HOUSE BILL 205

48TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2008

INTRODUCED BY

Daniel R. Foley

AN ACT

RELATING TO HEALTH INSURANCE; ENACTING THE HEALTH INSURANCE EXCHANGE ACT; PROVIDING FOR POWERS AND DUTIES; PROVIDING FOR PARTICIPATING EMPLOYER PLANS AND PARTICIPATING INSURANCE PLANS; PROVIDING FOR ELIGIBILITY AND BENEFITS; PROVIDING FOR STATE RESIDENT PARTICIPATION; REQUIRING NEW MEXICO RESIDENTS TO SHOW PROOF OF HEALTH COVERAGE; REPEALING THE HEALTH INSURANCE ALLIANCE ACT.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 15 of this act may be cited as the "Health Insurance Exchange Act".

Section 2. [NEW MATERIAL] DEFINITIONS.--As used in the Health Insurance Exchange Act:

A. "applicant" means an individual seeking to

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participate in the exchange;

B. "board" means the board of directors of the exchange;

C. "carrier" means a person or organization subject to the authority of the superintendent or the provisions of the New Mexico Insurance Code that provides one or more health benefit or insurance plans in the state;

D. "creditable coverage" means continual coverage of the applicant under any of the following health plans, not including excepted benefits, with no lapse in coverage of more than sixty-three days immediately prior to the date of application for coverage through the exchange:

(1) a group health plan;

(2) health insurance coverage;

(3) Part A or Part B of Title 18 of the Social Security Act;

(4) Title 19 or Title 21 of the Social Security Act;

(5) tricare, pursuant to Chapter 55 of Title 10, United States Code;

(6) the Medical Insurance Pool Act;

(7) the federal employees health benefits program pursuant to Chapter 89 of Title 5, United States Code;

(8) health coverage pursuant to Section 5(e) of the federal Peace Corps Act;

(9) a public health plan as defined by federal or state law or rule; or

(10) other qualifying coverage required by the federal Health Insurance Portability and Accountability Act of 1996;

E. "dependent" means the spouse of the principal insured or an individual that is related to the principal insured by birth, marriage or adoption and that meets the definition of a dependent pursuant to the federal Internal Revenue Code of 1986;

F. "eligible individual" means an individual that may participate in the exchange by reason of meeting one or more of the following qualifications:

(1) the individual is a resident of New Mexico where the individual is and continues to be legally domiciled and physically residing on a full-time basis in a place of habitation in the state that remains the individual's principal residence and from which the individual is absent only for a temporary or transitory purpose;

(2) the individual is a dependent and a full-time student attending an institution outside of New Mexico but prior to attending the educational institution met the requirements of Paragraph (1) of this subsection;

(3) the individual is not a resident of New Mexico but is employed, at least twenty hours per week on a

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regular basis, at a location within the boundaries of the state by a bona fide employer, and the individual's employer does not offer health coverage or the individual is not eligible to participate in any health coverage plan offered by the individual's employer;

(4) the individual, whether a resident of New Mexico or not, is enrolled in, or eligible to enroll in, a participating employer plan;

(5) the individual is self-employed in New Mexico and if the individual is a nonresident self-employed individual, the individual's principal place of business is in New Mexico;

(6) the individual is a full-time student attending an institution of higher education located in New Mexico; or

(7) the individual, whether a resident of New Mexico or not, is a dependent of another individual who is an eligible individual;

G. "employer" means a person that employs at least one and no more than fifty individuals and files payroll tax information on its employees;

H. "excepted benefits" means:

(1) benefits not subject to requirements, including:

(a) coverage only for accident or

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disability income insurance;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) medical expense and loss of income benefits;

(f) credit-only insurance;

(g) coverage for on-site medical clinics; or

(h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits;

(2) benefits not subject to requirements if offered separately, including:

(a) limited scope dental or vision benefits;

(b) benefits for long-term care, nursing home care, home health care or community-based care; or

(c) other similar, limited benefits;

(3) benefits not subject to requirements if offered as independent, noncoordinated benefits, including:

(a) coverage only for a specified

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disease or illness; and

(b) hospital indemnity or other fixed indemnity insurance; and

(4) benefits not subject to requirements if offered as a separate insurance policy, including:

(a) medicare supplemental health insurance;

(b) coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or

(c) similar supplemental coverage provided for coverage under a group plan;

I. "exchange" means the health insurance exchange for participating employer plans and participating insurance plans created pursuant to the Health Insurance Exchange Act;

J. "participating employer plan" means a group health plan, as defined in the federal Employee Retirement Income Security Act of 1974, that is sponsored by an employer and for which the plan sponsor has entered into an agreement with the exchange for the exchange to offer and administer health coverage benefits for enrollees in the plan;

