

HEALTH BENEFIT EXCHANGE IN NEW MEXICO

New Mexico Center on Law and Poverty

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The New Mexico Center on Law and Poverty is dedicated to advancing economic and social justice through education, advocacy and litigation. We work with low-income New Mexicans to improve living conditions, increase opportunities and protect the rights of people living in poverty.

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I. EXECUTIVE SUMMARY

New Mexico has one of the lowest rates of health insurance in the entire country – nearly one in four New Mexicans does not have healthcare coverage. The federal healthcare reform law promises to greatly expand coverage by making more people eligible for Medicaid and providing money to help other low- and middle-income individuals purchase private health insurance.

As part of healthcare reform, New Mexico, like other states, must establish a Health Benefit Exchange (Exchange). The Exchange will be a competitive marketplace where consumers and small employers can compare the prices and benefits of health plans offered by different insurance companies. This information will be available on a website where residents can shop for and purchase health insurance. The Exchange will also calculate the costs of coverage under each plan and will apply federal tax credits and subsidies to help make that plan affordable. The costs for developing an Exchange will be fully paid by the federal government.

New Mexico has flexibility under the law to design its Exchange to best meet the needs of local residents and address the unique challenges facing our state. Many communities in New Mexico are geographically isolated and have few healthcare providers. Major demographic disparities still exist in rates of uninsurance, access to care, and health outcomes. The Exchange is unlikely to address these challenges if it is a passive instrument that merely provides consumers with a menu of health plans on a website. Instead, New Mexico can take advantage of opportunities to make its Exchange a pro-consumer force that ensures high quality and affordable coverage for families and small businesses and that reaches individuals who are traditionally underserved or who live in remote areas. New Mexico can maximize the power of the Exchange by structuring it to:

1. **Improve access to high quality and affordable coverage for consumers and small employers.** The Exchange in New Mexico will be responsible for certifying which health plans can offer coverage through the Exchange. Federal law provides minimum standards for certifying plans, but each state can take additional steps to ensure that the plans provide good value to consumers. New Mexico's Exchange could review the past performance of plans and the quality of services to ensure they sufficiently meet the needs of the state's diverse population, such as by evaluating whether the plan has an adequate network of providers in underserved areas. The state could also ensure affordability for consumers and small employers by adopting measures that prevent "adverse selection" (where individuals enroll in plans outside of the Exchange, thereby shrinking the risk pool and driving up costs inside the Exchange).
2. **Be governed by a consumer-oriented agency that is transparent and accountable to the public.** New Mexico has the option of structuring its Exchange as a state agency or an independent agency. An independent agency is more likely to gain the trust of the public and achieve administrative efficiency. The state must also determine how the board of directors for the Exchange will be appointed. The board would have more credibility if chosen in a way that limits political influence and distributes power evenly between the Executive and the Legislature. One of the most important things the state could do is adopt strong conflict of interest rules to insulate the board from undue industry influence and ensure that it functions primarily in the interest of consumers and small employers, and with the appearance of independence and impartiality. However, the board should still be composed of experts – people with experience working with consumers, as well as individuals with background in the

healthcare and insurance industries. Finally, all decision-making processes of the governing body should be transparent and accountable to the public.

3. **Maximize enrollment for uninsured and underserved populations.** Many uninsured people in New Mexico do not know about the health reform law or understand the function of the Exchange. It is especially important that the Exchange prioritize outreach to maximize the number of New Mexicans who obtain healthcare coverage, spreading the risk of high-cost healthcare across the Exchange pool and keeping costs down for everyone. Because New Mexico is a rural, multilingual state, the state should adopt an outreach plan that is geographically comprehensive, creatively administered to reach low income and hard to reach populations, and accessible in multiple languages. In addition, enrollment procedures should be designed to make applying for and retaining coverage as easy as possible – by phone, online, in person, and through navigators (healthcare workers who will educate people about the Exchange and help enroll them in coverage). Immigrant families in particular face a host of complex eligibility rules that may create barriers to enrollment. The Exchange can ensure linguistically appropriate services and encourage all eligible family members to get coverage.
4. **Streamline enrollment systems with Medicaid and other coverage programs.** Health reform will greatly expand eligibility for Medicaid, the safety net health insurance program, to cover everyone under 138% of the poverty level. In addition, New Mexico may opt to implement a Basic Health Program (BHP), which would cover individuals with incomes between 138% and 200% of the poverty level. People with incomes up to 400% of the poverty level are eligible for tax credits and subsidies to purchase coverage through the Exchange. Because employment shifts and other changes affect a household's income, many individuals will move between these systems in a given year. While the health reform law requires the state to adopt streamlined procedures that ensure “no wrong door” enrollment into Medicaid or the Exchange, the state can also take measures to ensure that the enrollment process minimizes gaps in coverage for low-income individuals, reduces paperwork requirements, aligns eligibility rules, and establishes clear lines of communication between the Exchange, BHP, and Medicaid.
5. **Address the healthcare concerns and special legal requirements for Indian tribes and Urban Indian populations.** Native Americans make up over 10% of the population in New Mexico, yet they have far more limited access to healthcare than other racial and ethnic groups. Although the federal government is obligated to provide healthcare to Native Americans, they will be expected to pay a portion of premiums to enroll in coverage through the Exchange. As a result, many Native Americans will remain uninsured without advocacy efforts to amend the federal law or devise state level solutions. The state should also design its Exchange to accurately identify Native Americans, offer high quality plans, and provide aggressive outreach.

In order to achieve these objectives, New Mexico must pass Exchange-enabling legislation during the 2012 Legislative session. Without a law in 2012, the state will be unable to demonstrate readiness to operate an Exchange by January 1, 2013 (the deadline for states to prove their Exchanges will be operational by October 1, 2013), and the federal government will step in to run the Exchange. A federally run Exchange would be less likely to serve the needs of New Mexico consumers and small businesses. In addition, while the governors of several states have indicated that they may establish Exchanges by Executive Order, such an act would likely violate the state constitution in New Mexico. Instead, an Exchange should be enacted by state legislation to realize its promise of improving access to quality healthcare and better health outcomes for New Mexicans.

II. INTRODUCTION: WHAT IS A HEALTH BENEFIT EXCHANGE AND WHY IS IT IMPORTANT FOR NEW MEXICO?

Nearly a quarter of New Mexico residents do not have health insurance. Healthcare reform has the potential to cut that rate significantly, ensuring that 95% of people in the state have access to healthcare coverage. However, there are myriad challenges to converting that potential into reality. New Mexico's high poverty rate will make enrolling all eligible residents a challenge. Further, New Mexico is a rural state. This means not only that outreach will be more difficult, but it will also be critical to ensure that there is an adequate provider network in communities across the state. If it is structured to respond to these realities, a New Mexico-based Exchange has the potential to provide hundreds of thousands of currently uninsured and underinsured adults and families the opportunity to purchase subsidized, comprehensive healthcare coverage.

New Mexico has the second highest percentage of residents without health insurance in the country. In 2009, 23% of New Mexicans lacked access to comprehensive health insurance.¹ The New Mexico Office of Health Care Reform (OHCR) commissioned a study that found that 38% of uninsured adults said they never had health coverage as adults.² New Mexico also has the fourth highest rate of uninsurance (16%) among children aged 0-18.³ Further, rates of uninsurance are higher among racial and ethnic minority groups – in 2009, 28% of Hispanics in New Mexico lacked health insurance,⁴ and adults in New Mexico are more likely to say they have never had health insurance if they are Hispanic or Native American.⁵

Uninsured patients are generally unable to access preventive and otherwise medically necessary services. This directly threatens the health and well-being of New Mexico families and children, and also drives up healthcare costs for taxpayers and insured consumers who absorb the cost of providing medical care to the uninsured through expensive emergency room visits and tax-supported county indigent care funds.⁶ New Mexicans currently pay twice the national average in extra premiums for private insurance due to costs that are shifted from the uninsured to the insured.⁷ New Mexico also spent more than \$180 million on local indigent care programs in 2010.⁸

The Patient Protection and Affordable Care Act (ACA) provides several opportunities to address these high rates of uninsurance and their attendant costs. The ACA substantially expands Medicaid eligibility, making all individuals with incomes up to 138% of the Federal Poverty Level (FPL) eligible for coverage. (While federal law expands eligibility to 133% FPL, special income-counting rules will actually extend eligibility to 138% FPL.)⁹ States also have the option of establishing a Basic Health Program (BHP) that covers individuals with incomes between 138% and 200% FPL.¹⁰ Finally, individuals with incomes up to 400% FPL will be eligible for federal tax credits and subsidies to help them purchase private health insurance through an Exchange.¹¹ A recent Urban Institute report estimates that state and local governments in New Mexico will save between \$172 and \$344 million from 2014 to 2019 due to reductions in publicly provided healthcare programs.¹²

The Exchange will be a major avenue for extending healthcare coverage to more people. An Exchange is an organized marketplace where individuals and small businesses may purchase health insurance. The Exchange is intended to give consumers and small businesses more control and better choices when buying insurance. It provides standardized information about health plans on a website so that they can be compared in a meaningful way, and helps consumers enroll into those plans. This will promote competition among health plans and help reduce costs for consumers and

small businesses. The health plans offered in the Exchange must meet federal and state requirements regarding plan quality and comprehensiveness.¹³

The ACA requires the establishment of an Exchange where individuals can purchase coverage, as well as an Exchange where small employers can purchase coverage called the Small Business Health Options Program (“SHOP” Exchange).¹⁴ States may elect to combine these two marketplaces into one Exchange.¹⁵ For the purpose of this report, they will be referred to as a single entity.

