

November | 2010

SJM 1 Health Care Reform Working Group

Report of Recommendations

PRESENTED TO:

Legislative Health and Human Services Committee

Legislative Finance Committee

Governor Bill Richardson

Report Prepared By:

Deborah Armstrong, Chair

Executive Director, New Mexico Medical Insurance Pool

Special thanks to Claudia Vargas-Sitrick with the New Mexico Health Insurance Alliance for the meeting minutes and to Karen Wells and Michael Hely with the Legislative Council Service for their assistance with research, agendas, minutes, editing and administrative support services.

SJM 1 HEALTH CARE REFORM WORKING GROUP MEMBERS

Deborah Armstrong, Chair

New Mexico Medical Insurance Pool

Senator Sue Wilson Beffort

Representative Ray Begaye

Representative Donald E. Bratton (Advisory)

Representative Gail Chasey

Secretary Kathryn “Katie” Falls

Human Services Department

Senator Dede Feldman

Superintendent John Franchini

Insurance Division, Public Regulation Commission

Representative Keith J. Gardner

Sam Howarth

Director of Policy and Performance, Department of Health

Representative Gay G. Kernan

Representative Larry A. Larrañaga

Senator Cisco McSorley (Advisory)

Mike Nuñez

New Mexico Health Insurance Alliance

Senator Mary Kay Papen

Representative Danice Picraux

Senator Nancy Rodriguez (Advisory)

TABLE OF CONTENTS

- I. Work Plan and Meeting Schedule
- II. Executive Summary
- III. Final Report and Recommendations
- IV. Senate Joint Memorial 1
- V. Meeting Agendas
- VI. Meeting Minutes
- VII. PPACA Time Line Summary
- VIII. Appendix of Advisory Group Reports
 - Appendix A : Business
 - Appendix B: Medicaid
 - Appendix C: Long-Term Care
 - Appendix D: Consumer Protection and Education
 - Appendix E: Women’s Health
 - Appendix F: Health Insurance Exchange
- IX. Advisory Group Participants

WORK PLAN AND MEETING SCHEDULE

Senate Joint Memorial 1 (SJM 1) was co-sponsored by Senator Dede Feldman and Representative Danice Picraux during the 2010 legislative session. SJM 1 requested that the superintendent of insurance convene a health care reform working group (Working Group) with membership drawn from the Department of Health, Human Services Department, New Mexico Medical Insurance Pool and New Mexico Health Insurance Alliance, along with legislators appointed by the New Mexico Legislative Council representing the Legislative Health and Human Services Committee (LHHS) and the Legislative Finance Committee (LFC).

The purpose of the Working Group was to receive input and recommendations from the public and advisory groups for consideration and to present recommendations and proposed action steps to the governor, LHHS and LFC for administrative, legislative, regulatory, operational and financial initiatives necessary to implement and supplement any federal health care reform legislation. In addition, the Working Group was specifically charged with making recommendations on the creation of a health insurance exchange or other entity required under federal law or deemed necessary to implement federal health care reform.

Subsequent to the convening of SJM 1, the governor also established, by Executive Order 2010-012, the Executive Health Care Reform Leadership Team (Leadership Team) to develop a strategic plan to effectuate implementation of national health care reform and to oversee planning, development and implementation of reform. Additionally, Executive Order 2010-032 created the Office of Health Reform to plan, coordinate and administer implementation of federal health care reform, including determination of state laws that should be amended or enacted in order to achieve compliance with the federal Patient Protection and Affordable Care Act (PPACA).

It was the desire of the Working Group to coordinate efforts, to the extent possible and practical, with those of the Leadership Team to minimize duplication of effort. Thus, the Working Group agreed to focus its efforts on gathering information and public input on the major components of PPACA, including: insurance reforms, health insurance exchanges, tax and business implications, Medicaid, long-term care, workforce development, delivery system provisions, consumer protection and education, Native American provisions, quality initiatives and information technology requirements.

To engage the public, the Working Group called for the “self-formation” of advisory groups according to areas of interest. Advisory groups were requested to meet, as appropriate, to identify the following and report to the Working Group:

- Provisions of the law relating to the advisory group
- Time lines for implementation and decision-making
- Key implementation or policy issues

- The entity with primary or shared responsibility for the area
- Funding opportunities
- Specific recommendations on policy or implementation issues and decision points

Meetings were scheduled monthly, in coordination with the LHHS meeting schedule, covering topical areas as follows:

April 7, 2010 ~ Organizational Meeting; PPACA Overview

May 5, 2010 ~ Insurance Reforms; Federal High Risk Pool

June 9, 2010 ~ Health Insurance Exchange; Business Impact; Tax Provisions

July 9, 2010 ~ Medicaid; Long-Term Care

August 5, 2010 ~ Workforce Issues; Delivery Systems

September 2, 2010 ~ Consumer Protection; Consumer Education; Women's Health; Native American Provisions; Health Insurance Exchange

October 4, 2010 ~ Quality Initiatives; Information Technology; Final Recommendations on Health Insurance Exchange

EXECUTIVE SUMMARY

The SJM 1 Health Care Reform Working Group began its work in April 2010 with an overview of the Patient Protection and Affordable Care Act (PPACA) and development of a work plan. The Working Group met monthly through October in the State Capitol in Santa Fe.

The efforts of the Working Group focused on understanding the substantive provisions of PPACA and gathering public input and recommendations relative to its implementation in New Mexico. To facilitate the public input process, the Working Group called for the self-formation of advisory groups to brief the Working Group on key provisions of PPACA; time lines for implementation and funding opportunities; and to provide recommendations to the Working Group for consideration. (See Appendix for detailed reports submitted by advisory groups.) The topical areas considered by the Working Group included:

- Insurance reforms
- Temporary federal high risk pool program
- Business impacts and tax provisions
- Medicaid
- Long-term care
- Workforce and delivery systems
- Consumer protection and consumer education
- Women's health
- Native American provisions
- Quality initiatives
- Information technology
- Health insurance exchange

In general, the Working Group opted for including all recommendations put forth by advisory groups as worthy of due consideration, without specifically endorsing any particular recommendation or advisory group position. However, the Working Group did make some general recommendations, many of which have already been implemented, as well as some very specific recommendations regarding the establishment of a health insurance exchange. General recommendations include:

- Efforts between the Working Group, the Legislative Health and Human Services Committee and the executive leadership team should be coordinated, to the extent possible, to minimize duplication of effort.
- A comparison of the insurance provisions in PPACA and the New Mexico Insurance Code needs to be completed and legislation drafted with all necessary changes made to address conflicts and fully comply with PPACA.

- An executive agency or office should be designated as having the responsibility for tracking grant funding opportunities and coordinating responses.
- New Mexico should take full advantage of funding opportunities to maximize federal funding related to planning and implementation of all provisions of PPACA, including but not limited to:
 - Temporary federal high risk pool program
 - Early retiree funding
 - Rate review planning
 - Health insurance exchange planning
 - Ombudsman program
 - Workforce development
 - Delivery system models of care
 - Quality initiatives
 - Information technology
 - Wellness and prevention initiatives
- The Working Group should be formalized and continue its work during interim periods until PPACA is fully implemented.

Specific to a health insurance exchange, the Working Group had extensive dialogue and weighed the pros and cons of numerous options and recommends the following:

- New Mexico should operate its own exchange;
- New Mexico should operate a single exchange to administer individual and small group markets, recognizing the need to address the unique needs both of individuals and small groups;
- New Mexico should operate a single statewide exchange, recognizing the need to address the unique needs of different geographic areas of the state;
- New Mexico should proceed with developing a New Mexico-only exchange but leave open the possibility of interstate partnering, in whole or in part;
- New Mexico's exchange should be operated by a legislatively created, quasi-governmental nonprofit entity; and
- New Mexico's exchange should be robust with a scope of responsibility that exceeds the elements required by PPACA.

The Working Group further recommends that the legislature move forward expeditiously to enact legislation that creates or designates an entity with the

responsibility and authority to plan, develop, implement and administer the exchange in order to meet the readiness and implementation time lines required under PPACA.

FINAL REPORT AND RECOMMENDATIONS

INSURANCE REFORMS

PPACA requires myriad health insurance reforms, some of which are to be implemented this year and others of which are to be implemented over the next few years, with the bulk of reforms taking full effect in 2014. The Insurance Division of the Public Regulation Commission provided the Working Group with a comprehensive briefing on the key provisions and associated time lines for implementation. A full accounting of all the insurance provisions of PPACA are not attempted here, but, rather, reference is made to the summary of provisions provided by the superintendent of insurance (see Section VII). Comprehensive summaries and compilations, as well as other valuable resources on PPACA and its implementation, can also be found at numerous web sites, including but not limited to:

New Mexico Insurance Division at <http://www.nmprc.state.nm.us/id.htm>

New Mexico Human Services Department at
<http://www.hsd.state.nm.us/nhcr/nhcr1ao.htm>

National Association of Insurance Commissioners at <http://naic.org>

Kaiser Family Foundation at <http://www.kff.org>

HealthCare.Gov at <http://www.healthcare.gov>

After lengthy discussion and questions regarding implementation, the Working Group recommended that an analysis be completed of the health insurance provisions of PPACA as they compare to the provisions of the New Mexico Insurance Code to identify what legislative changes to the New Mexico Insurance Code must take place to be in full compliance with the provisions of PPACA. The Insurance Division responded that it is in the process of conducting such an analysis. Subsequently, the Legislative Council Service and the legal committee of the executive leadership team combined efforts with the division to undertake this massive project.

TEMPORARY FEDERAL HIGH RISK POOL

The first provision of PPACA to take effect is the establishment of a temporary federal high risk pool program. States were given the option of operating their own programs or opting out and defaulting to the federal government to operate the programs. The effective date of this provision was 90 days after enactment of PPACA, which was June 23, 2010.

The Working Group strongly recommended that New Mexico establish the program and further submitted a recommendation to Governor Richardson that the New Mexico Medical Insurance Pool operate the program alongside the existing state high risk pool program.

The Human Services Department subsequently entered into an agreement with the federal government for operation of the federal temporary high risk pool program (now referred to as the Pre-Existing Condition Insurance Program) and delegated full operation of the program to the New Mexico Medical Insurance Pool through a services agreement. The program was operational on July 1, 2010.

BUSINESS IMPACT AND TAX PROVISIONS

The PPACA substantially affects businesses through mandates for participation in providing health insurance to employees beginning in 2014, but it also provides for tax credits to small business, starting immediately upon passage of PPACA, to incentivize the provision of health insurance and to help offset the cost to small employers. In addition, because employers provide the primary access to health care coverage, business has a vested interest in the other provisions of PPACA, including Medicaid expansion, benefit mandates and access to health services. The Working Group was provided with an overview of the tax and employer provisions and heard testimony on the impact of health care reform measures on business. The following recommendations were offered for consideration by the Association of Commerce and Industry (ACI), on behalf of the business community (see Appendix A for a full report of ACI recommendations):

ACI, Representing the Business Community:

- 1. a proactive response to health reform, including: a moratorium on new state insurance mandates while reform is implemented; promoting a medical home model of service delivery; maximizing the use of federal funds; easing administrative burdens; and performing cost-benefit analyses of Medicaid expansion;**
- 2. implement public-private partnerships that reduce the cost of care, increase access to quality care, improve methods of financing, promote wellness and require full transparency to the public;**
- 3. increase the numbers of providers and access to health care services by maximizing federal funds to educate, train, recruit and retain health professionals; incentivize Medicaid providers; and support federally qualified health centers (FQHC);**
- 4. improve the use of technology, create electronic medical records and provide information about outcomes online;**
- 5. oppose the imposition of additional taxes or administrative burdens on employers; and**
- 6. oppose the expansion of Medicaid prior to federally mandated time frames.**

MEDICAID

Expansion of Medicaid and changes in Medicaid eligibility determination processes are a major component of PPACA. Starting in 2014, Medicaid will be expanded to cover low-income persons who earn less than 133% of the federal poverty level (FPL) with a 5% income disregard, effectively making income eligibility 138% FPL. Medicaid coverage will also be available for children up to age 26 who were covered by Medicaid while in foster care. The costs of covering newly eligible adults will be fully paid by the federal government for the first three years following implementation, after which the federal share will gradually decrease to 90%. Eligibility determination and enrollment in Medicaid will also be streamlined in 2014 and must seamlessly interface with the exchange.

The Working Group reviewed and discussed the breadth of Medicaid changes that will occur under PPACA and received testimony from the Human Services Department and the Medicaid Coalition, which functioned as an advisory group for this purpose. (See Appendix B for a full report from the Medicaid Coalition.) Recommendations put forth by the coalition can be summarized as follows:

The Medicaid Coalition:

- 1. protect access for children and adults who currently meet program requirements both to maintain stable health care coverage and to avoid violating provisions of PPACA requiring a maintenance of effort;**
- 2. prevent benefit cuts that would dismantle health care services for Medicaid participants; and preserve the health care infrastructure and workforce in rural, urban and tribal areas before reform takes full effect in 2014;**
- 3. take advantage of all federal grants and funding opportunities to build the health care infrastructure and develop high-quality systems of care;**
- 4. evaluate proposals for improving cost-effectiveness and performance of the Medicaid managed care system and for use of other systems of care coordination;**
- 5. develop the information technology capacity to permit a seamless interface between Medicaid and health insurance plans offered through exchanges;**
- 6. gradually extend coverage to newly eligible adults who are under 133% FPL before 2014; or begin pre-screening applications in 2013 to facilitate prompt enrollment in 2014;**
- 7. consider developing a “basic health program” model of state coverage for low-income individuals who are not eligible for Medicaid;**
- 8. simplify eligibility processes for children and members of Native American tribes; and**
- 9. ensure meaningful involvement of stakeholders before any change is implemented.**

LONG-TERM CARE

There are numerous provisions of PPACA that relate to long-term care and the needs of an aging population or those with disabilities. Insurance reforms such as guaranteed issue, bans on exclusions for preexisting conditions, a limitation on annual and lifetime benefit caps, mental health parity and other provisions will have a direct impact on persons experiencing debilitating conditions. PPACA has specific provisions relating to long-term care insurance, creating the CLASS (Community Living Assistance Services and Supports) Act, a national voluntary, long-term care insurance program. PPACA also includes a number of Medicaid options that favor expansion of home- and community-based programs, including a “Community First” option for attendant care services, expansion of the Medicaid state plan to include services currently only available under a waiver and “Money Follows the Person” grant opportunities.

The Working Group reviewed and discussed the various long-term care provisions of PPACA, as presented by the Aging and Long-Term Services Department as well as the Long-Term Care Advisory Group. (See Appendix C for a full advisory group report.) Recommendations received from the advisory group include:

Long-Term Care Advisory Group:

- 1. encourage individual and employer participation in the CLASS Act program of voluntary public long-term care insurance;**
- 2. adopt a “Community First Choice” Medicaid option for community-based attendant services;**
- 3. convene a stakeholder group to review the Medicaid plan option for home- and community-based services and develop the broadest affordable program;**
- 4. submit a state proposal for the Money Follows the Person federal grant; and**
- 5. add “medical home” services to the state Medicaid plan.**

WORKFORCE AND DELIVERY SYSTEM ISSUES

Health professional workforce issues are referenced more than 40 times throughout PPACA. The Workforce Advisory Group stressed several state issues that will need to be addressed, including: anticipated workforce shortages with 32 of New Mexico’s 33 counties designated as health professional shortage areas and particular shortages in physician, nursing and dental professions; access issues because New Mexico currently ranks last in access to health care and prevention; and undocumented workers creating additional pressures on the delivery system. The need to develop data-driven recruitment and retention strategies and capitalize on the many grant funding opportunities was identified and stressed. Recommendations of the Workforce Advisory Group include the following:

Workforce Advisory Group:

- 1. Pursue a joint workforce planning and development effort, identifying partners and a lead agency, and charge this agency with duties to align with PPACA, including:**
 - a. assessing the current capacity and distribution of health professionals in the state;**
 - b. establishing minimum standards for supply and distribution of health professionals;**
 - c. establishing strategic targets for state and local health professional development;**
 - d. developing integrated approaches for investment of state and local resources for education, educational financing, recruitment and retention incentives of health professionals; and**
 - e. maximizing federal funding and supplementing it with state funds, as needed.**

- 2. Develop coordinated, comprehensive and ongoing data collection on key health professionals:**
 - a. link data collection on the nature, extent and location of health professional practices to the relicensing process;**
 - b. coordinate efforts of licensing boards and agencies to maximize efficiencies in data collection and analysis;**
 - c. consolidate results and data analysis to facilitate cohesive workforce policymaking; and**
 - d. ensure that data collection is timely, accurate and complete.**

- Proposed Legislation: "Health Care Workforce Data Collection, Analysis and Policy Act".**

- 3. Incentivize coordination and funding of educational program development to supplement health profession training programs, contingent upon:**
 - a. multi-institutional coordination of program development;**
 - b. cost-effective, interdisciplinary training of multiple professions;**
 - c. development of training programs consistent with the highest priority professional needs;**
 - d. community-based programs to educate and train health care professionals in underserved communities with health workforce shortages; and**
 - e. providing state funding for expanded, coordinated outreach and application assistance to health professionals eligible for National Health Service Corps and other federal financial support.**

Testimony was also received from a number of provider organizations on the impact of health reform on providers and on the health care delivery system. Panelists included the New Mexico Hospital Association; the New Mexico Association for Home and Hospice Care; the New Mexico Health Care Association; the New Mexico Primary Care Association; the National Center for Frontier Communities; and persons representing Christian Scientists and the Association of Acupuncture and Oriental Medicine. Recommendations of these provider panels include the following:

Provider Panels:

1. protect Medicaid enrollment, benefits and provider payments;
2. protect indigent funding until the effects of health reform are fully determined;
3. apply for the full range of grants and pilots under PPACA, with a focus on building the health professional workforce and exploring new delivery models, such as accountable care organizations and patient-centered medical homes;
4. support a robust interaction among providers, health plans and the Human Services Department to develop a shared commitment to solutions aimed at “bending the cost curve”;
5. support the Health Care Associated Infection Advisory Committee as the means to coordinate state efforts to meet federal requirements;
6. support trauma and FQHC funding (PPACA funds expansion but not replacement of lost state and local funds for maintenance of current capacity);
7. support electronic medical records development incentives;
8. give particular attention to primary care workforce development;
9. pay particular attention to the cost impact of employer and individual health insurance mandates in 2014 and the gap created with reduced Medicaid reimbursement rates for providers;
10. closely monitor the impact of Medicare and Medicaid reimbursement rate structures; quality initiatives and benefit/service mandates will need to identify unintended consequences and impact on cost and quality; and
11. support alternative healing practices, including but not limited to acupuncture and oriental medicine, Native American healing practices and other spiritual or nonmedical forms of care.

CONSUMER PROTECTION AND CONSUMER EDUCATION

PPACA and the related Healthcare and Education Affordability Reconciliation Act will reform the health care system, public health programs and the private health insurance market throughout New Mexico. Consumer education and protection are critical to ensure that New Mexicans obtain the maximum benefits and protections created by PPACA. Consumer education and protection are not addressed in a single section or set of provisions within the act; rather, they permeate virtually every aspect of the new law.

The Consumer Protection and Consumer Education Advisory Group provided extensive testimony on the provisions and impact of PPACA relative to consumer protection and consumer education, pointing out the difference between these two strategies. The following is excerpted from the advisory group’s full report:

To best serve the needs and interests of consumers/patients in New Mexico, consumer education and consumer protection strategies are necessary. But they are not the same thing. Consumer health assistance bridges both consumer education and consumer protection. **Consumer education** requires widespread dissemination of accurate materials and information, targeting populations with particular needs or interests impacted by the new law and reaching all

communities in New Mexico. **Consumer protection** refers to the specific systems established to enable consumers who are denied coverage, insurance, reimbursement or who are improperly charged for services to challenge such decisions and have some mechanism for redress of their grievances. A viable consumer protection system needs to address both the system for considering consumer complaints/appeals/ inquiries as well as a system of information, education and representation that will inform consumers of their rights to bring a complaint or appeal and to know when they may have been denied access to services or coverage to which they are entitled.

(See Appendix D for the full report of the Consumer Protection and Consumer Education Advisory Group.)

The Consumer Protection and Consumer Education Advisory Group recommended:

- 1. the New Mexico Office for Health Care Reform should establish a *State Consumer Coordinating Committee* consisting of consumer advocates and staff from key agencies who will be responsible for coordinating statewide consumer education and protection efforts;**
- 2. New Mexico should incorporate consumer education and consumer protection planning into each element of health care reform implementation;**
- 3. consumer education planning should include strategies to ensure that currently uninsured persons will receive the maximum benefits available to them;**
- 4. state entities that address consumer protection in a health care or health insurance context should plan and coordinate consumer protection, appeal and ombudsman programs;**
- 5. funding should be provided for consumer education and protection programs to ensure accountability and effective PPACA implementation;**
- 6. New Mexico should establish an independent Consumer Health Assistance Program (CHAP) for consumer education and assistance that utilizes community-based agencies, community health workers, health care and social service providers and advocates; and**
- 7. transparency should be reflected as essential to an effective consumer protection system, and the public should have access to key data from state agencies in accessible, consumer-friendly formats.**

WOMEN'S HEALTH

The Working Group received testimony from the Women's Health Advisory Group, which pointed out that PPACA promises many benefits to women through specific provisions such as mandating pregnancy care as an essential benefit. More women than men live in poverty, and women live longer than men; so the expansion of Medicaid and subsidies for purchasing health insurance will benefit women to a greater extent than men. The provisions in health care reform for long-term care and elder care will benefit women not only because they live longer than men but because women are frequently the caretakers of their parents, spouse or partner's parents and their spouses or partners as they age. (See Appendix E for the written report received from the Women's Health Advisory Group.) Recommendations from the advisory group include:

The Women's Health Advisory Group:

1. **consumer input on implementing health care reform should include expertise on women's health issues and gender-specific approaches that decrease barriers and increase access for women and families;**
2. **screening for public benefits should be coordinated with screening for Medicaid and the exchange; screening should occur at multiple community access points;**
3. **recertification processes should be expedited and occur on an annual basis;**
4. **presumptive Medicaid eligibility for family planning services should be implemented immediately;**
5. **"doulas" should be included in the definition of "community health worker" in home visiting programs; community health workers and promotoras should be included as "navigators" for an exchange;**
6. **application should be made for PPACA's "Personal Responsibility Education Program" funding for abstinence and contraceptive education;**
7. **explore opportunities to increase the number of free-standing birth centers in rural areas through direct payments to certified nurse and professional midwives;**
8. **expand Medicaid coverage for children aging out of the foster care system from age 21 to 26, just as mandated insurance coverage for children on their parents' health plan has expanded to age 26;**
9. **promote PPACA's expanded adoption tax credit and adoption assistance programs;**
10. **protect the confidentiality of youths applying for family planning or pregnancy care by allowing use of alternate addresses when applying for Medicaid or coverage through the exchange;**
11. **support the Long-Term Care Advisory Group's recommendations;**
12. **target recipients of temporary assistance for needy families in workforce development efforts aimed at training and education in health care fields;**
13. **create "health homes" for women leaving incarceration, similar to those created for persons with chronic conditions; and**
14. **mental health and substance abuse parity should include, as a covered benefit, medication-assisted therapy for addictions.**

NATIVE AMERICAN PROVISIONS

An overview and discussion of Native American provisions of PPACA was provided to the Working Group by Secretary of Indian Affairs Alvin Warren. Native American populations will be affected by PPACA in five general areas:

- **Health Insurance Exchanges:** Native Americans will have special enrollment periods and no cost-sharing or mandates for participation for persons below 300% FPL
- **Medicaid and the State Children's Health Insurance Program:** Native Americans will have streamlined enrollment for children deemed eligible through "express lane agencies"
- **Indian Health Service:** PPACA eliminates Medicare Part B sunset provisions

- Reauthorization of the Indian Health Care Improvement Act. This act is now permanently reauthorized and new provisions are added
- PPACA provides numerous grant opportunities for Native Americans, tribes and tribal organizations

The Indian Affairs Department recommended:

1. **the state and tribes should coordinate on PPACA grant opportunities to maximize funding that addresses Native American health needs and disparities;**
2. **state agencies should communicate, collaborate and consult with tribes regarding health reform initiatives and policies that will affect American Indians;**
3. **state agencies should assess and include actions to implement the Indian provisions of PPACA in the agencies' strategic work plans; and**
4. **an Indian Health Care Reform ad hoc work group should be established within the executive health care reform leadership team to ensure adherence with and effective implementation of the Indian provisions of PPACA.**

QUALITY INITIATIVES

PPACA includes a number of provisions related to quality initiatives, including: the establishment of a national strategy to improve delivery of health services; health outcomes and population health; the development of national quality measures; establishment of mandatory physician reporting programs on quality and health disparity indicators; revisions to hospital payment standards based on quality; and establishment of a federal coordinating council for research on comparative effectiveness. Testimony to the Working Group provided an overview of these provisions as well as an update on the work being done by the Albuquerque Coalition for Healthcare Quality through a Robert Wood Johnson Foundation initiative called *Aligning Forces for Quality*.

INFORMATION TECHNOLOGY

Secretary of Human Services Kathryn "Katie" Falls led a discussion with the Working Group regarding the information technology issues relative to PPACA as they specifically relate to the requirements for streamlined Medicaid eligibility and enrollment processes, as well as the interface of Medicaid with the health insurance exchange. Of primary concern is the fact that the current Medicaid information technology system known as ISD2 is an antiquated "flat file" legacy system and not a relational database system. Thus, it is incapable, in its current state, of meeting the requirements set forth for communication and coordination in 2014 with Internal Revenue Service, Social Security Administration, the health insurance exchange and other entities. The department is currently working on issuing a request for proposals to engage a vendor to replace this complex system by 2013. A separate but related information technology system will be needed to carry out the requirements of the health insurance exchange. The potential for partnering with other states and the need

for the federal government to provide sufficient support in the development of information technology systems for the exchange were discussed.

HEALTH INSURANCE EXCHANGE

A primary focus of PPACA is the establishment of a health insurance exchange, an area to which the Working Group devoted much time and attention.

The concept of an exchange is one of a central, organized marketplace that provides one-stop shopping for individuals and small businesses to purchase insurance and compare rates, benefits and quality among the plans offered. The exchange will also screen individuals for public program eligibility and coordinate federal health insurance tax credits for those who qualify. Functions of an exchange required under PPACA can be summarized in the following four areas:

“Qualified Health Plans” (QHPs)

- Certify, recertify and decertify QHPs available through the exchange
- Create standardized benefit categories of QHPs, utilizing a standard format to present for comparison shopping
- Assign a quality “rating” to each QHP

Consumer Information and Assistance

- Maintain a call center for customer service
- Maintain an internet web site of information with comparative cost and quality information
- Publish/post consumer satisfaction ratings
- Establish an electronic calculator to determine cost of coverage
- Establish a “navigator” program for consumer outreach, education and assistance

Eligibility and Enrollment

- Determine and coordinate eligibility
 - Screen for, and inform individuals of, eligibility for Medicaid, Children’s Health Insurance Program and/or subsidies or tax credits
- Process applications and enroll eligible individuals and businesses

Administration

- Ensure that the exchange is self-sustaining by January 2015
- Keep accurate accounts of all activities and provide transparency in operations and reporting
- Consult with stakeholders

Testimony from the Exchange Advisory Group and consumer representatives was heard during two different meetings, and presentations were made on both the Massachusetts and Utah exchange models. In addition, testimony provided by most

advisory groups throughout the interim included comments on the exchange and its impact on or relationship to specific areas of interest such as Medicaid, businesses, insurance reforms, information technology, consumer education and protection and Native American provisions. Discussion centered around whether or not New Mexico should operate its own exchange, what functions should be included in an exchange, what type of entity should operate the exchange, the relationship of the exchange to Medicaid and the Insurance Division and the impact on consumers.

The Exchange Advisory Group recommended:

1. establishment of a state “office” responsible for planning and coordination of and information on PPACA and health reform, to which advisory groups could continue to report; and
2. consideration of using existing quasi-governmental entities such as the New Mexico Health Insurance Alliance and New Mexico Medical Insurance Pool to operate a New Mexico exchange, with appropriate modifications.

Health Action New Mexico, representing consumers recommended that an exchange:

1. negotiate the best quality deal for consumer purchasers;
2. provide clear and comparable choices;
3. assure that insurers comply with standards;
4. coordinate with public programs and provide a streamlined application;
5. oversee risk adjustment and reinsurance;
6. provide outreach and recruitment and set broker fees;
7. have a governing body that does not include those with conflicts of interest;
8. be relatively free of political swings;
9. be flexible enough to deal with changing conditions;
10. have a structure that facilitates interests of consumer purchasers; and
11. if the exchange is operated by an existing New Mexico entity, modify the entity to meet the above criteria.

Following extensive public input and discussion, the Working Group ultimately considered a series of questions regarding various options contemplated by PPACA and the pros and cons associated with each. The following chart summarizes the discussion and final recommendations of the Working Group:

| Should New Mexico Establish Its Own Exchange? | | |
|--|--|--|
| Options | Pros | Cons |
| Establish State Exchange | <ul style="list-style-type: none"> • PPACA requires an exchange anyway • NM (executive and legislature) will have more control and flexibility • Cultural and geographic diversity will be addressed most appropriately • Sets up a state presence even if a regional exchange is ultimately pursued | <ul style="list-style-type: none"> • Resource-intensive for state to develop and administer (time and personnel) • Potential to be more costly than the funds provided by federal government • Greater uniformity in federal exchange • Potential economies of scale may not be realized |

| | | |
|--------------------------------------|--|---|
| | <ul style="list-style-type: none"> • Federal government provides funding for planning and implementation • Does not lock in the state ~ final decision to feds is not due until 1/1/2013 | |
| Federal Government Operates Exchange | <ul style="list-style-type: none"> • Federal government bears full cost • Uniformity of design • More fully realize economies of scale | <ul style="list-style-type: none"> • Opportunity to design an exchange that meets NM's unique needs is lost • Loss of control over NM small-group and individual markets • Exact design of federal fallback is unknown • Limits opportunity for NM to change its mind later, as development will be lagging and 2013 readiness impaired |

RECOMMEND: New Mexico Should Operate Its Own Exchange.

Should New Mexico Have One or Two Exchanges for Individuals and Small Groups?

| Options | Pros | Cons |
|--|---|--|
| One Exchange (Single Exchange for Individual and Small Groups) | <ul style="list-style-type: none"> • One-stop shopping is less confusing for consumers, particularly those that go in/out of individual and group markets • Eliminates duplicative administrative structure; thus is more cost-effective • Allows for potential pooling together of markets • One governing body for consistent public policy decisions | <ul style="list-style-type: none"> • Individuals and small businesses have distinctly different needs related to marketing, enrollment and support services |
| Two Exchanges (Separate Individual and Small Group Exchanges) | <ul style="list-style-type: none"> • Each exchange could focus on the unique needs of either individuals or small groups | <ul style="list-style-type: none"> • Possibly more confusing to consumers, particularly those that move between individual and small-group markets • Duplicative administrative structure ~ more costly • Alone, neither may constitute a large enough risk pool to achieve competitive rates • May limit future flexibility |

RECOMMEND: One Exchange to Administer Individual and Small-Group Markets Recognize the need to address unique needs of individuals and small businesses.

