SENATE BILL 152

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

Howie C. Morales

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HEALTH SECURITY ACT TO PROVIDE FOR COMPREHENSIVE STATEWIDE HEALTH CARE; PROVIDING FOR HEALTH CARE PLANNING; ESTABLISHING PROCEDURES TO CONTAIN HEALTH CARE COSTS; CREATING A COMMISSION; PROVIDING FOR ITS POWERS AND DUTIES; PROVIDING FOR HEALTH CARE DELIVERY REGIONS AND REGIONAL COUNCILS; DIRECTING AND AUTHORIZING THE DEVELOPMENT OF A HEALTH SECURITY PLAN; PROVIDING FOR TRANSFER OF HEALTH INSURANCE EXCHANGE PERSONAL PROPERTY TO THE COMMISSION; PROVIDING PENALTIES; AMENDING A SECTION OF THE TORT CLAIMS ACT; MAKING AN APPROPRIATION.

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

SECTION 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 46 of this act may be cited as the "Health Security Act".

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SECTION 2. [NEW MATERIAL] PURPOSES OF ACT.--The purposes of the Health Security Act are to:

A. create a program that ensures health care coverage to all New Mexicans through a combination of public and private financing;

B. control escalating health care costs; and

C. improve the health care of all New Mexicans.

SECTION 3. [NEW MATERIAL] DEFINITIONS.--As used in the Health Security Act:

A. "beneficiary" means a person eligible for health care and benefits pursuant to the health security plan;

B. "budget" means the total of all categories of dollar amounts of expenditures for a stated period authorized for an entity or a program;

C. "capital budget" means that portion of a budget that establishes expenditures for:

(1) acquisition or addition of substantial improvements to real property; or

(2) acquisition of tangible personal property;

D. "case management" means a comprehensive program designed to meet an individual's need for care by coordinating and linking the components of health care;

E. "commission" means the health care commission;

F. "consumer price index for medical care prices" means that index as published by the bureau of labor statistics

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of the federal department of labor;

G. "controlling interest" means:

(1) a five percent or greater ownership interest, direct or indirect, in the person controlled; or

(2) a financial interest, direct or indirect, that, because of business or personal relationships, has the power to influence important decisions of the person controlled;

H. "financial interest" means an ownership interest of any amount, direct or indirect;

I. "group practice" means an association of health care providers that provides one or more specialized health care services or a tribal or urban Indian coalition in partnership or under contract with the federal Indian health service that is authorized under federal law to provide health care to Native American populations in the state;

J. "health care" means health care provider services and health facility services;

K. "health care provider" means:

(1) a person or network of persons licensed or certified and authorized to provide health care;

(2) an individual licensed or certified by a nationally recognized professional organization and designated as a health care provider by the commission; or

(3) a person that is a group practice of

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licensed providers or a transportation service;

L. "health facility" means a school-based clinic, an Indian health service facility, a tribally operated health care facility, a state-operated health care facility, a general hospital, a special hospital, an outpatient facility, a psychiatric hospital, a primary clinic pursuant to the Rural Primary Health Care Act, a laboratory, a skilled nursing facility or a nursing facility; provided that the health facility is authorized to receive state or federal reimbursement;

M. "health security plan" means the program that is created and administered by the commission for provision of health care pursuant to the Health Security Act;

N. "major capital expenditure" means construction or renovation of facilities or the acquisition of diagnostic, treatment or transportation equipment by a health care provider or health facility that costs more than an amount recommended and established by the commission;

O. "medicare offset" means a reimbursement that the federal government makes pursuant to the federal Health Insurance for the Aged Act, Title 18 of the Social Security Amendments of 1965, as then constituted or later amended;

P. "operating budget" means the budget of a health facility exclusive of the facility's capital budget;

Q. "person" means an individual or any other legal

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entity;

R. "primary care provider" means a health care provider who is a physician, osteopathic physician, nurse practitioner, physician assistant, osteopathic physician's assistant, pharmacist clinician or other health care provider certified by the commission to provide the first level of basic health care, including diagnostic and treatment services; services delivered at a primary clinic, telehealth site or a school-based health center; and behavioral health services if those services are integrated into the provider's service array;

S. "provider budget" means the authorized expenditures pursuant to payment mechanisms established by the commission to pay for health care furnished by health care providers participating in the health security plan;

T. "service" means a health care service or product offered or provided to an individual for the purpose of preventing, alleviating, curing or healing human physical or mental illness or injury or substance use disorder;

U. "superintendent" means the superintendent of insurance; and

V. "transportation service" means a person providing the services of an ambulance, helicopter or other conveyance that is equipped with health care supplies and equipment and that is used to transport patients to health care

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providers or health facilities.

SECTION 4. [NEW MATERIAL] HEALTH CARE COMMISSION CREATED--GOVERNMENTAL INSTRUMENTALITY.--As of December 1, 2016, the "health care commission" is created as a public body, politic and corporate, constituting a governmental instrumentality. The commission consists of fifteen members.

SECTION 5. [NEW MATERIAL] CREATION OF HEALTH CARE COMMISSION MEMBERSHIP NOMINATING COMMITTEE--MEMBERSHIP, TERMS AND DUTIES.--

A. As of April 15, 2016, the "health care commission membership nominating committee" is created, consisting of ten members, to reflect the geographic diversity of the state, as follows:

(1) three members appointed by the speaker of the house of representatives;

(2) three members appointed by the president pro tempore of the senate;

(3) two members appointed by the minority floor leader of the house of representatives; and

(4) two members appointed by the minority floor leader of the senate.

B. By March 1, 2016, the legislative council service shall provide the public with public notice to allow members of the public to request consideration of appointment to the nominating committee. The notice shall be advertised

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and reported on a publicly accessible web site that the nominating committee establishes and maintains, in media outlets throughout the state and through publication of a legal notice in major newspapers. Publication of the legal notice shall occur once each week for the two weeks preceding April 15, 2016.

C. At the first meeting of the nominating committee, it shall elect a chair and any other officers it deems necessary from its membership. The chair shall vote only in the case of a tie vote.

D. Members shall serve two-year terms.

E. A member shall serve until the member's successor is appointed and qualified. Successor members shall be appointed by the appointing authority that made the initial appointment to the nominating committee. A member shall be eligible for or enrolled in the health security plan. A person shall not serve on the nominating committee if that person:

(1) currently or within the previous thirty-six months:

(a) serves or has served as a member of the commission; or

(b) has, or is a member of the household of a person who has, been employed by, served as an agent or officer of or had a controlling interest in a person that is licensed to provide health insurance;

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(2) is a state employee who is exempt from the Personnel Act; or

(3) is an elected official.

F. Appointed members of the nominating committee shall have substantial knowledge of the health care system as demonstrated by education or experience.

G. The nominating committee shall advertise and report notice of its meetings and agendas at least seventy-two hours before each meeting on a publicly accessible web site that the commission establishes and maintains, in media outlets throughout the state and through publication of a legal notice in major newspapers. Publication of the legal notice shall occur once each week for the two weeks immediately preceding the date of a meeting. Meetings of the nominating committee shall be open to the public, and public comment shall be allowed.

H. A majority of the nominating committee constitutes a quorum. The nominating committee may allow members' participation in meetings by telephone or other electronic media that allow full participation. Meetings may be closed only for discussion of candidates prior to selection. Final selection of candidates shall be by vote of the members and shall be conducted in a public meeting.

I. The New Mexico legislative council shall convene the first meeting of the nominating committee on or before May

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16, 2016 and thereafter at the call of the chair.

J. The nominating committee shall actively solicit, accept and evaluate applications from qualified persons for membership on the commission subject to the qualification requirements for commission membership pursuant to Section 6 of the Health Security Act.

