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HOUSE BILL 33

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

Danice Picraux and Dede Feldman

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH INSURANCE; ENACTING THE NEW MEXICO HEALTH INSURANCE EXCHANGE ACT; PROVIDING FOR A BOARD OF DIRECTORS OF THE EXCHANGE; PROVIDING FOR POWERS AND DUTIES OF THE EXCHANGE; PROVIDING FOR QUALIFIED HEALTH PLAN CERTIFICATION; REQUIRING CARRIERS THAT OFFER HEALTH BENEFIT PLANS IN THE INDIVIDUAL OR SMALL GROUP MARKET TO OFFER QUALIFIED HEALTH PLANS THROUGH THE EXCHANGE; PROVIDING FOR ENROLLMENT AND COVERAGE ELECTION; PROVIDING FOR DISPUTE RESOLUTION; AMENDING AND ENACTING SECTIONS OF THE NMSA 1978; RECONCILING MULTIPLE AMENDMENTS TO THE SAME SECTION OF LAW IN LAWS 2009; DECLARING AN EMERGENCY.

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

SECTION 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 14 of this act may be cited as the "New Mexico Health Insurance Exchange Act".

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1 SECTION 2. ~~[NEW MATERIAL]~~ DEFINITIONS.--As used in the
2 New Mexico Health Insurance Exchange Act:

3 A. "actuarial value" means the percentage of
4 expected medical expenses paid by a health benefit plan for a
5 standard population, usually stated as a percentage from zero
6 percent for a health benefit plan that pays nothing to one
7 hundred percent for a health benefit plan that pays all medical
8 expenses;

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

11 C. "bronze level of coverage" means a level of
12 coverage that is designed to provide benefits that are
13 actuarially equivalent to sixty percent of the full actuarial
14 value of the benefits provided under a health benefit plan;

15 D. "carrier" means a person that is subject to
16 licensure by the superintendent or subject to the provisions of
17 the New Mexico Insurance Code and that provides one or more
18 health benefit or insurance plans in the state;

19 E. "catastrophic coverage" means a level of
20 coverage offered to individuals that provides essential health
21 benefits only after the covered individual has incurred cost-
22 sharing expenses in an amount equal to the dollar amount of the
23 annual limitation in effect under Section 223(c)(2)(A)(ii) of
24 the federal Internal Revenue Code of 1986;

25 F. "child" means an individual who is related to a

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1 principal insured by birth or adoption;

2 G. "dependent" means the spouse of a principal
3 insured or a child who is under the age of twenty-six;

4 H. "essential benefits" means the following
5 categories of items and services, as those items and services
6 are defined by federal regulation pursuant to Section 1302(b)
7 of the federal Patient Protection and Affordable Care Act:

- 8 (1) ambulatory patient services;
- 9 (2) emergency services;
- 10 (3) hospitalization;
- 11 (4) maternity and newborn care;
- 12 (5) mental health and substance abuse disorder
13 services, including behavioral health treatment;
- 14 (6) prescription drugs;
- 15 (7) rehabilitative and habilitative services
16 and devices;
- 17 (8) laboratory services;
- 18 (9) preventive and wellness services and
19 chronic disease management; and
- 20 (10) pediatric services, including oral and
21 vision care;

22 I. "exchange" means the New Mexico health insurance
23 exchange created pursuant to the New Mexico Health Insurance
24 Exchange Act offering qualified health plans to qualified
25 individuals in the individual market and the small group

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1 market;

2 J. "free choice voucher" means the amount equal in
3 value to what an employer would have contributed for a
4 qualified health plan if an employee would have been covered
5 under the qualified health plan; provided that:

6 (1) the required employee contribution exceeds
7 eight percent of the employee's household income for the
8 taxable year;

9 (2) the required employee contribution does
10 not exceed nine and eight-tenths percent of the employee's
11 household income for the taxable year;

12 (3) the employee's household income is not
13 greater than four hundred percent of the federal poverty level;
14 and

15 (4) the employee does not participate in the
16 qualified health plan chosen by the employee's employer;

17 K. "gold level of coverage" means a level of
18 coverage that is designed to provide benefits that are
19 actuarially equivalent to eighty percent of the full actuarial
20 value of the benefits provided under a health benefit plan;

21 L. "health benefit plan" means a policy, contract,
22 certificate or agreement offered by a carrier to provide,
23 deliver, arrange for, pay for or reimburse any of the costs of
24 health care services. "Health benefit plan" does not mean:

25 (1) coverage only for accident or disability

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1 income insurance, or a combination of both;

2 (2) coverage issued as a supplement to
3 liability insurance;

4 (3) liability insurance, including general
5 liability insurance and automobile liability insurance;

6 (4) workers' compensation or similar
7 insurance;

8 (5) automobile medical payment insurance;

9 (6) credit-only insurance;

10 (7) coverage for on-site medical clinics;

11 (8) other similar insurance coverage under
12 which benefits for medical care are secondary or incidental to
13 other insurance benefits; or

14 (9) self-insured plans;

15 M. "individual market" means the market for health
16 insurance coverage offered to individuals other than in
17 connection with a group health plan;

18 N. "level of coverage" means the superintendent's
19 rating of a qualified health plan on the basis of the actuarial
20 value of essential benefits provided under the plan, pursuant
21 to regulations issued by the federal secretary of health and
22 human services;

23 O. "navigator" means an entity that, in a manner
24 culturally and linguistically appropriate to the state's
25 diverse populations, conducts public education, distributes tax

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1 credit and qualified health plan enrollment information,
2 facilitates enrollment in qualified health plans or provides
3 referrals to consumer assistance or ombudsman services.

