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

SYNOPSIS
"New Jersey Public Option Health Care Act."

CURRENT VERSION OF TEXT
Introduced Pending Technical Review by Legislative Counsel.
AN ACT establishing a State health insurance public option 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 "New Jersey
Public Option Health Care Act.”

2. The Legislature finds and declares that:
   a. All residents of the State have the right to health care. While
      the federal Affordable Care Act brought many improvements in health
      care and health coverage, it still leaves many New Jerseyans without
      coverage or with inadequate coverage. New Jerseyans, as individuals,
      employers, and taxpayers have experienced a rise in the cost of health
      care and coverage in recent years, including rising premiums,
      deductibles and co-pays, restricted provider networks and high out-of-
      network charges.
   b. 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. Health care providers are also affected by
      inadequate health coverage in the State of New Jersey. A large portion
      of voluntary and public hospitals, health centers and other providers
      now experience substantial losses due to the provision of care that is
      uncompensated. Individuals often find that they are deprived of
      affordable care and choice because of decisions by health plans guided
      by the plan's economic needs rather than their health care needs.
   c. Affordable and comprehensive health coverage must be
      provided to address the fiscal crisis facing the health care system and
      the State and to ensure that New Jerseyans can exercise their right to
      health care. It is the intent of the Legislature to create the New Jersey
      Public Option Health Care Program to provide a universal health plan
      option available to every New Jerseyan.
   d. The State shall obtain waivers and other approvals relating to
      Medicaid, NJ FamilyCare, Medicare, the Affordable Care Act, and any
      other appropriate federal programs, under which federal funds and
      other subsidies that are paid to the State of New Jersey are used, as
      appropriate, to create a public option for New Jerseyans to purchase
      health insurance.
   e. If any necessary waiver or approval is not obtained, the State
      shall use State plan amendments and seek waivers and approvals to
      maximize, and make as seamless as possible, the use of federal funds
      to facilitate the New Jersey Public Option Health Care Program.
   f. In order to promote improved quality of, and access to, health
      care services and promote improved clinical outcomes, it is the policy
      of the State to encourage cooperative, collaborative and integrative
      arrangements among health care providers who will participate in the
New Jersey Public Option Health Care Program, under the active
supervision of the Commissioner of Health. It is the intent of the State
to supplant competition with such arrangements and regulation only to
the extent necessary to accomplish the purposes of this act.

g. The Department of Health shall create a New Jersey Public
Option Health Care Program that includes as many providers as
possible and comes at the lowest possible cost for New Jerseyans
shopping for health insurance and that provides an efficient,
competitive publicly-run alternative to the private insurance market.

3. As used in this act:

"Affordable Care 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.
"Board" means the board of the New Jersey Public Option Health
Care Program created pursuant to section 5 of this act.
“Commissioner” means the Commissioner of the Department of
Health.
“Department” means the Department of Health.
"Federally-matched public health program” means Medicaid and NJ
FamilyCare.
"Health care service” means any health care service, including care
coordination, included as a benefit under the program.
"Medicaid” means the Medicaid program established pursuant to
P.L.1968, c.413 (C.30:4D-1 et seq.).
"Medicare” means the coverage provided under Title XVIII of the
Social Security Act as amended in 1965 or its successor plan or plans.
"Member” means an individual who is enrolled in the program.
"New Jersey Public Option Trust Health Care Fund” means the
New Jersey Public Option Trust Fund established pursuant to section
11 of this act.
"NJ FamilyCare” means the NJ FamilyCare Program established
pursuant to P.L.2005, c.156 (C.30:4J-8 et al.).
"Participating provider” means any individual or entity that is a
health care provider qualified under section 7 this act that provides
health care services to members under the program, or a health care
organization.
"Program” means the New Jersey Public Option Health Care
Program created pursuant to 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, as
determined according to regulations of the commissioner. A
“resident” shall include a “small employer,” as defined in section 1 of

4. a. The New Jersey Public Option Health Care Program is
hereby created in the Department of Health. The Commissioner of
Health, in consultation with the Commissioner of Banking and
Insurance, shall establish and implement the program pursuant to this
act. The program shall provide a comprehensive health insurance
coverage option to every resident who enrolls in the program. The
health insurance coverage offered by the program shall compete in the
market with insurance offered by private health insurers.

b. The commissioner shall, to the maximum extent possible,
organize, administer and market the program and services as a single
program under the name "New Jersey Public Option Health Care
Program" or such other name as the commissioner shall determine. In
implementing this act, the commissioner shall avoid jeopardizing
federal financial participation in Federally-matched public health
programs and shall take care to promote public understanding and
awareness of available benefits and programs.

c. The commissioner shall determine when individuals may begin
enrolling in the program. There shall be an implementation period,
which shall begin on the date that individuals may begin enrolling in
the program and shall end as determined by the commissioner.