Under the ACA, individuals, families, and small employers will receive significant federal tax credits and subsidies to purchase health coverage through their state’s Exchange. In New Mexico, it is estimated that over 211,000 New Mexicans will receive some form of tax credit or subsidy to get coverage through an Exchange.¹⁶ In addition, small businesses will be eligible for tax credits to offset their costs by up to 50%. In total, these federally funded tax credits are expected to bring at least \$3.4 billion into New Mexico’s economy between the years 2014 to 2019.¹⁷

States must have a fully operational Exchange in place by October 1, 2013, when it must begin enrolling consumers.¹⁸ The federal government will pay the full costs for states to establish their Exchanges until January 1, 2015, when the Exchange must become self-sustaining (for example, by charging fees from health insurers). If a state cannot show by January 1, 2013 that it will be ready to operate an Exchange by October of that year, the federal government will step in to operate the Exchange.¹⁹ The ACA also allows states to collaborate in establishing regional Exchanges, and permits individual states to establish more than one Exchange within their state.²⁰ Exchanges will either operate as state agencies, instrumentalities of the state, or public not-for-profit corporations.²¹

The ACA provides considerable flexibility to states regarding the design and operations of their Exchanges. States retain significant authority to make important policy decisions regarding Exchange governance, the certification of qualified health plans, and outreach and enrollment strategies. While the state should ensure that as many consumers are able to purchase healthcare coverage through the Exchange as possible, achieving this goal will not guarantee that newly insured consumers are actually able to access medically necessary services. Adequate access to services is an especially important consideration in New Mexico, where people in rural communities have very limited access to primary care physicians and specialists. Ensuring that consumers are actually able to access healthcare services is both critical to the treatment of individual patients and a necessary element of systemic healthcare reform aimed at reducing long-term costs.

Under the ACA, the Exchange must perform certain baseline functions. It must:

1. *Determine which insurance plans may be offered through the Exchange.* The Exchange must certify that health plans meet certain federal minimum standards regarding plan quality and comprehensiveness. States may also elect to adopt additional standards for the certification of qualified health plans (QHPs). This certification function is important because tax credits and cost-sharing subsidies for consumers and small employers will only be available through the Exchange, so offering a plan through the Exchange gives an insurer access to a market of consumers unavailable anywhere else.

2. *Rate insurance plans under Platinum, Gold, Silver, or Bronze coverage standards.* The Exchange is directed to assign a rating to each QHP offered through the Exchange.²² Ratings are based on the level of coverage that each plan provides, as measured by the plan’s actuarial value (the percentage of medical expenses a plan covers, averaged across all consumers in a benefit category). Four categories

of coverage will be offered through the Exchange: Platinum, Gold, Silver and Bronze. Platinum coverage has the highest actuarial value (90%), and thus offers the most comprehensive coverage, while Bronze plans will have an actuarial value of (60%) and offer less coverage.²³

3. *Maintain a website and customer assistance hotline to provide consumers and small employers with information about their health insurance options and enroll them in the health plans of their choice.* This website must allow consumers to compare and purchase different health plans offered by various insurance companies.²⁴ Information about plans must be presented uniformly to make comparing plans easier.²⁵ The Exchange must also provide an online calculator that shows the costs of coverage after taking into account the tax credits and subsidies for which the individual qualifies.²⁶ Finally, the Exchange must have a toll-free customer assistance hotline.²⁷

4. *Provide information about federal tax credits and subsidies to help consumers and small businesses purchase coverage.* Consumers and small businesses are eligible to receive federal tax credits and subsidies if they purchase health insurance through the Exchange. The Exchange must, at a minimum, require health plans to provide information about the amount of cost-sharing required under the plan, and the Exchange must provide an online calculator that shows consumers the actual cost of coverage after applying any tax credits or cost-sharing subsidies.²⁸

Individual Tax Credits: For consumers, the tax credits are advanceable, which means they are available throughout the tax year rather than merely at the end.²⁹ The Exchange will send the request to the federal government for an individual to receive advanceable credits.³⁰ The health plan offering coverage through the Exchange will discount the cost of the insurance premium by the amount of the credit. The federal government sends the credits to the insurer on a monthly basis,³¹ and reconciles the payments against the amount reported on the individual’s next tax return.³² If the individual has paid too much or too little in premiums (which may occur due to job or salary changes), the IRS will compensate or bill the individual accordingly.³³ Consumers qualifying for the premium tax credit cannot pay more than a certain percentage of their total family income in premium costs; that percentage will vary based upon family size and poverty level. According to the ACA, the size of the tax credit will be equal to the premium cost of the second lowest cost Silver plan coverage in the Exchange minus the consumer’s total maximum allowable contribution.³⁴ Table 1 shows what percentage of household income a family may be required to pay for premiums.

Table 1: Maximum Premium Contribution by Household Income

Household Income, as a Percentage of Federal Poverty Level (FPL)	Maximum Allowable Premium Contribution, as a Percentage of Household Income
Up to 133%	2%
133-150%	3-4%
150-200%	4-6.3%
200-250%	6.3-8.05%
250-300%	8.05-9.5%
300-400%	9.5%

Source: Families USA³⁵

Small Employer Tax Credits: The ACA also incentivizes small employers to provide insurance coverage to their employees through the Small Business Health Options Program (“SHOP”

Exchange). Small businesses are already eligible for tax credits to cover up to 35% of the premiums paid for employee health insurance.³⁶ Beginning in 2014, small businesses with fewer than 25 employees that pay annual average wages below \$50,000 will be eligible for a small business tax credit to offset up to 50% of the cost of providing employer-sponsored insurance benefits.³⁷ Nonprofit employers will receive tax credits for up to 35% of the costs.³⁸ Small employers are only eligible for the tax credits if they pay at least 50% of the costs of premiums for their employees.³⁹

Consumer Subsidies for Out-of-Pocket Costs: Whether they purchase plans independently through the Exchange or are covered by a small employer purchasing coverage through the SHOP Exchange, consumers are also eligible for subsidies to offset out-of-pocket costs of insurance. Out-of-pocket costs are healthcare expenses that consumers must pay, apart from their premium contribution, because they are not covered by insurance. They include costs such as copayments and deductibles. The ACA limits the total amount of out-of-pocket costs for essential health benefits.⁴⁰ The limits are based on the maximum out-of-pocket limits for Health Savings Account-qualified health plans (\$5,950 for single coverage and \$11,900 for family coverage in 2010, indexed to the change in the Consumer Price Index until 2014 when the provision takes effect.)⁴¹ After 2014, the limits will be indexed to the change in the cost of health insurance.⁴² As shown in Table 2, people with incomes at or below 400% of poverty have their out-of-pocket liability capped at lower levels.

Table 2: Out-of-Pocket Costs - Maximum Liability by Household Income

Household Income, as a Percentage of Federal Poverty Level (FPL)	Maximum Allowable Out-of-Pocket Costs, as Proportion of Maximum Contribution to Health Savings Account
100-200%	Two-thirds of Maximum
200-300%	One-half of Maximum
300-400%	One-third of Maximum

The limits on out-of-pocket maximum amounts means that people with incomes of 150% of the poverty level who purchase coverage in the Exchange would have the limit on their out-of-pocket spending reduced to two-thirds of the generally applicable maximum (for example, if the provision were in effect in 2010, at 150% of the federal poverty level, the out-of-pocket maximum would be about \$1,981 for single coverage and \$3,963 for family coverage).⁴³

5. *Develop an outreach strategy and provide “no wrong door” access to individuals who may qualify for Medicaid.* The Exchange and the state’s Medicaid system must be coordinated to provide a “one-stop shop” where consumers’ eligibility for the Exchange, Medicaid, or the Children’s Health Insurance Program (CHIP) can be determined through a single application and the person must be enrolled in the appropriate program.⁴⁴ The Exchange must provide consumers the tools to allow for submission of this single, streamlined application via internet portal, telephone, mail, or in person.⁴⁵ In addition, the Exchange must conduct outreach to raise awareness among consumers about their coverage options and help people select and enroll in health plans. This outreach plan must include both an Exchange-operated “navigator program” and other education and outreach activities.⁴⁶

III. OPPORTUNITIES FOR IMPLEMENTATION: HOW AN EXCHANGE CAN BE STRUCTURED TO MAXIMIZE ACCESS TO HEALTHCARE IN NEW MEXICO

Whether the Exchange successfully increases access to high-quality healthcare for consumers and small employers will depend largely upon the policy choices made by the state in the areas where it has flexibility under the ACA. The state can ensure that the Exchange actually increases access to healthcare rather than simply increases access to health insurance by designing the Exchange to:

1) Have the authority to encourage high quality and affordable healthcare services in communities across the state; 2) Be governed by an agency that prioritizes the interests of consumers and small employers; 3) Maximize enrollment by using simple application procedures and developing an outreach plan that takes into account the state's geography and demography; 4) Streamline enrollment systems for Medicaid and the Exchange and ensure that individuals do not lose coverage if they transition from one system to another; and 5) Address the healthcare concerns and legal requirements for the state's large Native American population.

