SENATE BILL 38

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

INTRODUCED BY

Dede Feldman

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 DISPUTE RESOLUTION; PROVIDING FOR TRANSPARENCY OF EXCHANGE FUNDING AND OPERATIONS; 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 13 of this act may be cited as the "New Mexico Health

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Insurance Exchange Act".

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

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

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

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

D. "child" means an individual who is related to a principal insured by birth or adoption;

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

F. "exchange" means the New Mexico health insurance exchange created pursuant to the New Mexico Health Insurance Exchange Act offering qualified health plans to qualified individuals in the individual market and the small group market;

G. "free choice voucher" means the amount equal in

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value to what an employer would have contributed for a qualified health plan if an employee would have been covered under the qualified health plan; provided that:

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

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

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

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

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

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

(1) coverage only for accident or disability income insurance, or a combination of both;

(2) coverage issued as a supplement to

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liability insurance;

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

(4) workers' compensation or similar insurance;

(5) automobile medical payment insurance;

(6) credit-only insurance;

(7) coverage for on-site medical clinics;

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

(9) self-insured plans;

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

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

L. "Native American or Alaska Native" means:

(1) an individual who is a member of any federally recognized Indian nation, tribe or pueblo; or

(2) an individual who has been deemed eligible for services and programs provided to Native Americans or

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Alaska Natives by the United States public health service, the bureau of Indian affairs or other federal program;

M. "navigator" means an entity that, in a manner culturally and linguistically appropriate to the state's diverse populations, conducts public education, distributes tax credit and qualified health plan enrollment information, facilitates enrollment in qualified health plans or provides referrals to consumer assistance or ombudsman services. "Navigator" does not mean a carrier or a person that receives any consideration, directly or indirectly, from any carrier in connection with the enrollment of a qualified individual in a qualified health plan;

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

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

P. "qualified employer" means a small employer that elects to make its full-time employees, and, at the option of the employer, some or all of its part-time employees, eligible for one or more qualified health plans offered in the small group market through the exchange; provided that the employer:

(1) has its principal place of business in the

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state and elects to provide coverage through the exchange to all of its eligible employees, wherever employed; or

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

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

R. "qualified individual" means an individual who:

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

(a) the individual is a resident of the state and 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 person's principal residence and from which the person is absent only for a temporary or transitory purpose;

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

(c) the individual is a full-time student attending an institution of higher education located in

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the state;

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

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

(2) is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges; and

(3) is a citizen or national of the United States or an alien lawfully present in the United States, or who is reasonably expected to be a citizen or national of the United States or an alien lawfully present in the United States during the entire period for which enrollment in the exchange is sought;

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

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

(1) the small employer elects to make all

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

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

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

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

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

V. "superintendent" means the superintendent of insurance of the insurance division of the public regulation commission or its successor agency.

SECTION 3. [NEW MATERIAL] NEW MEXICO HEALTH INSURANCE EXCHANGE CREATED--CORPORATE FORM.--

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

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in the state. The exchange shall operate subject to the supervision and approval of the board. The exchange is a governmental entity for purposes of the Tort Claims Act.

B. The exchange shall offer qualified health plans to qualified individuals and qualified employers in the individual and small group markets.

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

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

B. Selection of the nine appointed voting members shall be as follows:

(1) the governor shall appoint four members:

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

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

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

(d) one of whom shall represent an Indian nation, tribe or pueblo; and

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(2) the New Mexico legislative council shall appoint five members:

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

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

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

(d) one of whom shall be an employee of a small employer; and

(e) one of whom shall have experience with the Indian health care system and financing and shall represent Native Americans or Alaska Natives who do not live on a reservation.

C. While serving on the board, appointed members shall not have any affiliation with or any income derived from:

(1) current or active employment as, a contract with or consultation for a health care provider; or

(2) current or active employment in, a contract with or consultation for the health care services finance sector or the health care services coverage sector.

D. The board is subject to and shall comply with the provisions of the Governmental Conduct Act, the Financial Disclosure Act, the Open Meetings Act and the Public Records

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Act as well as other statutes and rules applicable to state agencies.

E. Initially, appointed members shall have terms chosen by lot as follows: two members shall serve two-year terms; three members shall serve three-year terms; and four members shall serve four-year terms. Thereafter, members shall serve four-year terms. An appointed member shall not serve more than two consecutive terms. An appointed member shall serve until the member's successor is appointed and qualified or for six months, whichever period of time is shorter.

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

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

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

I. A member may be removed from the board by a majority vote of the members. The board shall set standards for attendance and may remove a member for lack of attendance,

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neglect of duty or malfeasance in office. A member shall not be removed without proceedings consisting of at least one ten-day notice of hearing and an opportunity to be heard. Removal proceedings shall be before the board and in accordance with procedures adopted by the board, including appeals procedures to the attorney general.

J. Appointed members may receive per diem and mileage in accordance with the Per Diem and Mileage Act, subject to appropriation by the legislature and travel policy as set by the board's bylaws. Appointed members shall receive no other compensation, perquisite or allowance.

