F I S C A L I M P A C T R E P O R T

SPONSOR HHGAC **ORIGINAL DATE** 02/23/11 **LAST UPDATED** **HB** CS/CS/33/aHFl#1

SHORT TITLE New Mexico Health Insurance Exchange Act **SB**

ANALYST Esquibel

ADDITIONAL OPERATING COSTS (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY11	**FY12**		
N/A	$5.0	Recurring	User Fees

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
General Services Department (GSD)
Children, Youth and Families Department (CYFD)
Administrative Office of the Courts (AOC)
Public Schools Insurance Authority (PSIA)
Department of Indian Affairs (DIA)
Aging and Long-Term Services Department (ALTSO)
Human Services Department (HSD)
Workers' Compensation Administration (WCA)
Department of Health (DOH)
Health Policy Commission (HPC)
Public Education Department (PED)
Higher Education Department (HED)

SUMMARY

Synopsis of House Floor Amendment #1

The House Floor Amendment #1 to the House Health and Government Affairs Committee Substitute for the House Consumer and Public Affairs Committee Substitute for House Bill 33 removes the requirement that the Superintendent of Insurance must certify the qualified health insurance plans that may be offered by the health insurance Exchange.

Synopsis of HHGAC Substitute for House Bill 33

The House Health and Government Affairs Committee Substitute for the House Consumer and Public Affairs Committee Substitute for House Bill 33 (HB33/HHGACS) creates the New Mexico Health Insurance Exchange Act that proposes to lay the framework for the implementation of a Health Insurance Exchange in New Mexico in accordance with the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Summary of HHGAC Changes from HCPAC Committee Substitute for HB 33:

- Removes long-term care insurance from the definition of "health benefit plan".
- Specifies the ad hoc advisory groups the Exchange board "may" create: quality improvement, cost containment and reimbursement policy.
- Adds "language interpretation services" as a required duty of the Exchange.
- In Section 9, removes contracting with vendors and producers as something the Exchange may perform.
- In Section 14, adds contracting with HSD and other state agencies that receive federal funds to fund the planning, implementation and operation of the Exchange replacing language that the Exchange may seek funding from state, federal, and philanthropic organizations.

Synopsis of HCPAC Substitute for House Bill 33

The House Consumer and Public Affairs Committee Substitute for House Bill 33 (HB33/HCPACS) creates the New Mexico Health Insurance Exchange Act that proposes to lay the framework for the implementation of a Health Insurance Exchange in New Mexico in accordance with the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). In addition to following the requirements of the PPACA, the HB33/HCPACS makes explicit the need for cooperation between the Medical Assistance Division of the New Mexico Human Services Department (HSD), the Insurance Division and the Superintendent of Insurance (superintendent) of the New Mexico Public Regulation Commission, the New Mexico Health Insurance Alliance (NMHIA), and the New Mexico Medical Insurance Pool (NMMIP) in areas of plan certification, dispute resolution, funding, and transitioning from one type of health care coverage to another. In addition, the bill makes explicit enrollment and coverage processes, including Native American enrollment, transparency in the premium rates requested by carriers, and other processes that the superintendent must follow in certification, recertification and decertification of a qualified health plan. The bill also makes explicit the requirement to offer bronze coverage, catastrophic coverage where applicable, and the need to determine when an individual is exempt from the mandate to purchase coverage.

Synopsis of Original Bill

House Bill 33 creates the New Mexico Health Insurance Exchange Act that proposes to lay the framework for the implementation of a Health Insurance Exchange in New Mexico in accordance with the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010

(Public Law 111-152). In addition to following the requirements of the PPACA, the HB33 makes explicit the need for cooperation between the Medical Assistance Division of the New Mexico Human Services Department (HSD), the Insurance Division and the Superintendent of Insurance (superintendent) of the New Mexico Public Regulation Commission, the New Mexico Health Insurance Alliance (NMHIA), and the New Mexico Medical Insurance Pool (NMMIP) in areas of plan certification, dispute resolution, funding, and transitioning from one type of health care coverage to another. In addition, the bill makes explicit enrollment and coverage processes, including Native American enrollment, transparency in the premium rates requested by carriers, and other processes that the superintendent must follow in certification, recertification and decertification of a qualified health plan. The bill also makes explicit the requirement to offer bronze coverage, catastrophic coverage where applicable, and the need to determine when an individual is exempt from the mandate to purchase coverage.