5. a. The New Jersey Public Option Health Care Board is hereby
created in the Department of Health. The board shall, at the request of
the commissioner, consider any matter to effectuate the provisions and
purposes of this act, and may advise the commissioner in that regard;
and it may, from time to time, submit to the commissioner any
recommendations to effectuate the provisions and purposes of this act.
The commissioner may propose regulations under this act and
amendments to the act for consideration by the board. The board shall
have no executive, administrative or appointive duties except as
otherwise provided by law. The board shall have power to establish,
and from time to time, amend regulations to effectuate the provisions
and purposes of this act, subject to approval by the commissioner.

b. The board shall be composed of:

(1) the Commissioner of Health, the Commissioner of Banking
and Insurance, and the Treasurer, or their designees, as ex officio
members;

(2) 11 members to be appointed by the Governor as follows:

(a) three of whom shall be representatives of health care
consumer advocacy organizations which have a Statewide or regional
constituency, who have been involved in activities related to health
care consumer advocacy, including issues of interest to low- and
moderate-income individuals;

(b) one of whom shall be a representative of professional
organizations representing physicians;

(c) one of whom shall be representatives of professional
organizations representing licensed or registered health care
professionals other than physicians;

(d) two of whom shall be representatives of hospitals, and of those
two, one of whom shall be a representative of public hospitals;
(e) one of whom shall be a representative of community health centers;

(f) one of whom shall be a representative of health care organizations;

(g) one of whom shall be a representative of organized labor; and

(h) one of whom shall have demonstrated expertise in health care finance; and

(3) six members appointed by the Governor; two of whom to be appointed on the recommendation of the Speaker of the General Assembly; two of whom to be appointed on the recommendation of the President of the Senate; one of whom to be appointed on the recommendation of the Minority Leader of the General Assembly; and one of whom to be appointed on the recommendation of the Minority Leader of the Senate.

c. Each member of the board shall serve at the pleasure of the Governor, except the ex officio members.

d. The chair of the board shall be appointed, and may be removed as chair, by the Governor from among the members.

e. The board shall meet at least four times each calendar year. Meetings shall be held upon the call of the chair and as provided by the board. A majority of the appointed members shall be a quorum of the board, and the affirmative vote of a majority of the members voting, but not less than 10, shall be necessary for any action to be taken by the board. The board may establish an executive committee to exercise any powers or duties of the board as it may provide, and other committees to assist the board or the executive committee. The chair of the board shall chair the executive committee and shall appoint the chair and members of all other committees. The board may appoint one or more advisory committees. Members of advisory committees need not be members of the board.

f. Members shall serve without compensation but shall be reimbursed for their necessary and actual expenses incurred while engaged in the business of the board.

g. The board and its committees and advisory committees may request and receive the assistance of the department and any other State or local governmental entity in exercising its powers and duties.

6. a. Every resident of the State shall be eligible and entitled to enroll as a member under the program. The Commissioner of Health, in consultation with the Commissioner of Banking and Insurance, shall establish premiums for which members are responsible and other charges for enrolling in or being a member under the program. The premium shall be determined in a manner to make the program viable, but at the lowest possible cost to members.

b. The program shall provide comprehensive health coverage to every member, which shall include all health care services required to be covered under any of the following, without regard to whether the
(1) NJ Family Care;
(2) Medicaid;
(3) Medicare;
(4) the New Jersey Individual Health Coverage Program established pursuant to section 9 of P.L.1992, c.161 (C.17B:27A-10);
(5) the New Jersey Small Employer Health Benefits Program established pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.); and
(6) any additional health care service authorized to be added to the program's benefits by the program.

c. The commissioner shall determine premiums, deductibles, co-payments or co-insurance under the program.

7. a. (1) The commissioner shall establish and maintain procedures and standards for health care providers to be qualified to participate in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of qualification to participate on a determination that the health care provider is an incompetent provider of specific health care services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety.

(2) The procedures and standards required by paragraph (1) of this subsection shall not limit health care provider participation in the program for economic purposes and shall be consistent with good professional practice.

(3) Any health care provider who is qualified to participate under Medicaid, NJ FamilyCare or Medicare shall be deemed to be qualified to participate in the program, and any health care provider's revocation, suspension, limitation, or annulment of qualification to participate in any of those programs shall apply to the health care provider's qualification to participate in the program; provided that a health care provider qualified under this paragraph shall follow the procedures to become qualified under the program by the end of the implementation period.

b. The commissioner 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 out-of-State health care services.

c. The commissioner may establish by regulation payment methodologies for health care services provided to members under the program by participating providers 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 assuring an adequate
and accessible supply of health care service.