K. "participating individual" means an individual who has been determined by the exchange to be, and continues to remain, an eligible individual for purposes of obtaining coverage under participating insurance plans offered through

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the exchange;

L. "participating insurance plan" means a health benefit plan offered through the exchange;

M. "plan year" means the period of time during which the insured is covered under a health benefit plan pursuant to the contract governing the plan;

N. "preexisting condition provision" means a provision in a health benefit plan that limits, denies or excludes benefits for a period of time for an enrollee for expenses or services related to a medical condition that was present before the date the coverage commenced, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that date; provided that the time period for a preexisting condition provision begins when application for insurance is made; and provided further that genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information;

O. "producer" means a person required to be licensed in the state to sell, solicit or negotiate insurance;

P. "qualifying event" means an event where an individual or dependent loses coverage or becomes eligible for coverage due to circumstances that include marriage, divorce, death of a spouse, adoption, change in employment or other similar event;

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Q. "rate" means the premium or fee charged by a health benefit plan for coverage under a plan; and

R. "superintendent" means the superintendent of insurance of the insurance division of the public regulation commission.

Section 3. [NEW MATERIAL] ESTABLISHMENT--PURPOSE AND CORPORATE FORM.--

A. The "health insurance exchange" is created as a nonprofit public corporation, separate and apart from the state, to provide increased access for health insurance in the state.

B. The exchange is created to provide the residents of the state and other individuals that may be eligible to participate with greater access to and choice and portability of health insurance products.

Section 4. [NEW MATERIAL] BOARD OF DIRECTORS.--

A. The exchange shall be governed by a board of directors. The board is a governmental entity for purposes of the Tort Claims Act, but neither the board nor the exchange shall be considered a governmental entity for any other purpose.

B. Each member shall be entitled to one vote in person or by proxy at each meeting.

C. The exchange shall operate subject to the supervision and approval of the board. The board shall consist

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of thirteen members that represent the geographic and ethnic diversity of the state as follows:

(1) two directors, elected by the carriers that participate in the exchange, who shall be officers or employees of those carriers;

(2) four directors, appointed by the governor, who shall be officers, general partners or proprietors of employers that participate in the exchange, as follows:

(a) one director that represents nonprofit corporations;

(b) one director that represents employers with fifty or fewer employees; and

(c) two directors that are nominated by the New Mexico legislative council;

(3) two directors, appointed by the governor, who shall be employees of employers that participate in the exchange;

(4) one director that is a physician licensed by the state and is elected by the New Mexico medical society;

(5) one director that represents and is elected by the New Mexico hospital association;

(6) one director that is elected by the New Mexico association of health underwriters;

(7) one director that represents the Indian nations, tribes and pueblos of the state; and

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(8) the superintendent or the superintendent's designee, who shall be a nonvoting member.

D. A majority of the thirteen board members shall constitute a quorum. The board may allow members' participation in meetings by telephone or other electronic medium that allows full participation. The board shall elect a chair and vice chair of the board once each even-numbered year.

E. The directors shall be elected for initial terms of three years or less, staggered so that the term of at least one director expires on June 30 of each year. The directors appointed by the governor shall be appointed for initial terms of three years or less, staggered so that the term of at least one director expires on June 30 of each year. Following the initial terms, directors shall be elected or appointed for terms of three years. A director whose term has expired shall continue to serve until a successor is elected or appointed.

F. Whenever a vacancy on the board occurs, the electing or appointing authority of the position that is vacant shall fill the vacancy by electing or appointing an individual to serve the balance of the unexpired term; provided that when a vacancy occurs in one of the director's positions elected by the members, the superintendent is authorized to appoint a temporary replacement director until the next scheduled election of directors elected by the members is held. The individual elected or appointed to fill a vacancy shall meet

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the requirements for initial election or appointment to that position.

G. Directors may be reimbursed by the board as provided in the Per Diem and Mileage Act for nonsalaried public officers, but shall receive no other compensation, perquisite or allowance from the board.

H. The board shall appoint an executive director of the exchange, who shall:

(1) be a full-time employee of the exchange;

(2) administer all of the exchange's activities and contracts;

(3) supervise staff of the exchange; and

(4) serve at the pleasure of the board.

