

ASSEMBLY, No. 987

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

Sponsored by:
Assemblyman HERB CONAWAY, JR.
District 7 (Burlington)

SYNOPSIS

"New Jersey Health Insurance Marketplace Act."

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 **AN ACT** establishing the New Jersey Health Insurance Marketplace
2 and 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 Insurance Marketplace 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 Insurance Marketplace 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 marketplace.

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 under a health benefits plan, including: an insurance
39 company authorized to issue health benefits plans; a health
40 maintenance organization; a health, hospital, or medical service
41 corporation; or any other entity providing a health benefits plan.
42 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
45 that in the case of an insurance company, health service
46 corporation, hospital service corporation, or medical service
47 corporation that is an affiliate of a health maintenance organization

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

6 “Commissioner” means the Commissioner of Banking and
7 Insurance.

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

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

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

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

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

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

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

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

16 “Marketplace” means the New Jersey Health Insurance
17 Marketplace established pursuant to this act.

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

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

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

27 “Qualified dental plan” means a limited scope dental plan
28 certified by the marketplace pursuant to this act.

29 “Qualified health benefits plan” means a health benefits plan
30 certified by the marketplace pursuant to this act.

31 “Secretary” means the United States Secretary of Health and
32 Human Services.

33 “SHOP” means the State Business Health Options Program
34 established within the marketplace pursuant to this act.

35 “Small employer” means a person, firm, corporation, or
36 partnership that is actively engaged in business, which employed an
37 average of at least two but not more than 50 employees on business
38 days during the preceding calendar year and at least two employees
39 on the first day of the current calendar year, and the majority of
40 which employees are employed in New Jersey. A small employer
41 that makes enrollment in qualified health benefits plans available to
42 its employees through SHOP, and ceases to be a small employer
43 due to an increase in the number of its employees, shall continue to
44 be treated as a small employer for the purposes of this act as long as
45 it makes enrollment in qualified health benefits plans available to
46 its employees through SHOP. All persons treated as a single
47 employer under subsections (b), (c), (m) or (o) of section 414 of the

1 federal Internal Revenue Code of 1986 (26 U.S.C. s.414) shall be
2 treated as one employer. For the purpose of determining the size of
3 an employer, and subject to the provisions of paragraph (2) of
4 subsection b. of section 6 of this act: all employees of an employer
5 shall be counted, including part-time employees and those not
6 eligible for employer-sponsored coverage; the size of an employer
7 shall be determined annually; and, in the case of an employer that
8 was not in existence during the preceding calendar year, the
9 determination of the size of the employer shall be based on the
10 average number of employees that the employer is reasonably
11 expected to employ on business days in the current calendar year.

12

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

26

27 5. a. The marketplace shall be governed by a board of
28 directors consisting of ten members as follows:

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

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

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

41 b. Each public member of the board shall have demonstrated
42 expertise in at least one of the following areas and be appointed in
43 such a manner as to ensure that the public membership of the board
44 includes individuals who have demonstrated expertise in the
45 following areas:

46 (1) individual health care coverage;

47 (2) small employer health care coverage;

