

ASSEMBLY, No. 3186

STATE OF NEW JERSEY 215th LEGISLATURE

INTRODUCED JULY 30, 2012

Sponsored by:

Assemblyman HERB CONAWAY, JR.

District 7 (Burlington)

Assemblyman TROY SINGLETON

District 7 (Burlington)

Assemblyman UPENDRA J. CHIVUKULA

District 17 (Middlesex and Somerset)

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District 19 (Middlesex)

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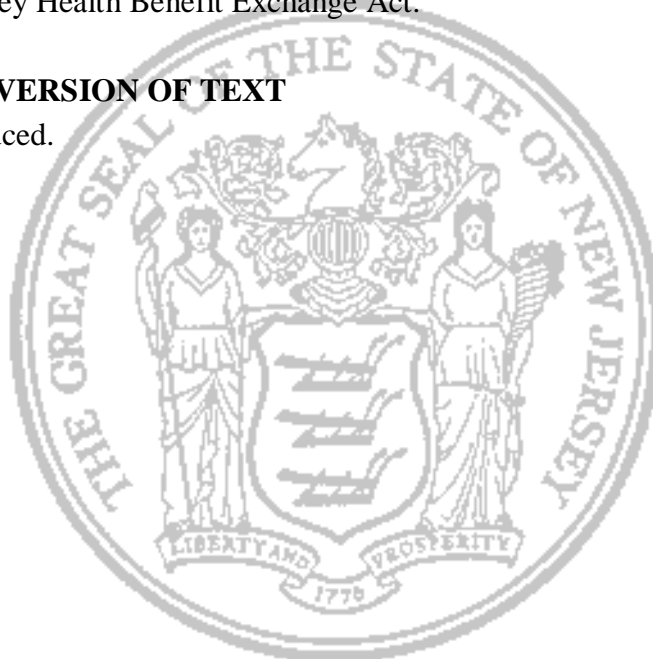
Assemblymen Johnson and Wimberly

SYNOPSIS

“New Jersey Health Benefit Exchange Act.”

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 10/12/2012)

1 AN ACT establishing the New Jersey Health Benefit Exchange and
2 supplementing Title 17B of the New Jersey Statutes.

3

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

6

7 1. This act shall be known and may be cited as the “New Jersey
8 Health Benefit Exchange Act.”

9

10 2. The Legislature finds and declares that it is the intent of this
11 act to provide statutory authorization for the establishment of an
12 American Health Benefit Exchange in New Jersey and its
13 administrative authority pursuant to the provisions of the federal
14 “Patient Protection and Affordable Care Act,” Pub.L.111-148, as
15 amended by the federal “Health Care and Education Reconciliation
16 Act of 2010,” Pub.L.111-152, and in so doing, to:

17 a. reduce the number of uninsured New Jerseyans by creating
18 an organized, transparent marketplace for the people of this State
19 to: purchase affordable, quality health care coverage; claim
20 available federal tax credits and cost-sharing subsidies; and meet
21 the personal responsibility requirements imposed by the federal act;

22 b. strengthen the health care delivery system in this State;

23 c. guarantee the availability and renewability of health care
24 coverage in New Jersey through the private health insurance market
25 to eligible persons and participating employers;

26 d. require that health benefits plans and health insurers issuing
27 coverage in the individual and employer markets in this State
28 compete on the basis of price, quality, and service, and not on risk
29 selection; and

30 e. meet the requirements of the federal act.

31

32 3. As used in this act:

33 “Board” means the board of directors of the exchange.

34 “Carrier” means an entity subject to the insurance laws and
35 regulations of this State, or subject to the jurisdiction of the
36 commissioner, that contracts or offers to contract to provide,
37 deliver, arrange for, pay for, or reimburse any of the costs of health
38 care services, including: an insurance company authorized to issue
39 health insurance; a health maintenance organization; a health,
40 hospital, or medical service corporation; or any other entity
41 providing a health benefits plan. The term "carrier" shall not
42 include a joint insurance fund established pursuant to State law.
43 For purposes of this act, carriers that are affiliated companies shall
44 be treated as one carrier, except that in the case of an insurance
45 company, health service corporation, hospital service corporation,
46 or medical service corporation that is an affiliate of a health
47 maintenance organization located in New Jersey or a health
48 maintenance organization located in New Jersey that is affiliated

1 with an insurance company, health service corporation, hospital
2 service corporation, or medical service corporation, the health
3 maintenance organization shall be treated as a separate carrier.

4 “Commissioner” means the Commissioner of Banking and
5 Insurance.

6 “Department” means the Department of Banking and Insurance.

7 “Enrollee” means a person receiving health care coverage
8 through the exchange, either as an individual or as an employee of a
9 participating employer.

10 “Exchange” means the New Jersey Health Benefit Exchange
11 established pursuant to this act.

12 “Executive director” means the executive director of the
13 exchange.

14 “Federal act” means the federal “Patient Protection and
15 Affordable Care Act,” Pub.L.111-148, as amended by the federal
16 “Health Care and Education Reconciliation Act of 2010,”
17 Pub.L.111-152, and any federal rules and regulations adopted
18 pursuant thereto.

19 “Health benefits plan” means a hospital and medical expense
20 insurance policy or certificate; health, hospital, or medical service
21 corporation contract or certificate; or health maintenance
22 organization subscriber contract or certificate delivered or issued
23 for delivery in this State. For the purposes of this act, “health
24 benefits plan” shall not include one or more, or any combination of,
25 the following: coverage only for accident or disability income
26 insurance, or any combination thereof; coverage issued as a
27 supplement to liability insurance; liability insurance, including
28 general liability insurance and automobile liability insurance;
29 workers' compensation or similar insurance; automobile medical
30 payment insurance; credit-only insurance; coverage for on-site
31 medical clinics; and other similar insurance coverage, as specified
32 in federal regulations, under which benefits for medical care are
33 secondary or incidental to other insurance benefits. “Health
34 benefits plan” shall not include the following benefits if they are
35 provided under a separate policy, certificate, or contract of
36 insurance or are otherwise not an integral part of the plan: limited
37 scope dental or vision benefits; benefits for long-term care, nursing
38 home care, home health care, community-based care, or any
39 combination thereof; and such other similar, limited benefits as are
40 specified in federal regulations. “Health benefits plan” shall not
41 include hospital confinement indemnity coverage if: the benefits
42 are provided under a separate policy, certificate, or contract of
43 insurance; there is no coordination between the provision of the
44 benefits and any exclusion of benefits under any group health
45 benefits plan maintained by the same plan sponsor; and those
46 benefits are paid with respect to an event without regard to whether
47 benefits are provided with respect to such an event under any group
48 health plan maintained by the same plan sponsor. “Health benefits

1 plan” shall not include the following if it is offered as a separate
2 policy, certificate, or contract of insurance: Medicare supplemental
3 health insurance as defined under section 1882(g)(1) of the federal
4 “Social Security Act” (42 U.S.C. s.1395ss(g)(1)); coverage that is
5 supplemental to the coverage provided under chapter 55 of Title 10,
6 United States Code (10 U.S.C. s.1071 et seq.); and similar coverage
7 that is supplemental to coverage provided under a group health
8 plan.

9 “Health care facility” means a health care facility licensed
10 pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.).