K. No later than October 1, 2016, the nominating committee shall submit to the governor the names of the persons recommended for appointment to the commission by a majority of the nominating committee. Immediately after receiving the nominating committee's nominations, the governor may make one request of the nominating committee for submission of additional names. If a majority of the nominating committee finds additional persons that would be qualified, the nominating committee shall promptly submit the additional names and recommend those persons for appointment to the commission. The nominating committee shall submit no more than three names for a membership position for each initial or additional appointment.

L. Appointed nominating committee members may be reimbursed pursuant to the Per Diem and Mileage Act for expenses incurred in fulfilling their duties.

M. The legislative council service shall provide staff to assist the nominating committee.

SECTION 6. [NEW MATERIAL] APPOINTMENT OF COMMISSION

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MEMBERS--MEETINGS--QUALIFICATIONS--TERMS.--

A. From the nominees submitted by the health care commission membership nominating committee, the governor shall appoint fifteen members to the commission, and the initial commission shall be in place by December 1, 2016. In the event that the governor does not appoint a member to a commission membership slot by December 1, 2016, the nominating committee shall make that appointment.

B. The New Mexico legislative council shall convene a first meeting of the commission by January 4, 2017. At the first meeting of the commission, the members shall elect from their membership a chair and a vice chair and any other officers they deem necessary. The chair, vice chair and any other officers shall serve for terms of two years.

C. After the first meeting of the commission, the commission shall meet at the call of the chair as the chair deems necessary and at least once each month.

D. The terms of the initial commission members appointed shall be chosen by lot: five members shall be appointed for terms of four years; five members shall be appointed for terms of three years; and five members shall be appointed for terms of two years. Thereafter, all members shall be appointed for terms of four years. After initial terms are served, no member shall serve more than two consecutive four-year terms. A member may serve until a

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successor is appointed.

E. A person shall not serve on the commission if that person:

(1) within the previous thirty-six months has served as a member of the nominating committee;

(2) has, or is a member of the household of a person who has, during the previous thirty-six months been employed by, served as an agent or officer of or had a controlling interest in a person that is licensed to provide health insurance;

(3) is a state employee who is exempt from the Personnel Act;

(4) is an elected official; or

(5) is not eligible for or enrolled in the health security plan.

F. When a vacancy occurs in the membership of the commission, the health care commission membership nominating committee shall meet and nominate a member to fill the vacancy within thirty days of the occurrence of the vacancy. From the nominees submitted, the governor shall fill the vacancy within thirty days after receiving final nominations. In the event that the governor does not appoint a member to the vacancy within thirty days, the nominating committee shall appoint a member to fill the vacancy.

G. The fifteen members of the commission shall

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include:

(1) five persons who represent either health care providers or health facilities;

(2) six persons who represent consumer interests; and

(3) four persons who represent employer interests; provided that a person who represents a health care provider or a health facility shall not serve as a member who represents employer interests.

H. A person appointed to the commission who does not represent a health care provider or a health facility shall have a knowledge of the health care system as demonstrated by experience or education.

I. To ensure fair representation of all areas of the state, members shall be appointed from each of the public education commission districts as follows:

(1) two from public education commission district 1;

(2) one from public education commission district 2;

(3) one from public education commission district 3;

(4) two from public education commission district 4;

(5) two from public education commission

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district 5;

(6) one from public education commission district 6;

(7) two from public education commission district 7;

(8) two from public education commission district 8;

(9) one from public education commission district 9; and

(10) one from public education commission district 10.

J. The presence of a majority of the commission's members constitutes a quorum for the transaction of business. The commission may allow members' participation in meetings by telephone or other electronic media that allow full participation.

K. A member may receive per diem and mileage at a rate equal to the rate at which state legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act for expenses incurred in fulfilling their duties. Additionally, members shall be compensated at the rate of two hundred dollars ($200) for each day of a meeting or training event actually attended not to exceed compensation for one hundred twenty meetings for a two-year period occurring in a term.

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L. The commission shall establish an electronic mail or "email" system for use by members in the conduct of commission business. Commission business shall be exclusively conducted on the commission's email system.

SECTION 7. [NEW MATERIAL] CONFLICT OF INTEREST--DISCLOSURE BY MEMBERS AND DISQUALIFICATION FROM VOTING ON CERTAIN MATTERS.--

A. The commission shall adopt a conflict-of-interest disclosure statement for use by all members that requires disclosure of a financial interest, whether or not a controlling interest, of the member or a member of the member's household in a person providing health care or health insurance.

B. A member representing health facilities or health care providers may vote on matters that pertain generally to health facilities or health care providers.

C. If there is a question about a conflict of interest of a commission member, the other members shall vote on whether to allow the member to vote.

SECTION 8. [NEW MATERIAL] COMMISSION CODE OF CONDUCT--MEMBER DISCIPLINE--REMOVAL.--The commission shall adopt and promulgate a code of conduct and procedures to be observed by members in the execution of their duties. The commission may remove a member for a violation of the commission code of conduct or a violation of the Health Security Act by a two-

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thirds' majority vote of all of the members at a meeting where all members, except the member who is the subject of the vote, are present. 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 commission and in accordance with procedures the commission has adopted and promulgated.

SECTION 9. [NEW MATERIAL] APPLICATION OF CERTAIN STATE LAWS TO COMMISSION.--The commission and regional councils created pursuant to the Health Security Act:

A. shall be subject to and shall comply with the provisions of the:

(1) Open Meetings Act;

(2) State Rules Act;

(3) Inspection of Public Records Act;

(4) Public Records Act;

(5) Financial Disclosure Act;

(6) Accountability in Government Act;

(7) Gift Act; and

(8) Tort Claims Act; and

B. shall not be subject to the provisions of the Procurement Code or the Personnel Act.

SECTION 10. [NEW MATERIAL] CHIEF EXECUTIVE OFFICER--STAFF--CONTRACTS--BUDGETS.--

A. The commission shall appoint and set the salary

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of a "chief executive officer". The chief executive officer shall serve at the pleasure of the commission and has authority to carry on the day-to-day operations of the commission and the health security plan.

B. The chief executive officer shall employ those persons necessary to administer and implement the provisions of the Health Security Act.

C. The chief executive officer and the chief executive officer's staff shall implement the Health Security Act in accordance with that act and the rules adopted by the commission. The chief executive officer may delegate authority to employees and may organize the staff into units to facilitate its work.

D. If the chief executive officer determines that the commission staff or a state agency does not have the resources or expertise to perform a necessary task, the chief executive officer may contract for performance from a person who has a demonstrated capability to perform the task. The commission shall establish the standards and requirements by which a contract is executed by the commission or the chief executive officer. A contract shall be reviewed by the commission or the chief executive officer to ensure that it meets the criteria, performance standards, expectations and needs of the commission.

E. The chief executive officer shall prepare and

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submit an annual budget request and plan of operation to the commission for its approval. The chief executive officer shall provide at least quarterly status reports on the budget and advise of a potential shortfall as soon as practicably possible.

