HOUSE JUDICIARY COMMITTEE SUBSTITUTE FOR
HOUSE BILL 100

54TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2020

AN ACT

RELATING TO THE NEW MEXICO HEALTH INSURANCE EXCHANGE; AMENDING AND ENACTING SECTIONS OF THE NEW MEXICO HEALTH INSURANCE EXCHANGE ACT; ADDING DUTIES AND POWERS FOR THE BOARD OF DIRECTORS OF THE NEW MEXICO HEALTH INSURANCE EXCHANGE; PROVIDING FOR STANDARDIZED HEALTH PLANS; REQUIRING REPORTING.

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

SECTION 1. Section 59A-23F-1 NMSA 1978 (being Laws 2013, Chapter 54, Section 1) is amended to read:

"59A-23F-1. SHORT TITLE.--[~~Sections 1 through 8 of this act~~] Chapter 59A, Article 23F NMSA 1978 may be cited as the "New Mexico Health Insurance Exchange Act"."

SECTION 2. Section 59A-23F-2 NMSA 1978 (being Laws 2013, Chapter 54, Section 2) is amended to read:

"59A-23F-2. DEFINITIONS.--As used in the New Mexico

Health Insurance Exchange Act:

A. "agent" means a person appointed by a health insurance issuer authorized to transact business in this state to act as its representative in any given locality;

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

C. "broker" means a person licensed as a broker pursuant to the New Mexico Insurance Code;

D. "bronze plan" means a level of coverage that is designed to provide benefits that are actuarially equivalent to sixty percent of the full actuarial value of the benefits provided under a health benefit plan or the allowable value for a bronze plan as defined by federal regulation;

E. "enrollee" means:

(1) a qualified individual or qualified employee enrolled in a qualified health plan;

(2) the dependent of a qualified employee enrolled in a qualified health plan through the small business health options program;

(3) a person who is enrolled in a qualified health plan through the small business health options program, consistent with applicable law and the terms of the group health plan; or

(4) a business owner enrolled in a qualified health plan through the small business health options program,

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provided that at least one employee of the business owner enrolls in a qualified health plan through the small business health options program, or the dependent of a business owner enrolled in a qualified health plan through the small business health options program;

[~~D.~~] F. "exchange" means the New Mexico health insurance exchange, composed of an exchange for the individual market and a small business health options program or "SHOP" exchange under a single governance and administrative structure;

G. "gold plan" 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 or the allowable value for a gold plan as defined by federal regulation;

H. "health benefit plan" means an individual or group policy or agreement entered into, offered or issued by a health insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

[~~E.~~] I. "health insurance issuer" means an insurance company, insurance service or insurance organization, including a health maintenance organization, that is licensed to engage in the business of insurance in the state;

[~~F.~~] J. "Native American" means:

(1) an individual who is a member of any

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federally recognized Indian nation, tribe or pueblo or who is an Alaska native; or

(2) an individual who has been deemed eligible for services and programs provided to Native Americans by the United States public health service or the bureau of Indian affairs;

[~~G.~~] K. "navigator" means a person 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 health insurance issuer or a person that receives any consideration, directly or indirectly, from any health insurance issuer in connection with the enrollment of a qualified individual in a qualified health plan; provided that a broker or an agent may be a navigator if the broker or the agent receives no consideration, directly or indirectly, from any health insurance issuer in connection with the enrollment of a qualified individual or qualified employer in a qualified health plan, an approved health plan or any other health coverage; [~~and~~]

L. "qualified employee" means an employee or former employee of a qualified employer who has been offered health insurance coverage by that qualified employer through the small

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business health options program for the employee or former employee and, if the qualified employer offers dependent coverage through the small business health options program, for the employee or former employee's dependents;

M. "qualified employer" means a small employer that elects to make, at a minimum, all of the employer's full-time employees eligible for one or more qualified health plans in the small group market offered through a small business health options program;

N. "qualified health plan" means a health plan that has in effect a certification from the superintendent that it meets the standards set forth in applicable federal and state law and regulations and rules as well as any additional requirements established by the board;

O. "qualified individual" means an individual who has been determined eligible to enroll through the exchange in a qualified health plan in the individual market;

P. "silver plan" 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 or the allowable value for a silver plan as defined by federal regulation;

Q. "small business health options program" means a program operated by the exchange through which a qualified employer can provide its employees and their dependents with

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access to one or more qualified health plans; and

[~~H.~~] R. "superintendent" means the superintendent of insurance."