4 "Navigator" does not mean a carrier or a person that receives
5 any consideration, directly or indirectly, from any carrier in
6 connection with the enrollment of a qualified individual in a
7 qualified health plan;

8 P. "plan year" means the period of time during
9 which a qualified individual is covered under a health benefit
10 plan pursuant to the contract governing the plan;

11 Q. "platinum level of coverage" means a level of
12 coverage that is designed to provide benefits that are
13 actuarially equivalent to ninety percent of the full actuarial
14 value of the benefits provided under a health benefit plan;

15 R. "premium" means the consideration for insurance,
16 by whatever name the consideration is called. Any
17 "assessment", "membership", "policy", "survey", "inspection",
18 "service" or similar fee or other charge in consideration for
19 an insurance contract is part of the premium;

20 S. "producer" means a person that is licensed in
21 the state to sell, solicit or negotiate insurance;

22 T. "qualified employer" means a small employer that
23 elects to make its full-time employees, and, at the option of
24 the employer, some or all of its part-time employees, eligible
25 for one or more qualified health plans offered in the small

1 group market through the exchange; provided that the employer:

2 (1) has its principal place of business in the
3 state and elects to provide coverage through the exchange to
4 all of its eligible employees, wherever employed; or

5 (2) elects to provide coverage through the
6 exchange to all of its eligible employees who are principally
7 employed in the state;

8 U. "qualified health plan" means health insurance
9 coverage or a group health plan that the superintendent has
10 certified as meeting the requirements in state and federal law
11 for coverage to be offered through the exchange;

12 V. "qualified individual" means an individual:

13 (1) who seeks to enroll or who participates in
14 a qualified health plan offered through the exchange and who
15 meets one of the following residency requirements:

16 (a) the individual is a resident of the
17 state and is, and continues to be, legally domiciled and
18 physically residing on a full-time basis in a place of
19 habitation in the state that remains the person's principal
20 residence and from which the person is absent only for a
21 temporary or transitory purpose;

22 (b) the individual is a full-time
23 student attending an educational institution outside of the
24 state but, prior to attending the educational institution, met
25 the requirements of Subparagraph (a) of this paragraph;

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1 (c) the individual is a full-time
2 student attending an institution of higher education located in
3 the state;

4 (d) the individual, whether a resident
5 or not, is a dependent; or

6 (e) the individual, whether a resident
7 or not, is an employee of a qualified employer; and

8 (2) who is not:

9 (a) incarcerated at the time of
10 enrollment, other than incarceration pending the disposition of
11 charges; or

12 (b) reasonably expected to be a citizen
13 or national of the United States or an alien lawfully present
14 in the United States;

15 W. "silver level of coverage" means a level of
16 coverage that is designed to provide benefits that are
17 actuarially equivalent to seventy percent of the full actuarial
18 value of the benefits provided under a health benefit plan;

19 X. "small employer" means a person that is actively
20 engaged in business that employed an average of at least one
21 but not more than fifty full-time-equivalent employees on
22 business days during the preceding calendar year and that
23 employs at least one employee in the first day of the plan
24 year; provided that:

25 (1) the small employer elects to make all

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1 full-time employees eligible for one or more qualified health
2 plans offered in the small group market through the exchange;

3 (2) persons that are affiliated persons or
4 that are eligible to file a combined tax return for purposes of
5 state income taxation shall be considered one small employer;

6 (3) in the case of an employer that was not in
7 existence throughout a preceding calendar year, the
8 determination of whether the employer is a small employer shall
9 be based on the average number of employees that the employer
10 is reasonably expected to employ on working days in the current
11 calendar year; and

12 (4) the person is not a self-insured entity;

13 Y. "small group market" means the small business
14 health options program under which employees obtain health
15 insurance coverage, directly or through any arrangement, on
16 behalf of the employees and their dependents through a
17 qualified health plan maintained by a qualified employer;

18 Z. "stand-alone dental benefits" means limited
19 scope dental benefits meeting the requirements of Section
20 9832(c)(2)(A) of the federal Internal Revenue Code of 1986 and
21 federal regulations regarding pediatric oral health benefits;
22 and

23 AA. "superintendent" means the superintendent of
24 insurance of the insurance division of the public regulation
25 commission or its successor agency.

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1 SECTION 3. ~~[NEW MATERIAL]~~ NEW MEXICO HEALTH INSURANCE
2 EXCHANGE CREATED--CORPORATE FORM.--The "New Mexico health
3 insurance exchange" is created as a nonprofit public
4 corporation, separate and apart from the state, to provide
5 increased access to health insurance in the state. The
6 exchange shall operate subject to the supervision and approval
7 of the board.

