Sponsored by:
Assemblyman JOHN S. WISNIEWSKI
District 19 (Middlesex)

SYNOPSIS
The “Healthy New Jersey Act;” establishes single-payer health care system.

CURRENT VERSION OF TEXT
As introduced.
AN ACT concerning comprehensive universal single-payer health

care coverage and supplementing Title 26 of the Revised

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 “Healthy

New Jersey Act.”

2. a. The Legislature finds and declares all of the following:

(1) All residents of this State have the right to health care.

While the federal Patient Protection and Affordable Care Act
(PPACA) brought many improvements in health care and health
care coverage, it still leaves many New Jersey residents without
coverage or with inadequate coverage.

(2) New Jersey residents, as individuals, employers, and
taxpayers, have experienced a rise in the cost of health care and
health care coverage in recent years, including rising premiums,
deductibles, and copays, as well as restricted provider networks and
high out-of-network charges.

(3) Businesses have also experienced increases in the costs of
health care benefits for their employees, and many employers are
shifting a larger share of the cost of coverage to their employees or
dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable
care and choice because of decisions by health benefits plans
guided by the plan’s economic needs rather than consumers’ health
care needs.

(5) To address the fiscal crisis facing the health care system and
the State, and to ensure New Jerseyans can exercise their right to
health care, comprehensive health care coverage needs to be
provided.

(6) It is the intent of the Legislature to enact legislation that
would establish a comprehensive universal single-payer health care
coverage program and a health care cost control system for the
benefit of all residents of the State.

b. (1) It is further the intent of the Legislature to establish the
Healthy New Jersey (HNJ) program to provide universal health care
coverage for every New Jersey residents based on his or her ability
to pay and funded by broad-based revenue.

(2) It is the intent of the Legislature for the State to work to
obtain waivers and other approvals relating to Medicaid, the State’s
Children’s Health Insurance Program, Medicare, the PPACA, and
any other federal programs so that any federal funds and other
subsidies that would otherwise be paid to the State of New Jersey,
New Jersey residents, and health care providers would be paid by
the federal government to the State of New Jersey and deposited in
the Healthy New Jersey Trust Fund.
(3) Under those waivers and approvals, those funds would be used for health care coverage that provides health benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(4) Those programs would be replaced and merged into the HNJ program, which will operate as a true single-payer program.

(5) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the State use State plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of federally matched public health programs and federal health programs in the HNJ program.

(6) Thus, even if other programs such as Medicaid or Medicare may contribute to paying for care, it is the goal of this act that the coverage be delivered by the HNJ program, and, as much as possible, that the multiple sources of funding be pooled with other HNJ program funds and not be apparent to HNJ program members or participating providers.

c. This act shall not create any employment benefit, nor does it require, prohibit, or limit the providing of any employment benefit.

d. (1) It is the intent of the Legislature not to change or impact in any way the role or authority of any licensing board or State agency that regulates the standards for or provision of health care and the standards for health care providers as established under current law.

(2) This act shall in no way be construed to authorize the Healthy New Jersey Board, the Healthy New Jersey program, or the Commissioner of Health to establish or revise licensure standards for health care providers.

e. It is the intent of the Legislature that neither health information technology nor clinical practice guidelines limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient’s wishes.

f. (1) It is the intent of the Legislature to prohibit the HNJ program, a State agency, a local agency, or a public employee acting under color of law from providing or disclosing to anyone, including, but not limited to, the federal government, any personally identifiable information obtained, including, but not limited to, a person’s religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(2) This act shall also prohibit law enforcement agencies from using the HNJ program’s funds, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register
with the federal government or any federal agency based on
religion, national origin, ethnicity, or immigration status.

3. For the purposes of this act:
“Affordable Care Act” or “PPACA” 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.
“Allied health practitioners” mean health professionals who
apply their expertise to prevent disease transmission, diagnose,
treat, and rehabilitate people of all ages and in all specialties.
Together with a range of technical and support staff, they may
deliver direct patient care, rehabilitation, treatment, diagnostics, and
health improvement interventions to restore and maintain optimal
physical, sensory, psychological, cognitive, and social functions.
Examples include, but are not limited to, audiologists, occupational
therapists, social workers, and radiographers.
“Board” means the Healthy New Jersey Board established
pursuant to section 5 of this act.
“Care coordination” means services provided by a care
coordinator pursuant to section 15 of this act.
“Care coordinator” means an individual or entity approved by
the board to provide care coordination pursuant to section 15 of this
act.
"Carrier" means an insurance company, health service
corporation, hospital service corporation, medical service
corporation, or health maintenance organization authorized to issue
health benefits plans in this State.
“Children’s Health Insurance Program” or “NJ FamilyCare”
means the Children’s Health Insurance Program established under
Title XXI of the federal Social Security Act (42 U.S.C. s.1397aa et
seq.) and the NJ FamilyCare program established pursuant to
P.L.2005, c.156 (C.30:4J-8 et seq.).
“Committee” means the public advisory committee established
pursuant to section 6 of this act.
“Essential community providers” means persons or entities
acting as safety net clinics, safety net health care providers, or rural
hospitals.
“Federally matched public health program” means Medicaid and
the Children’s Health Insurance Program.
“Fund" means the Healthy New Jersey Trust Fund established
pursuant to section 20 of this act.
“Health care organization” means an entity that is approved by
the board pursuant to section 17 of this act to provide health care
services to members under the program.
“Health care provider” means a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.), or a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Title 45 of the Revised Statutes and who is any of the following:

(1) An individual who practices that profession as an independent contractor or independent practice.

