BILL

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

INTRODUCED BY

DISCUSSION DRAFT

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".

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. "bronze level of coverage" 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;

D. "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;

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

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

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principal insured by birth or adoption;

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

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

(1) ambulatory patient services;

(2) emergency services;

(3) hospitalization;

(4) maternity and newborn care;

(5) mental health and substance abuse disorder services, including behavioral health treatment;

(6) prescription drugs;

(7) rehabilitative and habilitative services and devices;

(8) laboratory services;

(9) preventive and wellness services and chronic disease management; and

(10) pediatric services, including oral and vision care;

I. "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

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market;

J. "free choice voucher" means the amount equal in 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;

K. "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;

L. "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

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income insurance, or a combination of both;

(2) coverage issued as a supplement to 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;

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

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

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

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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;

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

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

R. "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;

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

T. "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

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group market through the exchange; provided that the employer:

(1) has its principal place of business in the 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;

U. "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, including the following requirements:

(1) that the carrier offering the health insurance coverage or group health plan is licensed and in good standing to offer health insurance coverage in the state;

(2) that the plan offers essential benefits at the bronze, silver, gold or platinum level of coverage or meets the requirements of a catastrophic plan;

(3) that the carrier offers at least one qualified health plan in the silver level of coverage and at least one plan in the gold level of coverage in the exchange;

(4) that the carrier agrees to charge the same premium for each qualified health plan within each level of coverage without regard to whether the plan is offered through the exchange, directly from the carrier or through a producer;

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and

(5) that the plan complies with state and federal regulations;

V. "qualified individual" means an individual:

(1) who 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 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; and

(2) who is not:

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

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

W. "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;

X. "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 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

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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;

Y. "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;

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

AA. "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.--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 in the state. The exchange shall operate subject to the supervision and approval of the board.

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

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A. The "board of directors of the New Mexico health insurance exchange" is created. The board shall consist of nine voting members. One voting ex-officio member shall be the superintendent. One voting ex-officio member shall be the secretary of human services or the secretary of the human services department's successor agency.

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

(1) the governor shall appoint three members as follows:

(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; and

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

(2) the New Mexico legislative council shall appoint four members as follows:

(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

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who purchases insurance in the individual insurance market; and

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

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

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 Administrative Procedures 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; two members shall serve three-year terms; and three 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.

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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, 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

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

M. The board may:

(1) create ad hoc advisory councils; and

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

N. The board shall create:

(1) a standing advisory committee made up of representatives of carriers;

(2) a standing advisory committee made up of health care providers licensed pursuant to Chapter 61 NMSA 1978;

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

(4) a standing advisory committee made up of

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two health care consumers who are private small employers and two health care consumers who are nonprofit public corporations.

O. 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 and equitable administration of the exchange.

B. The plan of operation shall:

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

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

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

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

(d) procedures are established for the

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collection of assessments from carriers, qualified employers, qualified individuals and producers as needed to support the operation of the exchange;

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

(f) penalties are established for nonpayment of assessments;

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

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

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

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

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

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

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

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A. 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 committee;

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

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

D. 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 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;

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

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

(2) combine the individual market and the small group market 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;

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

G. cooperate with the medical assistance division of 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 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.

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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;

(4) supervise the staff of the exchange; and

(5) serve at the pleasure of the board.

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

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

B. assign a rating to each qualified health plan offered through the exchange on the basis of relative quality, price and actuarial value in accordance with criteria established by the federal secretary of health and human services in consultation with the superintendent. On the basis of that rating and if offering the qualified health plan through the exchange is in the interest of the qualified individuals and qualified employers in this state, the exchange

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shall determine which qualified health plans that have been certified by the superintendent will be offered through the exchange;

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

D. 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;

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

F. make pediatric dental benefits available:

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

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

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

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

I. provide for an internet web site containing

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standardized comparative information on qualified health plans;

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

(1) participate in the exchange;

(2) enroll in a qualified health plan;

(3) receive a health coverage subsidy; and

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

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

L. establish and make available by electronic means a calculator to determine the actual cost of health coverage for a qualified individual after applying any premium tax credit and cost-sharing reductions for which the qualified individual is eligible;

M. grant certification to individuals for hardship or other exemptions from the individual responsibility to retain minimum essential coverage mandated pursuant to

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Section 1501 of the federal Patient Protection and Affordable Care Act;