- 1 (3) health benefits plan administration;
- 2 (4) health care finance; and
- 3 (5) consumer health care advocacy.
- 4 c. The public members shall be reimbursed for any expenses
- 5 incurred by them in the performance of their duties, subject to the
- 6 limits of funds appropriated or otherwise made available for this
- 7 purpose.
- 8 d. The public members of the board shall serve for a term of
- 9 four years; except that of the members first appointed, one of the
- 10 public members appointed upon the recommendation of the
- 11 President of the Senate, one of the public members appointed upon
- 12 the recommendation of the Speaker of the General Assembly, and
- 13 one additional public member shall each serve for a period of three
- 14 years, one of the public members appointed upon the
- 15 recommendation of the President of the Senate, one of the public
- 16 members appointed upon the recommendation of the Speaker of the
- 17 General Assembly, and one additional public member shall each
- 18 serve for a period of four years, and the other public member
- 19 appointed shall serve for a period of five years.
- 20 e. Each public member of the board shall hold office for the
- 21 term of his appointment and until his successor has been appointed.
- 22 Vacancies shall be filled in the same manner as the original
- 23 appointments were made. A member is eligible for reappointment.
- 24 f. The board shall organize as soon as practicable after the
- 25 appointment of its members and shall select a chairperson annually
- 26 from among its members.
- 27 g. (1) The board shall appoint an executive director of the
- 28 marketplace to supervise the administrative affairs and general
- 29 management and operations of the marketplace.
- 30 (2) The executive director shall:
- 31 (a) be a person qualified by training and experience to perform
- 32 the duties of that position;
- 33 (b) serve as a member of the senior executive or unclassified
- 34 service and be appointed without regard to the provisions of Title
- 35 11A of the New Jersey Statutes;
- 36 (c) attend all meetings of the board; and
- 37 (d) serve at the pleasure of the board, and receive such
- 38 compensation as the board shall determine, which shall not exceed
- 39 the compensation of a cabinet-level official of the State.
- 40 (3) With the approval of the board, the executive director shall:
- 41 (a) plan, direct, coordinate, and execute the administrative
- 42 functions of the marketplace in conformity with the policies and
- 43 directives of the board;
- 44 (b) employ professional and clerical staff as necessary to
- 45 implement the provisions of this act;
- 46 (c) report to the board on all operations under his control and
- 47 supervision;

1 (d) prepare an annual budget and manage the administrative
2 expenses of the marketplace; and

3 (e) undertake any other activities necessary to accomplish the
4 purposes of the marketplace.

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

7 h. While serving as a member of the board or an employee of
8 the marketplace and, except for a secretarial or clerical employee,
9 for a period of two years immediately following such service or
10 employment, a person shall not be:

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

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

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

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

29 j. A member of the board or an employee of the marketplace
30 shall not be liable in an action for damages to any person for any
31 action taken or recommendation made by the member or employee
32 within the scope of his functions as a member or employee, if the
33 action or recommendation was taken or made without malice. The
34 members of the board shall be indemnified and their defense of any
35 action provided for in the same manner and to the same extent as
36 employees of the State under the "New Jersey Tort Claims Act,"
37 N.J.S.59:1-1 et seq. on account of acts or omissions in the scope of
38 their employment.

39 k. (1) The board shall establish an advisory committee to
40 provide advice to the board concerning the operation of the
41 marketplace and any other matter relating to implementation of the
42 provisions of this act.

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

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

- 1 (b) health service corporations offering contracts in this State;
2 (c) insurance producers licensed pursuant to P.L.2001, c.210
3 (C.17:22A-26 et seq.);
4 (d) licensed general hospitals;
5 (e) licensed long-term care facilities;
6 (f) mental health care and addiction services providers;
7 (g) federally qualified health centers;
8 (h) licensed physicians;
9 (i) licensed nurses;
10 (j) small employers;
11 (k) public employee unions;
12 (l) private sector unions;
13 (m) consumer health care advocacy organizations;
14 (n) consumer legal advocacy organizations; and
15 (o) public health researchers or other academic experts with
16 knowledge and background relevant to the functions and goals of
17 the marketplace, including knowledge of the health care needs and
18 health disparities among the diverse communities of this State.
- 19 (3) The members of the advisory committee shall serve for a
20 term of three years; except that of the members first appointed, five
21 shall serve for a period of three years, five for a period of two years,
22 and five for a period of one year.
- 23 (4) Each member of the advisory committee shall hold office for
24 the term of his appointment and until his successor has been
25 appointed. Vacancies shall be filled in the same manner as the
26 original appointments were made. A member is eligible for
27 reappointment.
- 28 (5) The members of the advisory committee shall serve without
29 compensation but be reimbursed for any expenses incurred by them
30 in the performance of their duties, subject to the limits of funds
31 appropriated or otherwise made available for this purpose.
- 32 (6) The advisory committee shall organize as soon as practicable
33 after the appointment of its members and shall select a chairperson
34 annually from among its members, except that no member shall
35 serve as chairperson for a term exceeding two years.
- 36 (7) The board shall, within the limits of its existing staff and
37 resources, provide such staff support as the advisory committee
38 requires to perform its duties.
- 39
- 40 6. a. The board shall implement the marketplace pursuant to
41 the provisions of this act and as otherwise required by the federal
42 act or any other federal law. The board shall facilitate the purchase
43 of coverage under qualified health benefits plans through the
44 marketplace at affordable prices by enrollees.
- 45 b. (1) (a) The board shall establish the State Business Health
46 Options Program, or SHOP, separate from the activities of the board
47 related to the individual market, to assist participating employers in

1 facilitating the enrollment of their employees in qualified health
2 benefits plans offered through the marketplace in a manner
3 consistent with the provisions of the federal act.