I. The board shall set the salary of the executive director and staff of the exchange.

Section 5. [NEW MATERIAL] HEALTH INSURANCE EXCHANGE--DUTIES.--The exchange shall:

A. publicize the existence of the exchange and disseminate information on its eligibility requirements and enrollment procedures;

B. establish and administer procedures for enrolling eligible individuals in the exchange, including:

(1) creating a standard application form to collect information necessary to determine the eligibility and previous coverage history of an applicant; and

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(2) preparing and distributing certificate of eligibility forms and application forms to insurance producers and the general public;

C. establish and administer procedures for the election of coverage by participating individuals during and outside of open enrollment periods upon the occurrence of any qualifying event, including preparing and distributing to participating individuals:

(1) descriptions of the coverage, benefits, limitations, premiums and cost-sharing for all participating insurance plans; and

(2) forms and instructions for electing coverage and arranging payment for coverage;

D. collect and transmit to the applicable participating plans all premium payments or contributions made by or on behalf of participating individuals, including developing mechanisms to:

(1) receive and process automatic payroll deductions for participating individuals enrolled in participating employer plans;

(2) enable participating individuals to pay, in whole or in part, for coverage through the exchange by electing to assign to the exchange any state income tax credits or deductions or federal earned income tax credit payments due to the participating individual; and

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(3) receive and process any financial reimbursement received from or through federal or state funding or premium assistance support payments for health insurance, as may be provided by law;

E. upon request, issue certificates of previous coverage in accordance with the provisions of the federal Health Insurance Portability and Accountability Act of 1996 to all individuals who cease to be covered by a participating insurance plan;

F. establish procedures to account for all funds received and disbursed by the exchange, including:

(1) maintaining a separate, segregated management account for the receipt and disbursement of money allocated to fund for the administration of the exchange; and

(2) maintaining a separate, segregated operations account for:

(a) the receipt of all premium payments or contributions made by or on behalf of participating individuals; and

(b) the distribution of premium payments to participating insurance plans and of commissions or payments to producers and other organizations that are allowed pursuant to Section 13 of the Health Insurance Exchange Act to receive payments for their services in enrolling eligible individuals or groups in the exchange;

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G. submit to the superintendent, following the end of each plan year, the report of an independent audit of the exchange's accounts for the plan year;

H. operate in accordance with all requirements and restrictions set forth in the Health Insurance Exchange Act, the New Mexico Insurance Code and other applicable state and federal laws; and

I. provide a report by July 1, 2010 to the governor, the legislature and the superintendent on the feasibility of expanding the exchange to employers with more than fifty employees.

Section 6. [NEW MATERIAL] HEALTH INSURANCE EXCHANGE--POWERS.--The exchange may:

A. contract with vendors to perform one or more of the functions specified in Section 5 of the Health Insurance Exchange Act;

B. contract with private or public social service agencies to administer application, eligibility verification, enrollment and premium payments for specified groups or populations of eligible individuals or participating individuals;

C. contract with an employer to act as the plan administrator for participating employer plans to undertake the obligations required by the federal Employee Retirement Income Security Act of 1974 of a plan administrator;

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D. assess each participating insurance plan for the administration and operating expenses of the exchange in the previous calendar year an amount that achieves equity of adjustments among participating insurance plans; provided, however, that a plan may take a fifty percent credit on the plan's premium tax;

E. seek and directly receive grant funding from federal or state agencies or political subdivisions or private philanthropic organizations to defray the costs of operating the exchange;

F. establish and administer operating procedures governing the operations of the exchange, including an annual equitable and proportional assessment of all its participating insurance plans for the net administrative expenses that occurred in the previous calendar year, taking into account investment income for the period and other appropriate gains and losses;

G. establish one or more service centers within the state to facilitate enrollment;

H. sue and be sued or otherwise take any necessary or proper legal action;

I. establish bank accounts; and

J. enroll all eligible individuals through the exchange, subject to the provisions of the Health Insurance Exchange Act.

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Section 7. [NEW MATERIAL] ENROLLMENT AND COVERAGE ELECTION.--

A. Any individual may apply to participate in the exchange. Any public or private employer may apply on behalf of those individuals that may be eligible. Upon determination by the exchange that an individual is eligible to participate in the exchange, the individual may enroll or, if applicable, be enrolled by the individual's parent or legal guardian, in a participating insurance plan offered through the exchange during the next open enrollment period or when otherwise provided by the Health Insurance Exchange Act.

B. The exchange shall verify the eligibility of all applicants for private coverage. The state shall verify the eligibility of all applicants for state-sponsored or state-subsidized coverage, unless the state enters into an agreement with the exchange whereby the state reimburses the exchange for public program eligibility verification. The exchange may require that applicants submit appropriate documentation as considered necessary to verify the applicant's eligibility.

C. From November 1 to November 30 of each year, the exchange shall administer an open enrollment during which any eligible individual may enroll for coverage effective January 1 of the following calendar year in any participating insurance plan offered through the exchange without a waiting period and shall not be declined coverage.

