

[First Reprint]

**ASSEMBLY, No. 3186**

**STATE OF NEW JERSEY**  
**215th LEGISLATURE**

INTRODUCED JULY 30, 2012

**Sponsored by:**

**Assemblyman HERB CONAWAY, JR.**

**District 7 (Burlington)**

**Assemblyman TROY SINGLETON**

**District 7 (Burlington)**

**Assemblyman UPENDRA J. CHIVUKULA**

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**Assemblyman JOHN S. WISNIEWSKI**

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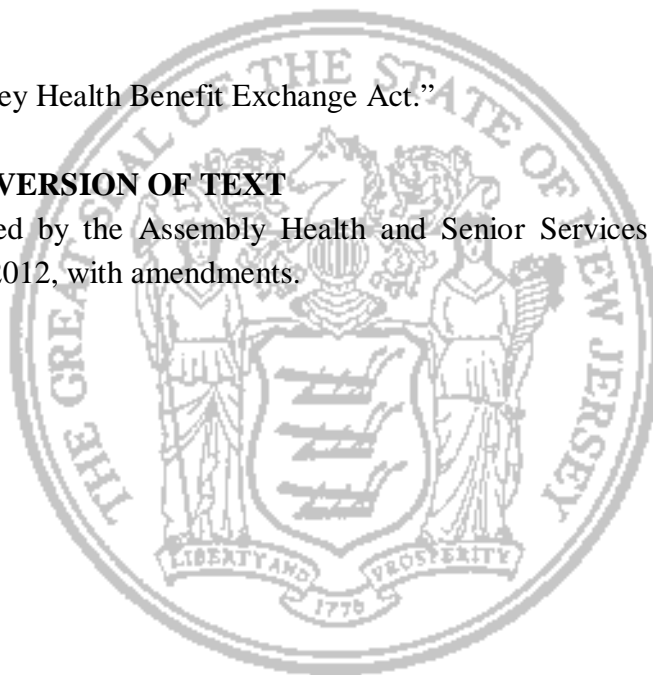
**Assemblymen Johnson, Wimberly and Assemblywoman Sumter**

**SYNOPSIS**

“New Jersey Health Benefit Exchange Act.”

**CURRENT VERSION OF TEXT**

As reported by the Assembly Health and Senior Services Committee on October 11, 2012, with amendments.



**(Sponsorship Updated As Of: 10/16/2012)**

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

3

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

6

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

9

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

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

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

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

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

30 e. meet the requirements of the federal act.

31

32 3. As used in this act:

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

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

**EXPLANATION** – Matter enclosed in bold-faced brackets **[thus]** in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

<sup>1</sup>Assembly AHE committee amendments adopted October 11, 2012.

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

9 “Commissioner” means the Commissioner of Banking and  
10 Insurance.

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

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

15 “Exchange” means the New Jersey Health Benefit Exchange  
16 established pursuant to this act.

17 “Executive director” means the executive director of the  
18 exchange.

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

24 “Health benefits plan” means a hospital and medical expense  
25 insurance policy or certificate; health, hospital, or medical service  
26 corporation contract or certificate; or health maintenance  
27 organization subscriber contract or certificate delivered or issued  
28 for delivery in this State. For the purposes of this act, “health  
29 benefits plan” shall not include one or more, or any combination of,  
30 the following: coverage only for accident or disability income  
31 insurance, or any combination thereof; coverage issued as a  
32 supplement to liability insurance; liability insurance, including  
33 general liability insurance and automobile liability insurance;  
34 workers' compensation or similar insurance; automobile medical  
35 payment insurance; credit-only insurance; coverage for on-site  
36 medical clinics; and other similar insurance coverage, as specified  
37 in federal regulations, under which benefits for medical care are  
38 secondary or incidental to other insurance benefits. “Health  
39 benefits plan” shall not include the following benefits if they are  
40 provided under a separate policy, certificate, or contract of  
41 insurance or are otherwise not an integral part of the plan: limited  
42 scope dental or vision benefits; benefits for long-term care, nursing  
43 home care, home health care, community-based care, or any  
44 combination thereof; and such other similar, limited benefits as are  
45 specified in federal regulations. “Health benefits plan” shall not  
46 include hospital confinement indemnity coverage if: the benefits  
47 are provided under a separate policy, certificate, or contract of  
48 insurance; there is no coordination between the provision of the

