



Policy Title: Plan of Operation
Issue Date: August 16, 2013
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PLAN OF OPERATION

Whereas, the fifty-first Legislature of the State of New Mexico created the New Mexico Health Insurance Exchange (the “Exchange”) and established the New Mexico Health Insurance Exchange Board of Directors by Laws of 2013, Chapter 54, in the regular session of 2013 (the “Act”);

Whereas, the Act created the Exchange in order to provide qualified individuals and qualified employers with increased access to health insurance in the state;

Whereas, the Act established the Exchange as a nonprofit public corporation and provided that the Exchange would be governed by a Board of Directors;

Whereas, the Act charges the Board of Directors with developing and implementing a plan of operation to ensure the fair, reasonable, and equitable administration of the Exchange, and the Exchange is operated using best practices for state-based exchanges in business administration, consumer engagement, and public outreach and marketing; and

Whereas, in 2013, the Board of Directors enacted the Plan of Operation, which provides that the Board of Directors shall periodically consider revisions to the Plan of Operation, and the Board has duly considered and chooses to adopt certain revisions to the Plan of Operation.

Wherefore, the Board of Directors hereby enacts this Plan of Operation to set forth the procedures, administrative actions, and policies of the Exchange as it carries out its mission of facilitating the provision of health insurance to qualified individuals and employers within the State of New Mexico.

PLAN OF OPERATION

Article I. Name

The name of the entity established by the Act is the New Mexico Health Insurance Exchange, also known as beWellnm.

Article II. Purpose and Policy

- 2.1 **Purpose.** The purpose of the Exchange is to provide qualified individuals and qualified employers with increased access to health insurance within the state.
- 2.2 **Policy.** It is the policy of the Board of Directors (the “Board”) of the Exchange that members of the Board, its committees, its advisory work groups, and its staff undertake their respective responsibilities with the sole consideration of acting for the public good. Directors shall manage the affairs of the Exchange with integrity and openness, and shall apply their expertise, skills, and judgment for the benefit of the people of the State of New Mexico and those individuals and employers who seek to obtain health insurance through the Exchange. And it shall further be the policy of the Board that the Board has the power to conduct any activities and implement all policies consistent with the Act.

Article III. Definitions

As used in this Plan of Operation:

- 3.1. “Act” means the New Mexico Health Insurance Exchange Act, as enacted by Laws of 2013, Chapter 54 and as amended from time to time;
- 3.2. “Board” means the board of directors of the Exchange;
- 3.3. "Exchange" means the New Mexico Health Insurance Exchange, also known as beWellnm, composed of an exchange for the individual market and a small business health options program or "SHOP" exchange under a single governance and administrative structure;
- 3.4. “Health insurance issuer” means an insurance company, insurance service or insurance organization, including a health maintenance organization, that is licensed to engage in the business of insurance in the state;

- 3.5. "Insurance producer" means a person required to be licensed in New Mexico to sell, solicit, or negotiate insurance;
- 3.6. "Native American" means (i) an individual who is a member of any federally recognized Indian nation, tribe or pueblo or who is an Alaska native, or (ii) an individual who has been deemed eligible for services and programs provided to Native Americans by the United States public health service or the bureau of Indian affairs;
- 3.7. "Navigator" means a person that, in a manner culturally and linguistically appropriate to the state's diverse populations, conducts public education, distributes tax credit and qualified health plan enrollment information, facilitates enrollment in qualified health plans or provides referrals to consumer assistance or ombudsman services.
"Navigator" does not mean a health insurance issuer or a person that receives any consideration, directly or indirectly, from any health insurance issuer in connection with the enrollment of a qualified individual in a qualified health plan; provided that an insurance producer may be a navigator if the insurance producer receives no consideration, directly or indirectly, from any health insurance issuer in connection with the enrollment of a qualified individual or qualified employer in a qualified health plan, an approved health plan or any other health coverage;
- 3.8. "PPACA" or "ACA" means the federal Patient Protection and Affordable Care Act;
- 3.10 "Qualified Health Plan" or "QHP" means a participating insurer who is certified by the Office of the Superintendent of Insurance (OSI) and the Exchange to offer insurance products on the Exchange; and
- 3.11 "Superintendent" means the superintendent of insurance.