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D. The first ninety days after the exchange begins to accept applications shall be considered the initial open season.

E. An eligible individual may enroll in a participating insurance plan offered through the exchange without a waiting period and shall not be declined coverage, at a time other than the annual open enrollment; provided that the individual does so within sixty-three days of one of the following qualifying events:

(1) the individual loses coverage in an existing health insurance plan due to the death of a spouse, parent or legal guardian;

(2) the individual or a covered dependent loses coverage in an existing health insurance plan due to a change in the individual's employment status;

(3) the individual or a covered dependent loses coverage in an existing health insurance plan because of a divorce, separation or other change in familial status;

(4) the individual loses coverage in an existing health insurance plan because the individual reaches an age at which coverage lapses under that plan;

(5) the individual or a covered dependent becomes newly eligible by becoming a resident of the state or because the individual's place of employment has been changed to the state;

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(6) the individual becomes newly eligible by becoming the spouse or dependent of an eligible individual by reason of birth, adoption, court order or a change in custody arrangement;

(7) the individual becomes subject to a court order requiring the individual to provide health insurance coverage to certain dependents, or enters into a new arrangement for the custody of dependents that requires the providing of health insurance for those dependents; or

(8) the individual loses coverage in a plan offered through the exchange by reason of the employer plan terminating participation in the exchange prior to the end of the plan year.

Section 8. [NEW MATERIAL] PARTICIPATION OF PLANS IN THE EXCHANGE.--

A. No health benefit plan may be offered through the exchange unless the superintendent has first certified to the exchange that:

(1) the carrier seeking to offer the plan is licensed to issue health insurance or provide health coverage in the state and is in good standing with the insurance division of the public regulation commission; and

(2) the plan meets the requirements of this section and the employer plan and the carrier are in compliance with all other applicable state health insurance laws.

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B. No plan shall be certified that excludes from coverage any individual otherwise determined by the exchange to be eligible.

C. The certification of plans to be offered through the exchange shall not be subject to any state law requiring competitive bidding; provided, however, that this does not apply to participating insurance plans offered pursuant to the Health Care Purchasing Act.

D. Each certification shall be valid for at least one year and may be made automatically renewable from year to year in the absence of notice of either:

(1) withdrawal by the superintendent; or

(2) discontinuation of participation in the exchange by the plan or carrier.

E. Certification of a plan may be withheld only after notice to the carrier and an opportunity for a hearing. The superintendent may decline to renew the certification of any carrier at the end of a certification term.

F. Each plan certified by the superintendent as eligible to be offered through the exchange shall contain a detailed description of benefits offered and patient cost-sharing amounts, including maximums, limitations, exclusions, benefit limits and other plan characteristics deemed necessary by the board for participants to make informed coverage selections.

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G. Each plan certified by the superintendent as eligible to be offered through the exchange shall provide, subject to the plan's patient cost-sharing amounts, major medical coverage that includes the following:

(1) hospital benefits;

(2) surgical benefits;

(3) in-hospital medical benefits;

(4) ambulatory patient benefits;

(5) prescription drug benefits; and

(6) mental health benefits.

H. Carriers shall offer participating insurance plans through the exchange at rates developed pursuant to Section 59A-18-13.1 NMSA 1978.

I. The rates determined for the first plan year for which the participating insurance plan is offered through the exchange may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits; provided, however, that any adjustments in rates shall be made in advance of the plan year for which they will apply and on a basis that, in the judgment of the superintendent, is consistent with the general practice of carriers that issue health benefit plans to large employers and in compliance with the New Mexico Insurance Code.

J. The exchange shall not decline, refuse to offer or otherwise restrict the offering to any participating

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individual of any participating insurance plan that has obtained in a timely fashion in advance of the annual open enrollment certification by the superintendent in accordance with the provisions of this section.

K. The exchange shall not impose on any participating insurance plan or on any carrier or plan seeking to participate in the exchange any terms or conditions, including any requirements or agreements with respect to rates or benefits, beyond or in addition to those terms and conditions established and imposed by the superintendent in certifying plans under the provisions of this section; provided, however, that nothing in this subsection shall be construed to prohibit the exchange from encouraging carriers to adopt standardized policy terms, benchmark benefit packages and similar cost-sharing requirements to facilitate comparison by participants.

L. The superintendent shall establish and administer regulations and procedures for certifying plans to participate in the exchange.