(2) An owner, officer, shareholder, or proprietor of a health care facility.

(3) An entity that employs or utilizes health care professionals to provide health care services.

A person licensed, certified, registered or authorized to practice pursuant to Title 45 of the Revised Statutes who practices exclusively as an employee of a health care provider is not a health care provider for purposes of this act.

“Health care providers’ representative” means a third party that is authorized by health care providers to negotiate on their behalf with Healthy New Jersey over terms and conditions affecting those health care providers.

“Health care service” means any health care service, including care coordination, that is included as a benefit under the program.

“Healthy New Jersey” or “HNJ” means the Healthy New Jersey program established pursuant to section 3 of this act.

“Implementation period” means the period specified in subsection f. of section 7 of this act, during which the program is subject to special eligibility and financing provisions until it is fully implemented pursuant to that section.

“Long-term care” means long-term care, treatment, maintenance, or services not covered under the Medicaid or NJ FamilyCare programs, as appropriate, with the exception of short-term rehabilitation, and as defined by the board.

"Medicaid" means the Medicaid program established pursuant to Title XIX of the federal Social Security Act (42 U.S.C. s.1396 et seq.) and P.L.1968, c.413 (C.30:4D-1 et seq.).

"Medicare" means the coverage provided under Title XVIII of the Social Security Act.

“Member” means an individual who is enrolled in the program.

“Out-of-State health care service” means a health care service provided in person to a member while the member is physically located out of the State under either of the following circumstances:

(1) It is medically necessary that the health care service be provided while the member physically is out of the State; and

(2) It is clinically appropriate and necessary, and cannot be provided in the State, because the health care service can only be provided by a particular health care provider physically located out of the State. However, any health care service provided to an HNJ member by a health care provider qualified under section 14 of this act that is located outside the State shall not be considered an out-
of-State service and shall be covered as otherwise provided in this
act.

“Participating provider” means any individual or entity that is a
health care provider qualified pursuant to section 14 of this act that
provides health care services to members under the program, or a
health care organization.

“Program” means the Healthy New Jersey program established in
section 4 of this act.

“Resident” means an individual whose primary place of abode is
in the State, without regard to the individual’s immigration status.

4. There is hereby established the Healthy New Jersey program
to be governed by the Healthy New Jersey Board pursuant to
section 5 of this act.

5. a. The Healthy New Jersey Board shall be an independent
public entity in but not of the Department of Health. For the
purpose of complying with the provisions of Articles V, Section IV,
paragraph 1 of the New Jersey Constitution, the Healthy New
Jersey Board is allocated within the Department of Health, but,
notwithstanding this allocation, the board shall be independent of
any supervision or control by the department or by any officer or
employee thereof. The board shall be governed by an executive
board consisting of nine members who are residents of
New Jersey.

Of the members of the board, four shall be appointed by the
Governor, two shall be appointed by the Senate President, and two
shall be appointed by the Speaker of the General Assembly. The
Commissioner of Health or his or her designee shall serve as a
voting, ex officio member of the board.

b. Members of the board, other than the ex officio member,
shall be appointed for a term of four years. Appointments by the
Governor shall be subject to confirmation by the Senate. A member
of the board may continue to serve until the appointment and
qualification of his or her successor. Vacancies shall be filled by
appointment for the unexpired term. The board shall elect a
chairperson on an annual basis.

c. (1) Each person appointed to the board shall have
demonstrated and acknowledged expertise in health care.

(2) Appointing authorities shall also consider the expertise of
the other members of the board and attempt to make appointments
so that the board’s composition reflects a diversity of expertise in
the various aspects of health care.

The appointees of the Senate President and the Speaker of the
General Assembly shall be composed of:

(a) at least one representative representing registered nurses.
(b) at least one representative of the general public.
(c) at least one representative of a labor organization.
(d) at least one representative of the medical provider
community.
d. Each member of the board shall have the responsibility and
duty to meet the requirements of this act, the Affordable Care Act,
and all applicable State and federal laws and regulations, to serve
the public interest of the individuals, employers, and taxpayers
seeking health care coverage through the program, and to ensure the
operational well-being and fiscal solvency of the program.

e. In making appointments to the board, the appointing
authorities shall take into consideration the cultural, ethnic, and
geographical diversity of the State so that the board’s composition
reflects the communities of New Jersey.

f. (1) A member of the board or of the staff of the board shall
not be employed by, a consultant to, a member of the board of
directors of, affiliated with, or otherwise a representative of, a
health care provider, a health care facility, or a health clinic while
serving on the board or on the staff of the board. A member of the
board or of the staff of the board shall not be a member, a board
member, or an employee of a trade association of health facilities,
health clinics, or health care providers while serving on the board or
on the staff of the board. A member of the board or of the staff of
the board shall not be a health care provider unless he or she
receives no compensation for rendering services as a health care
provider and does not have an ownership interest in a health care
practice.