Should There Be Regional Exchanges Within New Mexico?

| Options | Pros | Cons |
|------------------------|---|--|
| One Statewide Exchange | <ul style="list-style-type: none"> • Consistent operations | <ul style="list-style-type: none"> • Needs differ in different areas of |

| | | |
|---|--|---|
| | statewide <ul style="list-style-type: none"> • No need to change insurance if move within state • Eliminates duplicative administrative structure ~ more cost-effective • <i>Does not preclude regional or local presence and consumer assistance nor development of interstate provider networks</i> | state, particularly urban vs. rural <ul style="list-style-type: none"> • May limit border communities' ability to provide access across state lines |
| Separate Exchanges in Two or More Geographic Regions of State | <ul style="list-style-type: none"> • Greater local control, accountability and accessibility • Insurance markets and health care access vary, particularly urban vs. rural | <ul style="list-style-type: none"> • More complicated and costly to operate multiple exchanges within NM • Number of lives covered may be too small to achieve desired rates and risk sharing • Consumers who move within the state may have to move in/out of regional exchanges • Insurance carriers tend to be statewide |

RECOMMEND: One Statewide Exchange
Recognize the need to address unique needs of different areas of the state.

| Should New Mexico Participate in an Interstate Regional Exchange? | | |
|--|---|--|
| Options | Pros | Cons |
| New Mexico-Only Exchange | <ul style="list-style-type: none"> • NM has unique demographics, culture, markets • Even with a regional exchange, NM will need its own state presence • <i>Having a state exchange does not preclude partnering with other states for certain functions</i> | <ul style="list-style-type: none"> • May be “reinventing the wheel” by duplicating efforts of what other states are doing • NM may not have large enough pool of covered lives to be cost-effective in sharing risk |
| Regional Exchange with One or More Other States | <ul style="list-style-type: none"> • Capitalizes on economies of scale, both administratively and by potential pooling of populations • Capitalizes on work already done by other state(s) and facilitates sharing best practices • Shares administrative burden and costs | <ul style="list-style-type: none"> • Variations in insurance laws and regulations • A multi-state exchange would involve complex interstate compacts • Complicates regulatory oversight • May limit NM's flexibility to make changes as NM deems appropriate • Less able to design specific to NM's unique needs • Not aware, at this point, what other states may be interested |

RECOMMEND: Proceed with New Mexico-Only Exchange, But Leave Open Possibility of Interstate Partnering in Whole or Part

| What Type of Entity Should Operate the Exchange? | | |
|---|--|--|
| Options | Pros | Cons |
| State Agency | <ul style="list-style-type: none"> • Medicaid expertise and ease of coordination for seamless screening and enrollment (if Human Services Department) • Greater opportunity to integrate other publicly funded programs • Consistency of public policy through executive leadership • Direct control of executive | <ul style="list-style-type: none"> • Could become too bureaucratic • Exchange is a private market program; state agencies may be less experienced with private market system • Vulnerable to partisan politics • State budget shortfalls could negatively affect exchange operations |
| Independent Nonprofit | <ul style="list-style-type: none"> • Functions could be solely dedicated to goals of exchange • Independence from political environment much more likely • More flexibility in design and operation • Bound by contract terms to state | <ul style="list-style-type: none"> • Limited control by legislature or executive to ensure state priorities are met • More difficult to coordinate and link with Medicaid • No interest yet expressed by any NM nonprofit entity • Potential capacity issues of an existing governing body or staff • State is bound and potentially limited by procurement and contract process in selection and oversight of entity • State still ultimately responsible |
| Legislatively Created Quasi-Governmental Nonprofit | <ul style="list-style-type: none"> • Ultimately accountable to legislature • Can structure board appointments to provide diversity of representation and expertise • Executive director serves at pleasure of board • More transparent, open, accountable to public than independent nonprofit • Coordination, linkages with Medicaid and other public programs possible through interagency agreements • Can interact with private sector more easily than state agency • More flexible and less bureaucratic than state agency in hiring, procurement and other administrative functions • Less subject to partisan politics or state budgeting issues • Could utilize existing expertise | <ul style="list-style-type: none"> • Coordination and linkages with Medicaid still require development and negotiation of interagency agreement • Neither NM Medical Insurance Pool nor NM Health Insurance Alliance currently has the full range of experience or expertise needed • Health plans are currently board members of both NM Medical Insurance Pool and NM Health Insurance Alliance and would need to be transitioned from governing authority to advisory capacity |

| | | |
|--|--|--|
| | <p>of NM Medical Insurance Pool, NM Health Insurance Alliance or combination of both</p> <ul style="list-style-type: none"> ○ NM Medical Insurance Pool and NM Health Insurance Alliance already have expertise in health insurance for individuals and small groups ○ NM Medical Insurance Pool and NM Health Insurance Alliance already perform some functions required of an exchange ○ Less costly to use an existing entity than creating a new entity ○ Exchange can be established faster if an existing entity is utilized rather than starting anew | |
| <p>RECOMMEND: Quasi-Governmental, Nonprofit Entity Should Operate Exchange.</p> | | |

Lastly, the Working Group discussed functions of an exchange and whether New Mexico should focus on just those functions required by PPACA or consider an expanded scope, playing a stronger role in driving the market as a contracting agency and active purchaser rather than just a market organizer and distributor. Potential expanded functions are outlined below, followed by the Working Group recommendation.

“Qualified Health Plans” (QHPs)

- Ensure QHPs offer the same products inside and outside the exchange
- Negotiate actively with plans to ensure the “best price” for QHPs
- Consider offering a wider (or narrower) choice of plans to consumers

Consumer Information and Assistance

- Educate the public broadly about the provisions of PPACA
- Actively educate small businesses about the benefits of an exchange

Eligibility and Enrollment

- Develop a seamless enrollment and premium collection process
- Process applications and enroll eligible individuals and businesses

Administration

- Actively oversee rate regulation in cooperation with the Insurance Division
- Administer reinsurance and rate adjustment mechanisms
- Work with health plans to reshape policy

- Create a larger purchasing pool

| What Scope of Functions Should the Exchange Administer? | | |
|---|--|--|
| Options | Pros | Cons |
| Market Organizer and Distributor (Required Functions Only) | <ul style="list-style-type: none"> • These functions are sufficient to satisfy federal requirements • Preserves maximum operation of the free market • Least expensive approach | <ul style="list-style-type: none"> • Does not prevent carriers from shifting risk • Public education and outreach role is limited |
| Contracting Agent and Active Purchaser (Expanded Scope) | <ul style="list-style-type: none"> • Ensures competition based on quality and price • Allows increased oversight on insurance company practices • Allows for broader marketing and public relations | <ul style="list-style-type: none"> • Health insurers/plans could elect to leave state • Costs unknown; could be more costly or less costly |
| RECOMMEND: A Robust Exchange with Expanded Scope of Some/All Functions | | |

Further input was provided by consumer advocates on more specific considerations in the operational design and scope of responsibility for an exchange. (See Appendix F for a discussion paper, “Developing Health Insurance Exchanges to Support Health Reform in New Mexico”, submitted by consumer advocates to the Working Group for its consideration.) The recommendations support the establishment of a “robust” exchange with an expanded scope of responsibility and are summarized as follows:

Consumer Advisory Groups recommended:

1. **Overarching goals for a New Mexico health insurance exchange, including:**
 - a. **introducing competition and improving consumer choices;**
 - b. **shifting health coverage system from “risk avoidance” to enhancing competitive pricing and choice based on quality;**
 - c. **identifying affordable robust plan choices for individuals and small businesses; and**
 - d. **assessing and negotiating with plans, organizing infrastructure and monitoring implementation.**
2. **Principles to be considered in determining the governance structure:**
 - a. **should represent the interests of the purchaser and consumer and have access to appropriate expertise;**
 - b. **must have the capacity to understand and negotiate with state agencies and private insurance plans to support a strong insurance purchasing agency;**
 - c. **the board should have no conflicts of interest;**
 - d. **Medicaid and the Insurance Division should participate as ex-officio nonvoting members; and**
 - e. **must resist political pressures to amend or direct policy and assure continuity between election cycles.**
3. **Expectations, and supports necessary, for operation of an exchange:**

- a. assure board capacity and create expert advisory panels, particularly of public policy analysts and clinical health, quality and financial experts;**
- b. facilitate insurance plan participation and ensure that products are standardized and responsive to consumer needs;**
- c. provide transparency and accountability for the exchange's own operations;**
- d. operate with business efficiency, monitoring costs and services and make decisions based on sound, impartial impact analyses;**
- e. design an innovative system of enrollment to meet needs of differing communities with or without electronic access: urban, rural, frontier, tribal;**
- f. engage navigators and ombudsmen as components of consumer relations;**
- g. track consumer satisfaction with exchange operations, plans and providers;**
- h. regularly evaluate operations and adjust accordingly; and**
- i. develop an infrastructure to collect, analyze and share data as needed with state agencies and the federal government and to report to public.**

Finally, the Working Group recognized the extent of the work that will be required to plan, develop and implement the exchange and to meet the mandated time frames of PPACA. Although the exchange does not have to be fully operational until January 1, 2014, the state must indicate its intent to operate the exchange by January 1, 2013, and the state must sufficiently prove readiness at that time. Given these time lines, the Working Group expressed concern that enabling legislation creating, or designating an entity to operate, an exchange must be enacted during the 2011 legislative session. If this does not occur, planning and development will be significantly delayed and readiness by January 1, 2013 will be jeopardized.

1 A JOINT MEMORIAL

2 REQUESTING THE SUPERINTENDENT OF INSURANCE OF THE PUBLIC
3 REGULATION COMMISSION TO CONVENE A HEALTH CARE REFORM WORKING
4 GROUP TO MAKE RECOMMENDATIONS TO THE GOVERNOR AND THE
5 LEGISLATURE REGARDING IMPLEMENTATION AND SUPPLEMENTATION OF
6 ANY FEDERAL AND STATE HEALTH CARE REFORM MEASURES THAT MAY
7 OCCUR.

8
9 WHEREAS, the United States congress has been considering
10 health care reform legislation; and

11 WHEREAS, many components of the proposed federal health
12 care reform legislation call for some degree of action by the
13 states; and

14 WHEREAS, New Mexico has for many years been a leader in
15 venturing forward with incremental health care reform
16 measures; and

17 WHEREAS, regardless of the status of any federal health
18 care reform legislation this year, New Mexico must be in a
19 position to make a well-planned response to a number of
20 different health care reform options; and

21 WHEREAS, New Mexico should be poised to maximize any
22 federal assistance in implementing and supplementing health
23 care reform measures in the state; and

24 WHEREAS, New Mexico has reaped many benefits as the
25 result of having been one of the states to make quickest use

1 of federal American Recovery and Reinvestment Act of 2009
2 funding opportunities; and

3 WHEREAS, New Mexico would likely benefit greatly if it
4 were prepared to show the same kind of initiative in
5 implementing its role in any nationwide health care reform
6 effort as it has in making use of the opportunities afforded
7 by the American Recovery and Reinvestment Act of 2009;

8 NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE
9 STATE OF NEW MEXICO that the superintendent of insurance of
10 the public regulation commission be requested to convene a
11 health care reform working group with membership drawn from
12 the department of health, the human services department, the
13 legislative finance committee, the legislative health and
14 human services committee, the insurance division of the
15 public regulation commission, the New Mexico medical
16 insurance pool and the New Mexico health insurance alliance;
17 and

18 BE IT FURTHER RESOLVED that the New Mexico legislative
19 council appoint the legislative members of the working group;
20 and

21 BE IT FURTHER RESOLVED that the health care reform
22 working group meet monthly from March through September 2010;
23 and

24 BE IT FURTHER RESOLVED that the health care reform
25 working group receive staff assistance from state agencies,

1 the legislative finance committee and the legislative council
2 service as appropriate to carry out the work of the health
3 care reform working group; and

4 BE IT FURTHER RESOLVED that the health care reform
5 working group receive input and recommendations from the
6 public and from advisory groups for consideration and that
7 the health care reform working group present to the governor
8 and the legislature recommendations and proposed action steps
9 for administrative, legislative, regulatory, operational and
10 financial initiatives necessary to implement and supplement
11 any federal health care reform legislation; and

12 BE IT FURTHER RESOLVED that the health care reform
13 working group make recommendations regarding the creation of
14 any exchanges or other entities designated in any federal
15 legislation; the creation of any other entities the health
16 care reform working group considers necessary to supplement
17 any federal reforms; whatever changes in state regulations
18 are necessary to reconcile differences or conflicts between
19 federal and New Mexico insurance regulations; state
20 strategies to get access to any federal money available for
21 health care work force development, medicaid, community
22 clinics, addressing health care disparities and health care
23 information systems; any restructuring of medical assistance
24 programs to maximize federal funds; and other health-related
25 issues; and

1 BE IT FURTHER RESOLVED that the health care reform
2 working group receive recommendations from consumers;
3 advocates; licensed health care providers; health insurers;
4 payers, including employers and federal and state agencies;
5 Native American nations, tribes and pueblos; and other
6 interested parties as it deems necessary; and

7 BE IT FURTHER RESOLVED that the health care reform
8 working group present its recommendations to the governor,
9 the legislative finance committee and the legislative health
10 and human services committee by October 1, 2010; and

11 BE IT FURTHER RESOLVED that copies of this memorial be
12 transmitted to the governor; the chairs of the New Mexico
13 health policy commission, the legislative finance committee
14 and the legislative health and human services committee; the
15 co-chairs of the New Mexico legislative council; the
16 superintendent of insurance; the secretary of human services;
17 and the secretary of health.

NEW MEXICO PUBLIC REGULATION COMMISSION

COMMISSIONERS

DISTRICT 1 JASON MARKS
DISTRICT 2 DAVID W. KING, CHAIRMAN
DISTRICT 3 JEROME D. BLOCK, VICE CHAIRMAN
DISTRICT 4 CAROL K. SLOAN
DISTRICT 5 SANDY JONES



DIVISION OF INSURANCE

SUPERINTENDENT OF INSURANCE
MORRIS J. CHAVEZ

1120 Paseo de Peralta/P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4297

CHIEF OF STAFF

JOHNNY MONTOYA

Senate Joint Memorial Task Force Agenda

April 7, 2010

9:00 a.m. – 12:00 a.m.

Capitol Building Room 322

Meeting called by **The Superintendent of Insurance, Morris J. Chavez**

Members: Sen. Dede Feldman, Sen. Clinton D. Harden, Sen. Gay G. Kernan, Sen. Mary Kay Papen, Sen. Howie C. Morales, Sen. Nancy Rodriguez, Sen. Cisco McSorley, Sen. Sue Wilson-Beffort, Rep. Ray Begaye, Rep. Donald E. Bratton, Rep. Keith J. Gardner, Rep. Joni Marie Gutierrez, Rep. Rhonda S. King, Rep. Larry A. Larrañaga, Rep. Danice Picraux, Rep. Edward C. Sandoval, Sam Howarth, NMDOH, Kathyryn "Katie" Falls, NMHSD, Mike Nuñez

| | | |
|-----------------------|--|------------------|
| 9:00 a.m. – 9:15 a.m. | Welcome & Introductions SJM1 Link to Materials & Future Agendas at http://www.nmprc.state.nm.us/id.htm . Meeting Announcements | Morris J. Chavez |
|-----------------------|--|------------------|

| | | |
|-----------------------|---|---|
| 9:15 a.m. – 9:45 a.m. | Overview of SJM1 Goals of Today | Morris J. Chavez & Deborah Armstrong |
|-----------------------|---|---|

| | | |
|------------------------|--|------------------------------------|
| 9:45 a.m. – 10:30 a.m. | Implementation Timeline Briefing of the High Risk Pool Rulemaking | Deborah Armstrong & Brent Moore |
|------------------------|--|------------------------------------|

| | | |
|-------------------------|---|-------------------|
| 10:30 a.m. – 11:30 a.m. | Major Concepts Task force Assignments Meeting Schedule – Six Remaining Framework – Review of Areas of Concern | Deborah Armstrong |
|-------------------------|---|-------------------|

| | | |
|-------------------------|--|-------------------|
| 11:30 a.m. – 11:45 a.m. | Wrap-Up Next Meeting Review of Assignments for Next Meeting | Deborah Armstrong |
|-------------------------|--|-------------------|

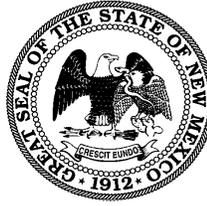
| | | |
|-------------------|-----------------------|--|
| 11:45 a.m. - noon | Public Comment | |
|-------------------|-----------------------|--|

Adjourn

NEW MEXICO PUBLIC REGULATION COMMISSION

COMMISSIONERS

DISTRICT 1 JASON MARKS
DISTRICT 2 DAVID W. KING, CHAIRMAN
DISTRICT 3 JEROME D. BLOCK, VICE CHAIRMAN
DISTRICT 4 CAROL K. SLOAN
DISTRICT 5 SANDY JONES



DIVISION OF INSURANCE

SUPERINTENDENT OF INSURANCE
MORRIS J. CHAVEZ

1120 Paseo de Peralta/P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4297

CHIEF OF STAFF

JOHNNY MONTOYA

Senate Joint Memorial Task Force Agenda

May 5, 2010

9:00 a.m. – 12:00 a.m.

Capitol Building Room 322

Chair: Deborah Armstrong, NMMIP

Members: Sen. Dede Feldman, Sen. Clinton D. Harden, Sen. Gay G. Kernan, Sen. Mary Kay Papen, Sen. Howie C. Morales, Sen. Nancy Rodriguez, Sen. Cisco McSorley, Sen. Sue Wilson-Beffort, Rep. Ray Begaye, Rep. Donald E. Bratton, Rep. Keith J. Gardner, Rep. Joni Marie Gutierrez, Rep. Larry A. Larrañaga, Rep. Danice Picraux, Rep. Edward C. Sandoval, Sam Howarth, NMDOH, Kathryn "Katie" Falls, NMHSD, and Mike Nuñez, NMHIA, Deborah Armstrong, NMMIP

| | | |
|------------------------|---|--|
| 9:00 a.m. – 9:15 a.m. | Welcome & Introductions Review and Approval of 4/7/2010 Meeting Meeting | Deborah Armstrong |
| 9:15 a.m. – 9:20 a.m. | Review & Approval of Agenda Review & Approval of Minutes Minutes of 4/7/2010 | Deborah Armstrong |
| 9:20 a.m. – 9:30 a.m. | Introductory Remarks Focus of Work Group | Deborah Armstrong |
| 9:30 a.m. – 12:00 p.m. | Insurance Reforms Review of Immediate & Future Reforms Medical Loss Ratio Rate Review Ombudsman Funding Opportunities DOI Priorities & Timelines | Brian Moore |
| 12:00 p.m. – 1:15 p.m. | Break for Lunch | Deborah Armstrong |
| 1:15 p.m. – 1:30 p.m. | High Risk Pool Update Briefing on the High Risk Pool Participation Getting Ready for the Next Step | Rudy Ann Esquibel & Deborah Armstrong |

1:30 p.m. – 2:15 p.m.

Advisory Groups

Formation
Task Definition

Deborah Armstrong

2:15 p.m. – 2:30 p.m.

Wrap-Up

Next Meeting
Review of Assignments for Next Meeting

Deborah Armstrong

2:30 p.m. – 3:30 p.m.

Public Comment

Adjourn

Revised: June 1, 2010

**TENTATIVE AGENDA
for the
SJM 1 HEALTH REFORM WORKING GROUP**

**June 3, 2010
Room 322, State Capitol
Santa Fe**

Thursday, June 3

- 9:00 a.m. **Call to Order**
- 9:05 a.m. **Welcome and Introductions**
- 9:10 a.m. **Update on High-Risk Pool**
—Deborah Armstrong, Executive Director, New Mexico Medical Insurance Pool
(NMMIP), Working Group Chair
- 9:30 a.m. **Overview: Health Insurance Exchanges**
—Anne Sperling, Vice Chair for Professional Development, National Association
of Health Underwriters
- 10:00 a.m. **Overview: Patient Protection and Affordable Health Care Act (PPACA)**
—Frederick Isasi, Senior Legislative Counsel for Healthcare, U.S. Senator Jeff
Bingaman
- 11:00 a.m. **Health Insurance Exchange — Report of Advisory Group**
—Anne Sperling, Vice Chair for Professional Development, National Association
of Health Underwriters
- 12:00 noon **Lunch**
- 1:00 p.m. **Health Insurance Exchange — Utah Model**
—John Sweeney, Vice President of Exchange Solutions, Health Equity
—Steve Neelman, M.D., Chief Executive Officer, Health Equity
- 1:30 p.m. **Health Insurance Exchange — Massachusetts Model and Consumer
Perspective**
—Dick Mason, Health Action New Mexico
- 2:00 p.m. **Considerations Regarding a State-Run Health Insurance Exchange**
—Mary Feldblum, Executive Director, Health Security for New Mexico
- 2:30 p.m. **PPACA — Business Implications**

—Gary Oppedahl, Chair, Health Committee, Association of Commerce and Industry

3:00 p.m. **PPACA — Tax Implications**
—Mike Nuñez, Executive Director, New Mexico Health Insurance Alliance

3:30 p.m. **Public Comment**

4:00 p.m. **Committee Discussion and Legislative Recommendations**
—Deborah Armstrong, Chair

4:30 p.m. **Wrap-Up and Adjourn**

Revised: July 8, 2010

**TENTATIVE AGENDA
for the
SJM 1 HEALTH CARE REFORM WORKING GROUP**

**July 9, 2010
Room 307, State Capitol
Santa Fe**

Friday, July 9

- 9:00 a.m. **Call to Order**
- 9:05 a.m. **Welcome and Introductions**
- 9:10 a.m. **Progress, Discussion and Recommendations**
—Deborah Armstrong, Chair, SJM 1 Health Care Reform Working Group
- 9:30 a.m. **Overview: Patient Protection and Affordable Health Care Act (PPACA) and Medicaid — Human Services Department (HSD)**
—Kathryn (Katie) Falls, Secretary, HSD
- 10:30 a.m. **Overview: PPACA and Medicaid — Medicaid Advisory Group**
—Sireesha Manne, Staff Attorney, Center on Law and Poverty
—Ruth Hoffman, Director, Lutheran Advocacy Ministry
- 11:30 a.m. **Medicaid Questions and Answers; Discussion**
- 12:00 noon **Lunch**
- 1:30 p.m. **Overview: PPACA and Long-Term Care — Aging and Long-Term Services Department (ALTSD)**
—Michael Spanier, Secretary, ALTSD
—Emily Kaltenbach, Director of Policy and Planning, ALTSD
- 2:30 p.m. **Overview: PPACA and Long-Term Care — Long-Term Care Advisory Group**
—Jim Jackson, Executive Director, Disability Rights New Mexico
—Ellen Pinnes, Health Policy Consultant
—Lisa Schatz Vance, Executive Director, Senior Citizen Law Office
- 3:30 p.m. **Long-Term Care Questions and Answers; Discussion**
- 4:00 p.m. **PPACA and Retirees — Retiree Health Care Authority (RHCA)**

—Wayne Propst, Director, RHCA

4:30 p.m. **Public Comment**

5:00 p.m. **Wrap-Up and Adjourn**

**TENTATIVE AGENDA
for the
SJM 1 HEALTH CARE REFORM WORKING GROUP**

**August 5, 2010
Room 322, State Capitol
Santa Fe**

Thursday, August 5

- 9:00 a.m. **Call to Order**
- 9:05 a.m. **Welcome and Introductions**
- 9:10 a.m. **Review of Work Force Components of the Patient Protection and Affordable Health Care Act of 2010 (PPACA)**
—Dan Derksen, M.D., Center for Community Partnerships, University of New Mexico (UNM), Robert Wood Johnson Health Policy Fellow
—Jerry Harrison, Ph.D., Executive Director, New Mexico Health Resources, Chair, Workforce Advisory Group
- 10:30 a.m. **Health Resources and Service Administration Competitive Grants**
—Sam Howarth, Director, Division of Policy and Performance, Department of Health (DOH)
—Pat Boyle, Executive Director, Center for Nursing Excellence
—Nancy Ridenauer, Ph.D., Director, School of Nursing, UNM
—Nikki Katalanos, Ph.D., Program Director, Physician Assistant Program, UNM
- 12:00 noon **Lunch**
- 1:30 p.m. **Health Care Delivery System; Opportunities and Challenges: PPACA**
—Robert Garcia, Vice President for Regional Administration, Presbyterian Healthcare Services; President, New Mexico Hospital Association
—Joie Glenn, Executive Director, New Mexico Association for Home and Hospice Care
—Mark Shinnerer, President, New Mexico Healthcare Association
—David Roddy, Executive Director, New Mexico Primary Care Association
—Carol Miller, Executive Director, National Center for Frontier Communities
- 3:30 p.m. **Next Steps**
 Data System and Coordination Issues —
 —Dan Derksen, M.D., Center for Community Partnerships, UNM, Robert Wood Johnson Health Policy Fellow
 Interdisciplinary Training Issues

—Betsy Van Leit, Ph.D., Area Health Education Centers,
UNM

Recruitment and Retention from a Broad Perspective

—Jerry Harrison, Ph.D., Executive Director, New Mexico Health
Resources; Chair, Workforce Advisory Group

4:30 p.m. **Public Comment**

5:00 p.m. **Wrap-Up and Adjourn**

**TENTATIVE AGENDA
for the
SJM 1 HEALTH CARE REFORM WORKING GROUP**

**September 2, 2010
Room 307, State Capitol
Santa Fe**

Thursday, September 2

- 9:00 a.m. **Call to Order**
- 9:05 a.m. **Welcome and Introductions**
- 9:10 a.m. **Approval of August Minutes**
- 9:10 a.m. **Native American Issues and the Patient Protection and Affordable Care Act**
—Alvin Warren, Secretary, Indian Affairs Department
- 10:00 a.m. **Consumer Protection and Consumer Education**
—Barbara K. Webber, Executive Director, Health Action New Mexico
—Jane Wishner, Executive Director, Southwest Women's Law Center
- 11:30 a.m. **Women's Health Issues**
—Giovanna Rossi, Executive Director, Office of the Governor's Council on
Women's Health
—Joan LaMunyon-Sanford, Director, New Mexico Religious Coalition for
Reproductive Choice
- 12:00 noon **Lunch**
- 1:30 p.m. **Health Insurance Exchange Planning Grant Application and Planning
Process**
—Ruby Ann Esquibel, Health Policy Coordinator, Human Services Department
- 2:15 p.m. **Health Insurance Exchange Recommendations, Including Small Business
Input**
—Health Insurance Exchange Advisory Committee
- 3:00 p.m. **Public Comment**
- 3:30 p.m. **Discussion and Recommendation Regarding a Health Insurance Exchange**
- 5:00 p.m. **Wrap-Up and Adjourn**

**TENTATIVE AGENDA
for the
SJM 1 HEALTH CARE REFORM WORKING GROUP**

**October 4, 2010
Room 322, State Capitol
Santa Fe**

Monday, October 4

- 9:00 a.m. **Call to Order**
- 9:05 a.m. **Welcome and Introductions; Approval of Minutes (August and September)**
- 9:10 a.m. **Information Technology; Broadband Access; Interface with Medicaid**
—Kathryn "Katie" Falls, Secretary, Human Services Department
- 10:10 a.m. **Quality, Transparency and Reporting**
—Dan Derksen, M.D., Center for Community Partnerships, University of New Mexico, Robert Wood Johnson Health Policy Fellow
- 11:10 a.m. **Public Comment**
- 12:00 noon **Lunch**
- 1:30 p.m. **Committee Discussion and Recommendations: Health Insurance Exchanges**
—Karen Wells, Researcher, Legislative Council Service
- 2:30 p.m. **Discussion: Other Legislative Recommendations**
—Deborah Armstrong, Chair, SJM 1 Health Care Reform Working Group
- 3:00 p.m. **Discussion: Final Report Content, Format and Overall Recommendations**
—Deborah Armstrong, Chair, SJM 1 Health Care Reform Working Group
- 3:30 p.m. **Wrap-Up and Adjourn**

**MINUTES
of the
ORGANIZATIONAL MEETING
of the
SENATE JOINT MEMORIAL 1 HEALTH CARE REFORM WORKING GROUP**

**April 7, 2010
Room 322, State Capitol
Santa Fe, NM**

The meeting was called to order on April 7, 2010 at 9:20 a.m. by Superintendent of Insurance Morris "Mo" Chavez. After general welcoming remarks, members of the working group introduced themselves.

Present

Deborah Armstrong, Executive Director,
New Mexico Medical Insurance Pool
(NMMIP)
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Morris "Mo" Chavez, Superintendent of
Insurance
Sen. Dede Feldman
Rep. Keith J. Gardner
Sam Howarth, Director of Policy and
Performance, Department of Health
(DOH)
Sen. Cisco McSorley
Mike Nunez, Executive Director, New
Mexico Health Insurance Alliance
Rep. Danice Picraux
Charissa Saavedra, Deputy Secretary,
Human Services Department (HSD)

Absent

Rep. Donald E. Bratton
Rep. Joni Marie Gutierrez
Sen. Clinton D. Harden, Jr.
Sen. Gay G. Kernan
Rep. Larry A. Larrañaga
Sen. Howie C. Morales
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Rep. Edward C. Sandoval

Guests

The guest list is in the meeting file.

Copies of all handouts and written testimony are in the meeting file.

Wednesday, April 7

Superintendent Chavez provided an overview of the purpose and goals of the working group as provided in SJM 1, which passed the legislature this year. He recognized Andrew Black, field representative for U.S. Senator Jeff Bingaman, and Paul Ritzma, deputy chief of staff to Governor Bill Richardson. He reviewed the handouts and agenda for the day, noting that all handouts would be available on the web site of the Insurance Division of the Public

Regulation Commission (PRC). He invited anyone on the working group or audience to share information that could be posted on the web site.

Senator Feldman, the sponsor of SJM 1, commented on the importance of the working group. She feels New Mexico is well-positioned to implement federal health reform initiatives because New Mexico has been proactive in this area for several years. She noted the importance of identifying conflicts between state and federal laws and said that all grants and funding opportunities should be optimized.

Mr. Ritzma was invited to address the working group about the governor's plans regarding seamless implementation of the federal reform law in New Mexico. At the request of the Obama administration, the governor intends to establish an executive leadership team to develop a strategic plan for implementation. One legislator will be invited to participate on this leadership team. He noted that the Office of the Governor has targeted four major areas of focus, including Medicaid reforms, the establishment of a health insurance exchange, other health insurance reforms and delivery system reforms. Much information has already been received from the federal government in these areas. He stressed the importance of cooperation between the working group and the leadership team to avoid duplication, identify grants and funding opportunities and identify and analyze data. He reported that the governor is concerned about several pressing deadlines, foremost of which is the need to name a point person to serve as a contact with the federal government on risk pool issues. He identified the legislature as key in two specific areas: information technology expansion to accommodate Medicaid eligibility determinations and tracking and identification of the type of exchange that the state should develop. He noted that the New Mexico Health Insurance Alliance could serve as the exchange. He anticipates that the governor will identify leadership team members before the end of the week.

Discussion and questions from working group members covered the following issues and concerns:

- the need for frequent and consistent cooperation between the executive and the working group;
- the need for expanded membership of the working group to include a member of the governor's leadership team;
- whether a special session of the legislature will be needed to implement federal health reform; none is anticipated;
- the amount of money available to expand coverage within the high-risk pool; \$5 billion over four years;
- whether funding is available to establish an exchange;
- specifically, how integration and cooperation between the executive and the working group will be accomplished; and
- a suggestion to merge the leadership team with the working group; Mr. Ritzma indicated that the governor desires a separate, executive leadership team and that this is the expectation of the Obama administration.

A motion was made and seconded to ask the governor to designate someone from his office to be a member of the working group. After discussion, the motion was approved unanimously. A suggestion was made that the working group, any advisory groups that are formed and the governor's leadership team meet concurrently to facilitate integration.

Ms. Armstrong briefed the working group on the provisions regarding temporary high-risk pools in the new federal law. New Mexico is well-positioned due to the existence of the NMMIP, which can easily meet the standards outlined in the federal act. She reiterated that the governor is required to name a point person for risk pool information by April 9, 2010. A letter of intent to contract with the federal Department of Health and Human Services to operate a risk pool under the law is needed by April 30, 2010. This year, the legislature passed HB 213, which gave the NMMIP authority to create new programs if necessary to comply with federal law and to ensure maximum participation and access to federal funding. The only requirement with which the NMMIP does not already comply is a requirement for premiums to be at 100% of the standard non-group rate in the state. The NMMIP is currently at 112% of the standard non-group rate.

A motion was made and seconded that the working group write a letter to the governor stating the desire of the working group that the NMMIP be utilized as the risk pool under the federal act. The motion was adopted unanimously. A motion was made and seconded to add to the letter the recommendation that Ms. Armstrong be named as the point person for the risk pool. The motion was adopted unanimously.

Brent Moore, general counsel, PRC, described conflicts between the new federal law and the new state law regarding medical loss ratios (MLR). HB 12 established an MLR of 85:15 for group and small group policies and an MLR range of between 85:15 and 75:15 for the individual market, with the superintendent of insurance having the flexibility through rulemaking to determine the exact MLR. The federal law establishes the group MLR at 85:15 and the small group MLR at 80:20, with the provision that the states can set more stringent requirements. The MLR established for the individual market in the federal law is 80:20. Through rulemaking, New Mexico will establish the more stringent standard for small groups that is contained in HB 12 and the more stringent MLR for individual policies that is contained in the federal law.

Questions and comments from working group members addressed the following:

- whether the rebate, if an insurer does not meet the MLR requirement, will be returned to the enrollee; and
- the period of time that will be used for determining whether the insurance companies meet the MLR standards.

Superintendent Chavez highlighted other health insurance reforms contained in the federal law and which of those reforms that New Mexico already addresses in state law. He noted that grant funding is available for each state to establish an ombudsman program. These items will be on the agenda at the next meeting of the working group for further discussion. He

announced that a rate review hearing is scheduled for April 26, 2010 to review the premium increases requested by Blue Cross Blue Shield of New Mexico.

Ms. Armstrong suggested a schedule for discussion of major topics as follows:

- April - orientation and overview;
- May - insurance reform provisions;
- June - Medicaid and long-term care provisions;
- July - exchange issues and tax benefits;
- August - work force and access; and
- September - data, reporting and development of the final report to the Legislative Health and Human Services Committee (LHHS).

She suggested meeting the first Wednesday of each month, with the possibility of an additional meeting in September to be fully prepared to meet the October 1, 2010 deadline for a report to the LHHS. At each meeting, attention will be given to identifying legislation that will be required to implement the federal law, a more detailed time line for implementation and a matrix of responsibility.