11 “Health care professional” means a health care professional who
12 is licensed or otherwise authorized to practice a health care
13 profession pursuant to Title 45 or Title 52 of the Revised Statutes
14 and is currently engaged in that practice.

15 “Medicaid” means the Medicaid program established pursuant to
16 P.L.1968, c.413 (C.30:4D-1 et seq.).

17 “NJ FamilyCare” means the NJ FamilyCare Program established
18 pursuant to section 3 of P.L.2005, c.156 (C.30:4J-10).

19 “Participating employer” means an employer that enters into an
20 agreement with the exchange to facilitate the offering of health
21 benefits plans to its employees through the State Business Health
22 Options Program established within the exchange pursuant to this
23 act.

24 “Qualified dental plan” means a limited scope dental plan
25 certified by the exchange pursuant to this act.

26 “Qualified health benefits plan” means a health benefits plan
27 certified by the exchange pursuant to this act.

28 “Secretary” means the United States Secretary of Health and
29 Human Services.

30 “SHOP” means the State Business Health Options Program
31 established within the exchange pursuant to this act.

32 “Small employer” means a person, firm, corporation, or
33 partnership that is actively engaged in business, which employed an
34 average of at least two but not more than 50 employees on business
35 days during the preceding calendar year and at least two employees
36 on the first day of the current calendar year, and the majority of
37 which employees are employed in New Jersey. A small employer
38 that makes enrollment in qualified health benefits plans available to
39 its employees through SHOP, and ceases to be a small employer
40 due to an increase in the number of its employees, shall continue to
41 be treated as a small employer for the purposes of this act as long as
42 it makes enrollment in qualified health benefits plans available to
43 its employees through SHOP. All persons treated as a single
44 employer under subsections (b), (c), (m) or (o) of section 414 of the
45 federal Internal Revenue Code (26 U.S.C. s.414) shall be treated as
46 one employer. For the purpose of determining the size of an
47 employer, and subject to the provisions of paragraph (2) of
48 subsection b. of section 6 of this act: all employees of an employer

1 shall be counted, including part-time employees and those not
2 eligible for employer-sponsored coverage; the size of an employer
3 shall be determined annually; and, in the case of an employer that
4 was not in existence during the preceding calendar year, the
5 determination of the size of the employer shall be based on the
6 average number of employees that the employer is reasonably
7 expected to employ on business days in the current calendar year.

8
9 4. There is established in the Executive Branch of State
10 Government the New Jersey Health Benefit Exchange, for the
11 purpose of effectuating the provisions of the federal act. For the
12 purpose of complying with the provisions of Article V, Section IV,
13 paragraph 1 of the New Jersey Constitution, the exchange is
14 allocated within the Department of Banking and Insurance; but,
15 notwithstanding that allocation, the exchange shall be independent
16 of any supervision or control by the department or by any board or
17 officer thereof. The exchange shall constitute an instrumentality of
18 the State exercising public and essential governmental functions,
19 and the exercise by the exchange of the powers conferred by this or
20 any other act shall be deemed and held to be an essential
21 governmental function of the State.

22
23 5. a. The exchange shall be governed by a board of directors
24 consisting of eight members as follows:

25 (1) the Commissioners of Banking and Insurance and Human
26 Services, or their designees, as nonvoting, ex officio members;

27 (2) the chairperson of the advisory committee established
28 pursuant to subsection k. of this section, as a nonvoting, ex officio
29 member; and

30 (3) five public members who are residents of this State, to be
31 appointed by the Governor with the advice and consent of the
32 Senate, including: one person who shall be a member in good
33 standing of the American Academy of Actuaries; and four other
34 persons, two of whom shall be appointed upon the recommendation
35 of the President of the Senate, and two of whom shall be appointed
36 upon the recommendation of the Speaker of the General Assembly.

37 b. The public members of the board appointed upon the
38 recommendation of the President of the Senate and the Speaker of
39 the General Assembly shall be appointed in such a manner as to
40 ensure that the public membership of the board includes individuals
41 who have demonstrated expertise in the following areas:

42 (1) individual health care coverage;

43 (2) small employer health care coverage;

44 (3) health benefits plan administration;

45 (4) health care finance; and

46 (5) consumer health care advocacy.

47 c. The public members of the board shall serve on a part-time
48 basis and receive an annual salary of \$50,000. The public members

1 shall also be reimbursed for any expenses incurred by them in the
2 performance of their duties, subject to the limits of funds
3 appropriated or otherwise made available for this purpose.

4 d. The public members of the board shall serve for a term of
5 four years; except that of the members first appointed, one of the
6 public members appointed upon the recommendation of the
7 President of the Senate and one of the public members appointed
8 upon the recommendation of the Speaker of the General Assembly
9 shall each serve for a period of three years, one of the public
10 members appointed upon the recommendation of the President of
11 the Senate and one of the public members appointed upon the
12 recommendation of the Speaker of the General Assembly shall each
13 serve for a period of four years, and the other public member
14 appointed shall serve for a period of five years.

15 e. Each public member of the board shall hold office for the
16 term of his appointment and until his successor has been appointed.
17 Vacancies shall be filled in the same manner as the original
18 appointments were made. A member is eligible for reappointment.

19 f. The board shall organize as soon as practicable after the
20 appointment of its members and shall select a chairperson annually
21 from among its members.

22 g. (1) The board shall appoint an executive director of the
23 exchange to supervise the administrative affairs and general
24 management and operations of the exchange.

25 (2) The executive director shall:

26 (a) be a person qualified by training and experience to perform
27 the duties of that position;

28 (b) serve as a member of the senior executive or unclassified
29 service and be appointed without regard to the provisions of Title
30 11A of the New Jersey Statutes;

31 (c) attend all meetings of the board; and

32 (d) serve at the pleasure of the board, and receive such
33 compensation as the board shall determine.

34 (3) With the approval of the board, the executive director shall:

35 (a) plan, direct, coordinate, and execute the administrative
36 functions of the exchange in conformity with the policies and
37 directives of the board;

38 (b) employ professional and clerical staff as necessary to
39 implement the provisions of this act;

40 (c) report to the board on all operations under his control and
41 supervision;

42 (d) prepare an annual budget and manage the administrative
43 expenses of the exchange; and

44 (e) undertake any other activities necessary to accomplish the
45 purposes of the exchange.

46 (4) All employees of the exchange, except the executive
47 director, shall be in the career service of the Civil Service.