(2) A board member shall not receive compensation for his or
her service on the board, but may receive a per diem and
reimbursement for travel and other necessary expenses, while
engaged in the performance of official duties of the board.

g. A member of the board shall not make, participate in
making, or in any way attempt to use his or her official position to
influence the making of a decision that he or she knows, or has
reason to know, will have a reasonably foreseeable material
financial effect, distinguishable from its effect on the public
generally, on him or her or a member of his or her immediate
family, or on either of the following:

(1) Any source of income, other than gifts and other than loans
by a commercial lending institution in the regular course of
business on terms available to the public without regard to official
status, aggregating $250 or more in value provided to, received by,
or promised to the member within 12 months prior to the time when
the decision is made.

(2) Any business entity in which the member is a director,
officer, partner, trustee, employee, or holds any position of
management.

h. The board or a member of the board, or an officer or
employee of the board, shall not be liable for any act or omission
performed in an official capacity, when done in good faith, without
intent to defraud.

i. The board shall hire an executive director to organize,
administer, and manage the operations of the board. The executive
director shall be exempt from civil service and shall serve at the
direction of the board.

j. 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 that act, 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).

k. The board may adopt rules and regulations, pursuant to the
seq.), necessary to effectuate the provisions of this act.

6. a. The Commissioner of Health shall establish a public
advisory committee to advise the board on all matters of policy for
the program.

b. The members of the committee shall include all of the
following:

(1) Four physicians, all of whom shall be board-certified in their
fields, and at least one of whom shall be a psychiatrist. The Senate
President and the Governor shall each appoint one member. The
Speaker of the General Assembly shall appoint two of these
members, both of whom shall be primary care providers.

(2) Two registered nurses, to be appointed by the Senate
President.

(3) One licensed allied health practitioner, to be appointed by
the Speaker of the General Assembly.

(4) One mental health care provider, to be appointed by the
Senate President.

(5) One dentist, to be appointed by the Governor.

(6) Three representatives of hospitals or hospital systems, to be
appointed by the Governor.

(7) Four consumers of health care. The Governor shall appoint
two of these members, one of whom shall be a member of the
disabled community. The Senate President shall appoint a member
who is 65 years of age or older. The Speaker of the General
Assembly shall appoint the fourth member.

(8) One representative of organized labor, to be appointed by
the Speaker of the General Assembly.

(9) One representative of essential community providers, to be
appointed by the Senate President.

(10) One member of organized labor, to be appointed by the
Senate President.

(11) One representative of a business that employs less than 25
people, to be appointed by the Governor.

(12) One representative of a business that employs more than 250
people, to be appointed by the Speaker of the General Assembly.

(13) One pharmacist, to be appointed by the Speaker of the
General Assembly.
c. In making appointments pursuant to this section, the Governor, the Senate President, and the Speaker of the General Assembly shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographical diversity of the State.

d. Any member appointed by the Governor, the Senate President, or the Speaker of the General Assembly shall serve a four-year term. These members may be reappointed for succeeding four-year terms.

e. Vacancies that occur shall be filled within 30 days after the occurrence of the vacancy, and shall be filled in the same manner in which the vacating member was initially selected or appointed. The Commissioner of Health shall notify the appropriate appointing authority of any expected vacancies on the public advisory committee.

f. Members of the committee shall serve without compensation, but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties to the extent that reimbursement for those expenses is not otherwise provided or payable by another public agency or agencies, and shall receive $100 for each full day of attending meetings of the committee. For purposes of this section, “full day of attending a meeting” means presence at, and participation in, not less than 75 percent of the total meeting time of the committee during any particular 24-hour period.

g. The public advisory committee shall meet at least six times per year in a place convenient to the public. All meetings 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.).

h. The public advisory committee shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

i. Appointed committee members shall have worked in the field they represent on the committee for a period of at least two years prior to being appointed to the committee.

j. It is unlawful for the committee members or any of their assistants, clerks, or deputies to use for personal benefit any information that is filed with, or obtained by, the committee and that is not generally available to the public.

7. a. The board shall have all powers and duties necessary to establish and implement the Healthy New Jersey program under this act. The program shall provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the State.

b. The board shall, to the maximum extent possible, organize, administer, and market the program and services as a single-payer program under the name “HNJ,” “Healthy New Jersey,” or any other name as the board determines, regardless of in which law or source the definition of a benefit is found, including, on a voluntary
basis, retiree health benefits. In implementing this act, the board shall avoid jeopardizing federal financial participation in the programs that are incorporated into Healthy New Jersey and shall take care to promote public understanding and awareness of available benefits and programs.

c. The board shall consider any matter to effectuate the provisions and purposes of this act. The board shall have no executive, administrative, or appointive duties except as otherwise provided by law.

d. The board shall employ necessary staff and authorize reasonable expenditures, as necessary, from the Healthy New Jersey Trust Fund to pay program expenses and to administer the program.

e. The board may do all of the following:

(1) Negotiate and enter into any necessary contracts, including, but not limited to, contracts with health care providers and care coordinators.

(2) Sue and be sued.

(3) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the State, and any municipality, county, or other political subdivision of the State.

(4) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions to be adopted by the board by regulation.