1. Improve Access to High-Quality and Affordable Coverage for Consumers and Small Employers

The basic function of the Exchange is to connect consumers and small employers to high-quality health insurance. To do this successfully, New Mexican consumers and small employers must be fully informed about how an Exchange can help them purchase federally subsidized health coverage. Many New Mexico residents who will become newly eligible for coverage under the ACA do not understand what an Exchange is or how it can benefit them. Further, the Exchange must be able to demonstrate to consumers that purchasing insurance is a good deal for them, by ensuring that plans offered in the Exchange meet the healthcare needs of consumers across the state. Finally, the Exchange can take prudent steps to keep healthcare coverage affordable for all participants.

Make Information about Health Plans Available and Easy to Understand

A successful Exchange will assist all participants in making fully informed decisions about their healthcare coverage. New Mexico's population is highly diverse in terms of its racial/ethnic, linguistic, geographic and socioeconomic composition. Rates of uninsurance tend to be higher among low-income and rural residents, as well as among Hispanics, Native Americans, and other racial and ethnic minorities. In order to ensure that all eligible consumers are able to purchase healthcare coverage and receive federal subsidies, the Exchange must provide consumers and small employers with appropriate, easy to understand information about their coverage options.

New Mexicans must be educated about what an Exchange is and what it will do. The state's Office of Health Care Reform (OHCR) recently commissioned surveys of uninsured and underserved populations, using a federal planning grant for Exchanges.⁴⁷ In the survey of the uninsured, 40% of those surveyed were unaware a health reform law had passed.⁴⁸ Only 15% of the uninsured said they were aware the law required an Exchange.⁴⁹ However, after being given a brief description of the Exchange, 82% of the uninsured said they believed an Exchange was a good idea.⁵⁰

The ACA requires that the Exchange provide consumers and small employers with choices about their coverage options by making information about health plans available and easy to compare on a website. The Exchange must use a standard online format for presenting information about plans.⁵¹ Further, the ACA directs the Exchange to set up a consumer hotline where people can get

information about health coverage options, ask general questions, and troubleshoot issues with their existing coverage.⁵²

The Exchange must also collect certain information from qualified health plans (QHPs) and provide that information to consumers via the Exchange website.⁵³ These reporting requirements include data on: claims payment policies and practices; periodic financial disclosures; enrollment; disenrollment; number of claims that are denied; data on rating practices; cost sharing and payments with respect to any out-of-network coverage; and enrollee rights.⁵⁴

Ensure that Health Plans Provide Affordable and High-Quality Coverage

Health reform will only improve health outcomes and reduce health disparities if it can offer consumers good value – high quality care at a price they can afford. Cost is the primary barrier to obtaining coverage for New Mexico’s uninsured. In the OHCR survey of the uninsured, 77% of those surveyed said they were currently not insured because they did not have access to affordable coverage.⁵⁵ In the survey of women, participants cited cost as a significant barrier to obtaining and maintaining coverage – and affordability was mentioned across all ethnic and income groups.⁵⁶ In the survey of young adults and the marginally employed, a majority of those surveyed said they feared financial disaster if they experienced a health problem.⁵⁷

Affordability: The ACA takes significant steps towards ensuring that consumers do not pay exorbitant costs for insurance by limiting the amounts they must pay for premiums and out-of-pocket costs (as shown previously in Tables 1 and 2). Both individuals and small businesses will be eligible for tax credits that will substantially decrease premium costs, and many individuals will also be eligible for subsidies to further reduce out-of-pocket expenditures. Moreover, individuals will be grouped into one risk pool in the Exchange, which will help keep costs down for everyone. The Exchange also gives small businesses purchasing power similar to what large businesses have so that small businesses can access better choices and lower prices.⁵⁸ The state, however, can go even further to make health plans affordable. The federal Department of Health and Human Services has proposed rules that clarify that states will be allowed to negotiate with health plans over their rates or implement competitive bidding processes.⁵⁹ New Mexico could authorize its Exchange to implement these strategies to ensure that the most affordable plans are offered on the Exchange.

Quality of Coverage: In addition to cost, there is a real concern among consumers that even if they have insurance, that insurance will not grant them access to the healthcare they need. Consumers expressed concern that individuals in rural areas would be unable to see a doctor even if they have insurance.⁶⁰ This concern is justified in New Mexico; as shown in Table 3, the ratio of primary care physicians per 1000 residents is very low in rural counties compared to the state’s urban centers. For instance, in 2010 there were 3.74 primary care physicians for every 1000 residents in Bernalillo County, the state’s most populous county and major economic center, while Hidalgo County, located in Southeastern New Mexico with a population of 5,932, did not have a single licensed primary care physician.⁶¹

Table 3: New Mexico Counties with the Lowest Ratio of Licensed Primary Care Physicians per 1000 Residents (2010)

County	Population (Population Density/Square Mile)	Licensed Primary Care Physicians per 1000 Residents
Bernalillo	662,564 (566.8/sqm)	3.74
De Baca	2,022 (0.95/sqm)	.44
Valencia	76,569 (62/sqm)	.44
Torrance	16,383 (5/sqm)	.28
Mora	4,881 (3/sqm)	.18
Hidalgo	4,894 (3/sqm)	0.00

Source: New Mexico Health Policy Commission⁶²

Survey participants suggested providing incentives to primary care providers in high-need areas and utilizing technology (such as teleconferencing) to bring specialists to rural communities.⁶³ Coverage statewide will ideally be both comprehensive and coordinated with other services – for example, some survey respondents suggested locating primary care providers near public benefits offices.⁶⁴ In addition, certain benefits that are not required under the ACA, such as dental, vision, hearing, and certain behavioral health and substance abuse treatment services, are essential to meeting the needs of some consumers – particularly those with disabilities.⁶⁵

Policymakers in New Mexico can ensure that our Exchange will address these cost and quality concerns. A key function of the Exchange will be to certify which health plans may be offered through the Exchange. The ACA requires that plans offered through the Exchange meet certain basic federal requirements regarding plan quality and comprehensiveness. At a minimum, qualified health plans must offer a “minimal essential benefits package”,⁶⁶ and must comply with other criteria regarding grievance procedures, adequacy of provider networks, and marketing practices.⁶⁷

States have the authority to establish additional plan selection criteria and to decide if offering a plan would be in the best interest of individual consumers and employers.⁶⁸ This gives New Mexico the opportunity to increase not just access to affordable insurance, but access to actual providers and services in the communities where these newly insured consumers live. The Exchange could develop selection criteria for qualified health plans that go beyond the minimum requirements in federal law to ensure that health plans provide consumers with affordable, high quality and comprehensive coverage. To this end, the Exchange in New Mexico should be given the power to:

1. Ensure health plans have adequate networks of healthcare providers that serve low-income communities, including rural areas, tribal areas, and traditionally medically underserved urban areas. While the ACA requires that plans have adequate provider networks,⁶⁹ the Exchange in New Mexico could set specific standards that meet the needs of our state’s population.
2. Develop standards for minimum essential benefits that adequately meet patient healthcare needs, for example, by requiring such benefits as dental or vision services, which have been identified by consumers as particularly important services
3. Improve health outcomes by encouraging health plans to adopt practices which increase the availability of services in rural and urban underserved areas and are likely to yield better

patient health outcomes. Under the ACA, the Secretary of Health and Human Services will be establishing guidelines on strategies for improving health outcomes,⁷⁰ for example by recommending that health plans report to the Exchange on care coordination, reductions in hospital readmissions, and wellness and health promotion activities, among other areas. The Exchange in New Mexico should evaluate these strategies and use them if appropriate.

In addition to establishing health plan selection criteria, the ACA also requires qualified health plans to report data on health plan performance, including information on patient utilization of healthcare services.⁷¹ The Exchange should consider ways to use this data to hold qualified health plans accountable for their performance. For instance, the Exchange could use health plan performance data as a factor in determining whether to re-certify plans.