- 1 h. While serving as a member of the board or an employee of
2 the exchange, and for a period of two years immediately following
3 such service or employment, a person shall not be:
- 4 (1) employed by, a consultant to, a member of the board of
5 directors of, affiliated with, or otherwise a representative of, a
6 carrier, an insurance agent or broker, a health care professional, a
7 health care facility, or an entity operating a navigator program as
8 set forth in subsection k. of section 8 of this act;
- 9 (2) a member, board member, or employee of a trade association
10 of carriers, insurance agents or brokers, health care professionals, or
11 health care facilities; or
- 12 (3) a health care professional, unless that person receives no
13 compensation for rendering services as a health care professional
14 and does not have an ownership interest in a health care
15 professional practice.
- 16 i. All meetings of the board shall be subject to the
17 requirements of the “Senator Byron M. Baer Open Public Meetings
18 Act,” P.L.1975, c.231 (C.10:4-6 et seq.). In addition to complying
19 with the notice requirements of P.L.1975, c.231, the board shall
20 provide electronic notice of its meetings as defined in section 1 of
21 P.L.2002, c.91 (C.10:4-9.1).
- 22 j. A member of the board or an employee of the exchange shall
23 not be liable in an action for damages to any person for any action
24 taken or recommendation made by the member or employee within
25 the scope of his functions as a member or employee, if the action or
26 recommendation was taken or made without malice. The members
27 of the board shall be indemnified and their defense of any action
28 provided for in the same manner and to the same extent as
29 employees of the State under the “New Jersey Tort Claims Act,”
30 P.L.1972, c.45 (C.59:1-1 et seq.) on account of acts or omissions in
31 the scope of their employment.
- 32 k. (1) The board shall establish an advisory committee to
33 provide advice to the board concerning the operation of the
34 exchange and any other matter relating to implementation of the
35 provisions of this act.
- 36 (2) The advisory committee shall include 15 members, to be
37 appointed by the board, who shall include one representative from
38 each of the following:
- 39 (a) health insurers or health maintenance organizations offering
40 health benefits plans in this State;
- 41 (b) health service corporations offering contracts in this State;
- 42 (c) insurance producers licensed pursuant to P.L.2001, c.210
43 (C.17:22A-26 et seq.);
- 44 (d) licensed general hospitals;
- 45 (e) licensed long-term care facilities;
- 46 (f) mental health care providers;
- 47 (g) federally qualified health centers;
- 48 (h) licensed physicians;

1 (i) licensed nurses;
2 (j) small employers;
3 (k) public employee unions;
4 (l) private sector unions;
5 (m) consumer health care advocacy organizations;
6 (n) consumer legal advocacy organizations; and
7 (o) public health researchers or other academic experts with
8 knowledge and background relevant to the functions and goals of
9 the exchange, including knowledge of the health care needs and
10 health disparities among the diverse communities of this State.

11 (3) The members of the advisory committee shall serve for a
12 term of three years; except that of the members first appointed, five
13 shall serve for a period of three years, five for a period of two years,
14 and five for a period of one year.

15 (4) Each member of the advisory committee shall hold office for
16 the term of his appointment and until his successor has been
17 appointed. Vacancies shall be filled in the same manner as the
18 original appointments were made. A member is eligible for
19 reappointment.

20 (5) The members of the advisory committee shall serve without
21 compensation but be reimbursed for any expenses incurred by them
22 in the performance of their duties, subject to the limits of funds
23 appropriated or otherwise made available for this purpose.

24 (6) The advisory committee shall organize as soon as practicable
25 after the appointment of its members and shall select a chairperson
26 annually from among its members, except that no member shall
27 serve as chairperson for a term exceeding two years.

28 (7) The board shall, within the limits of its existing staff and
29 resources, provide such staff support as the advisory committee
30 requires to perform its duties.

31

32 6. a. The board shall implement the exchange pursuant to the
33 provisions of this act and as otherwise required by the federal act or
34 any other federal law. The board shall facilitate the purchase of
35 coverage under qualified health benefits plans through the exchange
36 at affordable prices by enrollees.

37 b. (1) (a) The board shall establish the State Business Health
38 Options Program, or SHOP, separate from the activities of the board
39 related to the individual market, to assist participating employers in
40 facilitating the enrollment of their employees in qualified health
41 benefits plans offered through the exchange in a manner consistent
42 with the provisions of the federal act.

43 (b) A participating employer shall enter into a written agreement
44 with the exchange that governs the terms and conditions of its
45 participation and is consistent with the provisions of the federal act.
46 The written agreement shall:

47 (i) specify the responsibilities of the employer with regard to
48 the participation of its employees in qualified health benefits plans

1 and permit the employer to specify a level of coverage that any of
2 its employees may receive through a qualified health benefits plan
3 or provide a payment formulated in advance in accordance with the
4 federal act to be used as part of an employee choice plan;

5 (ii) indicate whether the employer is to communicate with a
6 carrier directly or through the exchange; and

7 (iii) require the exchange to provide premium aggregation and
8 other related services in order to minimize the administrative
9 burden on the employer.

10 (2) (a) The board: shall take such actions as are necessary to
11 permit small employers to purchase coverage through the exchange
12 beginning no later than January 1, 2014, and to permit employers
13 with at least 51 but not more than 100 employees to purchase
14 coverage through the exchange no later than January 1, 2016; and
15 may allow employers with more than 100 employees to purchase
16 coverage through the exchange beginning on January 1, 2017,
17 consistent with the provisions of the federal act and any regulations
18 adopted pursuant thereto.

19 (b) If the board decides not to allow employers with more than
20 100 employees to purchase coverage through the exchange
21 beginning on January 1, 2017, the board shall issue a report to the
22 Governor, and to the Legislature pursuant to section 2 of P.L.1991,
23 c.164 (C.52:14-19.1), that explains the reasons why it decided not
24 to allow those employers to purchase coverage through the
25 exchange, and shall make this report available to the public on the
26 Internet website of the exchange.

27 c. The board shall take such actions as are necessary to create
28 and offer a Basic Health Plan, in conjunction with the Department
29 of Human Services and consistent with the provisions of the federal
30 act, to enable persons with incomes of between 133% and 200% of
31 the federal poverty level, and noncitizens who would be eligible for
32 Medicaid except for not meeting the minimum residency
33 requirements provided in federal law, who would otherwise be
34 eligible to receive premium subsidies for the purchase of coverage
35 through the exchange, to purchase essential health benefits through
36 the provision of federal funds pursuant to the federal act.

37 d. The board shall develop and implement a plan of operation
38 for the exchange, which shall include, but not be limited to, the
39 following:

40 (1) procedures for the operations of the exchange;

41 (2) procedures and minimum requirements for the selection,
42 certification, and recertification of qualified health benefits plans to
43 be offered through the exchange that are consistent with guidelines
44 established by the United States Secretary of Health and Human
45 Services;

46 (3) criteria for determining that certain health benefits plans will
47 no longer be made available through the exchange and a procedure

1 to decertify these plans that includes providing prior notice to the
2 carrier;

3 (4) procedures, criteria, and a standard application form for
4 prospective enrollees seeking to obtain coverage under qualified
5 health benefits plans offered through the exchange;

6 (5) procedures, criteria, and a standard application form for the
7 enrollment of participating employers in SHOP;

8 (6) a customer service center, which shall operate a toll-free
9 telephone service and provide oral and written information in a
10 manner that is culturally and linguistically appropriate to the needs
11 of the population being served by the exchange, to manage
12 exchange enrollment, provide information to individuals and
13 employers about the exchange, provide carriers with information
14 about criteria for health benefits plans eligible to be offered through
15 the exchange, respond to requests for assistance from enrollees and
16 participating employers, and provide participating employers with
17 information about and services for establishing and maintaining
18 cafeteria plans for their employees pursuant to section 125 of the
19 federal Internal Revenue Code (26 U.S.C. s.125) and health
20 reimbursement arrangements for their employees pursuant to
21 section 105 of the federal Internal Revenue Code (26 U.S.C. s.105);

22 (7) maintenance of an Internet website that provides
23 standardized comparative information on qualified health benefits
24 plans, information on how to obtain assistance from navigators
25 chosen by the board pursuant to subsection k. of section 8 of this
26 act, and information on how to obtain assistance from a licensed
27 insurance producer for those individuals wishing to do so; and

28 (8) a strategy for publicizing the services, eligibility
29 requirements, and enrollment procedures of the exchange.