(5) Share information with relevant State departments, consistent with the confidentiality provisions of this act, necessary for the administration of the program.

f. The board shall determine when individuals may begin enrolling in the program. There shall be an implementation period that begins on the date that individuals may begin enrolling in the program and ends on a date determined by the board.

g. A carrier shall not offer benefits or cover any services for which coverage is offered to individuals under the program, but may, if otherwise authorized, offer benefits to cover health care services that are not offered to individuals under the program. However, this act does not prohibit a carrier from offering either of the following:

(1) Any benefits to or for individuals, including their families, who are employed or self-employed in the State but who are not residents of the State; or

(2) Any benefits during the implementation period to individuals who enrolled or may enroll as members of the program.

h. After the end of the implementation period, a person shall not be a board member unless he or she is a member of the program, except the ex officio member.

i. No later than two years after the effective date of this section, the board shall develop the following proposals:
(1) The board shall develop a proposal, consistent with the principles of this act, for provision by the program of long-term care coverage, including the development of a proposal, consistent with the principles of this act, for its funding. In developing the proposal, the board shall consult with an advisory committee, appointed by the chairperson of the board, including representatives of consumers and potential consumers of long-term care, providers of long-term care, members of organized labor, and other interested parties;

(2) The board shall develop proposals for both of the following:
   (a) Accommodating employer retiree health benefits for people who have been members of HNJ but live as retirees out of the State; and
   (b) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the State prior to the implementation of HNJ and live as retirees out of the State; and

(3) The board shall develop a proposal for HNJ coverage of health care services currently covered under the workers’ compensation system, including whether and how to continue funding for those services under that system and whether and how to incorporate an element of experience rating.

8. The board may contract with not-for-profit organizations to provide both of the following:
   a. Assistance to consumers with respect to selection of a care coordinator or health care organization, enrolling, obtaining health care services, disenrolling, and other matters relating to the program; and
   b. Assistance to health care providers providing, seeking, or considering whether to provide health care services under the program, with respect to participating in a health care organization and interacting with a health care organization.

9. The board shall provide funds from the Healthy New Jersey Trust Fund or funds otherwise appropriated for this purpose to the Commissioner of Labor and Workforce Development for a program for retraining and assisting job transition for individuals employed or previously employed in the fields of health insurance, health care service plans, and other third-party payments for health care or those individuals providing services to health care providers to deal with third-party payers for health care, whose jobs may be or have been ended as a result of the implementation of the program, consistent with otherwise applicable law.

10. The board shall provide for the collection and availability of all of the following data to promote transparency, assess adherence to patient care standards, compare patient outcomes, and review utilization of health care services paid for by the program:
a. Inpatient discharge data, including acuity and risk of mortality.
b. Emergency department and ambulatory surgery data, including charge data, length of stay, and patients’ unit of observation.
c. Hospital annual financial data, including all of the following:
   (1) Community benefits by hospital in dollar value.
   (2) Number of employees and classification by hospital unit.
   (3) Number of hours worked by hospital unit.
   (4) Employee wage information by job title and hospital unit.
   (5) Number of registered nurses per staffed bed by hospital unit.
   (6) Type and value of healthy information technology.
   (7) Annual spending on health information technology, including purchases, upgrades, and maintenance.
d. The board shall make all disclosed data collected under this section publicly available and searchable through an Internet web site.
e. The board shall, directly and through grants to not-for-profit entities, conduct programs using data collected through the Healthy New Jersey program to promote and protect public, environmental, and occupational health, including cooperation with other data collection and research programs consistent with this act and otherwise applicable law.
f. Prior to full implementation of the program, the board shall provide for the collection and availability of data on the number of patients served by hospitals and the dollar value of the care provided, at cost, for all of the following categories:
   (1) Patients receiving charity care.
   (2) Contractual adjustments of county and indigent programs, including traditional and managed care.
   (3) Bad debts.

11. a. Notwithstanding any other law, Healthy New Jersey, any State or local agency, or a public employee acting under color of law shall not provide or disclose to anyone, including, but not limited to, the federal government any personally identifiable information obtained, including, but not limited to, a person’s religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status for law enforcement or immigration purposes.
b. Notwithstanding any other law, law enforcement agencies shall not use Healthy New Jersey moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, or immigration status.
Every resident of the State shall be eligible and entitled to enroll as a member under the program. A member shall not be required to pay any fee, payment, or other charge for enrolling in or being a member under the program.

A member shall not be required to pay any premium, copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits.

c. A college, university, or other institution of higher education in the State may purchase coverage under the program for a student, or a student’s dependent, who is not a resident of the State.

13. a. Covered health care benefits under the program include all medical care determined to be medically appropriate by the member’s health care provider.

b. Covered health care benefits for members shall include, but are not limited to, all of the following:

(1) Licensed inpatient and licensed outpatient medical and health facility services.

(2) Inpatient and outpatient professional health care provider medical services.

(3) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(4) Medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for individual use.

(5) Inpatient and outpatient rehabilitative care.

(6) Emergency care services.

(7) Emergency transportation.

(8) Necessary transportation for health care services for persons with disabilities or who may qualify as low income.

(9) Child and adult immunizations and preventive care.

(10) Health and wellness education.

(11) Hospice care.

(12) Care in a skilled nursing facility.

(13) Home health care, including health care provided in an assisted living facility.

(14) Mental health services.

(15) Substance abuse treatment.

(16) Dental care.

(17) Vision care.

(18) Prescription drugs.

(19) Pediatric care.

(20) Prenatal and postnatal care.

(21) Podiatric care.

(22) Chiropractic care.