SECTION 3. Section 59A-23F-3 NMSA 1978 (being Laws 2013, Chapter 54, Section 3, as amended) is amended to read:

"59A-23F-3. NEW MEXICO HEALTH INSURANCE EXCHANGE CREATED--BOARD CREATED.--

A. The "New Mexico health insurance exchange" is created as a nonprofit public corporation to provide qualified individuals and qualified employers with increased access to health insurance in the state and shall be governed by a board of directors constituted pursuant to the provisions of the New Mexico Health Insurance Exchange Act. The exchange is a governmental entity for purposes of the Governmental Conduct Act, the Gift Act, the Sunshine Portal Transparency Act, the Whistleblower Protection Act, the Procurement Code and the Tort Claims Act, and neither the exchange nor the board shall be considered a governmental entity for any other purpose.

B. The exchange shall not duplicate, impair, enhance, supplant, infringe upon or replace, in whole or in any part, the powers, duties or authority of the superintendent, including the superintendent's authority to review and approve premium rates pursuant to the provisions of the [~~New Mexico~~] Insurance Code.

[~~C. The exchange shall not purchase qualified~~

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~~health plans from insurance health issuers to offer for purchase through the exchange.~~

~~D.~~] C. All health insurance issuers and health maintenance organizations authorized to conduct business in this state and meeting the requirements of the rules promulgated by the superintendent pursuant to Section 59A-23F-7 NMSA 1978, [~~as well as meeting~~] the [~~rules~~] regulations under [~~the~~] federal [~~act~~] law and the requirements established by the board shall be eligible to participate in the exchange.

[~~E.~~] D. The "board of directors of the New Mexico health insurance exchange" is created. The board consists of thirteen voting directors as follows:

(1) one voting director is the superintendent or the superintendent's designee;

(2) six voting directors appointed by the governor, including the secretary of human services or the secretary's designee, a health insurance issuer and a consumer advocate; and

(3) six voting directors, three appointed by the president pro tempore of the senate, including one health care provider, and three appointed by the speaker of the house of representatives, including one health insurance issuer. One of the directors appointed by the president pro tempore of the senate and one of the directors appointed by the speaker of the house of representatives shall be from a list of at least two

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candidates provided, respectively, by the minority floor leader of the senate and by the minority floor leader of the house of representatives.

[~~F.~~] E. Except as provided in Subsection [~~G~~] F of this section, managerial and full-time staff of the exchange shall be subject to applicable provisions of the Governmental Conduct Act and shall not have any direct or indirect affiliation with any health care provider, health insurance issuer or health care service provider.

[~~G.~~] F. Each director shall comply with the conflict-of-interest provisions of Subsection [~~F~~] E of this section, except as follows:

(1) directors who may be appointed from the [~~boards~~] board of directors of the New Mexico medical insurance pool [~~and the New Mexico health insurance alliance~~] shall not be considered to have a conflict of interest with respect to their association with [~~those entities~~] that entity;

(2) the secretary of human services, or the secretary's designee, shall not be considered to have a conflict of interest with respect to the secretary's performance of the secretary's duties as secretary of human services;

(3) the director who is a health care provider shall not be considered to have a conflict of interest arising from that director's receipt of payment for services as a

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health care provider; and

(4) directors who are representatives of health insurance issuers shall not be considered to have a conflict of interest with respect to those directors' association with their respective health insurance issuers.

[~~H.~~] G. Each director and employee of the exchange shall have a fiduciary duty to the exchange, to the state and to those persons who purchase or enroll in qualified health plan coverage or medical assistance coverage through the exchange.

[~~I.~~] H. The board shall be composed, as a whole, to assure representation of the state's Native American population, ethnic diversity, cultural diversity and geographic diversity.

