ACA Implementation—Monitoring and Tracking

New Mexico

Site Visit Report

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EXECUTIVE SUMMARY

New Mexico has long been recognized for its efforts to promote meaningful health reform. Prior to the Affordable Care Act (ACA), for example, the state had already expanded Medicaid eligibility to adults without dependent children, implemented premium assistance programs for the uninsured, and established a quasi-public entity to increase access to health insurance for small businesses and the self-employed.

In light of these previous efforts, it was no surprise that then-Governor Bill Richardson's administration embraced the passage of the ACA and began implementing many activities simultaneously. Then-Governor Richardson established the New Mexico Office of Health Care Reform (OHCR) in July 2010 and charged this new office with planning, coordinating, and administering federal health reform for the state. New Mexico also received federal funding for consumer assistance and its rate review process, and began to take steps to plan for a state-based exchange using a level one exchange planning grant.

Following seven years of the Richardson administration, New Mexicans elected a new governor – Susana Martinez – who was sworn in on January 1, 2011. Governor Martinez has urged the repeal of the ACA and, in lieu of full repeal, asked for significantly more flexibility in implementation of the law. With this change, New Mexico's pace of ACA implementation slowed, and it adopted a more measured approach to implementation. Although some informants expressed ambivalence and skepticism about the ACA, most noted that the Martinez administration recognizes that the ACA is the "law of the land" and has pushed ahead on implementation to ensure that New Mexico is positioned to be in compliance with the law if it is upheld by the Supreme Court.

As described in this case study, exchange implementation has been a difficult undertaking, and, like most states, New Mexico has encountered both success and challenges. At the time of our site visit in February 2012 and as described in this report, the state had taken a number of steps forward in exchange planning and development. However, recent developments since the time of our site visit suggest that New Mexico is taking steps to reevaluate its current approach to exchange development. For example, on May

10, 2012, New Mexico announced that it had selected Leavitt Partners, a health policy consulting firm, to assist the state in furthering its strategic planning for the exchange as well as assisting with the development of exchange policy, rules and regulations. In addition, as of this writing in May 2012, the OHCR has yet to issue an award in response to a request for proposals for exchange information technology (IT) that was issued in February 2012. Despite this shift, New Mexico has signaled that it intends to move forward in implementing an exchange but faces many important policy decisions ahead.

Health Insurance Exchange: Planning and Implementation—The concept of a health insurance exchange is not new in New Mexico and has been studied by the state legislature since at least 2007. Despite prior support for an exchange among conservative legislators, Governor Martinez has not signed exchange legislation. Soon after taking office in 2011, she vetoed an exchange bill after concluding that it was "premature" to approve such a bill without additional federal guidance. In 2012, exchange legislation was reintroduced during the state's short legislative session but the bill died in committee. Without exchange legislation, the governor has long been expected to issue an executive order establishing an exchange but, as of this writing in May 2012, no order has yet been issued.

Notwithstanding the absence of legislation or an executive order, New Mexico has made some key policy decisions surrounding the exchange. First, the governor's office, state officials, and health care stakeholders appear to be committed to pursuing a state-based exchange. Second, New Mexico is likely to have a single exchange established as a quasi-public entity. Although there is an existing quasi-public entity in New Mexico that may serve as the exchange, the issue of exchange governance has been of significant controversy and has yet to be resolved.

New Mexico has taken important steps towards establishing a state-based exchange. It received a federal exchange planning grant and, in November 2011, a level one establishment award. Much of these funds will be used to begin operationalizing the exchange, further engage stakeholders, and enhance interagency cooperation.

Health Insurance Exchange: Enrollment and Subsidy Determination—New Mexico has begun preparing its Medicaid and exchange IT systems to work seamlessly by 2013. To that end, New Mexico is considering a "no wrong door" approach as its vision for the exchange IT. The state could leverage its current eligibility system for Medicaid and other human services—which, separately, is undergoing a major overhaul—as it plans to build a separate exchange eligibility system. This simultaneous modernization of the Medicaid eligibility system could give New Mexico a head start in operationalizing its exchange IT system.

Consumer outreach on health reform was widely regarded as critical, especially because of the state's rural and small population as well as its high rate of uninsured. Informants particularly noted the importance of conducting outreach to the state's Native American population, which is disproportionately represented among the uninsured. New Mexico currently has no specific strategies for consumer outreach and education but has begun strategic planning on this issue.