(23) Acupuncture.
(24) Therapies that are shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective.

(25) Blood and blood products.

(26) Dialysis.

(27) Adult day care.

(28) Rehabilitative and habilitative services.

(29) Case management and care coordination.

(30) Language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication barriers.

(31) Health care and long-term supportive services currently covered under federally-matchred public health programs.

(32) Covered benefits for members shall also include all health care services required to be covered under Medicaid, NJ FamilyCare, Medicare, or any form of health benefits plan regulated pursuant to Title 17 of the Revised Statutes or Title 17A of the New Jersey Statutes.

(33) Any additional health care services authorized to be added to the program’s benefits by the program.

(34) All essential health benefits mandated by the Affordable Care Act as of January 1, 2017.

14  a. Any health care provider who is licensed to practice in New Jersey and is otherwise in good standing is qualified to participate in the program as long as the health care provider’s services are performed within the State of New Jersey.

b. The board shall establish and maintain procedures and standards for recognizing health care providers located out of the State for purposes of providing coverage under the program for members who require out-of-State health care services while the member is temporarily located out-of-State.

c. Any health care provider qualified to participate under this section may provide covered health care services under the program, as long as the health care provider is legally authorized to perform the health care service for the individual and under the circumstances involved.

d. A member may choose to receive health care services under the program from any participating provider, consistent with provisions of this act, the willingness or availability of the provider, subject to provisions of this act relating to discrimination, and the appropriate clinically relevant circumstances.

e. A member who chooses to enroll with a group medical practice, or essential community provider that offers comprehensive services, shall retain membership for at least one year after an initial three-month evaluation period during which time the member may withdraw for any reason.

f. The three-month period shall commence on the date when a member first sees a primary care provider.
g. A member who wants to withdraw after the initial three-month period shall request a withdrawal pursuant to the dispute resolution procedures established by the board and may request assistance from the patient advocate, which shall be provided for in the dispute resolution procedures, in resolving the dispute. The dispute shall be resolved in a timely fashion and shall not have an adverse effect on the care a patient receives.

15. a. Care coordination shall be provided to the member by his or her care coordinator. A care coordinator may employ or utilize the services of other individuals or entities to assist in providing care coordination for the member, consistent with regulations of the board and with the statutory requirements and regulations of the care coordinator’s licensure.

b. Care coordination includes administrative tracking and medical recordkeeping services for members.

c. Care coordination administrative tracking and medical recordkeeping services for members shall not be required to utilize a certified electronic health record, meet any other requirements of the federal Health Information Technology for Economic and Clinical Health Act, enacted under the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), or meet certification requirements of the federal Centers for Medicare & Medicaid Services’ Electronic Health Records Incentive Programs, including meaningful use requirements.

d. The care coordinator shall comply with all federal and State privacy laws, including, but not limited to, the federal Health Insurance Portability and Accountability Act (HIPAA; 42 U.S.C. Sec. 1320d et seq.) and its implementing regulations.

e. Referrals from a care coordinator are not required for a member to see any eligible provider.

f. A care coordinator may be an individual or entity that is approved by the program that is any of the following:

(1) A health care practitioner that is any of the following:
   (a) The member’s primary care provider.
   (b) The member’s provider of primary gynecological care.
   (c) At the option of a member who has a chronic condition that requires specialty care, a specialist health care practitioner who regularly and continually provides treatment to the member for that condition.

(2) An entity licensed as any of the following:
   (a) a health care facility;
   (b) a carrier;
   (c) a home health agency; or
   (d) a mental health care program;
   (3) a health care organization;
   (4) a Taft-Hartley fund, with respect to its members and their family members; provided that this provision shall not preclude a Taft-
Hartley fund from becoming a care coordinator or a health care organization pursuant to this act; or

(5) any not-for-profit or governmental entity approved by the program.

g. (1) A health care provider shall only be reimbursed for services if the member is enrolled with a care coordinator at the time the health care service is provided.

(2) Every member shall be encouraged to enroll with a care coordinator that agrees to provide care coordination prior to receiving health care services to be paid for under the program. If a member receives health care services before choosing a care coordinator, the program shall assist the member, when appropriate, with choosing a care coordinator.

(3) The member shall remain enrolled with that care coordinator until the member becomes enrolled with a different care coordinator or ceases to be a member.

h. A health care organization may establish rules relating to care coordination for members in the health care organization, different from this section but otherwise consistent with this act and other applicable laws.

i. An individual or entity may not be a care coordinator unless the services included in care coordination are within the individual’s professional scope of practice or the entity’s legal authority.

j. (1) The board shall develop and implement procedures and standards, by regulation, for an individual or entity to be approved as a care coordinator in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the individual or entity is incompetent to be a care coordinator or has exhibited a course of conduct that is inconsistent with program standards and regulations, or that exhibits an unwillingness to meet those standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards adopted by the board shall be consistent with professional practice, licensure standards, and regulations established pursuant to law.

(3) In developing and implementing standards of approval of care coordinators for individuals receiving chronic mental health care services, the board shall consult with the Assistant Commissioner for New Jersey Division of Mental Health and Addiction Services in the Department of Health.

k. To maintain approval under the program, a care coordinator shall do all of the following:

(1) Renew its status every three years pursuant to regulations adopted by the board.