Public comment was offered by the following individuals:

Mary Feldblum, executive director, Health Security for New Mexico, urged the working group to carefully analyze the cost to the state to implement the law. She believes the exchange concept will be very expensive to operate and will not control costs. She would like New Mexico to consider submitting a waiver in 2017 to create an alternative plan for reform.

Anne Sperling, insurance broker and founder of the New Mexico Health Insurance Alliance, offered to provide background and support. She requested that prevention and wellness initiatives be added to one of the agendas.

Carol Miller, citizen, supported Ms. Feldblum's comments. She expressed a concern that the provisions of the law regarding benefit packages leave loopholes for insurance companies to circumvent the intent of the law.

Barbara Weather, executive director, Health Action New Mexico, stressed the importance of setting up advisory committees and requested that rural issues and health disparities be addressed in these committees.

Harvey Licht, citizen, highlighted three additional areas of interest: Title IV of the act that deals with health improvement; the availability of state work force development grants; and health system enhancements through such models as medical homes.

Jane Wishner, executive director, Southwest Women's Law Center, noted that there is a disproportionate number of uninsured women in New Mexico and that provisions in the federal law address these disparities. Additionally, she recommended that an advisory committee be

formed to address consumer protection, education and outreach. She recommended coordination with the Consumer Protection Division of the Office of the Attorney General.

Charlie Alfero, executive director, Hidalgo Medical Services, commended the legislature for previous work done to address work force issues.

Mr. Black offered his office as a resource and as a bridge between New Mexico and Washington, D.C.

Brent Earnest, Legislative Finance Committee (LFC), informed the working group that on April 22, 2010, the LFC will hear testimony from Secretary of Human Services Katie Falls on Medicaid and federal health reform.

Jerry Harrison, executive director, New Mexico Health Resources, expressed concern regarding the potential for false promises to be made to the state.

A motion was made and seconded to ask the chair of the working group to write a letter to the governor to request joint meetings between the SJM 1 Health Care Reform Working Group and the governor's leadership team and to reflect a willingness to name advisory committees jointly. The motion was adopted unanimously.

A request was made to add the topic of advisory committee appointments to the May meeting. Names of Native Americans who would be valuable resources to these advisory committees were provided. An observation was made that legislators who were unable to attend this meeting would need to be educated about the issues. A request was made that the announcements of the meetings and links to the Insurance Division web site be added to the Legislative Council Service (LCS) web site.

Superintendent Chavez reviewed the letters the working group requested to be sent to the governor and reminded members that the next meeting would be held on May 5, 2010. He requested the LCS to try to coordinate dates of this work group with the LHHS.

The meeting was adjourned at 12:10 p.m.

MINUTES
of the
SENATE JOINT MEMORIAL HEALTH CARE REFORM WORKING GROUP
May 5, 2010
Room 322, State Capitol
Santa Fe, NM

The meeting of the Senate Joint Memorial (SJM) Health Care Reform Working Group was called to order on May 5, 2010 at 9:21 a.m. by Deborah Armstrong, chair. After general welcoming remarks, members of the working group introduced themselves.

Present

Deborah Armstrong, Executive Director,
New Mexico Medical Insurance Pool
(NMMIP), Chair
Rep. Ray Begaye
Kathryn "Katie" Falls, Secretary,
Human Services Department (HSD)
Sen. Dede Feldman
Rep. Keith J. Gardner
Sam Howarth, Director of Policy and
Performance, Department of Health
Sen. Gay G. Kernan
Rep. Larry A. Larrañaga
Mike Nunez, Executive Director
New Mexico Health Insurance
Alliance (NMHIA)
Rep. Danice Picraux

Absent

Sen. Sue Wilson Beffort
Rep. Donald E. Bratton
Rep. Joni Marie Gutierrez
Sen. Clinton D. Harden, Jr.
Sen. Cisco McSorley
Sen. Howie C. Morales
Sen. Mary Kay Papen
Sen. Nancy Rodriguez

Guests

The guest list in the meeting file.

Handouts

Copies of all handouts and written testimony are in the meeting file.

Wednesday, May 5

A motion to approve the agenda was adopted unanimously. A motion to approve the minutes of the April 7, 2010 meeting was adopted unanimously. Ms. Armstrong thanked the various association and advocacy groups in attendance for their interactions and willingness to participate in ongoing meetings.

Insurance Reforms

Presentation of the federal Patient Protection and Affordable Care Act (PPACA) was made by Brent Moore, general counsel, Insurance Division, Public Regulation Commission. Mr. Moore indicated that all presentation materials would be posted to the Insurance Division web

site. The source of the data presented was the National Association of Insurance Commissioners. Mr. Moore described the spreadsheets and federal registers that would be referred to during the presentation. Mr. Moore indicated that public comments on the medical loss ratio provisions and rate review provisions are due by May 14. Mr. Moore detailed the immediate health insurance market reforms required by the PPACA, including:

- annual and lifetime limits;
- rescissions;
- coverage of preventative health services;
- extension of adult dependent coverage;
- preexisting condition exclusions;
- uniform explanation of coverage documents and standardized definitions;
- provisions of additional information;
- prohibition on discrimination based on salary;
- ensuring quality of care;
- bringing down the cost of health care;
- the appeals process;
- patient protections;
- health insurance consumer assistance offices and ombudsmen;
- ensuring that consumers get value for their dollars;
- the temporary high-risk pool program;
- the temporary insurance program for early retirees;
- the web portal to identify affordable coverage options; and
- administration simplification requirements.

Discussion and questions from the working group members covered the following issues and concerns:

- which dependents up to age 26 will be covered;
- clarification regarding grandfathered plans versus compliant plans; 90-day waiting periods, lifetime limits, rescission, extension of dependent coverage to age 26, uniform summary of benefits and coverage and standardized definitions do apply to grandfathered plans. Provisions regarding coverage of preventative care without deductibles or co-payments, lifetime limits, preexisting condition exclusions, discrimination based on salary, quality of care and patient protections apply only to non-grandfathered plans;
- clarification regarding the required designations and preparations for the NMMIP to serve as the new, temporary high-risk pool effective July 1, 2010;
- concern regarding the adequacy of a network of primary care providers;
- the methodology of reimbursement for Medicare services; Secretary Falls indicated that the HSD had been asked to submit Medicaid data for review; and
- clarification regarding medical loss ratios; Tom Bowling, actuary, Insurance Division, responded.

Secretary Falls indicated that she has been appointed by the governor as the chair for the

governor's leadership team, which has been asked to collect and analyze data and identify resources relative to the implementation of the PPACA. The leadership team is charged with developing a strategic plan for implementation by July 1, 2010.

The impact of health care reform on Native American tribes was discussed. Mr. Moore indicated that the Indian Health Service is generally outside the insurance market. Secretary Falls indicated that under the Indian Health Care Improvement Act, which is included in the PPACA, individual mandates do not apply to tribal members. Mr. Moore will take a more serious look at the issue and conduct additional research and follow up with the group.

General questions were raised regarding how information will be communicated to New Mexicans. Mr. Moore indicated that the first step is a national web portal that is required to be up and running by July 1, 2010. Public comments on the portal are due by May 10, 2010.

The recent approved increase to Blue Cross Blue Shield of New Mexico rates was briefly discussed. Concern was voiced over rating practices in the individual market in which rate blocks are closed, resulting in what is known as a death spiral, wherein chronically ill or aging beneficiaries see ever-increasing premiums. This practice is likely to continue until 2014, when the PPACA is fully implemented. Mr. Moore indicated that the Insurance Division is interested in addressing this issue to strengthen provisions in state law and give the superintendent of insurance greater authority over rate increases.

Mr. Moore identified provisions in the PPACA that will become effective at a later date, but by 2014, including:

- preexisting condition exclusions for adults;
- federal oversight of health insurance premiums;
- prohibiting discrimination against individual participants and beneficiaries based on health status;
- prohibition on excessive waiting periods;
- provisions relating to offering of plans in more than one state;
- tax credits for small businesses to offer employee health insurance coverage; and
- minimum essential coverage requirements.

Discussion and questions from the working group members regarding the presentation covered the following issues and concerns:

- questions regarding the value of premiums and discrimination pricing;
- the entity responsible for assessment of penalties, which is the Internal Revenue Service;
- clarification regarding provision of medical care for an individual who chooses to ignore the individual mandate to purchase coverage; penalties are assessed, and the individual can be held responsible for covering medical claim expenses;
- what incentives exist for providers to participate; all willing providers are allowed under federal law; and

- whether insurers mandate in-network provision of services.

Mr. Moore indicated that there are no immediate requirements of the PPACA that necessitate legislative action. Some regulations will need to be revised to reconcile differences between state law and the PPACA regarding medical loss ratios, and legislation may need to be refined. In addition, carrier rebates that begin in 2011 need to be addressed. Mr. Moore agreed that litigation costs impact service delivery costs and are addressed through malpractice laws. He will follow up with the working group on court litigation. The Insurance Division will attempt to comment on federal medical loss ratio and rate review proposed regulations; comments will be provided to the working group.

High Risk Pool Update

Ms. Armstrong reported that the PPACA contains provisions for implementation of a high-risk pool for individuals with preexisting conditions but without insurance for a period of six months. The language in the federal law regarding high-risk pools was patterned after information from existing state high-risk pools. A total of 18 states elected not to participate and will allow the federal government to establish a national pool on their behalf. New Mexico notified the federal Department of Health and Human Services that it will participate with the state's existing high-risk pool. Ruby Ann Esquibel has been designated as the key state contact for this program. Funding of \$37.5 million has been set aside for New Mexico to fund coverage of qualified individuals for the next 3.5 years. The pool is intended as a bridge program to maximize coverage and access until full implementation of the insurance market reforms take place in 2014. During the 2010 legislative session, House Bill 216 was passed amending the NMMIP statute to provide authority for the NMMIP to offer different plans, eligibility and premium structure and accept funds from the federal government. Current NMMIP plans and the new federal high-risk coverage could coexist utilizing the same the same enrollment process as each program is tracked separately. Existing participants in the NMMIP are disqualified from participating in the federal pool because they are currently insured.

Additionally, the NMMIP does not have a waiting period, while the federal pool requires a six-month waiting period. Premiums for the NMMIP are set at 112% of the standard rate, while the federal pool premium will be set at 100%. Ms. Armstrong has developed a side-by-side analysis of the eligibility criteria for both pools, which will be provided to the working group. At the present time, all the guidelines and regulations are not known. As they become available, the high-risk pool will react accordingly.

Formation of Advisory Groups to the Working Group

Ms. Armstrong encouraged all interested parties to form advisory groups for input to the working group. At present, the following groups and volunteer leaders have formed:

- Medicaid, to be led by the Medicaid coalition;
- long-term care, to be led by the disability coalition;
- consumer protection and education, to be led by the Southwest Women's Law Center;

- and
- insurance and exchanges, to be led by the New Mexico Association of Health Underwriters;

Other advisory groups yet to be confirmed include:

- work force;
- business impact; and
- delivery systems.

Secretary Falls indicated that it is the intent of the governor's leadership team to utilize the same advisory groups. Additional sheets were provided to the general public to indicate interest in participating in each working group. As groups form, they are asked to meet and focus on the following questions:

- identify provisions of the law relating to the interest group;
- the time lines for implementation and decision-making;
- the key implementation or policy issues;
- the key decision points — legislative and administrative;
- what entity has primary responsibility (federal, state, agency or shared);
- funding opportunities, associated time lines and primary responsibility for grant applications; and
- any specific recommendations on policy or implementation issues and decision points.

Public Comment

Public comment was offered by the following individuals:

Jane Wishner, executive director, Southwest Women's Law Center, noted that a task force for consumer protection should be created. Additionally, grant opportunities need some planning and coordination to ensure that no funding is lost. The requirement for establishment of a web portal is a critical step in ensuring that consumers understand the new policies.

Ann Sperling, C.S.A., L.P.R.T., national vice chair for professional development for the National Association of Health Underwriters, read a letter to Kathleen Sebelius, secretary of health and human services, asking for adequate time to properly implement such provisions as medical loss ratios to avoid any unintended consequences.

Ms. Armstrong reviewed the proposed schedule for upcoming meetings of the SJM 1 Health Care Reform Working Group, which will meet monthly through October, and the topics to be addressed at each meeting. The next meeting is scheduled for June 3, 2010 and will address health insurance exchanges.

The meeting adjourned at 3:09 p.m.

MINUTES
of the
SENATE JOINT MEMORIAL 1 HEALTH CARE REFORM WORKING GROUP

June 3, 2010
Room 322, State Capitol
Santa Fe

The meeting was called to order on Thursday, June 3, 2010, at 9:21 a.m. by Debbie Armstrong, chair. After general welcoming remarks, members of the working group introduced themselves.

Present

Debbie Armstrong, Executive Director, New Mexico Medical Insurance Pool (NMMIP)
Craig Dunbar, Interim Superintendent, Division of Insurance, Public Regulation Commission
Sen. Dede Feldman
Rep. Keith J. Gardner
Sam Howarth, Director of Policy and Performance, Department of Health
Sen. Gay G. Kernan
Mike Nuñez, Executive Director, New Mexico Health Insurance Alliance (NMHIA)
Rep. Danice Picraux
Charissa Saavedra, Deputy Secretary, Human Services Department (HSD)

Absent

Sen. Sue Wilson Beffort
Rep. Ray Begaye
Katie Falls, Secretary, HSD
Rep. Joni Marie Gutierrez
Rep. Larry A. Larrañaga
Sen. Howie C. Morales
Sen. Mary Kay Papen

Advisory Members

Sen. Cisco McSorley

Rep. Donald E. Bratton
Sen. Clinton D. Harden, Jr.
Sen. Nancy Rodriguez

Guests

The guest list in the meeting file.

Handouts

Copies of all handouts and written testimony are in the meeting file.

Wednesday, June 3

A motion to approve the agenda was adopted unanimously. The minutes of the May 5, 2010 meeting were amended to correct information regarding the NMMIP by stating, "Additionally, the federal pool does not have a waiting period, while the NMMIP requires a

six-month waiting period for coverage of pre-existing conditions if the individual was uninsured for the previous six months." A motion to accept the minutes as amended was adopted unanimously. Ms. Armstrong thanked the various associations and advocacy groups in attendance for their continued willingness to participate in ongoing meetings.

Update on the High-Risk Pool

Ms. Armstrong indicated that an application to the federal Department of Health and Human Services (HHS) was submitted on June 1, 2010 for both the existing New Mexico high-risk pool and the new federally funded pool. The NMMIP is prepared to enroll new participants on July 1, 2010 with an effective date of August 1, 2010. Individuals who have a preexisting condition and who have not been enrolled in an insurance plan for more than six months qualify for the federal pool without a waiting period. Plans offered will include a \$500, \$1,000 and \$2,000 deductible. Approximately \$37 million will be provided to fund the new pool over the three-year period that begins on July 1, 2010. The NMMIP will be "media-alert" and provide web site updates for the general public regarding the opportunity to enroll. The HHS will launch a marketing plan once all questions regarding the discount program are answered. It is anticipated that the new federal pool will fund between 900 and 1,000 new participants. Currently, the New Mexico pool covers 8,150 members.

Overview: Health Insurance Exchanges

Anne Sperling, vice chair for professional development, National Association of Health Underwriters, reviewed the structure, duties and time line for the establishment of the American Health Benefit Exchange, for those purchasing individual health insurance coverage, and the Small Business Health Options Exchange (SHOP) insurance as required by the federal Patient Protection and Affordable Care Act (PPACA). She covered the consequences for not establishing these exchanges. The PPACA provides for navigators, which are individuals to help educate New Mexicans about how to access coverage through an exchange. Navigators cannot be paid by insurance carriers. Funding for navigators will be short-lived and not available for the long term. Risk pools and the possible combining of individual and small business groups were outlined. Medical loss ratios, actuarial cost parameters and uniform benefit designs, as well as state basic health plan design, were provided. Premiums charged for exchange plans must be the same inside and outside the exchange. Qualified health plan carrier requirements were outlined. Essential and required benefits were detailed. Catastrophic plans for participants under age 30 were reviewed. The individual mandate required by January 1, 2014 and related penalties for noncompliance were presented.

Ms. Sperling emphasized that communication will be key to the success of the exchanges' 24-hour hotlines to guide individuals, employees and employers.

Overview: PPACA

Frederick Isasi, senior legislative counsel for healthcare for United States Senator Jeff Bingaman, presented insights on the development of the PPACA by Congress, including the following priorities:

- preventive and wellness issues were always to be included;

- expanding coverage to the uninsured was a priority;
- intent was to cover employer groups with 50 or more employees; therefore, impact to New Mexico employers was minimized;
- the Health Insurance Exchange (HIE) would have robust oversight over the communication of plans and rate review and justification responsibilities;
- the HIE must be self-sustaining by 2015;
- the Internal Revenue Service would be responsible for applicable penalties;
- marketing would include online service, walk-ins and advertising;
- navigators would be utilized to communicate the role and intent of the exchange and educate the public;
- grants would be available in 2014 to 2015;
- the HIE would establish guidelines and review all marketing materials;
- undocumented workers would not be covered under the HIE;
- increased payroll taxes would impact less than 2% of New Mexicans;
- fraud and waste would be identified and minimized;
- New Mexico is ahead of curve for implementation with established pools and medical loss ratio legislation;
- immediate changes regarding coverage up to age 26, annual lifetime maximums and removal of dollar limits on benefits are expected by October 1, 2010. Many carriers are implementing reform earlier than required;
- tracking life event changes and qualified events will be difficult;
- technology will be the state's biggest challenge; and
- as New Mexico moves toward implementation, keeping the system simple will be very important.

Mr. Isasi committed the resources of Senator Bingaman's office to assist the working group and suggested monitoring the office's web site for additional information.

HIE — Report from the Advisory Group

Ms. Sperling reviewed the presentation entitled "Health Care Reform Working Group". Ms. Sperling gave the history of Senate Joint Memorial 1 and the enactment of the PPACA. The advisory group was formed during the May Health Care Reform Working Group meeting with the proposed strategy to identify provisions of law relating to interest groups. The advisory group met two times in May looking at the law, plan of operations and reporting of two current agencies: the NMHIA and the NMMIP.

The advisory group recommendations are:

- to continue the advisory group for a longer period of time;
- to have the advisory group report to the Office of Consumer Health Services or the New Mexico Health Policy Commission; and
- that the legislative session should identify the need for the strategic planning entity and identify a solution to meet that need.

HIE — Utah Model

John Sweeney, vice president of exchange solutions, Health Equity, presented the

structure and history of the Utah Health Exchange. Utah began its exchange in 2009 with a pilot target of 150 employers with a group size of two to 50 employees. A universal application was developed in October 2009. Health Equity is the Utah HIE banking partner responsible for premium billing, collection and aggregation. Health Equity is responsible for the calculation of risk adjustment payments between carriers. A total of 67 unique plans are offered under the exchange. Employers contribute a defined contribution and allow employees to utilize funds to purchase coverage under the exchange.

Factors that affect participation include:

- broker education and communication;
- a lengthy approval process;
- different pricing in parallel markets; and
- usability issues with the exchange interface.

The Utah HIE has not yet completed its first cycle of renewals. Cost reduction studies have not yet been conducted. Of the current enrollment, 40% of enrollees are under a health savings account (HSA) plan design. Oversight was placed under economic development rather than the health department. A defined contribution approach was adopted to give employers predictability. Medicaid is not offered.

HIE — Massachusetts Model and Consumer Perspective

Dick Mason, Health Action New Mexico, presented information on the Massachusetts model that included how the exchange began and its structure, functions and results. Massachusetts was one of the most expensive health care cost areas in the nation. Focus groups indicated that residents did not want a lot of choices in health care.

Mr. Mason discussed representing consumer/purchasing interest in the Health Benefits Exchange (HBE), with a focus on how the HBE can best represent consumer and purchaser interests, which include the following:

- through negotiation of the best deal and the highest quality;
- providing clear and comparable choices;
- assuring that insurers comply with standards;
- coordinating with public programs and developing streamlined applications;
- overseeing risk adjustments and reinsurance;
- outreach and recruitment and setting of broker fees;
- governing without conflicts of interest; and
- being relatively free of political swings and being flexible enough to deal with changing conditions.

Mr. Mason next discussed the type of structure for the HBE, which includes:

- a focus on representing the interests of consumers and purchasers;
- that the HBE is an existing New Mexico entity and must conform to the items listed above;
- creation of a separate authority; and

- that Health Action New Mexico will continue to study and provide a future recommendation.

Mr. Mason suggested inviting Jon Kingsdale, the outgoing executive director of the Commonwealth Health Insurance Connector Authority, to come to New Mexico and testify before the working group.

Considerations Regarding a State-Run HIE

Mary Feldblum, executive director, Health Security for New Mexico Campaign, stated that establishing a state exchange may not be the best approach, and she recommended encouraging freedom of choice. Ms. Feldblum stated the following:

- passage of the health care reform legislation is a major achievement;
- there are two options to meet the goals of the legislation;
- an exchange should be created or waivers should be sought;
- should New Mexico opt for an exchange, costs should be considered;
- costs to set up and operate should be determined;
- the costs of those who are uninsured and the impact on those currently insured;
- the overall impact of the exchange on overall health care costs;
- the exchange must be self-sufficient by 2015;
- there are no built-in premium controls, and the complex private system is maintained;
- the legislation is built on the Massachusetts model, which has not solved the cost problem; and
- it is critical to determine the cost to New Mexico before investing in an insurance exchange.

PPACA — Business Implications

Gary Oppendahl, chair, Health Committee, Association of Commerce and Industry (ACI), gave a presentation focused on the 2011 ACI interim legislative positions. He stated that:

- the ACI would like to be a voice for business and employers in implementing federal health care reform;
- the ACI favors maximizing the use of federal funds, including grant opportunities for innovation and cost reduction;
- the ACI would favor the use of federal funds to educate, train, recruit and retain more health care professionals and other providers; and
- the ACI supports incentives to Medicaid providers to expand, especially in underserved areas.

Mr. Oppendahl cited the difficulty in providing health coverage by Medicaid employers due to costs and reimbursement obstacles. With fixed reimbursement, it is difficult to afford health care for employees. Employers are paying \$9.00 per hour currently; implementing health care would move the cost to \$12.00 per hour.

PPACA — Tax Implications

Mr. Nuñez provided a year-by-year summary of tax provisions that impact business,

including:

- 2010: small business tax credits, hospital tax penalties and taxes on indoor tanning services;
- 2011: exclusion of over-the-counter drugs not prescribed, increased taxes on HSAs and Archer medical savings accounts that are not used for qualified medical expenses, pharmaceutical company-imposed annual fees and changes to Medicare and Medicare Advantage benefit reimbursements;
- 2013: limiting flexible spending account contributions, increasing the adjusted gross income threshold for unreimbursed medical expenses, eliminating Medicare Part D employer subsidies, increasing Medicare payroll taxes, increasing Medicare hospital insurance taxes and imposing annual fees on health insurance providers; and
- 2014: imposing a health coverage mandate and penalties for noncompliance and an excise tax on high-cost "Cadillac" plans.

Public comment was offered by the following individuals*:

- William Pratt;
- Lee Einer;
- Liz Copeland, teacher;
- Dana Middletin, Women's Chapter in Santa Fe;
- Dana Millen;
- Maury Castro, retiree and resident of Las Cruces;
- Susan Rodriguez, 22-year resident of New Mexico;
- Terry Riley;
- Doris Vician, retired emergency nurse from Albuquerque;
- Lindsey Tapper, acupuncture therapist; and
- Sister Marlene Perratte, practicing immigration law attorney.

* All expressed support for the Health Security for New Mexico Campaign.

Committee Discussion and Legislative Recommendations

Ms. Armstrong recognized the need for more experts to set the criteria for a good exchange. The use of focus groups was suggested to get a broader perspective. Consumers need to be recognized on the governance board of the exchange.

The next meeting of the working group will be on July 9, 2010 in Room 321 of the State Capitol.

The meeting adjourned at 3:09 p.m.

**MINUTES
of the
SENATE JOINT MEMORIAL 1 HEALTH CARE REFORM WORKING GROUP**

**July 9, 2010
Room 307, State Capitol
Santa Fe**

The meeting of the Senate Joint Memorial 1 Health Care Reform Working Group (HCRWG) was called to order on July 9, 2010 at 9:10 a.m. by Michelle Lujan Grisham, chair. After general welcoming remarks, members of the working group introduced themselves.

Present

Rep. Gail Chasey
Kathryn "Katie" Falls, Secretary of
Human Services
Sen. Dede Feldman
Sam Howarth, Director of Policy and
Performance, Department of Health
Michelle Lujan Grisham (for Debbie
Armstrong), Deputy Director, New
Mexico Medical Insurance Pool
(NMMIP)
Mike Nuñez, Executive Director,
New Mexico Health Insurance Alliance
Sen. Mary Kay Papen
Rep. Danice Picraux
Alan Seeley, Interim Superintendent
of Insurance, Public Regulation
Commission

Absent

Debbie Armstrong, Executive Director,
NMMIP
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Keith J. Gardner
Sen. Gay G. Kernan
Rep. Larry A. Larrañaga
Sen. Howie C. Morales

Advisory Members

Rep. Donald E. Bratton
Sen. Cisco McSorley
Sen. Nancy Rodriguez

Sen. Clinton D. Harden, Jr.
Rep. Edward C. Sandoval

Guests

The guest list in the meeting file.

Handouts

Copies of all handouts and written testimony are in the meeting file.

Friday, July 9

A motion was made to approve the minutes of the June 3, 2010 meeting with an amendment to clarify the state pool and federal pool requirements. Ms. Lujan Grisham will prepare a

handout with clarification on state and federal pools for the working group and general public on both requirements. The minutes were adopted unanimously.

Progress, Discussion and Recommendations

Ms. Lujan Grisham suggested that the working group take more time before making recommendations about health insurance exchanges, as discussed at the previous meeting. Senator Feldman indicated she had been contacted by small businesses that would like to be involved in the exchange advisory group. A recommendation was made to expand the advisory group to include small businesses and other interested parties. Mr. Nuñez indicated that he would work with Anne Sperling to accomplish this.

Ms. Lujan Grisham reported that the federal high-risk pool is up and running. The process was made possible through the work of Ms. Armstrong and Ruby Ann Esquibel of the Human Services Department (HSD).

Overview: The Patient Protection and Affordable Health Care Act (PPACA) and Medicaid — HSD

Secretary Falls explained the impact of the PPACA on the Medicaid program regarding expansion, benefit plans, procedures, data sharing and options for program improvements and funding. Under the PPACA, Medicaid eligibility will include everyone up to age 64 whose income is up to 133% of the federal poverty level (FPL). Approximately 200,000 New Mexicans will be eligible for Medicaid once expansion goes into effect in 2014. States will receive 100% federal medical assistance percentage for all newly eligible individuals enrolled in the program. It is uncertain at present whether New Mexicans enrolled in the State Coverage Insurance (SCI) program or on the waiting list for SCI will be considered newly eligible. Newly eligible adults will be covered by a benchmark benefit plan. The federal government will define what constitutes benchmark coverage. The PPACA changes the way income is calculated for the Medicaid program by basing eligibility on modified adjusted gross income with no asset or resources test. The PPACA requires maintenance of effort that prohibits states from changing current Medicaid eligibility levels, procedures and methodologies until January 2014 for adults and October 2019 for children. The PPACA requires simplified application and enrollment procedures. Screening for Medicaid eligibility and premium tax credits must occur seamlessly for the applicant and for determined eligibility for Medicaid and the amount of premium subsidies by using Internal Revenue Service data.

In order to accomplish this, the HSD's information technology (IT) eligibility system must be replaced. The HSD will need to coordinate with other state agencies and change the way of doing business to ensure simple procedures and educated consumers.

Overview: PPACA and Medicaid — Medicaid Advisory Group

Sireesha Manne, staff attorney, Center on Law and Poverty, and Ruth Hoffman, director, Lutheran Advocacy Ministry, provided a detailed report of the Medicaid Advisory Group. They discussed the impact of the PPACA on Medicaid and proposed nine recommendations:

- protect access to children and adults who currently meet program requirements; services reduction in Medicaid is not allowed due to maintenance of effort requirements;
- reduce Medicaid costs by taking advantage of federal grants;
- evaluate the managed care system; currently, managed care organizations negotiate rates with providers;
- develop IT capacity to permit seamless interface between Medicaid and health insurance plans offered through an exchange;
- gradually extend coverage to newly eligible adults who are under 133% of the FPL;
- consider developing a "basic health program" model for state coverage;
- simplify the eligibility process for children and other members of Native American tribes; and
- ensure a meaningful involvement of stakeholders through more consumer representation, as well as tribal governments and members of the executive, before any change is implemented.

A discussion followed with questions and comments regarding Medicaid and the PPACA. Federal funds are available for the upgrading of the Medicaid IT system. Currently, HSD's IT system is capable of screening but does not have electronic online application capability. The Medicaid management information system processes claims. The current income support system (ISD2) is 27 years old and needs to be replaced to meet the demands of the PPACA. Clarification was sought regarding the definition of basic benefit plans and benchmark plans. Newly eligible adults will be covered by a benchmark benefit plan. The federal government will define the benchmark plan. The federal Health and Human Services Department has issued some guidance as to what is a benchmark plan under the PPACA. Questions were asked regarding the basic health program; such a plan would provide coverage to those individuals between 133% and 200% FPL. The subsidy to the basic health program could be different as the New Mexico benchmark plan may differ from the one for the nation. The SCI program could be a benchmark program. SCI benefits would have to change, and the cap on coverage would need to be removed. This option is currently being analyzed while the HSD is waiting on further clarification of the specifics from the federal government. There is not yet a cost analysis of how this program will be sustained. More resources and expertise are needed to determine the fiscal impact of this program. The Workforce Advisory Committee may have recommendations and suggestions in its presentation during the next meeting of the HCRWG on August 5, 2010. Members of the executive have been meeting to analyze the PPACA, and a strategic implementation plan is being developed.

Overview: PPACA and Long-Term Care — Aging and Long-Term Services Department (ALTSD)

Michael Spanier, secretary, ALTSD, and Emily Kaltenbach, director, policy and planning, ALTSD, discussed long-term care provisions in the PPACA. Secretary Spanier testified that over the past 10 years, New Mexico has been active in transforming its long-term care system to address rapidly changing demographics, increased demand for services, limited resources and the growing preference for home and community-based services (HCBS). Options

for reform within

Medicaid emphasize HCBS. There are several options available to New Mexico. The first option is called the Community First Choice Option (Section 2401), in which the state would offer community-based attendant services. Services must be offered statewide. A second option is called Money Follows the Person (Section 2403). Federal support for this existing initiative has been extended to 2016, and the minimum residency requirement has been reduced from six months to 90 days. There is growing interest to rebalance the system of long-term care services from an institutional setting to an HCBS setting. The third option, the State Balancing Incentive Payments Program (Section 10202), is only available to states spending less than 50% of total Medicaid long-term services dollars on HCBS. Based on the state's experience, this is not an option to New Mexico. The fourth option involves improvements to the Medicaid state plan (Section 2402). This option provides personal care services to individuals who qualify for HCBS as a state plan benefit. Finally, the temporary expansion of spousal impoverishment protection (Section 2404) is a mandated rule. Committee discussion focused on the expanded access and additional benefits funded by federal programs in the short term and ultimately funded by the state over the long term.

Ms. Kaltenbach identified Medicare reforms in the PPACA. Prescription drug coverage (Sections 3301 and 3315) provides that in 2010, once an individual enters the coverage gap or "donut hole", the individual will receive a \$250 rebate. Beginning in 2011, when a person enters the donut hole, the person will get a discount of 50% on brand-name drugs and 7% on generic drugs. Over the next 10 years, beneficiaries will gradually receive more discounts for generic drugs as well as brands until the donut hole closes in 2020. Preventive care and improved health outcomes (Sections 2713 and 3024) reforms begin in 2011, when Medicare participants will be able to get an annual physical and many preventive services without co-payments. All co-insurance and deductibles for preventive services will be eliminated. Beginning in 2011, people with higher incomes will pay higher premiums for prescription drug coverage under Medicare, Part D. Assistance will be provided to low-income individuals by reducing premiums, deductibles and co-insurance. Higher federal payments to Medicare Advantage plans (Section 3201) will be phased out and replaced with a payment system that rewards plans that meet certain quality standards for care and customer service. Starting in 2014, plans must spend at least 85% of the money that they take in from premiums on medical care. The PPACA includes elder justice and protection reform with the Elder Justice Act (Sections 6701-6703), which provides federal grants to support adult protective services. The Nursing Home Transparency Act (Sections 6101-6114) provides consumer information regarding nursing homes via a web site. The CLASS Act (Sections 8001-8002) creates a voluntary public long-term care insurance program. Sections 2405 and 3306 expand aging and disability resources centers such as the one operated by the ALTSD. Grants support outreach and assistance to Medicare beneficiaries to facilitate navigation through the long-term care system. The Healthy Aging, Living Well Grant (Section 4202) will fund states or tribes to carry out five-year pilot projects that include public health community interventions, screening and clinical referral activities for persons ages 55 to 64. Workforce development grants (Sections 5305 and 3210) will fund training opportunities for direct care workers who are employed in long-term care settings.