Prevent Adverse Selection against the Exchange

For the Exchange to be successful at offering affordable and high quality coverage, the state will need to guard against the threat of “adverse selection” against the Exchange. Adverse selection occurs when a disproportionate number of people who are in poorer health and have high health expenses enroll in coverage through the Exchange, while healthier, lower-cost people enroll in plans offered through the markets outside of the Exchange.⁷² This would drive up costs not only for consumers and small employers purchasing coverage through the Exchange, but also for the federal government, which must provide tax credits and subsidies to help purchase the coverage. Higher premiums would depress participation in the Exchange if consumers and small businesses could get a better deal in the private market. This in turn could drive premiums in the Exchange even higher.⁷³

Adverse selection can also occur among plans offered in the Exchange. The ACA requires the Exchange to offer consumers an array of coverage options at different coverage levels: Bronze, Silver, Gold, and Platinum, as well as a Catastrophic plan option for certain consumers. Platinum plans will have the most comprehensive coverage while Bronze plans will have the least coverage. People with chronic conditions and greater healthcare needs could tend to choose more comprehensive coverage options, causing the premiums for such plans to become increasingly unaffordable.

The ACA provides some protection against adverse selection. First, the federal premium tax credits that will help low and moderate income people purchase insurance can only be used in the Exchange, making the Exchange an attractive option for many consumers. These credits will not, however, lower the risk of adverse selection for those individuals and small businesses that are *not* eligible for such subsidies and who may choose to purchase coverage outside of the Exchange.⁷⁴ Second, the ACA requires the use of a risk-adjustment system, in which plans with sicker-than-average participants receive payments to compensate them for the resultant higher costs. However, this generally only compensates plans for *some* of the differences in health costs. Finally, the ACA requires a “single risk pool,” meaning that each insurer will be required to treat all enrollees in a given plan – whether inside or outside the Exchange – as a single group when setting premiums.⁷⁵ This reduces the ability of insurers to “cherry pick” healthier enrollees and offer them coverage at lower prices outside of the Exchange. However, this only provides limited protection because the ACA does not require insurers to offer identical plans inside and outside of the Exchange.⁷⁶

It is therefore important that the state provide further protections against adverse selection, for example, by:

1. *Maximizing enrollment in the Exchange:* This will help spread risk throughout the pool of insured people because healthy individuals will be pooled with those who have health conditions.
2. *Making the rules for any insurance markets outside the Exchange consistent with the rules that apply inside the Exchange:* This would discourage insurers from refusing to participate in the Exchange and prevent insurers operating outside the Exchange from designing benefit packages and marketing campaigns to attract healthier people away from the Exchange.
3. *Requiring insurers to offer the same products inside and outside the Exchange:* This would remove incentives for insurers to only offer insurance outside of the Exchange where consumer protection rules may be weaker.
4. *Requiring all insurers that are licensed in the state to pay fees to support the Exchange, whether or not they participate in the Exchange:* This would encourage insurers to offer plans in the Exchange because they would be required to support its operations even if they did not participate.
5. *Offering Medicaid contracts only to insurers that offer plans on the Exchange:* This would leverage the substantial purchasing power that the Medicaid program has with insurance companies to discourage them from refusing to offer plans in the Exchange.
6. *Ensuring that risk-adjustment and risk-pooling requirements work effectively, and conducting strong and ongoing enforcement of premium pricing and actuarial value rules:* To work effectively, the ACA's requirements regarding premium pricing, risk pooling and actuarial value must be closely monitored and enforced.
7. *Establish a comprehensive baseline of Essential Health Benefits:* Detailed and standardized benefit rules could ensure that insurers cannot craft plans that scale back coverage in areas important to people with significant health needs.
8. *Require insurers that want to operate in the Exchange to offer products at all Exchange coverage levels:* This would ensure that Platinum plans are available and that insurers offering this coverage are not automatically attracting a disproportionate number of sicker consumers.

2. Ensure the Exchange is a Consumer-Oriented Agency that is Transparent and Accountable to the Public

The ACA provides states with considerable authority to decide how the Exchange will be governed. If the Exchange is going to effectively increase access to high-quality healthcare, it must be governed in an unbiased way and must be accountable to stakeholders and the public generally. This is achievable by structuring the Exchange as an independent “quasi-governmental” agency rather than a state agency, and imposing strict regulations against conflicts of interest for members of the

Exchange's board of directors and staff. It is important that the board be composed of experts in the field who do not stand to gain financially from the Exchange's operations. Further, the board will have more credibility if the appointment of board members is politically balanced and as free from the influence of changing political cycles as possible. Transparency and accountability are also critical and could be promoted by applying the state's sunshine laws to the Exchange and developing robust grievance procedures for consumers to resolve disputes.

Independent Non-Profit Agency that is “Quasi-Governmental”

Under the ACA, the Exchange must either operate as a state agency (or instrumentality of the state), or as a public not-for-profit corporation.⁷⁷ While there are advantages and drawbacks to both approaches, setting up the Exchange as an independent and “quasi-governmental” not-for-profit corporation has important benefits. First, an independent agency would be administratively efficient because it would not be subject to the same bureaucracy, salary limits, or procurement laws as a state agency. As a result, an independent Exchange would have the flexibility to hire technically competent staff and be responsive to changing conditions. An independent agency would also be more likely to have credibility with consumers and small businesses. For example, the young adults who were surveyed by the OHCR indicated a high level of mistrust of government's ability to provide a plan with high-quality coverage.⁷⁸

The state can also minimize the potential drawbacks of using an independent nonprofit agency to run the Exchange by adopting legislation to make it “quasi-governmental.” Specifically, the state could make the Exchange subject to the same transparency laws as state agencies and require that the Exchange report regularly on its activities to the Legislature. The state could also require state agencies to cooperate with the Exchange and contract with it as needed to coordinate enrollment and coverage systems. Finally, the state could maintain the authority to appoint board members who govern the Exchange in a balanced manner as discussed below.

Prohibitions against Conflicts of Interest

While the ACA requires that the Exchange must be governed by a board of directors, it does not address other key governance questions, such as how those members should be selected, or what qualifications they should have. Consumers will rely on the Exchange to protect their interests, and trust in the Exchange will be greatly affected by public perception of its independence.

It is critical that the Exchange is free of conflicts of interest. Those who stand to financially benefit from the activities of the Exchange, such as insurance industry representatives and healthcare providers, should not serve on the board or staff of the Exchange. Respondents to the OHCR survey agreed that the Exchange should be an unbiased source of information, independent of insurance companies and brokers, to protect consumers' interests.⁷⁹ To be optimally robust, conflict of interest rules should extend to both the board and staff of the Exchange. Because consumer confidence in the Exchange is so critical, strong conflict of interest protections will not only ensure more independent decision-making, but will also preserve the *appearance* of independence, which is key to gaining the public's trust. The National Association of Insurance Commissioners Consumer Liaison Committee agrees that insurers and healthcare providers should be excluded from the governing board in order to gain wide consumer acceptance.⁸⁰

These protections would also prevent one insurance company or healthcare provider from gaining an unfair competitive advantage over another. The Exchange is charged with determining whether health plans meet certification standards to offer coverage on the Exchange. It would not be fair to allow one insurance company to serve on the Exchange's board while denying another. The only way to promote fairness would be to have all the companies and healthcare providers serve on the board or staff of the Exchange, which would both be impractical and result in undue industry influence at the expense of consumer interests.

Such a prohibition would not prevent the board or staff from having adequate expertise. By prohibiting board and staff members from having current employment with insurers and healthcare providers, the state could still allow for persons with prior experience working in the health insurance industry to serve as members of the Exchange's board of directors.⁸¹ Members can also be drawn from academia, the nonprofit policy sector, and retired industry employees. For example, New Mexico State University has an actuarial sciences program. Other states have named retired actuaries to their Exchange boards. In addition, the Exchange can still seek consultation from health insurers and providers. Its decision-making could be fully informed by these stakeholders, but still be conducted solely by those who have knowledge of the issues and no troubling financial interests.

Expertise on Board of Directors

The Exchange will need board members who have the policy and technical experience necessary to carry out the functions of the Exchange, which will include evaluating the coverage provided by health plans and developing strategies to improve healthcare access, developing enrollment systems in coordination with other state and federal agencies, and maintaining an online system that is accessible, easy to understand, and provides useful information for consumers and small employers. The state can ensure that the board has these competencies by requiring that the members cover a wide range of expertise. Important areas of expertise will include experience with purchasing individual and small employer coverage, health plan administration, healthcare financing, health economics or healthcare policy, and enrollment strategies for reaching underserved communities.

Balanced and Non-Partisan Board of Directors

If consumers and small businesses feel they are being well-served by the Exchange, then they will be more likely to choose the Exchange as their source of coverage. An important ingredient in sustaining consumer confidence will be taking steps to make the Exchange as independent of political pressure as possible. As such, no single appointing authority (i.e. Governor or Legislature) should be able to appoint a majority of the voting members of the board, as this would create at least the perception of partisan political control over the Exchange. Further, members of the Exchange's board should be given proper autonomy to make decisions and govern the operations of the Exchange without the fear of being removed from office on the basis of partisan political interests. Board members should only be removed for cause, and should be provided with a public hearing prior to removal.