8 SECTION 4. ~~[NEW MATERIAL]~~ BOARD OF DIRECTORS.--

9 A. The "board of directors of the New Mexico health
10 insurance exchange" is created. The board consists of nine
11 voting members. The superintendent is an ex-officio voting
12 member. The secretary of human services or the secretary of
13 the human services department's successor agency is an ex-
14 officio voting member.

15 B. Selection of the seven appointed voting members
16 shall be as follows:

17 (1) the governor shall appoint three members:

18 (a) one of whom shall be an officer,
19 general partner or proprietor of a for-profit small employer;

20 (b) one of whom shall be an officer,
21 general partner or proprietor of a nonprofit corporation that
22 is a small employer; and

23 (c) one of whom shall have at least
24 three years' experience as a health care administrator; and

25 (2) the New Mexico legislative council shall

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1 appoint four members:

2 (a) one of whom shall have at least
3 three years' experience as an actuary certified by the society
4 of actuaries;

5 (b) one of whom shall have experience as
6 a consumer in the high-risk insurance market;

7 (c) one of whom shall be an individual
8 who purchases insurance in the individual insurance market; and

9 (d) one of whom shall be an employee of
10 a small employer.

11 C. Appointed members shall not have any income
12 derived from current or active employment in, a contract with
13 or consultation for the health care services finance or
14 coverage sector while serving on the board.

15 D. The board is subject to and shall comply with
16 the provisions of the Governmental Conduct Act, the Financial
17 Disclosure Act, the Open Meetings Act and the Administrative
18 Procedures Act as well as other statutes and rules applicable
19 to state agencies.

20 E. Initially, appointed members shall have terms
21 chosen by lot as follows: two members shall serve two-year
22 terms; two members shall serve three-year terms; and three
23 members shall serve four-year terms. Thereafter, members shall
24 serve four-year terms. An appointed member shall not serve
25 more than two consecutive terms. An appointed member shall

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1 serve until the member's successor is appointed and qualified
2 or for six months, whichever period of time is shorter.

3 F. A majority of voting members constitutes a
4 quorum. The board may allow members' participation in meetings
5 by telephone or other electronic media that allow full
6 participation. Any decision by the board shall require a
7 majority of members voting in favor of the decision.

8 G. Every third year, the board shall elect in open
9 session a chair and vice chair from among its members. The
10 chair or vice chair shall serve no more than two three-year
11 terms as chair and vice chair.

12 H. A vacancy on the board shall be filled by
13 appointment by the original appointing authority for the
14 remainder of the member's unexpired term.

15 I. A member may be removed from the board by a
16 majority vote of the members. The board shall set standards
17 for attendance and may remove a member for lack of attendance,
18 neglect of duty or malfeasance in office. A member shall not
19 be removed without proceedings consisting of at least one ten-
20 day notice of hearing and an opportunity to be heard. Removal
21 proceedings shall be before the board and in accordance with
22 procedures adopted by the board, including appeals procedures
23 to the attorney general.

24 J. Appointed members may receive per diem and
25 mileage in accordance with the Per Diem and Mileage Act,

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1 subject to appropriation by the legislature and travel policy
2 as set by the board's bylaws. Appointed members shall receive
3 no other compensation, perquisite or allowance.

4 K. The board shall meet at the call of the chair
5 and not less than once monthly from July 1, 2011 until January
6 1, 2014. Thereafter, the board shall meet no less often than
7 once per calendar quarter. There shall be at least one week's
8 notice given to members prior to any meeting. There shall be
9 sufficient notice provided to the public prior to meetings
10 pursuant to the Open Meetings Act.

11 L. The board shall report to the legislative health
12 and human services committee at least once a year or as
13 requested. The board shall report to the legislative finance
14 committee at least once per year, no later than September 1 of
15 each year.

16 M. The board may:
17 (1) create ad hoc advisory councils; and
18 (2) request assistance from other boards,
19 commissions, departments, agencies and organizations as
20 necessary to provide appropriate expertise to accomplish the
21 exchange's duties.

22 N. The board shall create:
23 (1) a standing advisory committee made up of
24 representatives of carriers;
25 (2) a standing advisory committee made up of

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1 health care providers licensed pursuant to Chapter 61 NMSA
2 1978;

3 (3) a standing advisory committee made up of
4 health care consumers with experience purchasing in the
5 individual market or a high-risk market or employees of small
6 employers; and

7 (4) a standing advisory committee made up of
8 two health care consumers who are private small employers and
9 two health care consumers who are nonprofit public
10 corporations.

11 O. The board may sue and be sued or otherwise take
12 any necessary or proper legal action.

13 SECTION 5. [NEW MATERIAL] PLAN OF OPERATION.--

14 A. The board shall submit a written plan of
15 operation to the superintendent with any provisions necessary
16 to ensure the fair, reasonable and equitable administration of
17 the exchange.