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

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

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

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

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

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

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

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

33 “Secretary” means the United States Secretary of Health and  
34 Human Services.

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

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

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

13

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

27

28 5. a. The exchange shall be governed by a board of directors  
29 consisting of ~~'[eight]~~ ten<sup>1</sup> members as follows:

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

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

35 (3) ~~'[five]~~ seven<sup>1</sup> public members who are residents of this  
36 State, to be appointed by the Governor with the advice and consent  
37 of the Senate, including: one person who shall be a member in  
38 good standing of the American Academy of Actuaries; and four  
39 other persons, two of whom shall be appointed upon the  
40 recommendation of the President of the Senate, and two of whom  
41 shall be appointed upon the recommendation of the Speaker of the  
42 General Assembly.

43 b. ~~'[The]~~ Each<sup>1</sup> public ~~'[members]~~ member<sup>1</sup> of the board  
44 ~~'[appointed upon the recommendation of the President of the~~  
45 ~~Senate and the Speaker of the General Assembly]'~~ shall 'have  
46 demonstrated expertise in at least one of the following areas and<sup>1</sup>  
47 appointed in such a manner as to ensure that the public membership

1 of the board includes individuals who have demonstrated expertise  
2 in the following areas:

- 3 (1) individual health care coverage;
- 4 (2) small employer health care coverage;
- 5 (3) health benefits plan administration;
- 6 (4) health care finance; and
- 7 (5) consumer health care advocacy.

8 c. ~~['The public members of the board shall serve on a part-~~  
9 ~~time basis and receive an annual salary of \$50,000.】'~~ The public  
10 members shall ~~['also】'~~ be reimbursed for any expenses incurred by  
11 them in the performance of their duties, subject to the limits of  
12 funds appropriated or otherwise made available for this purpose.

13 d. The public members of the board shall serve for a term of  
14 four years; except that of the members first appointed, one of the  
15 public members appointed upon the recommendation of the  
16 President of the Senate ~~['and】 ,'~~ one of the public members  
17 appointed upon the recommendation of the Speaker of the General  
18 Assembly ~~[' , and one additional public member']~~ shall each serve for  
19 a period of three years, one of the public members appointed upon  
20 the recommendation of the President of the Senate ~~['and】 ,'~~ one of  
21 the public members appointed upon the recommendation of the  
22 Speaker of the General Assembly ~~[' , and one additional public~~  
23 ~~member']~~ shall each serve for a period of four years, and the other  
24 public member appointed shall serve for a period of five years.

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

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

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

35 (2) The executive director shall:

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

38 (b) serve as a member of the senior executive or unclassified  
39 service and be appointed without regard to the provisions of Title  
40 11A of the New Jersey Statutes;

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

42 (d) serve at the pleasure of the board, and receive such  
43 compensation as the board shall determine ~~[' , which shall not exceed~~  
44 ~~the compensation of a cabinet-level official of the State']~~.