FISCAL IMPLICATIONS

Under the provisions of HB33/HHGACS, a provision is added requiring the Exchange offer language interpretation services. It is estimated these language interpretation services will cost approximately $500.00 a meeting with services needed for up to ten meetings a year for a total cost of $5 thousand annually. It is assumed these services will be funded via provider fees or some other source other than general fund revenue.

It is unclear if the provisions of HB33/HCPACS will repeal the statutes governing the NM Medical Insurance Pool and the Health Insurance Alliance. Of particular concern is the premium tax credit and how HB33/HCPACS will treat continued assessing of the premium tax credit for insurers. The disposition of this assessment and tax credit could have potential general fund impact.

The federal Patient Protection and Affordable Care Act of 2010 authorizes State Planning and Establishment Grants to help states establish Health Insurance Exchanges, and requires that State Exchanges to be self-sustaining. States are required to demonstrate they are capable of running an Exchange by January1, 2013.

On July 29, 2010, the Department of Health and Human Services (DHHS) issued a grant solicitation publicizing the availability of the first round of funding for the State Planning and Establishment Grants for Exchanges. These grants were up to $1 million for each State and the District of Columbia. These grants are intended to give states the resources to conduct the research and planning needed to build a better health insurance marketplace and determine how their Exchanges will be operated and governed.

The State of New Mexico has been awarded the $1,000,000 Planning and Establishment Grant and work is already underway to conduct the necessary market research and planning. The Grant is being used to:

- Develop a fiscal, actuarial and population tool based on the current environment that can provide ongoing information as adjustments are made to reflect policy decisions related to the Exchange(s).
- Assess current information technology (IT) systems and determine any Exchange IT needs;
- Gather data regarding New Mexico’s current health insurance market;

- Gather input from off-reservation leaders, providers and consumers to guide the Exchange planning process.

It is anticipated that in Spring 2011 an additional grant solicitation will be released by the U.S. DHHS for Exchange implementation funds. The amount and exact timing of this grant is unknown at this time.

Other fiscal implications to consider include the development of the new HSD, Income Support Division eligibility IT system (replacing the current ISD2), which must work seamlessly with the Exchange, and possible enhancements of the Medicaid Management Information System (MMIS). Also, the Exchange itself will need an appropriate IT system for successful implementation. There is a 90/10 Medicaid matching for the Medicaid IT infrastructure.

It should be noted that if an Exchange is run by a not-for-profit quasi-governmental agency, the operating costs would be incurred by that entity.

SIGNIFICANT ISSUES

In addition to following the requirements of the PPACA, the HB33/HCPACS makes explicit the need for cooperation between the Medical Assistance Division of the New Mexico Human Services Department (HSD), the Insurance Division and the Superintendent of Insurance (superintendent) of the New Mexico Public Regulation Commission, the New Mexico Health Insurance Alliance (NMHIA), and the New Mexico Medical Insurance Pool (NMMIP) in areas of plan certification, dispute resolution, funding, and transitioning from one type of health care coverage to another. In addition, the bill makes explicit enrollment and coverage processes, including Native American enrollment, transparency in the premium rates requested by carriers, and other processes that the superintendent must follow in certification, recertification and decertification of a qualified health plan. The bill also makes explicit the requirement to offer bronze coverage, catastrophic coverage where applicable, and the need to determine when an individual is exempt from the mandate to purchase coverage.

Below, the ad hoc NM Office of Health Care Reform has analyzed HB33/HCPACS in relationship to HB33.

Section by Section Analysis of HCPAC Substitute changes to HB33:

Section 1. HCPAC made no change. The short title of this bill is the "New Mexico Health Insurance Exchange Act" (Act).

Section 2. HCPAC added definitions for "employee," "health care facility," "health care provider," and health care services finance or coverage sector." The definition for "qualified individual" was corrected.

Section 3. HCPAC made no change. The section states the New Mexico Health Insurance Exchange (Exchange) will be a nonprofit public corporation, which will be a separate and distinct entity from the State of New Mexico.