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

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

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

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

19 (2) (a) The board: shall take such actions as are necessary to
20 permit small employers to purchase coverage through the
21 marketplace, and to permit employers with at least 51 but not more
22 than 100 employees to purchase coverage through the marketplace
23 no later than January 1, 2021; and may allow employers with more
24 than 100 employees to purchase coverage through the marketplace
25 beginning on January 1, 2022, consistent with the provisions of the
26 federal act and any regulations adopted pursuant thereto.

27 (b) If the board decides not to allow employers with more than
28 100 employees to purchase coverage through the marketplace
29 beginning on January 1, 2022, the board shall issue a report to the
30 Governor, and to the Legislature pursuant to section 2 of P.L.1991,
31 c.164 (C.52:14-19.1), that explains the reasons why it decided not
32 to allow those employers to purchase coverage through the
33 marketplace, and shall make this report available to the public on
34 the Internet website of the marketplace.

35 c. The board may take such actions as are necessary to create
36 and offer a Basic Health Plan, in conjunction with the Department
37 of Human Services and consistent with the provisions of the federal
38 act, to enable persons with incomes of between 133% and 200% of
39 the federal poverty level, and noncitizens who would be eligible for
40 Medicaid except for not meeting the minimum residency
41 requirements provided in federal law, who would otherwise be
42 eligible to receive premium subsidies for the purchase of coverage
43 through the marketplace, to purchase essential health benefits
44 through the provision of federal funds pursuant to the federal act.

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

- 1 (1) procedures for the operations of the marketplace;
 - 2 (2) procedures and minimum requirements for the selection,
3 certification, and recertification of qualified health benefits plans to
4 be offered through the marketplace that are consistent with
5 guidelines established by the secretary;
 - 6 (3) criteria for determining that certain health benefits plans will
7 no longer be made available through the marketplace and a
8 procedure to decertify these plans that includes providing prior
9 notice to the carrier;
 - 10 (4) procedures, criteria, and a standard application form for
11 prospective enrollees seeking to obtain coverage under qualified
12 health benefits plans offered through the marketplace;
 - 13 (5) procedures, criteria, and a standard application form for the
14 enrollment of participating employers in SHOP;
 - 15 (6) a customer service center, which shall operate a toll-free
16 telephone service and provide oral and written information in a
17 manner that is culturally and linguistically appropriate to the needs
18 of the population being served by the marketplace, to manage
19 marketplace enrollment, provide information to individuals and
20 employers about the marketplace, provide carriers with information
21 about criteria for health benefits plans eligible to be offered through
22 the marketplace, respond to requests for assistance from enrollees
23 and participating employers, and provide participating employers
24 with information about and services for establishing and
25 maintaining cafeteria plans for their employees pursuant to section
26 125 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.125)
27 and health reimbursement arrangements for their employees
28 pursuant to section 105 of the federal Internal Revenue Code of
29 1986 (26 U.S.C. s.105);
 - 30 (7) maintenance of an Internet website that provides
31 standardized comparative information on qualified health benefits
32 plans, information on how to obtain assistance from navigators
33 chosen by the board pursuant to subsection k. of section 8 of this
34 act, and information on how to obtain assistance from a licensed
35 insurance producer for those individuals wishing to do so; and
 - 36 (8) a strategy for publicizing the services, eligibility
37 requirements, and enrollment procedures of the marketplace.
- 38 e. The board shall also be authorized to:
- 39 (1) apply for such grants from the federal government as may be
40 available for the purposes of this act pursuant to the federal act or
41 any other federal law, and take such actions as are necessary to
42 ensure that any such funds received are utilized in a manner
43 consistent with the provisions of federal law;
 - 44 (2) seek and receive such grant funding as may be available
45 from private foundations for the purposes of this act;
 - 46 (3) contract with professional service firms as may be necessary
47 in its judgment, and fix their compensation, for which purpose the