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

- 1 (a) plan, direct, coordinate, and execute the administrative  
2 functions of the exchange in conformity with the policies and  
3 directives of the board;
- 4 (b) employ professional and clerical staff as necessary to  
5 implement the provisions of this act;
- 6 (c) report to the board on all operations under his control and  
7 supervision;
- 8 (d) prepare an annual budget and manage the administrative  
9 expenses of the exchange; and
- 10 (e) undertake any other activities necessary to accomplish the  
11 purposes of the exchange.
- 12 (4) All employees of the exchange, except the executive  
13 director, shall be in the career service of the Civil Service.
- 14 h. While serving as a member of the board or an employee of  
15 the exchange, and <sup>1</sup>, except for a secretarial or clerical employee.<sup>1</sup>  
16 for a period of two years immediately following such service or  
17 employment, a person shall not be:
- 18 (1) employed by, a consultant to, a member of the board of  
19 directors of, affiliated with, or otherwise a representative of, a  
20 carrier, an insurance agent or broker, a health care professional, a  
21 health care facility, or an entity operating a navigator program as  
22 set forth in subsection k. of section 8 of this act;
- 23 (2) a member, board member, or employee of a trade association  
24 of carriers, insurance agents or brokers, health care professionals, or  
25 health care facilities; or
- 26 (3) a health care professional, unless that person receives no  
27 compensation for rendering services as a health care professional  
28 and does not have an ownership interest in a health care  
29 professional practice.
- 30 i. All meetings of the board shall be subject to the  
31 requirements of the “Senator Byron M. Baer Open Public Meetings  
32 Act,” P.L.1975, c.231 (C.10:4-6 et seq.). In addition to complying  
33 with the notice requirements of P.L.1975, c.231, the board shall  
34 provide electronic notice of its meetings as defined in section 1 of  
35 P.L.2002, c.91 (C.10:4-9.1).
- 36 j. A member of the board or an employee of the exchange shall  
37 not be liable in an action for damages to any person for any action  
38 taken or recommendation made by the member or employee within  
39 the scope of his functions as a member or employee, if the action or  
40 recommendation was taken or made without malice. The members  
41 of the board shall be indemnified and their defense of any action  
42 provided for in the same manner and to the same extent as  
43 employees of the State under the “New Jersey Tort Claims Act,”  
44 <sup>1</sup>[P.L.1972, c.45 (C.59:1-1 et seq.)] N.J.S.59:1-1 et seq.<sup>1</sup> on  
45 account of acts or omissions in the scope of their employment.
- 46 k. (1) The board shall establish an advisory committee to  
47 provide advice to the board concerning the operation of the

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

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

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

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

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

11 (d) licensed general hospitals;

12 (e) licensed long-term care facilities;

13 (f) mental health care <sup>1</sup>and addiction services<sup>1</sup> providers;

14 (g) federally qualified health centers;

15 (h) licensed physicians;

16 (i) licensed nurses;

17 (j) small employers;

18 (k) public employee unions;

19 (l) private sector unions;

20 (m) consumer health care advocacy organizations;

21 (n) consumer legal advocacy organizations; and

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

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

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

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

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

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

46

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



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

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

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

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

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

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

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

34 (b) If the board decides not to allow employers with more than  
35 100 employees to purchase coverage through the exchange  
36 beginning on January 1, 2017, the board shall issue a report to the  
37 Governor, and to the Legislature pursuant to section 2 of P.L.1991,  
38 c.164 (C.52:14-19.1), that explains the reasons why it decided not  
39 to allow those employers to purchase coverage through the  
40 exchange, and shall make this report available to the public on the  
41 Internet website of the exchange.

42 c. The board ~~'shall~~ may<sup>1</sup> take such actions as are necessary  
43 to create and offer a Basic Health Plan, in conjunction with the  
44 Department of Human Services and consistent with the provisions  
45 of the federal act, to enable persons with incomes of between 133%  
46 and 200% of the federal poverty level, and noncitizens who would  
47 be eligible for Medicaid except for not meeting the minimum  
48 residency requirements provided in federal law, who would

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

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

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

9 (2) procedures and minimum requirements for the selection,  
10 certification, and recertification of qualified health benefits plans to  
11 be offered through the exchange that are consistent with guidelines  
12 established by the <sup>1</sup>['United States Secretary of Health and Human  
13 Services] secretary<sup>1</sup>;

