[First Reprint]

SENATE, No. 2135

STATE OF NEW JERSEY

215th LEGISLATURE

INTRODUCED JUNE 28, 2012

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Co-Sponsored by:
Senator Greenstein, Assemblymen Johnson, Wimberly and Assemblywoman Sumter

SYNOPSIS

"New Jersey Health Benefit Exchange Act."

CURRENT VERSION OF TEXT

As reported by the Senate Commerce Committee on October 1, 2012, with amendments.

(Sponsorship Updated As Of: 10/19/2012)

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

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

1. This act shall be known and may be cited as the "New Jersey Health Benefit Exchange Act."

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

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

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

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

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

e. meet the requirements of the federal act.

3. As used in this act:

"Board" means the board of directors of the exchange.

"Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services [1]under a health benefits plan[1], including: an insurance company authorized to issue health [1][~~insurance~~] benefits plans[1]; a health maintenance organization; a health, hospital, or medical service corporation; or any other entity providing a health benefits plan. The term "carrier" shall not include a joint insurance fund established pursuant to State law. For purposes of this act, carriers that are affiliated companies shall be treated as one carrier, except

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 SCM committee amendments adopted October 1, 2012.

that in the case of an insurance company, health service corporation, hospital service corporation, or medical service corporation that is an affiliate of a health maintenance organization located in New Jersey or a health maintenance organization located in New Jersey that is affiliated with an insurance company, health service corporation, hospital service corporation, or medical service corporation, the health maintenance organization shall be treated as a separate carrier.

"Commissioner" means the Commissioner of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

"Enrollee" means a person receiving health care coverage through the exchange, either as an individual or as an employee of a participating employer.

"Exchange" means the New Jersey Health Benefit Exchange established pursuant to this act.

"Executive director" means the executive director of the exchange.

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

"Health benefits plan" means a hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State. For the purposes of this act, "health benefits plan" shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. "Health benefits plan" shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in federal regulations. "Health benefits plan" shall not include hospital confinement indemnity coverage if: the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the

benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor; and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. "Health benefits plan" shall not include the following if it is offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal "Social Security Act" (42 U.S.C. s.1395ss(g)(1)); coverage that is supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. s.1071 et seq.); and similar coverage that is supplemental to coverage provided under a group health plan.

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

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

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

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

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

"Qualified dental plan" means a limited scope dental plan certified by the exchange pursuant to this act.

"Qualified health benefits plan" means a health benefits plan certified by the exchange pursuant to this act.

"Secretary" means the United States Secretary of Health and Human Services.

"SHOP" means the State Business Health Options Program established within the exchange pursuant to this act.

"Small employer" means a person, firm, corporation, or partnership that is actively engaged in business, which employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and at least two employees on the first day of the current calendar year, and the majority of which employees are employed in New Jersey. A small employer that makes enrollment in qualified health benefits plans available to its employees through SHOP, and ceases to be a small employer due to an increase in the number of its employees, shall continue to be treated as a small employer for the purposes of this act as long as it makes enrollment in qualified health benefits plans available to its employees through SHOP. All persons treated as a single

employer under subsections (b), (c), (m) or (o) of section 414 of the federal Internal Revenue Code (26 U.S.C. s.414) shall be treated as one employer. For the purpose of determining the size of an employer, and subject to the provisions of paragraph (2) of subsection b. of section 6 of this act: all employees of an employer shall be counted, including part-time employees and those not eligible for employer-sponsored coverage; the size of an employer shall be determined annually; and, in the case of an employer that was not in existence during the preceding calendar year, the determination of the size of the employer shall be based on the average number of employees that the employer is reasonably expected to employ on business days in the current calendar year.