18 B. The plan of operation shall:

19 (1) establish written procedures to implement
20 the provisions of the New Mexico Health Insurance Exchange Act
21 to create an exchange through which:

22 (a) qualified individuals employed by
23 qualified employers may enroll in any qualified health plan
24 offered through the exchange at the level of coverage specified
25 by the employer;

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1 (b) qualified employers can receive
2 assistance in the enrollment of their employees in qualified
3 health plans offered through the small group market;

4 (c) qualified individuals may enroll in
5 any qualified health plan offered through the individual
6 market;

7 (d) procedures are established for the
8 collection of assessments from carriers, qualified employers,
9 qualified individuals and producers as needed to support the
10 operation of the exchange;

11 (e) the amount of assessment is
12 established pursuant to Subsection A of Section 14 of the New
13 Mexico Health Insurance Exchange Act; and

14 (f) penalties are established for
15 nonpayment of assessments;

16 (2) establish written procedures and criteria
17 for determining which qualified health plans may be offered
18 through the exchange, which shall include:

19 (a) assessing the affordability of
20 qualified health plans; and

21 (b) assigning ratings on the basis of
22 relative quality, price and actuarial value of qualified health
23 plans;

24 (3) establish written procedures for handling
25 and accounting for the exchange's assets and money;

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1 (4) establish regular times and meeting places
2 for meetings of the board; and

3 (5) contain additional provisions necessary
4 and proper for the execution of the powers and duties of the
5 board.

6 SECTION 6. [NEW MATERIAL] BOARD DUTIES--REPORTING.--The
7 board shall:

8 A. provide quarterly reports on the implementation
9 of the exchange between July 1, 2011 and January 1, 2014 and
10 report annually and upon request thereafter to the legislative
11 health and human services committee and the legislative finance
12 committee;

13 B. keep an accurate accounting of all of the
14 activities, receipts and expenditures of the exchange and
15 submit this information annually to the federal secretary of
16 health and human services and the superintendent;

17 C. develop and implement strategies to avoid
18 adverse selection, and report findings and recommendations to
19 the legislative health and human services committee, the
20 legislative finance committee and the superintendent;

21 D. by or before January 1, 2014, provide
22 legislative recommendations to the legislative health and human
23 services committee and the legislative finance committee on
24 whether to change the number of full-time-equivalent employees
25 of a small employer from fifty to one hundred before January 1,

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1 2016. The board shall recommend a transition plan for the
2 exchange and carriers to follow when changing the number of
3 full-time-equivalent employees to one hundred whether the
4 change occurs prior to or on January 1, 2016;

5 E. by July 1, 2016, provide legislative
6 recommendations to the legislative health and human services
7 committee and the legislative finance committee on whether to:

8 (1) continue limiting qualified employer
9 status to small employers;

10 (2) combine the individual market and the
11 small group market into a single risk pool; and

12 (3) enter into an exchange with other states
13 or share resources or responsibilities to enhance the
14 affordability and effectiveness of the exchange;

15 F. develop and implement a program to publicize the
16 existence of the exchange and the requirements to become
17 eligible for and enroll in the exchange and to maintain public
18 awareness of the exchange; and

19 G. cooperate with the medical assistance division
20 of the human services department, or its successor in interest,
21 to share information and facilitate transitions between the
22 exchange, medicaid, the children's health insurance program or
23 any other state public health coverage program.

24 SECTION 7. [NEW MATERIAL] EXECUTIVE DIRECTOR--
25 APPOINTMENT--STAFF--DUTIES--POWERS.--

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1 A. The board shall appoint an executive director of
2 the exchange, subject to removal for cause. The executive
3 director shall have at least five years' experience in health
4 care policy, management, service delivery or coverage. The
5 board shall develop a process for evaluating the executive
6 director's performance. The executive director shall carry out
7 the day-to-day operations of the exchange.

8 B. The executive director of the exchange shall:

9 (1) employ and fix the compensation of those
10 persons necessary to discharge the duties of the exchange,
11 including regular, full-time employees;

12 (2) propose an annual budget for the exchange;

13 (3) report to the board no less than once
14 monthly from July 1, 2011 until January 1, 2013 and no less
15 than once quarterly after January 1, 2013; and

16 (4) supervise the staff of the exchange.

17 SECTION 8. [NEW MATERIAL] NEW MEXICO HEALTH INSURANCE
18 EXCHANGE--DUTIES.--The exchange shall:

19 A. negotiate with carriers to procure affordable,
20 qualified health plans in accordance with the New Mexico Health
21 Insurance Exchange Act. The exchange shall offer these
22 qualified health plans to qualified individuals and qualified
23 employers for purchase through the exchange;

24 B. assign a rating to each qualified health plan
25 offered through the exchange on the basis of relative quality,

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1 price and actuarial value in accordance with criteria
2 established by the federal secretary of health and human
3 services in consultation with the superintendent. On the basis
4 of that rating and if offering the qualified health plan
5 through the exchange is in the interest of the qualified
6 individuals and qualified employers in this state, the exchange
7 shall determine which qualified health plans that have been
8 certified by the superintendent will be offered through the
9 exchange;