Insurance Reforms—Although New Mexico's legislature considered bills in 2011 and in 2012 that would have adopted some of the ACA's market reforms, these bills did not pass. While New Mexico has not yet enacted new legislation on all of the ACA's market reforms, the state has passed legislation regarding medical loss ratio requirements and new, enhanced rate review requirements. The medical loss ratio legislation was passed immediately prior to the ACA in 2010 while the rate review legislation was passed in 2011. To promote compliance with the ACA's other early market reforms, the New Mexico Division of Insurance, a division of the Public Regulation Commission, issued a bulletin providing guidance to insurers about making changes to their policies and is tracking compliance through the review of insurer forms. According to informants, New Mexico insurers have largely complied with the new requirements.

Informants were confident that the state would come into compliance with the market reforms that go into effect in 2014 to avoid a regulatory takeover by the federal government. Although state officials have begun studying issues related to the 2014 market reforms, New Mexico has not yet made many broad policy decisions, such as whether to merge its individual and small group markets. New Mexico is using federal funding available under the ACA to analyze such policy issues, and the Division of Insurance received two federal rate review grants to enhance its regulatory capacity.

Medicaid Policy—State estimates indicate that New Mexico's Medicaid enrollment could increase by up to 36 percent between 2012 and 2020, from its current level of 550,000 to as many as 750,000 in 2020. While such growth is considerable, New Mexico's existing Medicaid program will serve as a strong foundation to support this coverage expansion. Its Medicaid eligibility standards, scope of services, and provider reimbursement levels are largely consistent with national standards and perceived as reasonable by informants. New Mexico can also draw upon its strong Medicaid managed care program. Currently covering about 80 percent of Medicaid enrollees, New Mexico's managed care program has been operating for 15 years and enjoys a stable relationship with all the state's major health plans.

Federal funding for Medicaid is helping New Mexico overhaul its Medicaid eligibility and enrollment IT system, which will help ensure that the state will be ready for ACA expansion in 2014. In the meantime, New Mexico aims to fundamentally restructure its Medicaid program in accordance with its recent Centennial Care plan. Citing concerns that the current Medicaid system is "not sustainable" and to prepare for future expansion, the Martinez administration's goal is to establish a comprehensive service delivery system that provides cost-effective care, slows the rate of Medicaid cost growth, and streamlines administrative burdens.

Providers and Insurers—New Mexico has a unique provider and insurance market, which presents challenges to health care access. The state has two large integrated health systems that dominate the state's hospital and managed care markets. Further, physicians are increasingly consolidating into large practices aligned with a particular health system or as employees of a health system. This combination results in a very competitive health care market in New Mexico with few new players able to enter and effectively compete. At the same time, New Mexico has a very low population density that limits the number of providers and insurers it can support.

These access issues are exacerbated by what informants indicated was a woefully inadequate health care workforce in the state. Of New Mexico's 33 counties, 32 are designated as Health Professional Shortage Areas or Medically Underserved Areas. Owing in part to the highly rural nature of the state, physician recruitment and retention is a long-standing problem in New Mexico, and there is broad consensus that this issue will not be resolved soon, certainly not by 2014. Although New Mexico has a large network of federally qualified health centers (FQHCs) with more than 100 medical sites across the state, access to care for the

uninsured was described as challenging, particularly for specialty care. Indeed, the University of New Mexico was often described as the sole source of specialty care for low-income individuals across the state. How the state's safety net health system will absorb those newly insured under the ACA is of ongoing concern in New Mexico.

Conclusions—New Mexico has taken important steps in implementing the ACA by, for example, designating a

central state office of health care reform to coordinate the state's reform efforts across various agencies as well as working with both federal officials and New Mexico health care stakeholders. Despite this progress, considerable work remains. In particular, the state must designate or establish an entity to run its exchange. It is unclear whether the state will do so in the near future given the uncertainty surrounding the ACA and the Martinez administration's ambivalence toward the law.

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers, and policy-makers learn from the process as it unfolds. This report is one of 10 state case study analyses. The quantitative component of the project will produce analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally. For more information about RWJF's work on coverage, visit www.rwjf.org/coverage.

BACKGROUND

New Mexico's initial response to the passage of ACA was one of embrace with many activities implemented simultaneously. Under the direction of then-Governor Bill Richardson (D) the Health Care Reform Leadership Team was established by executive order in April 2010, a month after the ACA became law. In July 2010, the leadership team issued a report and, based on its findings, Richardson established the New Mexico Office of Health Care Reform (OHCR), which was charged with planning, coordinating and administering federal health reform. Membership of the Health Care Reform Leadership Team was eventually expanded to include more state agency heads and meetings were held on at least a monthly basis.