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

L. The board may:

(1) create ad hoc advisory councils, including ad hoc advisory councils on quality improvement, cost containment and reimbursement policy; and

(2) request assistance from other boards, commissions, departments, agencies and organizations as necessary to provide appropriate expertise to accomplish the

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exchange's duties.

M. The board shall create and duly consider recommendations of standing advisory committees made up of representatives of carriers, health care providers licensed pursuant to Chapter 61 NMSA 1978, health care consumers, representatives of employers and Native Americans or Alaska Natives, some of whom live on a reservation and some of whom do not live on a reservation, to guide the implementation of the Indian-specific provisions of the federal Patient Protection and Affordable Care Act and the federal Indian Health Care Improvement Act.

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

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

A. The board shall submit a written plan of operation to the superintendent with any provisions necessary to ensure the fair, reasonable, equitable and self-sustaining administration of the exchange.

B. The plan of operation shall establish written procedures to implement the provisions of the New Mexico Health Insurance Exchange Act in accordance with the federal Patient Protection and Affordable Care Act and other state and federal laws for:

(1) determining which qualified health plans will be offered through the exchange;

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(2) determining eligibility of qualified individuals and qualified employers;

(3) enrolling qualified individuals;

(4) informing individuals of eligibility requirements for health coverage through medicaid, the children's health insurance program or any state or local public health coverage program and enrolling eligible individuals in those programs;

(5) determining eligibility for premium tax credits, reduced cost-sharing or exemptions to the individual responsibility requirement;

(6) developing and implementing a free choice voucher program;

(7) establishing a navigator program;

(8) establishing a consumer protection program;

(9) publicizing the existence of the exchange, the exchange's web site and the exchange's toll-free telephone hotline;

(10) administration of assessments and fees;

(11) payment of producers;

(12) negotiating with carriers to procure qualified health plans to be offered through the exchange;

(13) developing and implementing strategies to avoid adverse selection;

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(14) handling and accounting for assets and money received and disbursed by the exchange;

(15) providing language interpretation services;

(16) establishing regular times and meeting places for meetings of the board; and

(17) any other functions necessary and proper for the execution of the powers and duties of the board.

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

A. coordinate with the human services department to receive any federal planning and implementation grants for the establishment and operation of the exchange. The board may also on behalf of the exchange seek and directly receive grant funding from federal, state or local governments or private philanthropic organizations to defray the costs of operating the exchange; provided that the board avoid any conflict of interest that receipt of these funds may present;

B. report to the legislative health and human services committee and to the legislative finance committee no later than September 1 of each year, or as requested;

C. provide quarterly reports on the implementation of the exchange between July 1, 2011 and January 1, 2014 and report annually and upon request thereafter to the legislative health and human services committee and the legislative finance

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committee;

D. keep an accurate accounting of all of the activities, receipts and expenditures of the exchange and submit this information no later than September 1 of each year to the federal secretary of health and human services and the superintendent;

E. by or before January 1, 2012, report findings and submit recommendations on how to avoid adverse selection to the legislative health and human services committee, the legislative finance committee and the superintendent;

F. by or before January 1, 2014, provide legislative recommendations to the legislative health and human services committee and the legislative finance committee on whether to change the number of full-time-equivalent employees in the definition of a small employer from fifty to one hundred before January 1, 2016. The board shall recommend a transition plan for the exchange and carriers to follow when changing the number of full-time-equivalent employees to one hundred whether the change occurs prior to or on January 1, 2016; and

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

(1) continue limiting qualified employer status to small employers and, if qualified employer status is extended to include large employers, whether to combine the

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large employer risk pool with small employers;

(2) combine markets into a single risk pool; and

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

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

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

B. The executive director of the exchange shall:

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

(2) propose an annual budget for the exchange;

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

(4) supervise the staff of the exchange.

SECTION 8. [NEW MATERIAL] NEW MEXICO HEALTH INSURANCE

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EXCHANGE--DUTIES AND POWERS.--

A. The exchange shall:

(1) in accordance with the provisions of the New Mexico Health Insurance Exchange Act, create an implementation plan to demonstrate readiness to operate the exchange to the federal department of health and human services by January 1, 2013;

(2) make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014; and

(3) implement the procedures established in the plan of operation created pursuant to Section 5 of the New Mexico Health Insurance Exchange Act.

B. The exchange may:

(1) contract with an eligible entity or a producer for any of the functions described in Paragraphs (2) through (17) of Subsection B of Section 5 of the New Mexico Health Insurance Exchange Act. For the purposes of this subsection, an eligible entity means the human services department or any state agency that operates medicaid programs, the children's health insurance program or any applicable state or local public health coverage program; and

(2) enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities; provided that these agreements

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include adequate protections of the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

SECTION 9. [NEW MATERIAL] CERTIFICATION OF QUALIFIED HEALTH PLANS--SUPERINTENDENT OF INSURANCE DUTIES AND POWERS--RULEMAKING--BOARD POWERS.--

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

B. In accordance with guidelines established by the federal secretary of health and human services and in state law, the superintendent shall promulgate rules to govern how the board will certify, recertify and decertify plans as qualified health plans. The board may withdraw certification of a qualified health plan only after sixty days' notice to the carrier and an opportunity for hearing before the public regulation commission pursuant to Section 8-8-14 NMSA 1978 and commission rules. The superintendent may decline to renew the certification of any carrier at the end of a certification term.