10 C. assist qualified employers in the enrollment of
11 their employees in qualified health plans offered in the small
12 group market and assist qualified individuals to enroll in
13 qualified health plans offered in the individual market;

14 D. in accordance with the provisions of the New
15 Mexico Health Insurance Exchange Act, create an implementation
16 plan to demonstrate readiness to operate the exchange to the
17 federal department of health and human services by January 1,
18 2013;

19 E. make qualified health plans available to
20 qualified individuals and qualified employers beginning on or
21 before January 1, 2014;

22 F. make pediatric dental benefits available:

23 (1) in conjunction with the essential benefits
24 offered in a qualified health plan; or

25 (2) as a stand-alone dental benefits plan;

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1 G. provide for the operation of a toll-free
2 telephone hotline to respond to requests for assistance;

3 H. provide for enrollment periods in accordance
4 with the provisions in Subsection B of Section 12 of the New
5 Mexico Health Insurance Exchange Act;

6 I. provide for an internet web site containing
7 standardized comparative information on qualified health plans;

8 J. develop and implement a standardized format for
9 presenting information on how to:

10 (1) participate in the exchange;

11 (2) enroll in a qualified health plan;

12 (3) receive a health coverage subsidy; and

13 (4) receive an exemption from the individual
14 responsibility to maintain minimum essential coverage mandated
15 pursuant to Section 1501 of the federal Patient Protection and
16 Affordable Care Act;

17 K. inform individuals of eligibility requirements
18 for health coverage through medicaid, the children's health
19 insurance program or any state or local public health coverage
20 program. If the exchange determines through screening of an
21 individual's application that the individual is eligible for
22 any of those programs, the exchange shall enroll that
23 individual in that program;

24 L. establish and make available by electronic means
25 a calculator to determine the actual cost of health coverage

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1 for a qualified individual after applying any premium tax
2 credit and cost-sharing reductions for which the qualified
3 individual is eligible;

4 M. grant certification to individuals for
5 hardship or other exemptions from the individual responsibility
6 to retain minimum essential coverage mandated pursuant to
7 Section 1501 of the federal Patient Protection and Affordable
8 Care Act;

9 N. transfer to the federal secretary of the
10 treasury the following:

11 (1) a list of those individuals who are issued
12 a certification pursuant to Subsection M of this section,
13 including the name and taxpayer identification number of each
14 individual;

15 (2) the name and taxpayer identification
16 number of each individual who was an employee of an employer
17 but who was determined to be eligible for the premium tax
18 credit under Section 36B of the federal Internal Revenue Code
19 of 1986 because:

20 (a) the employer did not provide minimum
21 essential health benefits coverage; or

22 (b) the employer provided minimum
23 essential health benefits coverage, but the exchange determined
24 that the coverage was either unaffordable to the employee or
25 that the coverage did not provide the required minimum

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1 actuarial value; and

2 (3) the name and taxpayer identification
3 number of each individual who notifies the exchange that the
4 individual has changed employers and of each individual who
5 ceases coverage under a qualified health plan during a plan
6 year and the effective date of that coverage cessation;

7 O. provide to each employer the name of each
8 employee of the employer who ceases coverage under a qualified
9 health plan during a plan year and the effective date of that
10 coverage cessation;

11 P. perform duties required of, or delegated to, the
12 exchange by the federal secretary of health and human services
13 or the federal secretary of the treasury related to determining
14 eligibility for premium tax credits, reduced cost-sharing or
15 exemptions to the individual responsibility requirement;

16 Q. establish a navigator program by awarding grants
17 to entities that demonstrate that they meet the requirements to
18 be a navigator pursuant to state and federal law. The
19 navigator program shall:

20 (1) conduct public education activities to
21 raise awareness of the availability of qualified health plans;

22 (2) distribute fair and impartial information
23 concerning enrollment in qualified health plans, the
24 availability of premium tax credits under Section 36B of the
25 federal Internal Revenue Code of 1986 and cost-sharing

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1 reductions under Section 1402 of the federal Patient Protection
2 and Affordability Act;

3 (3) facilitate enrollment in qualified health
4 plans;

5 (4) provide referrals to any applicable office
6 offering health insurance consumer assistance, or any other
7 appropriate state agency, for any qualified individual with a
8 grievance, complaint or question regarding the individual's
9 qualified health plan or coverage or a determination under that
10 plan or coverage; and

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

14 R. in consultation with the superintendent, review
15 the growth rate in the cost of premiums within and outside of
16 the exchange;

17 S. develop and implement a free choice voucher
18 program, credit the amount of any free choice voucher to the
19 monthly premium of the qualified health plan in which a
20 qualified individual is enrolled and collect the amount
21 credited from the employer offering the free choice voucher;

22 T. consult with various stakeholders about carrying
23 out the exchange's responsibilities;

24 U. publicize the existence of the exchange, the
25 exchange's web site and the exchange's toll-free telephone

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1 hotline;

2 V. collect and transmit to administrators of the
3 applicable qualified health plans all premium payments or
4 contributions made by or on behalf of qualified individuals and
5 develop mechanisms to:

6 (1) receive and process automatic payroll
7 deductions for qualified individuals enrolled in qualified
8 health plans;

9 (2) enable qualified individuals to pay, in
10 whole or in part, for coverage through the exchange by electing
11 to assign to the exchange any federal earned income tax credit
12 payments due to the qualified individual; and

13 (3) receive and process any federal or state
14 tax credits, health coverage subsidy or other premium support
15 payments for health insurance as may be established by law; and

16 W. establish procedures to account for all funds
17 received and disbursed by the exchange in accordance with
18 generally accepted accounting principles.