Article IV. Board of Directors

- 4.1. **Composition.** The affairs of the Exchange shall be managed by a Board of Directors, which shall be composed of thirteen (13) members, each appointed in accordance with the New Mexico Health Insurance Exchange Act.
- 4.2. **Quorum and voting.** Attendance of seven (7) Directors shall constitute a quorum of the Board. A decision of the Board shall be made by a majority of Directors present and voting, unless otherwise specified in this Plan of Operation.
- 4.3. **Meetings.** The Board shall meet at the call of the Chair. The Board shall hold annual and regular meetings, and may hold special and emergency meetings, to consider and take action upon all matters within the scope of authority of the Exchange. Meetings shall be held in accordance with the Open Meetings Act pursuant to the Open Meetings Act Resolution adopted by the Board.
- 4.4. **Annual meeting.** The Board shall convene an annual meeting in the first quarter of the calendar year, which may be held at the same time or in concurrence with a regular

meeting. At the annual meeting, the Board shall:

- 441. Consider revisions to the Plan of Operation;
 - 442. Review Board policies;
 - 443. Review and evaluate the performance of the administration of the Exchange and contracted consultants and vendors;
 - 444. Consider any other matter as determined by the Chair; and
 - 445. Review and monitor quality of care for coverage issued by health plans through the Exchange.
- 4.5. **Regular meetings.** The Board shall convene a regular meeting at least quarterly or as often as necessary. Notice of the date, time, and location of a regular meeting shall be given to Directors and the public at least seven (7) days before the scheduled meeting. This notice may be waived by a Director in writing and shall be waived by the attendance of a Director at a regular meeting except when attendance at the meeting is for the sole purpose of objecting because the meeting was not lawfully convened.
- 4.6. **Special meetings.** The Board may convene a special meeting when circumstances require the Board to meet with less than seven (7) days' notice. Notice of the date, time, and location of a special meeting shall be given to Directors and the public at least seventy-two (72) hours before the scheduled meeting.
- 4.7. **Emergency meetings.** The Board may convene an emergency meeting only to consider a matter that could not have been anticipated and that threatens the health, welfare, or safety of the citizens of New Mexico if not addressed immediately by the Board. Notice of the date, time, and location of an emergency meeting shall be given to Directors and the public as early as practicable, with due consideration of the conditions that necessitate the calling of the emergency meeting.

4.8. Attendance of Directors.

- 481. Directors shall make reasonable efforts to attend all scheduled Board and committee meetings in person for the entirety of the meeting. When it is difficult or impossible for the Director to attend the meeting in person, the Director may attend by conference telephone, provided that each Director participating by conference telephone can be identified when speaking, all participants are able to hear each other at the same time, and members of the public attending the meeting are able to hear any Director who speaks during the meeting.
- 482. No Director shall miss more than 25% of all regular Board meetings held within a two-year period. Any Director missing more than 25% of regular Board meetings over a two-year period shall be subject to removal by a two-thirds (2/3)

majority vote of the Board, after notice and an opportunity to be heard in accordance with procedures adopted by the Board. A Director's failure to meet attendance requirements may be brought before the Board at the request of any Director or as determined by the Chair.

4.9. **Removal of Directors.** By a two-thirds (2/3) majority vote, the Board may remove a Director for lack of attendance, neglect of duty, or malfeasance in office. A Director shall not be removed without proceedings consisting of at least one ten-day notice of hearing and an opportunity to be heard. The Board shall adopt procedures in accordance with the Act and this Plan of Operation prior to initiating removal proceedings against a Director.

4.10. Staff and contracting.

4.10.1. The Board shall hire a Chief Executive Officer (CEO). The CEO shall act in accordance with direction of the Board and under the supervision of the Board. In addition to other duties that may be delegated to the CEO from time to time, the CEO shall:

4.10.1.1. Manage and supervise Exchange operations, administrative functions, budget, marketing, outreach and education, and other day to day activities of the Exchange;

4.10.1.2. Ensure that the Exchange operates in compliance with all federal and state statutes, rules, and regulations applicable to the Exchange;

4.10.1.3. Recruit, hire, and maintain qualified, professional, and ethical staff; and

4.10.1.4. Contract with vendors and procure necessary services and items of tangible property necessary to meet Exchange obligations and directives, provided that no contractor shall be a health insurance issuer or a producer. This authority is subject to oversight of the Board and shall not be exercised in excess of any limitations and restrictions imposed by the Board.

4.11. **Per diem and mileage.** Appointed Directors shall receive no compensation, perquisite, or allowance in consideration of their service on the Board, but may receive per diem and mileage in accordance with the Per Diem and Mileage Act, NMSA 1978 §§ 10-8-1 *et seq.*, according to policy established by the Board.

4.12. Officers.

4.12.1. The Board shall elect a Chair, a Vice-Chair, a Treasurer and such other officers as the Board may decide are necessary and proper. Officers shall be elected for a term of three years and shall not serve more than two consecutive three-year terms.