Overview: PPACA and Long-Term Care — Long-Term Care Advisory Group

Jim Jackson, executive director, Disability Rights New Mexico, Ellen Pinnes, health policy consultant, and Lisa Schatz Vance, executive director, Senior Citizen Law Office, provided information and recommendations of the Long-Term Care Advisory Group. Long-term care serves 10 million Americans annually and is expected to serve 15 million by 2020. Approximately 14% of all New Mexicans need help with at least one of the activities of daily living (ADL), and 10% under age 65 need help with at least one ADL. By 2030, the percent of New Mexico's population age 65 and older is expected to double. Under the PPACA, there is recognition that seniors and people with disabilities who need long-term services and support prefer to receive them in homes/communities. The law does not eliminate bias toward facility-based care but does recommend that Congress address long-term services in a comprehensive manner that guarantees seniors and people with disabilities the care they need.

Information was provided about the Community Living Assistance Services and Support (CLASS) Act contained in the PPACA. CLASS is a national voluntary long-term care insurance program that is federally administered but not taxpayer-funded. Coverage is offered through employers on an opt-out basis. Enrollment begins January 1, 2011, with the first benefits available in 2016. Recommendations of the Long-Term Care Advisory Committee are summarized as follows:

- CLASS — encourage individual and employer participation;
- adopt a community First Choice option;
- convene a stakeholder group to review the state Medicaid plan for HCBS and develop the broadest affordable program;
- submit a proposal for new Money Follows the Person grants (the deadline is November 2010); and
- apply for a planning grant and add medical home services to the state Medicaid plan.

A discussion ensued, and questions were asked regarding long-term care. There was clarification regarding the statement that New Mexico is not the state with the fourth-highest population of people over the age of 65 in the country but rather has the fourth-highest percentage of population over the age of 65 in the country. There was also clarification that the HSD is the only department that can apply for Money Follows the Person funding.

PPACA and Retirees — Retiree Health Care Authority (RHCA)

Wayne Propst, director, RHCA, indicated that the federal government has made available a \$5 billion grant to fund early retiree excess claims. The RHCA has made an early application for this federal grant to cover excess claims of more than \$15,000 and less than \$90,000 per each non-Medicare retiree. Federal funds are available on a first-come, first served basis. New Mexico has applied for approximately \$23 million. The RHCA board of directors also approved an 8% increase in retiree contributions effective January 1, 2011.

There being no public comment, the meeting adjourned at 5:30 p.m.

MINUTES
of the
SJM 1 HEALTH CARE REFORM WORKING GROUP

August 5, 2010
Room 322, State Capitol
Santa Fe

The meeting was called to order on Thursday, August 5, 2010, at 9:00 a.m. by Deborah Armstrong, chair, in Room 322 of the State Capitol. After general welcoming remarks, members of the working group introduced themselves.

Present

Deborah Armstrong, Executive Director,
New Mexico Medical Insurance Pool,
Chair
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Gail Chasey
Craig Dunbar, Interim Superintendent,
Insurance Division, Public Regulation
Commission
Ruby Ann Esquibel, Health Policy
Coordinator, Human Services
Department (HSD)
Sen. Dede Feldman
Rep. Keith J. Gardner
Sam Howarth, Director of Policy and
Performance, Department of Health
(DOH)
Mike Nuñez, Executive Director, New
Mexico Health Insurance Alliance
Sen. Mary Kay Papen
Rep. Danice Picraux

Advisory Members

Rep. Donald E. Bratton
Sen. Cisco McSorley

Absent

Kathryn "Katie" Falls, Secretary, HSD
Sen. Gay G. Kernan
Rep. Larry A. Larrañaga
Sen. Howie C. Morales

Sen. Clinton D. Harden, Jr.
Sen. Nancy Rodriguez
Rep. Edward C. Sandoval

Guests

The guest list in the meeting file.

Handouts

Copies of all handouts and written testimony are in the meeting file.

Thursday, August 5

A quorum being present, a motion to approve the minutes of the July 9, 2010 meeting was approved unanimously.

Review of Work Force Components of the Federal Patient Protection and Affordable Care Act of 2010 (PPACA)

Dan Derksen, M.D., Center for Community Partnerships, University of New Mexico (UNM), stated that in 2014, some 300,000 to 400,000 additional New Mexicans will receive health insurance. With 40 or so references to health professional work force issues in the PPACA, several state issues need to be addressed, including:

- anticipated work force shortages; 32 of 33 New Mexico counties are designated as health profession shortage areas;
- a Commonwealth Fund study ranking New Mexico last in access to health care and prevention;
- undocumented workers creating additional pressure on the delivery system; and
- New Mexico facing pressing health work force shortages, especially in the physician, nursing and dental professions.

New Mexico does not have one entity responsible for overseeing health professional work force issues. There is no lead agency for health work force assessments, planning and development. New Mexico work force program oversight is currently the responsibility of multiple agencies, including the Higher Education Department, the Workforce Solutions Department and the DOH. There is no ongoing data collection and analysis system that would permit the state to answer simple questions such as how many doctors are available in the state. To inform policymakers and plan accordingly, it is critical to have more reliable and timely health work force data.

Questions were raised regarding the readiness of laboratories, classroom space, teachers and scholarships to train additional health professionals. The infrastructure at the moment has reached capacity, and classroom space needs should be formally addressed. Legislation, titled the "Health Care Workforce Data Collection, Analysis and Policy Act", will be introduced in the 2011 session of the legislature. The act will address the need for timely and accurate data regarding the health professional work force. New data will be collected from health professionals at the time of licensure or upon renewal. Data will include employment status; practice setting; specialty; practice location; average hours worked; and future practice plans.

Dr. Dersken testified that the PPACA provides funding opportunities for educational institutions seeking to expand their health professional training programs. However, PPACA funds will not cover the full cost of program implementation and operation. State funding for the

program operations should be anticipated. Recommendations include establishing a fund to supplement health professional training program expansion; making awards contingent upon multi-institution coordination; cost-effective joint training for multiple health professional disciplines; developing training programs by priority needs; and developing community-based education and training.

Open discussion and questions followed. A comment was made that New Mexico needs to compete regionally to get and retain more professionals in the state. The teaching community is aging, with the average teacher age at 53 years; class size can be doubled, but the quality of teaching will be negatively impacted. Teaching institutions will need to have additional space to train health professionals. Ms. Esquibel and Senator Feldman announced that the PPACA has awarded health professional grants totaling \$694,151 in New Mexico. Funding will be distributed to advance nursing traineeships with over \$38,000 for the UNM Health Sciences Center. Also, nurse education, practice, quality and retention grants were given to the UNM Health Sciences Center for \$406,000 and to Western New Mexico University for \$249,000. Concern was expressed that the primary source for work force funding is through UNM. Going forward, when addressing state work force issues and solutions, New Mexico State University should be included as a working partner in grant applications and discussions. There was general acknowledgment that the state is turning students away from its universities. Demand for health professional education is exceeding state resources. There is a need to create increased opportunities for students to enhance their skills and offer financial incentives to encourage students to remain and grow within the state. In addition, steps should be taken to stop losing providers to other states because it is far less expensive to keep providers than to replace them.

Next Steps: Data System and Coordination Issues

Dr. Derksen stated that there is a lack of health work force data among all key licensed health professions, including physicians, physician's assistants, nurses, dentists, dental hygienists, psychologists, counselors, chiropractors and optometrists. The state needs better ways of measuring work force capacity and needs. While there is a known shortage of health professionals, in order to be able to target the specific gaps, better information is needed. As of today, the state is basing its projections on information that is five years old and with many working assumptions. Up-to-date information is needed, or the state's ability to compete for new PPACA work force programs will be limited.

Health Resources and Service Administration Planning Grants

Mr. Howarth explained that on the HSD web site, all grant information and known application activities are available. Many funding opportunities are available, and many departments and university entities are pursuing them. It is important to have good applications that cover the state's concerns; yet, the DOH lacks the ability to coordinate health care grant applications through state universities. Mr. Howarth noted that the state needs to work on making the practice environment for health professionals inviting. The state needs to work on solutions that demonstrate provider value and appreciation in an effort to retain more physicians. Incentives such as student loan assistance or loan forgiveness should be instituted in exchange

for provider guarantees to work in underserved areas of the state. Suggestions were made to rekindle the interests of students who had not completed coursework as another way to identify potential providers. Several health care work force planning and development grants are intended to help students with their student loans. Only two behavioral health professionals have been recruited in the past two years. The state needs to improve coordination and engage in better efforts for psychiatry. Retention of these professionals is critical. Mr. Howarth noted that according to federal standards for dentists, New Mexico is 1,800 dentists short. New Mexico does not have a dental school, but there are opportunities for students to receive tuition assistance if they come back to the state. So far, 94% of the dental students so assisted have returned.

Nancy Ridenauer, Ph.D., dean, College of Nursing, UNM, explained that the national shortage of registered nurses is estimated to reach 500,000 by 2025. Factors are related to financial barriers and shortages of nursing school teachers. The Institute of Medicine recommends that 75% of all nurses should be prepared at the bachelor's degree level or higher; currently, only 37% of nurses in New Mexico hold a bachelor of science degree. Finally, work force diversity to provide care to underserved minorities is low nationally. The American Association of Colleges of Nursing reported in 2009 that only 7.2% of the nation's enrolled baccalaureate nursing students are minorities. UNM faculty members formed the New Mexico Nursing Education Consortium in December 2009 and are determined to use teamwork and statewide collaboration to improve the future of nursing in the state. New Mexico stands fiftieth in the nation for the ratio of nurses to population. New Mexico colleges and educational institutions turn away several hundred qualified applicants every year. The goals of the consortium are three-fold: increase the number of baccalaureate and graduate nurses through existing community colleges within their home communities; improve efficiency, quality and educational outcomes of nursing education; and increase work force diversity by improving access to nursing education to minorities, particularly in rural areas. The overarching goal is to have a coordinated nursing program across the state. Dr. Ridenauer testified that the Board of Nursing is challenged by a lack of statewide nursing work force data. She supports the concepts presented by Mr. Howarth and Dr. Derksen. Private grant collaboration is needed to ensure the best possible chance of obtaining work force development grants for New Mexico. Working group members observed that state workforce development boards through the Workforce Solutions Department do not have a complete understanding of the health care bill nor do they have health care expertise. Currently, the boards are located in three regional offices. These offices could serve as locations to centralize planning for grant applications. It was suggested that the DOH reach out to the Workforce Solutions Department and offer its expertise.

Nikki Katalanos, Ph.D., program director, Physician Assistant Program, UNM, testified that the program is severely challenged due to a lack of physical space and a lack of funding.

Health Care Delivery System: Opportunities and Challenges: PPACA

Robert Garcia, vice president for regional administration, Presbyterian Healthcare Services, and president, New Mexico Hospital Association (NMHA), urged the legislature to protect the state's health care infrastructure by protecting Medicaid. Recommendations include protecting Medicaid enrollment, benefits and provider payments; protecting sole community provider funding until the full range of grants and pilots available under the PPACA are determined; developing a shared commitment and solutions to bend the cost curve through delivery system and reimbursement innovations; removing any barriers to physician licensing and medical liability coverage; supporting trauma funding; and supporting the Hospital-Acquired Infection Advisory Committee. Mr. Garcia noted that the current state of the New Mexico budget shortfall represents a serious challenge for the Medicare program. Current proposed regulations state that if a hospital and a health plan are unable to negotiate a contract successfully, reimbursement will automatically default to 90% of the fee-for-service reimbursement rate. From the NMHA's point of view, this will result in a 10% cut, as health plans will have little reason to negotiate rates in this circumstance. No one knows how to address this change in reimbursements. He suggested having the Health Care Reform Working Group form a financial task force to find short- and long-term solutions for this issue.

Joie Glenn, executive director, New Mexico Association for Home and Hospice Care, discussed the challenges and opportunities for home and hospice care providers under the PPACA. Challenges include implementing and encouraging home- and community-based services; implementing mandated health insurance for home health agencies; facing the economic downturn while still providing services for vulnerable and fragile populations; and dealing with inadequate reimbursements that may lead to lower wages and a shortage of skilled workers. Opportunities include increased disease management through interdisciplinary teams and participation in accountable care organizations and medical homes; expansion of home- and community-based services addressing everyone's desire to stay at home when given a choice; and work force development through partnering with providers to do more with less through emerging technologies that can result in higher productivity.

Mark Schinnerer, president, New Mexico Health Care Association (NMHCA), identified health care reform opportunities for nursing facilities and described key focus areas for consideration by the working group. First, the impact of anticipated Medicaid cuts will be severe for nursing facilities statewide. Annually, Medicare rates are adjusted for inflation, and, in 2012, the adjustment will be a reduction. New Mexico nursing facilities are currently experiencing a shortfall in Medicaid reimbursement of \$15.00 to \$20.00 per patient per day. This shortfall is expected to grow even more due to Medicare reductions. The state should focus on reducing this gap. Second, some home- and community-based services are eligible for an additional 6% reimbursement in the PPACA. New Mexico currently leads the nation in the amount of money spent for home- and community-based services in Medicaid. The NMHCA believes that individuals should receive long-term care in the least restrictive and most appropriate setting, including home- and community-based services. Mr. Schinnerer identified numerous provisions in the PPACA that are not expected to affect Medicaid directly, but are likely to affect providers on a day-to-day basis. Several additional areas in the PPACA were

identified that will potentially affect state agency oversight and management of health care services and programs.

David Roddy, executive director, New Mexico Primary Care Association, explained key provisions in the PPACA for community health centers. The PPACA contains a total of \$11 billion in new funding for community health centers over five years; \$9.5 billion of this funding will allow health centers to expand their operational capacity to serve nearly 20 million new patients and to enhance their medical, oral and behavioral health services. The PPACA also includes \$1.5 billion over five years for the National Health Services Corps to enhance opportunities for recruitment and retention of health care providers in rural areas. The expansion of Medicaid to 133% of the federal poverty level in 2014 without any restrictions will ensure coverage of nearly 16 million Americans and will significantly reduce New Mexico's uninsured population. The PPACA adds preventive services to the federally qualified health center (FQHC) Medicare payment rate and eliminates the outdated Medicare payment cap on FQHC payments. The federal government wants to expand FQHCs. The challenge to growth in New Mexico stems from the fact that New Mexico's community health centers already serve 13.3% of the state population (more than double the national average of 6%), as well as New Mexico's geographic characteristics as a rural/frontier area, work force challenges and payment systems issues. The PPACA contains an enhanced reimbursement requirement for FQHCs but still discriminates against the primary care provider. Mr. Roddy suggested four additional areas of opportunity: funding for a health center residency program; development of accountable care organization pilot projects; implementation of incentives for electronic health records; and payment system reforms.

Carol Miller, executive director, National Center for Frontier Communities, said the overall mission of the center is to ensure geographic democracy. New Mexicans should have access to programs and services no matter where they live.

Working group members had comments and questions concerning medical home services. Concerns were raised about the applicability of medical homes in small communities and rural areas without internet access and how rural New Mexicans will be able to access the services from health professionals.

Next Steps; Interdisciplinary Training Issues

Betsy Van Leit, Ph.D., Area Health Education Centers (AHECs), UNM, explained the purpose of the AHECs. These organizations provide work force development and community health support services to underserved populations and support primary care health disciplines. AHECs connect students to health careers and connect health professionals to interested students, which results in improved community health. All 33 New Mexico counties are covered by the AHECs. AHECs promote interest about health professions among students from minorities and disadvantaged backgrounds. AHECs also provide financial support for students enrolled in professional training programs, and they offer continuing education to health care providers such as promotoras, who provide culturally sensitive quality care in New Mexico communities.

There was no public comment.

Ms. Esquibel announced the state health reform leadership team will meet at Plaza La Preza on August 18, 2010 from 10:00 a.m. to 12:00 noon. The mission of this team is to develop a strategic plan for the implementation of the PPACA. The team will move forward to have some recommendations and to begin formulating suggested legislative changes for consideration by the legislature.

Ms. Armstrong announced that next month's meeting of the Health Care Reform Working Group will cover consumer protection and information technology services. During the September or October meeting, the working group will discuss Native American issues. Due to many inquiries on the health insurance exchange, that topic will be revisited.

There being no further business, the meeting was adjourned 4:30 p.m.

**MINUTES
of the
SJM 1HEALTH CARE REFORM WORKING GROUP**

**September 2, 2010
Room 307, State Capitol
Santa Fe**

The meeting of the SJM 1 Health Care Reform Working Group was called to order on September 2, 2010 at 9:00 a.m. by Debbie Armstrong, chair. After general welcoming remarks, members of the working group introduced themselves.

Present

Debbie Armstrong, Executive Director, New Mexico Medical Insurance Pool (NMMIP), Chair
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Gail Chasey
Kathryn "Katie" Falls, Secretary, Human Services Department (HSD)
Sen. Dede Feldman
John Franchini, Superintendent, Insurance Division, Public Regulation Commission (PRC)
Rep. Keith J. Gardner
Sam Howarth, Director of Policy and Performance, Department of Health
Rep. Patricia A. Lundstrom
Mike Nuñez, Executive Director, New Mexico Health Insurance Alliance (NMHIA)
Sen. Mary Kay Papen
Rep. Danice Picraux

Advisory Members

Rep. Donald E. Bratton
Sen. Cisco McSorley
Sen. Nancy Rodriguez

Absent

Rep. Joni Marie Gutierrez
Sen. Gay G. Kernan
Rep. Larry A. Larrañaga
Sen. Howie C. Morales

Sen. Clinton D. Harden, Jr.
Rep. Edward C. Sandoval

Guests

The guest list in the meeting file.

Handouts

Copies of all handouts and written testimony are in the meeting file.

Thursday, September 2

Ms. Armstrong announced that minutes from the August 5, 2010 meeting were under development and will be approved at the next scheduled meeting. She thanked the various association and advocacy groups in attendance for their continued willingness to participate in ongoing meetings.

Native American Issues and the Federal Patient Protection and Affordable Care Act (PPACA)

Alvin Warren, secretary, Indian Affairs Department, indicated that Native American populations would be affected by the PPACA in five general areas: health insurance exchanges; Medicaid and the State Children's Health Insurance Program (SCHIP); the Indian Health Service (IHS); through the reauthorization of the Indian Health Care Improvement Act; and through grant opportunities for Native Americans, tribes and tribal organizations. He provided information about each of the five areas as follows.

- Health insurance exchanges: Native Americans will have more specialty enrollment periods and no cost-sharing for households below 300% of the federal poverty level and will be exempted from penalties for failure to carry minimum coverage.
- Medicaid and SCHIP: the PPACA establishes that through the IHS, an Indian tribe, tribal organization or urban Indian organization qualifies as an "express lane agency" that can determine whether a child satisfies one or more Medicaid or SCHIP eligibility factors. The PPACA also provides grants to the IHS and Indian tribes to facilitate program outreach.
- IHS: the PPACA defines the IHS, an Indian tribe, a tribal organization or an urban Indian organization health program as the payor of last resort. It eliminates a sunset provision for all Medicare Part B services. Absent the change, IHS facilities would be paid for only selected Part B services. The PPACA states that that out-of-pocket prescription drug costs are to be treated as incurred costs for the purposes of calculating the Medicare Part D out-of-pocket threshold.
- Indian Health Care Improvement Act: the PPACA makes the Indian Health Care Improvement Act permanent. This act within an act establishes comprehensive behavioral health prevention and treatment programs; authorizes hospice, assisted living and long-term and home and community-based care; and provides for tribally operated facilities to recover costs. It updates current law on the collection of Medicare, Medicaid and SCHIP reimbursements and allows tribes to purchase health coverage for IHS beneficiaries. It authorizes IHS arrangements with the federal Department of Veterans Affairs and the Department of Defense to share medical facilities and services; allows a tribe or tribal organization to purchase coverage for employees from the federal employees health benefits program; and authorizes community health representative programs. It authorizes a feasibility study regarding

- the creation of a Navajo tri-state (New Mexico, Utah and Arizona) Medicaid agency; expands and reauthorizes the community health aid program; allows for implementation of dental health aide therapists; and provides grants to facilitate Medicaid and SCHIP enrollment.
- Grant opportunities: state strategic actions to implement the PPACA include coordination of grant opportunities by encouraging state agencies to communicate, collaborate and consult with tribes regarding reform initiatives and policies that affect American Indians; monitoring state agency assessments and actions during the implementation of the PPACA; and establishing an Indian provision health care reform ad hoc work group.

The working group posed questions regarding state government restructuring and the possible negative impact or dilution of efforts on Indian affairs and cultural affairs.

Consumer Protection and Consumer Education

Kimberley Scott, Insurance Division, PRC, presented the consumer assistance grant proposal submitted by the Insurance Division. An application was submitted for \$200,000 for a 12-month period to provide statewide services. The purpose of the grant is to expand health care insurance consumer assistance services, including consumer assistance with the filing of complaints and appeals; enrollment into health insurance coverage; consumer education on rights and responsibilities with respect to group health plans and coverages; collection of data on consumer inquiries and complaints; and conducting an independent external review of consumer needs. If the grant is awarded, the Insurance Division will create an ombudsman position, establish a consumer hotline, provide interpreter services for Spanish and Navajo speakers and partner with community advocates and the Office of the Attorney General.

Ms. Janov, a consumer, presented her personal story regarding the denial of payment for health insurance claims. Ms. Janov researched treatment options and spent her own money to investigate options suggested through her physicians. She explained the administrative and personal difficulty of pursuing and fighting to receive approval for treatment after being denied through the appeals process.

Jane Wishner, executive director, Southwest Women's Law Center, presented a comprehensive list of consumer protection and education recommendations, including:

- establishment of a state consumer coordinating committee;
- incorporation of consumer protection planning into each element of health care reform implementation;
- greater use of stakeholders such as health care providers, insurance companies, brokers, employers, chambers of commerce and state, local and federal agencies in implementation of the PPACA;
- planning for the consumer protection, appeals and ombudsman programs through executive agencies, the Insurance Division and the Office of the Attorney General;
- legislative funding;

- establishment of an independent consumer health assistance program to utilize community-based agencies, community health workers, health care providers, social services providers and advocates; and
- measures to ensure public transparency.

The working group asked that these recommendations be made a part of the SJM 1 Health Care Reform Working Group legislative report.

Barbara K. Webber, executive director, Health Action New Mexico (HANM), described HANM's position regarding the statewide public education campaigns that are necessary to educate consumers on new benefits and protections afforded under the PPACA.

Women's Health Issues

Giovanna Rossi Pressley, executive director, Office of the Governor's Council on Women's Health, presented an overview of the state of women's health in New Mexico. She contended that the PPACA's intentions are to bring costs down, cover more services and improve the quality of care. Under the PPACA, women will not pay more than men for the same insurance plan. Many uninsured women will receive insurance subsidies to pay for premiums and out-of-pocket costs on health insurance exchange-based plans. The PPACA will increase pregnancy-related services, preventive benefits and mental and substance abuse services, and lower-paid workers will get the same plan as higher-paid workers.

Joan LaMunyon-Sanford, director, New Mexico Religious Coalition for Reproductive Choice, spoke to the benefits of the PPACA for women. She identified that women live longer than men not only due to biological reasons, but because women are frequently the caretakers of parents and spouses as they age. She recommended that the state should adopt presumptive eligibility for family planning services under Medicaid immediately; increase the number of free-standing birth centers and equitably reimburse certified nurse midwives and certified professional midwives; apply for funding available under the PPACA for the personal responsibility educational program; and advocate for contraceptive equity action under the definition of essential benefits plan. Regarding children, Ms. LaMunyon-Sanford suggested that the state should consider gradually increasing the age of consent from age 21 to age 26; educate the public on the adoption tax credit; and protect the safety and confidentiality of youths who are applying for family planning or pregnancy care by allowing for the use of alternative mailing addresses when applying for Medicaid. Regarding PPACA provisions for elder care, the state should enhance coverage for home and community-based elder services and create a public education campaign about the federal Community Living Assistance Service and Support Act.

Health Insurance Exchange Planning Grant Application and Planning Process

Ruby Ann Esquibel, health policy coordinator, HSD, presented a summary of the PPACA and events and stakeholders in New Mexico that have been involved in the health insurance exchange planning process. Once the PPACA was signed, the governor issued an executive order to create the Executive Health Care Reform Leadership Team, which was charged with developing a strategic plan for PPACA implementation. The strategic plan includes a

recommendation for the development of a strong health insurance exchange. Goals for the exchange were presented along with the resources available through the HSD, NMHIA, NMMIP and the Insurance Division. An exchange will serve individuals and small businesses. One of the major challenges facing the state will be the communication effort required to inform New Mexicans of the programs and benefits of an exchange. Time lines were presented whereby New Mexico must make decisions to create one or two exchanges and where the exchange should be housed. The HSD has submitted a grant application for \$1 million for planning for the establishment of a state health insurance exchange. The grant proposal will fund efforts to find background information on the state, maximize stakeholder involvement and provide consultant assistance in information technology. The grant proposal will study all exchange options and analyze the pros and cons of quasi-governmental or state-run governance structures. The grant funding will be used to identify provisions that are needed to develop proposed legislation, amendments to the New Mexico Insurance Code, Medicaid changes and other changes as needed. The budget for the study is distributed as follows:

| | |
|------------------------------------|------------------|
| Financial modeling tool and report | \$275,000 |
| Oversight by technical experts | \$225,000 |
| Information technology assessment | \$200,000 |
| Stakeholder involvement and input | <u>\$300,000</u> |
| Total | \$1,000,000 |

Health Insurance Exchange Recommendations, Including Small Business Input

Anne Sperling, Health Insurance Exchange Advisory Committee, identified the advisory committee recommendations for elements of an exchange as identified by each of the advisory committee participants. Participants included the NMHIA, NMMIP, the Association of Commerce and Industry, brokers, the National Association of Health Underwriters, New Mexico health plans, the Association of Health Insurance Providers and the Office of Health Reform within the HSD. Areas discussed included stakeholder involvement, program integration, state resources and capabilities, governance, financing and information technology infrastructure. Both the NMHIA and the NMMIP expressed an interest in housing the exchange and identified the strengths and weaknesses that each would bring to it. The handout identifying all the perspectives of the advisory committee members is part of the permanent record.

Public Comment

Sharon House, representing Christian Science, requested the state to find ways to accommodate spiritual, nonmedical care as a treatment option.

Discussion and Legislative Recommendations Regarding a Health Insurance Exchange

Ms. Armstrong polled working group members to determine if they were ready to make recommendations. She suggested areas in which the working group will consider action on the establishment of an exchange, including whether the state should establish an exchange or have the federal government do it; whether the exchange should be state-run or offered through a quasi-governmental or other nonprofit entity; and whether the state should have one exchange or two.

Michael Hely of the Legislative Council Service was asked to review previously introduced bills to create an exchange for legislative changes that would be needed to comply with the PPACA. A suggestion was made to present the requirements of the PPACA that will affect New Mexico to the New Mexico Legislative Council. A consensus was expressed that a federally run exchange should not be pursued. Recommendations regarding the state high-risk pool were discussed.

Five exchange possibilities were reviewed by the working group: an exchange operated by the federal government; an exchange operated by a nonprofit entity; an exchange operated within a state agency; joining a regional exchange with other states; and creating more than one exchange in New Mexico. Working group members requested that a description of the pros and cons of each option be provided for their review and debate. Members suggested the working group next meet on October 4 to come up with an exchange recommendation to be presented to the Legislative Health and Human Services Committee (LHHS). The members requested that the dates of the LHHS meeting be changed to October 5 through 7 in order to receive the recommendations of the working group. The timing of these meetings is critical as the Government Restructuring Task Force will meet soon thereafter to consider money and consolidation issues. It was agreed that the next meeting will be held on October 4, 2010.

The meeting adjourned at 5:30 p.m.

MINUTES
of the
SENATE JOINT MEMORIAL 1 HEALTH CARE REFORM WORKING GROUP

October 4, 2010
Room 322, State Capitol
Santa Fe

The final meeting of the Senate Joint Memorial 1 Health Care Reform Working Group (HCRWG) was called to order on October 4, 2010 at 9:15 a.m. by Debbie Armstrong, chair. After general welcoming remarks, members of the working group introduced themselves.

Present

Debbie Armstrong, Executive Director,
New Mexico Medical Insurance Pool
(NMMIP)
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Gail Chasey
Kathryn "Katie" Falls, Secretary,
Human Services Department (HSD)
Sen. Dede Feldman
John Franchini, Superintendent,
Insurance Division, Public
Regulation Commission (PRC)
Sen. Gay G. Kernan
Mike Nuñez, Executive Director,
New Mexico Health Insurance
Alliance (NMHIA)
Rep. Danice Picraux
Jessica Sutin, Deputy Secretary,
Department of Health (DOH) (for
Sam Howarth)

Absent

Rep. Keith J. Gardner
Rep. Larry A. Larrañaga
Sen. Howie C. Morales
Sen. Mary Kay Papen

Advisory Members

Sen. Cisco McSorley
Sen. Nancy Rodriguez

Rep. Donald E. Bratton
Sen. Clinton D. Harden, Jr.

Guests

The guest list in the meeting file.

Handouts

Copies of all handouts and written testimony are in the meeting file.

Monday October 4

Minutes from the August 5, 2010 and September 2, 2010 meetings were approved.

Information Technology; Broadband Access; Interface with Medicaid

Secretary Falls stated that a contingent of HSD and Insurance Division employees recently traveled to Seattle to a national meeting regarding health insurance exchanges. The group took advantage of the opportunity to speak to representatives from other states and advisors from the federal Centers for Medicare and Medicaid Services (CMS). Secretary Falls reviewed the multitude of changes in Medicaid eligibility, eligibility procedure requirements and Medicaid system requirements that will be necessitated as a result of the federal Patient Protection and Affordable Care Act (PPACA) and the establishment of a health insurance exchange. Massive changes to the Medicaid eligibility system (ISD2) will be needed to accommodate these new requirements. The current ISD2 system also supports the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy Families (TANF) Program and general assistance programs. The HSD plans to issue a request for proposals in November 2010 and select a contractor in the early spring of 2011 to develop the system changes that are needed. Secretary Falls anticipates that it will take three to four years to replace the current Medicaid system, which must be replaced by 2013 in order to be in compliance with the PPACA. The details regarding many significant issues governing interactions with the exchange are still unknown, but they are expected in the early spring of 2011. Significant implementation issues to be addressed include the development of a single application for Medicaid and the exchange and funding for the replacement of the Medicaid eligibility and enrollment systems. Information technology resources are scarce and will be needed on other projects as well.

Quality, Transparency and Reporting

Dan Derksen, M.D., Center for Community Partnerships, University of New Mexico (UNM), Robert Wood Johnson Foundation health policy fellow, highlighted quality and transparency aspects of the PPACA. The PPACA authorizes the federal secretary of health and human services (HHS) to establish a national strategy and develop a plan by 2011 to improve the delivery of health care services and health outcomes and to improve the health of populations nationwide. Dr. Derksen described measures that are under development for determining health outcomes, coordination of care, meaningful use of health information technology and the safety and effectiveness of care. The Albuquerque Coalition for Healthcare Quality has posted a consumer-friendly version of the HHS's "Hospital Compare" web site on the coalition's web site to increase consumer awareness. It will publish its first ambulatory primary care public report for the Albuquerque area in December. The report will include six nationally endorsed quality measures. Public reporting is expected to improve transparency about the health system for the community.

Dr. Derksen discussed physician quality reporting and financial incentives, which are mandated in the PPACA and are scheduled for implementation in 2015. In addition, a physician comparison web site will be established in 2011. The PPACA also requires reporting data on patient race, ethnicity and language (R/E/L) with a goal of reducing health disparities by using

language services, community outreach and cultural competency training. The Albuquerque Coalition for Healthcare Quality is working with the New Mexico Hospital Association and Albuquerque area hospitals to standardize the collection of R/E/L data to allow for data stratification. In May 2009, Albuquerque joined an elite group of communities by being designated by the Robert Wood Johnson Foundation as an Aligning Forces For Quality (AF4Q) community. The AF4Q effort is being led locally by the Albuquerque Coalition for Healthcare Quality and involves health plans, hospitals, health care providers, employers and consumers. The project is housed in and administrated by the New Mexico Medical Review Association, which is the federally contracted Medicare quality improvement organization for New Mexico.

The PPACA revises Medicare hospital payment standards to establish a hospital value-based purchasing program. The PPACA will work toward creating a coordinating council for comparative effectiveness research. Dr. Derksen noted the importance of a health insurance exchange, which creates a real connection with consumers. He recommended a continuation of the exchange advisory committee and serious, ongoing involvement with a diverse group of stakeholders.

Public Comment

Dick Mason, Health Action New Mexico, recommended that the exchange be a quasi-governmental entity and should assume the role of a strong purchaser with maximum transparency. The federal government should be responsible to pay implementation costs.

Eric Raymond Buckley, doctor of oriental medicine (DoM), spoke on behalf of the New Mexico Society for Acupuncture and Asian Medicine. He would like to provide data regarding DoMs and to offer solutions for the current shortage of physicians and nurses.