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

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

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

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

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

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

45 e. The board shall also be authorized to:

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

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

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

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

11 (a) publicly announced prior to being awarded;

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

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

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

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

24 (6) maintain an office in the State;

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

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

29

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

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

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

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

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

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

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

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

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

34 (1) include within its health care provider network **[those]** <sup>1</sup>all<sup>1</sup>  
35 essential community providers, where available, that serve  
36 predominately low-income, medically underserved individuals,  
37 including: <sup>1</sup>all<sup>1</sup> health care providers as defined in section  
38 340B(a)(4) of the Public Health Service Act (42 U.S.C.  
39 s.256b(a)(4)) <sup>1</sup>, including those who were identified as covered  
40 entities under section 340B(a)(4) on March 27, 2012<sup>1</sup>; and  
41 providers as described in section 1927(c)(1)(D)(i)(IV) of the federal  
42 Social Security Act (42 U.S.C. s.1396r-8(c)(1)(D)(i)(IV)); <sup>1</sup>**[and]**<sup>1</sup>

43 (2) pay essential community providers within its health care  
44 provider network at the <sup>1</sup>**[highest]** generally applicable payment<sup>1</sup>  
45 rate that it pays to <sup>1</sup>**[comparable]** similarly situated<sup>1</sup> providers  
46 <sup>1</sup>who are not essential community providers<sup>1</sup> for each category of  
47 services provided by the essential community provider, except that

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

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

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

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

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

35 (2) if the carrier sells any products to individuals outside the  
36 exchange, fairly and affirmatively offer, market, and sell all  
37 products made available to individuals in the exchange to  
38 individuals purchasing coverage outside the exchange; if the carrier  
39 sells any products to employers outside the exchange, fairly and  
40 affirmatively offer, market, and sell all products made available to  
41 employers in SHOP to employers purchasing coverage outside the  
42 exchange;

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

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

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

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

17 (a) claims payment policies and practices;

18 (b) periodic financial disclosures;

19 (c) data on enrollment and disenrollment;

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

21 (e) data on rating practices;

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

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

27 (6) make available to the public and submit to the board such  
28 other information as may be required pursuant to the federal act or  
29 as the board reasonably determines necessary to accomplish the  
30 purposes of this act <sup>1</sup>; and

31 (7) not discriminate, as provided in section 1201 of the federal  
32 act, adding section 2706 to the Public Health Service Act, (42  
33 U.S.C. s.300gg-5), with respect to coverage or participation under a  
34 health plan against any health care provider who is acting within the  
35 scope of that provider's license or certification under applicable  
36 State law<sup>1</sup>.

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

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

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

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

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

10

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

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

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

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

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

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

- 1 exemption from repayment of the advance premium tax credit that  
2 would otherwise be required pursuant to federal or State law; and
- 3 (5) utilize any other measures that the board deems necessary  
4 and appropriate for the purposes of this subsection, so as to ensure  
5 the most efficient, cost-effective, and comprehensive health care  
6 coverage possible and continuity of coverage and care when an  
7 enrollee transitions between participation in a qualified health  
8 benefits plan and participation in Medicaid or NJ FamilyCare, or  
9 the reverse, consistent with the provisions of the federal act and any  
10 other applicable federal law and regulations;
- 11 b. undertake activities necessary to market and publicize the  
12 availability of health care coverage and federal subsidies through  
13 the exchange, and undertake outreach and enrollment activities that  
14 seek to assist enrollees and potential enrollees with enrolling and  
15 reenrolling in the exchange in the least burdensome manner,  
16 including populations that may experience barriers to enrollment,  
17 such as persons with disabilities and those with limited English  
18 language proficiency;
- 19 c. assign a rating to each qualified health benefits plan offered  
20 through the exchange in accordance with criteria developed by the  
21 secretary;
- 22 d. utilize a standardized format for presenting health benefits  
23 plan options in the exchange;
- 24 e. establish and make available by electronic means a  
25 calculator to determine the actual cost of coverage after the  
26 application of any premium tax credit and any cost-sharing  
27 reduction provided for under the federal act;
- 28 f. establish uniform billing and payment policies for qualified  
29 health benefits plans and coordinate these policies with Medicaid  
30 and NJ FamilyCare;
- 31 g. grant a certification attesting that a person is exempt from  
32 the tax imposed under the federal act for not having qualifying  
33 health care coverage as specified in the federal act, because: there  
34 is no affordable qualified health benefits plan available through the  
35 exchange or the person's employer to cover that person; or the  
36 person meets the requirements for any other exemption from the tax  
37 under the federal act;
- 38 h. perform such duties as are required of, or delegated to, the  
39 exchange by the secretary or the Secretary of the Treasury, pursuant  
40 to the federal act, relating to the determination of eligibility for  
41 premium tax credits, reduced cost sharing, or exemptions from the  
42 tax imposed under the federal act for not having qualifying health  
43 care coverage;
- 44 i. provide notice to enrollees of their right of appeal with  
45 respect to certain medical decisions by carriers under the  
46 Independent Health Care Appeals Program established pursuant to  
47 section 11 of P.L.1997, c.192 (C.26:2S-11);