- 4.122. If a vacancy occurs in any office, the Board shall elect a successor who shall serve the remainder of the term to which the Director is elected.
- 4.123. Officers may be removed from the office by the Board for any or no reason.
- 4.124. The Chair shall call meetings of the Board, determine the agenda for such meetings, and shall assume such other duties as shall be designated from time to time by the Board.
- 4.125. The Chair shall execute and deliver documents in the name of the Exchange, unless authority to do so has been delegated by the Board to another individual.
- 4.126. The Vice-Chair shall function as Chair in the Chair's absence.
- 4.127. The Treasurer shall maintain oversight of the Exchange's financial operations, work with the CEO and Chief Financial Officer (CFO) to report and to account for all financial activities of the Exchange to the Board, and shall ensure the completion of an annual audit.

Article V. Committees

- 5.1. **General.** The Board shall establish committees as set forth below. The primary duty of the committees is to make advisory recommendations to the Board. Members of the committees shall be named by and serve at the pleasure of the Chair. The committees shall have the duties and responsibilities specified. The Board may further delegate to any committee such Board powers, duties, and functions falling within the committee's area of cognizance as the Board deems proper.
- 5.2. **Meetings.** Meetings of a committee shall be open to the public, unless the chair of the committee determines, at the Chair's discretion, the meeting should be closed. Notice of a committee meeting shall be given to the extent practicable. If possible, the committee shall post on the Exchange website the time and place of the meeting and the agenda or matters to be discussed.

If a committee meets for the purpose of taking final action or formulating public policy and not in an advisory capacity in which it develops recommendations for Board approval, the committee shall hold its meetings in compliance with the Open Meetings Act and the Board's Open Meetings Act Resolution.

5.3. Standing committees.

- 5.3.1. **Finance Committee.** The Finance Committee shall oversee the financial affairs of the Exchange and ensure prudent financial management in all aspects of operations and careful stewardship of public funds. The Finance Committee shall also monitor and review the Exchange budget, contracting and other expenditures, revenue, and bank statements and act as the Board's Audit Committee.

The Finance Committee shall be comprised of no more than six Board members as appointed by the Chair of the Board, one of which shall be the Board Treasurer. The Chair of the Finance Committee shall designate one Finance Committee member to serve as Vice-Chair.

5.3.2. **Operations Committee.** The Operations Committee shall oversee the general operations; oversee the implementation and maintenance of information technology for both the Individual and Small Business Health Options Program (SHOP) Exchange; and govern policies and procedures related to the operation of both the Individual and SHOP Exchanges.

The Operations Committee shall be comprised of no more than six Board members as appointed by the Chair of the Board. The Chair of the Operations Committee shall designate one Operations Committee member to serve as Vice-Chair.

5.3.3. **Outreach and Education Committee.** The Outreach and Education Committee shall monitor the external communications of the Exchange and oversee relationships with key stakeholders to ensure that all New Mexicans are educated about their options on the Exchange and have no-cost help available near them to make an informed decision about their health insurance plan. The Outreach and Education Committee shall also oversee the in-house referral call center while the Exchange enrolls individuals through the Federal platform.

The Outreach and Education Committee shall be comprised of no more than six Board members as appointed by the Chair of the Board. The Chair of the Outreach and Education Committee shall designate one Outreach and Education Committee member to serve as Vice-Chair.

5.3.4. **Native American Committee.** The Native American Committee shall promote the effective communication and collaboration between the Exchange and the Native American communities of New Mexico. The Native American Committee ensures adherence to Native American-specific provisions included in the Affordable Care Act (ACA), Indian Health Care Improvement Act (IHCIA), or any other Exchange related policy. The Native American Committee shall nurture communication and collaboration as established via the Native American Liaison.

The Native American Committee shall be comprised of no more than six Board members as appointed by the Chair of the Board. The Chair of the Native American Committee shall designate one Native American Committee member to serve as Vice-Chair.

5.3.5. **Executive Committee.** The Executive Committee shall guide the creation and implementation of policies and procedures to provide for the effective operation of the Board and of the Exchange.

The Executive Committee shall be comprised of no more than six Board members as

appointed by the Chair of the Board, which shall include the Chair of the Board, the Vice-Chair of the Board, the Board Treasurer, the Secretary of the New Mexico Human Services Department, and the Superintendent of Insurance. The Chair of the Executive Committee shall designate one Executive Committee member to serve as Vice-Chair.

- 5.3.6 **Health Benefits Plan Committee.** The Health Benefits Plan Committee shall consult and coordinate with the OSI to develop rules to be promulgated and implement provisions of the Act; establish policies and procedures for the review and recommendation of standardized QHPs to be offered on the Exchange; determine additional minimum requirements for a health insurance issuer to be considered for participation in the Exchange; determine standards and criteria for health benefits plans to be offered through the Exchange that offer an optimal level of affordability, choice, value, quality, and service and that are in the best interests of qualified individuals and qualified small employers; and oversee the evaluation and establishment of standardized QHPs in accordance with Article XV of this Plan of Operation. The committee shall be supported by Exchange staff and shall work in conjunction with other entities having plan oversight, including the OSI.