In September 2010, New Mexico was awarded a health insurance exchange planning grant from the U.S. Department of Health and Human Services (HHS). Funds from the grant were used for several contracted studies, including reports from a variety of stakeholder groups on how they would be affected by health reform. New Mexico also passed legislation regulating medical loss ratios and permitting the state to administer a temporary high-risk pool established by the ACA. Although the New Mexico legislature considered legislation that would have adopted some of the ACA's insurance reforms, this legislation did not pass.

Once Governor Martinez was sworn in on January 1, 2011, New Mexico's pace of ACA implementation slowed, but the state has continued to move forward. This is true even though informants expressed ambivalence and skepticism about the ACA. The Medicaid expansion called for by the ACA, for example, was described by some as especially problematic because the state would likely incur additional costs in the long run. While acknowledging that Medicaid expansion will be fully financed by the federal government until 2017, some informants expressed concern about future costs that the state would be forced to contribute towards the coverage for a sizable number of new enrollees. New enrollment is expected to be significant and, according to state estimates could increase by as much as 36 percent by 2020.3 Finally, some informants noted that the ACA was unduly imposed on the state, was not specific to the state's needs, and could potentially harm the state's already fragile health care system.

At the same time, the Martinez administration has recognized that the ACA is the "law of the land" and has pushed ahead on implementation. The state has not taken a "full-bore" implementation approach to the ACA, but, instead, has adopted a "practical" and "pragmatic" approach. New Mexico is working to ensure that, if the ACA is upheld by the Supreme Court, it is in a "good position" to be compliant with the law. Toward that end, the Martinez administration has undertaken several ACA

implementation activities: It re-established the OHCR that the Richardson administration created and, in August 2011, hired a new director and additional staff. The OHCR has maintained the stakeholder groups established under the planning grant and held numerous meetings on health reform to seek stakeholder input. The OHCR also regularly convenes an interagency leadership group that includes representatives from the Division of Insurance and other agencies within the Human Services Department.

The Martinez administration was described as being supportive of an exchange, which is an idea that had been considered by the New Mexico legislature, including conservative legislators, since 2007. Despite this support, Governor Martinez vetoed exchange legislation that narrowly passed the legislature in 2011. In her veto message, she cited the legal challenges to the ACA, the potential costs of an exchange, and the lack of federal guidance on exchange implementation as her reasons for not signing the bill.4 Notwithstanding this veto, the OHCR continued its efforts to plan for an exchange and, in November 2011. New Mexico was awarded a \$34 million level one establishment award from HHS. At the time of our visit, the OHCR planned to use this funding to make progress on developing an IT infrastructure to support the exchange. In an expedited procurement process, vendors submitted responses to a request for proposals for exchange IT services in March 2012 but, as of this writing, no award has yet been issued.

Because Governor Martinez vetoed exchange legislation in 2011 and newly introduced legislation did not advance out of committee in 2012, she is widely expected to issue an executive order establishing an exchange. At the time of our site visit in February 2012, release of such an executive order was described as imminent, and the state was planning to apply for a level two establishment award in March 2012. As of this writing in May 2012, however, Governor Martinez has yet to release an executive order, and the director of the OHCR resigned in March.⁵

Even with these setbacks, New Mexico appears to be continuing to pursue health care reform implementation: On March 29, 2012, the state released a request for proposals seeking consulting services to help with the

establishment of the exchange, particularly in the areas of stakeholder consultation, programmatic integration, health insurance market reforms and business operations. According to the proposal request, New Mexico had planned to apply for a level two establishment award by July 2012. In May 2012, New Mexico announced that it had selected Leavitt Partners, a health policy consulting firm, to assist the state in furthering its strategic planning for the exchange as well as assisting with the development of exchange policy, rules and regulations.

In 2011, 41.6 percent of New Mexico's 1.8 million residents under age 65 had employer-sponsored insurance, according to the estimates from the Urban Institute's Health Insurance Policy Simulation Model. Just over 4 percent had non-group coverage and 26.7 percent had Medicaid, CHIP or other public coverage. Nearly 28 percent of New Mexicans under age 65 were uninsured. Once the ACA is fully implemented in 2014, the New Mexico's uninsurance rate is projected to drop to 13.9 percent with 162,000 individuals gaining insurance coverage through the exchange (45,000 employer sponsored and 117,000 non-group) and an additional 152,000 through Medicaid and the Children's Health Insurance Program CHIP.