1 board, as it deems necessary to effectuate the purposes of this act,
2 may enter into a contract for the provision of goods or performance
3 of services without public advertising for bids, provided that the
4 contract shall be:

- 5 (a) publicly announced prior to being awarded;
- 6 (b) negotiated on the basis of demonstrated competence and
7 qualifications for the type of professional services required and at
8 fair and reasonable compensation; and
- 9 (c) awarded through a process that, to the maximum extent
10 practicable, meets the same procedural requirements as those set
11 forth in P.L.1997, c.399 (C.52:34-9.1 et seq.) for a professional firm
12 providing professional architectural, engineering, or land surveying
13 services in this State, but without regard to the dollar value of the
14 contract;
- 15 (4) adopt by-laws for the regulation of its affairs and the
16 conduct of its business;
- 17 (5) adopt an official seal for the marketplace and alter the same;
- 18 (6) maintain an office in the State;
- 19 (7) sue and be sued in its own name; and
- 20 (8) approve the use of its trademarks, brand names, seals, logos,
21 and similar instruments by carriers, participating employers, and
22 other organizations.

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

34 (2) The board shall permit a carrier participating in the
35 marketplace to offer to enrollees a plan that provides limited scope
36 dental benefits, which meets the requirements of subparagraph (A)
37 of paragraph (2) of subsection (c) of section 9832 of the federal
38 Internal Revenue Code of 1986 (26 U.S.C. s.9832) and is provided
39 either in conjunction with a qualified health benefits plan or under a
40 separate policy, certificate, or contract of insurance, if the plan
41 provides pediatric dental benefits that meet the requirements of
42 subparagraph (J) of paragraph (1) of subsection (b) of section 1302
43 of the federal act (42 U.S.C. s.18022), and such other dental
44 benefits as the board or the secretary may prescribe by regulation.

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

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

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

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

18 (3) The marketplace and any carrier participating in the
19 marketplace shall not charge a person a fee or other monetary
20 penalty for the termination of coverage under a qualified health
21 benefits plan if the person enrolls in another type of minimum
22 essential coverage because the person has become newly eligible
23 for that coverage or because the person's employer-sponsored
24 coverage has become affordable under the standards of
25 subparagraph (C) of paragraph (2) of subsection (c) of section 36B
26 of the federal Internal Revenue Code of 1986 (26 U.S.C. s.36B).

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

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

38 (2) pay essential community providers within its health care
39 provider network at the generally applicable payment rate that it
40 pays to similarly situated providers who are not essential
41 community providers for each category of services provided by the
42 essential community provider, except that: (a) in no case shall this
43 rate be less than Medicaid pays for the same service; and (b) in the
44 case of federally qualified health centers, a plan shall pay the
45 Medicaid prospective payment system (PPS) rate, as set forth in
46 section 1902(bb) of the federal Social Security Act (42 U.S.C.
47 1396a(bb)), or a mutually agreed upon payment rate provided that

1 rate is at least equal to the plan's generally applicable payment rate;
2 and

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

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

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

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

31 (2) if the carrier sells any products to individuals outside the
32 marketplace, fairly and affirmatively offer, market, and sell all
33 products made available to individuals in the marketplace to
34 individuals purchasing coverage outside the marketplace; if the
35 carrier sells any products to employers outside the marketplace,
36 fairly and affirmatively offer, market, and sell all products made
37 available to employers in SHOP to employers purchasing coverage
38 outside the marketplace;

39 (3) provide a detailed description of the benefits offered by a
40 qualified health benefits plan through an Internet website and by
41 other means for individuals without access to the Internet, which
42 specifies: maximum benefits; limitations, exclusions, and other
43 benefit limits; and the amount of cost sharing, including, but not
44 limited to, deductibles, copayments, and coinsurance, under the
45 plan that an individual would be responsible for paying with respect
46 to the furnishing of a specific item or service by a participating
47 health care provider;