30 e. The board shall also be authorized to:

31 (1) apply for such grants from the federal government as may be
32 available for the purposes of this act pursuant to the federal act or
33 any other federal law, and take such actions as are necessary to
34 ensure that any such funds received are utilized in a manner
35 consistent with the provisions of federal law;

36 (2) seek and receive such grant funding as may be available
37 from private foundations for the purposes of this act;

38 (3) contract with professional service firms as may be necessary
39 in its judgment, and fix their compensation, for which purpose the
40 board, as it deems necessary to effectuate the purposes of this act,
41 may enter into a contract for the provision of goods or performance
42 of services without public advertising for bids, provided that the
43 contract shall be:

44 (a) publicly announced prior to being awarded;

45 (b) negotiated on the basis of demonstrated competence and
46 qualifications for the type of professional services required and at
47 fair and reasonable compensation; and

1 (c) awarded through a process that, to the maximum extent
2 practicable, meets the same procedural requirements as those set
3 forth in P.L.1997, c.399 (C.52:34-9.1 et seq.) for a professional firm
4 providing professional architectural, engineering, or land surveying
5 services in this State, but without regard to the dollar value of the
6 contract;

7 (4) adopt by-laws for the regulation of its affairs and the
8 conduct of its business;

9 (5) adopt an official seal for the exchange and alter the same;

10 (6) maintain an office in the State;

11 (7) sue and be sued in its own name; and

12 (8) approve the use of its trademarks, brand names, seals, logos,
13 and similar instruments by carriers, participating employers, and
14 other organizations.

15

16 7. a. (1) The exchange shall offer to enrollees only health
17 benefits plans that have been certified by the board, approved for
18 issuance or renewal in this State by the commissioner, and
19 underwritten by a carrier. The board shall certify those plans that it
20 determines offer the optimal combination of choice, value, quality,
21 and service to enrollees, so as to provide an appropriate range of
22 health care coverage choices within the exchange that achieves the
23 purposes of the federal act, including, in each region of the State, a
24 choice of qualified health benefits plans in each of the benefit
25 categories required under the federal act.

26 (2) The board shall permit a carrier participating in the exchange
27 to offer to enrollees a plan that provides limited scope dental
28 benefits, which meets the requirements of subparagraph (A) of
29 paragraph (2) of subsection (c) of section 9832 of the federal
30 Internal Revenue Code (26 U.S.C. s.9832) and is provided either in
31 conjunction with a qualified health benefits plan or under a separate
32 policy, certificate, or contract of insurance, if the plan provides
33 pediatric dental benefits that meet the requirements of subparagraph
34 (J) of paragraph (1) of subsection (b) of section 1302 of the federal
35 act (42 U.S.C. s.18022), and such other dental benefits as the board
36 or the secretary may prescribe by regulation.

37 (a) Carriers permitted to offer qualified dental plans shall be
38 licensed to offer dental coverage, but need not be licensed to offer
39 other health benefits.

40 (b) Two or more carriers may jointly offer a comprehensive plan
41 through the exchange in which the dental benefits are provided by a
42 carrier through a qualified dental plan and the other benefits are
43 provided by a carrier through a qualified health plan, provided that
44 the plans are priced separately and are also made available for
45 purchase separately at the same price.

46 (c) A carrier that offers a qualified health benefits plan in
47 conjunction with a plan that provides limited scope dental benefits,
48 in accordance with the provisions of this paragraph, shall provide

1 separate pricing for the health benefits plan and the dental plan and
2 also make each of the plans available for purchase separately.

3 (d) A carrier that offers a qualified health benefits plan that
4 includes limited scope dental coverage in that plan shall offer and
5 price the health benefits plan without the limited scope dental
6 coverage and shall offer and price the limited scope dental coverage
7 without the health benefits plan, so that either can be purchased
8 separately.

9 (3) The exchange and any carrier participating in the exchange
10 shall not charge a person a fee or other monetary penalty for the
11 termination of coverage under a qualified health benefits plan if the
12 person enrolls in another type of minimum essential coverage
13 because the person has become newly eligible for that coverage or
14 because the person's employer-sponsored coverage has become
15 affordable under the standards of subparagraph (C) of paragraph (2)
16 of subsection (c) of section 36B of the federal Internal Revenue
17 Code (26 U.S.C. s.36B).

18 b. To be certified as a qualified health benefits plan, a plan
19 shall, at a minimum:

20 (1) include within its health care provider network those
21 essential community providers, where available, that serve
22 predominately low-income, medically underserved individuals,
23 including: health care providers as defined in section 340B(a)(4) of
24 the Public Health Service Act (42 U.S.C. s.256b(a)(4)); and
25 providers as described in section 1927(c)(1)(D)(i)(IV) of the federal
26 Social Security Act (42 U.S.C. s.1396r-8(c)(1)(D)(i)(IV)); and

27 (2) pay essential community providers within its health care
28 provider network at the highest rate that it pays to comparable
29 providers for each category of services provided by the essential
30 community provider, except that in no case shall this rate be less
31 than Medicaid pays for the same service.

32 c. The board may require carriers participating in the exchange
33 to make available to the exchange and regularly update an
34 electronic directory of contracting health care providers so that
35 enrollees seeking coverage through the exchange can search by
36 health care provider name to determine which health benefits plans
37 in the exchange include that health care provider in their network.
38 The board may also require a carrier to provide regularly updated
39 information to the exchange as to whether a health care provider is
40 accepting new patients in a particular health benefits plan. The
41 exchange may provide an integrated and uniform consumer
42 directory of health care providers indicating which carriers the
43 providers contract with and whether the providers are currently
44 accepting new patients. The exchange may also establish methods
45 by which health care providers may transmit relevant information
46 directly to the exchange, rather than through a carrier.

47 d. The board shall require that a carrier, as a condition of
48 participation in the exchange, do all of the following consistent with

1 the provisions of the federal act and in such a manner as is
2 prescribed by regulation of the board or the commissioner, as
3 applicable:

4 (1) fairly and affirmatively offer, market, and sell in the
5 exchange at least one product within each of the categories of health
6 benefits plans that the federal act requires to be offered through the
7 exchange;

8 (2) if the carrier sells any products to individuals outside the
9 exchange, fairly and affirmatively offer, market, and sell all
10 products made available to individuals in the exchange to
11 individuals purchasing coverage outside the exchange; if the carrier
12 sells any products to employers outside the exchange, fairly and
13 affirmatively offer, market, and sell all products made available to
14 employers in SHOP to employers purchasing coverage outside the
15 exchange;

16 (3) provide a detailed description of the benefits offered by a
17 qualified health benefits plan through an Internet website and by
18 other means for individuals without access to the Internet, which
19 specifies: maximum benefits; limitations, exclusions, and other
20 benefit limits; and the amount of cost sharing, including, but not
21 limited to, deductibles, copayments, and coinsurance, under the
22 plan that an individual would be responsible for paying with respect
23 to the furnishing of a specific item or service by a participating
24 health care provider;