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

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

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

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

(b) the employer provided minimum essential health benefits coverage, but the exchange determined that the coverage was either unaffordable to the employee or that the coverage did not provide the required minimum actuarial value; and

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

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

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

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

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

(2) distribute fair and impartial information concerning enrollment in qualified health plans, the availability of premium tax credits under Section 36B of the federal Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal Patient Protection and Affordability Act;

(3) facilitate enrollment in qualified health plans;

(4) provide referrals to any applicable office offering health insurance consumer assistance, or any other

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appropriate state agency, for any qualified individual with a grievance, complaint or question regarding the individual's qualified health plan or coverage or a determination under that plan or coverage; and

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

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

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

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

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

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

(1) receive and process automatic payroll

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deductions for qualified individuals enrolled in qualified health plans;

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

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

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

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

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

B. contract with an eligible entity for any of the functions described in Section 8 of the New Mexico Health Insurance Exchange Act. For the purposes of this subsection, an eligible entity includes medicaid, the children's health insurance program or any applicable state or local public health coverage program, but a carrier is not an eligible entity;

C. enter into information-sharing agreements with

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federal and state agencies and other state exchanges to carry out its responsibilities; provided that these agreements include adequate protections of the confidentiality of the information to be shared and comply with all state and federal laws and regulations; and

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

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

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

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

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

(1) the plan provides essential benefits;

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

(a) is certified as a catastrophic plan;

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

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

(3) the carrier offering the plan:

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

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

(c) charges the same premium for each qualified health plan without regard to whether the plan is offered through the exchange, directly from the carrier or through a producer; and

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

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

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

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

(2) through imposition of premium price

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controls; or

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

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

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

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

(2) make available to the public, in plain language, and submit to the superintendent, the exchange and the federal secretary of health and human services accurate and timely disclosure of the following:

(a) claims payment policies and practices;

(b) periodic financial disclosures;

(c) data on enrollment;

(d) data on disenrollment;

(e) data on the number of claims that are denied;

(f) data on rating practices;

(g) information on cost-sharing and payments with respect to any out-of-network coverage;

(h) information on enrollee and participant rights pursuant to state and federal law; and

(i) other information as determined appropriate by the federal secretary of health and human services; and

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

G. The premium rates determined for the first plan year for which the qualified health plan is offered through the exchange may be adjusted by the carrier for subsequent plan years based on experience and any later modifications to plan benefits; provided, however, that any adjustments in premiums shall be made at least sixty days in advance of the plan year for which the carrier applies for certification of a plan as a qualified health plan.

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

(1) withdrawal by the superintendent; or

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

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

SECTION 12. [NEW MATERIAL] ENROLLMENT AND COVERAGE ELECTION.--

A. A qualified individual may apply to participate in the exchange. A qualified employer may apply on behalf of its employees or the employees' dependents. Upon determination by the exchange that an individual is a qualified individual, the qualified individual may enroll or, if applicable, be

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enrolled by the qualified individual's parent or legal guardian in a qualified health plan offered through the exchange during the next open enrollment or as otherwise provided in Subsection B of this section.

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

(1) an initial open enrollment period;

(2) an annual open enrollment for calendar years after the initial open enrollment period;

(3) special enrollment periods specified in Section 9801 of the federal Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to the periods specified in that federal act, pursuant to Part D of Title 18 of the federal Social Security Act; and

(4) special monthly enrollment periods for Indians, as "Indians" is defined in Section 4 of the federal Indian Health Care Improvement Act.

SECTION 13. [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 to participate

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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 14. [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;

B. shall publish the average costs of licensing, regulatory 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; and

C. may seek and directly receive grant funding from federal, state or local governments or private philanthropic

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organizations to defray the costs of operating the exchange.

SECTION 15. 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

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permit, driver's license or other official authorization to use 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;

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(5) members of state or local selection panels 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 of the New Mexico health insurance exchange;

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

[~~(14)~~] (15) volunteers, employees and board

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members of court-appointed special advocate programs;

[~~(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 16. [NEW MATERIAL] COOPERATION WITH THE NEW MEXICO HEALTH INSURANCE EXCHANGE.--The medical assistance division of the human services department, or its successor in interest, shall cooperate with the New Mexico health insurance

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exchange 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 17. TEMPORARY PROVISIONS--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 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,

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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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