Informants widely acknowledged the need to shore up the state's "fragile as a spider web's" health care system, which was ranked last among states in access to care in a 2009 Commonwealth Fund study.8 Informants highlighted many factors that contributed this low rating: New Mexico has the second highest rate of uninsurance in the country and the fourth highest rate of uninsurance for children. New Mexico also has the second highest poverty rate in the country with 26 percent of New Mexicans with incomes below 100 percent of the federal poverty level (FPL) in 2011.9 It is also among the least populated states - ranked fifth among states in terms of land mass but with only 2 million residents -making it very challenging to establish and maintain a robust health care provider network. Indeed, 32 out of New Mexico's 33 counties are designated as Health Professional Shortage Areas.

HEALTH INSURANCE EXCHANGE: PLANNING AND IMPLEMENTATION

Legislative Developments

New Mexico has adopted a pragmatic approach to developing a health insurance exchange and is committed to doing so in a way that reflects the state's unique characteristics, including its small and rural population, its high poverty rate, its sizable Native American population, its high number of uninsured, and its small state budget.

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The concept of a New Mexico exchange is not new and has been studied by state legislators since 2007. This prior support for exchanges—particularly from the governor's chief-of-staff during his tenure as a state legislator. Although the governor is in favor of repealing the ACA, she appears to support a state-operated exchange to "maintain control over the design of a market-based exchange, instead of allowing the federal government to define the process." To that end, Governor Martinez submitted a letter of endorsement of New Mexico's level one establishment award application.

Despite this avowed support, New Mexico has not yet approved exchange legislation. In 2011, the legislature passed the New Mexico Health Insurance Exchange Act which was ultimately vetoed by Governor Martinez. ¹⁵ The failed legislation would have established a new, non-profit public corporation and prohibited insurers or individuals with a financial conflict of interest from serving on the board. ¹⁶ In vetoing the bill, the governor indicated her "general support of the creation of a framework to establish a state insurance exchange" but believed that signing such a bill was "premature" in light of the legal challenges to the ACA, the potential costs of an exchange, and the lack of federal guidance on exchange implementation. ¹⁷ Some informants

described the legislation as "overly prescriptive" while others suggested that it did not give the governor the power to control major features of the exchange such as appointing all members of the board or prohibiting the exchange from being an active purchaser.

Exchange legislation was re-introduced during New Mexico's short 2012 legislative session but it did not advance. One informant noted that the lack of action on the bill was appropriate because the governor's concerns about the 2011 exchange legislation—legal challenges, cost, and clarity—still had not been addressed.

To avoid having a federally-facilitated exchange, New Mexico must demonstrate its readiness to operate a state-based exchange. In January 2013, and at the time of our site visit in February 2012, Governor Martinez was expected to issue an executive order establishing an exchange. If she does issue an executive order, consumer advocacy organizations are anticipated to challenge the order's constitutionality by arguing that the governor cannot veto exchange legislation and then circumvent the legislature by issuing an executive order establishing the exchange. Although some informants do not expect such a challenge to be successful, others pointed to two decisions from the New Mexico Supreme Court from the 1990s that could serve as precedent to limit the governor's authority to issue such an executive order that circumvents the authority of the legislature. 19 No executive order has been issued as of this writing in May 2012.

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Progress in Operationalizing the Exchange

Even though New Mexico has not yet passed exchange legislation or issued an executive order, the OHCR has

continued with reform planning efforts that began during the Richardson administration. The OHCR received a \$1,000,000 planning grant in September 2010 which, according to one stakeholder, was used to generate "foundational buyin" from stakeholders. The OHCR established seven stakeholder groups: the insurance industry; health care providers; consumer advocates; small employers; Native Americans; Medicaid; and IT stakeholders. The OHCR also commissioned 13 studies of stakeholder needs. No further reports are expected even though informants reported that the OHCR had only spent about \$600,000 of the planning grant as of our visit.