Section 4. HCPAC made several changes regarding the Exchange's proposed Board of Directors as follows:

- The Board will consist of eleven voting members, up from nine voting members under the original bill. The Superintendent of Insurance has been removed as a voting member.
- Conflict of interest provisions have been expanded from the original bill, which prohibited persons with affiliation with, or income derived from, the "health care services finance or coverage" sector from serving as board members. This prohibition has been extended to include both Board members and exchange employees, and to further prohibit members and employees from affiliating with or deriving income from providers. The bill adds an affirmative statement that "each board member and employee of the Exchange shall have a fiduciary duty to the Exchange."
- The substitute removes the types of past employment required and states, in identical language as found in SB 370, that Board members must have demonstrated knowledge or experience in at least one of the following areas: purchasing coverage in the individual market; purchasing coverage in the small employer market; health care finance; health care economics; health care policy; or the enrollment of underserved residents in health care coverage.
- The original bill required the governor to appoint three members and the New Mexico Legislative Council (NMLC) to appoint four. This bill requires the governor and the NMLC to each appoint five members. The 11th voting member is an ex-officio member, the secretary of health and human services (HSD).
- The substitute includes the Exchange, as well as the Board, as subject to various state governmental conduct acts, and further states that neither the Exchange nor the Board are subject to the Procurement Code or the Personnel Act.
- Standing advisory committee language was expanded and changed to conform to SB 38. The added language requires the board to duly consider the recommendations of the committees, and the committees must include advocates for low-income or underserved residents and representatives of American Indians or Native Alaskans, living on and off-reservation.

Section 5. HCPAC made no change. The section states that the Board must submit a plan of operation to the Superintendent of Insurance. This plan must include written procedures describing how to implement an exchange in accordance with the Act. Specifically, the written procedures must describe which health plans individuals and employers may subscribe to. In addition, the written procedures must also create policies to address which qualified health plans may be offered through the Exchange.

Section 6. HCPAC added a deadline of January 1, 2012 for reporting on strategies to avoid adverse selection, and recommendations on whether to change the number of full-time-equivalent employees of a small employer from 50 to 100. The section further describes the reports that the Board must create for the LHHSC, the LFC, the Secretary of the U.S. Department of Health and Human Services (U.S. DHHS), and the Superintendent of Insurance (superintendent). The Board must keep records of all the activities of the Exchange and submit this report annually to the U.S. DHHS and to the superintendent. In addition, the Board must formulate recommendations and submit these to the LHHSC, the LFC and the superintendent.

The Board must also provide three other recommendations to the LHHSC and the LFC by July 1, 2016: whether to 1) continue limiting qualified employer status to small employers; 2) combine the individual market and the small group market into a single risk pool; and 3) enter into an Exchange with other states or share resources or responsibilities to enhance the affordability and effectiveness of the Exchange. The Board must develop a program to publicize the existence and requirements of the Exchange.

Section 7. HCPAD made no change. The section states that the Board must appoint an executive director for the Exchange. The Board must also develop methods to evaluate the director's performance. The director must have at least five years experience in health care policy, and will be subject to removal for cause. The director will be responsible for the day-to-day operations of the Exchange. Specifically, the director must employ and compensate those working in the Exchange. In addition, the director must propose an annual budget for the Exchange and report to the Board at least once monthly between July 1, 2011 and January 1, 2013. However, after January 1, 2013 the director need only report on a quarterly basis to the Board.

Section 8. HCPAC added the following provision regarding duties of the Exchange: in developing a standard form for presenting information, the form must include how to receive an exemption from cost-sharing pursuant to Section 2901 of the federal PPACA. The remainder of the section lists the duties of the Exchange. First, the Exchange must negotiate with carriers to provide affordable plans that are in accordance with the Act. The Exchange will then assign a rating to each health plan offered based on quality, price and actuarial value. These ratings will determine which health plans will be offered through the Exchange.

The Exchange must submit a plan to the U.S. DHHS demonstrating the readiness to operate the Exchange by January 1, 2013, and the Exchange must have health plans available to qualified individuals and qualified employers by January 1, 2014. Once the Exchange is created, the Exchange will assist qualified employers and qualified individuals to enroll in qualified health plans. In order to provide assistance, the Exchange will set up a toll-free telephone hotline and an internet website containing comparative information on the qualified health plans.

While providing assistance, the Exchange must screen individuals to determine if they are eligible for health insurance through Medicaid or any state or local public health coverage program. If the Exchange determines an individual is eligible for any of those programs, the Exchange must enroll the individual in the program. However, if the Exchange determines that an individual is not able to afford a qualified health plan and is not eligible for Medicaid, the Exchange may grant the individual an exemption from purchasing and maintaining health insurance. The Exchange must report this individual's name and taxpayer identification number to the federal Secretary of the Treasury.