Transparency and Accountability to the Public

The Exchange is more likely to develop policies that are in the interest of consumers and small employers if it is held accountable to these stakeholders. Requiring the Exchange to conduct its

business in a way that is transparent and accessible to the general public is essential to maintaining public confidence in the Exchange.

Sunshine Laws for Open Meetings, Public Records, and Rulemaking Procedures: Like other government agencies, the Exchange should be subject to state sunshine laws such as the Open Meetings Act and the Inspection of Public Records Act, which would allow the public to attend board meetings of the Exchange and to access its records. Importantly, the state can also require that the Exchange be subject to rulemaking procedures that require notice and public hearings whenever policies are adopted for the Exchange. This would give consumers and small employers the opportunity to comment upon the Exchange's policies as they are being developed.

Consultation with Stakeholders: To further promote transparency, the Exchange must consult with the public as a part of its decision-making process.⁸² The federal Department of Health and Human Services has recently proposed a list of stakeholder groups that the state must consult with, including but not limited to: healthcare consumers; individuals with experience in facilitating enrollment in health coverage; advocates for enrolling hard to reach populations, including those who are advocates for individuals with disabilities and those who need culturally and linguistically appropriate services; small businesses and the self-employed; state Medicaid and CHIP agencies; federally recognized tribes; public health experts; healthcare providers; large employers; and health insurance issuers and agents and brokers.⁸³

In New Mexico, Urban Indians are another important constituency that should be consulted with about the Exchange. Urban Indians are Native Americans who live off the reservation; they make up a significant portion of the Native population in New Mexico. This population experiences higher than average rates of uninsurance and significant difficulty in accessing healthcare services.

The state can ensure that this consultation occurs on an ongoing basis by adopting legislation that requires the Exchange to have advisory committees comprised of the various stakeholder groups. Maintaining a broad network of consulting stakeholder groups also provides the Exchange with an opportunity to secure policy and technical advice from insurance industry representatives and healthcare providers without creating the conflict of interest that would result from these individuals serving directly on the governing board of the Exchange.

Grievance Procedures: Finally, public accountability and transparency should extend to the plans that participate in the Exchange. The ACA requires the Exchange-funded navigator programs to provide consumers with information on filing complaints and grievances in the event they have been unlawfully denied benefits or services by their health insurance plan.⁸⁴ The state can ensure that the Exchange has comprehensive, non-discriminatory and consumer-friendly grievance procedures. This will protect the rights of consumers and small employers who may have disputes regarding their eligibility for coverage, benefits, costs or cost-sharing level, or denial of claims. This is especially important to minimize wrongful denials of eligibility or services.

3. Maximize Enrollment for Uninsured and Underserved Populations

Healthcare reform presents a remarkable opportunity to increase access to healthcare and address health disparities in New Mexico. Health insurance will also become more affordable if more people get coverage. Higher enrollment in the Exchange will help bring down the costs of insurance for consumers and small employers by spreading risk across a larger pool of people.

However, this opportunity will be converted into reality only if eligible individuals actually enroll in coverage. The availability of coverage does not guarantee enrollment; for example, there are tens of thousands of children who are eligible for Medicaid in New Mexico who are still not covered. Moreover, awareness about the healthcare reform law is low among the individuals who will become newly eligible for coverage under the ACA, especially among people who are currently underserved. For example, the OHCR survey of individuals with disabilities in New Mexico found that people with disabilities are generally uninformed about the ACA, and that awareness of the law was particularly rare among Native Americans with disabilities.⁸⁵

Maximum enrollment in the Exchange requires that the Exchange's plan for outreach and education be community-based and address the challenges unique to New Mexico's rural, diverse population. Outreach should be conducted by people who know the community. Applying for and retaining coverage should be easy and require as little paperwork as possible. The application process can also be strengthened to ensure that it does not create unnecessary barriers for immigrant families.

Outreach and Education Plan

Federal law directs the Exchange to establish a navigator program that will provide consumers with information about their coverage options and facilitate enrollment in the Exchange. This assistance will be especially necessary for people who have never purchased insurance in the private market.⁸⁶ The state could significantly increase enrollment by requiring the Exchange to develop an outreach plan for reaching underserved and vulnerable populations.

In OHCR's general consumer survey, participants agreed that it will be critical to build public awareness of the Exchange well in advance of the launch of an Exchange, using broadcast and print media, community and workplace events, and the internet.⁸⁷ Effectively getting the word out about the Exchange in New Mexico will be a challenge. In addition to the informational barriers discussed earlier in this brief, there are substantial linguistic, cultural, and geographic barriers to enrollment. It will be particularly important to make information accessible in multiple languages. In New Mexico, 36% of the population older than age 5 speaks a language other than English at home, and 27% of them report they do not speak English "very well".⁸⁸ The two most predominant non-English languages are Spanish and Navajo.⁸⁹ Some states have developed original information materials in languages other than English. Rather than simply providing translated materials, New Mexico should consider following their lead, as these original-language documents tend to be more culturally responsive and appropriate than translated materials.

Outreach and education efforts will be more effective if conducted by established community-based groups. These groups are well-positioned to reach people who may be underserved because they already provide other resources, such as food banks, case management, or counseling, and thus are likely to understand the unique needs of the community. They can ensure that populations that are at risk of not obtaining insurance, even though they are eligible for it at low cost or no cost, are actually enrolled. For example, outreach efforts can target people who are exempt from penalties for not carrying coverage, such as Native Americans, or low-income people who have incomes below the tax filing threshold. Community-based workers can also take a holistic, whole-family approach and refer household members who do not or cannot enroll in coverage to other sources of healthcare.

Simple Enrollment Process

The application for the Exchange must be as easy and accessible as possible. To that end, the ACA requires that the application for healthcare coverage through the Exchange (including for tax credits and subsidies) be made available in a number of ways, including in person, online, by postal mail, and by telephone.⁹⁰ The state can ensure that these processes are user-friendly and accessible to people with disabilities and individuals with limited English proficiency. For example, the Department of Justice has instructions for states on how to make websites that are well-designed and accessible for people with disabilities.⁹¹ In addition, the Exchange should make interpretation and translation services available for people with limited English proficiency. Finally, the Exchange should reduce paperwork requirements to facilitate enrollment according to the recommendations in the next section on streamlining Exchange and Medicaid enrollment systems.

Responding to Challenges for Immigrant Families

From 2005 to 2009, according to U.S. Census data, 9.5% of New Mexico residents were immigrants.⁹² The majority of immigrant families contain children that are U.S. citizens,⁹³ meaning that most immigrants live in “mixed status” households – households that may contain some combination of citizens, lawful permanent residents (“green card” holders), other lawfully residing immigrants, and undocumented immigrants.

Immigrants face substantial barriers to enrollment in healthcare coverage. In fact, 46% of all noncitizens nationally are uninsured.⁹⁴ In New Mexico, language barriers are a key consideration, as 36% of New Mexico residents speak a language other than English at home.⁹⁵ Further, immigrant families may not know that they are eligible for services or that some members can get services even though others cannot. New Mexico can employ targeted approaches to outreach and enrollment in order to ensure that all eligible immigrants are connected to the healthcare coverage they need.

Require Immigration Status Information Only When Necessary: Undocumented immigrants are not eligible for services under the ACA. They cannot enroll in Medicaid, cannot purchase plans through the Exchange, and they qualify for neither tax credits nor subsidies. This exclusion of undocumented immigrants from care will have a substantial impact on mixed-status households (households with some combination of citizens, lawfully residing immigrants, and/or undocumented immigrants). Lawfully residing immigrants will be eligible for coverage and subject to the individual mandate, but may fear that providing verification and enrollment information will compromise their undocumented family members’ safety. This fear could deter some applications, leaving eligible immigrants – many of them children – without critically needed care.

The state can address these barriers by adopting current Medicaid rules regarding when questions may be asked about immigration status during the Exchange’s application and renewal process. These rules make clear that social security numbers and information on immigration status may be required only for individuals seeking healthcare coverage for themselves.⁹⁶ In addition to developing application and renewal forms that clearly request information on immigration status only when it is required to determine eligibility, state workers, Exchange employees, and navigators must be trained about when it is appropriate to ask questions about immigration status and how to do so sensitively given the prevalence of mixed-status households in the state. This training should highlight the deterrent effect of improper questioning and emphasize that the primary goal is the enrollment of every eligible individual in healthcare coverage.