25 (4) submit a justification to the board for any premium increase
26 in a qualified health benefits plan prior to implementation of the
27 increase, and prominently post that information on its Internet
28 website, which the board shall consider in determining whether to
29 make the health benefits plan available through the exchange, in
30 addition to considering any information and recommendations
31 provided to the board by the department and any excess of premium
32 growth outside the exchange as compared to the rate of that growth
33 inside the exchange;

34 (5) make available to the public and submit to the board, the
35 secretary, and the commissioner, as applicable, accurate and timely
36 information, with respect to a qualified health benefits plan,
37 concerning the following:

38 (a) claims payment policies and practices;

39 (b) periodic financial disclosures;

40 (c) data on enrollment and disenrollment;

41 (d) data on the number of claims that are denied;

42 (e) data on rating practices;

43 (f) information on cost sharing and payments with respect to
44 any out-of-network coverage; and

45 (g) information on enrollee and participating employer rights as
46 specified under federal law or otherwise determined appropriate by
47 the secretary; and

1 (6) make available to the public and submit to the board such
2 other information as may be required pursuant to the federal act or
3 as the board reasonably determines necessary to accomplish the
4 purposes of this act.

5 e. The board shall establish procedures necessary to avoid risk
6 selection between qualified health benefits plans offered through
7 the exchange and health benefits plans offered outside the exchange
8 and among qualified health benefits plans offered within the
9 exchange, including, but not limited to, such mechanisms as the
10 board determines appropriate for adjusting payments to qualified
11 health benefits plans to account for risk selection and assure market
12 stability.

13 f. The provisions of this section shall not be construed as
14 requiring a carrier that does not participate in the exchange to meet
15 any requirements relating to health care coverage or its operations
16 that are not otherwise imposed on that carrier under federal or State
17 law.

18 g. The board may permit a carrier participating in the exchange
19 to offer to enrollees a plan that provides nonmedical remedial
20 treatment rendered in accordance with a recognized religious
21 method of healing.

22 h. The provisions of subsections d., e., and f. of this section
23 shall apply to qualified dental plans to the extent relevant to
24 qualified dental plans.

25

26 8. For the purpose of effectuating its direction and oversight of
27 the operation of the exchange and the provision of health care
28 coverage through the exchange, the board shall:

29 a. provide for the processing of applications, the determination
30 of eligibility for premium tax credits and any cost-sharing reduction
31 and the redetermination of eligibility as necessary due to changes in
32 an individual's income or circumstances, the enrollment and
33 disenrollment of enrollees, and the establishment of an enrollee
34 database, and coordinate those activities with Medicaid and NJ
35 FamilyCare, and any other State and local government entities as
36 applicable, in furtherance of which the board shall:

37 (1) adopt policies and procedures, pursuant to a written
38 agreement to be established between the board and the Division of
39 Medical Assistance and Health Services in the Department of
40 Human Services, by which the exchange: provides eligibility
41 determination and redetermination services for, and enrollment in,
42 the exchange, Medicaid, and NJ FamilyCare, as appropriate to the
43 individual's income and circumstances, through the use of a single
44 application form; and ensures the timely processing of applications
45 and enrollment, as appropriate, utilizing consistent methods and
46 standards that, to the maximum extent practicable, are employed by
47 both the exchange and the Division of Medical Assistance and
48 Health Services;

1 (2) arrange, pursuant to the written agreement established
2 between the board and the Division of Medical Assistance and
3 Health Services pursuant to paragraph (1) of this subsection, for the
4 sharing of data with respect to enrollees and recipients of Medicaid
5 and NJ FamilyCare;

6 (3) ensure that clear and comprehensible information is
7 provided to applicants that fully explains the application process, as
8 well as the possibility of overpayments of advance premium tax
9 credits to an enrollee that may render the enrollee liable for
10 repayment and the procedures for reconciliation used in those cases;

11 (4) establish procedures to assist an enrollee in reporting a
12 change in income to the exchange that might affect the amount of
13 advance premium tax credit to which the enrollee is entitled
14 pursuant to the federal act, as well as in qualifying for any
15 exemption from repayment of the advance premium tax credit that
16 would otherwise be required pursuant to federal or State law; and

17 (5) utilize any other measures that the board deems necessary
18 and appropriate for the purposes of this subsection, so as to ensure
19 the most efficient, cost-effective, and comprehensive health care
20 coverage possible and continuity of coverage and care when an
21 enrollee transitions between participation in a qualified health
22 benefits plan and participation in Medicaid or NJ FamilyCare, or
23 the reverse, consistent with the provisions of the federal act and any
24 other applicable federal law and regulations;

25 b. undertake activities necessary to market and publicize the
26 availability of health care coverage and federal subsidies through
27 the exchange, and undertake outreach and enrollment activities that
28 seek to assist enrollees and potential enrollees with enrolling and
29 reenrolling in the exchange in the least burdensome manner,
30 including populations that may experience barriers to enrollment,
31 such as persons with disabilities and those with limited English
32 language proficiency;

33 c. assign a rating to each qualified health benefits plan offered
34 through the exchange in accordance with criteria developed by the
35 secretary;

36 d. utilize a standardized format for presenting health benefits
37 plan options in the exchange;

38 e. establish and make available by electronic means a
39 calculator to determine the actual cost of coverage after the
40 application of any premium tax credit and any cost-sharing
41 reduction provided for under the federal act;

42 f. establish uniform billing and payment policies for qualified
43 health benefits plans and coordinate these policies with Medicaid
44 and NJ FamilyCare;

45 g. grant a certification attesting that a person is exempt from
46 the tax imposed under the federal act for not having qualifying
47 health care coverage as specified in the federal act, because: there
48 is no affordable qualified health benefits plan available through the

- 1 exchange or the person's employer to cover that person; or the
2 person meets the requirements for any other exemption from the tax
3 under the federal act;
- 4 h. perform such duties as are required of, or delegated to, the
5 exchange by the secretary or the Secretary of the Treasury, pursuant
6 to the federal act, relating to the determination of eligibility for
7 premium tax credits, reduced cost sharing, or exemptions from the
8 tax imposed under the federal act for not having qualifying health
9 care coverage;
- 10 i. provide notice to enrollees of their right of appeal with
11 respect to certain medical decisions by carriers under the
12 Independent Health Care Appeals Program established pursuant to
13 section 11 of P.L.1997, c.192 (C.26:2S-11);
- 14 j. provide for an appeal mechanism for enrollees with respect
15 to exchange-related determinations, when the subject of appeal is
16 not covered by an existing mechanism or is not within the
17 jurisdiction of the department under current law or regulations, and
18 which relates to the filing of enrollee grievances against the
19 exchange itself, or other appeals as required under the federal act,
20 and provide notice to enrollees of such an appeal mechanism that
21 includes an explanation of the relevant procedures and enrollee
22 rights in connection with filing such an appeal; and
- 23 k. establish the navigator program in accordance with the
24 federal act, under which any entity chosen by the exchange as a
25 navigator shall:
- 26 (1) conduct public education activities to raise awareness of the
27 availability of qualified health benefits plans;
- 28 (2) distribute fair and impartial information concerning
29 enrollment in qualified health benefits plans and the availability of
30 premium tax credits and cost-sharing reductions pursuant to the
31 federal act;
- 32 (3) facilitate enrollment in qualified health benefits plans;
- 33 (4) provide referrals to the appropriate office within the
34 department for health insurance consumer assistance in the case of
35 an enrollee in a qualified health benefits plan with a grievance,
36 complaint, or question regarding that person's plan, coverage, or a
37 determination under that plan or coverage;
- 38 (5) provide information in a manner that is culturally and
39 linguistically appropriate to the needs of the population being
40 served by the exchange;
- 41 (6) be evaluated and paid by the board based upon such
42 standards for performance and compensation as the board
43 determines appropriate for this purpose;
- 44 (7) be incorporated, organized, and operated in such a manner as
45 to qualify as a nonprofit corporation described in section 501(c)(3)
46 of the federal Internal Revenue Code, 26 U.S.C. s.501(c)(3) or any
47 successor provision that is exempt from taxation pursuant to section