Section 9. [NEW MATERIAL] UNDERWRITING RULES.--The following rules shall govern the imposition by carriers of a preexisting condition provision and rate surcharges with respect to any participating individual covered by any participating insurance plan:

A. except as otherwise specified in Subsection C of

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this section, during any open enrollment a participating individual who elects to choose a different participating insurance plan or plan option for the next plan year shall not be subject to a preexisting condition provision and shall be charged the standard rate of the new participating insurance plan or plan option developed pursuant to Section 59A-18-13.1 NMSA 1978. The provisions of this subsection shall also apply to any election by a participating individual of coverage for any dependent who is also a participating individual;

B. a new participating individual with eighteen months or more of creditable coverage who enrolls in a participating insurance plan shall not be subject to a preexisting condition provision and shall be charged the standard rate for the participating insurance plan developed pursuant to Section 59A-18-13.1 NMSA 1978;

C. a new participating individual with creditable coverage of less than eighteen months may enroll in a participating insurance plan, but the participating individual may be subject to a preexisting condition provision for a period not to exceed twelve months or charged a premium not to exceed an amount pursuant to Section 59A-18-13.1 NMSA 1978; provided that any rate surcharge shall not be applied on or after the third year of the individual's enrollment in any participating insurance plan;

D. in cases where an individual is enrolled in a

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participating insurance plan as a newly eligible dependent of a participating individual by reason of birth, adoption, court order or a change in custody arrangement, either during open season or outside of open season, a carrier shall not impose a preexisting condition provision or any change in the rate charged to the participating individual, except for a difference in the participating insurance plan's standard rates that reflect the addition of a new dependent to the participating individual's coverage;

E. periods of creditable coverage with respect to an individual shall be established through presentation of certifications or in such other manner as may be specified in state or federal law;

F. for new participating individuals without creditable coverage, or with only limited creditable coverage as defined in Subsection C of this section, a carrier may elect to waive the imposition of a preexisting condition provision and instead extend the applicable rate surcharge for an additional year beyond the time provided for in those subsections;

G. for purposes of this section, any individual who is a participating individual by reason of enrollment in a participating employer plan shall be deemed to have eighteen months of creditable coverage;

H. for purposes of this section, any federal health

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coverage tax credit eligible individual shall be deemed to have eighteen months of creditable coverage; and

I. a participating individual may continue or renew an individual policy in existence on July 1, 2008 that has a permanent exclusion of payment for preexisting conditions.

Section 10. [NEW MATERIAL] CONTINUATION OF COVERAGE.--

A. Any participating individual may continue to participate in any participating insurance plan as long as the individual remains an eligible individual, subject to the carrier's rules regarding cancellation for nonpayment of premiums or fraud, and shall not be canceled or nonrenewed because of any change in employer or employment status, marital status, health status, age, membership in any organization or other change that does not affect eligibility as defined in the Health Insurance Exchange Act.

B. A participating individual who is not a resident of the state and who ceases to be an eligible individual due to a qualifying event shall be deemed to remain an eligible individual and shall be deemed to remain a participating individual for a period not to exceed thirty-six months from the date of the qualifying event, if:

(1) the qualifying event consists of a loss of eligible individual status due to:

(a) voluntary or involuntary termination of employment for reasons other than gross misconduct; or

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(b) loss of qualified dependent status for any reason; and

(2) the participating individual elects to remain a participating individual and notifies the exchange of such election within sixty-three days of the qualifying event.

Section 11. [NEW MATERIAL] DISPUTE RESOLUTION.--

A. The superintendent shall establish procedures for resolving disputes arising from the operation of the exchange in accordance with the provisions of the Health Insurance Exchange Act, including disputes with respect to:

(1) the eligibility of an individual to participate in the exchange;

(2) the imposition of a coverage surcharge on a participating individual by a participating insurance plan; and

(3) the imposition of a preexisting condition provision on a participating individual by a participating insurance plan.

B. In cases where a carrier imposes a preexisting condition provision or a premium surcharge in connection with enrollment of a participating individual in a participating insurance plan offered by the carrier, and the participating individual disputes the imposition of such a provision or surcharge, the participating individual may request that the superintendent issue a determination as to the validity or

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extent of such provision or surcharge pursuant to the Health Insurance Exchange Act. The superintendent shall issue a determination within thirty days of the request being filed with the insurance division of the public regulation commission. If either the participating individual or the carrier disagrees with the outcome, a request for a hearing may be made pursuant to Chapter 59A, Article 4 NMSA 1978.