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

5. a. The exchange shall be governed by a board of directors consisting of '[eight] ten' members as follows:

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

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

(3) '[five] seven' 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 shall be a member in good standing of the American Academy of Actuaries; and four other persons, two of whom shall be appointed upon the recommendation of the President of the Senate, and two of whom shall be appointed upon the recommendation of the Speaker of the General Assembly.

b. '[The] Each' public '[members] member' of the board '[appointed upon the recommendation of the President of the Senate and the Speaker of the General Assembly]' shall 'have demonstrated expertise in at least one of the following areas and' 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:

(1) individual health care coverage;

(2) small employer health care coverage;

(3) health benefits plan administration;

(4) health care finance; and

(5) consumer health care advocacy.

c. ¹[The public members of the board shall serve on a part-time basis and receive an annual salary of $50,000.]¹ The public members shall ¹[also]¹ 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.

d. The public members of the board shall 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 ¹[and],¹ one of the public members appointed upon the recommendation of the Speaker of the General Assembly ¹, and one additional public member¹ shall each serve for a period of three years, one of the public members appointed upon the recommendation of the President of the Senate ¹[and],¹ one of the public members appointed upon the recommendation of the Speaker of the General Assembly¹, and one additional public member¹ shall each serve for a period of four years, and the other public member appointed shall serve for a period of five years.

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

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

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

(2) The executive director shall:

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

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

(c) attend all meetings of the board; and

(d) serve at the pleasure of the board, and receive such compensation as the board shall determine¹, which shall not exceed the compensation of a cabinet-level official of the State¹.

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

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

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

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

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

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

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

h. While serving as a member of the board or an employee of the exchange, and¹, except for a secretarial or clerical employee,¹ for a period of two years immediately following such service or employment, a person shall not be:

(1) employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier, an insurance agent or broker, a health care professional, a health care facility, or an entity operating a navigator program as set forth in subsection k. of section 8 of this act;

(2) a member, board member, or employee of a trade association of carriers, insurance agents or brokers, health care professionals, or health care facilities; or

(3) a health care professional, unless that person receives no compensation for rendering services as a health care professional and does not have an ownership interest in a health care professional practice.

i. All meetings of the board shall be subject to the requirements of the "Senator Byron M. Baer Open Public Meetings Act," P.L.1975, c.231 (C.10:4-6 et seq.). In addition to complying with the notice requirements of P.L.1975, c.231, the board shall provide electronic notice of its meetings as defined in section 1 of P.L.2002, c.91 (C.10:4-9.1).

j. A member of the board or an employee of the exchange shall not be liable in an action for damages to any person for any action taken or recommendation made by the member or employee within the scope of his functions as a member or employee, if the action or recommendation was taken or made without malice. The members of the board shall be indemnified and their defense of any action provided for in the same manner and to the same extent as employees of the State under the "New Jersey Tort Claims Act," ¹**[**P.L.1972, c.45 (C.59:1-1 et seq.)**]** N.J.S.59:1-1 et seq.¹ on account of acts or omissions in the scope of their employment.

k. (1) The board shall establish an advisory committee to provide advice to the board concerning the operation of the

exchange and any other matter relating to implementation of the provisions of this act.

(2) The advisory committee shall include 15 members, to be appointed by the board, who shall include one representative from each of the following:

(a) health insurers or health maintenance organizations offering health benefits plans in this State;

(b) health service corporations offering contracts in this State;

(c) insurance producers licensed pursuant to P.L.2001, c.210 (C.17:22A-26 et seq.);

(d) licensed general hospitals;

(e) licensed long-term care facilities;

(f) mental health care [and addiction services] providers;

(g) federally qualified health centers;

(h) licensed physicians;

(i) licensed nurses;

(j) small employers;

(k) public employee unions;

(l) private sector unions;

(m) consumer health care advocacy organizations;

(n) consumer legal advocacy organizations; and

(o) public health researchers or other academic experts with knowledge and background relevant to the functions and goals of the exchange, including knowledge of the health care needs and health disparities among the diverse communities of this State.

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

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

(5) The members of the advisory committee shall serve without compensation but 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.

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

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

6. a. The board shall implement the exchange pursuant to the provisions of this act and as otherwise required by the federal act or

any other federal law. The board shall facilitate the purchase of coverage under qualified health benefits plans through the exchange at affordable prices by enrollees.