1 501(a) of the federal Internal Revenue Code, 26 U.S.C. s.501(a) or
2 any successor provision; and

3 (8) meet any certification and training requirements established
4 by the board, provided however that the board shall not require a
5 navigator to be an insurance producer licensed pursuant to
6 P.L.2001, c.210 (C.17:22A-26 et seq.).
7

8 9. a. There is established in the Department of the Treasury a
9 nonlapsing revolving fund to be known as the "New Jersey Health
10 Benefit Exchange Trust Fund." This fund shall be the repository
11 for monies collected pursuant to subsection c. of this section and
12 other monies received as grants or otherwise appropriated for the
13 purposes of the exchange. The monies in the fund shall be used
14 only for the purpose of supporting the activities of the exchange.

15 b. The State Treasurer is the custodian of the fund and all
16 disbursements from the fund shall be made by the State Treasurer
17 upon vouchers signed by the executive director or the executive
18 director's designee. The monies in the fund shall be invested and
19 reinvested by the Director of the Division of Investment in the
20 Department of the Treasury as are other trust funds in the custody
21 of the State Treasurer in the manner provided by law. Interest
22 received on the monies in the fund shall be credited to the fund.

23 c. The exchange may apply a uniform surcharge to all qualified
24 health benefits plans, and a uniform assessment on carriers that do
25 not contract with the exchange, as the board determines necessary
26 to effectuate the purposes of this act. The proceeds therefrom shall
27 be deposited into the fund and be used only to pay for
28 administrative and operational expenses that the exchange incurs in
29 order to carry out its responsibilities pursuant to this act and as
30 otherwise required under the federal act or any other federal law or
31 regulation.
32

33 10. Records maintained by the exchange shall be subject to
34 P.L.1963, c.73 (C.47:1A-1 et seq.) and P.L.2001, c.404 (C.47:1A-5
35 et al.), commonly referred to as the open public records act.
36

37 11. a. In addition to furnishing such information to any
38 department or agency of the federal government as may be required
39 pursuant to the federal act or any other federal law or regulation, the
40 board shall annually: make a report of the activities, receipts, and
41 expenditures of the exchange as of the end of the State fiscal year to
42 the Governor, the Legislature pursuant to section 2 of P.L.1991,
43 c.164 (C.52:14-19.1), and the State Auditor; and make this
44 information available on the Internet website of the exchange.

45 b. The State Auditor shall conduct an audit of the exchange at
46 least once in each five-year period, and may otherwise examine the
47 operation, property, and records of the exchange, and prescribe

1 methods of accounting and the rendering of periodic reports in
2 relation to activities undertaken by the exchange.

3

4 12. The commissioner shall present a report to the Governor,
5 and to the Legislature pursuant to section 2 of P.L.1991, c.164
6 (C.52:14-19.1), no later than January 1, 2018, which contains the
7 commissioner's findings and recommendations, including such
8 recommendations for administrative or legislative action as the
9 commissioner deems appropriate, concerning whether to:

10 a. continue the New Jersey Individual Health Coverage
11 Program established pursuant to P.L.1992, c.161 (C.17B:27A-2 et
12 seq.) and the New Jersey Small Employer Health Benefits Program
13 established pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), as
14 provided under current law;

15 b. revise these programs to reflect the provisions of this act; or

16 c. phase out these programs and transition the health care
17 coverage provided thereunder to coverage provided under qualified
18 health benefits plans through the exchange, in which case the
19 commissioner shall specify a projected schedule for effecting this
20 transition in the most efficient and effective manner possible.

21

22 13. The board, the commissioner, and the Commissioner of
23 Human Services, pursuant to the "Administrative Procedure Act,"
24 P.L.1968, c.410 (C.52:14B-1 et seq.) and in consultation with each
25 other, shall each adopt such rules and regulations as may be
26 necessary to effectuate the purposes of this act.

27

28 14. This act shall take effect on the first day of the seventh
29 month following the date of enactment, but the board, the
30 commissioner, and the Commissioner of Human Services shall take
31 such anticipatory administrative action in advance thereof as shall
32 be necessary for the implementation of this act.

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STATEMENT

36

37 This bill, which is designated as the "New Jersey Health Benefit
38 Exchange Act," creates a Statewide health insurance exchange
39 pursuant to the federal "Patient Protection and Affordable Care
40 Act," Pub.L.111-148, as amended by the "Health Care and
41 Education Reconciliation Act of 2010," Pub.L.111-152 ("the federal
42 act"). On June 28, 2012, the Supreme Court of the United States, in
43 National Federation of Independent Business, et al. v. Sebelius,
44 upheld the primary components of the federal act. In light of this
45 decision, it is in the State's best interest to create a health benefit
46 exchange.

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48 The bill provides specifically as follows:

The Administration of the Exchange

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- The New Jersey Health Benefit Exchange (“the exchange”) is established in the Executive Branch of State Government in order to effectuate the provisions of the federal act, and is allocated within the Department of Banking and Insurance (DOBI) but is to be independent of any supervision or control by DOBI or any board or officer thereof.
- The exchange is to be governed by a board of directors (“the board”) consisting of eight members as follows:
 - the Commissioners of Banking and Insurance and Human Services, or their designees, as nonvoting, ex officio members;
 - the chairperson of the advisory committee, to be established by the board pursuant to the bill’s provisions, as a nonvoting, ex officio member; and
 - five public members who are residents of this State, to be appointed by the Governor with the advice and consent of the Senate, including: one person who is a member in good standing of the American Academy of Actuaries; and four other persons, two of whom are to be appointed upon the recommendation of the President of the Senate and two upon the recommendation of the Speaker of the General Assembly.
- The public members of the board appointed upon the recommendation of the President of the Senate and the Speaker of the General Assembly are to be appointed in such a manner as to ensure that the public membership of the board includes individuals who have demonstrated expertise in the following areas: individual health care coverage; small employer health care coverage; health benefits plan administration; health care finance; and consumer health care advocacy.
- The public members of the board are to serve on a part-time basis and receive an annual salary of \$50,000. The public members are also to be reimbursed for any expenses incurred by them in the performance of their duties, subject to the limits of funds appropriated or otherwise made available for this purpose.
- The public members of the board are to serve for a term of four years; except that of the members first appointed, one of the public members appointed upon the recommendation of the President of the Senate and one of the public members appointed upon the recommendation of the Speaker of the General Assembly will each serve for a period of three years, one of the public members appointed upon the recommendation of the President of the Senate and one of the public members appointed upon the recommendation of the Speaker of the General Assembly will each serve for a period of four years, and the other public member appointed will serve for a period of five years.
- The board is to appoint an executive director of the exchange to supervise the administrative affairs and general management, and