Develop Simple Application Procedures for Children Living in Mixed Status Households: In order to be certified to offer plans in the Exchange, an insurer must offer plans that cover children only, without their parents.⁹⁷ For mixed-status families, it is particularly important that applications for these plans – and for the accompanying tax credits and subsidies – be made readily available. In addition, the Exchange must develop methods of income verification other than the previous year tax return process for households that do not file tax returns. These alternate methods should track methods of income documentation currently used in public benefits programs, where individuals may prove income through documentary evidence (such as a letter from the employer or pay stubs), a collateral contact who can verify employment and income, or – if neither of these is available, such as when an employer refuses to verify employment for their workers – self-attestation.

Provide Free, Full Coverage through the Exchange to Lawfully Residing Immigrants Who Are Not Eligible for Medicaid Due to Their Immigration Status: Some lawfully residing immigrants, including adults with lawful permanent residency (green card holders), are not eligible for Medicaid until they have been in a “qualified” immigration status for five years. This means that some lawfully residing immigrants with incomes below 138% FPL will have to purchase coverage through the Exchange. Even with access to premium tax credits and cost-sharing subsidies, many of these immigrants will be unable to afford coverage if they are required to pay for a portion of it out-of-pocket. If federal regulations do not extend tax credits and subsidies sufficient to cover all premium and out-of-pocket costs for these immigrants, the state can provide additional funding to ensure that lawfully residing immigrants who would be eligible for Medicaid but for their immigration status can afford coverage.

4. Streamline Enrollment Systems with Medicaid and Other Programs to Provide Seamless Transitions and Continuous Coverage

Medicaid and the Children’s Health Insurance Program (CHIP) are the nation’s healthcare safety net, providing health insurance to low-income children, mothers, seniors, and people with disabilities. In New Mexico, Medicaid covers about 25% of the state’s population, or nearly 550,000 people, mostly children.⁹⁸ Currently, adults are generally not eligible for Medicaid unless they are very low-income parents (who make less than 30% FPL in most cases), pregnant women, seniors, or people with disabilities. Although New Mexico created State Coverage Insurance (SCI) to fill the gap for other low-income adults and to provide coverage options for small employers that cannot afford health insurance for their employees, the program is frozen to new enrollment. The ACA expands Medicaid eligibility to all individuals with incomes up to 138% of the federal poverty line (FPL); this will provide new healthcare coverage to over 145,000 New Mexicans.⁹⁹

Under the ACA, New Mexico will also have the option to implement a “Basic Health Program” (BHP) for individuals with incomes between 138% and 200% FPL who are ineligible for Medicaid.¹⁰⁰ The state can either establish the BHP for this population, or may enroll these individuals through the Exchange with the rest of the uninsured population. Under the BHP, eligible consumers may not obtain subsidized insurance through an Exchange. Instead, they are covered through state contracted health plans.¹⁰¹ To fund these contracts, the state receives 95% of what the federal government would have spent if BHP enrollees had received premium tax credits and subsidies for out-of-pocket costs in the Exchange.¹⁰² The state negotiates the terms of the contracts with health plans, determining which benefits will be offered and how much will be charged to consumers. Any excess federal funds after the award of these contracts must, by law, be used to reduce premiums and cost-sharing, or to provide additional benefits, for individuals enrolled in the BHP.¹⁰⁵ Like the Exchange, the BHP is a potentially powerful tool to increase access to high-quality

healthcare for low-income New Mexicans; however, also like the Exchange, the BHP's ability to meet the needs of this population is dependent upon the choices the state makes in the areas that the federal law gives the state flexibility. New Mexico should only implement a BHP if it is pro-consumer and puts enrollees in a better position – in terms of both affordability and quality of coverage – than they would be in if they were to purchase coverage through the Exchange.

States must streamline the enrollment system for the Exchange, Medicaid, CHIP, and the BHP (if established). Under the ACA, states must provide a single application for all of the programs. The state can take additional steps to ensure that consumers are immediately enrolled in the appropriate coverage option, regardless of which program they apply for, and are able to make seamless transitions between programs if their income levels or circumstances change. In poor states like New Mexico, current and future Medicaid recipients are subject to frequent fluctuations in income and household composition. As a result, New Mexico will have a higher proportion of people than many other states who transition or “churn” between Medicaid/CHIP, the Exchange, and the Basic Health Program (if established). The Urban Institute estimates that 35% of consumers between 138% and 200% FPL will need to transition between Medicaid and the Exchange at least once every six months.¹⁰⁴ This could result in disruptions to healthcare and negatively impact health outcomes.

No Wrong Door Enrollment

The ACA mandates that the Exchange maintain a streamlined “no wrong door” enrollment process through which an individual can apply for and receive a determination of eligibility for coverage in the Exchange, Medicaid, CHIP and/or a BHP through a single application.¹⁰⁵ This coordination is important for consumers because income eligibility rules are complex, and many applicants will not know how their income compares to the federal poverty guidelines or whether they qualify for an Exchange plan, Medicaid/CHIP, or a BHP. It also will help save administrative costs because application processes will not need to be duplicated and any investments into the technological infrastructure for enrollment will benefit both the Medicaid program and the Exchange.

New Mexico can take important steps to streamline the enrollment system for consumers and small employers. First, the information technology systems (IT) that will be used for the Exchange and Medicaid will be most effectively coordinated if they are developed in tandem. Under the ACA, there must be a “secure electronic interface” between enrollment systems to allow information to be shared between Medicaid and the Exchange.¹⁰⁶ The state could also use the same system to determine the eligibility of people for other public benefits programs. The New Mexico Human Services Department has already begun replacing its outdated computer system. This replacement project, which affects multiple benefits programs, including Medicaid, Supplemental Nutritional Assistance Program (SNAP – formerly food stamps), and Temporary Assistance for Needy Families (TANF – cash assistance), will be a large scale effort costing over \$65 million.¹⁰⁷ However, new federal matching funds will pay 90% of the costs for replacing the Medicaid eligibility system, so long as it is coordinated with an Exchange.¹⁰⁸ The sooner the state establishes a governance structure for its Exchange, the more likely it can effectively coordinate the Medicaid and Exchange systems in their early phases of development.

In addition, the state could give the Exchange the authority to determine whether applicants for the Exchange meet the eligibility requirements for Medicaid. The Human Services Department (HSD) could enroll the individual immediately into the program without a separate verification process. Although this would be difficult to do under the current income eligibility rules for Medicaid, the

ACA will simplify the income calculation rules. Starting in 2014, all states will be required to use a “Modified Adjusted Gross Income” (MAGI) standard for most Medicaid applicants. This will make it easier for the Exchange to determine a person’s eligibility for Medicaid. In addition, the Exchange could contract with HSD to allow the Medicaid program to determine eligibility for subsidies in the Exchange. Finally, state Medicaid employees, Exchange employees, and navigators should be cross-trained in the eligibility and enrollment rules for all programs.

Reducing Paperwork

Coordinating the enrollment systems for Medicaid and the Exchange has the potential to greatly simplify the application process for consumers and small employers, and reduce the paperwork required to prove eligibility for the programs. States can use data matching systems that confirm eligibility for the Exchange or Medicaid rather than requiring consumers to bring in paperwork. The ACA requires that the Department of Health and Human Services (HHS) establish the capacity to electronically verify information submitted by applicants to an Exchange. For example, applicants will submit their name, birth date, and social security number to the Exchange to attest to their citizenship. HHS will then electronically submit this information to the Social Security Administration to be verified. The Medicaid program currently has the option of conducting the same type of electronic matches to verify citizenship, but the state has not developed this system yet. The Exchange could also perform similar data matches using tax records or employment history to verify a person’s income.

Consumers are also more likely to keep their healthcare coverage if the enrollment process maintains their information on file. The state can use the electronic system for the Exchange and Medicaid to store a person’s application data so that they do not have to verify their information again if their income changes and they become newly eligible for a different coverage program.

One challenge will be to determine how to align income verification requirements across the Exchange, Medicaid/CHIP, and BHP. Medicaid currently uses “point in time” income verification procedures where applicants must show recent pay stubs to prove their income. By contrast, the Exchange requires information from applicants about the prior tax year. These two systems must be reconciled.

Another priority will be to protect the confidentiality of applicants’ records. While the ACA has provisions that protect records from disclosure by federal agencies (such as tax, citizenship, or other information),¹⁰⁹ the state should also review its laws on electronic records to ensure they adequately protect the confidentiality of application information that may be provided to the Exchange, Medicaid, or a BHP.

Finally, the state should take measures to ensure that applicants have alternative ways of verifying their information if electronic matches of their records cannot be obtained. This is especially important for individuals who may not have filed tax returns, lawfully residing immigrants who will not have citizenship information stored with the SSA, or for citizens who live in “mixed status” households that have some family members who are undocumented immigrants and do not have their income information on file with any state or federal agency.

Minimizing Gaps in Coverage

In addition to aligning enrollment systems, the state should adopt policies and procedures designed to facilitate continuous coverage for individuals who may churn between Medicaid, the Exchange, and the BHP (if established). Studies have shown that gaps in coverage can worsen health outcomes; the uninsured receive less preventive care and are diagnosed at more advanced disease states than the insured.¹¹⁰ Further, the primary source of funding for uncompensated care, such as visits to the emergency room when health conditions become dire, is local government dollars.