Deborah Righter, Righter's Insurance, presented a model for the New Mexico health insurance exchange. She suggested that the exchange should be the state's most sustainable provider of small-group and individual health insurance using the highest quality care delivery systems for New Mexicans.

Shannon House, speaking on behalf of Christian Scientists, sought assurances that religious considerations expressed at the previous HCRWG meeting were received and would be considered. She offered to provide more information to the working group. Ms. House requested that New Mexico find ways to accommodate spiritual, nonmedical care as a treatment option.

William Wiese, M.D., associate director, Robert Wood Johnson Foundation, Center for Health Policy at UNM, expressed concerns over the projected costs associated with the establishment of a health insurance exchange and the lack of cost-containment measures under the PPACA.

Jane Wishner, executive director, Southwest Women's Law Center, suggested that the working group integrate all of the previous advisory work groups' comments into its final report.

Discussion and Recommendations: Health Insurance Exchanges

Karen Wells, researcher, Legislative Council Service, presented an overview of health insurance exchange functions and a matrix of questions to assist the working group members to develop a recommendation regarding the establishment of a New Mexico exchange or exchanges. A health insurance exchange was described as a central organized marketplace that provides one-stop shopping for individuals and small businesses to purchase health insurance and compare rates, benefits and quality among the plans offered. Minimal federally required exchange functions for a market organizer and distributor would include: certification of qualified health plans (QHPs); creation of standardized benefits plans of QHPs; utilization of a standard format to permit comparison shopping; assignment of QHP quality ratings; providing consumer information assistance; determining and coordinating eligibility and enrollment; and program administration. Additional exchange functions that could be included as a contracting agent and active purchaser include: ensuring that QHPs offer the same products inside and outside of the exchange; negotiating actively with plans to ensure the best price for QHPs; considering offering a wider choice of plans to consumers; providing more aggressive consumer information and assistance; broadening public education about provisions of the PPACA; actively educating small businesses about the benefits of an exchange; developing seamless enrollment and premium collection processes; processing applications and enrolling eligible individuals and businesses; actively overseeing rate regulation in cooperation with the Insurance Division; working with health plans to reshape policy; and creating a larger purchasing pool. Principles for exchange design previously put forth by health consumer advocates include an exchange that:

- is consumer-focused and consumer-friendly;
- is flexible and responsive;
- is transparent and accountable;
- is incentivized to promote quality and innovation;
- includes standardization and portability of products;
- is cost-effective and less expensive;
- avoids conflicts of interest;
- is accessible statewide via multiple modalities;
- is coordinated and streamlined; and
- is protected from political winds.

The working group debated the following issues and questions:

- Should New Mexico establish its own health insurance exchange, or should it allow the federal government to establish the exchange for New Mexico? (Establish a New Mexico state exchange.)
- Should New Mexico have one or two exchanges for individuals and small groups? (Establish one exchange with individual and group markets administratively combined, but defer combining of the risk pools.)
- Should New Mexico have two or more regional exchanges within New Mexico? No.

- Should New Mexico join an interstate exchange with one or more other states? (Not initially; however, the potential for sharing resources with other states should be explored.)
- What type of entity should operate an exchange? (A legislatively created, nonprofit quasi-governmental entity.)
- What functions should be included in the exchange? (Options include: the exchange as a market organizer and distributor performing only the federally required functions; or the exchange as a contracting agent and active purchaser performing additional functions. After discussion, a motion was made to support a more robust exchange, including additional functions beyond the federal requirements. Senators Beffort and Kernan were opposed; all other members supported the motion.)

Other Legislative Recommendations; Final Report Content and Format

Ms. Armstrong provided a summary of recommendations made by the various advisory groups throughout the interim. Members of the working group agreed that all summary recommendations should be included in the final report. Ms. Armstrong presented suggested topics and a report format for the final report, which was accepted by the working group members as presented. The members recommended the continuation of the HCRWG to facilitate collaboration with the executive health care reform leadership team and stakeholder advisory groups.

Ms. Armstrong thanked all the members and staff for their contributions. There being no further business, the meeting adjourned at 5:30 p.m.

NEW MEXICO PUBLIC REGULATION COMMISSION

COMMISSIONERS

DISTRICT 1 JASON MARKS
DISTRICT 2 DAVID W. KING, CHAIRMAN
DISTRICT 3 JEROME D. BLOCK, VICE CHAIRMAN
DISTRICT 4 CAROL K. SLOAN
DISTRICT 5 SANDY JONES



DIVISION OF INSURANCE

1120 Paseo de Peralta/P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-3928

CHIEF OF STAFF

Johnny Montoya, Interim

MORRIS J. CHAVEZ

SUPERINTENDENT OF INSURANCE

SENATE JOINT MEMORIAL 1 TASK FORCE

TO: Sen. Dede Feldman
Sen. Clinton D. Harden
Sen. Gay G. Kernan
Sen. Mary Kay Papen
Sen. Howie C. Morales
Sen. Nancy Rodriguez
Sen. Cisco McSorley
Sen. Sue Wilson-Beffort
Rep. Ray Begaye
Rep. Donald E. Bratton

Rep. Keith J. Gardner
Rep. Joni Marie Gutierrez
Rep. Rhonda S. King
Rep. Larry A. Larrañaga
Rep. Danice Picraux
Rep. Edward C. Sandoval
Deborah Armstrong, NMMIP
Kathryn "Katie" Falls, NMHSD
Sam Howarth, NMDOH
Mike Nuñez, NMHIA

FROM: Morris J. Chavez, Superintendent of Insurance

DATE: April 7, 2010

RE: Summary Timeline for Implementation of Federal Health Care Legislation

Attached for the review and consideration of the members of the Senate Joint Memorial 1 Task Force is a summary timeline for the implementation of Patient Protection and Affordable Care Act, H.R. 3590, and the Health Care and Education Reconciliation Act of 2010, H.R. 4872.¹ The timeline is not intended to be a comprehensive summary of the federal legislation, but merely highlights of the significant aspects of the legislation.

¹ <http://www.kff.org/healthreform/8060.cfm>

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than \$50,000 that provide health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.

Medicare

- Provide a \$250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.

- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers, and adjust for productivity.
- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Creates a state option to cover childless adults through a Medicaid State Plan Amendment.
- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women.
- Creates a new option for states to provide CHIP coverage to children of state employees eligible for health benefits if certain conditions are met.
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

Quality Improvement

- Support comparative effectiveness research by establishing a non-profit Patient-Centered Outcomes Research Institute.
- Establish a commissioned Regular Corps and a Ready Reserve Corps for service in time of a national emergency.
- Reauthorize and amend the Indian Health Care Improvement Act.

Workforce

- Establish the Workforce Advisory Committee to develop a national workforce strategy.
- Increase workforce supply and support training of health professionals through scholarships and loans.
- Establish Teaching Health Centers to provide Medicare payments for primary care residency programs in federally qualified health centers.

Tax Changes

- Impose additional requirements on non-profit hospitals. Impose a tax of \$50,000 per year for failure to meet these requirements.
- Limit the deductibility of executive and employee compensation to \$500,000 per applicable individual for health insurance providers.
- Impose a tax of 10% on the amount paid for indoor tanning services.
- Exclude unprocessed fuels from the definition of cellulosic biofuel for purposes of applying the cellulosic biofuel producer credit.
- Clarify application of the economic substance doctrine and increase penalties for underpayments attributable to a transaction lacking economic substance.

2011

Long-term Care

- Establish a national, voluntary insurance program for purchasing community living assistance services and supports (CLASS program).

Medical Malpractice

- Award five-year demonstration grants to states to develop, implement, and evaluate alternatives to current tort litigations.

Prevention/Wellness

- Improve prevention by covering only proven preventive services and eliminating cost-sharing for preventive services in Medicare; increase Medicare payments for certain preventive services to 100% of actual charges or fee schedule rates. For states that provide Medicaid coverage for and remove cost-sharing for preventive services recommended by the US Preventive Services Task Force and recommended immunizations, provide a one percentage point increase in the FMAP for these services.
- Provide Medicare beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan and provide incentives to Medicare and Medicaid beneficiaries to complete behavior modification programs.
- Provide grants for up to five years to small employers that establish wellness programs.
- Establish the National Prevention, Health Promotion and Public Health Council to develop a national strategy to improve the nation's health.
- Require chain restaurants and food sold from vending machines to disclose the nutritional content of each item.

Medicare

- Require pharmaceutical manufacturers to provide a 50% discount on brand-name prescriptions filled in the Medicare Part D coverage gap beginning in 2011 and begin phasing-in federal subsidies for generic prescriptions filled in the Medicare Part D coverage gap.
- Provide a 10% Medicare bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas. (Effective 2011 through 2015)
- Restructure payments to Medicare Advantage (MA) plans by setting payments to different percentages of Medicare fee-for-service (FFS) rates.

- Prohibit Medicare Advantage plans from imposing higher cost-sharing requirements for some Medicare covered benefits than is required under the traditional fee-for-service program.
- Reduce annual market basket updates for Medicare providers beginning in 2011.
- Provide Medicare payments to qualifying hospitals in counties with the lowest quartile Medicare spending for 2011 and 2012.
- Freeze the income threshold for income-related Medicare Part B premiums for 2011 through 2019 at 2010 levels, and reduce the Medicare Part D premium subsidy for those with incomes above \$85,000/individual and \$170,000/couple.
- Create an Innovation Center within the Centers for Medicare and Medicaid Services.

Medicaid

- Prohibit federal payments to states for Medicaid services related to health care acquired conditions.
- Create a new Medicaid state plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home. Provide states taking up the option with 90% FMAP for two years for health home related services including care management, care coordination and health promotion.
- Create the State Balancing Incentive Program in Medicaid to provide enhanced federal matching payments to increase non-institutionally based long-term care services.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

Quality Improvement

- Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health.
- Establish the Community-based Collaborative Care Network Program to support consortiums of health care providers to coordinate and integrate health care services, for low-income uninsured and underinsured populations.
- Establish a new trauma center program to strengthen emergency department and trauma center capacity.

- Improve access to care by increasing funding by \$11 billion for community health centers and the National Health Service Corps over five years; establish new programs to support school-based health centers and nurse-managed health clinics.

Tax Changes

- Exclude the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account.
- Increase the tax on distributions from a health savings account or an Archer MSA that are not used for qualified medical expenses to 20% of the disbursed amount.
- Impose new annual fees on the pharmaceutical manufacturing sector.

2012

Medicare

- Make Part D cost-sharing for full-benefit dual eligible beneficiaries receiving home and community-based care services equal to the cost-sharing for those who receive institutional care.
- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.
- Reduce Medicare payments that would otherwise be made to hospitals by specified percentages to account for excess (preventable) hospital readmissions.
- Create the Medicare Independence at Home demonstration program.
- Establish a hospital value-based purchasing program in Medicare and develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers.
- Provide bonus payments to high-quality Medicare Advantage plans.
- Reduce rebates for Medicare Advantage plans.

Medicaid

- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).

Quality Improvement

- Require enhanced collection and reporting of data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier populations.

2013

Insurance Reforms

- Create the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to offer qualified health plans. (Appropriate \$6 billion to finance the program and award loans and grants to establish CO-OPs by July 1, 2013)
- Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (rules adopted July 1, 2011; effective January 1, 2013), electronic funds transfers and health care payment and remittance (rules adopted July 1, 2012; effective January 1, 2014), and health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (rules adopted July 1, 2014; effective January 1, 2016). Health plans must document compliance with these standards or face a penalty of no more than \$1 per covered life. (Effective April 1, 2014)

Medicare

- Begin phasing-in federal subsidies for brand-name prescriptions filled in the Medicare Part D coverage gap (to 25% in 2020, in addition to the 50% manufacturer brand-name discount).
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care.

Medicaid

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100% federal funding.

Quality Improvement

- Require disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies.

Tax Changes

- Increase the threshold for the itemized deduction for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% of adjusted gross income for regular tax purposes; waive the increase for individuals age 65 and older for tax years 2013 through 2016.

- Increase the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly and impose a 3.8% assessment on unearned income for higher-income taxpayers.
- Limit the amount of contributions to a flexible spending account for medical expenses to \$2,500 per year increased annually by the cost of living adjustment.
- Impose an excise tax of 2.3% on the sale of any taxable medical device.
- Eliminate the tax-deduction for employers who receive Medicare Part D retiree drug subsidy payments.

2014

Individual and Employer Requirements

- Require U.S. citizens and legal residents to have qualifying health coverage (phase-in tax penalty for those without coverage).
- Assess employers with more than 50 employees that do not offer coverage and have at least one full-time employee who receives a premium tax credit a fee of \$2,000 per full-time employee, excluding the first 30 employees from the assessment. Employers with more than 50 employees that offer coverage but have at least one full-time employee receiving a premium tax credit, will pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee. Require employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer. Employees may opt out of coverage.

Insurance Reforms

- Create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization, through which individuals and small businesses with up to 100 employees can purchase qualified coverage.
- Require guarantee issue and renewability and allow rating variation based only on age (limited to 3 to 1 ratio), premium rating area, family composition, and tobacco use (limited to 1.5. to 1 ratio) in the individual and the small group market and the Exchanges.
- Reduce the out-of-pocket limits for those with incomes up to 400% FPL to the following levels:
 - 100-200% FPL: 1/3 of the HSA limits (\$1,983/individual and \$3,967/family);
 - 200-300% FPL: 1/2 of the HSA limits (\$2,975/individual and \$5,950/family);
 - 300-400% FPL: 2/3 of the HSA limits (\$3,987/individual and \$7,973/family).
- Limit deductibles for health plans in the small group market to \$2,000 for individuals and \$4,000 for families unless contributions are offered that offset deductible amounts above these limits.
- Limit any waiting periods for coverage to 90 days.
- Create an essential health benefits package that provides a comprehensive set of services, covers at least 60% of the actuarial value of the covered benefits, limits annual cost-sharing to the current law HSA limits (\$5,950/individual and \$11,900/family in 2010), and is not more extensive than the typical employer plan.

- Require the Office of Personnel Management to contract with insurers to offer at least two multi-state plans in each Exchange. At least one plan must be offered by a non-profit entity and at least one plan must not provide coverage for abortions beyond those permitted by federal law.
- Permit states the option to create a Basic Health Plan for uninsured individuals with incomes between 133-200% FPL who would otherwise be eligible to receive premium subsidies in the Exchange.
- Allow states the option of merging the individual and small group markets. (Effective January 1, 2014)
- Create a temporary reinsurance program to collect payments from health insurers in the individual and group markets to provide payments to plans in the individual market that cover high-risk individuals.
- Require qualified health plans to meet new operating standards and reporting requirements.

Premium Subsidies

- Provide refundable and advanceable premium credits and cost sharing subsidies to eligible individuals and families with incomes between 133-400% FPL to purchase insurance through the Exchanges.

Medicare

- Reduce the out-of-pocket amount that qualifies an enrollee for catastrophic coverage in Medicare Part D (effective through 2019);
- Establish an Independent Payment Advisory Board comprised of 15 members to submit legislative proposals containing recommendations to reduce the per capita rate of growth in Medicare spending if spending exceeds a target growth rate. (Issue recommendations beginning January 2014)
- Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided.
- Require Medicare Advantage plans to have medical loss ratios no lower than 85%.

Medicaid

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to

133% FPL based on modified adjusted gross income (MAGI) and provides enhanced federal matching for new eligibles.

- Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.
- Increase spending caps for the territories.

Prevention/Wellness

- Permit employers to offer employees rewards of up to 30%, increasing to 50% if appropriate, of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Establish 10-state pilot programs to permit participating states to apply similar rewards for participating in wellness programs in the individual market.

Tax Changes

- Impose fees on the health insurance sector.

2015

Insurance Reforms

- Permit states to form health care choice compacts and allow insurers to sell policies in any state participating in the compact. (Compacts may not take effect before January 1, 2016)

Medicare

- Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. (Effective fiscal year 2015)

Tax Changes

- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values that exceed \$10,200 for individual coverage and \$27,500 for family coverage. (Effective January 1, 2018)

Appendix A



ACI Interim Positions, 2011 Legislative Session

HEALTH CARE

ACI SUPPORTS:

A Proactive Response to Federal Health Care Reform

- A voice for business and employers in implementing federal health care reform at the state level.
- A moratorium on new state health care mandates while federal reform is implemented.
- Implementation of the reform legislation shall incorporate components that promote efficiencies such as Patient Centered Medical Homes and insurance options such as Health Savings Accounts.
- An ongoing fiscal and cost-benefit analysis regarding the expansion and increased enrollment of the Medicaid program and the impact on the state economy and revenues.
- Maximize the use of federal funds; including grant opportunities for innovation and cost reduction.
- Ease administrative burdens where possible and facilitate business compliance through education.

Reducing Costs

Implement private and public partnerships that reduce the overall cost of care, increase access to quality care, and improve the method of financing the health care system.

- Aggressively pursue initiatives and incentives that cut costs of health care, i.e. Health Savings Accounts and Health Homes.
- Enable individuals to maximize the efficiency of their health care by providing choices, options, prices and incentives (such as High Deductible HSAs) that encourage quality care most affordably. State employee health insurance should offer HSA options and lead innovation.
- Recognize the need for wellness programs, education and coaching to lower health care costs, incentivize and motivate state employee wellness programs and encourage and protect business efforts to implement same.
- Require full transparency for all health coverage programs, including information on costs, benefits, utilization, demographics, claims experience, federal waivers and plans, per member per month costs, and other information to allow sufficient public oversight and analysis of programs by stakeholders and policymakers.

Increasing the Number of Providers and Access to Meet Increased Demand

- Maximize use of federal funds to educate, train, recruit and retain more health care professionals and other providers.
- Raise Medicaid reimbursements to providers to enable compliance with PPACA, or exempt Medicaid providers from taxes and penalties.
- Provide incentives to Medicaid providers to expand, especially in under-served areas.
- Support federally funded health centers for under-served areas.

Improving the Use of Technology

- Create incentives for providers to make effective use of information technology, and maximize federal funds for this effort.
- Create individual electronic health records controlled and accessible by consumers.

- Provide online outcomes information on health care services, professionals and institutions.

ACI OPPOSES:

- Additional tax or administrative burdens on employers.
- Expansion of Medicaid prior to federally mandated time frames.

DETAILED POSITION STATEMENTS

ACI recognizes the importance of health care reform and its relationship to economic growth and development. ACI supports public-private partnerships that reduce the overall cost of purchasing health care, increase access to quality care and improve the method of financing the health care system. ACI supports facilitating consumer purchased insurance as a complement to employer selected group coverage.

ACI supports a competitive environment to lower the cost and improve the quality of insurance and delivery of health care. ACI supports legislation to aggressively pursue and implement initiatives and incentives that will reduce costs for providers, prices to consumers and insurance premiums. ACI believes that health care costs must be contained by controlling cost-shifting at all levels and educating consumers about the true cost of health care service. ACI believes that individuals should have more accountability for their health and welfare by paying a portion of their costs. ACI encourages wellness and prevention as a part of any comprehensive solution.

ACI believes that New Mexico's response to passage of federal health care reform (PPACA), should:

- Ensure personal responsibility and appropriate cost-sharing by covered individuals;
- Be subject to appropriation and oversight by the Legislature;
- Not jeopardize or violate ERISA;
- Be funded by existing revenues or a broad-based revenue source not tied to businesses based on employment;
- Be responsive to the needs of businesses, providers, and consumers;
- Not mandate imposition of fees or increased taxes on employers; and
- Provide a strong and direct role for employers in the development of any state proposals or of any state plans in response to any federal reforms.

A Proactive Response to Federal Health Care Reform

ACI supports business involvement in SJM1. It is essential that New Mexico get ahead of the curve and optimizes PPACA for all New Mexicans. This includes looking at the true, practical impact that PPACA will have on individuals, Medicaid, Medicare, state and local government and business. The key stakeholders, which include business, need a seat at the table as the details of PPACA are hammered out (i.e. SJM1 Task Force, etc.) to avoid unintended consequences that could have catastrophic impact on health care coverage and livelihoods for New Mexicans.

ACI supports incentives that incorporate components promoting efficiencies such as patient-centered Medical Homes and insurance options such as health savings accounts that incentivize consumers toward effective choices and wellness. Without these components, health care costs will continue to rise uncontrollably and will bankrupt ALL public or private payers.

ACI supports controlling costs by measuring the efficacy of expenditures. We have all experienced the cost of well intentioned programs get out of hand quickly and put the state budget in trouble. We must put in place tracking mechanisms and cost-benefit analysis to monitor the fiscal impact on the state budget; especially with respect to the anticipated huge increase in the enrollment in the Medicaid program.

ACI supports maximizing the use of federal dollars in the form of grants. New Mexico should be first in line to take advantage of the federal dollars set aside to help states implement PPACA. This provides a great opportunity for some public and private partnerships to apply for grants that would fund the gathering of information, the application of metrics, and facilitate pilot programs to investigate the best, most cost effective ways to deliver health care under the PPACA. Indeed, ACI has applied for a Robert Wood Johnson Foundation grant to help businesses adapt to PPACA.

All currently unmatched health care dollars in the state should be analyzed for creative methods to match these federal funds. One mechanism to maximize federal funds in the interim is the SCI program. Options should also be explored with county indigent funds such as use of the funds to provide the match for SCI or to pay deductibles for people to get into the New Mexico Medical Insurance Pool.

ACI supports the formation of an exchange under PPACA which is not a state agency or a federal “takeover”. The exchange should be as unbureaucratic as possible and not politically driven. ACI believes the state should not rush and should look at what other states are doing and seek expertise to ensure the best exchange for all New Mexicans.

ACI supports New Mexico legislation that helps businesses expand and hire more individuals by helping educate New Mexico businesses on their rights and responsibilities under PPACA and to ease administrative burdens where possible.

ACI supports initiatives that provide maximum flexibility for insurers and employers to design and purchase affordable health care coverage without regulatory mandates.

ACI opposes legislation that creates additional mandated health care benefits that would increase the cost of doing business, and ACI believes the current level of mandates should be reduced. Most mandates increase the cost of health insurance and reduce opportunities for employees to obtain basic coverage and place additional burdens on employers.

ACI also opposes a state-mandated medical insurance plan for all employers that require uniform benefits.

Reducing Costs

A concern with PPACA is that it does not adequately address cost containment and cost savings as a way to make health care more affordable to all. Other states and health care systems have shown dramatic reductions in the cost of health care by implementing systems which encourage and incentivize consumers and medical professionals to modify behaviors that lead to cost savings. High Deductible HSAs and patient centered Medical Homes are two proven methods. Health Savings Accounts greatly incentivize individuals toward the effective use of health care dollars since savings that the consumer has direct control over benefit the consumer directly since the money then goes into their retirement account. Thus, the consumer is “spending their own money.” We have seen the power of this in the success of Wal-Mart and decreasing prices of goods due to the ability of consumers to compare prices so easily. Further, most of us are very aware of the one medical procedure that has greatly increased and quality while reducing and cost: Lasik. The reason for this is directly tied to consumers “spending their own money.”

Patient Centered Medical Homes centralize patient information and greatly increase the efficiencies of the health care system. We used to all have a “family doctor”, who knew everything about us, and followed us into the hospital and through our treatments etc. That is no longer the case, and will get worse as the “Primary Care Physician” shortage worsens. The answer is the patient centered medical home, where a team of health care professionals fill the essential function of the old family doctor model. This model has been proven in many states and health care systems to lower costs.

The lessons and results of both of these methods should be encouraged at the state level; through incentives to businesses and through state and local employee health care systems.

ACI believes that personal responsibility is an important component of controlling costs and utilization in health care and supports appropriate co-payments and cost-sharing to encourage this responsibility. Publicly supported programs should have some level of cost-sharing to encourage appropriate use of the health care system.

Additional health insurance products that encourage employees to share premium costs with employers; for example, tiered benefit plans should also be considered. ACI also supports coverage mechanisms which would provide employers and employees with tax credits and rebates to encourage the offering and purchasing of insurance.

Wellness programs are essential to the long term viability of our nation's health care system. State employee health care systems should lead the way on this, and businesses should be encouraged and protected while implementing same.

One part of assisting in consumer choice and lowering costs in general is transparency for all health coverage programs, including information on costs, benefits, utilization, demographics, claims experience, federal waivers and plans, per member per month costs, and other information applicable to the goal.

Increasing the Number of Providers and Access to Meet Increased Demand

The New Mexico health care network is fragile at best. If we do not increase the number of health care providers in New Mexico, it won't increase how many individuals are "covered". We need to maximize the use of federal funds to acquire more health care providers.

We need to raise reimbursements for Medicaid providers – which have been flat or reduced for years – to enable compliance with PPACA, or exempt Medicaid providers from taxes and penalties for non-compliance. Medicaid depends on providers to provide services, but doesn't reimburse adequately for PPACA compliance. Therefore, Medicaid providers do not currently provide employer paid major medical insurance to their employees. Under PPACA, these providers will be required to operate at a loss, which is not sustainable. The tax credits only help very small companies and the provider must still spend money they don't have to get a "partial" reimbursement in the future. Banks are tightening or eliminating lines of credit for these providers now, so providers will not be able to "afford to take the tax credit".

Rural areas in New Mexico are a large concern, especially when considering that many of the estimated 300,000 new Medicaid enrollees will be in rural areas. We must provide incentives to providers to expand into rural areas and to support and assist the creation and maintenance of federally funded health centers. ACI supports educational assistance, training and low interest loans or loan repayment plans for existing and new providers.

ACI supports expanding enrollment with a commensurate increase in appropriations in health care professional degree programs in the state's higher education institutions, including career ladder programs for nursing professionals.

ACI supports incentives for doctors and nurses to stay in New Mexico after completing their education. Such incentives should have a requirement that the recipient stay in New Mexico and practice for a period commensurate with the level of assistance.

ACI supports full implementation of the UNM combined degree program (BA/MD) which is designed to increase the size of the UNM Medical School enrollment, with the additional students coming from medically underserved areas of New Mexico where they will return to practice medicine.

ACI supports increased health care training opportunities within the state.

ACI supports permitting health care personnel who are trained and certified in their fields to provide a broader range of services in their scope of practice.

ACI supports reducing the burden that the gross receipts tax on health care services imposes upon consumers and providers. ACI opposes any action that would increase the tax burden on any provider of health care services performed in New Mexico.

ACI supports an independent study to determine the feasibility of establishing a dental school in New Mexico and the most cost effective ways to address the shortage of dentists in New Mexico.

Improving the Use of Technology

The use of technology has given us great access to information. However, medical information is still difficult to get into the hands of the medical professional who needs it.

ACI supports maximizing the opportunities for use of health care information technology with the federal stimulus funds available to providers. ACI supports aggressive approaches to development of a health information exchange for the state.

ACI supports incentives for providers to adopt new information technology for the purpose of improving outcomes, increasing patient safety and reducing administrative costs.

ACI supports initiatives for insurers and providers to furnish easy consumer access to readily comparable information about the cost and quality of their services.

Regulatory Burden on Business

ACI opposes any additional administrative burdens on New Mexico businesses. PPACA requires many new administrative burdens that will further reduce business' ability to valuable goods and services expand and hire new people. These include new requirements for 1099 reporting for ALL vendors, the "four page twelve font" document to all employees explaining PPACA, additional employees to administer PPACA requirements within the company, revising procedures, additional software. Every new regulation requires a real expense by employers, but PPACA's burdens are excessive.

Prescription Drug Prices

ACI opposes the imposition of artificial price controls that shift costs to other consumers. ACI recognizes the problems and hardship associated with increasing pharmaceutical prices. ACI, however, believes that innovative, market-based solutions to reduce pharmaceutical inflation and lower costs should be fully explored before imposing government-driven price control measures.

ACI believes prescription drug coverage issues should be addressed at the federal level and not at the state level.

ACI opposes a state-defined formulary for prescription drugs in private medical insurance plans.

County Indigent Funds

ACI supports the existing county indigent fund and sole community provider hospital programs that assist hospitals in meeting the burden of providing uncompensated care throughout the state and thereby reduce cost-shifting to commercial payers.

ACI opposes initiatives to reduce funds intended for and currently used to provide indigent care.

Appendix B



Medicaid and Healthcare Reform in New Mexico: Opportunities and Recommendations

Report for New Mexico's Healthcare Reform Working Group

July 9, 2010

Presented by the New Mexico Center on Law and Poverty

Prepared and submitted by: The Arc of New Mexico ▪ Bernalillo County Off-Reservation Native American Health Commission ▪ Brain Injury Association of New Mexico ▪ The Disability Coalition ▪ Disability Rights New Mexico ▪ Health Action New Mexico ▪ Lutheran Advocacy Ministry–NM ▪ New Mexico Center on Law and Poverty ▪ New Mexico Voices for Children ▪ New Mexico Women's Agenda ▪ Pegasus Legal Services for Children ▪ Senior Citizens Law Office ▪ Southwest Women's Law Center

Appendix B

MEDICAID AND HEALTHCARE REFORM IN NEW MEXICO: OPPORTUNITIES AND RECOMMENDATIONS

Summary

Medicaid will play a critical role in expanding healthcare coverage to working families and low-income New Mexicans under health reform. The new coverage will boost the state's economy and create thousands of jobs in the healthcare sector. Many of the most vulnerable New Mexicans who currently cannot get healthcare coverage will become eligible for Medicaid.

With careful planning, New Mexico can create a unified system of healthcare coverage that responds to the needs of our communities. It is imperative in the upcoming years that New Mexico supports the network of providers and facilities that deliver healthcare statewide. ***Making cuts to the Medicaid program now will harm participants who could lose vital services and would severely impact the healthcare infrastructure in New Mexico*** at the time when it is most needed.

To prepare for reform and maximize opportunities for the state, New Mexico should:

- #1 Protect access to Medicaid for children and adults who are currently eligible for the program to ensure stable healthcare coverage and avoid violating the reform law. *Effective now until January 1, 2014 for adults and until October 1, 2019 for children.*
- #2 Prevent benefit cuts that would dismantle healthcare services for Medicaid participants. Protect New Mexico's healthcare infrastructure and workforce in rural, urban, and tribal areas before reform takes full effect in 2014. *Action required in 2011 state legislative session to appropriate adequate funding for Medicaid.*
- #3 Take advantage of federal grants and funding opportunities for Medicaid to build the state's healthcare infrastructure and develop high quality systems of coverage and care management. *Effective dates vary for each grant or funding opportunity.*
- #4 Evaluate proposals for improving the cost-effectiveness and performance of the Medicaid managed care system, and for using other models of care coordination in New Mexico. *Action may be required in 2011 legislative session.*
- #5 Develop the information technology (IT) capacity to:
 - Ensure "no wrong door" to apply for Medicaid or an Exchange.
 - Reduce the paperwork burdens on Medicaid applicants by using electronic matches with other agencies.
 - Coordinate screening for eligibility with other public benefits (such as TANF).
 - Collect and report data on enrollment and retention in Medicaid.
 - Protect the rights of people with disabilities to receive accessible services.

- Protect the rights of people with limited English proficiency to receive appropriate services, and track the language interpretation services provided to them.
- Protect the confidentiality of applicant records.

Action should begin immediately to ensure completion by January 1, 2014.

#6 Gradually extend Medicaid coverage to newly eligible adults who live under 133 percent of the poverty level before 2014. If coverage cannot be extended to the entire group before 2014, work with the Centers for Medicare and Medicaid Services (CMS) to develop a system to pre-screen applicants so that everyone can be promptly enrolled on January 1, 2014, to take full advantage of 100 percent federal financing available at that time for their coverage. *Option available now through January 1, 2014.*

#7 Consider models for state coverage plans that could be offered to other low-income New Mexicans, such as offering coverage through Medicaid or a “Basic Health Program”, and through the Children’s Health Insurance Program. *Medicaid and Basic Health Program options are available on January 1, 2014. CHIP options are available now.*

#8 Simplify enrollment procedures by implementing:

- Express lane to automatically enroll children in Medicaid and CHIP. *Available now.*
- Presumptive eligibility for more populations. *Available now for family planning services and low income families, and available in 2014 for newly eligible adults and for hospitals to make determinations.*

#9 Ensure that there is meaningful consultation with stakeholders in decision-making about the Medicaid program. This includes tribal governments, healthcare providers, and constituency groups that represent low income populations, children, women, people with disabilities and the elderly. Provide information to the public that facilitates discussion and complies with transparency requirements in the reform law.

*** Note: This report does not include recommendations or provisions affecting Medicaid long term care services or the home and community based waiver programs for people with disabilities.** These services will be the focus of a separate advisory group report to New Mexico’s Health Reform Working Group.