The Health Benefits Plan Committee will generally operate in accordance with the timelines and processes set forth in Article XV of this Plan of Operation. The committee also may meet under circumstances deemed an emergency by the committee Chair to consider changes to the plans offered on the Exchange, in coordination with the OSI.

The Health Benefits Plan Committee shall be comprised of no more than six Board members as appointed by the Chair of the Board. The Chair of the Health Benefits Plan Committee shall designate one Health Benefits Plan Committee member to serve as Vice-Chair.

- 5.4. **Advisory committees.** Pursuant to NMSA 1978, § 59A-23F-3(T), the Board shall create and duly consider recommendations from the following advisory committees.

5.4.1. **Stakeholder Advisory Committee.** The Stakeholder Advisory Committee shall consist of representatives of a broad spectrum of members of the public with expertise in and interest in the successful operations of the Exchange. Members shall include health insurance issuers, health care consumers, health care providers, health care practitioners, insurance producers, qualified employer representatives, and advocates for low-income or underserved residents.

5.4.2. **Native American Advisory Committee.** The Native American Advisory Committee shall consist of Native Americans, those living on and off a reservation, who shall advise the Board on implementation of provisions of the Act and the Patient Protection and Affordable Care Act that specifically address Native Americans.

5.4.3. **New Mexico Medical Insurance Pool Transition Advisory Committee.**

The New Mexico Medical Insurance Pool (NMMIP) Transition Advisory Committee is established to provide recommendations to the Board in the fulfillment of the Exchange's mission of transitioning the NMMIP members into the Exchange. The committee shall consist of key stakeholders and members served by the NMMIP. The committee shall exist until a transition plan has been adopted or until the Board deems the advisory committee no longer necessary.

- 5.5. **Ad hoc, subcommittees, and other advisory committees.** The Board may establish such ad hoc, subcommittees, and other advisory committees as it deems necessary to accomplish the provisions of the Act and this Plan of Operation.

Article VI. Financial Management; Records; and Reports

- 6.1. **Fiscal Year.** The fiscal year of the Exchange shall be the calendar year, from January 1 to December 31.

- 6.2. **Finances.** The financial affairs of the Exchange shall be managed by the CEO of the Exchange with oversight by the Treasurer and by the Board.

6.2.1. The CEO shall maintain strict account of all receipts and expenditures of the Exchange. The CEO shall render reports and accountings to the Board as directed by the Board or the Treasurer regarding all financial business of the Exchange.

6.2.2. The Exchange shall establish such checking, savings, and investment accounts as necessary and shall deposit all funds of the Exchange in such accounts. The CEO, and other staff members of the Exchange as designated by the Board, shall have authority to make deposits, withdrawals, disbursements, and transfers of Exchange funds, and shall be authorized to sign for all activities related to Exchange accounts, including those deposits, withdrawals, disbursements, and transfers required by the activities of the Exchange.

6.3. Audit.

6.3.1. Annual audit. Beginning with the first year of operation in which access to health insurance is provided, the Board shall obtain an annual audit of the Exchange's operations.

6.3.2. Periodic audit. The Board may conduct periodic audits to assure the general accuracy of the financial data submitted to the Exchange.

6.3.3. Additional audits. The Board shall provide for such additional audits as are necessary to ensure the financial operations of the Exchange comply with all state and federal law as may be applicable to grants or other sources of funding provided to the Exchange. Any required audit shall be conducted by an independent certified public accountant qualified to conduct such audits.

6.4. Reports.

6.4.1. Between July 1, 2013 and January 1, 2015, the Board shall provide quarterly reports to the legislature, the Governor, and the Superintendent on the implementation of the Exchange. Thereafter, the Board shall report annually and upon request.

6.4.2. The Board shall keep an accurate accounting of all of the activities, receipts and expenditures of the exchange and shall submit this information annually to the Superintendent and as required by federal law to the federal secretary of health and human services.

6.4.3. The Board shall publish the administrative costs of the Exchange as required by state or federal law.

6.4.4 The Board shall produce the following reports, which shall be made publicly available on the Exchange's website or upon request:

6.4.4.1. During all Exchange open enrollment periods beginning on or after October 1, 2021, a weekly report that includes information on: (1) applications; (2) plan selections; (3) new enrollees; (4) enrollees renewing coverage; (5) call center volume; and (6) website traffic;

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

6.4.4.3. Beginning on September 1, 2022, and on each succeeding September 1, in consultation with the Superintendent, a report that includes analysis of: (1) the individual health insurance market; (2) on- and off-exchange enrollment and demographics; (3) small business enrollment; (4) Qualified Health Plan pricing; (5) outreach and enrollment assistance activities; (6) the impact of offering standardized health plans; and (7) the remaining uninsured in New Mexico and strategies to reach them.