Information technology systems can help consumers maintain coverage by minimizing duplicative applications and verification processes that can make the enrollment process burdensome. An individual who applied for and was enrolled in Medicaid should not have to start over again from square one if she takes a higher paying job. Instead, the Exchange should be able to access her application information from the Medicaid database, and she should only have to provide documentation of factors that have changed, such as her income or residence. In addition, when an individual's income change renders her ineligible for Medicaid, she could automatically be evaluated for tax credit eligibility and should receive information about choosing a plan through the Exchange.

The state could also take steps to minimize coverage gaps that may occur between the time a person loses coverage through Medicaid or the Exchange and gains enrollment in the other program. For example, the state could permit and encourage individuals who know a change in circumstances (i.e. a new job or a new baby) is coming to apply ahead of time for coverage. The state should also evaluate whether individuals may be forced to go without coverage for certain times because of the timeframes for special enrollment periods into the Exchange. While Medicaid has open, year-round enrollment, the Exchange will have only one annual enrollment period. While there will be special enrollment periods each month if there is a triggering event (such as the termination of Medicaid), and for Native Americans, these enrollment periods will only be open for a limited number of days each month. The state could require that individuals who will be losing coverage in Medicaid be given enough advance notice so that they can enroll in new coverage through the Exchange during a special enrollment period.

Continuity of Healthcare Services

This churning between the Exchange and Medicaid may also create significant systemic problems with accessing healthcare. If consumers are required to switch health plans, they may not have access to the same package of benefits or the same network of providers that they were previously using. It could be difficult to switch doctors, especially if the person has had an extensive medical history or serious health conditions that have required ongoing management. It could also be difficult to find primary care doctors who will take new patients. Differences in provider networks may also result in certain services (e.g. being assessed by a primary care physician) being repeated for consumers. Further, because Medicaid eligibility rules are more generous for children than they are for adults, differences in provider networks may mean that some members of a family will have to go to one set of providers while the rest of the family receives care from a different set of providers. These inefficiencies create additional costs for individuals and for the state.

In order to prevent disruptions in patient care, the state should take steps to align the health plans offered through the Exchange, Medicaid or the BHP (if established), to the extent possible. For example, Medicaid and the BHP may choose to only contract with those health plans that offer

comparable coverage on the Exchange. The Exchange might also choose a standard for minimum essential benefits that must be offered by health plans to resemble the full benefits package that is provided to Medicaid recipients. The Exchange could also require that every health plan provide coverage statewide and have a sufficient provider network to reach all areas of the state. Consumers would also benefit if the enrollment process included questions about the person's prior health plan and primary care doctor, and helped connect the person with similar coverage.

5. Address the Healthcare Concerns and Special Legal Requirements for Native Americans

One serious challenge for the state will be to ensure that Native Americans are guaranteed healthcare coverage through an Exchange or a Basic Health Program (if established). Although the federal government has the obligation under numerous treaties and by statute to provide healthcare coverage to all Native Americans, it has never fully delivered on this promise. As a result, Native Americans suffer rampant disparities in accessing healthcare. The ACA is a step in the right direction towards improving this situation, but there are still significant gaps in the law that will leave many Native Americans uninsured. The federal government will not pay the full cost for Native Americans to purchase coverage through an Exchange or Basic Health Program. Advocacy efforts will be required to fix these loopholes or, alternatively, to devise state level solutions to ensure that all Native Americans in New Mexico receive high quality healthcare coverage.

New Mexico has a significant Native American population that comprises 10.5% of the state's total population.¹¹¹ Nearly 65% of Native Americans live off the reservation, and mostly in urban areas.¹¹² Albuquerque has one of the highest off-reservation Native American populations of any city in the United States.¹¹³ Native Americans face significant disparities in both access to and quality of healthcare. On-reservation healthcare facilities provide only limited services and typically do not provide specialty care, in-patient services or significant emergency care. Off-reservation access to care is limited by Indian Health Services regulations which result in the vast majority of off reservation Native Americans ("Urban Indians") being unable to access healthcare services at all.

In New Mexico, the overall health of Native Americans is significantly worse than that of the state's general population or any other ethnic or racial group. Native Americans are likely to die younger and are sicker. High rates of poverty and unemployment in Native communities make it difficult for Native Americans to access healthcare coverage.¹¹⁴

These disparities underscore the need for the federal government to live up to its obligation to fully pay for the healthcare costs for Native Americans, or alternatively, for the states cover the costs. In addition, the Exchange in New Mexico should be designed to ensure that health plans offer high quality coverage for Native American communities. Aggressive outreach and education will also be necessary to ensure Native Americans get enrolled into coverage through the Exchange.

Costs of Healthcare Coverage for Native Americans in the Exchange

The federal government has long recognized its obligation to provide healthcare coverage to all Native Americans in exchange for over 500,000 acres of land that were ceded to the United States government over two centuries. This obligation is enshrined in numerous treaties and statutes, including in the Indian Health Care Improvement Act (IHCIA), originally enacted in 1976 and reauthorized as part of healthcare reform. The IHCIA declares that "it is the policy of this Nation, in fulfillment of its special responsibilities and legal obligations to the American Indian people, to

assure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.”¹¹⁵ To this end, the IHCA establishes federal grants and programs that are designed to improve healthcare services for Native Americans.

The primary vehicles for providing healthcare coverage to Native Americans will be through Medicaid and the Exchange. The ACA recognizes the special legal status of Native Americans and exempts them from paying co-payments and deductibles on the Exchange, if they have incomes less than 300% of the poverty level.¹¹⁶ For Native Americans above 300% of the poverty level, cost-sharing is eliminated for services or items received from an Indian Health Services or Indian tribe or Urban Indian healthcare facility.¹¹⁷

However, all Native Americans will still be required to pay premiums if they choose to enroll in health plans through the Exchange (receiving the same level of tax credits as the rest of the population).¹¹⁸ As a result, many Native Americans will likely forego coverage altogether. Native Americans will not be subject to tax penalties if they do not obtain coverage.¹¹⁹

The failure to exempt Native Americans from paying premiums is a major discrepancy in the law that could be fixed in several ways. The most effective and responsible solution would be for the federal government to amend the ACA to ensure that Native Americans are not required to pay premiums to purchase coverage on the Exchange. This would be consistent with the law’s provisions that exempt Native Americans from other types of cost-sharing. The state policymakers, tribal governments, and community groups could urge New Mexico’s congressional delegation to pursue the amendment. If the federal law is not changed, the state could provide its own coverage plan for Native Americans, either by working in partnership with tribal governments to pay for the premiums for health plans on the Exchange or by establishing a Basic Health Program (BHP) that exempts Native Americans from all premiums or cost-sharing. It should be noted, however, that the ACA is unclear as to whether the cost sharing for Native Americans in the BHP will be paid by the federal government. This issue must be clarified by federal regulations.

Identifying Native Americans for Enrollment and Coverage

The Exchange will be responsible for applying the special cost sharing rules for Native Americans. In addition, Native Americans are also eligible for a special monthly enrollment period.¹²⁰ In order to carry out these duties, the Exchange must be able to recognize tribal enrollment documents and accurately determine if an individual meets the definition of “Indian” under federal law. The Exchange should be able to effectively share this identification information with the IRS, Medicaid, Indian Health Services, and any other coverage systems in order to ensure that individuals do not have to repeatedly prove their tribal membership. An audit process would be useful to ensure compliance with these provisions.

There is also a unique problem with the definition of “Indian” that must be clarified in federal law. The Indian Health Services, ACA, and CMS definitions of “Indian” are not consistent with one another.¹²¹ These inconsistencies may cause problems for individuals who transition between Medicaid and Exchange coverage and who may lose options or services to which they are entitled. In order to resolve these inconsistencies, the state and its stakeholders could advocate for the federal government to clarify the ACA definition of “Indian” so that it includes children and grandchildren of enrolled tribal members and non-member spouses.

High Quality Health Plans for Native Americans

On- and off-reservation Native Americans face many barriers in accessing healthcare services. Even with coverage through an Exchange, this situation may not improve if Native Americans cannot see their providers of choice or access culturally competent care.

The Exchange could require that health plans offered on the Exchange provide high quality services that meet the needs of Native Americans. This could include allowing Native American to continue to seek care from IHS or Indian-run facilities by including them as participating providers in the plan; offering plans that cover traditional healing methods (e.g. sweat lodge ceremonies, medicine healers) which are proven to increase Native American utilization of healthcare; ensuring that Native Americans can access specialty care services which are not usually available on the reservations; providing for transportation if the service is not near the area; and ensuring that every health plan has an adequate statewide provider network so that Native Americans do not have to change their primary care doctors if they churn between Medicaid and the Exchange.

