the information regarding performance measurements required to be disclosed to the oversight monitor pursuant to section 2 of this bill, which shall include information on and how performance measurements are used as selection standards to determine the placement of health care providers in a tier;

(3) a notice that the health care provider performance measurements are only a guide to choosing a health care provider and that consumers should confer with their primary care physician before selecting other health care providers;

(4) any limitations of the data, methodology, or performance measurements used by the carrier, and that the performance measurements may have a risk of error and should not be used as the sole basis for selecting another health care provider; and

(5) information on how a consumer can register a complaint with the carrier and the oversight monitor with respect to any aspect of a health care provider's placement in a tier or any disclosure required pursuant to this section.

The carrier shall disclose this information on its website and in accordance with any other requirements to be determined by the oversight monitor.

The bill also requires a carrier to disclose to a health care provider, as to each plan that provides for a tiered network:

(1) the information provided to the oversight monitor concerning quality of performance and cost-efficiency measurements used as selection standards to determine the placement of health care providers in a tier, as required pursuant to section 3 of this bill;

(2) a notice that a health care provider has a right to seek review from, and provide additional information to, the carrier with respect to any quality of performance and cost-efficiency measurements used as selection standards to determine the placement of the health care provider in a tier, and the data, methodology, formulas or methods used to establish the performance measurements, and to request the carrier to correct errors and to consider additional information;

(3) a notice that a health care provider has a right to appeal the carrier's placement of the health care provider in a tier, through an appeal process that shall be developed by the Commissioner of Banking and Insurance.

The carrier shall disclose this information in a manner to be determined by the oversight monitor on at least an annual basis and otherwise as frequently as the oversight monitor deems necessary.

The bill further requires the Commissioner of Banking and Insurance to appoint, and contract with, an independent, nationally recognized standard-setting organization as an oversight monitor to review and evaluate the disclosure processes required to be

maintained by carriers pursuant to the bill. The commissioner shall select a non-profit organization that is tax exempt pursuant to 29 U.S.C. s.501(3) of the Internal Revenue Code of 1986 and that has experience in the processes and methodologies used in health care provider performance measurement systems and in monitoring those systems.

The bill requires that the contract specify the responsibilities of the oversight monitor, including the monitoring of each carrier's disclosures, the developing of an appeals process for health care providers as to their placement in a tier, and the developing of a process to evaluate consumer complaints.

Finally, the bill also provides the Commissioner of Banking and Insurance with the authority to apply an annual surcharge to health benefits plans to pay for the expenses incurred for the oversight monitor and other expenses, and with the authority to assess penalties and take other actions for violations of the bill's provisions.