SECTION 11. [NEW MATERIAL] COMMISSION--GENERAL DUTIES.--The commission shall:

A. adopt a transition plan to ensure the seamless transition of health security plan beneficiaries from other sources of coverage, public and private. The transition plan shall ensure the proper assignment and payment of claims incurred on behalf of beneficiaries before the implementation of the health security plan;

B. by February 15, 2017, obtain legal counsel to advise the commission in the execution of its duties;

C. by April 1, 2017, adopt and promulgate rules for the procurement of goods and services. With the exception of audit-related services, rules relating to the procurement of goods and services shall provide for a preference for New Mexico vendors;

D. pursuant to federal law, apply for any federal waiver that the commission deems necessary to implement the health security plan;

E. design the health security plan to fulfill the purposes of and conform with the provisions of the Health

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Security Act;

F. provide a program to educate the public, health care providers and health facilities about the health security plan and the persons eligible to receive its benefits;

G. study and adopt as provisions of the health security plan cost-effective methods of providing quality health care to all beneficiaries, according high priority to increased reliance on:

(1) preventive and primary care that includes immunization and screening examinations;

(2) providing health care in rural or underserved areas of the state;

(3) in-home and community-based alternatives to institutional health care; and

(4) case management services when appropriate;

H. establish annual health security plan budgets and budgets for those projected future periods that the commission believes appropriate;

I. establish capital budgets for health facilities, limited to capital expenditures subject to the Health Security Act, and include and adopt in establishing those budgets:

(1) standards and procedures for determining the budgets; and

(2) a requirement for prior approval by the commission for major capital expenditures by a health facility;

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J. negotiate and enter into health care reciprocity agreements with out-of-state health care providers and negotiate and enter into other health care agreements with out-of-state health care providers and health facilities;

K. develop claims and payment procedures for health care providers, health facilities and claims administrators and include provisions to ensure timely payments and provide for payment of interest when reimbursable claims are not paid within a reasonable time;

L. establish, in conjunction with state agencies similarly charged, a comprehensive system to collect and analyze health care data, including claims data and other data, necessary to improve the quality, efficiency and effectiveness of health care and to control costs of health care in New Mexico, which system shall include data on:

(1) mortality, including accidental causes of death, and natality;

(2) morbidity;

(3) health behavior;

(4) physical and psychological impairment and disability;

(5) health care system costs and health care availability, utilization and revenues;

(6) environmental factors;

(7) availability, adequacy and training of

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health care personnel;

(8) demographic factors;

(9) social and economic conditions affecting health; and

(10) other factors determined by the commission;

M. standardize data collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for reporting health information;

N. foster a health care delivery system that is efficient to administer and that eliminates unnecessary administrative costs;

O. adopt rules necessary to implement and monitor a preferred drug list, bulk purchasing or other mechanism to provide prescription drugs and a pricing procedure for nonprescription drugs, durable medical equipment and supplies, eyeglasses, hearing aids and oxygen;

P. establish a pharmacy and therapeutics committee to:

(1) research federal and state incentives and discount programs for the purchase, manufacture or supply of drugs, biologics and medical equipment and supplies to maximize the health security plan's savings potential through these incentives and programs;

(2) establish a formulary of drugs and

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biologics that is in accordance with clinical best practices for safety, efficacy and effectiveness while, in strict observance of those best practices, maximizing fiscal soundness;

(3) conduct concurrent, prospective and retrospective drug utilization review;

(4) consult with specialists in appropriate fields of medicine for therapeutic classes of drugs;

(5) recommend therapeutic classes of drugs, including specific drugs within each class to be included in the preferred drug list;

(6) identify appropriate exclusions from the preferred drug list; and

(7) conduct periodic clinical reviews of preferred, nonpreferred and new drugs;

Q. study and evaluate the adequacy and quality of health care furnished pursuant to the Health Security Act, the cost of each type of service and the effectiveness of cost-containment measures in the health security plan;

R. in conjunction with the human services department, apply to the United States department of health and human services for all waivers of requirements under health care programs established pursuant to the federal Social Security Act that are necessary to enable the health security plan to receive federal payments for services rendered to

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medicaid or medicare beneficiaries;

S. except for those programs designated in Subsection B of Section 21 of the Health Security Act, identify other federal programs that provide federal funds for payment of health care services to individuals and apply for any waivers or enter into any agreements that are necessary for services covered by the health security plan; provided, however, that agreements negotiated with the federal Indian health service or tribal governments shall not impair treaty obligations of the United States government and that other agreements negotiated shall not impair portability or other aspects of the health care coverage;

T. seek an amendment to the federal Employee Retirement Income Security Act of 1974 to exempt New Mexico from the provisions of that act that relate to health care services or health insurance, or apply to the appropriate federal agency for waivers of any requirements of that act if congress provides for waivers to enable the commission to extend coverage through the Health Security Act to as many New Mexicans as possible; provided, however, that the amendment or waiver requested shall not impair portability or other aspects of the health care coverage;

U. analyze developments in federal law and regulation relevant to the health security plan, and provide updates and any legislative recommendations to the legislature

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that the commission deems necessary pursuant to those developments;

V. work with the counties to determine the expenditure of funds generated pursuant to the Indigent Hospital and County Health Care Act and the Statewide Health Care Act;

W. seek to maximize federal contributions and payments for health care services provided in New Mexico and ensure that the contributions of the federal government for health care services in New Mexico will not decrease in relation to other states as a result of any waivers, exemptions or agreements;

X. study and monitor the migration of persons to New Mexico to determine if persons with costly health care needs are moving to New Mexico to receive health care and, if migration appears to threaten the financial stability of the health security plan, recommend to the legislature changes in eligibility requirements, premiums or other changes that may be necessary to maintain the financial integrity of the health security plan;

Y. collaborate with state agencies and experts to study and evaluate health care work force data and research, and information solicited from health care providers and health care work force experts, on the effect of the health security plan on the state's provider community. This shall include the

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study and evaluation of the supply of health care providers in the state and providers' ability to provide high-quality health care under the health security plan;

Z. study and evaluate the cost of health care provider professional liability insurance and its impact on the price of health care services and recommend changes to the legislature as necessary;

AA. establish and approve changes in coverage services and service standards in the health security plan in compliance with federal and state law;

BB. conduct necessary investigations and inquiries;

CC. adopt rules necessary to implement, administer and monitor the operation of the health security plan;

DD. designate a Native American liaison who shall:

(1) serve on the Native American advisory board established pursuant to Subsection A of Section 13 of the Health Security Act;

(2) assist the commission in developing and ensuring implementation of communication and collaboration between the commission and Native Americans in the state;

(3) serve as a contact person between the commission and New Mexico Indian nations, tribes and pueblos; and

(4) ensure that training is provided to the staff of the commission, which may include training in:

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(a) cultural competency;

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

(c) other matters relating to the functions of the health security plan with respect to Native Americans in the state;

EE. report at least once annually to the legislature and the governor on the commission's activities and the operation of the health security plan and include in the annual report:

(1) a summary of information about health care needs, health care services, health care expenditures, revenues received and projected revenues and other relevant issues relating to the health security plan; and

(2) recommendations on methods to control health care costs and improve access to and the quality of health care for state residents, as well as recommendations for legislative action; and

FF. provide at least one annual training for its members on health care coverage, policy and financing.

SECTION 12. [NEW MATERIAL] COMMISSION--AUTHORITY.--The commission has the authority necessary to carry out the powers and duties pursuant to the Health Security Act. The commission retains responsibility for its duties but may delegate authority to the chief executive officer; provided, however,

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that only the commission may:

A. approve the commission's budget and plan of operation;

B. approve the health security plan and make changes in the health security plan;

C. make rules and conduct both rulemaking and adjudicatory hearings in person or by use of a hearing officer;

D. issue subpoenas to persons to appear and testify before the commission and to produce documents and other information relevant to the commission's inquiry and enforce this subpoena power through an action in a state district court;

E. make reports and recommendations to the legislature;

F. subject to the prohibitions and restrictions of Section 21 of the Health Security Act, apply for program waivers from any governmental entity if the commission determines that the waivers are necessary to ensure the participation by the greatest possible number of beneficiaries;

G. apply for and accept grants, loans and donations;

H. acquire or lease real property and make improvements on it and acquire by lease or by purchase tangible and intangible personal property;

I. dispose of and transfer personal property, but

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only at public sale after adequate notice;

J. appoint and prescribe the duties of employees, fix their compensation, pay their expenses and provide an employee benefit program;

K. establish and maintain banking relationships, including establishment of checking and savings accounts;

L. participate as a qualified entity in the programs of the New Mexico finance authority; and

M. enter into agreements with an employer, group or other plan to provide health care services for the employer's employees or retirees; provided, however, that nothing in the Health Security Act shall be construed to reduce or eliminate services to which the employee or retiree is entitled.