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 and payment methodologies.

e. Notwithstanding any provision of law to the contrary, the
commissioner shall provide by regulation for payment methodologies
and procedures for paying for drugs provided by pharmacies under the
program, in coordination with reimbursement for prescription drugs
under section 340B of the federal Public Health Service Act (42
U.S.C. s.2566), where applicable, and for prescription drugs provided
by health care providers other than pharmacies.

f. Payment for health care services established under this act shall
be considered payment in full. A participating provider shall not
charge any rate in excess of the payment established under this act for
any health care service under the program provided to a member and
shall not solicit or accept payment from any member or third-party for
any such service except as otherwise permitted pursuant to this act;
provided, however, this subsection shall not preclude the program
from acting as a primary or secondary payer in conjunction with
another third-party payer where permitted under this act.

g. The commissioner shall provide by regulation for payment
methodologies and procedures for paying for out-of-State health care
services.

8. a. Every participating provider shall furnish to the program
such information to, and permit examination of its records by, the
program, as may be reasonably required for purposes of reviewing
accessibility and utilization of health care services, quality assurance,
and 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.

b. In developing requirements and standards and making other
policy determinations under this act, the commissioner shall consult
with representatives of members, health care providers, care
coordinators, health care organizations and other interested parties.

c. The program shall maintain the confidentiality of all data and
other information collected under the program when such data would
be normally considered confidential data between a patient and health
care provider. Aggregate data of the program which is derived from
confidential data but does not violate patient confidentiality shall be
public information.

9. a. The commissioner, in consultation with the Commissioner
of Banking and Insurance, shall seek all federal waivers and other
federal approvals and arrangements and submit State plan amendments
necessary to operate the program consistent with this act and to
maximize access to health care for residents of the State.
b. The commissioner 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 New Jersey Public Option Health Care Program members to receive all benefits under the program through the program and to enable the State to implement this act and to receive and deposit all federal payments under those programs, where appropriate, 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 New Jersey Public Option Health Care Trust Fund and to use those funds for the New Jersey Public Option Health Care Program and other provisions of this act.

c. The commissioner may require members, or applicants to be members, to provide information necessary for the program to comply with any waiver or arrangement under this section.

d. The commissioner may waive or modify the applicability of 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 benefit to the New Jersey Public Option Health Care Program under this section, provided that the commissioner, in consultation with the State Treasurer, shall determine that such waiver or modification is in the best interests of the members affected by the action and the State.

e. The commissioner may apply for coverage under any federally-matched public health program on behalf of any member and enroll the member in the federally-matched public health program or Medicare if the member is eligible for it. 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.

10. a. The commissioner shall directly, and through contracts with nonprofit organizations, provide:

(1) consumer assistance to individuals with respect to enrolling, obtaining health care services, disenrolling, and other matters relating to the program; and

(2) health care provider assistance to health care providers providing, and seeking or considering whether to provide, health care services under the program.

b. The commissioner shall, directly and through grants to nonprofit entities, conduct programs using data collected through the New Jersey Public Option Health Care Program, to promote and protect public, environmental and occupational health, including cooperation with other data collection and research programs of the department, consistent with this act and otherwise applicable law.
11. a. There is established in the Department of the Treasury a nonlapsing revolving fund to be known as the “New Jersey Public Option Health Care 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 program. The monies in the fund shall be used only for the purpose of supporting the activities of the program and this act.

b. The State Treasurer is the custodian of the fund and all disbursements from the fund shall be made by the State Treasurer. 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 fund shall be the repository for:

(1) all monies obtained from premiums collected pursuant to 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 Department of Health 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 which are equivalent to health benefits covered under the program; and

(4) State monies, as appropriate, for services and benefits covered under the New Jersey Public Option Health Care Program.

12. This act shall take effect on the first day of the third month after enactment.

STATEMENT

This bill, the "New Jersey Public Option Health Care Act," creates the New Jersey Public Option Health Care Program in the Department of Health. The bill requires the Commissioner of Health, in consultation with the Commissioner of Banking and Insurance, to establish and implement the program, which will provide a comprehensive health insurance coverage option to every State resident who enrolls in the program. The health insurance coverage offered by the program shall compete in the market with insurance offered by private health insurers.

The commissioner will determine when individuals may begin enrolling in the program. There shall be an implementation period,
which shall begin on the date that individuals may begin enrolling
in the program and shall end as determined by the commissioner.