- 1 operations of the exchange. The executive director will serve at
2 the pleasure of the board and receive such compensation as the
3 board determines. All employees of the exchange, except the
4 executive director, are to be in the career service of the Civil
5 Service.
- 6 • While serving as a member of the board or employee of the
7 exchange, and for a period of two years immediately following
8 such service or employment, a person is prohibited from being:
 - 9 -- employed by, a consultant to, a member of the board of
10 directors of, affiliated with, or otherwise a representative of, a
11 carrier, an insurance agent or broker, a licensed health care
12 professional, a health care facility, or an entity operating a
13 navigator program as set forth in this bill;
 - 14 -- a member, board member, or employee of a trade association
15 of carriers, insurance agents or brokers, health care professionals,
16 health care facilities, or entities operating a navigator program; or
 - 17 -- a licensed health care professional, unless that person receives
18 no compensation for rendering services as a licensed health care
19 professional and does not have an ownership interest in a health
20 care professional practice.
 - 21 • All meetings of the board are subject to the requirements of the
22 “Senator Byron M. Baer Open Public Meetings Act.” The board
23 is to provide advance notice of its meetings on the Internet.
 - 24 • A member of the board or an employee of the exchange will not
25 be liable in an action for damages to any person for any action
26 taken or recommendation made by the member or employee
27 within the scope of his functions as a member or employee, if the
28 action or recommendation was taken or made without malice.
 - 29 • The board is to establish an advisory committee to provide advice
30 to the board concerning the operation of the exchange and any
31 other matter relating to the responsibilities of the board pursuant
32 to this bill.
 - 33 -- The advisory committee is to include 15 members, to be
34 appointed by the board, who will include one representative from
35 each of the following: health insurers or health maintenance
36 organizations offering health benefits plans in this State; health
37 service corporations offering contracts in this State; licensed
38 insurance producers; licensed general hospitals; licensed long-term
39 care facilities; mental health care providers; federally qualified
40 health centers; licensed physicians; licensed nurses; small
41 employers; public employee unions; private sector unions;
42 consumer health care advocacy organizations; consumer legal
43 advocacy organizations; and public health researchers or other
44 academic experts with knowledge and background relevant to the
45 functions and goals of the exchange, including knowledge of the
46 health care needs and health disparities among the diverse
47 communities of this State.

1 -- The members of the advisory committee are to serve for a term
2 of three years; except that of the members first appointed, five are
3 to serve for a period of three years, five for a period of two years,
4 and five for a period of one year.

5 -- The members of the advisory committee are to serve without
6 compensation but be reimbursed for any expenses incurred by them
7 in the performance of their duties, subject to the limits of funds
8 appropriated or otherwise made available for this purpose.

9 -- The board, within the limits of its existing staff and resources,
10 is to provide such staff support as the advisory committee requires
11 to perform its duties.

12

13 **The Activities of the Exchange**

14

- 15 • The board is to facilitate the purchase, through the exchange, of
16 coverage under health benefits plans certified and offered by the
17 exchange (“qualified plans”), at affordable prices, by persons
18 enrolled in the exchange (“enrollees”).
- 19 • The board is to establish the State Business Health Options
20 Program (SHOP), separate from the activities of the board related
21 to the individual market, to assist participating employers in
22 facilitating the enrollment of their employees in qualified plans.
23 Eligible employers: would include, beginning no later than
24 January 1, 2014, employers with at least two but not more than 50
25 employees, beginning no later than January 1, 2016, employers
26 with at least 51 but not more than 100 employees; and, may
27 include, beginning on January 1, 2017, employers with more than
28 100 employees.
- 29 • The board is to create and offer a Basic Health Plan, in
30 conjunction with the Department of Human Services and
31 consistent with the provisions of the federal act, to enable persons
32 with incomes of between 133% and 200% of the federal poverty
33 level, and noncitizens who would be eligible for Medicaid except
34 for not meeting the minimum residency requirements provided in
35 federal law, who would otherwise be eligible to receive premium
36 subsidies for the purchase of coverage through the exchange, to
37 purchase essential health benefits through the provision of federal
38 funds pursuant to the federal act.
- 39 • The board is to develop and implement a plan of operation for the
40 exchange, which includes, but is not limited to: procedures and
41 minimum requirements for the selection, certification, and
42 recertification of qualified plans; criteria and procedures for
43 decertifying plans; and procedures, criteria, and a standard
44 application form for prospective enrollees seeking to obtain
45 coverage under qualified plans, and for the enrollment of
46 participating employers in SHOP.
- 47 • The board is to provide: a customer service center, which will
48 operate a toll-free telephone service and provide oral and written

- 1 information in a manner that is culturally and linguistically
2 appropriate to the needs of the population being served by the
3 exchange; and an Internet website that provides standardized
4 comparative information on qualified plans, and which also
5 provides information on how to obtain assistance from a
6 navigator chosen by the board or from a licensed insurance
7 producer for those individuals wishing to do so.
- 8 • The board is authorized to apply for any available federal grants
9 and receive any grant funding available from private foundations.
 - 10 • The board, as it deems necessary to effectuate the purposes of the
11 bill, may enter into a contract for the provision of goods or
12 performance of services without public advertising for bids,
13 provided that the process for awarding the contract meets certain
14 specified requirements.

15

16 **Qualified Plans and Participating Carriers in the Exchange**

17

- 18 • The exchange is to offer to enrollees only health benefits plans
19 that have been certified by the board, approved for issuance or
20 renewal in this State by the Commissioner of Banking and
21 Insurance, and underwritten by a carrier. The board is to certify
22 those plans that it determines offer the optimal combination of
23 choice, value, quality, and service to enrollees, and to provide, in
24 each region of the State, a choice of qualified plans in each of the
25 benefit categories required under the federal act.
- 26 • A health insurance carrier participating in the exchange may offer
27 to enrollees a plan that provides limited scope dental benefits that
28 meets the requirements of section 9832 of the federal Internal
29 Revenue Code (26 U.S.C. s.9832), if the plan provides pediatric
30 dental benefits that meet the requirements of section 1302 of the
31 federal act (42 U.S.C. s.18022), and such other dental benefits as
32 the board of directors of the exchange or the Secretary of Health
33 and Human Services may prescribe by regulation.
- 34 • Carriers permitted to offer qualified dental plans are required to
35 be licensed to offer dental coverage, but need not be licensed to
36 offer other health benefits.
- 37 • Two or more carriers may jointly offer a comprehensive plan
38 through the exchange in which the dental benefits are provided by
39 a carrier through a qualified dental plan and the other benefits are
40 provided by a carrier through a qualified health plan, provided
41 that the plans are priced separately and are also made available
42 for purchase separately at the same price.
- 43 • A carrier that offers a qualified health benefits plan in
44 conjunction with a plan that provides limited scope dental
45 benefits is required to provide separate pricing for the health
46 benefits plan and the dental plan and also make each of the plans
47 available for purchase separately.