Once Governor Martinez took office in January 2011, New Mexico's exchange efforts slowed, and the OHCR's activities were largely limited to grant management and facilitating stakeholder meetings. According to informants, the team lacked leadership and a clear mandate, and was directed by the governor's office and the Secretary of the Human Services Department to only meet minimum federal guidelines until an OHCR director could be appointed. It took about six months to do so, but Governor Martinez appointed a director of the OHCR in August 2011.²² According to informants, the new director focused his energy on quickly preparing and submitting a level one establishment award application for \$34 million which was awarded in November 2011.²³

New Mexico plans to use its level one funding to begin operationalizing the exchange. According to reports on the state's implementation efforts, about \$24 million will be used to fund the IT system; however, the OHCR had yet to award these funds at the time of this writing in May 2012.²⁴ According to informants at the time of our site visit, the remaining funds are to be distributed among the OHCR's interagency partners who will each play a role in exchange planning. Major partners and roles are expected to be the following:

- New Mexico Health Insurance Alliance (NMHIA). The NMHIA is a quasi-public entity established in 1994 that was named as the exchange entity in the state's level one establishment award application. It will continue the planning and development activities required to operationalize the exchange, establish a Native American service center, and hire staff under a memorandum of understanding with the OHCR.
- New Mexico Division of Insurance (DOI). The DOI
 will begin the process of preparing to certify qualified
 health plans as well as license and certify navigators,
 among other activities.

- New Mexico Medical Insurance Pool (NMMIP).
 The NMMIP is the state's high risk pool which has begun working on issues related to risk adjustment and reinsurance to be operational in 2014.
- University of New Mexico (UNM). UNM will provide training to navigators and organizations such as the Primary Care Association on eligibility and enrollment.

At the time of our visit, the OHCR was expected to apply for level two funding to further support exchange development but had not submitted an application for such funding at the time of this writing.

Policy Issues: Decisions Made and Sources of Controversy

New Mexico appears to be committed to pursuing a state-operated exchange. This approach is supported by the governor's office, key officials, and stakeholders because a state-operated exchange is seen as being more responsive to the diversity of New Mexico's population than a federal exchange.

New Mexico has made few formal policy decisions pertaining to the exchange and uncertainty remains about how and whether such decisions will be reflected in an executive order. Despite this, New Mexico appears to be committed to pursuing a state-operated exchange. This approach is supported by the governor's office, key officials, and stakeholders because a state-operated exchange is seen as being more responsive to the diversity of New Mexico's population than a federal exchange. There also appears to be broad support to establish a single individual and Small Business Health Options Program (SHOP) exchange as a quasi-public entity. Although not all informants agreed, most indicated that New Mexico's exchange will likely have insurers on the exchange board, not be an active purchaser, and use brokers in some capacity to market exchange plans. However, these decisions—like many others—are not yet formal and will likely be decided after the governor issues an executive order.

The governance of the exchange board—specifically whether to allow insurers on the board—has been a source of significant controversy in New Mexico and appears to have led the OHCR to name the NMHIA as the exchange entity in its level one application. The NMHIA is a quasi-public entity created by the New Mexico legislature in 1994

to increase access to health insurance for small businesses, the self-employed, and other qualified individuals. ²⁵ Insurers make up a significant number of the members of the NMHIA board with the remaining members appointed by the governor. ²⁶ Informants acknowledged that enrollment in NMHIA products has not been robust and only 3,896 lives were covered by its products in 2010. ²⁷ It was suggested that enrollment has been historically low because the NMHIA's plans are not designed or priced to compete well against those offered in the traditional small group market. Informants further noted the board is "overly governed by carriers and brokers" without adequate community input.

Some informants indicated that because the NHMIA already possesses the legal authority to perform some exchange-like functions it was named in the level one application to strengthen the state's proposal. Others, however, suggested that the NMHIA was named to ensure that the exchange board included insurers and that the governor could control the board through her existing appointment power. The consumer advocate stakeholder group appears to have been particularly vocal in criticizing the OHCR's decision to name the NMHIA in its level one application. According to informants, the legislature will likely need to amend the NMHIA's statutory authority to serve as the exchange because its existing authority is not "a perfect fit" with federal requirements.

Another source of controversy has been among the stakeholder groups established by the OHCR. Of particular note was that not all stakeholders were engaged in the process. For example, the small employers stakeholder group and IT stakeholder group met only twice. Informants suggested that, for example, small employer stakeholders are not well-organized or engaged on health reform issues. In addition, informants noted that even the active stakeholder groups were difficult to manage because the state did not define goals or outcomes for the groups. To address these issues, the OHCR has been considering plans to transition to a structure where stakeholder groups are organized by topic (e.g., "essential health benefits") rather than by the type of stakeholder.