- 1 (4) submit a justification to the board for any premium increase
- 2 in a qualified health benefits plan prior to implementation of the
- 3 increase, and prominently post that information on its Internet
- 4 website, which the board shall consider in determining whether to
- 5 make the health benefits plan available through the marketplace, in
- 6 addition to considering any information and recommendations
- 7 provided to the board by the department and any excess of premium
- 8 growth outside the marketplace as compared to the rate of that
- 9 growth inside the marketplace;
- 10 (5) make available to the public and submit to the board, the
- 11 secretary, and the commissioner, as applicable, accurate and timely
- 12 information, with respect to a qualified health benefits plan,
- 13 concerning the following:
- 14 (a) claims payment policies and practices;
- 15 (b) periodic financial disclosures;
- 16 (c) data on enrollment and disenrollment;
- 17 (d) data on the number of claims that are denied;
- 18 (e) data on rating practices;
- 19 (f) information on cost sharing and payments with respect to
- 20 any out-of-network coverage; and
- 21 (g) information on enrollee and participating employer rights as
- 22 specified under federal law or otherwise determined appropriate by
- 23 the secretary;
- 24 (6) make available to the public and submit to the board such
- 25 other information as may be required pursuant to the federal act or
- 26 as the board reasonably determines necessary to accomplish the
- 27 purposes of this act; and
- 28 (7) not discriminate, as provided in section 1201 of the federal
- 29 act, adding section 2706 to the Public Health Service Act,
- 30 (42 U.S.C. s.300gg-5), with respect to coverage or participation
- 31 under a health plan against any health care provider who is acting
- 32 within the scope of that provider's license or certification under
- 33 applicable State law.
- 34 e. The board shall establish procedures necessary to avoid risk
- 35 selection between qualified health benefits plans offered through
- 36 the marketplace and health benefits plans offered outside the
- 37 marketplace and among qualified health benefits plans offered
- 38 within the marketplace, including, but not limited to, such
- 39 mechanisms as the board determines appropriate for adjusting
- 40 payments to qualified health benefits plans to account for risk
- 41 selection and assure market stability.
- 42 f. The provisions of this section shall not be construed as
- 43 requiring a carrier that does not participate in the marketplace to
- 44 meet any requirements relating to health care coverage or its
- 45 operations that are not otherwise imposed on that carrier under
- 46 federal or State law.

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

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

8

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

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

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

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

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

42 (4) establish procedures to assist an enrollee in reporting a
43 change in income to the marketplace that might affect the amount of
44 advance premium tax credit to which the enrollee is entitled
45 pursuant to the federal act, as well as in qualifying for any
46 exemption from repayment of the advance premium tax credit that
47 would otherwise be required pursuant to federal or State law; and

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

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

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

20 d. utilize a standardized format for presenting health benefits
21 plan options in the marketplace;

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

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

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

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

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

46 j. provide for an appeal mechanism for enrollees with respect
47 to marketplace-related determinations, when the subject of appeal is

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

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

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

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

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

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

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

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

29 (7) be incorporated, organized, and operated in such a manner as
30 to qualify as a nonprofit corporation described in section 501(c)(3)
31 of the federal Internal Revenue Code of 1986, 26 U.S.C. s.501(c)(3)
32 or any successor provision that is exempt from taxation pursuant to
33 section 501(a) of the federal Internal Revenue Code of 1986,
34 26 U.S.C. s.501(a) or any successor provision; and

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

39
40 9. a. There is established in the Department of the Treasury a
41 nonlapsing revolving fund to be known as the "New Jersey Health
42 Insurance Marketplace Trust Fund." This fund shall be the
43 repository for monies collected pursuant to subsection c. of this
44 section and other monies received as grants or otherwise
45 appropriated for the purposes of the marketplace. The monies in
46 the fund shall be used only for the purpose of supporting the
47 activities of the marketplace.

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

18
19 10. Records maintained by the marketplace 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 marketplace as of the end of the State fiscal year
28 to 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 marketplace.

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

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, 2022, 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;

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

This bill which is designated as the “New Jersey Health Insurance Marketplace Act,” creates a Statewide health insurance marketplace pursuant to the federal “Patient Protection and Affordable Care Act,” Pub.L.111-148, as amended by the “Health Care and Education Reconciliation Act of 2010,” Pub.L.111-152 (“the federal act”). The exchange operating in the State currently is operated by the Federal Government. This bill would create a framework for the State to operate its own exchange.