[~~J.~~] I. Directors shall have demonstrated knowledge or experience in at least one of the following areas:

(1) purchasing coverage in the individual market;

(2) purchasing coverage in the small employer market;

(3) health care finance;

(4) health care economics or health care actuarial science;

(5) health care policy;

(6) the enrollment of underserved residents in

health care coverage;

(7) administration of a private or public health care delivery system;

(8) information technology;

(9) starting a small business with fifty or fewer employees; or

(10) provision of health care services.

[~~K.~~] J. The governor shall appoint no more than four directors from the same political party.

[~~L.~~] K. Except for the secretary of human services, the non-health insurance issuer 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. The non-health insurance insurer directors appointed by the legislature 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. The health insurance issuers appointed to the board shall, upon appointment, select one of them by lot to have an initial term ending on June 30 following one year of service and one to have an initial term ending on June 30 following two years of service. Following the initial terms, health insurance issuer directors shall be appointed for terms of two years. A director whose term has expired shall continue to serve until a successor is appointed by the respective

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appointing authority. Health insurance issuer directors shall not serve two consecutive terms.

[~~M.~~] L. The exchange, members of the board and employees of the exchange shall operate consistent with provisions of the Governmental Conduct Act, the Inspection of Public Records Act, the Financial Disclosure Act, the Gift Act, the Whistleblower Protection Act, the Open Meetings Act and the Procurement Code and shall not be subject to the Personnel Act.

[~~N.~~] M. The board and the exchange shall implement performance-based budgeting and submit annual budgets for the exchange to the secretary of finance and administration and the legislative finance committee.

[~~O.~~] N. The exchange shall cover its directors and employees under a surety bond, in an amount that the director of the risk management division of the general services department shall prescribe.

[~~P.~~] O. A majority of directors constitutes a quorum. The board may allow members to attend meetings by telephone or other electronic media. A decision by the board requires a quorum and a majority of directors in attendance voting in favor of the decision.

[~~Q.~~] P. Within thirty days of the effective date of the New Mexico Health Insurance Exchange Act, the board shall be fully appointed and the superintendent shall convene an organizational meeting of the board, during which the board

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shall elect a chair and vice chair from among the directors. Thereafter, every three years, the board shall elect in open meeting a chair and vice chair from among the directors. The chair and vice chair shall serve no more than two consecutive three-year terms as chair and vice chair.

[~~R.~~] Q. A vacancy on the board shall be filled by appointment by the original appointing authority for the remainder of the director's unexpired term.

[~~S.~~] R. A director may be removed from the board by a two-thirds majority vote of the directors. The board shall set standards for attendance and may remove a director for lack of attendance, neglect of duty or malfeasance in office. A director 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.

[~~T.~~] S. Appointed directors may receive per diem and mileage in accordance with the Per Diem and Mileage Act, subject to the travel policy set by the board. Appointed directors shall receive no other compensation, perquisite or allowance.

[~~U.~~] T. The board shall:

(1) meet at the call of the chair and no less often than once per calendar quarter. There shall be at least seven days' notice given to directors prior to any meeting.

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There shall be sufficient notice provided to the public prior to meetings pursuant to the Open Meetings Act;

(2) create, make appointments to and duly consider recommendations of an advisory committee or committees made up of stakeholders, including health insurance issuers, health care consumers, health care providers, health care practitioners, brokers, qualified employer representatives and advocates for low-income or underserved residents;

(3) create an advisory committee made up of members insured through the New Mexico medical insurance pool to make recommendations to the board regarding the transition of each organization's insured members into the exchange. The advisory committee shall only exist until a transition plan has been adopted by the board;

(4) create an advisory committee made up of Native Americans, some of whom live on a reservation and some of whom do not live on a reservation, to guide the implementation of the Native American-specific provisions of the federal Patient Protection and Affordable Care Act and the federal Indian Health Care Improvement Act;

(5) designate a Native American liaison, who shall assist the board in developing and ensuring implementation of communication and collaboration between the exchange and Native Americans in the state. The Native American liaison shall serve as a contact person between the

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exchange and New Mexico Indian nations, tribes and pueblos and shall ensure that training is provided to the staff of the exchange, which may include training in:

(a) cultural competency;

(b) state and federal law relating to Indian health; and

(c) other matters relating to the functions of the exchange with respect to Native Americans in the state; and

(6) establish at least one walk-in customer service center where persons may, if eligible, enroll in qualified health plans or public coverage programs."