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

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

(i) specify the responsibilities of the employer with regard to the participation of its employees in qualified health benefits plans and permit the employer to specify a level of coverage that any of its employees may receive through a qualified health benefits plan or provide a payment formulated in advance in accordance with the federal act to be used as part of an employee choice plan;

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

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

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

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

c. The board [shall] may take such actions as are necessary to create and offer a Basic Health Plan, in conjunction with the Department of Human Services and consistent with the provisions of the federal act, to enable persons with incomes of between 133% and 200% of the federal poverty level, and noncitizens who would be eligible for Medicaid except for not meeting the minimum residency requirements provided in federal law, who would

otherwise be eligible to receive premium subsidies for the purchase of coverage through the exchange, to purchase essential health benefits through the provision of federal funds pursuant to the federal act.

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

(1) procedures for the operations of the exchange;

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

(3) criteria for determining that certain health benefits plans will no longer be made available through the exchange and a procedure to decertify these plans that includes providing prior notice to the carrier;

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

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

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

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

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

e. The board shall also be authorized to:

(1) apply for such grants from the federal government as may be available for the purposes of this act pursuant to the federal act or any other federal law, and take such actions as are necessary to

ensure that any such funds received are utilized in a manner consistent with the provisions of federal law;

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

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

(a) publicly announced prior to being awarded;

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

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

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

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

(6) maintain an office in the State;

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

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

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

(2) The board shall permit a carrier participating in the exchange to offer to enrollees a plan that provides limited scope dental benefits, which meets the requirements of subparagraph (A) of paragraph (2) of subsection (c) of section 9832 of the federal Internal Revenue Code (26 U.S.C. s.9832) and is provided either in conjunction with a qualified health benefits plan or under a separate policy, certificate, or contract of insurance, if the plan provides pediatric dental benefits that meet the requirements of subparagraph (J) of paragraph (1) of subsection (b) of section 1302 of the federal

act (42 U.S.C. s.18022), and such other dental benefits as the board or the secretary may prescribe by regulation.

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

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

(c) A carrier that offers a qualified health benefits plan in conjunction with a plan that provides limited scope dental benefits, in accordance with the provisions of this paragraph, shall provide separate pricing for the health benefits plan and the dental plan and also make each of the plans available for purchase separately.

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

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

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

(1) include within its health care provider network **[**those**]** ¹all¹ essential community providers, where available, that serve predominately low-income, medically underserved individuals, including: ¹all¹ health care providers as defined in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. s.256b(a)(4)) ¹, including those who were identified as covered entities under section 340B(a)(4) on March 27, 2012¹; and providers as described in section 1927(c)(1)(D)(i)(IV) of the federal Social Security Act (42 U.S.C. s.1396r-8(c)(1)(D)(i)(IV)); ¹**[**and**]**¹

(2) pay essential community providers within its health care provider network at the ¹**[**highest**]** generally applicable payment¹ rate that it pays to ¹**[**comparable**]** similarly situated¹ providers ¹who are not essential community providers¹ for each category of services provided by the essential community provider, except that

ˈ: (a)ˈ in no case shall this rate be less than Medicaid pays for the same service ˈ; and (b) in the case of federally qualified health centers, a plan shall pay the Medicaid prospective payment system (PPS) rate, as set forth in section 1902(bb) of the federal Social Security Act (42 U.S.C. 1396a(bb)), or a mutually agreed upon payment rate provided that rate is at least equal to the plan's generally applicable payment rate; and

(3) contract with essential community providers for all of the services that the essential community providers provide to the extent those services are covered under the health benefits planˈ.

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

d. The board shall require that a carrier, as a condition of participation in the exchange, do all of the following consistent with the provisions of the federal act and in such a manner as is prescribed by regulation of the board or the commissioner, as applicable:

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

(2) if the carrier sells any products to individuals outside the exchange, fairly and affirmatively offer, market, and sell all products made available to individuals in the exchange to individuals purchasing coverage outside the exchange; if the carrier sells any products to employers outside the exchange, fairly and affirmatively offer, market, and sell all products made available to employers in SHOP to employers purchasing coverage outside the exchange;