In addition, the Exchange should have ongoing consultation with tribal governments and Urban Indians. Urban Indians have unique characteristics and healthcare needs that differ from those who continue to live on the reservation and they should be part of the consultation process.

Finally, tribal governments should determine whether it is appropriate to develop their own Exchanges, for example, to encompass all Native American individuals living in New Mexico, or to extend across state borders into a regional Exchange. The state should work with tribal governments to further examine the merits of these alternative approaches.

Outreach and Enrollment of Native Americans

Native Americans may not be willing to enroll in state-run Exchange plans because the federal government is obligated to provide healthcare to them. It is even less likely that they will enroll in the Exchange if they must pay a portion of the premiums. Native Americans are also exempt from penalties for failing to carry insurance and so do not have the same financial incentives to enroll in an Exchange plan as the rest of the population.¹²² Many Native Americans may also lack internet access, and may be more likely to enroll in the Exchange if they are able to consult with a person who can explain the process and help with enrollment.

The navigator system and outreach plan in New Mexico should prioritize outreach to Native Americans communities, both on and off reservations. Community-based navigators should be used in order to foster trust with community members. Navigators can explain the various plans and facilitate enrollment into the best plans. Alternatives to web-based systems should be used in order to maximize enrollment. It would also be beneficial to have customer service centers located in tribal areas and remote communities that educate individuals about their options and facilitate enrollment.

IV. HOW WILL THE EXCHANGE BE ESTABLISHED IN NEW MEXICO?

New Mexico must act immediately to establish its Exchange in order to demonstrate that the state will be ready to operate an Exchange by October 1, 2013. Otherwise, the ACA mandates that the federal government step in to run the Exchange for the state.¹²³ This would not be desirable for New Mexico given the unique characteristics of our population and the numerous opportunities for the state to design an Exchange that could meaningfully improve access to healthcare. The state would also miss considerable federal funding opportunities that will pay the full costs for establishing an Exchange.

Funding the Exchange

The ACA mandates that the federal government pay the full costs for states to develop their Exchanges. The HHS Secretary must award grants to states to establish Exchanges and the federal government must make an appropriation in an amount necessary to fund these awards.¹²⁴ The HHS Secretary has issued guidance stating that “necessary Exchange costs will be fully funded by HHS until 2015.”¹²⁵ This includes full funding for states to develop computer infrastructure for the Exchange.¹²⁶ New Mexico can therefore expect that the entire costs for developing an Exchange will be paid by the federal government. After January 1, 2015, Exchanges must become self-sufficient.¹²⁷ At that time, the Exchange may choose to charge assessments or “user fees” to insurers.¹²⁸ The Exchange could also apply for local or philanthropic grants to support its operations.

Further, the federal government is offering to pay 90% of costs for the state to develop its Medicaid computer system so long as it coordinates enrollment with the Exchange.¹²⁹ The Medicaid program can receive a 90% federal matching rate for developing its computer eligibility systems until December 31, 2015, and a 75% matching rate for ongoing operations after that date.¹³⁰ However, one condition for receiving this generous match is for the Medicaid system to ensure seamless coordination with the Exchange and interoperability with the Exchange’s outreach and enrollment services.¹³¹ This could save significant costs for New Mexico which has already begun the process of replacing its outdated ISD2 eligibility system for Medicaid and other public benefit programs.

State Legislation to Establish an Exchange

The New Mexico State Legislature passed a bill during the 2011 Legislative Session to establish an Exchange. The bill would have set up an independent quasi-governmental entity to run the Exchange and had numerous consumer-oriented provisions, including robust rules against conflicts of interest, appointments for the board of directors by both the Legislature and Executive, requirements for the Exchange to develop an outreach plan to reach underserved communities and to enroll eligible individuals into Medicaid, and transparent rulemaking procedures. Governor Martinez vetoed the bill, describing the legislation as “premature” because “federal law does not require the state to demonstrate its readiness to run an Exchange before January 2013.”¹³²

In New Mexico, the Legislature generally meets for only 60 days in odd years and 30 days in even years – starting in January of each year. As a result, New Mexico now has only one opportunity – the 30-day 2012 session – to pass Exchange-enabling legislation. Otherwise, the state will fail to meet the January 1, 2013, federal readiness deadline. If New Mexico fails to pass Exchange legislation in the 2012 session and cannot meet milestones for showing progress on developing an Exchange, it will lose out on federal funding that will pay the full costs for planning and development of the

Exchange. HHS has recommended that one such milestone is for states to enact legislation this year.¹³³ Moreover, the state would not be able to move forward in developing its Medicaid computer system in coordination with the Exchange, and would thus lose out on the generous 90% federal match that is available for this. Instead, the state's project to upgrade its ISD2 computer system for the public benefits programs would likely be delayed (while waiting for the federal government to develop an Exchange for New Mexico), or result in much higher costs for the state.

Executive Order

The ACA does not specify what method states should use to establish an Exchange.¹³⁴ While the ACA may allow states to establish their Exchange through non-legislative means, those alternate means would raise significant state constitutional questions in New Mexico. The Exchange will be charged with performing extensive functions in the interest of the health and safety of the public. The New Mexico Constitution vests the Legislature with the general authority to determine the fundamental public policy of the state of New Mexico.¹³⁵ The Legislature is charged with enacting the laws and the Executive with faithfully executing the laws.¹³⁶ Further, a key function of the Legislature's authority is to create and state the purpose of new public bodies. Establishing an Exchange by Executive Order would likely violate the separation of powers embodied in the state constitution.

If an Executive Order were used in this case, the Governor would be usurping legislative functions, and in so doing unilaterally creating new public policy for the state of New Mexico without the consent and approval of the people's elected law makers. The legislative process provides stakeholders the opportunity to engage their elected officials in discussion about how an Exchange can best serve their interests, and hold them accountable for the policy decisions they make.

Further, it is not clear that an Exchange established by Executive Order would address the concerns of consumers and small employers for expanding access to healthcare coverage. For example, the possibility of an Executive Order would raise concerns about whether the Exchange will be given the authority to set certification standards for health plans or take steps to maximize enrollment that go beyond the minimum standards in federal law, whether the Exchange would be a state agency or an independent nonpartisan agency, whether appointments to the board will create an impartial and independent board, and if there will be strong rules against conflicts of interest for members of the board and staff of the Exchange.

Federally Run Exchange in New Mexico

The ACA directs the HHS Secretary to establish an Exchange in those states that (1) do not elect to establish an Exchange, (2) will not have an Exchange operational by January 1, 2014, (3) have not taken actions the Secretary deems necessary to establish an Exchange, and/or (4) set up an Exchange that does not comply with requirements outlined in the ACA.¹³⁷

While the ACA directs HHS to approve state Exchanges as being ready to begin operations by January 1, 2013, the Department has recently clarified that some systems development and contracting activities may continue into 2013 after the deadline for approval.¹³⁸ As such, HHS has proposed rules to grant states conditional approval on the presumption that the state's Exchange will be operational by January 1, 2014, even if it cannot demonstrate complete readiness on January

1, 2013. HHS would continue to monitor the progress of states with conditional approval until a determination of full approval is made, or until the conditional approval is revoked.¹³⁹

Administrative issues may compromise the ability of a federally run Exchange to meet New Mexico's unique healthcare needs. A federally run Exchange would create additional layers of complexity in the operation of a New Mexico-based Health Benefit Exchange, and could potentially mean that critical policy decisions are made by administrators that do not have "on the ground" experience working with New Mexico providers or consumers.

V. CONCLUSION

New Mexico stands to benefit substantially from a legislatively established Exchange, as long as the Exchange is dedicated to the interests of consumers and small employers, and works to improve access to healthcare in all of New Mexico's diverse communities. Done right, the Exchange will provide an array of high-quality products to New Mexico's uninsured at prices they can afford. A strong consumer-oriented Exchange will be accountable and responsive to the public. It will have the authority to promote investment in healthcare infrastructure and the development of statewide provider networks that serve low-income New Mexico residents. And it will employ targeted, linguistically and culturally appropriate outreach and customer service to maximize enrollment across the state. This broad pool of healthcare consumers will keep healthcare affordable and accessible, reducing racial, ethnic and socioeconomic health disparities, and improving New Mexico's health and quality of life.

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states that do elect to operate their own Exchange may partner with the federal government to share certain business functions.

²¹ACA § 1311(d)(1).

²²ACA § 1311 (c)(3) & (d)(4)(D).

²³ACA § 1302 (d)(1)(A)-(D).

²⁴ACA § 1311 (d)(4)(C) (requiring the Exchange to establish a web portal).

²⁵ACA § 1311 (d)(4)(C) & (d)(4)(E) (requiring the Exchange to provide a standardized format for comparing plans).

²⁶ACA § 1311 (d)(4)(G) (requiring the Exchange to provide, by electronic means, a benefits calculator).

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²⁸ACA § 1311 (d)(4)(G) & (e)(C).

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