The Exchange must also set up a navigator program, and award grants to entities that demonstrate that they are eligible to become navigators pursuant to state and federal law. Navigator programs will conduct public education activities to raise awareness about the qualified health plans. A navigator program is meant to facilitate enrollment in qualified health plans and to provide assistance to the public regarding a grievance with an individual's health plan. In addition, navigator programs will inform the public about federal premium tax credits.

Section 8 also states that the Exchange must set up and implement a free choice voucher program. The Exchange must also collect all payments made on behalf of qualified individuals. The Exchange must enable individuals to pay the premiums by allowing individuals to apply any federal earned income tax credit payments due to the qualified individual. Individuals will also be permitted to apply any other federal or state credits towards the health insurance. Finally, the Exchange will gather all of these payments and transmit them to the administrators of the respective health plans.

Lastly, the Exchange must perform any duties required by the Secretary of U.S. DHHS or the federal Secretary of the Treasury.

Section 9. The HCPAC substituted a provision that gave the Exchange the authority to contract with Medicaid, the CHIP program or any applicable state or local public health coverage program, with more general language allowing the Exchange to contract with other persons or organizations as necessary or proper to carry out Exchange functions. The section further lists four powers granted to the Exchange: 1) the Exchange may establish service centers within the state to enroll qualified individuals; 2) the Exchange may contract with an "eligible entity" to carry out the duties of the Exchange (Section 8 of Act); 3) the Exchange may enter into information-sharing agreements with federal and state agencies to help carry out its responsibilities (as long as consumer confidentiality is maintained; 4) the Exchange may contract with vendors and producers to perform one or more of the functions specified in Section 8 of the Bill.

Section 10. The HCPAC deleted all earlier references to the Superintendent of Insurance duties to certify, recertify and decertify plans as qualified health plans. This section creates duties of the Superintendent of Insurance to include approval, after notice and hearing, of the plan of operation, or, should the Board fail to submit a plan of operation within 180 days after appointment of the Board, promulgation of rules to create a plan of operation. At any time, should the Board fail to submit amendments to the plan of operation that the Superintendent deems necessary, the Superintendent must adopt rules to effectuate those amendments.

Section 11. HCPAC made no change. The section requires carriers that offer a health benefit plan in the individual or small group market in the State of New Mexico to offer at least two qualified health care plans in the Exchange; one at the silver level and one at the gold level of coverage as defined by the bill.

Section 12. HCPAC made no change. The section provides for general enrollment rights; a qualified individual may apply to participate, and a qualified employer may apply on behalf of its employees or the employees' dependents. The Exchange must set dates for initial open enrollment, annual open enrollment and special enrollment periods, and special monthly enrollments for Indians.

Section 13. HCPAC made no change. The section provides for the superintendent to promulgate rules for dispute resolution arising from the operation of the Exchange. Areas to be covered include: eligibility of individuals to participate in the Exchange; exemptions from the individual responsibility to have minimum essential coverage; and the Exchange's responsibilities to collect and transmit enrollment applications, premium payments and contributions to the qualified health plans.

Section 14. HCPAC made no change. The section allows the Exchange to charge assessments or user fees to carriers, qualified employers, qualified individuals and producers or otherwise generate funding needed to support operations. To educate consumers, the Exchange must publish on a website the average costs of licensing, regulatory fees and other payments required by the Exchange, administrative costs of the Exchange, and money lost to waste, fraud and abuse.

Section 15. HCPAC made no change. The section amends the Tort Claims Act to include members of the board of directors and staff of the Exchange as public employees.

Section 16. HCPAC made no change. The section requires the Medical Assistance Division of the HSD to cooperate with the Exchange to share information and facilitate transitions between the Exchange, Medicaid, CHIP and other state public health coverage programs.

Section 17. HCPAC made no change. The section requires the Exchange board members to meet with the board members of the NMHIA and the NMMIP, to provide for transition to the Exchange including, to the extent possible, portability of coverage. The board must prepare a report to the First Session of the 55th Legislature on the transition of functions of the NMHIA and the NMMIP to the Exchange.

Section 18. HCPAC made no change. The section contains a severability clause.

Section 19. HCPAC made no change. The section declares an emergency and requires that this act take effect immediately.