(3) provide a detailed description of the benefits offered by a qualified health benefits plan through an Internet website and by other means for individuals without access to the Internet, which specifies: maximum benefits; limitations, exclusions, and other benefit limits; and the amount of cost sharing, including, but not limited to, deductibles, copayments, and coinsurance, under the

plan that an individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating health care provider;

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

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

(a) claims payment policies and practices;

(b) periodic financial disclosures;

(c) data on enrollment and disenrollment;

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

(e) data on rating practices;

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

(g) information on enrollee and participating employer rights as specified under federal law or otherwise determined appropriate by the secretary; **[**and**]**

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

(7) not discriminate, as provided in section 1201 of the federal act, adding section 2706 to the Public Health Service Act, (42 U.S.C. s.300gg-5), with respect to coverage or participation under a health plan against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

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

f. The provisions of this section shall not be construed as requiring a carrier that does not participate in the exchange to meet any requirements relating to health care coverage or its operations

that are not otherwise imposed on that carrier under federal or State law.

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

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

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

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

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

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

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

(4) establish procedures to assist an enrollee in reporting a change in income to the exchange that might affect the amount of advance premium tax credit to which the enrollee is entitled pursuant to the federal act, as well as in qualifying for any

exemption from repayment of the advance premium tax credit that would otherwise be required pursuant to federal or State law; and

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

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

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

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

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

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

g. grant a certification attesting that a person is exempt from the tax imposed under the federal act for not having qualifying health care coverage as specified in the federal act, because: there is no affordable qualified health benefits plan available through the exchange or the person’s employer to cover that person; or the person meets the requirements for any other exemption from the tax under the federal act;

h. perform such duties as are required of, or delegated to, the exchange by the secretary or the Secretary of the Treasury, pursuant to the federal act, relating to the determination of eligibility for premium tax credits, reduced cost sharing, or exemptions from the tax imposed under the federal act for not having qualifying health care coverage;

i. provide notice to enrollees of their right of appeal with respect to certain medical decisions by carriers under the Independent Health Care Appeals Program established pursuant to section 11 of P.L.1997, c.192 (C.26:2S-11);

j. provide for an appeal mechanism for enrollees with respect to exchange-related determinations, when the subject of appeal is not covered by an existing mechanism or is not within the jurisdiction of the department under current law or regulations, and which relates to the filing of enrollee grievances against the exchange itself, or other appeals as required under the federal act, and provide notice to enrollees of such an appeal mechanism that includes an explanation of the relevant procedures and enrollee rights in connection with filing such an appeal; and

k. establish the navigator program in accordance with the federal act, under which any entity chosen by the exchange as a navigator shall:

(1) conduct public education activities to raise awareness of the availability of qualified health benefits plans;

(2) distribute fair and impartial information concerning enrollment in qualified health benefits plans and the availability of premium tax credits and cost-sharing reductions pursuant to the federal act;

(3) facilitate enrollment in qualified health benefits plans;

(4) provide referrals to the appropriate office within the department for health insurance consumer assistance in the case of an enrollee in a qualified health benefits plan with a grievance, complaint, or question regarding that person's plan, coverage, or a determination under that plan or coverage;

(5) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange;

(6) be evaluated and paid by the board based upon such standards for performance and compensation as the board determines appropriate for this purpose;

(7) be incorporated, organized, and operated in such a manner as to qualify as a nonprofit corporation described in section 501(c)(3) of the federal Internal Revenue Code, 26 U.S.C. s.501(c)(3) or any successor provision that is exempt from taxation pursuant to section 501(a) of the federal Internal Revenue Code, 26 U.S.C. s.501(a) or any successor provision; and

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

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

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

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

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

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

b. The State Auditor shall conduct an audit of the exchange at least once in each five-year period, and may otherwise examine the operation, property, and records of the exchange, and prescribe methods of accounting and the rendering of periodic reports in relation to activities undertaken by the exchange.

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

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

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

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

'13. No later than January 1, 2015, the board shall present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), which contains the board's findings and recommendations, including the status of any decision or efforts, concerning whether or not to create and offer a Basic Health Plan pursuant to subsection c. of section 6 of this act.'

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

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