SECTION 4. Section 59A-23F-5 NMSA 1978 (being Laws 2013, Chapter 54, Section 5, as amended) is amended to read:

"59A-23F-5. PLAN OF OPERATION.--

A. [~~Within sixty days of the effective date of the New Mexico Health Insurance Exchange Act, the board shall create a preliminary plan of operation containing provisions to ensure the fair, reasonable and equitable administration of the exchange. Within six months of the effective date of the New Mexico Health Insurance Exchange Act, the board shall create and implement a final plan of operation containing provisions to ensure that the exchange is administered using best practices in business administration~~] No later than September 1, 2020, the board shall review its plan of operation and

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approve amendments to it as appropriate to ensure that the exchange is operated using best practices for state-based exchanges in business administration, consumer engagement and public outreach and marketing.

B. The board shall provide for public notice and hearing prior to approving amendments to the plan of operation.

C. The [~~preliminary~~] plan of operation shall contain:

(1) [~~establish~~] procedures to implement the provisions of the New Mexico Health Insurance Exchange Act, consistent with state and federal law;

(2) [~~establish~~] procedures for handling and accounting for the exchange's assets and money; [~~and~~]

(3) [~~establish~~] regular times and meeting places for meetings of the board;

[~~D. The final plan of operation shall:~~

~~(1) establish~~] (4) a statewide consumer assistance program, including a navigator program;

[~~(2) establish~~] (5) procedures for consumer [~~complaint~~] complaints and [~~grievance procedures~~] grievances for issues relating to the exchange;

[~~(3) establish~~] (6) procedures for alternative dispute resolution between the exchange and contractors or health insurance issuers;

[~~(4) develop and implement~~] (7) policies

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that:

(a) promote effective communication and collaboration between the exchange and Indian nations, tribes and pueblos, including communicating and collaborating on those nations', tribes' and pueblos' plans for creating or participating in health insurance exchanges; and

(b) promote cultural competency in providing effective services to Native Americans;

[~~(5) establish~~] (8) conflict-of-interest policies and procedures; [~~and~~]

(9) details on the contents of the reports required pursuant to the New Mexico Health Insurance Exchange Act; and

[~~(6) contain additional~~] (10) provisions necessary and proper for the execution of the powers and duties of the board and exchange."

SECTION 5. Section 59A-23F-7 NMSA 1978 (being Laws 2013, Chapter 54, Section 7) is amended to read:

"59A-23F-7. SUPERINTENDENT OF INSURANCE--RULEMAKING.--The superintendent shall coordinate with the board to promulgate rules necessary to implement and carry out the provisions of the New Mexico Health Insurance Exchange Act, including rules to establish the criteria for certification of qualified health plans."

SECTION 6. A new section of the New Mexico Health

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Insurance Exchange Act is enacted to read:

"[NEW MATERIAL] BOARD--ADDITIONAL DUTIES AND POWERS.--In addition to other duties and powers in the New Mexico Health Insurance Exchange Act, the board shall:

A. in consultation with the superintendent:

(1) establish policies and procedures for the review and recommendation of health benefits plans to be offered on the exchange;

(2) determine additional minimum requirements for a health insurance issuer to be considered for participation in the exchange; and

(3) determine standards and criteria for health benefits plans to be offered through the exchange that offer an optimal level of choice, value, quality and service and that are in the best interests of qualified individuals and qualified small employers;

B. establish policies and procedures that allow city, county and state governments, Indian nations, tribes and pueblos, tribal organizations, urban Native American organizations, private foundations and other entities to pay premiums and cost-sharing on behalf of qualified individuals consistent with federal requirements;

C. provide for the operation of a toll-free hotline to respond to requests for assistance, using staff that is trained to provide assistance in a culturally and

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linguistically appropriate manner;