6.5. **Records.** The Exchange shall maintain all financial records, books, and reports of the financial activities of the Exchange at the principal office of the Exchange and shall make the records available at the request of any Director or member of the public during regular business hours for inspection and copying.

6.6 **Procurement Code.** The Exchange shall comply with the New Mexico Procurement Code, NMSA 1978, §§ 13-1-28 to 13-1-199, and applicable Procurement Code regulations.

Article VII. Statewide Consumer Assistance Program

7.1. The Exchange shall establish a statewide consumer assistance program to provide education, outreach, and in-person assistance to educate consumers about the Exchange and insurance affordability programs and to encourage participation of New Mexicans seeking information about and access to health insurance.

7.2. The consumer assistance program shall be operated in a manner that will ensure customer assistance is readily available to New Mexicans of all cultures, language proficiencies, geographic areas, and socio-economic status. The Exchange shall engage Navigators, Enrollment Counselors, insurance producers, and other consumer assistance program personnel. Consumer assistance personnel shall conduct public education activities; provide fair, accurate, and impartial information to consumers; facilitate enrollment; and provide referrals to other consumer assistance programs. Consumer assistance personnel shall conduct their activities in compliance with applicable standards relating to conflicts of interest, training, provision of culturally and linguistically appropriate services, and ensuring access to people with disabilities. Navigators, Enrollment Counselors and other consumer assistance personnel shall perform all services directed by the Board, which services may include but are not limited to:

- Meeting with customers in person and in groups to explain Enrollment Counselor services, the benefit of having health insurance, and options for coverage;
- Assisting customers with opening or accessing an account with the Exchange;
- Explaining insurance affordability programs, qualified health plans, essential health benefits, and rights when using insurance;
- Assisting customers with application for getting help with the advanced premium tax credit and cost-sharing reductions available through the Exchange;
- Assisting customers with understanding web-based decision tools to help narrow the choices for qualified health plans;
- Ensuring customers know about their health plan options through the Exchange and help them filter and select based on those options;
- Referring customers with appeals, grievances, and complaints to the appropriate agency;
- Making referrals as needed to the Exchange's customer service center, certified brokers, or government and community resources;
- Explaining to customers when life changes can be reported and when renewal will be needed;
- Providing all services in a manner that is culturally and linguistically relevant to the customer;
- Maintaining expertise about Exchange programs and certification; and
- Accurately tracking and recording activities for reporting to the Exchange.

7.3. The CEO shall periodically report to the Board regarding the performance of the consumer assistance program, and shall make recommendations to the Board for improved performance of the program.

Article VIII. Complaints and Grievances

8.1. Complaints against the Exchange.

8.1.1. Any person may file a complaint with the Exchange for any issue related to the Exchange.

8.1.2. Complaints may be made orally, but a formal complaint shall be made in writing and shall (1) describe in detail the circumstances giving rise to the complaint, (2) be signed by the person responsible for submitting the complaint, and (3) be submitted to the Exchange within ninety (90) days of the incident giving rise to the complaint. The Exchange shall assist a complainant who needs or requests assistance in formalizing an oral complaint.

8.1.3. The Exchange shall promptly review the complaint and shall either (1) refer the complaint to an appropriate entity if not the Exchange, or (2) attempt to resolve the circumstances giving rise to the complaint and respond to the complainant.

8.1.4. If the aggrieved party is not satisfied with the resolution, the aggrieved party may notify the CEO directly of its disagreement with the resolution. The CEO may:

- Direct further investigation of the complaint;
- Confirm or reject the Exchange's resolution of the complaint; or
- Take further action as deemed appropriate.

8.1.5. The CEO shall periodically report to the Board regarding the resolution of complaints against the Exchange, to determine if the Board should take action to address significant or recurring complaints.

8.2. Complaints against a health insurance issuer and others.

8.2.1. A complaint against a health insurance issuer shall be made pursuant to the issuer's grievance procedures, which shall be established in accordance with federal law and all applicable regulations of the Office of the Superintendent of Insurance, including NMAC 13.10.17.

8.2.2. If a complaint against a health insurance issuer or other entity is lodged with the Exchange, or if a person requests assistance from the Exchange regarding a potential complaint against an issuer, for example a complaint related to an enrollee's health plan, coverage, or a determination under the plan or coverage, the Exchange shall refer that person to the Office of Superintendent of Insurance, any applicable consumer assistance office, or ombudsman established under federal law or other appropriate state agency and shall otherwise assist that person as advisable.

Article IX. Alternative Dispute Resolution between the Exchange and Health Insurance Issuers

Methods of alternative dispute resolution should be utilized to the extent possible to resolve contractual disputes between the Exchange and health insurance issuers and other contractors. Except as otherwise stated by contractual agreement, parties shall avoid

litigation and agree instead to resolve disputes first through good faith negotiation, and if unsuccessful, through mediation and/or arbitration. Any disputes over certification of qualified health plans shall be the purview of the Office of Superintendent of Insurance. The process for alternative dispute resolution is as follows.