19 SECTION 9. [NEW MATERIAL] NEW MEXICO HEALTH INSURANCE
20 EXCHANGE--POWERS.--The exchange may:

21 A. establish one or more service centers within the
22 state to determine eligibility and enroll qualified individuals
23 and qualified employers in qualified health plans;

24 B. contract with an eligible entity for any of the
25 functions described in Section 8 of the New Mexico Health

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1 Insurance Exchange Act. For the purposes of this subsection,
2 an eligible entity includes medicaid, the children's health
3 insurance program or any applicable state or local public
4 health coverage program, but a carrier is not an eligible
5 entity;

6 C. enter into information-sharing agreements with
7 federal and state agencies and other state exchanges to carry
8 out its responsibilities; provided that these agreements
9 include adequate protections of the confidentiality of the
10 information to be shared and comply with all state and federal
11 laws and regulations; and

12 D. contract with vendors and producers to perform
13 one or more of the functions specified in Section 8 of the New
14 Mexico Health Insurance Exchange Act.

15 SECTION 10. [NEW MATERIAL] SUPERINTENDENT OF INSURANCE
16 DUTIES AND POWERS--RULEMAKING--CERTIFICATION OF PLANS.--

17 A. The superintendent shall promulgate rules to
18 avoid adverse selection against the exchange.

19 B. The superintendent shall promulgate rules to
20 certify, recertify and decertify plans as qualified health
21 plans in accordance with guidelines established by the federal
22 secretary of health and human services and in state law.

23 C. The superintendent shall certify a health
24 benefit plan as a qualified health plan if:

25 (1) the plan provides essential benefits;

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1 (2) the plan provides at least a bronze level
2 of coverage, unless the plan:

3 (a) is certified as a catastrophic plan;

4 (b) meets the requirements pursuant to
5 Section 223(c)(2)(A)(ii) of the federal Internal Revenue Code
6 of 1986 for catastrophic plans; and

7 (c) will only be offered to individuals
8 eligible for catastrophic coverage;

9 (3) the carrier offering the plan:

10 (a) is licensed and in good standing to
11 offer health insurance coverage in the state;

12 (b) offers at least one qualified health
13 plan in the silver level of coverage and at least one plan in
14 the gold level of coverage in the exchange;

15 (c) charges the same premium for each
16 qualified health plan within each level of coverage without
17 regard to whether the plan is offered through the exchange,
18 directly from the carrier or through a producer; and

19 (d) complies with the regulations
20 developed by the federal secretary of health and human services
21 and such other requirements as the exchange or the
22 superintendent may establish; and

23 (4) the plan meets the requirements of
24 certification as promulgated by regulation by the federal
25 secretary of health and human services and by the rules

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1 promulgated by the superintendent.

2 D. The superintendent shall not refuse to certify a
3 health benefit plan:

4 (1) on the basis that the plan is a fee-for-
5 service plan;

6 (2) through imposition of premium price
7 controls; or

8 (3) on the basis that the plan provides
9 treatments necessary to prevent patients' deaths in
10 circumstances that the superintendent determines are
11 inappropriate or too costly.

12 E. The superintendent shall have an actuarial
13 analysis performed on each health benefit plan that a carrier
14 seeks to offer on the exchange to determine whether that health
15 benefit plan meets the level of coverage that the carrier has
16 designated for that plan.

17 F. The superintendent shall require a carrier
18 seeking certification of a plan as a qualified health plan to:

19 (1) submit a justification for any premium
20 increase before implementation of that increase. The carrier
21 shall prominently post the information on its internet web
22 site;

23 (2) make available to the public, in plain
24 language, and submit to the superintendent, the exchange and
25 the federal secretary of health and human services accurate and

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1 timely disclosure of the following:

2 (a) claims payment policies and
3 practices;
4 (b) periodic financial disclosures;
5 (c) data on enrollment;
6 (d) data on disenrollment;
7 (e) data on the number of claims that
8 are denied;

9 (f) data on rating practices;
10 (g) information on cost-sharing and
11 payments with respect to any out-of-network coverage;

12 (h) information on enrollee and
13 participant rights pursuant to state and federal law; and
14 (i) other information as determined
15 appropriate by the federal secretary of health and human
16 services; and

17 (3) disclose to the public the amount of cost-
18 sharing, including deductibles, copayments and coinsurance,
19 that the qualified individual would be responsible for under
20 the qualified individual's plan or coverage. At a minimum,
21 this information shall be made available to the individual
22 through an internet web site and through other means for
23 individuals without access to the internet.