SECTION 13. [NEW MATERIAL] ADVISORY BOARDS.--

A. The commission shall establish the following in matters requiring the expertise and knowledge of the advisory boards' members:

(1) a "health care provider advisory board" made up of health care providers;

(2) a "health facility advisory board" made up of representatives of health facilities; and

(3) a "Native American advisory board" made up of Native Americans, some of whom live on a reservation and some of whom do not live on a reservation, and the Native American liaison established pursuant to Subsection DD of

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Section 11 of the Health Security Act. The Native American advisory board shall make recommendations to the commission on:

(a) matters relating to Native American beneficiaries; and

(b) agreements between the commission and tribal governments.

B. The commission may establish advisory boards in addition to the advisory boards established pursuant to Subsection A of this section to assist the commission in performing its duties.

C. The commission shall not appoint to an advisory board:

(1) more than two members of the commission;

(2) more than five persons who are not members of the commission; or

(3) a person who represents or who has a controlling interest, direct or indirect, in a person licensed to provide health insurance in the state.

D. Except for the members of the health care provider advisory board and the health facility advisory board, no more than two members of any advisory board shall represent or have a controlling interest, direct or indirect, in a health care provider or a health facility.

E. Advisory board members may be paid per diem and mileage equal to the rate at which state legislators are

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reimbursed in accordance with the provisions of the Per Diem and Mileage Act.

F. Staff and technical assistance for advisory boards shall be provided by the commission as necessary.

SECTION 14. [NEW MATERIAL] HEALTH CARE DELIVERY REGIONS.--The commission shall establish health care delivery regions in the state, based on geography and health care resources. The regions may have differential fee schedules, budgets, capital expenditure allocations or other features to encourage the provision of health care in rural and other underserved areas or to tailor otherwise the delivery of health care to fit the needs of a region or a part of a region.

SECTION 15. [NEW MATERIAL] REGIONAL COUNCILS.--

A. The commission shall designate regional councils in the designated health care delivery regions. In selecting persons to serve as members of regional councils, the commission shall consider the comments and recommendations of persons in the region who are knowledgeable about health care and the economic and social factors affecting the region.

B. The regional councils shall be composed of the commission members who live in the region and five other members who live in the region and are appointed by the commission. No more than two noncommission council members shall have a controlling interest, direct or indirect, in a person providing health care. The commission shall not appoint

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to a regional council an individual who is, or whose household contains an individual who is, employed by or an officer of or who has a controlling interesting in a person licensed to provide health insurance, directly or as an agent of a health insurer.

C. Members of a regional council may be paid per diem and mileage equal to the rate at which state legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act.

D. The regional councils shall hold public hearings to receive comments, suggestions and recommendations from the public regarding regional health care needs. The councils shall report to the commission at times specified by the commission to ensure that regional concerns are considered in the development and update of short- and long-range plans and projections, fee schedules, budgets and capital expenditure allocations.

E. Staff technical assistance for the regional councils shall be provided by the commission.

SECTION 16. [NEW MATERIAL] RULEMAKING.--

A. The commission shall adopt rules necessary to carry out the duties of the commission and the provisions of the Health Security Act.

B. The commission shall not adopt, amend or repeal any rule affecting a person outside the commission without a

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public hearing on the proposed action before the commission or a hearing officer designated by the commission. The hearing officer may be a member of the commission's staff. The hearing shall be held in a county that the commission determines would be in the interest of those affected. Notice of the subject matter of the rule, the action proposed to be taken, the time and place of the hearing, the manner in which interested persons may present their views and the method by which copies of the proposed rule or an amendment or repeal of an existing rule may be obtained shall be published once at least thirty days prior to the hearing date on a publicly accessible web site that the commission establishes and maintains and in media outlets throughout the state. Notice shall also be published in an informative nonlegal format in one newspaper published in each health care delivery region and mailed at least thirty days prior to the hearing date to all persons who have made a written request for advance notice of hearing.

C. All rules adopted by the commission shall be filed in accordance with the State Rules Act.

SECTION 17. [NEW MATERIAL] HEALTH SECURITY PLAN.--

A. The commission shall design the health security plan to provide comprehensive, necessary and appropriate health care services, including but not limited to the "minimum essential health benefits" required under federal and state law. The commission may establish additional preventive health

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care and primary, secondary and tertiary health care for acute and chronic conditions.

B. Covered health care services shall not include:

(1) surgery for cosmetic purposes other than for reconstructive purposes;

(2) medical examinations and medical reports prepared for purchasing or renewing life insurance or participating as a plaintiff or defendant in a civil action for the recovery or settlement of damages; and

(3) orthodontic services and cosmetic dental services except those cosmetic dental services necessary for reconstructive purposes.

C. The health security plan shall specify the health care to be covered and the amount, scope and duration of services.

D. The health security plan shall contain provisions to control health care costs so that beneficiaries receive comprehensive, high-quality health care consistent with available revenue and budget constraints.

E. The health security plan shall phase in eligibility for beneficiaries as their participation becomes possible through contracts, waivers or federal legislation. The health security plan may provide for certain preventive health care to be offered to all New Mexicans regardless of a person's eligibility to participate as a beneficiary.

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SECTION 18. [NEW MATERIAL] LONG-TERM CARE.--

A. No later than one year after the effective date of the operation of the health security plan, the commission shall appoint an advisory "long-term care committee" made up of representatives of health care consumers, family members of consumers, providers and administrators to develop a plan for integrating long-term care into the health security plan. The committee shall report its plan to the commission no later than one year from its appointment. Committee members may receive per diem and mileage as provided in the Per Diem and Mileage Act.

B. The long-term care component of the health security plan shall provide for case management and noninstitutional services when appropriate.

C. Nothing in this section affects long-term care services paid through private insurance or state or federal programs subject to the provisions of Section 39 of the Health Security Act.

SECTION 19. [NEW MATERIAL] MENTAL AND BEHAVIORAL HEALTH SERVICES--PARITY.--

A. No later than one year after the effective date of the operation of the health security plan, the commission shall appoint an advisory "mental and behavioral health services committee" made up of representatives of mental and behavioral health care consumers, family members of consumers,

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providers and administrators to develop a plan for coordinating mental and behavioral health services within the health security plan. The committee shall report its plan to the commission no later than one year from its appointment. Committee members may receive per diem and mileage as provided in the Per Diem and Mileage Act.

B. The commission shall ensure that the health security plan conforms to federal and state mental and behavioral health services parity laws.

C. The mental and behavioral health services component of the health security plan shall provide, where appropriate, for:

(1) inpatient crisis evaluation services;

(2) inpatient residential substance abuse treatment services without a step therapy requirement; and

(3) case management, care coordination and noninstitutional services.

D. Nothing in this section limits mental and behavioral health services paid through private insurance or state or federal programs subject to the provisions of Section 39 of the Health Security Act.

SECTION 20. [NEW MATERIAL] MEDICAID COVERAGE--AGREEMENTS.--The commission may enter into appropriate agreements with the human services department, another state agency or a federal agency for the purpose of furthering the

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goals of the Health Security Act. These agreements may provide for certain services provided pursuant to the medicaid program under Title 19 or Title 21 of the federal Social Security Act and any waiver or provision of that act to be administered by the commission to implement the health security plan.

SECTION 21. [NEW MATERIAL] HEALTH SECURITY PLAN COVERAGE--CONDITIONS OF ELIGIBILITY FOR BENEFICIARIES--EXCLUSIONS.--

A. An individual is eligible as a beneficiary of the health security plan if the individual has been physically present in New Mexico for one year prior to the date of application for enrollment in the health security plan and if the individual has a current intention to remain in New Mexico and not to reside elsewhere. A dependent of an eligible individual is included as a beneficiary.