- 9.1. **Negotiation.** The parties are encouraged to resolve disputes through negotiation prior to mediation or arbitration. In the event of any dispute, claim, question, or disagreement arising from or relating to a contract or the breach thereof, the parties shall use their best efforts to settle the dispute, claim, question, or disagreement. To this effect, they shall consult and negotiate with each other in good faith and, recognizing their mutual interests, attempt to reach a just and equitable solution satisfactory to both parties. If they do not reach such solution within a period of 30 days, then, upon notice by either party to the other, all disputes, claims, questions, or differences shall be mediated or finally settled by arbitration administered by the American Arbitration Association (AAA) in accordance with the provisions of its Commercial Arbitration Rules.
- 9.2. **Mediation.** If a dispute arises out of or relates to a contract between the Exchange and a health insurance issuer, or the breach thereof, and if the dispute cannot be settled through negotiation, the parties may first try in good faith to settle the dispute by mediation administered by the American Arbitration Association under its Commercial Mediation Procedures. Parties may agree upon a mediator and the terms of the mediation, or may use an AAA administrator to assist the parties regarding selection of the mediator, scheduling, pre-mediation information exchange and attendance of appropriate parties at the mediation conference. The mediation shall be scheduled within 30 days of notice to the other party that one party seeks to mediate the dispute.
- 9.3. **Arbitration.** If negotiation and mediation fail to resolve the dispute, or the time frames establish for negotiation or mediation pass, a controversy or claim arising out of a contract between the Exchange and a health insurance issuer, or the breach of such contract, shall be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.
- 9.4. **Governing law.** Disputes covered by this Article IX shall be governed by the laws of the state of New Mexico and, where applicable, federal law.
- 9.5. **Time periods.** The time periods established in this Article IX may be amended by mutual agreement of the parties.

Article X. Communication, Collaboration, and Provision of Culturally Competent Service to Native Americans

- 10.1. **Purpose.** The Exchange seeks to promote effective communications and collaboration between the Exchange and Indian nations, tribes, and pueblos, including communicating about and collaborating on those nations', tribes', and pueblos' plans for creating or participating in the Exchange. The Exchange also seeks to promote cultural competency

in providing effective services to Native Americans within the state.

10.2. Native American Committee. Consistent with Section 5.3.4., the Native American Committee shall oversee and direct the Exchange's efforts to communicate with, collaborate with, and provide services to Native Americans.

10.3. Communication, collaboration, and cultural competency. To promote communication, collaboration, and culturally competent services, the Exchange shall:

10.3.1. Create an advisory committee made up of Native American representation, consistent with Section 5.4.2 of this document.

10.3.2. Designate a Native American liaison, who shall assist the Board in developing and ensuring implementation of and collaboration between the Exchange and Native Americans in the state. The Native American liaison shall serve as a contact person between the Exchange and New Mexico Indian nations, tribes, and pueblos and shall ensure that training is provided to the staff of the Exchange. The training may include matters related to (i) cultural competency, (ii) state and federal law relating to Indian health, and (iii) other matters relating to the functions of the Exchange with respect to Native Americans in the state;

10.3.3. Ensure that customer walk-in service centers are capable of assisting Native American customers to enroll, if eligible, in qualified health plans or public coverage programs;

10.3.4. Ensure that Navigators, Enrollment Counselors and assisters are qualified to provide services to the Native American population, including in the areas of public education, tax credit and qualified health plan information, facilitating enrollment in qualified health plans, and in providing referrals to other consumer assistance or ombudsman services where other services would be helpful; and ombudsman services where other services would be helpful; and

10.3.5. Engage in community outreach to gauge the needs of the Native American community and better understand how Exchange activities may be tailored to best meet those needs.

Article XI. Conflict of Interest Policies and Code of Conduct

The Exchange is committed to establishing and maintaining a high level of ethical conduct among Directors and employees of the Exchange. Directors and employees shall treat their positions as positions of public trust and shall use the powers and resources of the position only to advance the public interest and not to obtain personal benefits or pursue private interests.

Directors and employees shall model their conduct on and shall conform their behavior to the standards of conduct and conflict of interest policies expressed in the Code of Conduct:

Governing Principles and Conflicts of Interest, adopted by the Board on April 30, 2013, as it may be amended from time to time.

Article XII. Amendment.

The Plan of Operation may not be amended except by written amendment approved by the Board.