D. provide for an annual regular enrollment period and special enrollment periods in the best interest of qualified individuals and qualified small employers;

E. maintain an internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on those plans;

F. use a standardized format for presenting health benefit plan options in the exchange;

G. determine the criteria and process for eligibility, enrollment and disenrollment of enrollees and potential enrollees in the exchange and coordinate that process with the human services department in order to ensure consistent eligibility and enrollment processes and seamless transitions between coverages;

H. inform individuals of eligibility requirements for medicaid, the children's health insurance program or other applicable state or local public programs. If the exchange assesses that an individual may be eligible for a program, the board shall share information with that program to facilitate the eligibility determination and enrollment of the individual;

I. establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credits and cost-sharing reductions under applicable federal or state law;

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J. perform duties required of, or delegated to, the exchange by the secretary of the United States department of health and human services or the United States secretary of the treasury related to determining eligibility for premium tax credits or reduced cost sharing;

K. maintain a statewide consumer assistance program, including a navigator program; and

L. maintain a small business health options program exchange through which qualified employers may access coverage for their employees, providing as appropriate premium aggregation and other related services to minimize the administrative burdens for qualified employers and to:

(1) enable a qualified employer to specify a level of coverage so that its employees may enroll in a qualified health plan offered through the small business health options program exchange at the specified level of coverage; or

(2) enable a qualified employer to provide a specific amount or other payment formulated in accordance with federal law to be used as part of an employee's choice of plan."

SECTION 7. A new section of the New Mexico Health Insurance Exchange Act is enacted to read:

"[NEW MATERIAL] STANDARDIZED HEALTH PLANS.--

A. The board may establish no more than three standardized health plans for each of three levels of coverage

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with increasing benefits, designated bronze, silver and gold plans.

B. In establishing standardized health plans, the board may design those plans to:

(1) limit increases in health plan premium rates;

(2) reduce the deductible portion of a benefit an insured individual is required to pay;

(3) make more services available before a deductible amount is applied to a benefit;

(4) provide predictable cost sharing;

(5) maximize available subsidies;

(6) limit adverse premium impacts;

(7) reduce barriers to maintaining and improving health; and

(8) encourage choice based on value.

C. The board may update the standardized health plans annually.

D. The board shall provide for notice and public comment before finalizing each year's standardized health plans.

E. The board shall establish a procedure and time line for providing written notice of the standardized health plans to health insurance issuers before the year in which the health plans are to be offered on the exchange.

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F. Beginning on January 1, 2022, the board may require a health insurance issuer offering a qualified health plan through the exchange to offer one silver standardized health plan and one gold standardized health plan on the exchange. If a health insurance issuer offers a bronze health plan through the exchange, the exchange may also require the issuer to offer one bronze standardized health plan through the exchange.

G. A health insurance issuer offering standardized health plans through the exchange may also offer nonstandardized health plans through the exchange.

H. The actuarial value of nonstandardized silver health plans offered through the exchange shall not be less than the actuarial value of the standardized silver health plan with the lowest actuarial value."

SECTION 8. A new section of the New Mexico Health Insurance Exchange Act is enacted to read:

"[NEW MATERIAL] REPORTING.--The board shall make reports publicly available as follows:

A. during all exchange open enrollment periods beginning on or after October 1, 2021, the board shall produce weekly reports that include information on:

(1) applications;

(2) plan selections;

(3) new enrollees;

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(4) enrollees renewing coverage;

(5) call center volume; and

(6) website traffic;

B. within sixty days following the last day of each open enrollment period beginning on or after October 1, 2021, the board shall produce a report with the number of effectuated enrollments from the most recent open enrollment period; and

C. beginning on September 1, 2022, and on each succeeding September 1, the board, in consultation with the superintendent, shall issue a report that includes analysis of:

(1) the individual health insurance market;

(2) on- and off-exchange enrollment and demographics;

(3) small business enrollment;

(4) qualified health plan pricing;

(5) outreach and enrollment assistance activities;

(6) the impact of offering standardized health plans; and

(7) the remaining uninsured in New Mexico and strategies to reach them."