Section 12. [NEW MATERIAL] PARTICIPATING EMPLOYER PLANS.--

A. Any employer may apply to the exchange to be the sponsor of a participating employer plan.

B. Any employer seeking to be the sponsor of a participating employer plan shall, as a condition of participation in the exchange, enter into a binding agreement with the exchange, which shall include the following conditions:

(1) the sponsoring employer designates the exchange to be the plan's administrator for the employer's group health plan, and the exchange agrees to undertake the obligations required of a plan administrator under federal law;

(2) only the coverage and benefits offered by participating insurance plans shall constitute the coverage and benefits of the participating employer plan;

(3) any individuals eligible to participate in the exchange by reason of their eligibility for coverage under

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the employer's participating employer plan, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan, may elect coverage under any participating insurance plan and neither the employer nor the exchange shall limit the individual's choice of coverage from among all the participating insurance plans;

(4) the employer reserves the right to offer benefits supplemental to the benefits offered through the exchange, but any supplemental benefits offered by the employer shall constitute a separate plan or plans under federal law, for which the exchange may be the plan administrator;

(5) the employer agrees that, for the term of the agreement, the employer shall not offer to individuals eligible to participate in the exchange by reason of their eligibility for coverage under the employer's participating employer plan any separate or competing group health plan offering the same or substantially similar benefits as those provided by participating insurance plans through the exchange, regardless of whether any such individuals would otherwise qualify as eligible individuals if not enrolled in the participating employer plan;

(6) the employer reserves the right to determine the criteria for eligibility, enrollment and participation in the participating employer plan and the terms

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and amounts of the employer's contributions to that plan; provided that for the term of the agreement with the exchange, the employer agrees not to alter or amend any criteria or contribution amounts at any time other than during an annual period designated by the exchange for participating employer plans to make such changes in conjunction with the exchange's annual open season;

(7) the employer agrees to make available to the exchange any of the employer's documents, records or information, including copies of the employer's federal and state tax and wage reports that the superintendent reasonably determines are necessary for the exchange to verify:

(a) that the employer is in compliance with the terms of its agreement with the exchange governing the employer's sponsorship of a participating employer plan;

(b) that the participating employer plan is in compliance with applicable laws relating to employee welfare benefit plans; and

(c) the eligibility under the terms of the employer's plan of those individuals enrolled in the participating employer plan; and

(8) the employer agrees also to sponsor a "cafeteria plan" as permitted pursuant to 26 USCA Section 125 for all employees eligible for coverage under the employer's participating employer plan.

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C. The exchange shall not enter into an agreement with an employer with respect to a participating employer plan if the agreement does not, at a minimum, incorporate the conditions specified in Subsection B of this section.

D. The exchange shall not enter into an agreement with an employer with respect to a participating employer plan for the exchange to provide the participating employer plan with any additional or different services or benefits not otherwise provided or offered to all other participating employer plans.

Section 13. [NEW MATERIAL] PRODUCERS.--

A. In cases when a producer licensed in the state enrolls in the exchange an eligible individual or group, the plan chosen by each individual or group shall pay the producer a commission as previously agreed upon and approved by the superintendent.

B. In cases when a member organization enrolls in the exchange its eligible members or the eligible members of its member entities, the plan chosen by each member organization shall pay the organization a fee equal to a commission as previously agreed upon and approved by the superintendent. Nothing in this section shall be deemed either to require a membership organization that enrolls persons in the exchange to be licensed by the state as a producer or to permit such an organization to provide any other services

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requiring licensure as a producer without first obtaining the license.

C. In cases when an individual or family is referred to or enrolled in a publicly financed or publicly subsidized plan through the exchange, an administrative enrollment and service fee may be charged in an amount not to exceed five dollars ($5.00) per month per family or individual, whichever is less. Producers that participate in training about state-sponsored or state-funded creditable coverage that are certified by the exchange as having participated in such training shall not be liable for any action associated with offering those products so long as they are acting in good faith and in accordance with the training they received.

Section 14. [NEW MATERIAL] INSURANCE MARKET CONSOLIDATION.--

A. A carrier shall not issue or renew an individual health benefit plan, other than through the exchange, after the first day of the plan year following the first regular open season conducted by the exchange.

B. A carrier shall not issue or renew a group health benefit plan to an employer with fewer than fifty employees, other than through the exchange, after the first day of the plan year following the first regular open season conducted by the exchange.

C. Subsections A and B of this section shall not

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apply to any health benefit plan that consists solely of one or more excepted benefits.

Section 15. [NEW MATERIAL] PERSONAL RESPONSIBILITY.--

A. Effective July 1, 2010, a resident of New Mexico who is over the age of eighteen and under the age of sixty-five shall obtain coverage or offer proof of the resident's ability to pay for medical care for the resident and the resident's dependents.

B. An individual subject to the requirement in Subsection A of this section shall be deemed to be in compliance if the individual:

(1) indicates coverage under any health benefit plan; or

(2) demonstrates proof of financial security in accordance with Subsection C of this section.