Article XIII. Financial Sustainability

The Patient Protection and Affordable Care Act and federal regulations issued pursuant to the ACA provide that no federal grants shall be awarded for establishment of state exchanges after January 1, 2015 and that a state shall ensure its exchange has sufficient funding to support ongoing operations as of January 1, 2015. The New Mexico Health Insurance Exchange Act authorizes the Exchange to “generate funding, including by charging assessments or fees, to support its operations in accordance with provisions of the New Mexico Health Insurance Exchange Act solely for the reasonable administrative costs of the exchange; provided that no assessment or user fee shall be imposed upon a carrier that exclusively offers policies, plans or contracts outside the exchange intended to supplement major medical coverage, including Medicare supplement, long-term care, disability income, specified disease, accident-only, hospital indemnity or other limited-benefit health insurance policy.” NMSA 1978, § 59A-23F- 4(B).

In exercise of the powers and authority granted to the Exchange and the Board, the Exchange determines that it is necessary to generate funding for the reasonable administrative costs of the Exchange as follows:

- 13.1 The Exchange shall generate funding for the operations of the Exchange, in an amount necessary solely for the administrative costs of the Exchange, by imposing assessments on all health insurance issuers operating in the State of New Mexico, except those exempted by NMSA 1978, § 59A-23F-4(B).
- 13.2 The Board shall adopt a budget by no later than the fourth quarter of each calendar year that determines, to the best of the Board’s ability, the operational funds necessary for the administrative costs of the Exchange for the succeeding calendar year.
- 13.3 **Annual assessment.** The annual assessment for each health insurance issuer subject to the annual assessment as defined in Section 13.1 shall be determined by multiplying the total Exchange budget by a fraction, the numerator of which equals that health insurance issuer's premium and subscriber contract charges or their equivalent for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums and subscriber contract charges or their equivalent for health insurance written in the state in the same time period; provided that premiums written shall include receipts of major medical premiums and Medicaid managed care premiums sold on and off the Exchange. Receipts shall not include premiums written for limited-benefit health plans or any payments by the secretary of health and human

services pursuant to a contract issued under Section 1876 of the Social Security Act, as amended. The annual assessment shall be billed to health insurance issuers in January. The Exchange may permit health insurance issuers to pay the annual assessment in more than one installment, at the Exchange's discretion. The annual assessment shall be subject to revision pursuant to paragraph 13.7.

13.4 **Reserve assessment.** For each calendar year, the Exchange shall ensure that it holds cash equivalents, investments, or other similarly liquid funds sufficient for a reserve equal to approximately six months of the annual operating budget, provided that for purposes of calculating the reserve, the Exchange may exclude amounts budgeted for non-recurring capital expenditures if including such amounts would result in an unnecessarily large reserve. If an assessment is necessary to generate reserve funds, a reserve assessment shall be determined by multiplying the amount needed by the Exchange in accordance with the formula in paragraph 13.3.

13.4.1

13.5 **Final assessment.** The Exchange shall make a final assessment after the close of each calendar year. To determine the amount of premium upon which a health insurance issuer's final assessment will be based for a particular year, the Exchange shall mail a reporting form to each health insurance issuer no later than May 1 of the following year. The reporting form shall be completed, signed by an officer of the health insurance issuer, and returned to the Exchange, along with a copy of the insurer's annual NAIC statutory filing Schedule T – Premiums and Other Considerations and the health insurance issuer's Exhibit of Premiums, Enrollment, and Utilization for the insurer's New Mexico business. The Exchange shall review the amount of premium reported to confirm that the amount reported agrees with the amount reported in the annual statutory filing. This documentation will be retained for audit substantive testing and evidence supporting assessment revenue.

13.6 If annual assessments exceed the actual administrative costs of the Exchange, as determined at the end of each calendar year, the excess shall be held at interest and used by the Exchange to offset the amounts calculated to be generated through assessments for the subsequent calendar year.

13.7 If the budget for the Exchange changes during the course of a calendar year, whether increasing so that the amount assessed is insufficient or decreasing so that the amount assessed is excessive, the assessments shall be revised according to the formula provided in paragraph 13.3.

13.8 The Exchange may abate or defer, in whole or in part, the assessment of a health insurance issuer if, in the opinion of the Exchange, payment of the assessment would endanger the ability of the health insurance issuer to fulfill its contractual obligation. In the event an assessment against a health insurance issuer is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed

against the other health insurance issuers in a manner consistent with the basis for assessments set forth in Paragraph 3 of this Resolution. The health insurance issuer receiving the abatement or deferment shall remain liable to the Exchange for the deficiency for four years.

13.9 The Exchange shall promptly inform the Office of the Superintendent of Insurance (OSI) of the failure of any health insurance issuer to pay an assessment after 30 days' written notice to the health insurance issuer that payment is due. The Exchange shall report any continuing delinquency to the OSI.