PERFORMANCE IMPLICATIONS

The ad hoc New Mexico Office of Health Care Reform indicates HB33/HCPACS meets the requirements laid forth in the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HB33/HCPACS relates to and, in some parts, duplicates SB38 and SB 370 as described below by HSD:

Introductory Statement
HB 33/HCPACS specifies procedures for enrollment and coverage election, including provisions regarding Native American enrollment. SB 38 and SB 370 are more general and provide authority for the exchange and the superintendent of insurance to create a plan of operation and promulgate rules to implement the provisions of the Exchange.

SB 38 provides for transparency of Exchange funding and operations. These provisions, requiring that HSD cooperate in providing federal funding to the Exchange, are included in Sections 6, 12 and 13. HB33/HCPACS has no equivalent provisions. SB 370 requires that the Exchange be designated as the entity for the state to receive any federal funds for planning and implementation of an Exchange.

Definitions
HB33/HCPACS contains definitions for bronze and platinum coverage, catastrophic coverage, essential benefits, plan year, and stand-alone dental benefits, none of which are included in either SB 38 or SB 370. However, HB33/HCPACS does not employ the terms "bronze," "platinum" or "catastrophic coverage" in the body of the bill.

Terms added in this committee substitute include "employee," "health care facility," "health care provider," and health care services finance or coverage sector," which are identical to the definitions in SB 370. The definition for "qualified individual" was corrected, and is identical to the definition in both SB 38 and SB 370.

Exchange as governmental entity for purposes of the Tort Claims Act
HB33/HCPACS, SB 38 and SB 370 each amends the Tort Claims Act to provide for the Exchange as a governmental entity.

Board of Directors
Overview: HB33/HCPACS made many changes to the "Board of Directors" section of the bill, so that it now aligns in many ways with the board of director provisions of SB 370. Unlike SB 370, however, this bill does not require appointment of members from the New Mexico Health Insurance Alliance or the New Mexico Medical Insurance Pool, nor does the superintendent of insurance have any appointment authority under HB33/HCPACS.

HB33/HCPACS creates a board of directors consisting of 11 voting members, consistent with SB 370 and SB 38, though in SB 38 the superintendent of insurance is a voting member. In both SB 370 and HB33/HCPACS he is not a voting member. SB 38 includes a governor-appointee who represents an Indian nation, tribe or pueblo and a New Mexico legislative council appointee who has experience with the Indian health care system and financing and shall represent Native Americans or Alaska Natives who do not live on a reservation. HB33/HCPACS and SB 370 do not require this specification in membership.

HB33/HCPACS conflict of interest provisions prohibited members and exchange employees from affiliation or income derived from both the "health care services finance or coverage" sector and providers. SB 38 and SB 370 do not include employees in their conflict of interest provisions.
The bill adds an affirmative statement that "each board member and employee of the exchange shall have a fiduciary duty to the exchange," which is identical to the statement made in SB 370.

HB33/HCPACS does not specifically require Native American board membership, but the following provision was added from the original bill, and is identical to a provision in SB 370, stating that the board "shall be composed, as a whole, to ensure representation of the state's Native American population, ethnic diversity, cultural diversity and geographic diversity."

HB33/HCPACS requires compliance with the Administrative Procedures Act, while SB 38 does not – rather it requires compliance with the Inspection of Public Records Act, which is not mentioned in HB33/HCPACS. Both HCPAC/HB 33 and SB 370 state that the board shall not be subject to either the Procurement Code or the Personnel Act.

Standing advisory committee language was expanded and changed in HB33/HCPACS to conform to SB 38. The added language requires the board to duly consider the recommendations

of the committees, and the committees must include advocates for low-income or underserved residents and representatives of American Indians or Native Alaskans, living on and off-reservation. SB 370 contains a separate statement to provide for an advisory committee of Native Americans.

Plan of Operation
HB33/HCPACS, SB 38 and SB 370 all require the board to submit a written plan of operation to the superintendent to establish procedures for implementation of the Act. These provisions are almost identical, though SB 38 adds that the plan should provide for a *self-sustaining* administration of the Exchange, that implementation procedures should be in accordance with PPACA and state law and should address the provision of language interpretation services.

Board Reporting Requirements
Section 6 of both HB33/HCPACS and SB 38 contain similar reporting requirements from the board to the legislature, though the dates for reporting have been moved up in HB33/HCPACS, to provide for reporting by July 1, 2012 on recommendations regarding both adverse selection and increasing small employer size from 50 to 100 employees. In a July 1, 2016 report to the legislature, SB 38 adds that if qualified employer status has been extended to include large employers, then the board must address whether to combine the large employer risk pool with small employers. SB 370 contains similar quarterly reporting, and requires that by July 1, 2013 the board report to LFC and other appropriate interim committees on recommendations regarding funding mechanisms and a plan to achieve self-sufficiency.