C. An individual electing to demonstrate proof of financial security to pay for medical expenditures shall provide to the department of finance and administration proof of a bond in an amount equal to ten times the average annual premium rate for individual coverage for that individual's rating factors or shall deposit with the department an amount equal to that average annual premium rate in an escrow account that shall bear interest at a rate determined by the department.

D. If an individual subject to the requirement in

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Subsection A of this section fails to comply with the requirement, the secretary of finance and administration shall:

(1) establish an escrow account in the name of the individual;

(2) retain and deposit in the account all funds that may be owed to the individual by the state, including any overpayment by the individual of taxes imposed by the state; or

(3) obtain an order for the attachment of wages of the individual to satisfy the requirements of this section.

E. With respect to any escrow account established pursuant to this section, either by reason of an individual making the election specified in Subsection C of this section or by reason of an individual being subject to Subsection D of this section, the amount deposited, retained or collected shall not exceed the amount determined pursuant to Subsection C of this section for any individual. Nothing in this section shall be construed to authorize the secretary of finance and administration to retain any amount for purposes that otherwise would be paid to a state agency.

F. Money held in escrow pursuant to this section shall be disbursed by the secretary of finance and administration only to pay for medical claims for health care services provided to the individual during the period when the

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individual was not in compliance with Subsection A of this section. The secretary of finance and administration shall close the account and remit the remaining funds to the individual within six months of receiving notification that the individual has:

(1) elected to comply with the requirement in Subsection A of this section by submitting proof of insurance coverage pursuant to Subsection B of this section; or

(2) is no longer subject to Subsection A of this section by reason of no longer being a resident of the state.

G. If the secretary of finance and administration determines that an individual for whom an account has been established has not been a resident of the state for a consecutive period of thirty-six months or more, the secretary shall close the account and remit the remaining funds to the individual. If the secretary cannot locate the individual within twelve months, the secretary shall dispose of the funds pursuant to the Uniform Unclaimed Property Act (1995).

H. Any judgment payable by an individual to a hospital, physician or other health care provider for charges incurred during a period when the individual failed to comply with Subsection A of this section shall include an order permitting the attachment of the wages of the individual to satisfy the judgment.

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I. An individual may file with the department of finance and administration:

(1) an affidavit or written affirmation from an officer of a recognized religious denomination that the individual or family are bona fide members of a denomination whose religious teaching requires reliance upon prayer or spiritual means alone for health care or other healing; or

(2) an affidavit or written affirmation from the individual that the individual's religious beliefs, held either individually or jointly with others, do not permit the use of health insurance for health care or other healing.

J. Upon filing and approval of the affidavit or affirmation, the individual or family is exempt from the legal requirement of financial responsibility for health care for a period not to exceed twelve months on the basis of any one affidavit or affirmation; provided, however, that the individual or family is still subject to the provisions of Subsection H of this section.

K. The secretary of finance and administration shall compile and provide to the secretary of human services a list of individuals without known coverage and who may be eligible for programs administered by the human services department.

Section 16. Section 13-7-4 NMSA 1978 (being Laws 1997, Chapter 74, Section 4) is amended to read:

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"13-7-4. MANDATORY CONSOLIDATED PURCHASING.--

A. The publicly funded health care agencies shall enter into a cooperative consolidated purchasing effort to provide plans of health care benefits for the benefit of eligible participants of the respective agencies. The request for [~~proposal~~] proposals shall set forth one or more plans of health care benefits and shall include accommodation of fully funded arrangements as well as varying degrees of self-funded pool options.

B. A consolidated purchasing request for proposals for all health care benefits by the publicly funded health care agencies shall be issued on or before July 1, 1999, and any contracts for health care benefits renewed or issued on or after July 1, 2000 shall be the result of consolidated purchasing.

C. All requests for proposals issued as part of the consolidated purchasing shall include at least one distinct service area consisting of the Albuquerque metropolitan area. Proposals on a distinct service area shall be evaluated separately.

D. The publicly funded health care agencies shall purchase health care coverage for their eligible participants through participating insurance plans in the health insurance exchange created pursuant to the Health Insurance Exchange Act."

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Section 17. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] HEALTH COVERAGE--PUBLIC PROGRAMS--PURCHASE THROUGH THE HEALTH INSURANCE EXCHANGE.--The department shall contract with participating insurance plans through the health insurance exchange created pursuant to the Health Insurance Exchange Act to purchase health coverage for individuals eligible for programs that are funded in whole or in part by the state, including programs created by Title 19 or Title 21 of the Social Security Act."