13.10 Assessments to health insurance issuers shall be mailed at least 30 days prior to the due date for payment.

13.11 Any proposed adjustment to the amount of premium reported shall be reviewed for approval by the Exchange. If any adjustment to the amount of premium is made as a result of that review, the health insurance issuer affected by the adjustment will be notified in writing of the adjustment.

13.12 The Exchange may determine a threshold amount of premium and subscriber contract charges or their equivalent for health insurance written in the state during the preceding calendar year, below which a health insurance issuer will not be charged assessments.

13.13 Any health insurance issuer who wishes to appeal the amount of an assessment may do so by filing a complaint or grievance with the Exchange in accordance with paragraph 8.1 of this Plan of Operation.

13.14 After the final assessments for a particular year have been determined and collected, the Exchange shall determine if any health insurance issuer has overpaid its assessments. If any such overpayment has been made, the Exchange, upon approval by the Board, shall refund to the health insurance issuer the amount of the overpayment. No interest shall be paid by the Exchange on the overpayment.

Article XIV. Plan Management

The Superintendent of Insurance shall review and certify Qualified Health Plans (QHP) and Qualified Dental Plans (QDP) in accordance with state and federal laws and regulations.

The Board shall review approved QHP and QDP plans and rates prior to the beginning of any open enrollment period.

The Exchange shall work with the OSI to ensure regulatory requirements are complied with regarding activities carried out by the Exchange and the OSI in support of - implementation of the Affordable Care Act.

Article XV. Standardized Health Plans.

The Board may establish no more than three standardized health plans for each of three levels of coverage with increasing benefits, designated bronze, silver, and gold plans.

- 15.1 In establishing standardized health plans, the Board may design those plans to: (1) limit increases in health plan premium rates; (2) reduce the deductible portion of a benefit an insured individual is required to pay; (3) make more services available before a deductible amount is applied to a benefit; (4) provide predictable cost sharing; (5) maximize available subsidies; (6) limit adverse premium impacts; (7) reduce barriers to maintaining and improving health; (8) encourage choice based on value, and (9) limit adverse premium impacts.
- 15.2 The Board may update the standardized health plans annually in accordance with the processes set forth in this Article, provided that the Board shall establish a procedure and timeline for providing written notice of the standardized health plans to health insurance issuers before the year in which the health plans are to be offered on the Exchange.
- 15.3 The Health Benefits Plan Committee, in conjunction with Exchange staff, Office of Superintendent of Insurance, and utilizing actuarial analysis, shall evaluate potential standardized health plans fifteen to twelve months prior to the year in which the standardized health plans would be offered on the Exchange.
- 15.4 During the process of evaluating and establishing standardized health plans, the Health Benefits Plan Committee shall solicit input from Directors, advocates, carriers, consumers, health insurance issuers, insurance producers, the public and other stakeholders. Input shall be supported by at least one public work session, with more as appropriate.
- 15.5 The Health Benefits Plan Committee shall bring any proposed standardized health plan to the Board for consideration at the January Board meeting prior to the year in which the standardized health plan would be offered on the Exchange. The Exchange will communicate the Board's adoption of any standardized health plan to OSI for implementation.
- 15.6 Before finalizing each year's standardized health plans the Board shall provide for notice of and public comment on the proposed standardized health plans. Public comment should be conducted for no fewer than 30 days, unless a shorter timeframe is necessary given exceptional circumstances. The Health Benefits Plan Committee shall respond in writing to all comments received during the public comment period.
- 15.7 Beginning on January 1, 2022, the Board may require a health insurance issuer offering a qualified health plan through the Exchange to offer one silver standardized health plan and one gold standardized health plan on the Exchange. If a health insurance issuer offers a bronze health plan through the Exchange, the Exchange may also require the issuer to offer one bronze standardized health plan through the Exchange.

- 15.8 The Board and Health Benefits Plan Committee shall adhere to all state and federal plan design laws.
- 15.9 The Health Benefits Plan Committee shall meet and consider additional revisions in special circumstances, such as changes in the healthcare landscape, federal law, or state law.
- 15.10 **Nonstandardized plans.** A health insurance issuer offering standardized health plans through the Exchange may also offer nonstandardized health plans through the Exchange, provided that the actuarial value of nonstandardized silver health plans offered through the Exchange shall not be less than the actuarial value of the standardized silver health plan with the lowest actuarial value.

Nonstandardized plans. A health insurance issuer offering standardized health plans through the Exchange may also offer nonstandardized health plans through the Exchange, provided that the actuarial value of nonstandardized silver health plans offered through the Exchange shall not be less than the actuarial value of the standardized silver health plan with the lowest actuarial value.

PASSED, APPROVED, AND ADOPTED on 2020. NEW

MEXICO HEALTH INSURANCE EXCHANGE BOARD

Approved by:

David Shaw
Chair