B. Individuals covered under the following governmental programs shall not be brought into coverage:

(1) federal retiree health plan beneficiaries;

(2) active duty and retired military personnel; and

(3) individuals covered by the federal active and retired military health programs.

C. Federal Indian health service or tribally operated health care program beneficiaries shall not be brought into coverage except through agreements with:

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(1) Indian nations, tribes or pueblos;

(2) consortia of tribes or pueblos; or

(3) a federal Indian health service agency subject to the approval of the tribes or pueblos located in that agency.

D. If an individual is ineligible due to the residence requirement, the individual may become eligible by paying the premium required by the health security plan for coverage for the period of time up to the date the individual fulfills that requirement if the individual is an employee who physically resides and intends to reside in the state because of employment offered to the individual in New Mexico while the individual was residing elsewhere as demonstrated by furnishing that evidence of those facts required by rule adopted by the commission.

E. An employer, group or other plan that provides health care benefits for its employees after retirement, including coverage for payment of health care supplementary coverage if the retiree is eligible for medicare, may agree to participate in the health security plan, provided that there is no loss of benefits under the retiree health benefit coverage. An employer, group or other plan that participates in the health security plan shall contribute to the health security plan for the benefit of the retiree, and the agreement shall ensure that the health benefit coverage for the retiree shall

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be restored in the event of the retiree's ineligibility for health security plan coverage.

F. The commission shall prescribe by rule conditions under which other persons in the state may be eligible for coverage pursuant to the health security plan.

SECTION 22. [NEW MATERIAL] HEALTH SECURITY PLAN COVERAGE OF NONRESIDENT STUDENTS.--

A. Except as provided in Subsection B of this section, an educational institution shall purchase coverage under the health security plan for its nonresident students through fees assessed to those students. The governing body of an educational institution shall set the fees at the amount determined by the commission.

B. A nonresident student at an educational institution may satisfy the requirement for health care coverage by proof of coverage under a policy or plan in another state that is acceptable to the commission. The student shall not be assessed a fee in that case.

C. The commission shall adopt rules to determine proof of an individual's eligibility for the health security plan or a student's proof of nonresident health care coverage.

SECTION 23. [NEW MATERIAL] REMOVING INELIGIBLE PERSONS.--The commission shall adopt rules to provide procedures for removing persons no longer eligible for coverage.

SECTION 24. [NEW MATERIAL] ELIGIBILITY CARD--USE--

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PENALTIES FOR MISUSE.--

A. A beneficiary shall receive a card as proof of eligibility. The card shall be electronically readable and shall contain a photograph or electronic image of the beneficiary, information that identifies the beneficiary for treatment and billing, payment and other information the commission deems necessary. The use of a beneficiary's social security number as an identification number is not permitted.

B. The eligibility card is not transferable. A beneficiary who lends the beneficiary's card to another and an individual who uses another's card shall be jointly and severally liable to the commission for the full cost of the health care provided to the user. The liability shall be paid in full within one year of final determination of liability. Liabilities created pursuant to this section shall be collected in a manner similar to that used for collection of delinquent taxes.

C. A beneficiary who lends the beneficiary's card to another or an individual who uses another's card after being determined liable pursuant to Subsection B of this section of a previous misuse is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978. A third or subsequent conviction is a fourth degree felony, and the offender shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

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SECTION 25. [NEW MATERIAL] PRIMARY CARE PROVIDER--RIGHT TO CHOOSE--ACCESS TO SERVICES.--

A. Except as provided in the Workers' Compensation Act, a beneficiary has the right to choose a primary care provider.

B. The primary care provider is responsible for providing health care provider services to the patient except for:

(1) services in medical emergencies; and

(2) services for which a primary care provider determines that specialist services are required, in which case the primary care provider shall advise the patient of the need for and the type of specialist services.

C. Except as otherwise provided in this section, health care provider specialists shall be paid pursuant to the health security plan only if the patient has been referred by a primary care provider. Nothing in this subsection prevents a beneficiary from obtaining the services of a health care provider specialist and paying the specialist for services provided.

D. The commission shall by rule specify when and under what circumstances a beneficiary may self-refer, including self-referral to a chiropractic physician, a doctor of oriental medicine, mental and behavioral health service providers and other health care providers who are not primary

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care providers.

E. The commission shall by rule specify the conditions under which a beneficiary may select a specialist as a primary care provider.

SECTION 26. [NEW MATERIAL] DISCRIMINATION PROHIBITED.--A health care provider or health facility shall not discriminate against or refuse to furnish health care to a beneficiary on the basis of age, race, color, income level, national origin, religion, gender, sexual orientation, disabling condition or payment status. Nothing in this section shall require a health care provider or health facility to provide services to a beneficiary if the provider or facility is not qualified to provide the needed services or does not offer them to the general public.

SECTION 27. [NEW MATERIAL] BENEFICIARY RIGHTS--CLAIMS REVIEW--INTERNAL APPEALS--EXTERNAL APPEALS--GRIEVANCES.--

A. The commission shall adopt and promulgate rules to provide for:

(1) a system of service claim review pursuant to which any final decision shall be made by a health professional qualified and legally authorized to make the determination. The service claim review system shall include an internal and external appeals process for adverse determinations of service claims, including:

(a) a determination that a service is

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not medically necessary;

(b) a denial of coverage for a service because it is determined to be experimental, investigational or inappropriate; and

(c) any other determination that results in a denial of, or partial payment for, a service claim;

(2) expedited appeals of adverse determinations of service claims, including the grounds for expedited appeals and the time lines for hearing and decisions on expedited appeals;

(3) procedures and evidentiary rules relating to the internal appeals process;

(4) a beneficiary's right to continue to receive services that are the subject of an appeal and that the beneficiary was receiving before the beneficiary filed the appeal; and

(5) a beneficiary's right to emergency services that are immediately available without prior authorization requirements and appropriate out-of-state emergency services that are not subject to additional cost to the beneficiary.

B. The commission shall adopt and promulgate rules to provide beneficiaries with a prompt and fair grievance procedure for resolving patient complaints and for addressing patient questions and concerns relating to any aspect of the

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health security plan not relating to the service claim review system.

C. Within a reasonable time after enrollment and at subsequent periodic times as the commission deems appropriate, the health security plan shall provide beneficiaries with written materials that contain, in a clear, conspicuous and readily understandable form, a full disclosure of:

(1) the health security plan's covered services, limitations and exclusions;

(2) conditions of eligibility;

(3) prior authorization requirements;

(4) rights to appeals of adverse service claim determinations and to grievance procedures, including but not limited to:

(a) a beneficiary's right to have a service claim denial, reduction or termination communicated promptly in writing;

(b) a beneficiary's right to review the beneficiary's file and to present evidence and testimony as part of the appeals and grievance processes;

(c) the availability of the office of the ombudsman at the office of superintendent of insurance to assist beneficiaries with appeals and grievances;

(d) a beneficiary's right to continue to receive services that are the subject of an appeal and that the

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beneficiary was receiving before the beneficiary filed the appeal; and

(e) a beneficiary's right to have the outcome of an appeal or grievance communicated promptly in writing; and

(5) a beneficiary's right to emergency services that are immediately available without prior authorization requirements and appropriate out-of-state emergency services that are not subject to additional costs to the beneficiary.

D. The superintendent shall adopt and promulgate rules to establish an external appeals process for review of beneficiary service claim appeals in accordance with the provisions of the Health Security Act.

E. The superintendent shall appoint one or more qualified individuals to review external service claim appeals. The superintendent shall fix the reasonable compensation of each appointee based upon, but not limited to, compensation amounts suggested by national or state legal or medical professional societies, organizations or associations. The commission shall pay the compensation directly to each appointee who participated in the external grievance appeal review.

F. Upon completion of the external service claim appeal review, the superintendent shall prepare a detailed

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statement of compensation due each appointee and shall present the statement to the beneficiary and the commission.