Section 18. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] COLLECTION AND USE OF ENROLLMENT DATA.--

A. The superintendent shall collect and compile enrollment information on a quarterly basis as follows:

(1) a list from the health insurance exchange of individuals currently enrolled in a participating insurance plan through the exchange;

(2) a list from the human services department of individuals currently enrolled in health coverage programs administered by the department; and

(3) a list from health insurers of individuals currently enrolled in each benefit plan they provide through insurance or administrative services.

B. The superintendent shall communicate enrollment

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information to the secretary of finance and administration to ensure compliance with Section 15 of the Health Insurance Exchange Act.

C. The superintendent may communicate enrollment information to an agency or a state contractor solely for the purpose of establishing a statewide electronic eligibility verification system accessible by healthcare providers; provided, however, that patient information is protected pursuant to the federal Health Insurance Portability and Accountability Act of 1996."

Section 19. Section 59A-23C-5 NMSA 1978 (being Laws 1991, Chapter 153, Section 5, as amended) is amended to read:

"59A-23C-5. RESTRICTIONS RELATING TO PREMIUM RATES.--

A. Premium rates for health benefit plans subject to the Small Group Rate and Renewability Act shall be subject to the following provisions:

(1) the index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than [~~twenty percent~~] the following percentages for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

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(c) sixteen percent for calendar year 2010;

(d) fourteen percent for calendar year 2011;

(e) thirteen percent for calendar year 2012;

(f) twelve percent for calendar year 2013;

(g) eleven percent for calendar year 2014; and

(h) ten percent for every year thereafter;

(2) for a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to those employers under the rating system for that class of business, shall not vary from the index rate by more than [~~twenty percent of the index rate~~] the following percentages of the index rate for policies issued or delivered in the respective year:

(a) twenty percent through December 31, 2008;

(b) eighteen percent for calendar year 2009;

(c) sixteen percent for calendar year

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2010;

(d) fourteen percent for calendar year 2011;

(e) thirteen percent for calendar year 2012;

(f) twelve percent for calendar year 2013;

(g) eleven percent for calendar year 2014; and

(h) ten percent for every year thereafter;

(3) the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate;

(b) an adjustment, not to exceed ten percent annually and adjusted pro rata for rating periods of less than one year due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the carrier's rate manual for

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the class of business; and

(c) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business; and

(4) in the case of health benefit plans issued prior to the effective date of the Small Group Rate and Renewability Act, a premium rate for a rating period may exceed the ranges described in Paragraph (1) or (2) of this subsection for a period of five years following the effective date of the Small Group Rate and Renewability Act. In that case, the percentage increase in the premium rate charged to a small employer in that class of business for a new rating period may not exceed the sum of the following:

(a) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business for which the small employer carrier is not issuing new policies, the carrier shall use the percentage change in the base premium rate; and

(b) any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

B. Nothing in this section is intended to affect

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the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

C. A small employer carrier shall not involuntarily transfer a small employer into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration since issue.

D. Prior to usage and June 14, 1991, each carrier shall file with the superintendent the rate manuals and any updates thereto for each class of business. A rate filing fee is payable under Subsection U of Section 59A-6-1 NMSA 1978 for the filing of each update. The superintendent shall disapprove within sixty days of receipt of a complete filing or the filing is deemed approved. If the superintendent disapproves the form during the sixty-day review period, [~~he~~] the superintendent shall give the carrier written notice of the disapproval stating the reasons for disapproval. At any time, the superintendent, after a hearing, may disapprove a form or withdraw a previous approval. The superintendent's order after

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the hearing shall state the grounds for disapproval or withdrawal of a previous approval and the date not less than twenty days later when disapproval or withdrawal becomes effective."

Section 20. TEMPORARY PROVISION--HEALTH INSURANCE ALLIANCE.--The board of directors of the health insurance exchange created pursuant to the Health Insurance Exchange Act shall meet with the board of directors of the New Mexico health insurance alliance by October 1, 2008 and at least quarterly through June 30, 2009 to:

A. provide portability of coverage for individuals covered through the New Mexico health insurance alliance to the extent possible through the health insurance exchange;

B. provide for the transition of other functions of the New Mexico health insurance alliance to the health insurance exchange as permitted by law or rule; and

C. prepare a report to the first session of the forty-ninth legislature on the transition of functions to the health insurance exchange and on any recommendations to the legislature for continued and expanded health coverage of the state's residents.

Section 21. REPEAL.--Sections 59A-56-1 through 59A-56-25 NMSA 1978 (being Laws 1994, Chapter 75, Sections 1 through 25, as amended) are repealed effective July 1, 2009.

Section 22. EFFECTIVE DATE.--The effective date of the

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provisions of this act is July 1, 2008.