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

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

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

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

19 (3) facilitate enrollment in qualified health benefits plans;

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

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

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

31 (7) be incorporated, organized, and operated in such a manner as  
32 to qualify as a nonprofit corporation described in section 501(c)(3)  
33 of the federal Internal Revenue Code, 26 U.S.C. s.501(c)(3) or any  
34 successor provision that is exempt from taxation pursuant to section  
35 501(a) of the federal Internal Revenue Code, 26 U.S.C. s.501(a) or  
36 any successor provision; and

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

41

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

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

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

18  
19       10. Records maintained by the exchange shall be subject to  
20 P.L.1963, c.73 (C.47:1A-1 et seq.) and P.L.2001, c.404 (C.47:1A-5  
21 et al.), commonly referred to as the open public records act.

22  
23       11. a. In addition to furnishing such information to any  
24 department or agency of the federal government as may be required  
25 pursuant to the federal act or any other federal law or regulation, the  
26 board shall annually: make a report of the activities, receipts, and  
27 expenditures of the exchange as of the end of the State fiscal year to  
28 the Governor, the Legislature pursuant to section 2 of P.L.1991,  
29 c.164 (C.52:14-19.1), and the State Auditor; and make this  
30 information available on the Internet website of the exchange.

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

36  
37       12. The commissioner shall present a report to the Governor,  
38 and to the Legislature pursuant to section 2 of P.L.1991, c.164  
39 (C.52:14-19.1), no later than January 1, 2018, which contains the  
40 commissioner's findings and recommendations, including such  
41 recommendations for administrative or legislative action as the  
42 commissioner deems appropriate, concerning whether to:

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

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

1 c. phase out these programs and transition the health care  
2 coverage provided thereunder to coverage provided under qualified  
3 health benefits plans through the exchange, in which case the  
4 commissioner shall specify a projected schedule for effecting this  
5 transition in the most efficient and effective manner possible.  
6

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

14 <sup>1</sup>~~[13.]~~ 14.<sup>1</sup> The board, the commissioner, and the Commissioner  
15 of Human Services, pursuant to the "Administrative Procedure  
16 Act," P.L.1968, c.410 (C.52:14B-1 et seq.) and in consultation with  
17 each other, shall each adopt such rules and regulations as may be  
18 necessary to effectuate the purposes of this act.  
19

20 <sup>1</sup>~~[14.]~~ 15.<sup>1</sup> This act shall take effect on the first day of the  
21 seventh month following the date of enactment, but the board, the  
22 commissioner, and the Commissioner of Human Services shall take  
23 such anticipatory administrative action in advance thereof as shall  
24 be necessary for the implementation of this act.