G. The decision to approve or deny a service claim based on a technicality shall be made in a timely manner and shall not exceed time limits established by rule of the commission.

H. The fact of and the specific reasons for a denial of a service claim shall be communicated promptly in writing to both the provider and the beneficiary involved.

SECTION 28. [NEW MATERIAL] QUALITY OF CARE--HEALTH CARE PROVIDER AND HEALTH FACILITIES--PRACTICE STANDARDS.--

A. The commission shall adopt rules to establish and implement a quality improvement program that monitors the quality and appropriateness of health care provided by the health security plan, including evidence-based medicine, best practices, outcome measurements, consumer education and patient safety. The commission shall set standards and review benefits to ensure that effective, cost-efficient, high-quality and appropriate health care is provided under the health security plan.

B. The commission shall establish a quality improvement program. The quality improvement program shall include an ongoing system for monitoring patterns of practice. Pursuant to the quality improvement program, the commission shall review and adopt professional practice guidelines

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developed by state and national medical and specialty organizations, federal agencies for health care policy and research and other organizations as it deems necessary to promote the quality and cost-effectiveness of health care provided through the health security plan.

C. The commission shall appoint a "health care practice advisory committee" consisting of health care providers, health facilities and other knowledgeable persons to advise the commission and staff on health care practice issues. The committee shall include both health care providers and health facilities from counties having fifty thousand or fewer inhabitants as of the most recent federal decennial census and health care providers and health facilities from counties having more than fifty thousand inhabitants as of the most recent federal decennial census. The committee may appoint subcommittees and task forces to address practice issues of a specific health care provider discipline or a specific kind of health facility, provided that the subcommittee or task force includes providers of substantially similar specialties or types of facilities. The advisory committee shall provide to the commission recommended standards and guidelines to be followed in making determinations on practice issues.

D. With the advice of the health care practice advisory committee, the commission shall establish a system of peer education for health care providers or health facilities

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determined to be engaging in aberrant patterns of practice pursuant to Subsection B of this section. If the commission determines that peer education efforts have failed, the commission may refer the matter to the appropriate licensing or certifying board.

E. The commission may provide by rule for the assessment of administrative penalties for up to three times the amount of excess payments if it finds that excessive billings were part of an aberrant pattern of practice. Administrative penalties shall be deposited in the current school fund.

F. After consultation with the health care practice advisory committee, the commission may suspend or revoke a health care provider's or health facility's privilege to be paid for health care provided under the health security plan based upon evidence clearly supporting a determination by the commission that the provider or facility engages in aberrant patterns of practice, including inappropriate utilization, attempts to unbundle health care services or other practices that the commission deems a violation of the Health Security Act or rules adopted pursuant to that act. As used in this subsection, "unbundle" means to divide a service into components in an attempt to increase, or with the effect of increasing, compensation from the health security plan.

G. The commission shall report a suspension or

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revocation of the privilege to be paid for health care pursuant to the Health Security Act to the appropriate licensing or certifying board.

H. The commission shall report cases of suspected fraud by a health care provider or a health facility to the attorney general for investigation and prosecution. The office of the attorney general has independent authority to investigate and prosecute suspected fraud without a prior commission report of fraud.

SECTION 29. [NEW MATERIAL] HEALTH CARE PROVIDER AND HEALTH FACILITY RIGHTS--DISPUTE RESOLUTION--GRIEVANCE PROCEDURES--RULEMAKING.--

A. The health security plan shall not:

(1) adopt a gag rule or practice that prohibits a health care provider or health facility from discussing a treatment option with a beneficiary even if the health security plan does not approve of the option;

(2) include in any of its contracts with health care providers or health facilities any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to a beneficiary; or

(3) require a health care provider or health facility to violate any recognized fiduciary duty of the health care provider's profession or place the health care provider's or health facility's license in jeopardy.

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B. If the health security plan proposes to make an adverse determination affecting the participation of a health care provider or health care facility in the health security plan, it shall explain in writing the rationale for its proposed adverse determination and deliver reasonable advance written notice to the provider or facility prior to the proposed effective date of the termination.

C. The commission shall adopt and promulgate rules to implement a dispute resolution system, and include in each contract with a health care provider or a health facility a dispute resolution provision, to permit the provider or facility to dispute:

(1) a denial of, or partial payment for, a service that the health care provider or health facility has rendered to a beneficiary; or

(2) the existence of adequate cause to terminate the provider's or facility's participation in the plan when the termination is made for cause.

D. The commission shall adopt and promulgate rules to implement procedures pursuant to which a health care provider or a health facility may file a grievance relating to administration of the plan. The rules shall provide, at a minimum, the provider or facility with the right to present to the commission a grievance and evidence to support that grievance. A grievance may relate to:

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(1) the quality of and access to health care services; or

(2) the choice of health care providers and health facilities under the plan.

E. As used in this section, "adverse determination" means any of the following actions against a health care provider or health facility:

(1) restriction of or termination from participation in the health security plan;

(2) the recoupment of payment; or

(3) the assessment of an administrative penalty.

SECTION 30. [NEW MATERIAL] HEALTH SECURITY PLAN BUDGET--PREMIUM RATES--EMPLOYER CONTRIBUTIONS.--

A. Annually, the commission shall develop a health security plan budget. The budget shall be the commission's recommendation for the total amount to be spent by the plan for covered health care services in the next fiscal year.

B. The superintendent shall adopt and promulgate rules for the establishment or modification of premium rates and employer contribution rates. The rules shall include, at a minimum, provisions for:

(1) the transparency of rate filings;

(2) grounds for the establishment or modification of rates;

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(3) the issuance of findings by the superintendent;

(4) procedures pursuant to which the commission or a member of the public may obtain a redetermination of the superintendent's findings; and

(5) procedures pursuant to which the commission or a member of the public may appeal a redetermination of the superintendent's findings in a court of competent jurisdiction.

C. In developing the health security plan budget, the commission shall provide that credit be taken in the budget for all revenues produced for health care in the state pursuant to any law other than the Health Security Act.

D. The health security plan shall include a maximum amount or percentage for administrative costs, and this maximum, if a percentage, may change in relation to the total costs of services provided under the health security plan. For the sixth and subsequent calendar years of operation of the health security plan, administrative costs shall not exceed five percent of the health security plan budget.

SECTION 31. [NEW MATERIAL] PAYMENTS TO HEALTH CARE PROVIDERS.--

A. The commission shall prepare a budget to provide payment for all covered health care services rendered by health care providers. The commission may adopt a variety of payment

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systems, including fee-for-service or shared incentives. The commission shall negotiate payment with providers as provided by rule and in accordance with federal antitrust law. In the event that negotiation fails to develop an acceptable payment plan, the disputing parties shall submit the dispute for resolution pursuant to Section 29 of the Health Security Act.

B. Supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care in rural and other underserved areas throughout the state.

C. An annual percentage increase in the amount allocated for provider payments in the budget shall be no greater than the annual percentage increase in the consumer price index for medical care prices published by the bureau of labor statistics of the federal department of labor using the year prior to the year in which the health security plan is implemented as the baseline year. The annual limitation in this subsection may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

D. Payment, or the offer of payment whether or not that offer is accepted, to a health care provider for services covered by the health security plan shall be payment in full for those services. A health care provider shall not charge a beneficiary an additional amount for services covered by the plan.

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SECTION 32. [NEW MATERIAL] PAYMENTS TO HEALTH FACILITIES--COPAYMENTS.--

A. A health facility shall negotiate an annual operating budget with the commission. The operating budget shall be based on a base operating budget of past performance and projected changes upward or downward in costs and services anticipated for the next year. If a negotiated annual operating budget is not agreed upon, a health facility shall submit the budget to dispute resolution pursuant to Section 29 of the Health Security Act. An annual percentage increase in the amount allocated for a health facility operating budget shall be no greater than the change in the annual consumer price index for medical care prices, published annually by the bureau of labor statistics of the federal department of labor. The annual limitation in this subsection may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

B. Supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care services in rural and other underserved areas throughout the state.