Executive Director
HB33/HCPACS and SB 38 call for the board to appoint an executive director of the Exchange, and contain identical provisions regarding director qualifications and other requirements. SB 370 does not contain this provision.

Exchange Duties
HB33/HCPACS, SB 38 and SB 370 all describe the duties of the Exchange. HB33/HCPACS has an explicit list of duties, while SB 38 and SB 370 include more general statements, and refer to PPACA requirements for implementation requirements, without describing details of implementation.

HB33/HCPACS adds Exchange duties to include negotiating with carriers to provide affordable plans that are in accordance with the Act; and ratings will determine which health plans will be offered through the Exchange. In addition, HCPAC/HB 33 goes into greater detail regarding the Exchange duties to assist in enrollment of individuals and employers, screen and enroll individuals for state or local public health coverage program, grant individuals exemptions from retaining health care and reporting exemptions to the federal secretary of the treasury, setting up the navigator program, and implementing a free choice voucher program. There is also greater detail on how the Exchange must collect, distribute and account for all payments, and enable individuals to pay premiums through federal earned income tax credit payments and other federal or state credits towards the coverage. HB33/HCPACS includes a separate Section 12 on enrollment, further explicitly stating enrollment rights, including the requirement that the Exchange provide special enrollment for Indians. While not included in SB 38 and SB 370, these rights are required under federal law and would need to be addressed in the bill's required Plan of Operation.

Superintendent Duties and Powers
HB33/HCPACS, SB 38 and SB 370 require the superintendent of insurance to promulgate rules to avoid adverse selection against the Exchange. Only SB 38 mentions that the superintendent must promulgate rules to govern how the board will certify, recertify and decertify plans as qualified health plans. Both HB33/HCPACS and SB 38 contain a provision to help avoid adverse selection against the Exchange by requiring carriers that offer a health benefit plan in the individual or small group market in the state of New Mexico to offer at least two qualified health care plans in the Exchange; one at the silver level of coverage and one at the gold level of coverage. SB 370 has no similar provision; rather SB 370 must recommend generally how the Exchange will achieve and maintain self-sufficiency, which in the end demands similar results.

SB 38, Section 14, requires that the insurance division of the PRC cooperate with the Exchange to share information and assist in the implementation of the functions of the Exchange.

Dispute Resolution
HB33/HCPACS, SB 38, and SB 370 each require dispute resolution. HB33/HCPACS and SB 38 are nearly identical, calling for the superintendent to promulgate dispute resolution rules arising from the operation of the Exchange. SB 38, Section 11, includes issues that may arise as to the eligibility of *individuals, employers or carriers* to participate in the Exchange. HB33/HCPACS, Section 13 limits the issue to *individuals.*

Transparency in Publication of Licensing, Fees and Other Payments
HB33/HCPACS, in Section 14, states that the Exchange must publish on a website "the average costs of licensing, *regulatory* fees and other payments"… SB 38, in Section 12, requires publication of "the average costs of licensing, fees and other payments," presumably broadening what must be published.

Cooperation with Information-sharing and Transitions with HSD
HB33/HCPACS and SB 38 contain nearly identical provision that allow the Exchange to contract for certain services, enter into information-sharing agreements with other state and federal agencies, and that require cooperation with HSD for enrollment and transition issues, and further cooperation with NMHIA and NMMIP for portability and transition issues.

SB 38, Sections 13 and 14, places dual responsibility on the Exchange board and HSD, while HB33/HCPACS, Section 16, places the responsibility on the medical assistance division of the HSD. SB38, Section 14 places additional responsibilities on HSD to cooperate with federal funding for the Exchange.

Severability
HB33/HCPACS and SB 38 both contain a severability clause.

Emergency Clause
HB33/HCPACS, SB 38 and SB 370 each contain an emergency clause for the act to take effect immediately.

Native-American specific provisions
In relationship to the Native-American specific requirements found in PPACA, SB38 and SB 370 each define "Native American" in Section 2, while HB33/HCPACS appears to refer to the PPACA legislation for definition. HB33/HCPACS specifically addresses Native American

enrollment and exemption from coverage, while SB 38 refers generally to the issue by requiring the Board to duly consider the recommendations of standing advisor committees, to include Native Americans or Alaska Natives, "to guide the implementation of the Indian-specific provisions of PPACA and the federal Indian Health Care Improvement Act."