Insurers Participation and Expected Enrollment in Exchange Plans

Informants described New Mexico's insurance market as very competitive in both the individual and small group market and suggested that the state's major insurers were likely to participate in the exchange. As one informant noted, participation in the exchange will be an "important part of business strategy" in the individual market. Although informants were not convinced that new national insurers would enter the market because of the exchange alone, some noted that at least one insurer currently offering

New Mexico Health Connections: A Co-op for New Mexico

In 2012, a newly established nonprofit co-op called the New Mexico Health Connections received \$6 million in federal start-up funds to be followed by a \$64 million line of credit. One informant described the co-op as a potential "game-changer" because it can achieve goals that traditional health insurers and Medicaid managed care organizations have been unable to achieve such as adopting alternative funding mechanisms, addressing health disparities, and promoting positive health outcomes. According to informants, the co-op did not seek formal governmental support from the governor or legislature but the co-op's leaders did present their plan to one of the state's interim legislative committees and eventually received letters of support from New Mexico's U.S. congressional delegation. The co-op also received critical

support from the DOI which agreed to accept the co-op's federal loan as reserves to allow the co-op to meet state regulatory requirements.

The co-op will be offered on the exchange and plans to make its products available in rural areas and to Native Americans. It is expected to be operational in 2013 with anticipated enrollment of 15,000 to 20,000 individuals in its first year. Some informants noted the co-op will generate consumer trust because it is a consumer-driven plan led by strong advocates for health reform and access to care. However, even supportive informants expressed caution about how much work remains and that the co-op's leaders will need the requisite expertise to manage such an undertaking.

policies in only the Medicaid managed care market in New Mexico will likely enter the commercial market through the exchange. In addition, New Mexico Health Connections, a newly established nonprofit, received funding for a consumer-oriented and operated health plan (co-op) and is planning to participate in the exchange.²⁸ Informants also noted the possible development of a private exchange for groups of 100 or more.

New Mexico estimates indicate that 23 percent of New Mexico's 2.0 million residents—about 430,000—are uninsured.²⁹ Of the uninsured, as many as 250,000 are

predicted to be eligible for the exchange between 2014 and 2020, and up to 135,000 uninsured are predicted to enroll in either Medicaid or a qualified health plan through the exchange in 2014. Native Americans are disproportionately represented among the uninsured and account for an estimated 50,000 of the state's overall uninsured population.³⁰ Given that the ACA contains special provisions regarding Native Americans (such as exempting Native Americans with incomes below 300 percent of poverty from cost-sharing requirements), some of this coverage disparity may diminish in the future.

HEALTH INSURANCE EXCHANGE: ENROLLMENT AND SUBSIDY DETERMINATIONS

As of the February visit, the OHCR planned to implement a "no wrong door" approach for the exchange and build upon its IT eligibility and enrollment system for Medicaid and social services. New Mexico's eligibility system for Medicaid is already integrated with other human services programs such as Temporary Assistance for Needy Families and low-income housing. Under a separate Medicaid IT modernization effort, the state has begun a major overhaul of its current Medicaid system to a new system referred to as ASPEN (Automated System Program and Eligibility Network).31 One informant noted that the state is "a step ahead" of other states because this work is well underway and New Mexico's existing eligibility and enrollment process already allows individuals to simultaneously enroll in multiple programs. In short, New Mexico will not be "starting from scratch" in integrating the exchange with Medicaid and other human services programs.

The OHCR plans to implement a "no wrong door" approach for the exchange and build upon its IT eligibility and enrollment system for Medicaid and social services.

According to the OHCR's request for proposals issued in February 2012, exchange IT is expected to be built in parallel with the Medicaid IT system and will be integrated with ASPEN, with the expectation that both systems work together "seamlessly." ASPEN will perform eligibility determinations for Medicaid while the exchange IT system

will do so for qualified health plans, premium tax credits, and cost-sharing reductions. The state's goal is to implement the exchange as a "one-stop shop" with a single portal called "Yes New Mexico" where an individual enters basic information and self-attests to their income and other data. This data will be communicated in real-time to the federal hub and then verified through eligibility and rules systems. If the individual is eligible for Medicaid, they will be directed to the Medicaid website. He they are not eligible for Medicaid, they will be directed to the exchange website.

Deloitte is building the ASPEN system and many informants expect them to also bid for the exchange which would result in a single vendor working on ASPEN and exchange IT, thereby allowing the state to leverage the ASPEN rules engine. However, according to informants, the state will evaluate all bids and a different vendor could successfully "bolt on" the exchange IT to ASPEN and connect to the federal hub to verify eligibility. At the time of this writing in May 2012, this contract had not yet been awarded.