Medicaid Coalition Report to New Mexico’s Healthcare Reform Working Group submitted by:
*The Arc of New Mexico ▪ Bernalillo County Off-Reservation Native American Health Commission ▪
 Brain Injury Association of New Mexico ▪ The Disability Coalition ▪ Disability Rights New Mexico ▪
 Health Action New Mexico ▪ Lutheran Advocacy Ministry–NM ▪ New Mexico Center on Law and Poverty ▪
 New Mexico Voices for Children ▪ New Mexico Women’s Agenda ▪ Pegasus Legal Services for Children ▪
 Senior Citizens Law Office ▪ Southwest Women’s Law Center*

*For more information on this report, please contact
 Sireesha Manne, New Mexico Center on Law and Poverty, at (505) 255-2840.*

INTRODUCTION: NEW OPPORTUNITIES FOR HEALTHCARE COVERAGE

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, brings promising new reforms and opportunities that will improve access to affordable and quality healthcare coverage throughout the United States. In New Mexico, healthcare reform will significantly reduce the number of uninsured people. Our state has the second highest uninsured rate in the country (23 percent), with an estimated 450,000 uninsured residents.¹ Under PPACA, approximately 315,000 New Mexicans are expected to gain healthcare coverage.² About half of these individuals will be covered by Medicaid.

Starting in 2014, Medicaid will cover low-income people who earn less than 133 percent of the poverty level (less than \$24,360 per year for a family of three) who are non-elderly and not already in a mandatory Medicaid group. This new coverage will in fact reach adults up to 138 percent of the poverty level because of a standard 5 percentage point disregard that will apply to every state's program.³ Coverage will also be available in 2014 to children up to age 26 who were in foster care on the date they turned 18 years old, and who were covered by Medicaid while in foster care.⁴

The costs for covering newly eligible adults will be fully paid by the federal government for the first three years, from January 1, 2014 to December 31, 2016.⁵ The federal matching rate will then remain high in future years (95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond).⁶ On average, over the six years, the federal government will pay over 95 percent of the costs of new coverage.⁷ **This is expected to bring in over \$4.5 billion to New Mexico between the years 2014 to 2019.** **No new state spending will be required until 2017**, at which time state spending on Medicaid overall is expected to rise by only 2.1%.⁹

The new Medicaid coverage and infusion of federal funding will:

- ✓ ***Provide healthcare coverage to more than 145,000 New Mexicans:*** Many adults in New Mexico are currently not eligible for Medicaid coverage, even if they are living below the poverty level. Health reform closes these gaps, and will provide new Medicaid coverage to over 145,000 low-income New Mexicans.¹⁰ Extending Medicaid to more families will also help secure coverage for over 50,000 children who are currently eligible but not yet enrolled in Medicaid and the Children's Health Insurance Program.
- ✓ ***Contribute to healthier communities:*** It is estimated that one American dies every 12 minutes from the consequences of not having health insurance.¹¹ In New Mexico alone, 300 deaths each year could be prevented simply by expanding coverage.¹²
- ✓ ***Create more than \$1.65 billion in local economic activity each year and generate more than 20,000 jobs in New Mexico:*** The PPACA will result in a huge influx of new federal Medicaid funding for the state beginning in 2014. By 2019, when new enrollment is fully implemented, the annual economic benefits of these new federal funds will be enormous, including:¹³
 - New federal Medicaid spending: at least \$988 million.

- New annual economic activity: at least \$1.65 billion.
 - New jobs: at least 20,100.
 - New annual wages and salaries: at least \$737 million.
- ✓ ***Preserve the healthcare infrastructure and workforce throughout New Mexico particularly in rural areas:*** Medicaid funding is extremely important to the viability of healthcare provider networks, especially in rural areas that already struggle with workforce shortages. Hospitals also depend heavily upon Medicaid for a major portion of their revenues. For UNM Hospital alone, over 30% of revenues are from Medicaid admissions.¹⁴
- ✓ ***Provide healthcare to Native Americans and strengthen the network of Indian Health Services and tribal programs.*** Medicaid has become an increasingly important source of coverage for Native Americans, serving as a primary vehicle for the federal government to fulfill its trust obligations to provide healthcare to all Native Americans. Not only will reform serve the healthcare needs of more Native Americans living in New Mexico, the improvements to Medicaid coverage will help strengthen the network of providers in many of the poorest areas of the state by providing a major stream of revenues for Indian Health Services and tribal programs.
- ✓ ***Stabilize private insurance premiums.*** New Mexico has seen some of the highest increases of private insurance premiums in the country due to cost shifting from the uninsured.¹⁵ We absorb an estimated \$335 million in uncompensated care each year.¹⁶ Health care reform should slow the rate of increase in private insurance premiums.
- ✓ ***Reduce uncompensated care costs currently paid by taxpayers and healthcare providers.*** Uninsured New Mexicans must often rely upon county indigent funds and the public hospitals for healthcare. Uncompensated care is generally paid by taxpayers and absorbed by providers at nearly four times the cost of Medicaid because the expense is not matched by federal funds. New Mexico spent over \$87 million on indigent funds for healthcare in FY 09.¹⁷

As New Mexico prepares for reform, the key to a successful transition is to protect the Medicaid program and to preserve the State's healthcare infrastructure in upcoming years. The program must be adequately funded to meet the needs of New Mexicans, and to provide for the healthcare system that depends on Medicaid revenues. New Mexico should not continue to cut benefits or slow enrollment precisely at the time when we need to develop a thriving healthcare workforce and adequate infrastructure to support reform. For every dollar the State spends on Medicaid, we receive three times the amount in federal matching funds. This money will be critical for helping the state's economic recovery and supporting thousands of jobs in our healthcare sector.¹⁸

This report offers recommendations for how New Mexico can take advantage of opportunities under healthcare reform and explains several important requirements of the new law affecting Medicaid.

RECOMMENDATION #1: Protect access to Medicaid for children and adults who are currently eligible for the program to maintain stable healthcare coverage and avoid violating the reform law.

Effective now until January 1, 2014 for adults and until October 1, 2019 for children.

New Mexicans who are currently eligible for Medicaid are protected from losing access to its coverage in the coming years. Under the reform law, states cannot restrict eligibility levels or tighten enrollment procedures to reduce the number of children or adults who can receive coverage through Medicaid, the Children’s Health Insurance Program, or the waiver programs.

These “maintenance of effort” requirements went into effect the date PPACA was enacted into law on March 23, 2010 and will remain in effect for adults until January 1, 2014 (when the insurance Exchanges are fully operational), and for children until October 1, 2019.¹⁹

Under the requirements, states may not.²⁰

- Eliminate coverage for any group;
- Impose stricter income eligibility guidelines or stricter asset or resource tests;
- Impose new paperwork requirements or change enrollment or recertification processes to make it more difficult for individuals to establish or maintain eligibility;
- Implement or raise premiums or enrollment fees in Medicaid;
- Impose more stringent disability criteria;
- Change section 1915(c) waiver eligibility for home and community-based services to replace aggregate cost neutrality with individual cost neutrality; or
- Reduce the number of 1915(c) waiver slots for home and community-based services.

Reducing eligibility levels for Medicaid, including waiver programs, in violation of maintenance of effort requirements, would cause New Mexico to lose all federal funding for the program.²¹

There is one exception to the requirement, but it largely does not apply to New Mexico. States may restrict eligibility levels for non-pregnant and non-disabled adults earning more than 133 percent of the federal poverty level (FPL) in the years 2011 to 2013 upon certification by the State that it is facing a budget deficit that year.²² This limited exception would affect few Medicaid-eligible people in New Mexico because most participants above 133 percent FPL are pregnant, people with disabilities, or children.

RECOMMENDATION #2: Prevent benefit cuts that would dismantle healthcare services for Medicaid participants. Protect New Mexico's healthcare infrastructure and workforce in rural, urban, and tribal areas, before reform takes full effect in 2014.

Legislative action is required in the 2011 session to appropriate adequate funding for Medicaid.

With the passage of health reform, it is especially important that New Mexico preserve the integrity of the Medicaid benefits package in the upcoming years. This will be a major challenge for the state which continues to face revenue shortfalls. As a result of additional federal funding for Medicaid through last year's stimulus, a significant amount of state funding was redirected from the Medicaid program to other state expenditures. If these funds are not restored to Medicaid, the program will face disproportionate and massive cuts on top of the deep cuts that were made to Medicaid in the last year, and that continue through the current fiscal year: healthcare provider payment rates were reduced, enrollment in the State Coverage Insurance program was frozen leaving over 15,000 people on the waitlist, outreach to enroll children was stopped, and numerous reductions were made, and continue to be made, to healthcare benefits.

New Mexico should carefully guard against making further cuts to Medicaid services for the following reasons:

1. New Mexico must protect its healthcare infrastructure, especially in rural areas, and ensure that thousands of jobs are not lost in the medical sector before reform takes full effect. In 2014, a new surge of people will gain access to coverage. The demands on the healthcare system will be great, and without careful planning, the state could face shortages of medical personnel. This is especially the case for rural areas that already struggle to maintain an adequate network of healthcare provider and clinics. For example, cutting dental services in Medicaid would only exacerbate the existing shortages of dental practitioners statewide, making it difficult to attract and retain providers through 2014.

New Mexico's healthcare infrastructure and its larger economy depend heavily on Medicaid revenues:

- Every \$100 million in state funding for Medicaid currently supports 5,000 jobs in the state.²³
- Medicaid provides a significant portion of hospital revenues. In the case of UNM Hospital, Medicaid admissions make up nearly 30% of all revenues.²⁴

Cuts to Medicaid could have severe consequences on the healthcare infrastructure, and in the worst case scenario, could result in some facilities shutting down their doors.

2. Cutting benefits to Native Americans would cause New Mexico to forgo 100 percent federal funding that is provided to Indian Health Services and tribal programs, detrimentally impacting the quality of healthcare services in many of New Mexico's poorest communities. Pursuant to its trust obligation to provide healthcare services to Native Americans, the federal government pays the full cost of services that Medicaid enrollees receive at I.H.S. and tribal facilities. Decisions by the state to cut Medicaid benefits could also cut off vital funding streams to I.H.S. and tribal programs. This would harm the ability of I.H.S., which is already severely underfunded, to provide adequate

healthcare to some of the most underserved areas of the state. It would frustrate the goals of the recently reauthorized Indian Health Care Improvement Act which establishes a framework to provide “the highest possible health status to Indians, and to provide existing Indian health services with all resources necessary to effect that policy.”²⁵

3. Medicaid provides services that low-income people may be unable to obtain anywhere else.

Medicaid enrollees have few, if any, other options for obtaining services that are not covered by Medicaid. Native Americans often must travel off-reservation to seek specialty care for their conditions because I.H.S. cannot treat them. If Medicaid does not cover the specialist, the person could be left with no other options. For example, I.H.S. does not provide specialized diagnostic tests and may not have the funding to pay for them through contract health services.

4. Cutting services is short-sighted and may actually raise costs by increasing the use of more expensive services. For example, reducing access to preventive services and medically necessary care results in more use of emergency rooms and hospital inpatient care because medical conditions worsen when they are not treated in a timely manner. These are extremely expensive ways to provide care that should be discouraged in New Mexico. If access to community-based long term care services is reduced, seniors and people with disabilities will be forced into institutional care at a much higher cost than that for home and community-based services.

5. Reducing the services covered by Medicaid would represent a regressive policy shift for New Mexico, especially in comparison to other states. Under federal law, every state must provide a set of mandatory services for Medicaid participants and has the option to provide others. New Mexico designed its Medicaid benefits package to include mandatory services and optional services that meet essential healthcare needs, such as prescription drugs, dental and vision care, and hospice care. Some services, such as nurse practitioner services, are covered because they provide cost-effective alternatives for care and improve access to services in rural areas of our state where the number of health professionals is limited.

The optional benefits covered by New Mexico’s Medicaid program are typical of those covered in other states. For example, like New Mexico, all fifty states have elected to cover prescription drugs and home and community-based long-term services, 49 states cover nurse practitioner services, 47 cover hospice care and 45 cover dental services.²⁶

The Medicaid program only covers services when they are medically necessary for the individual. Reducing benefits would deprive Medicaid enrollees of necessary services that are essential to their health and well-being. This would be a regressive move for New Mexico that previously made sound policy decisions to include the benefits. It would also bring us out of step with the overwhelming majority of other states.

6. New Mexico cannot reduce services for children in Medicaid or CHIP due to legal limitations.

States are required by law to provide a comprehensive set of services for children. Children who are covered by Medicaid are eligible for Early and Periodic Screening and Diagnostic Testing (“EPSDT”). Under EPSDT, children must receive preventive testing, health screenings, regular check-ups, and treatment for conditions or illnesses that are found in the exams and screenings.

In New Mexico, EPSDT must be provided to children in Medicaid and the Children's Health Insurance Program because our CHIP program is considered a Medicaid "expansion" rather than a separate program.²⁷ New Mexico therefore cannot cut benefits for children.

7. Reducing benefits now to a "benchmark" standard would be ill-advised, premature, and likely inconsistent with standards that will go into effect in 2014. Federal law allows for states to provide "benchmark" plans to some Medicaid recipients, which is a reduced benefits package.²⁸

Like most states, New Mexico does not use benchmark plans for Medicaid, and should refrain from using them for Medicaid enrollees now or in the future for the following reasons:

- Low-income people would not have the ability to purchase coverage elsewhere or pay the costs of medical care that is not covered by a Medicaid benchmark plan.
- Low-income individuals are likely to have higher healthcare needs that require comprehensive services.²⁹ States are currently prohibited from requiring many Medicaid participants to enroll in benchmark plans in recognition that these groups require the entire Medicaid package. For example, pregnant women, people with disabilities, parents eligible for TANF, children in foster care, terminally ill hospice patients, and many other groups cannot be forced to enroll in benchmark plans and must instead be provided full coverage under the state plan.³⁰ Likewise, all low income people should receive full coverage under Medicaid.
- Native Americans should be exempt from having to use benchmark packages due to the federal trust obligation to provide them with healthcare services. Benchmark plans could exclude services provided by I.H.S. and tribal providers, cutting off important funding streams that support the medical care provided to Native Americans.
- It would be premature to cut benefits before new benchmark standards are defined for 2014. PPACA adds new provisions to the existing definition of benchmark package, requiring that they meet the "minimum essential coverage" standards for insurance plans on the Exchange in 2014, which have not been defined yet by the HHS Secretary.³¹ The Secretary must survey typical employer health plans to determine the final standards,³² but in this process must also evaluate the needs of the population to be served,³³ making it probable that the new benchmark standard will be more expansive than the current one. If the State cuts services now, it could be difficult to bring the benefits back in the future.

8. The state should offer seamless coverage for individuals who transition between income levels due to employment changes or transition between categories for coverage (such as pregnant women who become parents). Creating different benefits packages for different types of enrollees (such as full benefits for some enrollees and benchmark packages for other enrollees) would only serve to increase the administrative complexity of the program and fragment coverage for participants. The state should strive to offer a full benefits package for all enrollees.

RECOMMENDATION #3: Take advantage of federal grants and funding opportunities to build the state’s healthcare infrastructure and develop high quality systems of coverage and care management.

Effective dates vary depending on each grant or funding opportunity (see below).

New Mexico should take advantage of new funding opportunities to promote better health, healthcare affordability, and quality of care. Federal funding is available to help the state build its healthcare workforce and improve preventive care for many New Mexicans who cannot afford it now. This funding increases the likelihood that serious medical problems will be caught and treated at an early stage when treatment is more effective and less expensive. The projects could potentially garner cost savings for the state and create long-lasting improvements to the healthcare delivery system.

There are numerous grants and funding incentives that could improve the healthcare infrastructure in New Mexico. For example, among the PPACA provisions designed to increase the supply of providers—both physicians and para-professionals – federal funding opportunities exist to:

- Increase the Medicaid payment rates for certain primary care services to 100 percent of the Medicare payment rates, with the federal government paying the full amount of the rate increase between January 1, 2013 and January 1, 2015.³⁴
- Subsidize the medical education of providers who agree to work after graduation in underserved areas.
- Support residency programs in community health clinics.
- Provide additional federal funding for community health clinics (135 in New Mexico), which primarily serve lower-income individuals, and school-based clinics (85 in New Mexico).

While many of these grants and funding incentives are outside the scope of this report, they are summarized in a Federal Funds Information for States (FFIS) “inventory of funding opportunities”, posted on the New Mexico Human Services Department website.³⁵ Along with these opportunities, we recommend that New Mexico pursue the following:

Incentives for Prevention of Chronic Diseases in Medicaid. *Project begins January 1, 2011 (or on the date the HHS Secretary develops the program criteria, whichever is first), and continues for three years at the minimum, and for up to five years.*

The federal government will provide \$100 million in grants over five years to states that provide programs to Medicaid beneficiaries that are designed to encourage healthy behaviors and achieve one or more of the following outcomes: smoking cessation, weight control, lowering cholesterol, lowering blood pressure, and avoiding the onset or management of diabetes.³⁶ States that receive grants must conduct outreach to Medicaid participants to make them aware of the program.³⁷ Participating in these programs will not affect a person’s eligibility for Medicaid.

“Health Homes” for Enrollees with Chronic Conditions. *Effective January 1, 2011. Funds for planning grants will be available until expended.*

States may provide “health homes” to individuals with chronic conditions, and receive federal grants and matching funds to implement the system. “Health homes” refer to a healthcare provider (such

as a physician, clinic, community health center, or other health agency) or to a team of healthcare professionals selected by an individual with chronic conditions to provide services including: comprehensive case management, care coordination, comprehensive transitional care, patient and family support, and referrals to community and social support services if relevant.³⁸

The federal government will award up to \$25 million of planning grants to help states develop the system and submit a state plan amendment.³⁹ The state's payments to health homes will also receive a 90 percent federal matching rate for the first two years.⁴⁰

Community First Choice Option. Effective October 1, 2011.

States will receive a federal matching rate of an additional six percentage points for providing home and community-based supports and services to individuals with disabilities who are eligible for Medicaid, have incomes up to 150 percent of the FPL (and up to 225 percent FPL in New Mexico by option of the state), and who require an institutional level of care.⁴¹ Services must be provided according to a person-centered care plan and in a home or community setting.⁴²

Pediatric Accountable Care Demonstration Projects. Project begins January 1, 2012 and ends December 31, 2016.

Pediatric medical providers can be recognized as "accountable care organizations" (ACO's) and receive payments from the state to provide care coordination to Medicaid enrollees. States that choose to participate in the project must work with the HHS Secretary to develop performance guidelines to ensure quality of care and cost savings.⁴³ Both the state and ACO will receive incentive payments if the ACO achieves targeted levels of cost savings.⁴⁴ Providers that take part in the project must participate for at least three years.⁴⁵

Demonstration Project to Evaluate Integrated Care Around a Hospitalization. Project begins January 1, 2012 and ends December 31, 2016.

This demonstration project will be available to only eight states that will be chosen based on their potential to lower costs in Medicaid while improving the quality of care for Medicaid beneficiaries. The projects will evaluate the use of "bundled payments" to healthcare providers for delivering integrated services for Medicaid participants who have been hospitalized and receive concurrent physician services during the hospitalization.⁴⁶

Preventive Services for Adults Enrolled in Medicaid. Effective January 1, 2013.

States that offer preventive services to adults covered by Medicaid will be rewarded with a 1 percent increase in the federal matching rate for those services if they are provided to adults enrolled on Medicaid without cost sharing.⁴⁷ Qualifying services are ones that have been recommended by the US Preventive Services Task Force with a grade of A or B, and immunizations.⁴⁸

RECOMMENDATION #4: Evaluate proposals for improving the cost-effectiveness and performance of the Medicaid managed care system, and for using other models of care coordination in New Mexico

Legislative action may be required in 2011 to designate an entity to perform this evaluation.

As the state prepares to fully implement healthcare reform, there is no better time to evaluate how healthcare is delivered in New Mexico. The state should explore ways to improve care coordination, save costs, and how to use its bargaining power to potentially bring down premium costs not only within Medicaid, but to also encourage private insurance plans on an Exchange to reduce premiums. We recommend that New Mexico:

- 1. Review past evaluations of the MCO system and formulate proposals to improve the performance of managed care for Medicaid and reduce costs.** More than 60% of New Mexico's Medicaid participants, including the lowest income families and children, are enrolled in the state's managed care program, SALUD! The state's Medicaid agency pays over \$2.5 billion each year to managed care organizations (MCO) through SALUD, CLTS, behavioral health, and SCI.

Yet, recent data shows that the MCO's are not ensuring that Medicaid enrollees receive basic health services. In 2009, less than 50% of Medicaid enrollees in managed care received well child visits for adolescents (and less than 60% for babies and less than 70% for children), less than 55% received eye exams, and less than 60% received post-partum care.⁴⁹ In addition, the Legislative Finance Committee (LFC) issued a report in 2009 finding major overpayments to MCO's by the state of over \$100 million between FY 2006 and 2008.⁵⁰ Stronger oversight of the MCO system is likely to reveal ways to improve performance and cost savings.

- 2. Work with healthcare providers to apply for Medicaid demonstration projects that pilot "health homes" for chronic conditions and "accountable care organizations" directed by pediatric providers** (as recommended in the previous section). The healthcare reform bill encourages states to try various care coordination models, and provides federal funding incentives to do so.
- 3. An independent study of health homes and other care coordination systems would be useful in New Mexico.** New Mexico passed legislation in 2009 that requested HSD to work with managed care organizations to develop a "medical home" model for use in New Mexico.⁵¹ The MCO's do not appear to have rigorously pursued the option. An independent taskforce, commission, or non-profit entity may be able to more effectively compare models, including the experiences of states that have implemented medical homes without using an MCO system.
- 4. A critical component to accurately evaluating the managed care system is to obtain useful data.** The LFC and advocates have had great difficulty obtaining specific information about the payments made by the state's Medicaid agency to managed care plans.⁵² House Bill 544 which would have secured this data and required greater transparency was vetoed in 2009. Legislative action may be required once again to ensure that the necessary information is produced. Other useful data would include information on the performance of MCO's for delivering healthcare services, including data on racial, ethnic, gender, or income disparities between populations.

RECOMMENDATION #5: Develop the administrative and information technology (IT) capacity to:

- Ensure “no wrong door” to apply for Medicaid or the Exchange.
- Reduce paperwork from applicants by using electronic match systems.
- Coordinate screening for eligibility with other public benefits programs.
- Collect and report data on enrollment and retention in Medicaid.
- Protect the rights of people with disabilities to receive accessible services.
- Protect the rights of people with limited English proficiency to receive appropriate services.
- Protect the confidentiality of applicant records.

*Action should begin immediately to ensure completion by January 1, 2014.
Legislative action is required in 2011-2013 for appropriations.*

The health reform law aims to streamline enrollment processes for Medicaid and the insurance Exchange. This presents great opportunities and challenges for New Mexico. When developing new computer and administrative systems, the state should ensure that the system meets the following goals to comply with the reform law and simplify procedures for applicants:

Goal #1: Ensure “No Wrong Door” to apply for Medicaid or the Exchange: Under the reform law, states must provide one gateway for consumers to obtain health insurance.⁵³ The state Medicaid agency must coordinate with the federal Health and Human Services Department (HHS) to develop a “secure electronic interface” that allows for an exchange of data so that applicants can be determined eligible for Medicaid, CHIP, premium assistance, or qualified health plans on an Exchange through one single application.⁵⁴ One particular challenge will be to coordinate screening for individuals to obtain subsidies to help pay premiums and cost-sharing for plans on an Exchange.

Goal #2: Reduce paperwork from applicants by using electronic matches with other agencies: A coordinated electronic system with HHS could greatly simplify enrollment procedures and reduce the paperwork requirements for Medicaid applicants. For example, the healthcare reform law allows applicants for an Exchange to simply submit their name, birth date, and social security number to attest to their citizenship – information which is then sent by the HHS Secretary to the Social Security Administration to make an electronic match.⁵⁵ This could replace the current system for Medicaid which requires citizens to submit paper documents. If any information cannot be verified through electronic matches with federal agencies, applicants must be given 90 days to provide other documentary proof.⁵⁶

Electronic matches can also be useful for facilitating “express lane” enrollment (discussed below), which is currently allowed for children in Medicaid and CHIP, and could potentially open up to other applicants in the future. The ability to transfer information between agencies should be included as an important feature of any new IT system.

Goal #3: Coordinate screening for eligibility with other public benefits programs: The Department’s IT and administrative capacities should be developed to coordinate Medicaid applications, to the extent possible, with the screening systems for other public benefits in order to ensure that applicants for other programs (such as Food Stamps/SNAP or TANF) receive healthcare coverage, and vice versa.

Goal #4: Collect and report data on enrollment and retention: States must submit annual reports to the HHS Secretary, beginning in January 2015, that provide enrollment and retention data, including the total number of enrolled and newly enrolled people, and any other data that the HHS Secretary finds necessary to monitor enrollment and retention in Medicaid and the waiver programs.⁵⁷ Currently, the New Mexico Human Services Department (HSD) does not publicly report upon the number of newly enrolled people. According to HSD, its computer system is very outdated and makes the retrieval of enrollment information difficult, if not impossible.

The state should ensure that its new IT system can collect and report the data required by law, as well as other data that would be useful for assessing enrollment processes, and that is widely reported by other states, such as the reasons why applications are denied or not renewed.

Goal #5: Protect the rights of people with disabilities to receive accessible services. State agencies are required by law to provide equal access to their programs for people with disabilities. However, HSD does not have a compliance plan for the American with Disabilities Act or Section 504 of the Rehabilitation Act. The Department should create one. In addition, the Department of Justice (DOJ) has instructed government agencies to ensure that their websites have accessible pages and are well-designed.⁵⁸ For example, certain designs and color schemes can make it impossible for people who use assistive technology for their computers to navigate websites and online applications. HSD should use the resources provided by DOJ to ensure that any electronic Medicaid application system is designed and tested to provide access for people with disabilities.

Goal #6: Protect the rights of people with limited English proficiency to receive appropriate services, and track the language interpretation services provided to them. The state is required by law to provide language interpretation services to Medicaid and CHIP applicants who have limited English proficiency. However, HSD has struggled with updating its archaic computer system to send translated notices to Spanish-speakers. This should be a central priority while planning for a new IT system. Moreover, under the CHIP Reauthorization Act of 2009, the federal administrative matching rate was increased to 75% for language services provided for children applying for Medicaid, and to a generous 85% federal match for children applying for CHIP. New Mexico would receive windfall funding for the services it already provides merely by tracking the services.

Goal #7: Protect the confidentiality of applicant records. The new streamlined application process raises confidentiality concerns for the records that are electronically transferred between agencies. While the health reform law protects against disclosure of information about applicants that is provided to federal agencies (such as tax, citizenship, or other information),⁵⁹ the state should take steps to safeguard the confidentiality of records including:

- Review state laws regarding the security of electronic information, and strengthen these laws as necessary to protect confidentiality. HSD has encountered security breaches in the past with its computer system and records maintained by third-party contractors.
- Ensure that Medicaid applicants are aware of the option to provide paper documentation in the event that electronic matches cannot be obtained.
- Protect the confidentiality rights of victims of violence and other individuals, such as youth who seek family planning services, by allowing them to use alternative mailing addresses when applying for Medicaid or the Exchange, and to receive their application materials or health records at the alternative address.

RECOMMENDATION #6: Gradually extend Medicaid coverage to newly eligible adults who live under 133 percent of the poverty level before 2014. If coverage cannot be extended to the entire group before 2014, work with CMS to develop a system to pre-screen applicants so that everyone can be promptly enrolled on January 1, 2014 to take full advantage of the 100 percent federal financing available at that time for their coverage.

*Option to cover new groups is available to states now through January 1, 2014.
Requires state plan amendment by HSD.*

In 2014, Medicaid will be available to every non-elderly adult who lives under 133 percent of the poverty level. States may choose to provide the coverage sooner. **Gradually improving coverage for adults before 2014 would be especially beneficial in New Mexico because it would:**

- Build a healthcare infrastructure that can accommodate more insured patients in 2014, rather than face a sudden onset of demand and potential workforce shortages;
- Close the existing gaps in healthcare coverage for low-income adults, and offer full coverage to the thousands of individuals on the SCI waitlist or who only get limited benefits now;
- Ensure that all newly eligible adults are enrolled by January 1, 2014 when the 100 percent federal financing for their coverage takes effect;
- Promote better health outcomes for all New Mexicans; and
- Reap the benefits of Medicaid coverage, which receives federal dollars that boost the economy and jobs, and reduces uncompensated care costs born by taxpayers and providers.

Medicaid currently does not cover many adults who are living in poverty, with children comprising more than two-thirds of Medicaid enrollees in New Mexico. The program only covers adults if they are very low-income parents of minor children, are pregnant, or have disabilities.

The income cut-off levels can also be very restrictive. For example, for parents to currently qualify for Medicaid, they must have net incomes under 30 percent of the poverty level (less than \$5,493 per year for a family of three).⁶⁰ In addition, people with disabilities can only enroll on Medicaid if they are in nursing facilities, working, or their disability is severe enough and their income low enough to qualify for Supplemental Security Income (SSI), a cash assistance program that serves disabled individuals with incomes under 75% federal poverty level (FPL).

Medicaid is also not available during the time a person waits for an SSI determination, which can take several months to over a year. In the interim, many of these people cannot get medical care even if they have severe disabilities.

Income Limits for Medicaid in New Mexico*

| <u>Category</u> | <u>% of poverty level</u> |
|------------------------|-----------------------------------|
| Children | 235% |
| Cervical/Breast Cancer | 250% |
| Working Disabled | 250% |
| Pregnant Women | 185% |
| Family Planning | 185% |
| SSI Disabled | 75% |
| Parents | 30%** |
| Other Adults | (Not eligible except for waivers) |

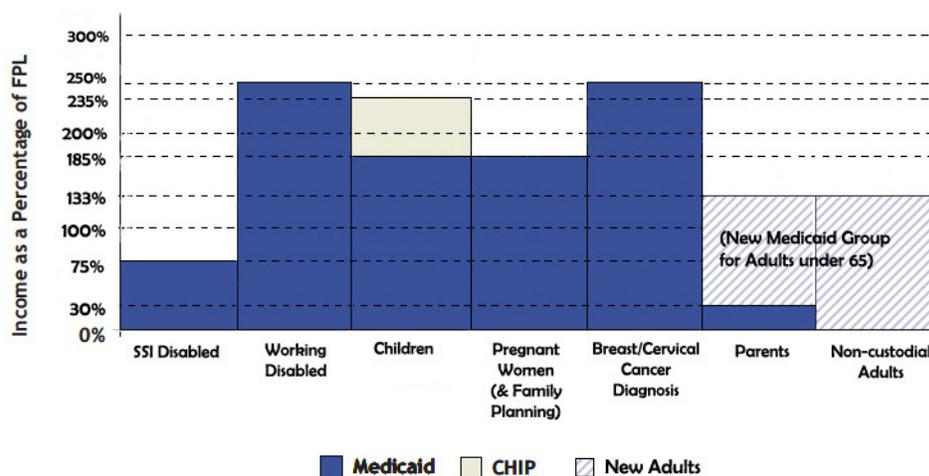
** Table does not include disregards that can affect the countable income used to determine eligibility.*

*** While gross income must be less than 85% FPL for parents, the net income must usually be less than 30% FPL.*

New Mexico has been committed to closing the gaps for low-income adults. The state opted to provide several “waiver” programs for people who are not eligible for Medicaid, including State Coverage Insurance (SCI) for parents and childless adults, and the home and community-based services waivers for people with disabilities. However, **the number of people who can be covered through the waivers is limited.** For example, SCI currently has over 15,000 people on the waiting list. **Applicants for home and community based waivers must wait years for services.**

Fortunately, many of these people will become newly eligible for Medicaid in 2014, and even sooner if New Mexico chooses an option to cover them before that time. PPACA establishes a new Medicaid coverage group for adults in 2014 defined as individuals with incomes below 133 percent federal poverty level (FPL) who are under the age of 65, not pregnant, not enrolled in Medicare and not eligible under any other mandatory Medicaid coverage group.⁶¹

GRAPH 1: New Medicaid Group for New Mexico in 2014 (for non-elderly populations)⁶²



States can immediately start covering some or all of the individuals in this new group, and could choose to take an incremental approach to phase in coverage between now and 2014.⁶³ PPACA authorizes the state to expand coverage before 2014 and still receive 100 percent federal funding for these enrollees beginning in 2014. Some states have already chosen this option to expand Medicaid coverage to adults, including Connecticut and the District of Columbia.

New Mexico could immediately begin providing coverage to individuals up to 133 percent FPL, or gradually raise eligibility to that level, as the economy improves and funding for Medicaid stabilizes. The state would receive its regular federal matching rate (about 72 percent) for covering these adults until 2014 when the federal government will begin paying the entire cost.⁶⁴

If it is not feasible for New Mexico to cover every adult under 133 percent of the poverty level before January 1, 2014, **the state should consider working with CMS to develop a pre-screening system** that would allow people to be screened before January 1, 2014 and then promptly enrolled on that date. This would ensure that New Mexico receives every dollar of federal funding for Medicaid – coverage of the new adults will be funded 100 percent by the federal government from 2014 to 2016.

RECOMMENDATION #7: Consider models for state coverage plans that could be offered to other low-income New Mexicans, such as through Medicaid or a “Basic Health Program”, and through the Children’s Health Insurance Program.

Medicaid Option: available January 1, 2014. Requires state plan amendment by HSD.