SB 38 includes Native Americans as decision-makers on the Board, while SB 370 and HB33/HCPACS does not specifically require that any board members be members of Native American or Alaskan tribes.

HB33/HCPACS/HHGACS also relates to the following:

- HB245 (Health Insurance Purchasing Cooperative),
- HB246 (Amend Health Insurance Alliance Act),
- HB257 (LFC Perform FIR on Health Care Reform Designs),
- HB323 ("Interstate Health Care Freedom Compact"),
- SB5 (Health Security Act),
- SB89 (Private Health Insurance Purchasing Co-Op Act),
- SB90 (Health Insurance Access for Large Employers),
- SB208 (Health Insurance Rate Increase Review),
- SB227 (Benchmark Usual & Customary Rates),
- SB386 (LFC to Conduct FIRs on Health Care Designs), and
- SJR5 (State Health Care System, CA).

TECHNICAL ISSUES

HB33/HCPACS establishes a nonprofit public corporation to govern and operate the Exchange. It should be noted that quasi-governmental public corporations are not subject to the Legislature's appropriating and oversight authority. A fund in the New Mexico treasury could be created to collect funds assessed by the Exchange and these funds could then be appropriated by the New Mexico Legislature.

OTHER SUBSTANTIVE ISSUES

The ad hoc NM Office of Health Care Reform indicates various legal challenges have been brought against the PPACA. Final judicial resolution of these challenges is likely to take years.

The New Mexico Center on Law and Poverty indicates the federal government estimates that nearly 250,000 New Mexicans and over 20,000 small businesses could qualify for tax credits to purchase health insurance through an Exchange when it is fully operational in 2014.

By federal law, the federal government is committed to paying the full costs for states to establish Exchanges, and will continue to pay these costs until January 1, 2015. Thus, there is no fiscal impact on New Mexico for developing an Exchange. New Mexico also stands to gain significant financial benefits by establishing an Exchange because the State will become eligible for 90% federal matching funds to develop its Medicaid computer eligibility systems. One important condition for receiving this enhanced match is that the Medicaid system must effectively coordinate enrollment with an Exchange. When federal funding for the Exchange ceases in January 1, 2015, the Exchange may continue to be self-sufficient by assessing charges or user fees from participating health insurers, and obtaining local or philanthropic grants.

The sooner that New Mexico establishes its Exchange, the more likely the state will meet these benchmarks and receive sufficient funding to fully develop its Exchange by 2014. In fact, HHS has developed a worksheet of example milestones that states should attempt to meet each year; it suggests that states should draft enabling legislation and develop a governance structure for the Exchange in the year 2011.[1] If New Mexico adopts legislation this year, the State would be on track to achieve the milestones for federal funding.

Federal funding will pay the full costs of developing a computer system for the Exchange and will provide 90% matching funds to Medicaid programs to develop systems that interact with the Exchange.

In summary:

1. Federal law mandates the federal government to pay the full costs for states to establish Exchanges.
2. Federal funding is already available for planning and will be increased according to state performance.
3. Federal funding will pay the full costs of developing a computer system for the Exchange and will provide 90% matching funds to Medicaid programs to develop systems that interact with the Exchange.
4. The Exchange may assess fees and apply for grants to become self-sufficient after January 1, 2015.
5. By developing models for the Exchange, the federal government can reduce costs and afford the full costs to fund state initiatives to establish Exchanges.
6. New Mexico must be capable of meeting benchmarks for progress to receive federal grant awards and avoid the federal government taking over operations of an Exchange for the State.
7. Delaying legislation may interfere with the effectiveness of the Exchange in carrying out its duties.
8. Medicaid IT system will receive significantly enhanced federal funding if it meets conditions to coordinate with an Exchange. Establishing the Exchange will be necessary for meeting this requirement.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

If New Mexico does not demonstrate, in early 2013, that it will be ready to run an Exchange by January 1, 2014, the federal government will implement and run an Exchange in the state.

RAE/bym:mew

[1] Department of Health and Human Services, *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*, at p. 6 (Jan. 20, 2011) (hereinafter "HHS Cooperative Agreement"), http://apply07.grants.gov/apply/opportunities/instructions/oppIE-HBE-11-004-cfda93.525-cidIE-HBE-11-004-012241-instructions.pdf.