24 G. The premium rates determined for the first plan
25 year for which the qualified health plan is offered through the

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1 exchange may be adjusted by the carrier for subsequent plan
2 years based on experience and any later modifications to plan
3 benefits; provided, however, that any adjustments in premiums
4 shall be made at least sixty days in advance of the plan year
5 for which the carrier applies for certification of a plan as a
6 qualified health plan.

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

10 (1) withdrawal by the superintendent; or

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

13 I. Certification of a qualified health plan may be
14 withdrawn only after sixty days' notice to the carrier and an
15 opportunity for hearing before the public regulation commission
16 pursuant to Section 8-8-14 NMSA 1978 and commission rules. The
17 superintendent may decline to renew the certification of any
18 carrier at the end of a certification term.

19 SECTION 11. [NEW MATERIAL] CARRIERS--REQUIREMENT TO OFFER
20 QUALIFIED HEALTH PLANS IN THE EXCHANGE AT THE SILVER AND GOLD
21 LEVELS OF COVERAGE.--A carrier that offers a health benefit
22 plan in the individual or small group market in the state shall
23 offer qualified health plans through the exchange at the silver
24 and gold levels of coverage.

25 SECTION 12. [NEW MATERIAL] ENROLLMENT AND COVERAGE

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1 ELECTION.--

2 A. A qualified individual may apply to participate
3 in the exchange. A qualified employer may apply on behalf of
4 its employees or the employees' dependents. Upon determination
5 by the exchange that an individual is a qualified individual,
6 the qualified individual may enroll or, if applicable, be
7 enrolled by the qualified individual's parent or legal guardian
8 in a qualified health plan offered through the exchange during
9 the next open enrollment or as otherwise provided in Subsection
10 B of this section.

11 B. The exchange shall set the dates of the
12 following enrollment periods, which shall be in compliance with
13 regulations promulgated by the federal secretary of health and
14 human services:

- 15 (1) an initial open enrollment period;
- 16 (2) an annual open enrollment for calendar
17 years after the initial open enrollment period;
- 18 (3) special enrollment periods specified in
19 Section 9801 of the federal Internal Revenue Code of 1986 and
20 other special enrollment periods under circumstances similar to
21 the periods specified in that federal act, pursuant to Part D
22 of Title 18 of the federal Social Security Act; and
- 23 (4) special monthly enrollment periods for
24 Indians, as "Indians" is defined in Section 4 of the federal
25 Indian Health Care Improvement Act.

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1 SECTION 13. ~~[NEW MATERIAL]~~ DISPUTE RESOLUTION.--The
2 superintendent shall promulgate rules for resolving disputes
3 arising from the operation of the exchange in accordance with
4 the provisions of the New Mexico Health Insurance Exchange Act,
5 including disputes with respect to:

6 A. the eligibility of an individual to participate
7 in the exchange;

8 B. receiving an exemption from the individual
9 responsibility to retain minimum essential coverage mandated
10 pursuant to Section 1501 of the federal Patient Protection and
11 Affordable Care Act; and

12 C. the exchange's collection and transmission to
13 the applicable qualified health plans any applications for
14 enrollment and all premium payments or contributions made by or
15 on behalf of qualified individuals or qualified employers
16 participating in the exchange.

17 SECTION 14. ~~[NEW MATERIAL]~~ FUNDING--PUBLICATION OF
18 COSTS.--The exchange:

19 A. may charge assessments or user fees to carriers,
20 qualified employers, qualified individuals and producers or
21 otherwise generate funding necessary to support its operations
22 provided pursuant to the New Mexico Health Insurance Exchange
23 Act;

24 B. shall publish the average costs of licensing,
25 regulatory fees and any other payments required by the

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1 exchange, and administrative costs of the exchange, on an
2 internet web site to educate consumers on such costs. This
3 information shall include information on money lost to waste,
4 fraud and abuse; and

5 C. may seek and directly receive grant funding from
6 federal, state or local governments or private philanthropic
7 organizations to defray the costs of operating the exchange.

8 SECTION 15. Section 41-4-3 NMSA 1978 (being Laws 1976,
9 Chapter 58, Section 3, as amended by Laws 2009, Chapter 8,
10 Section 2 and by Laws 2009, Chapter 129, Section 2 and also by
11 Laws 2009, Chapter 249, Section 2) is amended to read:

12 "41-4-3. DEFINITIONS.--As used in the Tort Claims Act:

13 A. "board" means the risk management advisory
14 board;

15 B. "governmental entity" means the state or any
16 local public body as defined in Subsections C and H of this
17 section;

18 C. "local public body" means all political
19 subdivisions of the state and their agencies, instrumentalities
20 and institutions and all water and natural gas associations
21 organized pursuant to Chapter 3, Article 28 NMSA 1978;

22 D. "law enforcement officer" means a full-time
23 salaried public employee of a governmental entity, or a
24 certified part-time salaried police officer employed by a
25 governmental entity, whose principal duties under law are to

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1 hold in custody any person accused of a criminal offense, to
2 maintain public order or to make arrests for crimes, or members
3 of the national guard of New Mexico when called to active duty
4 by the governor;