Although informants indicated that the state is largely ahead of other states in its IT development, questions remain about how the eligibility system will function. Questions were raised about how the system will address changes in eligibility in real-time as well as whether and how it will collect payments. As in many other states, eligibility verification was another concern, including how eligibility will be electronically verified, whether the federal hub will be ready on time, and the meaning of communicating "real-time" data to consumers. Others

noted concerns that the state is "building the car as we're driving down the road" because many federal requirements—such as the federal hub and business processes—have not been finalized. According to informants, because of the uncertainty around final system requirements, the OHCR set aside about \$1,000,000 in its level one funding to accommodate IT changes the federal government may make in the future.

Maximizing Enrollment in Medicaid and Exchange Plans

Informants widely acknowledged that consumer outreach and education will be critical to the success of the exchange. Although there are no specific strategies or plans in place for consumer outreach, the state is beginning strategic planning on this issue. In particular, informants emphasized the need to train Medicaid eligibility workers, medical workers, and navigators to use the IT system and provide accurate information to consumers. To do so, the state is expected to work with University of New Mexico as mentioned above.

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New Mexico is also evaluating how to reach the 36 percent of New Mexicans estimated to be without internet access and exploring strategies to conduct outreach to New Mexico's Native American population, which accounts for about 10 percent of state's total population and is overrepresented among the uninsured. To help improve Native American enrollment in Medicaid and in the exchange, the state plans to establish a dedicated Native American resource service center that could potentially train Native American navigators. Informants suggested that the

exchange may offer qualified health plans specifically for Native Americans to make such health plans attractive and accommodate the ACA's special eligibility rules for the population. For example, Native Americans are exempt from the ACA's requirement to obtain health insurance; can enroll or dis-enroll in coverage on a monthly basis; and do not face cost-sharing if their income is 300 percent of the federal poverty line or higher, rather than the standard 200 percent for other individuals.

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Many informants expect insurance brokers to play a role in eligibility and enrollment for the exchange. New Mexico has a heavily broker-mediated market and, according to informants, navigators may refer individuals to brokers for assistance with exchange enrollment. New Mexico has yet to decide how to finance navigators or involve brokers in the exchange, but informants noted that the NMHIA currently uses brokers and has its own certification program to train brokers on its products.

New Mexico also plans to partner with the DOI's consumer assistance program, which received a federal Consumer Assistance Program grant of about \$226,000. The DOI used this funding to hire a new consumer ombudsman to assist individuals looking for health insurance; develop a statewide plan for outreach to consumers on the ACA's insurance reforms; and establish a dedicated telephone line available in different languages, including Native American languages.

INSURANCE REFORMS

New Mexico has made recent changes to state law to address some—but not all—of the market reforms established by the ACA. For example, the state passed legislation on rate review and medical loss ratio requirements but not the other early market reforms which went into effect in 2010.³⁷ Though the New Mexico legislature considered legislation in 2011 and 2012 that would have adopted many of the ACA's market reforms, the bills did not pass.³⁸ Informants, however, were

confident that the state will bring its laws into compliance ahead of 2014, particularly because of the threat of a federal takeover if it fails to do so.

New Mexico's health insurance industry is regulated by the DOI, which unlike most states, does not sit within the executive branch and is, instead, part of the state's Public Regulation Commission. Informants indicated that this division between the executive branch and the commission has been challenging for ACA implementation. In 2012, the legislature passed a proposed constitutional amendment that, subject to voter approval, would remove the DOI from the commission and make it an executive department in July 2013.³⁹ Many informants expressed support for the amendment and predicted that it will be approved by voters when it appears on the ballot in November 2012.

New Mexico has made recent changes to state law to address some—but not all—of the market reforms established by the ACA.

Implementation and Impacts of the ACA's Early Market Reforms

Although the New Mexico legislature considered legislation addressing the ACA's early market reforms, ⁴⁰ this legislation did not pass. Despite this failed legislation, the ACA sets a federal floor for consumer protections and allows—but does not require—states to adopt and enforce these reforms. Under federal law, the early market reforms went into effect in September 2010 and include expanding dependent coverage up to age 26, covering preventive services without cost-sharing, and the right to have an appeal externally reviewed by an independent organization. Informants noted that some of these protections were already reflected in state law, such as a restriction on rescissions.

To promote compliance with the early market reforms, the DOI issued guidance to insurers in September 2010 about making changes to their policies and is tracking compliance through the review of insurer forms. ⁴¹ According to informants, insurers have largely complied with the new requirements with few, if any, difficulties although at least one insurer ceased to offer grandfathered plans because of the administrative burden of monitoring grandfathered status and the lack of final rules from the federal government.