The bill establishes the New Jersey Health Insurance Marketplace (“the marketplace”) in the Executive Branch of State Government in order to effectuate the provisions of the federal act, and allocates the marketplace within the Department of Banking

1 and Insurance (DOBI), but it is to be independent of any
2 supervision or control by DOBI or any board or officer thereof.

3 The marketplace is to be governed by a board of directors (“the
4 board”) consisting of ten members as follows:

5 -- the Commissioners of Banking and Insurance and Human
6 Services, or their designees, as nonvoting, ex officio members;

7 -- the chairperson of the advisory committee, to be established by
8 the board pursuant to the bill’s provisions, as a nonvoting, ex
9 officio member; and

10 -- seven public members who are residents of this State, to be
11 appointed by the Governor with the advice and consent of the
12 Senate, including: one person who is a member in good standing of
13 the American Academy of Actuaries; and four other persons, two of
14 whom are to be appointed upon the recommendation of the
15 President of the Senate and two upon the recommendation of the
16 Speaker of the General Assembly.

17 The public members of the board are to be appointed in such a
18 manner as to ensure that the public membership of the board
19 includes individuals who have demonstrated expertise in the
20 following areas: individual health care coverage; small employer
21 health care coverage; health benefits plan administration; health
22 care finance; and consumer health care advocacy.

23 The board is to appoint an executive director of the marketplace
24 to supervise the administrative affairs and general management, and
25 operations of the marketplace. The executive director will serve at
26 the pleasure of the board and receive such compensation as the
27 board determines, which shall not exceed the compensation of a
28 cabinet-level official of the State. All employees of the
29 marketplace, except the executive director, are to be in the career
30 service of the Civil Service.

31 To avoid conflicts of interest, certain restrictions are placed on
32 individuals while serving as members of the board or employees of
33 the marketplace and, except for secretarial or clerical employees,
34 for a period of two years immediately following such service or
35 employment.

36 In addition, the board is to establish an advisory committee to
37 provide advice to the board concerning the operation of the
38 marketplace and any other matter relating to the responsibilities of
39 the board pursuant to this bill. The advisory committee is to
40 include 15 members, to be appointed by the board, who will include
41 one representative from each of the following: health insurers or
42 health maintenance organizations offering health benefits plans in
43 this State; health service corporations offering contracts in this
44 State; licensed insurance producers; licensed general hospitals;
45 licensed long-term care facilities; mental health care and addiction
46 services providers; federally qualified health centers; licensed
47 physicians; licensed nurses; small employers; public employee

1 unions; private sector unions; consumer health care advocacy
2 organizations; consumer legal advocacy organizations; and public
3 health researchers or other academic experts with knowledge and
4 background relevant to the functions and goals of the marketplace,
5 including knowledge of the health care needs and health disparities
6 among the diverse communities of this State.

7 8 **The Activities of the Marketplace** 9

10 The board is to facilitate the purchase, through the marketplace,
11 of coverage under health benefits plans certified and offered by the
12 marketplace (“qualified plans”), at affordable prices, by persons
13 enrolled in the marketplace (“enrollees”).

14 The board will also establish the State Business Health Options
15 Program (SHOP), separate from the activities of the board related to
16 the individual market, to assist participating employers in
17 facilitating the enrollment of their employees in qualified plans.

18 Additionally, the board may create and offer a Basic Health Plan,
19 in conjunction with the Department of Human Services and
20 consistent with the provisions of the federal act, to enable persons
21 with incomes of between 133% and 200% of the federal poverty
22 level, and noncitizens who would be eligible for Medicaid except
23 for not meeting the minimum residency requirements provided in
24 federal law, who would otherwise be eligible to receive premium
25 subsidies for the purchase of coverage through the marketplace, to
26 purchase essential health benefits through the provision of federal
27 funds pursuant to the federal act.

28 The board is also required to implement a plan of operation for
29 the marketplace and provide a customer service center and website
30 for the marketplace.