SECTION 10. [NEW MATERIAL] CARRIERS--REQUIREMENT TO OFFER QUALIFIED HEALTH PLANS THROUGH THE EXCHANGE.--A carrier that offers a health benefit plan in the individual or the small group market in the state shall offer through the exchange at least one qualified health plan at the silver level of coverage and at least one qualified health plan at the gold level of

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coverage.

SECTION 11. [NEW MATERIAL] DISPUTE RESOLUTION.--The superintendent shall promulgate rules for resolving disputes arising from the operation of the exchange in accordance with the provisions of the New Mexico Health Insurance Exchange Act, including disputes with respect to:

A. the eligibility of an individual, employer or carrier to participate in the exchange;

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

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

SECTION 12. [NEW MATERIAL] FUNDING--PUBLICATION OF COSTS.--The exchange:

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

B. shall publish the average costs of licensing,

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fees and any other payments required by the exchange, and administrative costs of the exchange, on an internet web site to educate consumers on such costs. This information shall include information on money lost to waste, fraud and abuse.

SECTION 13. [NEW MATERIAL] COOPERATION WITH THE HUMAN SERVICES DEPARTMENT.--The board shall cooperate with the human services department, or its successor in interest, to share information and facilitate transitions between the exchange, medicaid, the children's health insurance program or any other state public health coverage program.

SECTION 14. [NEW MATERIAL] COOPERATION WITH THE NEW MEXICO HEALTH INSURANCE EXCHANGE.--The human services department, or its successor in interest, shall cooperate with the New Mexico health insurance exchange to provide funding the department receives from the federal government or from other sources for the planning and establishment of the exchange and to share information and facilitate transitions between the exchange, medicaid, the children's health insurance program or any other state public health coverage program.

SECTION 15. [NEW MATERIAL] COOPERATION WITH THE NEW MEXICO HEALTH INSURANCE EXCHANGE.--The insurance division of the public regulation commission, or its successor in interest, shall cooperate with the New Mexico health insurance exchange to share information and assist in the implementation of the functions of the exchange.

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SECTION 16. Section 41-4-3 NMSA 1978 (being Laws 1976, Chapter 58, Section 3, as amended by Laws 2009, Chapter 8, Section 2 and by Laws 2009, Chapter 129, Section 2 and also by Laws 2009, Chapter 249, Section 2) is amended to read:

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

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

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

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

D. "law enforcement officer" means a full-time salaried public employee of a governmental entity, or a certified part-time salaried police officer employed by a governmental entity, whose principal duties under law are to hold in custody any person accused of a criminal offense, to maintain public order or to make arrests for crimes, or members of the national guard of New Mexico when called to active duty by the governor;

E. "maintenance" does not include:

(1) conduct involved in the issuance of a permit, driver's license or other official authorization to use

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the roads or highways of the state in a particular manner; or

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

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

(1) elected or appointed officials;

(2) law enforcement officers;

(3) persons acting on behalf or in service of a governmental entity in any official capacity, whether with or without compensation;

(4) licensed foster parents providing care for children in the custody of the human services department, corrections department or department of health, but not including foster parents certified by a licensed child placement agency;

(5) members of state or local selection panels

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established pursuant to the Adult Community Corrections Act;

(6) members of state or local selection panels established pursuant to the Juvenile Community Corrections Act;

(7) licensed medical, psychological or dental arts practitioners providing services to the corrections department pursuant to contract;

(8) members of the board of directors of the New Mexico medical insurance pool;

(9) individuals who are members of medical review boards, committees or panels established by the educational retirement board or the retirement board of the public employees retirement association;

(10) licensed medical, psychological or dental arts practitioners providing services to the children, youth and families department pursuant to contract;

(11) members of the board of directors of the New Mexico educational assistance foundation;

(12) members of the board of directors of the New Mexico student loan guarantee corporation;

(13) members of the board of directors and staff of the New Mexico health insurance exchange;

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

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

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

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

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

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

H. "state" or "state agency" means the state of New Mexico or any of its branches, agencies, departments, boards, instrumentalities or institutions."

SECTION 17. TEMPORARY PROVISION--NEW MEXICO HEALTH INSURANCE EXCHANGE--NEW MEXICO MEDICAL INSURANCE POOL--NEW MEXICO HEALTH INSURANCE ALLIANCE.--The board of directors of the New Mexico health insurance exchange shall meet with the board of directors of the New Mexico health insurance alliance

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and the New Mexico medical insurance pool by October 1, 2011 and at least quarterly through October 1, 2013 to:

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

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

C. prepare a report to the first session of the fifty-first legislature on the transition of functions of the New Mexico health insurance alliance and the New Mexico medical insurance pool to the New Mexico health insurance exchange and on any recommendations to the legislature for continued and expanded health coverage of the state's residents.

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

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

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