Basic Health Plan Option: available January 1, 2014. Requires state legislation.

CHIP Option: available now. Requires state plan amendment by HSD.

With reform, many people who are not covered by Medicaid or through their employers will become eligible for subsidies in the form of tax credits to help them purchase insurance through an Exchange in 2014. However, even under the most optimistic estimates, ***it is very likely that tens of thousands of low-income New Mexicans will remain uninsured for at least some periods of time after PPACA is fully implemented***, including:

- Individuals who do not have affordable coverage options and are therefore exempt from the tax consequences of not purchasing insurance;⁶⁵
- Native Americans who may remain without coverage because they are exempt from the tax consequences of not purchasing insurance.⁶⁶
- Individuals who cannot afford the premium on any given month and are left with unstable coverage. Even with premium subsidies, low-income New Mexicans will still be required to pay anywhere from 3 percent to over 6 percent of their income on insurance premiums.
- Other individuals determined to have “hardships” (to be defined by the HHS Secretary).⁶⁷

States have options that will be subsidized by the federal government to ensure that individuals who cannot or do not purchase insurance on an Exchange can receive healthcare. ***New Mexico has a long-standing commitment to strengthening access to health care for low income New Mexicans, and should assure coverage for individuals between 133 and 200 percent the poverty level.*** The options that should be considered include:

1. Medicaid coverage for adults between 133 and 200 percent FPL: Starting on January 1, 2014, states can provide Medicaid coverage to non-elderly adults between 133 and 200 percent FPL.⁶⁸ Parents can only be enrolled in this category if their children are on Medicaid or have other health insurance.⁶⁹ The state could choose to phase in the coverage by offering it to a smaller subset of the low-income population rather than to everyone up to 200 percent FPL. The state would receive the regular federal matching rate in effect at the time for Medicaid.

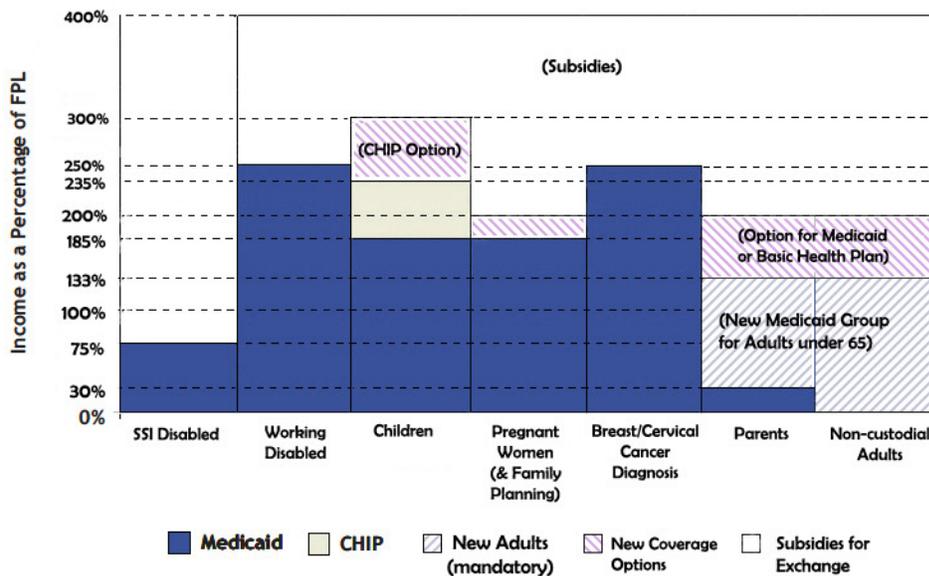
2. “Basic Health Program” for adults between 133 and 200 percent FPL: States may alternatively create a Basic Health Program for uninsured people with incomes between 133 and 200 percent FPL and who are not eligible for Medicaid.⁷⁰ If the state chooses to do this, low-income people would not receive subsidies from the federal government to help them purchase insurance on an Exchange. Instead, the state would contract with one or more health plans to provide the coverage. The state would receive 95 percent of the federal subsidies that would have been paid directly to the individuals.⁷¹ ***Thus, a Basic Health Program could potentially be offered to low-income people at no cost to the state.*** While individuals who would become eligible for the Basic Health Plan would no longer be eligible for the subsidies, they would continue to have a choice of plans because

the Basic Health Program must be structured to the extent possible to offer multiple standard health plans.⁷²

3. CHIP Coverage for Children between 235 to 300 percent FPL: New Mexico currently covers children in Medicaid and the Children’s Health Insurance Program (CHIP) who live in households up to 235 percent FPL. The reform law protects this coverage until October 1, 2019. New Mexico has options to ensure greater coverage by:

- Allowing state employees to enroll their children in CHIP if income-eligible and the employee’s premiums and cost sharing contributions exceed 5 percent of the family’s income.⁷³
- Expanding CHIP coverage of children to 300 percent FPL at any time. The state could do this at no cost starting on October 1, 2015, when CHIP will be financed 100 percent by the federal government (the current federal match is 80 percent).⁷⁴

GRAPH 2: Options for Improving Coverage in New Mexico in 2014.⁷⁵



Providing better coverage for low-income New Mexicans would:

- Ensure that individuals who either cannot or do not purchase insurance on the Exchange, or who are not subject to the individual mandate can still receive adequate healthcare;
- Potentially encourage private insurance companies to lower premium costs;
- Provide seamless coverage for individuals who transition between income levels or jobs if the new plan’s eligibility and benefits system is structured in alignment with Medicaid;
- Receive 100 percent federal financing starting on October 1, 2015 for covering children through the Children’s Health Insurance Program (CHIP).

New Mexico should further evaluate these options as federal guidance is issued to clarify the details. The state should consider factors such as the ability of a state coverage plan to meet the needs of low-income populations, reduce private insurance costs, provide stable coverage, and ensure coverage for people who transition between jobs and income levels.

RECOMMENDATION #8: Simplify enrollment procedures by implementing:

- Express lane to automatically enroll children in Medicaid and CHIP
- Presumptive eligibility options for more populations.

Available now and in 2014 depending on the option.

Action required by HSD to submit state plan amendments.

Healthcare reform expands the options for states to simplify enrollment for Medicaid and CHIP, helping to ensure that people who are eligible for Medicaid are able to obtain coverage right away. New Mexico should strive to implement the following in the upcoming years:

1. Express Lane Enrollment for Children: New Mexico may enroll children in Medicaid and CHIP using “express lane” determinations (as described under the CHIP Reauthorization Act in 2009). The Human Services Department may enter into agreements with public agencies that offer income-based programs to use the information that those agencies have collected about children (such as income or other criteria) to enroll eligible children in Medicaid and CHIP upon parental consent.⁷⁶

New Mexico has new opportunities under health reform to improve enrollment for Native American children through express lane. PPACA adds Indian Health Services, Indian Tribes, Tribal Organizations, or Urban Indian Organizations to the list of “express lane” agencies whose findings can be accurately relied upon to automatically enroll children in Medicaid and CHIP.⁷⁷

Unfortunately, New Mexico has not implemented express lane enrollment for most children statewide, even as opportunities continue to arise that would facilitate the enrollment process.

For example, Medicaid requires more documentation than other income-based programs for applicants to prove citizenship. However, the CHIP Reauthorization Act of 2009 gave states the option to develop a system that would simply match an applicant’s name and birth date against the database with the Social Security Administration (SSA) to verify citizenship, rather than require families to submit paper documentation. This policy would make express lane enrollment easier, reduce administrative burdens, and allow the state to still make accurate eligibility decisions.

2. Presumptive Eligibility for More Populations: Presumptive eligibility allows for people who are eligible for Medicaid coverage to receive medical care right away. Certified healthcare providers and facilities that have been qualified by the state can make preliminary decisions that a person appears to be eligible for Medicaid or CHIP based solely on their declaration of income. The applicant is enrolled in Medicaid for a short term that lasts through the month of the determination and the following month. To continue receiving coverage beyond this time, the person must complete a full application with the Income Support Division office.

Before healthcare reform was enacted, federal law only allowed for presumptive eligibility decisions to be made for children, pregnant women, and uninsured women who have been diagnosed with breast or cervical cancer. New Mexico implemented all of these options. However, effective immediately, the state may also make presumptive eligibility decisions for family planning services and for low-income families.⁷⁸ In 2014, the option expands to newly eligible groups. Hospitals will also be allowed to get certified by the state to make decisions for any Medicaid-eligible patient.⁷⁹

RECOMMENDATION #9: Ensure that there is meaningful consultation with stakeholders in decision-making for the Medicaid program. This includes tribal governments, healthcare providers, and constituency groups. Provide information to the public for discussion and to comply with transparency requirements in the reform law.

A key to the successful implementation of healthcare reform is involving stakeholders in the decision-making process. We recommend that:

- **The state’s legislative and executive leadership teams on healthcare reform implementation should include consumer representation.** Although both teams are taking public comments and input from advisory groups, we recommend including at least two consumer representatives on each team to contribute to the decision-making process.
- **By law, the state must consult with tribal governments, Indian Health Services (I.H.S.), Tribal Organizations and Urban Indian programs about Medicaid and CHIP prior to submitting changes to CMS.** States are required to seek ongoing consultation with Indian Health Programs and Urban Indian Programs before submitting state plan amendments, proposed demonstrations, or waiver proposals to CMS for Medicaid or CHIP.⁸⁰ The Indian Health Care Improvement Act, reauthorized under PPACA, also emphasizes consultation with tribes on healthcare issues and the government to government relationships with tribes.⁸¹
- **The Human Services Department (HSD) should continue to meet with advisory groups to evaluate its proposals for the Medicaid program,** including healthcare providers and advocacy groups that represent low-income consumers, children, women, people with disabilities, the elderly, and the Urban Indian population.
- **HSD should provide regular updates to the public and hold listening sessions before adopting new proposals.** The Department recently started posting its proposals and documents online. It also regularly provides updates at the Medicaid Advisory Council meetings. However, the Department should also encourage public input by holding listening sessions and distributing its proposals in advance to consumers.
- **HSD should provide the data necessary for evaluating the costs and benefits of proposals to change the Medicaid program.** In order to solicit meaningful input and make well-supported decisions, the Department should provide information that is necessary and requested by the advisory groups, the public, and the legislature.
- **HSD must abide by all rulemaking procedures when making changes to the Medicaid, CHIP, and waiver programs.** The state must provide adequate notice and comment periods for the public. In addition, PPACA clarifies that states making changes to Section 1115 demonstration programs, such as New Mexico’s State Coverage Insurance (SCI) program, must abide by rule-making procedures, and directs the Secretary of HHS to issue regulations within 180 days of the enactment of the health reform bill to establish a process for public notice and comment.⁸²

CITATIONS

- ¹ Kaiser Family Foundation, State Health Facts: Health Coverage and Uninsured in New Mexico (2008), www.statehealthfacts.org.
- ² *Health Coverage in New Mexico: How Will Health Reform Help?*, Families USA 2(2010).
- ³ See 42 U.S.C. § 1396a(e)(14)(I).
- ⁴ See 42 U.S.C. § 1396a(a)(10)(A)(i)(IX), codifying Patient Protection and Affordable Care Act (“PPACA”) § 2004.
- ⁵ See 42 U.S.C. § 1396d(y)(1).
- ⁶ *Id.*
- ⁷ Holahan and Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Kaiser Commission on Medicaid and the Uninsured 2 (2010).
- ⁸ *Id.* at p. 10-11.
- ⁹ *Id.* at p. 42 (estimating the increase in state spending for 2014 to 2019 over what the state would have spent in the absence of health reform. The average increase in state spending for all states is 1.4%). See also Angeles and Broaddus, Center on Budget and Policy Priorities, *Federal Government Will Pick Up Nearly All Costs of Health Reform’s Medicaid Expansion*, June 18, 2010, p. 4 (estimating that state spending will rise on average by 1.25% in years 2014 to 2019).
- ¹⁰ *Medicaid Coverage and spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Kaiser Commission on Medicaid and the Uninsured 10 (2010).
- ¹¹ Wilper, et al., *Health Insurance and Mortality in U.S. Adults*, 99 American Journal of Public Health 12, (2009) (study by Harvard Medical School and Cambridge Health Alliance that estimates 44,789 deaths are caused annually by lack of health insurance).
- ¹² Calculated by multiplying the number deaths caused nationally due to the lack of health insurance by New Mexico’s proportion of the national population (.0067%).
- ¹³ Calculations by New Mexico Voices for Children using IMPLAN software. The economic multiplier is 1.667, using base figures from Kaiser Commission on Medicaid and the Uninsured, *Medicaid Coverage and spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, May 2010.
- ¹⁴ UNM Health Sciences Center, *Report 3: Patient Revenue by Funding Source*, November 19, 2009 (data for FY2009).
- ¹⁵ Furnas & Harbage, Center for American Progress Action Fund, *The Cost Shift from the Uninsured*, March 24, 2009.
- ¹⁶ HealthReform.gov (the White House), *Health Insurance Reform and New Mexico*, May 6, 2010.
- ¹⁷ New Mexico Health Policy Commission, *2009 County Financing of Health Care Report*, February 2010, pg. 8.
- ¹⁸ Assuming a 72% Federal Matching Assistance Percentage (FMAP) rate, for every dollar the state spends, it receives 2.57 times the amount in federal funds.
- ¹⁹ 42 U.S.C. § 1396a(gg)(1) and (2), codifying PPACA § 2001(b)(2)(“a State shall not have in effect eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the Patient Protection and Affordable Care Act”)
- ²⁰ Centers for Medicare and Medicaid Services (CMS), *Dear State Medicaid Director Letter, SMD#09-005, ARRA #5*, Aug. 19, 2009, p. 4 and 5.
- ²¹ See 42 U.S.C. § 1396a(gg)(1), codifying PPACA § 2001(b)(2).
- ²² See 42 U.S.C. § 1396a(gg)(3), codifying PPACA § 2001(b)(2).
- ²³ UNM Bureau of Business and Economic Research, *Presentation to Legislative Health and Human Services Committee*, by Dr. Lee Reynis, Director Applied Research Center, September 16, 2009 (as revised and submitted on September 17, 2009). Note that this estimate assumes the current 80% enhanced federal match, which will be reduced to 72% by SFY 2012.
- ²⁴ UNM Health Sciences Center, *Report 3: Patient Revenue by Funding Source*, November 19, 2009 (data for FY2009).
- ²⁵ See 25 U.S.C. § 1602.
- ²⁶ Kaiser Family Foundation, *Medicaid Benefits: Online Database*, available at: www.medicaidbenefits.kff.org (last accessed on July 7, 2010).

-
- ²⁷ See Letter from Center for Medicaid and State Operations to State Health Director, Dear State Health Director Official, Re: Dental Coverage in CHIP, SHO #09-012, CHIPRA #7, October 7, 2009, p. 1 (“States that provide title XXI coverage to children through a Medicaid expansion program are required to provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, as defined in Section 1905(r) of the Act.”)
- ²⁸ See 42 U.S.C. §1396u-7(b) (describing benchmark packages to be those that are the same or equivalent in actuarial value to either the state employee plan, federal employee plan, or the HMO plan provided to the largest number of people statewide.)
- ²⁹ See Matthew Broaddus, Center on Budget and Policy Priorities, *Childless Adults Who Become Eligible for Medicaid In 2014 Should Receive Standard Benefits Package*, July 6, 2010.
- ³⁰ 42 U.S.C. §1396u-7(a)(2)(B), codifying Section 1397(a)(2) of Social Security Act. See also 42 C.F.R. § 440.315,
- ³¹ See 42 U.S.C. §1396u-7(b)(5), codifying PPACA § 1302(b).
- ³² See 42 U.S.C. §18022(b)(2), referred by 42 U.S.C. § 1396u-7(b)(5), codifying PPACA § 1302(b).
- ³³ See 42 U.S.C. §18022(b)(4), referred by 42 U.S.C. § 1396u-7(b)(5), codifying PPACA § 1302(b).
- ³⁴ See 42 U.S.C. §1396d(dd), referencing 42 U.S.C. § 1396a(a)(13)(C).
- ³⁵ See New Mexico Human Services Department website on health reform funding opportunities, available at: <http://www.hsd.state.nm.us/nhcr/nhclao.htm>.
- ³⁶ PPACA Section 4108, also cited as P.L. 111-148, Title IV, Subtitle B, § 4108, 124 Stat. 561 (March 23, 2010).
- ³⁷ *Id.*
- ³⁸ 42 U.S.C. § 1396w-4(h)(3) and (4).
- ³⁹ 42 U.S.C. § 1396w-4(c)(3).
- ⁴⁰ 42 U.S.C. § 1396w-4(c)(1).
- ⁴¹ See 42 U.S.C. § 1396n(k), codifying PPACA § 2401.
- ⁴² See 42 U.S.C. § 1396n(k)(1)(A).
- ⁴³ PPACA § 2706(c), also cited as P.L. 111-148, Title II, Subtitle I, § 2706, 124 Stat. 325 (March 23, 2010).
- ⁴⁴ PPACA § 2706(d).
- ⁴⁵ PPACA § 2706(c)(3).
- ⁴⁶ PPACA § 2704, also cited as P.L. 111-148, Title II, Subtitle I, § 2704, 124 Stat. 323 (March 23, 2010).
- ⁴⁷ PPACA § 4106 (prospective amendment that will be codified at 42 U.S.C. § 1396d(b), effective January 1, 2013).
- ⁴⁸ PPACA § 4106 (prospective amendment that will be codified at 42 U.S.C. § 1396d(a)(13)(A), effective January 1, 2013).
- ⁴⁹ Data collected by the New Mexico Center on Law and Poverty in 2009.
- ⁵⁰ Report to the Legislative Finance Committee, *Department of Human Services Program Evaluation: Medicaid Managed Care (Physical Health)*, January 14, 2009, p. 2.
- ⁵¹ See N.M. Stat. Ann. § 27-2-12.15.
- ⁵² See Report to the Legislative Finance Committee, *Department of Human Services Program Evaluation: Medicaid Managed Care (Physical Health)*, January 14, 2009, p. 23-24.
- ⁵³ See 42 U.S.C. § 1396w-3(a) and (b), codifying PPACA Section 2201(a) and (b).
- ⁵⁴ See 42 U.S.C. § 18083(c), codifying PPACA §1413(c).
- ⁵⁵ See 42 U.S.C. § 18081(b) and (c), codifying PPACA Section 1411(a)(4).
- ⁵⁶ See 42 U.S.C. § 18081(e)(4) and (f), codifying PPACA §1411(e) and (f).
- ⁵⁷ 42 U.S.C. § 1396a(a)(75), codifying PPACA §2001(d)(1).
- ⁵⁸ Civil Rights Division, Department of Justice, *Accessibility of State and Government Websites to People with Disabilities* (2010), available at: <http://www.ada.gov/websites2.htm> (last accessed on June 29, 2010).
- ⁵⁹ 42 U.S.C. § 18081(g), codifying PPACA §1411(g).
- ⁶⁰ Applicants for the “JUL Medicaid” for low-income families must meet the income test for TANF. While the gross income test is less than 85% FPL, applicants must also meet the TANF “standard of need” which requires incomes of less than 30% for parents without any earned income, and potentially up to 69% for working parents.
- ⁶¹ See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), codifying PPACA § 2001(a)(1).
- ⁶² Chart adapted by the New Mexico Center on Law and Poverty from the Lewin Group, with permission.

⁶³ See 42 U.S.C. § 1396a(k)(2), codifying PPACA § 2001(a)(4). *See also*, Letter from CMS to State Medicaid Directors, Dear State Medicaid Director Letter, Re: New Option for Coverage of Individuals under Medicaid, SMDL#10-005, PPACA #1, page 2, April 9, 2010.

⁶⁴ Letter from CMS to State Medicaid Directors, Dear State Medicaid Director Letter, Re: New Option for Coverage of Individuals under Medicaid, SMDL#10-005, PPACA #1, 2, April 9, 2010 (“Taking up the optional early expansion does not preclude or in any way affect receipt of the increased matching rate (based on the requirements in effect when this group becomes mandatory in 2014).”)

⁶⁵ See 26 U.S.C. § 5000A(e)(1), codifying PPACA § 1501(b).

⁶⁶ See 26 U.S.C. § 5000a(e)(3).

⁶⁷ See 26 U.S.C. § 5000a(e)(5) and 26 U.S.C. § 1311(d)(4)(H).

⁶⁸ See 42 U.S.C. § 1396a(a)(10)(A)(ii)(XX), codifying PPACA § 2001(e).

⁶⁹ See 42 U.S.C. § 1396a(hh)(2), codifying PPACA § 2001(e).

⁷⁰ 42 U.S.C. § 18051, codifying PPACA § 1331.

⁷¹ See 42 U.S.C. § 18051(d)(3).

⁷² See 42 U.S.C. § 18051(c)(3).

⁷³ See 42 U.S.C. § 1397jj(b)(6)(c).

⁷⁴ 42 U.S.C. § 1397ee(b), codifying PPACA § 2101(a).

⁷⁵ Chart adapted by the New Mexico Center on Law and Poverty from the Lewin group, with permission.

⁷⁶ See 42 U.S.C. § 1396a(e)(13)(describing express lane enrollment for children in Medicaid).

⁷⁷ 42 U.S.C. § 1396a(e)(13)(F)(ii)(IV), codifying PPACA § 2901.

⁷⁸ See 42 USC § 1396r-1c(a), codifying PPACA § 2303(b) (family planning services). *See also* 42 U.S.C. § 1396r-1(e), referring 42 U.S.C. § 1396u-1 (allowing presumptive eligibility for low income families if the state provides presumptive eligibility for pregnant women or children).

⁷⁹ See 42 U.S.C. § 1396r-1(e), codifying PPACA § 2001(a)(4)(B) (newly eligible groups). *See* 42 U.S.C. § 1396a(a)(47)(B), codifying PPACA § 2202(a) (hospitals may make presumptive eligibility determinations if certified by the State).

⁸⁰ See 42 U.S.C. § 1396a(a)(73)(state must have process to seek ongoing advice from Indian Health Programs and Urban Indian Organizations on Medicaid state plan amendments, waiver requests, or proposals for demonstration projects that are “likely to have a direct effect on Indians, Indian Health Programs, or Urban Indian Organizations) and 42 U.S.C. § 1397gg(1)(requiring the same consultation for CHIP as is required for Medicaid), codifying American Recovery and Reinvestment Act § 5006(e).

⁸¹ 25 U.S.C. § 1602 (requiring all actions under the Indian Health Care Improvement Act be carried out with meaningful consultation with Indian tribes and tribal organizations, and in conference with urban Indian organizations, and emphasizing the government to government relationship of the United States and Indian tribes).

⁸² 42 U.S.C. § 1315(d), codifying PPACA § 10201(i).

Appendix C

SJM1 Health Care Reform Task Force
Long-Term Services Advisory Group
Summary of Presentation and Recommendations

Background

Long-term services and supports (LTS) are services and items needed for a prolonged period of time to assist people with disabilities, including frail elders, with activities of daily living (ADLs). It is estimated that 14% of all New Mexicans currently need assistance with one or more ADLs, including 10% of those under age 65. The need for LTS will continue to increase as the population ages and the number of persons living with a disability grows. By 2030, New Mexico is projected to have the fourth-highest percentage in the U.S. of residents over age 65.

Most LTS are provided on an unpaid basis by family and friends, a situation that imposes a huge toll on caregivers in stress and lost income. Medicaid pays for the largest share of paid services; out-of-pocket payments by individuals with LTS needs and their families account for another significant percentage. Although it covers a population that is largely elderly or disabled, Medicare pays for very little long-term care. Private health insurance provides minimal coverage for LTS, and commercial long-term care insurance, for a variety of reasons, covers very few people and often provides quite limited coverage.

The new health care reform law, (the Patient Protection and Affordable Care Act, or ACA) makes commercial insurance more responsive to the needs of persons with disabilities, through measures including guaranteed issue; bans on pre-existing condition exclusions, annual or lifetime benefit caps, and rescissions; limits on out-of-pocket expenses; and establishment of a minimum benefits package that includes coverage for mental health and habilitation services. However, private health insurance still will not be a major source of LTS coverage.

Long-term care insurance

To help address the need for affordable LTS insurance that provides coverage for home- and community-based services (HCBS), the ACA creates **CLASS (Community Living Assistance Services & Supports)**, a new national long-term care insurance program which will be federally administered but not taxpayer-funded, as it is required by law to be self-supporting without federal subsidy. Enrollment will be available to working people through employers or through alternative enrollment mechanisms for people who are self-employed or whose employers choose not to participate. Participation will be voluntary but employees will be enrolled automatically unless they choose not to participate.

An individual will become eligible for CLASS benefits after paying premiums for five years; the person must have been working for at least three of those years. Enrollment is scheduled to begin in January 2011. Eligible individuals will receive an average cash benefit of \$75/day to pay for long-term supports. Benefits may be used to pay for institutional care if the recipient so chooses, but the emphasis of the CLASS program is on self-directed supports provided in home- and community-based settings.

CLASS will play a significant role in addressing the increasing LTS needs of an aging population at no cost to the state and will reduce state expenditures. The new insurance will decrease reliance on Medicaid for LTS because participants will have access to an alternative payment source. Also, if a person receiving CLASS benefits also is covered by Medicaid, a portion of the CLASS payments will go to the state to help cover Medicaid costs.

The ACA requires the state to assess whether there are enough fiscal agents to assist CLASS beneficiaries with employment-related tasks and to create new fiscal agents if needed. This is to be done by March 2012. In addition, by 2016 when CLASS benefits will begin to be paid after the initial five-year vesting period, state Medicaid systems must link with federal government systems to identify individuals who are receiving both CLASS and Medicaid benefits and arrange for transfer of CLASS benefit payments to the state Medicaid program.

Recommendations relating to CLASS

State agencies should promote participation in CLASS by:

- ***providing information to the public about CLASS,***
- ***encouraging individuals to participate, and***
- ***encouraging employers to participate and making this as easy as possible.***

Medicaid

Medicaid is the largest funding source for LTS but operates with an “institutional bias” under which institutional care such as nursing homes is an entitlement but access to HCBS is more limited. The ACA takes steps to address this bias through provisions that make it easier for states to offer HCBS in their Medicaid programs.

■ **Community First Choice** – The ACA creates a new option to include attendant care and other services for individuals needing a nursing home level of care as part of the Medicaid state plan. This makes these services available to all who qualify rather than only through a limited number of waiver slots. The state can choose to set the income eligibility level at 150% or 225% of the federal poverty level (FPL), which would expand access compared to the current personal care option (PCO) program that is generally available only to people below 75% FPL. CFC services would carry an enhanced federal match rate, so that replacing the current PCO with CFC would allow New Mexico to expand the number of people receiving services without increasing expenditures. Effective October 2011.

■ **HCBS as state plan benefits (§1915i)** – The ACA improves an option in existing federal law that allows states to offer HCBS currently available only through waivers as part of the regular Medicaid program. In order to take advantage of this option, the state must set a more stringent level of care standard for receiving facility-based care than for HCBS. This option became available to states in April 2010.

■ **Money Follows the Person** – Federal MFP grants provide incentives to move individuals and funding from facility-based care to HCBS; the incentive is in the form of a greatly enhanced federal match rate for Medicaid services to these individuals. The ACA extends the federal MFP grant program for another five years and makes additional funding available for grants to states like New Mexico that chose not to participate in the earlier round of grants.

Other Medicaid provisions of the ACA relating to persons with disabilities and LTS include:

■ **Medical homes** – The ACA provides enhanced federal funding for states to implement medical homes for individuals who have or are at risk for a chronic physical or mental health condition. Medical home services include care coordination, health promotion, and referral to community services, among others. Planning grants are available to help states develop state

plan amendments to implement medical homes. Medical homes are expected to improve care while reducing costs for these high-needs populations.

■ **Maintenance of effort** – The state may not implement eligibility changes that make it harder to qualify for Medicaid. This means the state cannot reduce the number of waiver slots, set higher level of care criteria, or change cost neutrality calculations from an aggregate to an individual basis.

■ **Protections against spousal impoverishment** – The ACA requires that these protections apply to the spouses of all individuals receiving Medicaid LTS, whether through state plan HCBS, waivers, or facility-based care. New Mexico already extends such protections to waiver recipients and now must apply them also to spouses of state plan service recipients

■ The ACA creates a Rebalancing Initiatives Program to encourage states to undertake structural reforms designed to shift Medicaid expenditures from institutional care to HCBS. However, because the enhanced federal funding is available only to states that currently spend less than 50% of their Medicaid long-term services funds on HCBS rather than institutional care, New Mexico does not qualify for this program

Medicaid recommendations

- ***Adopt and implement Community First Choice when available in October 2011.***
- ***Convene a stakeholder group to review the §1915i option to provide HCBS as state plan benefits and develop a plan to implement the broadest program that is deemed to be affordable.***
- ***Apply for a federal MFP grant and implement MFP as required by New Mexico law.***
- ***Seek a medical home planning grant and amend the state plan to implement a medical home program for individuals with chronic conditions.***

Medicare

The ACA makes a number of changes relating to long-term services in Medicare. These include demonstration programs to coordinate care for high-needs populations, improvements to prescription drug coverage, and a variety of nursing home reforms. No action is required on the part of the state.

Other ACA provisions affecting long-term services

The ACA provides grants to improve aging and disability resource center operations and for caregiver training and certification. In addition, the Act makes amendments to the Elder Justice Act to strengthen adult protective services and LTS ombudsman programs.

.....

Presenters: Jim Jackson, Executive Director, Disability Rights New Mexico
Ellen Pinnes, Health Policy Consultant
Lisa Schatz Vance, Executive Director, Senior Citizens Law Office

Appendix D

**Consumer Protection and Education in Federal Health Care Reform Implementation:
September 2, 2010**

For more information, contact Jane Wishner, Executive Director, Southwest Women's Law Center
jwishner@swwomenslaw.org

**Consumer Protection and Education in Health Care Reform
Implementation in New Mexico**

Recommendations to the Senate Joint Memorial 1 Work Group and the Governor's Health Care
Reform Leadership Team
September 2, 2010

The following recommendations were prepared by an ad hoc working group that met to address consumer issues in health care reform (HCR) implementation in New Mexico for the Senate Joint Memorial 1 Work Group and Governor Richardson's Health Care Reform Leadership Team. The ad hoc consumer advisory group met regularly over the summer and included representatives from the following agencies:

Insurance Division, Public Regulation Commission
Consumer Protection Division, Office of the New Mexico Attorney General
Health Action New Mexico
New Mexico Legal Aid
Senior Citizens Law Office
Southwest Women's Law Center

EARLIER RECOMMENDATIONS ADDRESSED THROUGH THE STATE'S STRATEGIC PLAN

In June, this working group submitted recommendations to the Governor's executive leadership team. We would like to publicly thank Human Services Department Secretary Katie Falls, Ruby Ann Esquibel and the Leadership Team for integrating consumer protection and education strategies into the State's strategic plan and for helping to facilitate communication between state agencies and consumer advocates. The Strategic Plan includes a recommendation that the New Mexico Office of Health Care Reform develop and oversee a coordinated plan to address consumer education and protection and adopted specific recommendations made by this working group:

6. Develop a comprehensive and cost-effective consumer protection and education plan that (1) promotes widespread consumer education as components of PPACA are rolled out, (2) creates an independent consumer protection system with procedures and resources available for every county and tribal community, and (3) obtains funding through the PPACA to coordinate and advance consumer protection and education throughout New Mexico.

Implementing Federal Health Care Reform – A Road map for New Mexico, Strategic Plan at 7 (July 12, 2010)(<http://www.hsd/state.nm.us/nhcr/nhcriao.htm>). See also Strategic Plan at 42-44. This report builds on that commitment.

SUMMARY OF KEY RECOMMENDATIONS

1. The New Mexico Office of Health Care Reform should establish a ***State Consumer Coordinating Committee*** consisting of consumer advocates and staff members from key agencies who will be responsible for coordinating statewide consumer education and protection efforts. (See pages 42-44 of NM Strategic Plan)
2. The State should incorporate consumer education and consumer protection planning into each

Consumer Protection and Education in Federal Health Care Reform Implementation: September 2, 2010

element of health care reform implementation.

3. Consumer education planning should address the complexity of an outreach program that will help ensure the estimated 300,000 New Mexicans who are currently uninsured will receive the maximum benefits available to them under health care reform.
4. State entities that address consumer protection in the health care and health insurance context should plan and coordinate their consumer protection, appeal and ombudsman programs.
5. The Legislature should provide funding for consumer education and protection programs to ensure accountability and effective implementation of federal health care reform.
6. New Mexico should establish an independent Consumer Health Assistance Program (CHAP) for consumer education and assistance that utilizes community-based agencies, community health workers, health care and social service providers, and advocates.
7. Transparency is essential to an effective consumer protection system and therefore the public should have access to key data from state agencies overseeing different health programs, and state agencies should provide this information in accessible, consumer-friendly formats.