- 1 • A carrier that offers a qualified health benefits plan that includes
2 limited scope dental coverage in that plan must offer and price the
3 health benefits plan without the limited scope dental coverage and
4 must offer and price the limited scope dental coverage without the
5 health benefits plan, so that either can be purchased separately.
- 6 • To be certified as a qualified health benefits plan, a plan, at a
7 minimum, is to: include within its health care provider network
8 those essential community providers, where available, that serve
9 predominately low-income, medically underserved individuals, as
10 specified in the bill; and pay those providers at the highest rate
11 that it pays to comparable providers for each category of services
12 provided by the essential community provider, but in no case less
13 than what Medicaid pays for the same service.
- 14 • The board may require carriers participating in the exchange to
15 make available to the exchange and regularly update an electronic
16 directory of contracting health care providers, and the exchange
17 may provide an integrated and uniform consumer directory of
18 providers indicating which carriers the providers contract with
19 and whether the providers are currently accepting new patients.
- 20 • The board is to require that a carrier, as a condition of
21 participation in the exchange:
 - 22 -- fairly and affirmatively offer, market, and sell in the exchange
23 at least one product within each of the categories of health benefits
24 plans that the federal act requires to be offered through the
25 exchange;
 - 26 -- if the carrier sells any products to individuals outside the
27 exchange, fairly and affirmatively offer, market, and sell all
28 products made available to individuals in the exchange to
29 individuals purchasing coverage outside the exchange; and if the
30 carrier sells any products to employers outside the exchange, fairly
31 and affirmatively offer, market, and sell all products made available
32 to employers in SHOP to employers purchasing coverage outside
33 the exchange;
 - 34 -- provide a detailed description of the benefits offered by a
35 qualified plan through an Internet website and by other means for
36 individuals without access to the Internet;
 - 37 -- submit a justification to the board for any premium increase in
38 a qualified plan before implementing the increase, and prominently
39 post that information on its Internet website;
 - 40 -- make available to the public and to the board, the U.S.
41 Secretary of Health and Human Services (“the secretary”), and the
42 Commissioner of Banking and Insurance, as applicable, accurate
43 and timely information, with respect to a qualified plan, concerning
44 claims payment policies and practices, financial data, enrollment
45 and disenrollment, claims denied, rating practices, cost sharing and
46 payments for any out-of-network coverage, and enrollee and
47 participating employer rights specified under federal law or
48 determined appropriate by the secretary; and

- 1 -- make available to the public and submit to the board such
2 other information as may be required pursuant to the federal act or
3 as the board reasonably determines necessary to accomplish the
4 purposes of the bill.
- 5 • The board is to establish procedures necessary to avoid risk
6 selection between qualified plans offered through the exchange
7 and plans offered outside the exchange and among qualified plans
8 offered within the exchange, including, but not limited to, such
9 mechanisms as it determines appropriate for adjusting payments
10 to qualified plans to account for risk selection and assure market
11 stability.
 - 12 • The provisions of the bill are not to be construed to require a
13 carrier not participating in the exchange to meet any requirements
14 relating to health care coverage or its operations not otherwise
15 imposed under federal or State law.

16
17 **The Provision of Health Care Coverage through the Exchange**

- 18
- 19 • The board is to:
 - 20 -- provide for the processing of applications, determination of
21 eligibility for premium tax credits and any cost-sharing reduction
22 and eligibility redetermination due to changes in income or
23 circumstances, and establishment of an enrollee database, and
24 coordinate and share data with Medicaid, NJ FamilyCare, and other
25 State and local government entities as applicable, to ensure
26 efficient, cost-effective, and comprehensive health care coverage
27 and continuity of coverage and care when an enrollee transitions
28 between a qualified plan and Medicaid or NJ FamilyCare, or the
29 reverse, consistent with federal law and regulations;
 - 30 -- require that a written agreement be established between the
31 board and the Division of Medical Assistance and Health Services
32 in the Department of Human Services to govern eligibility
33 determination and redetermination services for, and enrollment in,
34 the exchange, Medicaid, and NJ FamilyCare;
 - 35 -- market, publicize, and provide outreach to enrollees and
36 potential enrollees in regard to health care coverage and federal
37 subsidies available through the exchange;
 - 38 -- assign a rating to each qualified plan in accordance with
39 criteria developed by the secretary; and utilize a standardized
40 format for presenting plan options in the exchange;
 - 41 -- establish and make available by electronic means a calculator
42 to determine the actual cost of coverage after the application of any
43 premium tax credit and cost-sharing reduction under the federal act;
 - 44 -- establish uniform billing and payment policies for qualified
45 plans and coordinate those policies with Medicaid and NJ
46 FamilyCare;
 - 47 -- grant a certification attesting that a person is exempt from the
48 tax imposed under the federal act for not having qualifying health

- 1 care coverage if the person meets the requirements for that
2 exemption;
- 3 -- perform such duties as are required of the exchange by the
4 secretary or the Secretary of the Treasury under the federal act,
5 relating to the determination of eligibility for premium tax credits,
6 reduced cost sharing, or exemptions from the tax imposed under the
7 federal act for not having qualifying health care coverage;
- 8 -- notify enrollees of their right to appeal health care coverage
9 determinations by carriers under State and federal law and to file a
10 grievance against the exchange itself; and
- 11 -- establish the navigator program, in accordance with the federal
12 act, to: increase public awareness of, and facilitate enrollment in,
13 qualified plans; and provide appropriate referrals for health
14 insurance consumer assistance for enrollees with a grievance,
15 complaint, or question relating to their plan or coverage.

16

17 **New Jersey Health Benefit Exchange Trust Fund**

18

- 19 • The bill establishes the New Jersey Health Benefit Exchange
20 Trust Fund in the Department of the Treasury as a nonlapsing
21 revolving fund, to be the repository for monies collected from
22 carriers pursuant to the bill and other monies received as grants or
23 otherwise appropriated for the purposes of the exchange. The
24 monies in the fund are to be used only for the purpose of
25 supporting the activities of the exchange.
- 26 • The exchange may apply a uniform surcharge to all qualified
27 health benefit plans, and a uniform assessment on carriers that do
28 not contract with the exchange, as the board determines necessary
29 to effectuate the purposes of this substitute. The proceeds are to
30 be deposited into the fund and used only to pay for administrative
31 and operational expenses of the exchange in carrying out its
32 responsibilities and as otherwise required under federal law or
33 regulation.

34

35 **Other Provisions**

36

- 37 • In addition to furnishing information to any federal department or
38 agency as required under the federal act or any other federal law
39 or regulation, the board is to annually report on the activities,
40 receipts, and expenditures of the exchange to the Governor,
41 Legislature, and State Auditor, and to make this information
42 available on its Internet website; and the State Auditor is to
43 conduct an audit of the exchange at least once in each five-year
44 period.
- 45 • The Commissioner of Banking and Insurance is to report to the
46 Governor and the Legislature, no later than January 1, 2018, on
47 the commissioner's findings and recommendations concerning
48 whether to: continue the New Jersey Individual Health Coverage

- 1 Program and the New Jersey Small Employer Health Benefits
2 Program, as provided under current law; revise these programs to
3 reflect the provisions of this bill; or phase out these programs and
4 transition their health care coverage to coverage provided through
5 the exchange.
- 6 • The bill takes effect on the first day of the seventh month
7 following enactment, but authorizes the board and the
8 Commissioners of Banking and Insurance and Human Services to
9 take anticipatory administrative action in advance as necessary
10 for its implementation.