The bill creates the New Jersey Public Option Health Care
Board to consider any matter to effectuate the provisions and
purposes of the bill, and to advise the commissioner in that regard.
The board shall be composed of the Commissioner of Health, the
Commissioner of Banking and Insurance, and the Treasurer, or their
designees, as ex officio members. In addition, the board will have
11 members to be appointed by the Governor:

1. three of whom shall be representatives of health care
consumer advocacy organizations which have a Statewide or
regional constituency, who have been involved in activities related
to health care consumer advocacy, including issues of interest to
low- and moderate-income individuals;

2. one of whom shall be a representative of professional
organizations representing physicians;

3. one of whom shall be a representative of professional
organizations representing licensed or registered health care
professionals other than physicians;

4. two of whom shall be representatives of hospitals, and of
those two, one of whom shall be a representative of public
hospitals;

5. one of whom shall be a representative of community health
centers;

6. one of whom shall be a representative of health care
organizations;

7. one of whom shall be representatives of organized labor; and

8. one of whom shall have demonstrated expertise in health
care finance; and

The board will also include six members appointed by the
Governor; two of whom to be appointed on the recommendation of
the Speaker of the General Assembly; two of whom to be appointed
on the recommendation of the President of the Senate; one of whom
to be appointed on the recommendation of the Minority Leader of
the General Assembly; and one of whom to be appointed on the
recommendation of the Minority Leader of the Senate.

Members shall serve without compensation but shall be
reimbursed for their necessary and actual expenses incurred while
engaged in the business of the board.

Under the bill, every resident of the State shall be eligible and
entitled to enroll as a member under the program. The
Commissioner of Health is to establish premiums for which
members are responsible and other charges for enrolling in or being
a member under the program. The premium shall be determined in
a manner to make the program viable, but at the lowest possible
cost to members.

The bill provides that the program shall provide comprehensive
health coverage to every member. The commissioner shall also
determine premiums, deductibles, co-payments or co-insurance under the program.

The commissioner is also required to establish and maintain procedures and standards for health care providers to be qualified to participate in the program, including but not limited to procedures and standards relating to the revocation, suspension, limitation, or annulment of qualification to participate on a determination that the health care provider is an incompetent provider of specific health care services or has exhibited a course of conduct which is either inconsistent with program standards and regulations or which exhibits an unwillingness to meet such standards and regulations, or is a potential threat to the public health or safety. Such procedures and standards shall not limit health care provider participation in the program for economic purposes and shall be consistent with good professional practice. Any health care provider who is qualified to participate under Medicaid, NJ FamilyCare or Medicare shall be deemed to be qualified to participate in the program, and any health care provider's revocation, suspension, limitation, or annulment of qualification to participate in any of those programs shall apply to the health care provider's qualification to participate in the program; provided that a health care provider qualified in this manner shall follow the procedures to become qualified under the program by the end of the implementation period.

The program shall engage in good faith negotiations with health care providers' representatives including, but not limited to, in relation to rates of payment and payment methodologies.

Every participating provider is required to furnish to the program such information to, and permit examination of its records by, the program, as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, and 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.

The bill specified that the program shall maintain the confidentiality of all data and other information collected under the program when such data would be normally considered confidential data between a patient and health care provider. Aggregate data of the program which is derived from confidential data but does not violate patient confidentiality shall be public information.

The bill provides that the commissioner shall seek all federal waivers and other federal approvals and arrangements and submit State plan amendments necessary to operate the program consistent with the bill and to maximize access to health care for residents of the State. The commissioner shall apply to the 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 New Jersey Public Option Health Care Program members to receive all benefits under the program through the program and to enable the State to implement the provisions of the bill and to receive and deposit all federal payments under those programs, where appropriate, 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 New Jersey Public Option Health Care Trust Fund and to use those funds for the New Jersey Public Option Health Care Program and other provisions under the bill.

The Commissioner shall also directly, and through contracts with not-for-profit organizations, provide:

(1) consumer assistance to individuals with respect to enrolling, obtaining health care services, disenrolling, and other matters relating to the program; and

(2) health care provider assistance to health care providers providing and seeking or considering whether to provide, health care services under the program, with respect to participating in a health care organization and dealing with a health care organization.

The bill establishes in the Department of the Treasury a nonlapsing revolving fund to be known as the “New Jersey Public Option Health Care Trust Fund.” This fund shall be the repository for monies collected under the bill and other monies received as grants or otherwise appropriated for the purposes of the program. The monies in the fund shall be used only for the purpose of supporting the activities of the program and as otherwise provided for in the bill.