5 E. "maintenance" does not include:

6 (1) conduct involved in the issuance of a
7 permit, driver's license or other official authorization to use
8 the roads or highways of the state in a particular manner; or

9 (2) an activity or event relating to a public
10 building or public housing project that was not foreseeable;

11 F. "public employee" means an officer, employee or
12 servant of a governmental entity, excluding independent
13 contractors except for individuals defined in Paragraphs (7),
14 (8), (10), (14) and (17) of this subsection, or of a
15 corporation organized pursuant to the Educational Assistance
16 Act, the Small Business Investment Act, ~~[or]~~ the Mortgage
17 Finance Authority Act or the New Mexico Health Insurance
18 Exchange Act or a licensed health care provider, who has no
19 medical liability insurance, providing voluntary services as
20 defined in Paragraph ~~[(16)]~~ (17) of this subsection and
21 including:

22 (1) elected or appointed officials;

23 (2) law enforcement officers;

24 (3) persons acting on behalf or in service of
25 a governmental entity in any official capacity, whether with or

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- 1 without compensation;
- 2 (4) licensed foster parents providing care for
- 3 children in the custody of the human services department,
- 4 corrections department or department of health, but not
- 5 including foster parents certified by a licensed child
- 6 placement agency;
- 7 (5) members of state or local selection panels
- 8 established pursuant to the Adult Community Corrections Act;
- 9 (6) members of state or local selection panels
- 10 established pursuant to the Juvenile Community Corrections Act;
- 11 (7) licensed medical, psychological or dental
- 12 arts practitioners providing services to the corrections
- 13 department pursuant to contract;
- 14 (8) members of the board of directors of the
- 15 New Mexico medical insurance pool;
- 16 (9) individuals who are members of medical
- 17 review boards, committees or panels established by the
- 18 educational retirement board or the retirement board of the
- 19 public employees retirement association;
- 20 (10) licensed medical, psychological or dental
- 21 arts practitioners providing services to the children, youth
- 22 and families department pursuant to contract;
- 23 (11) members of the board of directors of the
- 24 New Mexico educational assistance foundation;
- 25 (12) members of the board of directors of the

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1 New Mexico student loan guarantee corporation;

2 (13) members of the board of directors of the
3 New Mexico health insurance exchange;

4 [~~(13)~~] (14) members of the New Mexico mortgage
5 finance authority;

6 [~~(14)~~] (15) volunteers, employees and board
7 members of court-appointed special advocate programs;

8 [~~(15)~~] (16) members of the board of directors
9 of the New Mexico small business investment corporation;

10 [~~(16)~~] (17) health care providers licensed in
11 New Mexico who render voluntary health care services without
12 compensation in accordance with rules promulgated by the
13 secretary of health. The rules shall include requirements for
14 the types of locations at which the services are rendered, the
15 allowed scope of practice and measures to ensure quality of
16 care; and

17 [~~(17)~~] (18) an individual while participating
18 in the state's adaptive driving program and only while using a
19 special-use state vehicle for evaluation and training purposes
20 in that program;

21 G. "scope of duty" means performing any duties that
22 a public employee is requested, required or authorized to
23 perform by the governmental entity, regardless of the time and
24 place of performance; and

25 H. "state" or "state agency" means the state of New

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1 Mexico or any of its branches, agencies, departments, boards,
2 instrumentalities or institutions."

3 SECTION 16. [NEW MATERIAL] COOPERATION WITH THE NEW
4 MEXICO HEALTH INSURANCE EXCHANGE.--The medical assistance
5 division of the human services department, or its successor in
6 interest, shall cooperate with the New Mexico health insurance
7 exchange to share information and facilitate transitions
8 between the exchange, medicaid, the children's health insurance
9 program or any other state public health coverage program.

10 SECTION 17. TEMPORARY PROVISION--NEW MEXICO HEALTH
11 INSURANCE EXCHANGE--NEW MEXICO MEDICAL INSURANCE POOL--NEW
12 MEXICO HEALTH INSURANCE ALLIANCE.--The board of directors of
13 the New Mexico health insurance exchange shall meet with the
14 board of directors of the New Mexico health insurance alliance
15 and the New Mexico medical insurance pool by October 1, 2011
16 and at least quarterly through October 1, 2013 to:

17 A. provide portability of coverage for individuals
18 covered through the New Mexico medical insurance pool to the
19 extent possible through the New Mexico health insurance
20 exchange;

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

24 C. prepare a report to the first session of the
25 fifty-first legislature on the transition of functions of the

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1 New Mexico health insurance alliance and the New Mexico medical
2 insurance pool to the New Mexico health insurance exchange and
3 on any recommendations to the legislature for continued and
4 expanded health coverage of the state's residents.

5 SECTION 18. SEVERABILITY.--If any part or application of
6 the New Mexico Health Insurance Exchange Act is held invalid,
7 the remainder or its application to other situations or persons
8 shall not be affected.

9 SECTION 19. EMERGENCY.--It is necessary for the public
10 peace, health and safety that this act take effect immediately.