31 32 **Qualified Plans and Participating Carriers in the Marketplace** 33

34 The marketplace shall offer to enrollees only health benefits
35 plans that have been certified by the board, approved for issuance or
36 renewal in this State by the Commissioner of Banking and
37 Insurance, and underwritten by a carrier. The board is to certify
38 those plans that it determines offer the optimal combination of
39 choice, value, quality, and service to enrollees, and to provide, in
40 each region of the State, a choice of qualified plans in each of the
41 benefit categories required under the federal act.

42 A health insurance carrier participating in the marketplace may
43 offer to enrollees a plan that provides limited scope dental benefits
44 that meets the requirements of section 9832 of the federal Internal
45 Revenue Code of 1986 (26 U.S.C. s.9832), if the plan provides
46 pediatric dental benefits that meet the requirements of section 1302
47 of the federal act (42 U.S.C. s.18022), and such other dental
48 benefits as the board of directors of the marketplace or the

1 Secretary of Health and Human Services may prescribe by
2 regulation.

3 Two or more carriers may jointly offer a comprehensive plan
4 through the marketplace in which the dental benefits are provided
5 by a carrier through a qualified dental plan and the other benefits
6 are provided by a carrier through a qualified health plan, provided
7 that the plans are priced separately and are also made available for
8 purchase separately at the same price.

9 To be certified as a qualified health benefits plan, a plan, at a
10 minimum, must meet certain network requirements.

11 The board shall require that a carrier, as a condition of
12 participation in the marketplace, meet certain requirements to
13 prevent adverse selection in the marketplace and other health
14 insurance markets in the State. The carriers are also required to
15 meet certain other requirements concerning transparency and make
16 certain products available to the public and relevant government
17 agencies.

18

19 **The Provision of Health Care Coverage through the**
20 **Marketplace**

21

22 The board shall: perform administrative functions regarding the
23 processing of applications, determination of eligibility for premium
24 tax credits and any cost-sharing reduction and eligibility
25 redetermination due to changes in income or circumstances,
26 establishment of an enrollee database, and coordinate and share data
27 with Medicaid, NJ FamilyCare, and other State and local
28 government entities as applicable, to ensure efficient, cost-effective,
29 and comprehensive health care coverage and continuity of coverage
30 and care when an enrollee transitions between a qualified plan and
31 Medicaid or NJ FamilyCare, or the reverse, consistent with federal
32 law and regulations.

33

34 **New Jersey Health Insurance Marketplace Trust Fund**

35

36 The bill also establishes the “New Jersey Health Insurance
37 Marketplace Trust Fund” in the Department of the Treasury as a
38 nonlapsing revolving fund, to be the repository for monies collected
39 from carriers pursuant to the bill and other monies received as
40 grants or otherwise appropriated for the purposes of the
41 marketplace. The monies in the fund are to be used only for the
42 purpose of supporting the activities of the marketplace.

43 The marketplace may apply a uniform surcharge to all qualified
44 health benefit plans, and a uniform assessment on carriers that do
45 not contract with the marketplace, as the board determines
46 necessary to effectuate the purposes of this bill. The proceeds are
47 to be deposited into the fund and used only to pay for administrative

1 and operational expenses of the marketplace in carrying out its
2 responsibilities and as otherwise required under federal law or
3 regulation.

4
5 **Other Provisions**

6
7 In addition to furnishing information to any federal department
8 or agency as required under the federal act or any other federal law
9 or regulation, the board shall annually report on the activities,
10 receipts, and expenditures of the marketplace to the Governor,
11 Legislature, and State Auditor, and to make this information
12 available on its Internet website; and the State Auditor is to conduct
13 an audit of the marketplace at least once in each five-year period.

14 In addition, the Commissioner of Banking and Insurance shall
15 report to the Governor and the Legislature, no later than January 1,
16 2022, on the commissioner's findings and recommendations
17 concerning whether to: continue the New Jersey Individual Health
18 Coverage Program and the New Jersey Small Employer Health
19 Benefits Program, as provided under current law; revise these
20 programs to reflect the provisions of this bill; or phase out these
21 programs and transition their health care coverage to coverage
22 provided through the marketplace.

23 Finally, no later than one year from the board's organization, the
24 board shall present a report to the Governor and Legislature which
25 contains the board's findings and recommendations, including the
26 status of any decision or efforts, concerning whether or not to create
27 and offer a Basic Health Plan pursuant to the bill.