C. Each health care provider employed by a health facility shall be paid from the facility's operating budget in a manner determined by the health facility.

SECTION 33. [NEW MATERIAL] BENEFICIARY COPAYMENTS--

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PREVENTIVE SERVICES--OUT-OF-STATE SERVICES--THIRD-PARTY PAYMENTS--ASSIGNMENT OF CLAIMS.--

A. The commission may establish a copayment schedule if a required copayment is determined to be an effective cost-control measure. A copayment shall not be required for preventive health care services, as the commission defines "preventive health care services" by rule in accordance with state and federal law. When a copayment is required, a health care provider or health facility shall not waive it, and if it remains uncollected, the provider or facility shall demonstrate a good-faith effort to collect the copayment.

B. A beneficiary may obtain health care services covered by the health security plan out of state; provided, however, that the services shall be reimbursed at:

(1) the same rate that would apply if those services had been received in New Mexico; or

(2) a rate higher than the reimbursement rate the health security plan would have paid if the services had been received in New Mexico if the commission negotiates a reimbursement agreement or other agreement with:

(a) the state in which the health care services were received; or

(b) the health care provider or health facility rendering the services.

C. The health security plan shall make reasonable

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efforts to ascertain any legal liability of third-party persons that are or may be liable to pay all or part of the health care services costs of injury, disease or disability of a beneficiary.

D. When the health security plan makes payments on behalf of a beneficiary, the health security plan is subrogated to any right of the beneficiary against a third party for recovery of amounts paid by the health security plan.

E. By operation of law, an assignment to the health security plan of the rights of a beneficiary:

(1) is conclusively presumed to be made of:

(a) a payment for health care services from any person, including an insurance carrier; and

(b) a monetary recovery for damages for bodily injury, whether by judgment, contract for compromise or settlement;

(2) shall be effective to the extent of the amount of payments by the health security plan; and

(3) shall be effective as to the rights of any other beneficiary whose rights can legally be assigned by the beneficiary.

SECTION 34. [NEW MATERIAL] STANDARD CLAIM FORMS FOR INSURANCE PAYMENT.--The commission shall adopt standard claim forms and electronic formats that shall be used by all health care providers and health facilities that seek payment through

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the health security plan or from private persons, including private insurance companies, for health care services rendered in the state. Each claim form or electronic format may indicate whether a person is eligible for federal or other insurance programs for payment. To the extent practicable, the commission shall require the use of existing, nationally accepted standardized forms, formats and systems.

SECTION 35. [NEW MATERIAL] HEALTH RESOURCE CERTIFICATE--COMMISSION RULES--REQUIREMENT FOR REVIEW.--

A. The commission shall adopt rules stating when a health facility or health care provider participating in the health security plan shall apply for a health resource certificate, how the application will be reviewed, how the certificate will be granted, how an expedited review is conducted and other matters relating to health resource projects.

B. Except as provided in Subsection F of this section, a health facility or health care provider participating in the health security plan shall not make or obligate itself to make a major capital expenditure without first obtaining a health resource certificate.

C. A health facility or health care provider shall not acquire through rental, lease or comparable arrangement or through donation all or a part of a capital project that would have required review if the acquisition had been by purchase

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unless the project is granted a health resource certificate.

D. A health facility or health care provider shall not engage in component purchasing in order to avoid the provisions of this section.

E. The commission shall grant a health resource certificate for a major capital expenditure or a capital project undertaken pursuant to Subsection C of this section only when the project is determined to be needed.

F. This section does not apply to:

(1) the purchase, construction or renovation of office space for health care providers;

(2) expenditures incurred solely in preparation for a capital project, including architectural design, surveys, plans, working drawings and specifications and other related activities, but those expenditures shall be included in the cost of a project for the purpose of determining whether a health resource certificate is required;

(3) acquisition of an existing health facility, equipment or practice of a health care provider that does not result in a new service being provided or in increased bed capacity;

(4) major capital expenditures for nonclinical services when the nonclinical services are the primary purpose of the expenditure; and

(5) the replacement of equipment with

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equipment that has the same function and that does not result in the offering of new services.

G. No later than November 1, 2017, the commission shall report to the appropriate committees of the legislature on the capital needs of health facilities, including facilities of state and local governments, with a focus on underserved geographic areas with substantially below-average health facilities and investment per capita as compared to the state average. The report shall also describe geographic areas where the distance to health facilities imposes a barrier to care. The report shall include a section on health care transportation needs, including capital, personnel and training needs. The report shall make recommendations for legislation to amend the Health Security Act that the commission determines necessary and appropriate.

SECTION 36. [NEW MATERIAL] FISCAL AND ACTUARIAL REVIEWS--AUDITS.--

A. The commission shall provide for annual independent fiscal and actuarial reviews of the health security plan and any funds of the commission or the plan.

B. The commission shall provide by rule requirements for independent financial audits of health care providers and health facilities.

C. The commission, through its staff or by contract, shall perform announced and unannounced reviews,

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including financial, operational, management and electronic data processing reviews of health care providers and health facilities. Review findings shall be reported directly to the commission. The commission may request the state auditor to review preliminary findings or to consult with review staff before the findings are reported to the commission.

D. Actuarial review, fiscal reviews, financial audits and internal audits are public documents after they have been released by the commission, provided that the reports protect private and confidential information of a patient or provider. Copies of reviews, audits and other reports shall be transmitted to the governor, the legislature, appropriate interim committees of the legislature and the office of the state auditor as well as made available via the internet.

SECTION 37. [NEW MATERIAL] INFORMATION TECHNOLOGY SYSTEM.--The commission shall establish guidelines for maximizing participation of health care providers and health facilities in the health security plan's information technology network that provides for electronic transfer of payments to health care providers and health facilities; transmittal of reports, including patient data and other statistical reports; billing data, with specificity as to procedures or services provided to individual patients; and any other information required or requested by the commission. To the extent practicable, the commission shall require the use of existing,

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nationally accepted standardized forms, formats and systems.

SECTION 38. [NEW MATERIAL] REPORTS REQUIRED--CONFIDENTIAL INFORMATION.--

A. The commission shall require reports by all health care providers and health facilities of information needed to allow the commission to evaluate the health security plan, cost-containment measures, utilization review, health facility operating budgets, health care provider fees and any other information the commission deems necessary to carry out its duties pursuant to the Health Security Act.

B. The commission shall establish uniform reporting requirements for health care providers and health facilities.

C. Information confidential pursuant to other provisions of law shall be confidential pursuant to the Health Security Act. Within the constraints of confidentiality, reports of the commission are public documents.

SECTION 39. [NEW MATERIAL] CONSUMER, PROVIDER AND HEALTH FACILITY ASSISTANCE PROGRAM.--

A. The commission shall establish a consumer, health care provider and health facility assistance program to take complaints and to provide timely and knowledgeable assistance to:

(1) eligible persons and applicants about their rights and responsibilities and the coverages provided in accordance with the Health Security Act; and

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(2) health care providers and health facilities about the status of claims, payments and other pertinent information relevant to the claims payment process.

B. The commission shall establish a toll-free telephone line and publicly accessible web site for the consumer, health care provider and health facility assistance program and shall have persons available throughout the state to assist beneficiaries, applicants, health care providers and health facilities in person.

SECTION 40. [NEW MATERIAL] PRIVATE HEALTH INSURANCE COVERAGE LIMITED--VOLUNTARY PURCHASE OF OTHER INSURANCE.--

A. After the date on which the health security plan begins operating:

(1) a beneficiary may purchase supplemental health insurance benefits; and

(2) a person shall not provide private health insurance to a beneficiary for a health care service that is covered by the health security plan, except as follows:

(a) transitional coverage as provided in Section 45 of the Health Security Act; and

(b) a retiree health insurance plan that does not enter into contract with the health security plan.