(2) Provide to the program any data required by the board that would enable the board to evaluate the impact of care coordinators on quality, outcomes, and cost of health care.
16. a. The board shall adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided to members under the program by participating providers, care coordinators, and health care organizations. There may be a variety of different payment methodologies, including those established on a demonstration basis. All payment rates under the program shall be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services.

b. Health care services provided to members under the program, except for care coordination, shall be paid for on a fee-for-service basis unless and until another payment methodology is established by the board.

c. Notwithstanding subsection b. of this section, essential community providers and group medical practices that provide comprehensive, coordinated services may choose to be reimbursed on the basis of a capitated system operating budget or a noncapitated system operating budget that covers all costs of providing health care services.

d. The program shall engage in good faith negotiations with health care providers’ representatives, including, but not limited to, in relation to rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies. Those negotiations shall be through a single entity on behalf of the entire program for prescription and nonprescription drugs.

e. (1) Payment for health care services established under this act shall be considered payment in full.

(2) A participating provider shall not charge any rate in excess of the payment established under this act for any health care service provided to a member under the program and shall not solicit or accept payment from any member or third party for any health care service, except as provided under a federal program.

(3) However, this section does not preclude the program from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

f. The program may adopt, by regulation, payment methodologies for the payment of capital related expenses for specifically identified capital expenditures incurred by not-for-profit or governmental entities that are health care facilities. Any capital related expense generated by a capital expenditure that requires prior approval shall have received that approval in order to be paid by the program.

g. Payment methodologies and payment rates shall include a distinct component of reimbursement for direct and indirect graduate medical education.
h. The board shall adopt, by regulation, payment methodologies and procedures for paying for health care services provided to members while the member is located out-of-State.

17. a. A member may choose to enroll with and receive program care coordination and ancillary health care services from a health care organization.

b. A health care organization shall be a not-for-profit or governmental entity that is approved by the board.

c. (1) The board shall develop and implement procedures and standards, by regulation, for an entity to be approved as a health care organization in the program, including, but not limited to, procedures and standards relating to the revocation, suspension, limitation, or annulment of approval on a determination that the entity is incompetent to be a health care organization or has exhibited a course of conduct that is inconsistent with program standards and regulations, or that exhibits an unwillingness to meet those standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards adopted by the board shall be consistent with professional practice and licensure standards established pursuant to law.

(3) In developing and implementing standards of approval of health care organizations, the board shall consult with the Commissioner of Human Services.

d. To maintain approval under the program, a health care organization shall do both of the following:

(1) Renew its status at a frequency determined by the board.

(2) Provide data to the board to enable the board to evaluate the health care organization in relation to the quality of health care services, health care outcomes, and costs.

e. This act shall not be construed to alter in any way the professional practice of health care providers or their licensure standards established pursuant to Title 45 of the Revised Statutes.

f. Health care organizations shall not use health information technology or clinical practice guidelines that limit the effective exercise of the professional judgment of physicians and registered nurses. Physicians and registered nurses shall be free to override health information technology and clinical practice guidelines if, in their professional judgment, it is in the best interest of the patient and consistent with the patient’s wishes.

18. a. The Healthy New Jersey program shall establish a single standard of safe, therapeutic care for all residents of the State by the following means: the board shall establish requirements and standards, by regulation, for the program and for health care organizations, care coordinators, and health care providers, consistent with this act and consistent with the applicable professional practice and licensure standards of health care
providers and health care professionals established pursuant to law
concerning:

(1) The scope, quality, and accessibility of health care services.
(2) Relations between health care organizations or health care
providers and members.
(3) Relations between health care organizations and health care
providers, including credentialing and participation in the health
care organization, and terms, methods, and rates of payment.
   b. The board shall establish requirements and standards, by
regulation, under the program that include, but are not limited to,
provisions to promote all of the following:
      (1) Simplification, transparency, uniformity, and fairness in
health care provider credentialing and participation in health care
organization networks, referrals, payment procedures and rates,
claims processing, and approval of health care services, as
applicable.
      (2) In-person primary and preventive care, care coordination,
efficient and effective health care services, quality assurance, and
promotion of public, environmental, and occupational health.
      (3) Elimination of health care disparities.
      (4) Consistent with law, nondiscrimination with respect to
members and health care providers on the basis of race, color,
ancestry, national origin, religion, citizenship, immigration status,
primary language, mental or physical disability, age, sex, gender,
sexual orientation, gender identity or expression, medical condition,
genetic information, marital status, familial status, military or
veteran status, or source of income; however, health care services
provided under the program shall be appropriate to the patient’s
clinically relevant circumstances.
      (5) Accessibility of care coordination, health care organization
services, and health care services, including accessibility for people
with disabilities and people with limited ability to speak or
understand English.
      (6) Providing care coordination, health care organization
services, and health care services in a culturally competent manner.
   c. The board shall establish, by regulation, requirements and
standards, to the extent authorized by federal law, for replacing and
merging with the Healthy New Jersey program health care services
and ancillary services currently provided by other programs,
including, but not limited to, Medicare, the Affordable Care Act,
and federally matched public health programs.
   d. Any participating provider or care coordinator that is
organized as a for-profit entity shall be required to meet the same
requirements and standards as entities organized as not-for-profit
entities, and payments under the program paid to those entities shall
not be calculated to accommodate the generation of profit, revenue
for dividends, or other return on investment or the payment of taxes
that would not be paid by a not-for-profit entity.
e. Every participating provider shall furnish information as required by the board and permit examination of that information by the program as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental, and occupational health.

f. In developing requirements and standards and making other policy determinations under this section, the board shall consult with representatives of members, health care providers, care coordinators, health care organizations, labor organizations representing health care employees, and other interested parties.