THE LEGISLATURE AND EXECUTIVE BRANCH SHOULD ADDRESS CONSUMER EDUCATION AND PROTECTION ISSUES EARLY IN THE IMPLEMENTATION PROCESS

The Patient Protection and Affordable Care Act and the related Healthcare and Education Affordability Reconciliation Act (“PPACA”) will reform the health care system, public health programs, and the private health insurance market throughout New Mexico. Some provisions have the potential for improving public health outcomes in communities that are pro-active and are able to develop collaborative partnerships to take advantage of some of the competitive grant and funding programs authorized by the Act.

Consumer education and protection are critical to ensure that New Mexicans obtain the maximum benefits and protections created by PPACA. Consumer education and protection are not addressed solely in a single section or set of provisions within the Act; rather they permeate almost every aspect of the new law, including those addressing Medicaid expansion, Medicare provisions, the new insurance exchanges, the new protections applicable to employer-sponsored health insurance, and the significant funding opportunities for workforce development, community health centers and specific projects that could be available to communities throughout New Mexico.

New Mexico needs a coordinated plan to address consumer education and protection to:

- ensure that the new benefits and protections created by PPACA are implemented efficiently and in a timely manner;
- create a system of accountability for government agencies and private insurance companies that are primarily responsible for implementation and operation of the new systems created by the Act;
- minimize the significant confusion among consumers, health care providers, insurers and employers as different provisions of the law go into effect, beginning in 2010;
- create opportunities for New Mexicans to obtain the maximum protections available under the Act;
- protect New Mexicans from fraudulent practices and scam artists who are already preying on the elderly and other vulnerable consumers under the guise of health care reform;
- ensure that members of tribal communities – both on and off tribal land – receive accurate information about unique choices and opportunities available under the Act;

Consumer Protection and Education in Federal Health Care Reform Implementation: September 2, 2010

- ensure that New Mexicans with limited English proficiency are included in the Act's implementation and obtain comprehensive information and assistance to navigate the new system;
- ensure that technological requirements in the Act and technology and information systems created to implement the Act do not create barriers to New Mexicans who lack access to the internet; and
- ensure that implementation in New Mexico includes alternative (non-internet based) mechanisms for consumers/patients to obtain essential information, sign up for Medicaid and/or obtain subsidies for purchase of private insurance.

CONSUMER EDUCATION AND CONSUMER PROTECTION: RELATED BUT DISTINCT ISSUES AND CHALLENGES

To best serve the needs and interests of consumers/patients in New Mexico, consumer education and consumer protection strategies are necessary. But they are not the same thing. Consumer health assistance bridges both consumer education and consumer protection.

Numerous organizations, public, private and nonprofit, will engage in **consumer education** efforts around PPACA, most likely focusing on specific issues that affect those organizations or about which that organization has expert knowledge and information. There will also be misinformation, confusion, and potentially even fraud. Developing mechanisms for wide dissemination of accurate materials, targeting populations with particular needs or interests impacted by the new law, and sharing summaries and fact sheets prepared by national and local agencies are all among the strategies that should be explored.

Consumer protection refers to the specific systems established to enable consumers who are denied coverage, insurance, reimbursement or who are improperly charged for services to challenge such decisions and have some mechanism for redress of their grievances. There are two elements to an effective consumer protection system: (i) the system for considering and resolving consumer grievances and complaints; and (ii) an effective consumer assistance program independent of the agency that will resolve the complaints. A viable consumer protection system needs to address both the system for considering consumer complaints/appeals/inquiries as well as a system of information, education and representation that will inform consumers of their rights to bring a complaint or appeal and to know when they may have been denied access to services or coverage to which they are entitled. An effective **consumer protection** system requires sufficient **consumer education** regarding consumers' rights and responsibilities under the PPACA.

A **Consumer Health Assistance Program (CHAP)** addresses both areas by helping consumers navigate and access health coverage as well as pursue complaints when benefits are denied. Federal funding will be made available to support **consumer navigator** systems. This is a critical element of consumer health assistance. CHAPs can help families and communities perplexed by or unaware of the benefits provided to them under health care reform. They can also provide assistance and support if a consumer is denied coverage or benefits and wants to challenge such a decision. CHAPs can:

- help consumers enroll in Medicaid or with an appropriate insurance plan;
- educate health care consumers about how to use their health insurance to get the care they need;
- inform consumers of their rights;
- provide tools to help consumers resolve problems with their health plans; and

Consumer Protection and Education in Federal Health Care Reform Implementation: September 2, 2010

- provide valuable feedback to policy makers.

One particularly important aspect of CHAPs is that they are grassroots, and their strength lies in the relationships they build with a given community. Meaningful consumer health assistance in New Mexico should be coordinated but not centralized and run from the top down. One size will not fit all. People who might not otherwise seek assistance for health issues from the Division of Insurance or the Human Services Department will seek help from a community agency.

One of the core recommendations of this work group is that New Mexico develop a ***Consumer Health Assistance Program*** that takes advantage of new federal funding opportunities and builds on a network of existing community programs throughout the State so that New Mexicans will be able to access meaningful assistance and support in the communities where they live.

Thus the strategies regarding consumer education and consumer protection are related but distinct. Attorneys and those trained to handle consumer complaints, both within state agencies (such as the Attorney General's Office) and in legal services agencies (such as New Mexico Legal Aid) are particularly equipped to handle consumer protection complaints. But a much wider array of individuals and organizations can provide invaluable help in: educating consumers about PPACA generally and specific benefits that apply to them; assisting consumers in navigating their choices and helping them sign up for coverage; and informing consumers about their rights and the consumer protection procedures available in the State.

RECOMMENDATIONS

1. **The New Mexico Office of Health Care Reform should establish a *State Consumer Coordinating Committee* consisting of consumer advocates, and staff members from key agencies who will be responsible for coordinating statewide consumer education and protection efforts. (See pages 42-44 of NM Strategic Plan)**
 - a. Without significant additional resources, no single state agency can develop the knowledge and expertise to effectively oversee and ensure consumer education to the myriad populations, communities and health systems impacted by HCR. Some new programs and benefits have already been implemented under HCR; many others will go into effect for new health plans created after September 23, 2010. A collaborative system utilizing the expertise of diverse agencies, consumer advocates and professionals can devise the best methods for informing New Mexicans of the new benefits and programs of HCR. Informal, ad hoc communication and networking – and the use of the internet – can help promote education and outreach with the use of limited resources in the short-term as longer-term plans are being developed. We recommend that the following agencies, at a minimum, be included in a Consumer Coordinating Committee: the Division of Insurance of the Public Regulation Commission (DOI), the Consumer Protection Division of the Office of the NM Attorney General (NMAG), the Human Services Department (HSD), the Department of Health (DOH), the Children Youth and Families Department (CYFD), the Department of Indian Affairs, and the Aging and Long-Term Services Department (ALTSD).
 - b. The NM Office of Health Care Reform should develop a listserv of interested individuals and agencies who are consumer advocates in NM and communicate with them about planning and specific educational efforts related to consumer education and protection.
 - c. Consumer representatives on the Coordinating Committee should include racially and ethnically diverse communities and advocates including but not limited to anti-poverty, legal

**Consumer Protection and Education in Federal Health Care Reform Implementation:
September 2, 2010**

services, aging, women's, immigrant, tribal, disability rights, and other organizations with experience working in communities of uninsured New Mexicans. The Southwest Women's Law Center and the Senior Citizens Law Office have prepared sample materials with information particularly relevant to the communities they serve. These sample materials are attached to this report as examples of the kinds of resources that can be developed by non-governmental entities and widely disseminated by the State.

- d. The Coordinating Committee should hold regular public meetings and convene ad hoc working groups on specific issues as implementation deadlines approach to maximize consumer education and protections under HCR.

2. The State should incorporate consumer education and consumer protection planning into each element of health care reform implementation.

- a. While the overall plan and specific elements of consumer education and protection need to be developed in a coherent and coordinated way, the State should not address consumer education and protection issues in isolation; rather it should integrate them into other major planning and implementation efforts.
- b. Planning and implementation grants from the federal government should include input and in-person meetings with consumer advocates. This may take a form similar to that of the Division of Insurance's Rate Review Grant.
- c. Consumer education and protection are core elements of the Insurance Exchanges authorized by PPACA, and New Mexico's planning and implementation of a State Insurance Exchange should incorporate strong consumer protection and consumer assistance provisions.
- d. The Legal Work Group of the Executive Leadership Team should seek out and incorporate input from consumer advocates regarding recommended changes in law that can strengthen consumer protections as HCR is implemented in New Mexico.

3. Consumer education planning should include the following key elements to ensure the estimated 300,000 New Mexicans who are currently uninsured will receive the maximum benefits available to them under health care reform:

- a. Identifying the numerous stakeholders who can provide information to consumers/patients, such as:
 - o Health care providers (e.g., hospitals, public health clinics, community health centers, family planning clinics, nursing homes, home health providers, pharmacies, private medical practices, oral health providers, vision providers, associations of health care providers, school-based health clinics, birthing centers, mental health centers);
 - o Health Insurance companies, brokers;
 - o Employers, chambers of commerce, and other business associations, including those that can address the needs of small business owners;
 - o Government agencies (state, federal, local), particularly agencies already working with low-income populations (e.g., ISD offices);
 - o Nonprofits that provide services and support at the community level (e.g., legal

**Consumer Protection and Education in Federal Health Care Reform Implementation:
September 2, 2010**

- services providers, counseling, youth programs, services for domestic violence and sexual assault survivors);
 - o Other consumer and community-based advocacy and service organizations;
 - o Housing agencies; and
 - o Schools.
 - b. Developing a timeline for key implementation dates and integrating community education campaigns to target those stakeholders most likely to reach the populations that will be affected at each stage of implementation – priority should be given to immediate changes going into effect in 2010 and 2011 and the most vulnerable populations who will be impacted by those changes;
 - c. Identifying the state agencies that have responsibility for different aspects of the new law and identifying the consumer/patient information relating to each and the constituencies that need to be informed about the new law, particularly with respect to Medicaid, Medicare, the new insurance exchange, and insurance regulation;
 - d. Developing State-wide strategies to implement the web-based health insurance information system required under the Act and to develop meaningful alternative means of communication to New Mexicans who do not have ready access to the internet and/or who have limited English proficiency;
 - e. Developing specific strategies and efforts to reach out to primary care providers and community health centers that currently serve indigent populations who will benefit from HCR and who will continue to need critical safety net services offered by community health clinics; and
 - f. Developing creative and diverse marketing strategies that will reach as many uninsured New Mexicans as possible and ensuring that all consumer materials include information regarding consumers’ rights along with the hotline number, street address and email address for consumers to use in seeking information and bringing complaints regarding benefits and coverage.
- 4. State entities that address consumer protection in the health care and health insurance context should plan and coordinate their consumer protection, appeal and ombudsman programs.**
- a. Whether through the Legal Work Group or a separate ad hoc group of agency experts that address consumer protection, complaints, appeals, due process and overall ombudsman programs, the State should develop recommendations on how best to coordinate such programs.
 - b. In addition to the executive branch agencies, the Division of Insurance and the Office of Attorney General should participate in this planning.
 - c. Legal services providers and other consumer advocates should be included in this planning process.
 - d. This coordination should be built into DOI’s consumer protection/ombudsman planning grant and program.

**Consumer Protection and Education in Federal Health Care Reform Implementation:
September 2, 2010**

5. **The Legislature should provide funding for consumer education and protection programs to ensure accountability and effective implementation of PPACA.**
 - a. Funding is needed to coordinate meaningful consumer education and dissemination of information to New Mexico's geographically diverse populations.
 - b. In the short run, using public websites to provide links to summaries, fact sheets and other materials available about health care reform is extremely valuable. But resources will be needed to create brochures and other written materials in different languages and for those who do not have easy access to the internet.
 - c. A commitment should be made to ensure that consumer assistance resources are not simply allocated to existing programs and used to move money around among existing programs. New Mexico needs a vibrant and meaningful consumer health assistance system to ensure New Mexicans in every part of the state realize the benefits provided under PPACA.
6. **New Mexico should establish an independent Consumer Health Assistance Program (CHAP) for consumer education and assistance that utilizes community-based agencies, community health workers, health care and social service providers, and advocates.**

As a preliminary matter, the following steps will assist in developing an effective consumer health assistance system in New Mexico:

- a. Evaluate current community resources to assist patients in signing up for and obtaining particular benefits under government-funded health programs and pursuing complaints and appeals if requests are denied.
- b. Analyze Consumer Health Assistance Programs operated in other states that provide consumer protection resources independent from the agencies that provide health care coverage and benefits.
- c. Prepare a summary of the existing consumer appeal, consumer protection, consumer ombudsman systems and procedures currently existing within various government agencies related to health programs, insurance, and other benefits, including HSD, DOH, ALTSD, CYFD, the Attorney General's Office, and the Division of Insurance.
- d. Analyze the different legal/procedural requirements needed for different agencies and benefits (e.g., entitlement programs which trigger due process protections versus other systems currently in effect) – recognize that some differences in procedures may be required by law.
- e. Evaluate the effectiveness of current systems in New Mexico to address insurance fraud and other scams that could harm New Mexicans during and after implementation.
- f. Review the timeline for implementation developed by the Executive Leadership Team to identify priority populations and communities for piloting effective consumer health assistance efforts.

Following a review of existing systems, the Consumer Coordinating Committee—in coordination with the DOI's consumer protection and rate review planning efforts and HSD's planning efforts around creation of a state insurance exchange—should:

- Make specific recommendations on how to **coordinate existing consumer protection, complaint and appeals systems within government agencies** consistent with current law while ensuring that such systems have an independent decision-maker to consider consumer complaints; and

**Consumer Protection and Education in Federal Health Care Reform Implementation:
September 2, 2010**

- Make specific recommendations on the creation and support of an ***independent non-governmental consumer health assistance program or system***, which will be a resource for local communities, legal service providers, advocates, and consumer “navigators” throughout New Mexico.

An effective consumer assistance program should:

- Provide consumer assistance for private employer-based insurance, subsidized insurance, individual plans, and public benefits programs including Medicaid and Medicare, including a guide to finding and obtaining health insurance coverage;
- Establish minimum standards for such assistance programs, including cultural and linguistic competency, experience working with vulnerable populations and capacity and training to respond to consumer concerns; and
- Provide sufficient resources to assist consumers throughout the state, including in every county and tribal community.

7. Transparency is essential to an effective consumer protection system and therefore the public should have access to key data from state agencies overseeing different health programs, and state agencies should provide this information in accessible consumer-friendly formats.

- a. Transparency is essential to help consumers make informed decisions about their own health care coverage and to enable the public to evaluate and make recommendations regarding public policies impacting availability of health care services and coverage.
- b. Many different types of data should be made public in ways that protect patient confidentiality but provide the public with information regarding insurance companies and public entities that provide health coverage, including:
 - quality assurance data;
 - benefits and pricing information;
 - multi-year data on premium increases;
 - financial statements about medical loss ratios;
 - rate review information;
 - data regarding complaints filed and how they were resolved; and
 - actuarial summaries.

PPACA requires states agencies to gather and submit much of this data to the federal government. State agencies should make all such information readily available to the public. Meaningful consumer protection cannot occur without transparency in the establishment and administration of insurance pricing.

Appendix E

TO: SJM1 Health Care Reform Working Group
FROM: SJM1 Women's Health Advisory Committee
RE: Summary Report and Recommendations
DATE: October 1, 2010

Health Care Reform promises many benefits to women through specific provisions such as mandating pregnancy care as an essential benefit but also because women are greater users of healthcare overall. More women than men live in poverty so the expansion of Medicaid and subsidies for purchasing health insurance will benefit women to a greater extent than men. The provisions in health care reform for long term care and elder care will benefit women not only because on average, they live longer than men but are frequently the care takers of their parents, spouse or partners parents and their spouse or partner as they age.

PRIORITY ONE: In order to ensure consumer input on women's health issues during the planning and implementation of health care reform, the advisory group requests formal support to continue to provide expertise and advice on issues impacting women's lives.

PRIORITY TWO: **Coordination of Programs**

For women who may have little or no internet access, systems should be developed to coordinate screening for other public benefits such as SNAP, TANF, WIC with Medicaid, the Basic Health Plan or SCI or the Exchange at multiple access points, (schools, libraries, community centers, ISD offices, WIC offices, food banks) in one visit and allow electronic matching of documentation with other agencies. Require re-certification yearly instead of every 6 months and if there are no changes in the applicant's status, expedite re-certification in the same manner as the SCI program currently allows.

OTHER RECOMMENDATIONS:

Reproductive Health Care

The Patient Protection and Affordability Act allows states to make Presumptive Eligibility decisions for family planning services under Medicaid. New Mexico should implement this change immediately.

New Mexico should include Doulas in the definition of "Community Health Worker" as it applies to Section 5313: Grants to Promote the Community Health Workforce and Section 2951, Maternal, Infant and Early Childhood Home Visiting Programs. The state should also use Community Health Workers and Promotoras as part of the non-profit system of "navigators" to help individuals and small groups buy subsidized health coverage from the new "health insurance exchange" system.

The state should research whether the PPACA requirement to make direct payments to free standing birthing centers and equitably reimburse Certified Nurse Midwives and Certified Professional Midwives provides an opportunity to increase the number of free standing birth centers, especially in the rural areas of the state.

Children

One of the first provisions of Health Care Reform to go into effect was the expansion of eligibility of young adults to age 26 on their parent's health insurance plan.

The PPACA will expand Medicaid to children as they age out of the foster care system to age 26 in 2014. Currently New Mexico has expanded coverage to foster children until age 21. Since the state of New Mexico is the “parent” of children in the foster care system, the state should consider gradually increasing the age of coverage to account for this inequity, until 2014 when health care reform is fully implemented.

Educate the public on the expansion of the Adoption Tax Credit and create a public education campaign to inform people who are considering adopting a foster child that they are potentially eligible for the adoption tax credit. Continue to incentivize the adoption of children in the foster care system as allowed through the Fostering Connections to Success and Increasing Adoptions Act of 2008.

Protect the safety and confidentiality of youth who are applying for family planning or pregnancy care by allowing them to use alternative mailing addresses when applying for Medicaid or the Exchange, and to receive their application materials or health records at the alternative address.

Elder health care

New Mexico should take advantage of the option to enhance access to home and community-based elder services through amending the state’s Medicaid plan through the Community First Choice Option and amending Section 1915(i) of the Social Security Act, Removal of Barriers to Providing Home and Community-based Services and applying to the Money Follows the Person Rebalancing Demonstration Program.

Unique populations

The PPACA provides funding for innovative “health homes” for individuals with chronic conditions. A “health home” for women leaving incarceration could encourage community re-integration, family re-unification and prevent re-offending. This should use tele-med capacities to connect the woman with a medical provider of her choice, comprehensive case management, care coordination, comprehensive transitional care, patient and family support, and referrals to community and social support services in the community where she will be living after her release. She should be pre-screened for Medicaid or the “exchange” prior to her release and make sure she is enrolled promptly upon her release.

Health reform applies mental health and substance abuse parity requirements to all individual health plans (including existing plans) beginning in 2014. In addition, all health plans sold to individual and groups through the new Exchanges must meet requirements for mental health parity. This should include medication assisted therapy for addictions as a covered benefit and include these medications on all prescription formularies.

Conclusion

New Mexico has one of the highest rates of women who are uninsured, under-insured and living in poverty. Access to the “exchange” through the Internet can be difficult for women living in poverty or in rural and reservation areas of the state. New Mexico should be mindful that no new, unintended barriers to the benefits of healthcare reform be created and should encourage a healthcare system that can be gender specific in its delivery. We would encourage the state to make the best use of PPACA grants by funding new and innovative programs rather than using the grants to shore up budget deficits.

Appendix F

DRAFT FOR DISCUSSION

| |
|---|
| DEVELOPING HEALTH INSURANCE EXCHANGES TO SUPPORT HEALTH REFORM IN NEW MEXICO |
|---|

Assumptions underlying the Affordable Care Act include: controlling the rate of growth of health spending (bending the cost curve); improving choice of coverage through new purchasing structures (creating health insurance exchanges - HIE); making health insurance more affordable for individuals, families and businesses; expanding health insurance coverage to prevent cost shifting from the uninsured to the insured; and holding providers, insurers and providers accountable for cost and quality whether patients are publicly or privately insured.

Over time the Affordable Care Act eliminates rescissions¹ and lifetime limits, and guarantees issue whether or not a person has a pre-existing medical condition. The Act establishes a medical loss ratio for the proportion of premiums that must be spent on patient care, versus administrative costs, and delineates reporting requirements to verify plan performance.

Health Insurance Exchanges (HIE) will help drive these changes and assure accountability related to cost and performance within all sectors of the health system. States have the option of setting up their own HIE. But before that decision is made, there has to be a general consideration of the role of the HIE, its governance, and the outcomes it could support under the law.

New Mexico's HIE should:

- Negotiate contractual agreements with private insurance vendors
- Coordinate with the state's high risk pool, and consider the role of risk adjustment strategies in the determination of "high risk"
- Create performance metrics related to cost, access, efficiency and quality
- Develop methods to reduce adverse selection to health plans that participate in the HIE
- Include incentives to promote innovation
- Evaluate and present differences in quality and price between plans in user-friendly language
- Enable enrollment into public and private coverage plans
- Enable enrollment through websites, or by navigators.
- Encourage private-public collaboration
- Align fiscal incentives with desired cost, efficiency and quality outcomes to promote coordination of care, team based care, and integration of care (patient centered medical home, accountable care organizations)
- Standardize enrollment and reporting consistent with federal regulations
- Review, approve/deny premium rates
- Assure coverage portability
- Ensure that data is available to measure reductions in health disparities in low-income, minority and rural populations.
- Encourage the use of evidence based practice in plans offered through the HIE

¹ Rescission: Retroactive denials of coverage; Lifetime limits: A maximum level of payout on expenditures on a plan beyond which the coverage will be withdrawn; guaranteed issue: no denials of coverage based on pre-existing conditions.

DRAFT FOR DISCUSSION

- Promulgate rules for implementation and ongoing operations for all of these benchmarks

An HIE will face competing pressures. New Mexico's HIE should encourage market-based competition, operate within federal and state regulations, work with the private and public sectors so that affordable choices are available, eliminate barriers to legitimate business processes that improve quality and efficiency, simplify processes in private and public plans for patients (enrollment and benefits), providers (billing, denials, authorizations), insurers (payment, reporting) and other entities (long term care, hospice) in the health system.

Overarching Goals for the NM HIE

The overarching HIE Goals are to introduce competition, improve consumer choices, and assure high quality, efficiency, and controlled cost growth. Since insurance plans cannot deny coverage based on pre-existing condition, or impose lifetime limits or deny coverage retroactively (i.e. risk avoidance), plans need to refocus on enhancing competitive efficiency and choice based on price and quality. An HIE should assure robust, affordable health plan choices for individuals and employees of businesses and meet the needs of New Mexico's diverse populations.

New Mexico's HIE must have the capacity to assess and negotiate with health insurance plans, develop and operate the infrastructure, and monitor and enforce the implementation and operations consistent with state and federal laws.

Proposed Governance Structure

States have considerable latitude to organize an HIE. When HIE regulations are finalized, more detailed work plans can be formulated. In the meantime, basic principles for HIE governance should:

1. Create a New Mexico HIE Board to represent stakeholder interests and appropriate agencies.
2. Develop Conflict of Interest policies so that decisions made by the Board are not unduly influenced by financial or other interests of lobbyists, advocacy groups and stakeholders.
3. Assure the cooperation of appropriate state agencies such as New Mexico Human Services Department (overseeing Medicaid), the State Insurance Commission and others assist the HIE Board's work providing staff, data, and assistance, and to ensure that HIE actions do not counteract federal requirements from public coverage agencies.
4. Insulate Board members from political and lobbyist pressures. Appointments to the HIE Board and hiring of the Executive Director and staff should assure continuity and smooth operations regardless of election cycles and partisan interests.

DRAFT FOR DISCUSSION

Functions/Operations: Based on current law, New Mexico's HIE should:

1. Create web-based tools for consumers to compare plans, determine costs, and understand the variations in price and quality among the different plans. Ensure that enrollment occurs efficiently and across private and public programs.
2. Oversee the enrollment process in New Mexico communities in urban, rural, frontier, and tribal areas, and use Navigators and Ombudsmen to assist HIE operations.
3. Track consumer satisfaction with the HIE, and participating insurers and providers.
4. Standardize health plan requirements to streamline administrative costs and inefficiencies.
5. Analyze data related to publicly and privately insured New Mexicans.
6. Create expert advisory panels of clinical health care experts, policy analysts, and others to assist with Affordable Care Act implementation, and help assure compliance with the quality, safety and regulatory objectives outlined in the law and generated during its implementation and subsequent modification.
7. Encourage incentives to address health professions shortages in rural areas and inner city underserved populations and plan for the impact of additional demands caused by expanded coverage.²
8. Work with public and private insurers to assure product lines offered in the Exchange are high quality, accessible and responsive to consumer needs.
9. Assure transparency and accountability from insurance plans, providers and others in the health system.
10. Provide data as required by federal and state laws.
11. Hold regular public sessions to report and discuss data and reports; elicit feedback and suggestions for improvement from consumers, insurers and providers related to HIE operations; and provide real time information that help consumers, insurers and providers improve health system performance.
12. Conduct operations with business efficiency. Staff will manage reporting and monitoring functions, and make decisions based on sound, impartial analyses.
13. Evaluate its own operations and use data to improve performance.

² Starting in 2014 an estimated 350,000 uninsured New Mexicans will receive health insurance, about 240,000 through the HIE and the remainder through an expansion of Medicaid. All but one New Mexico county is federally designated as a full or partial Health Professions Shortage Area (HPSA), Medically Underserved Area or Population (MUA/P).

DRAFT FOR DISCUSSION

14. Collect, analyze and share data as needed with state agencies, the federal government, insurers, providers, and the public.

Additional Decisions and Questions Related to New Mexico's HIE:

1. Should the HIE be a state agency, a quasi-state agency, or an independent non-profit organization?
2. Should New Mexico have the federal government operate the HIE?
3. Should New Mexico have an HIE with other states? Could interstate cooperation generate cost savings by creating economies of scale for operational functions such as hiring skilled administrators and staff, creating actuarial forecasts, developing risk adjustment strategies, implementing the infrastructure for enrollment, customer service, quality improvement, call center, etc.

Acknowledgements: Nandini Kuehn developed the discussion draft. The following individuals provided support, input, advice, and comments that shaped this document:

Mr. Charlie Alfero

Dr. Dan Derksen

Mr. Dick Mason

Dr. David Scrase

Dr. James Tryon

Ms Barbara Webber

Dr. Bill Wiese

DRAFT FOR DISCUSSION

Overview of the Health Insurance Exchange as Described in the Affordable Care Act

- An HIE can be a state agency or a not-for-profit agency. It cannot be a state Medicaid agency.
 - States can “opt out” of establishing an HIE by enacting a law to not create an HIE. The federal government will then manage an HIE directly or through agreement with a not-for-profit entity in the state
 - States can decide to create subsidiary exchanges within the state if the geographic region is of substantial size
 - States can work with other states on multi-state exchanges or infrastructure support
 - States can define “small employer” as 50 and less, or 100 and less employees. Once an employer purchases insurance from the Exchange, it can stay in the exchange regardless of growth and change in employees.

- An Exchange must be self-sustaining. By January 1, 2015 HIE’s must generate user fees from health plans to create its operating budget and to pay Navigators.
 - Planning grants will be available to Exchanges by 2013, but not after January 1, 2015.
 - HIE must not indulge in wasteful spending defined such as promotional giveaways, excessive executive compensation etc., and abide by federal funding restrictions.
 - An HIE must follow federal reinsurance and risk adjustment regulations.

- An HIE can offer only qualified health plans that provide essential health benefits. Essential benefits will be defined by HHS regulations. Essential health benefits will include:
 - Ambulatory care; emergency care; hospitalization; maternity and newborn care; mental health and substance abuse; prescription drugs; rehabilitative services and devices; laboratory services; prevention and wellness, pediatric services including oral and vision care.

- The HIE must certify plans as specified by regulations. This includes restrictions on marketing to avoid enrollment by individuals with risk; ensure sufficient choice of providers; providers that serve hard to reach populations; plans offered must comply with performance on clinical quality; utilization management; provider credentialing, etc.

- The HIE must:
 - Operate a toll free hotline to assist enrollees
 - Have a website where individuals and employers/employees can obtain standardized, comparative information on health plans
 - Implement a rating system on the basis of relative quality and price
 - Present health plan options in a standardized format
 - Inform applicants about their eligibility for government programs such as Medicaid, Children’s Health Insurance Program (CHIP), and other state subsidized programs such as State Coverage Insurance (SCI), premium subsidy information, and help enroll eligible applicants into these plans
 - Provide an electronic calculator to determine cost of coverage, premium tax credits, and cost sharing impact across various plans
 - Provide official exemption to individuals who cannot afford any plans on the exchange – notify IRS.
 - Provide notification to employers about employees who cease coverage during a plan year.

DRAFT FOR DISCUSSION

- The HIE must establish a Navigator program to assist consumers, paid for from HIE operating funds (not from federal planning dollars).
 - Navigators can be drawn from trade organizations, community associations, advocacy groups, chambers of commerce, licensed insurance agents and brokers. Navigators cannot be a health insurance issuer, nor receive consideration directly or indirectly from any health insurance issuer in connection with any enrollment/enrollee.
 - The Secretary will establish standards for Navigators to ensure information is disseminated in a fair manner. Procedures may include rate schedules for broker commissions paid through an exchange.
 - Duties of Navigators: Conduct public education about the availability of various plans, distribute fair and impartial information concerning enrollment in qualified health plans, and provide referrals to appropriate state agency or ombudsman for resolution of grievances, provide information in culturally and linguistically appropriate manner.

- An HIE cannot impose premium price controls. It must conduct premium rate reviews to authorize premium increases.

- HIE must publicly publish its costs for licensing and regulatory fees, administrative costs, and revenues lost to fraud, waste and abuse

- **Consultation:** The HIE must consult with stakeholders – health care consumers who are enrollees, those with experience in enrollment, small business, state Medicaid, and advocates for hard to reach populations

- Purchasing coverage through an Exchange is voluntary. No individual or employer has to purchase insurance coverage from an Exchange. However, premium subsidies are only available for plans made available through an Exchange.

Financial Integrity: An HIE must file detailed financial reports with the Department of Health and Human Services (DHHS). The HHS Secretary, with the Attorney General can investigate an Exchange and audit its operations. If a pattern of abuse is determined, penalties will be imposed until problem is corrected.

Note: Only state agencies can manage Medicaid, however, the HIE can assess eligibility for these programs and enroll clients if they meet state guidelines. Hospitals and clinics can establish presumptive eligibility for Medicaid.

ADVISORY GROUP PARTICIPANTS

| | | |
|------------------|----------------------------|-------------------------|
| Erin Armstrong | Jim Jackson | Brian Pietrewicz |
| Vanessa Alarid | Lucrecia Jaramillo | Ellen Pinnes |
| Charlie Alfero | Emily Kaltenbach | Debbie Ranger |
| Mary Attenberg | Nikki Katalanos | Nancy Ridenour |
| Danine Baca | Karen Kennedy | David Roddy |
| John Block | Gary Kilpatrick | Michael Rogers |
| Patricia Boyle | Kim Kinsey | Giovanna Rossi Pressley |
| Rebecca Branch | Connie Koshewa | Ted Roth |
| Elissa Breitbard | Nandini Kuehn | Charlotte Roybal |
| Eric Buckley | Joan Lamunyon Sanford | Sylvia Ruiz |
| BJ Ciesielski | Sandra Lapham | Buffy Saavedra |
| JR Dameron | Harvey Licht | Scott Scanland |
| Kasey Daniel | Summer Little | Lisa Schatz-Vance |
| Gina DeBlasie | Susan Loubet | Kimberley Scott |
| Dan Derksen | Debbie Maestas-Trainor | David Scrase |
| John Diedrick | Sireesha Manne | Linda Sechovec |
| Mike Donnelly | Randy Marshall | Mark Shinnerer |
| Jeff Dye | Larry Martinez | Marla Shoats |
| Reese Edwards | Suzan Martinez de Gonzalez | Rebecca Shuman |
| Brent Earnest | Dick Mason | Anne Sperling |
| Judith Espinosa | Althea McCluckie | Roxane Spruce-Bly |
| Tara Ford | Carol Miller | Justina Trott |
| David Foster | Lori Monteverdi | Thom Turbett |
| Joie Glenn | Brent Moore | James Tryon |
| Eric Griego | Michael Murray | Angie Vachio |
| Jerry Harrison | Dan Najjar | Betsy Van Leit |
| Ryan Hedin | Julie Neerken | Claudia Vargas-Sitrick |
| Ruth Hoffman | Gary Oppendahl | Deborah Walker |
| Laura Hopkins | Mark Padilla | Mike Wallace |
| Shannon Horst | Gabriel Parra | Dan Weeks |
| Sharon Huerta | Janice Paster | Barbara Webber |
| Robin Hunn | Elizabeth Peterson | Bill Wiese |
| Doris Husted | | Jane Wishner |