B. Nothing in this section affects insurance coverage pursuant to the federal Employee Retirement Income Security Act of 1974 unless the state obtains a congressional

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exemption or a waiver from the federal government. Health coverage plans that are covered by the provisions of that act may elect to participate in the health security plan.

C. Nothing in the Health Security Act shall be construed to prohibit the voluntary purchase of insurance coverage for health care services not covered by the health security plan or for individuals not eligible for coverage under the health security plan.

SECTION 41. [NEW MATERIAL] AUTOMOBILE MEDICAL COVERAGE--WORKERS' COMPENSATION--RATES--SUPERINTENDENT DUTIES.--

A. The superintendent shall work closely with the legislative finance committee pursuant to Section 42 of the Health Security Act to identify premium costs associated with health care coverage in workers' compensation and automobile medical coverage. The superintendent shall develop an estimate of expected reduction in those costs based upon assumptions of health care services coverage in the health security plan and, by September 15, 2015, shall report the findings to the legislative finance committee to determine the financing of the health security plan.

B. The superintendent shall ensure that workers' compensation and automobile insurance premiums on insurance policies written in New Mexico reflect a lower rate to account for the medical payment component to be assumed by the health

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security plan.

SECTION 42. [NEW MATERIAL] FISCAL ANALYSIS--FINANCING THE HEALTH SECURITY PLAN.--

A. The legislative finance committee shall undertake a fiscal analysis relating to the first five years of the health security plan's establishment and operation. The fiscal analysis shall include a projection of plan costs and a review of financing options for the health security plan.

B. In its fiscal analysis performed pursuant to Subsection A of this section, the legislative finance committee shall be guided by the following requirements and assumptions:

(1) before estimating beneficiary and employer contributions to the health security plan budget, the committee shall identify and estimate the amount of public finances that may be contributed to the plan budget;

(2) health care services to be included and for which costs are to be projected in determining the financing options shall be no less than the health care services afforded to state employees pursuant to the Health Care Purchasing Act;

(3) financing options may set minimum and maximum levels of costs to a beneficiary based on the following factors, as they apply to a given beneficiary:

(a) the beneficiary's income;

(b) federal premium tax credits;

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(c) federal cost-sharing subsidies; and

(d) medicare offsets; and

(4) financing options may set minimum and maximum levels of employer contributions, taking into consideration an employer's payroll and number of employees.

C. The legislative finance committee shall:

(1) make projections regarding the impact of the health security plan upon the state budget;

(2) project the costs of establishing and administering the health security plan;

(3) prepare a report of its determinations with the specific options and recommendations no later than November 2, 2015; and

(4) submit its report prepared pursuant to Paragraph (3) of this subsection to the appropriate interim legislative committees for consideration by the fifty-second legislature.

D. The commission shall reimburse the legislative finance committee for any state funds it expended in undertaking the fiscal analysis pursuant to this section.

SECTION 43. [NEW MATERIAL] GRANT FUNDING AND OTHER RESOURCES--PARTNERSHIPS.--The legislative finance committee shall seek partnerships among state agencies and private nonprofit persons to identify and apply for available grant funding and other in-kind and financial resources for its study

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of financing options for the health security plan pursuant to Section 41 of the Health Security Act. Any amounts received in grant funds or from other financial resources shall first be used to offset any state funds that the legislature appropriates or allocates. Any grant funds or other financial resources received in excess of legislative appropriations or allocations shall be used for the study of financing options for the health security plan.

SECTION 44. [NEW MATERIAL] REIMBURSEMENT TO HEALTH SECURITY PLAN FROM FEDERAL AND OTHER HEALTH INSURANCE PROGRAMS.--

A. The commission shall seek payment to the health security plan from medicaid, medicare or any other federal or other insurance program for any reimbursable payment provided under the plan.

B. The commission shall seek to maximize federal contributions and payments for health care services provided in New Mexico and shall ensure that the contributions of the federal government for health care services in New Mexico will not decrease in relation to other states as a result of any waivers, exemptions or agreements.

C. The commission shall maintain sufficient reserves to provide for catastrophic and unforeseen expenditures.

SECTION 45. [NEW MATERIAL] HEALTH BENEFITS EXCHANGE OR

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HEALTH INSURANCE EXCHANGE PROPERTY--FEDERAL WAIVER FOR TRANSFER OF HEALTH INSURANCE EXCHANGE FUNCTIONS--TRANSFER OF HEALTH INSURANCE EXCHANGE.--

A. Unless otherwise provided by federal law, any personal property that the state has procured to implement or operate a state health benefits exchange or health insurance exchange pursuant to federal law shall remain state property.

B. As soon as allowed under federal law, the secretary of human services shall seek a waiver to allow the state to suspend operation of any health benefits exchange or health insurance exchange and to allow the commission to administer in accordance with federal law the federal premium tax credits, cost-sharing subsidies and small business tax credits. In implementing the provisions of the Health Security Act, the human services department shall provide for the commission's use any personal property used in the operation of a state health insurance exchange.

C. As used in this section:

(1) "health insurance exchange" means an entity established pursuant to federal law to provide qualified health plans to qualified individuals and qualified employers on the individual and small group or large group insurance markets;

(2) "personal property" means property other than real property; and

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(3) "real property" means an estate or interest in, over or under land and other things or interests, including minerals, water, structures and fixtures that by custom, usage or law pass with a transfer of land even if the estate or interest is not described or mentioned in the contract of sale or instrument of conveyance and, if appropriate to the context, the land in which the estate or interest is claimed.

SECTION 46. [NEW MATERIAL] TRANSITION PERIOD ARRANGEMENTS--PRIVATE CONTRACT--COLLECTIVE BARGAINING.--A person who, on the date benefits are available under the Health Security Act's health security plan, receives health care benefits under a private contract or collective bargaining agreement entered into prior to July 1, 2017 shall continue to receive those benefits until the contract or agreement expires or unless the contract or agreement is renegotiated to provide participation in the health security plan.

SECTION 47. Section 41-4-3 NMSA 1978 (being Laws 1976, Chapter 58, Section 3, as amended) 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;

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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 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 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 a licensed health care provider, who has no

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medical liability insurance, providing voluntary services as defined in Paragraph (16) 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 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;

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(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 New Mexico mortgage finance authority;

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

(15) members of the board of directors of the small business investment corporation;

(16) 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;

(17) 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; [~~and~~]

(18) the staff and members of the board of

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directors of the New Mexico health insurance exchange established pursuant to the New Mexico Health Insurance Exchange Act; and

(19) the staff and members of the health care commission established pursuant to the Health Security Act;

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 48. TEMPORARY PROVISION--HEALTH CARE COMMISSION--TRANSFER OF HEALTH INSURANCE EXCHANGE DUTIES.--The health care commission shall devise a plan for the timely and efficient transfer of health insurance exchange functions and health insurance exchange property to the commission pursuant to Section 44 of the Health Security Act.

SECTION 49. TEMPORARY PROVISION.--

A. If the fifty-second legislature approves implementation and financing of the health security plan, the health security plan shall be operational by July 1, 2018. Upon an affirmative vote by a two-thirds majority of the health care commission's members, the commission may extend the operational date by as much as one year.

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B. If the fifty-second legislature fails to implement the recommendations of the legislative finance committee or otherwise fails to determine and approve financing of the health security plan, the health security plan shall not become effective.

SECTION 50. APPROPRIATION.--Two hundred fifty thousand dollars ($250,000) is appropriated from the general fund to the legislative finance committee for expenditure in fiscal year 2016 to undertake the fiscal analysis required pursuant to Section 42 of the Health Security Act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

SECTION 51. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2015.

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