19. a. The board shall seek all federal waivers and other federal approvals and arrangements and submit State plan amendments as necessary to operate the program consistent with this act.

b. (1) The board shall apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal programs that provide federal funds for payment for health care services that are necessary to enable all Healthy New Jersey members to receive all benefits under the program through the program, to enable the State to implement this act, and to allow the State to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the Healthy New Jersey Trust Fund, and to use those funds for the program and other provisions under this act.

(2) To the fullest extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to Healthy New Jersey in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs.

(3) The board may require members or applicants to provide information necessary for the program to comply with any waiver or arrangement under this act. Information provided by members to the board for the purposes of this section shall not be used for any other purpose.

(4) The board may take any additional actions necessary to effectively implement Healthy New Jersey to the maximum extent possible as a single-payer program consistent with this act.

c. The board may take actions consistent with this article to enable the program to administer Medicare in New Jersey, and the program shall be a provider of supplemental insurance coverage (Medicare Part B) and shall provide premium assistance drug
coverage under Medicare Part D for eligible members of the
program.

d. The board may waive or modify the applicability of any
provisions of this section relating to any federally-matched public
health program or Medicare, as necessary, to implement any waiver
or arrangement under this section or to maximize the federal
benefits to the program under this section, provided that the board
determines that the waiver or modification is in the best interest of
the State and members affected by the action.

e. The board may apply for coverage for, and enroll, any
eligible member under any federally matched public health program
or Medicare. Enrollment in a federally matched public health
program or Medicare shall not cause any member to lose any health
care service provided by the program or diminish any right the
member would otherwise have.

f. (1) Notwithstanding any other law, the board, by regulation,
shall increase the income eligibility level, increase or eliminate the
resource test for eligibility, simplify any procedural or
documentation requirement for enrollment, and increase the benefits
for any federally matched public health program and for any
program in order to reduce or eliminate an individual’s coinsurance,
cost-sharing, or premium obligations or increase an individual’s
eligibility for any federal financial support related to Medicare or
the Affordable Care Act.

(2) The board may act under this section, upon a finding by the
Commissioner of Human Services and the board that the action
does all of the following:

(a) Will help to increase the number of members who are
eligible for and enrolled in federally matched public health
programs, or for any program to reduce or eliminate an individual’s
coinsurance, cost-sharing, or premium obligations or increase an
individual’s eligibility for any federal financial support related to
Medicare or the Affordable Care Act.

(b) Will not diminish any individual’s access to any health care
service or right the individual would otherwise have.

(c) Is in the interest of the program.

(d) Does not require or has received any necessary federal
waivers or approvals to ensure federal financial participation.

(3) Actions under this section shall not apply to eligibility for
payment for long-term care.

g. To enable the board to apply for coverage for, and enroll,
any eligible member under any federally matched public health
program or Medicare, the board may require that every member or
applicant provide the information necessary to enable the board to
determine whether the applicant is eligible for a federally matched
public health program or for Medicare, or any program or benefit
under Medicare.

h. As a condition of continued eligibility for health care
services under the program, a member who is eligible for benefits
under Medicare shall enroll in Medicare, including Parts A, B, and D.

i. The program shall provide premium assistance for all members enrolling in a Medicare Part D drug coverage under Section 1860D of Title XVIII of the Social Security Act (42 U.S.C. s.1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare Advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to the program.

j. If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the Social Security Act (42 U.S.C. s.1395w-114), the member shall provide, and authorize the program to obtain, any information or documentation required to establish the member’s eligibility for that subsidy; however, the board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

k. The program shall make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member shall be notified in writing that he or she has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member’s coverage under the program may be terminated. Information provided by members to the board for the purposes of this section shall not be used for any other purpose.

l. The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

20. a. The Healthy New Jersey Trust Fund is hereby created in the State Treasury for the purposes of this act. This fund shall be the repository for monies collected pursuant to this act and other monies received as grants or otherwise appropriated for the purposes of the this act.

b. Notwithstanding any other law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, or a county general fund or any other county fund.

c. The board shall establish and maintain a prudent reserve in the fund.

d. All interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

e. The fund shall consist of all of the following:

(1) All moneys obtained pursuant to legislation enacted as proposed under section 21 of this act.
(2) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established under Medicare, any federally matched public health program, or the Affordable Care Act.

(3) The amounts paid by the State that are equivalent to those amounts that are paid on behalf of residents of this State under Medicare, any federally matched public health program, or the Affordable Care Act for health benefits that are equivalent to health benefits covered under Healthy New Jersey.

(4) Federal and State funds for purposes of the provision of services authorized under Title XX of the Social Security Act (42 U.S.C. s.1397 et seq.) that would otherwise be covered under Healthy New Jersey.

(5) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care services for services and benefits covered under Healthy New Jersey. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this act.

f. All federal moneys shall be placed into the Healthy New Jersey Federal Funds Account, which is hereby created within the Healthy New Jersey Trust Fund.

g. Moneys in the fund shall only be used for the purposes established in this act.

21. a. It is the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the program, and consistent with the provisions of this section. In developing the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

b. It is the intent of the Legislature to enact legislation that would require all State revenues from the program to be deposited in an account within the Healthy New Jersey Trust Fund pursuant to section 20 of this act.

c. The basic structure of the revenue plan shall be as follows: revenue for the program shall come from two premiums, referred to in this section as the "premiums." First, there shall be a progressively graduated premium on all payroll and self-employed income, referred to in this section as the "payroll premium," paid by employers, employees and the self-employed, in a manner similar to the Medicare tax. Higher brackets of income subject to this premium shall be assessed at a higher marginal rate than lower brackets. Second, there shall be a progressively graduated premium on taxable income, such as interest, dividends, and capital gains, not subject to the payroll premium, referred to in this section as the
"non-payroll premium." The premiums shall be set at levels anticipated to produce sufficient revenue to finance the program and other provisions of this act, to be scaled up as enrollment grows, taking into consideration anticipated federal revenue available for the program. Provision shall be made for State residents who are employed out-of-State and are eligible for the program, and non-residents who are employed in the State and are not eligible for the program.

22. a. Health care providers may meet and communicate for the purpose of collectively negotiating with Healthy New Jersey on any matter relating to Healthy New Jersey, including, but not limited to, rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies.

b. This section shall not be construed to allow or authorize an alteration of the terms of the internal and external review procedures set forth in law.

c. This section shall not be construed to allow a strike of Healthy New Jersey by health care providers’ related to the collective negotiations.

d. This act shall not be construed to allow or authorize terms or conditions that would impede the ability of Healthy New Jersey to obtain or retain accreditation by the National Committee for Quality Assurance or a similar body, or to comply with applicable State or federal law.

23. a. Collective negotiation rights granted by this act shall meet all of the following requirements:

(1) Health care providers may communicate with other health care providers regarding the terms and conditions to be negotiated with HNJ.

(2) Health care providers may communicate with health care providers’ representatives.

(3) A health care providers’ representative is the only party authorized to negotiate with HNJ on behalf of the health care providers as a group.

(4) A health care provider can be bound by the terms and conditions negotiated by the health care providers’ representatives.

(5) In communicating or negotiating with the health care providers’ representative, HNJ is entitled to offer and provide different terms and conditions to individual competing health care providers.

b. This act shall not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

c. This act shall not affect or limit collective action or collective bargaining on the part of a health care provider with his
or her employer or any other lawful collective action or collective bargaining.

24. a. Before engaging in collective negotiations with HNJ on behalf of health care providers, a health care provider’s representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative’s plan of operation, and the representative’s procedures to ensure compliance with this section.

b. Each person who acts as the representative of negotiating parties under this section shall pay a fee to the board to act as a representative. The board, by regulation, shall set fees in amounts it determines are reasonable and necessary to cover the costs incurred by the board in administering this section.

25. a. This act shall not authorize competing health care providers to act in concert in response to a health care provider’s representative’s discussions or negotiations with HNJ, except as authorized by other law.

b. A health care provider’s representative shall not negotiate any agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by any health care provider or group of health care providers with respect to the performance of services that are within the health care provider’s scope of practice, license, registration, or certificate.

26. This act shall take effect on the 180th day after enactment.

STATEMENT

This bill, the “Healthy New Jersey Act,” creates the Healthy New Jersey program to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the State. The bill, among other things, provides that the program cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and State provisions, including, but not limited to, Medicaid, NJ FamilyCare, and the federal Medicare program. The bill requires the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to the Healthy New Jersey program, which would then assume responsibility for all benefits and services previously paid for with those funds.

Under the bill’s provisions, every resident of the State is eligible and entitled to enroll as a member under the program. A member is not required to pay any fee, payment, or other charge for enrolling in or being a member under the program. Additionally, a member is
not required to pay any premium, copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits. Covered health care benefits under the program include all medical care determined to be medically appropriate by the member’s health care provider.

This bill also provides for the participation of health care providers in the program, requires care coordination for members, provides for payment for health care services and care coordination, and specifies program standards.

The bill states the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for the Healthy New Jersey program. The basic structure of the revenue plan is to come from two premiums. One premium is to be a progressively graduated premium on all payroll and self-employed income. The second premium is to be a progressively graduated premium on taxable income, such as interest, dividends, and capital gains, not subject to the payroll premium. The bill creates the Healthy New Jersey Trust Fund in the State Treasury, consisting of any federal and State moneys received for the purposes of the bill.

This bill creates the Healthy New Jersey Board to govern the program, made up of nine members with demonstrated and acknowledged expertise in health care, and appointed as provided. The bill provides the board with all the powers and duties necessary to establish the Healthy New Jersey program, including, but not limited to, determining when individuals may start enrolling in the program, employing necessary staff, and negotiating and entering into any necessary contracts. The bill also requires the Commissioner of Health to establish a public advisory committee to advise the board on all matters of policy for the Healthy New Jersey program.

This bill prohibits health insurance carriers from offering health benefits or covering any service for which coverage is offered to individuals under the program, except as provided. The bill authorizes health care providers, as defined, to collectively negotiate rates of payment for health care services, rates of payment for prescription and nonprescription drugs, and payment methodologies using a third-party representative, as provided.