One of the ACA's early market reforms restricts insurers from denying coverage to children under the age of 19 based on a preexisting condition. In response to this new requirement, all insurers in New Mexico initially ceased to offer child-only coverage in the individual market. New Mexico did not take official action to encourage the sale of child-only policies as other states have done, but the board of the NMMIP, the state's high risk pool, agreed to allow children to enroll in the pool if they could not obtain child-only policies elsewhere. Following the availability of NMMIP coverage,

Presbyterian Healthcare Services, the state's largest insurer, resumed offering child-only policies, but at premiums that were adjusted significantly based on health status. According to informants, Presbyterian is currently the only private carrier voluntarily offering child-only policies in the state.

Planning for the Insurance Reforms of 2014

Informants agreed that New Mexico will likely have to pass new legislation to implement the ACA's broader market reforms that go into effect in 2014 – such as the ban on preexisting condition exclusion periods and strict rating requirements – because the state does not have the authority to enforce federal law. The legislature considered a bill in 2012 that would have addressed many of these market reforms, but it did not pass in part because of uncertainty about whether the ACA will be struck down or repealed. Despite this uncertainty, the New Mexico legislature did pass a measure before the ACA was enacted that phases out the use of gender in setting rates which will be consistent with the federal rating standards that go into effect in 2014.

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New Mexico has not yet made many policy decisions regarding the 2014 market reforms. In approaching these decisions, informants highlighted the need to minimize market disruption. One key government informant was supportive of merging the individual and small group markets in the exchange and defining small employers as groups with 2 to 100 employees, but this remains undecided. This is also true of establishing a benchmark for the state's essential health benefits requirements. According to informants, the DOI is reviewing benchmark options, and the OHCR, in conjunction with the DOI, is identifying diverse stakeholders to serve on a working group and generate consensus on the issue. Most informants were confident that New Mexico would define its own benchmark but some expressed concern about the high number of insurance

mandates that already exist in the state that may make coverage costly for newly insured populations.

New Mexico has also begun working on risk adjustment and reinsurance but has made no formal decisions. The DOI is currently working with officials from the state's high risk pool, NMMIP, to evaluate New Mexico's options regarding these issues. Some indicated that the DOI will develop its own risk adjustment methodology to compare to the federal methodology while others suggested that the state may not have the expertise to do so. NMMIP staff is identifying a non-profit to manage reinsurance and testing models for risk adjustment with the hope that insurers will voluntarily release claims data since New Mexico does not have an all-payer claims database.

High-Risk Pool

The NMMIP, New Mexico's high risk pool, is widely regarded as a model program with enrollment of more than 8,000 individuals. 45 Because of its success in enrollment, informants expressed concern about seamlessly enrolling NMMIP enrollees into the exchange while limiting adverse selection. In 2010, the legislature amended the NMMIP statute to allow the organization to run the federal Pre-Existing Condition Insurance Plan (PCIP).46 According to informants, there was little resistance among state leaders in taking on the PCIP because enrollees in the federal program likely would have enrolled in the NMMIP and. therefore, the PCIP saves money for the state. Unlike most states, New Mexico is subsidizing the PCIP using state funds because the state extended tax credits available to NMMIP enrollees to PCIP enrollees. One informant noted that this was done because potential enrollees are highly price-sensitive and would have been driven from the PCIP into the NMMIP if the PCIP did not also provide discounted premiums. According to an informant, the PCIP has already exceeded its enrollment expectations and claims have been two to three times higher than anticipated, requiring the state to work with federal regulators to secure additional funding. Without this additional funding, the informant indicated that PCIP enrollment would have ceased months earlier.

Focus on Affordability: Medical Loss Ratio and Rate Review

Medical Loss Ratio. Prior to the ACA, New Mexico passed legislation on medical loss ratio (MLR) requirements.⁴⁷ The state initially required that individual and small group insurers maintain an MLR of 75 and 85 percent, respectively, instead of 80 percent as required by the ACA. In light of the ACA, the DOI deferred enactment

of its MLR standard until the release of federal MLR regulations and later issued a bulletin requiring an MLR of 80 percent in the individual market. As New Mexico retained its MLR standard of 85 percent in the small group market which exceeds the federal standard of 80 percent. Some informants suggested that the state standard should be the same as the federal law to avoid confusion. Even though New Mexico insurers had significantly lower MLRs prior to these new requirements, New Mexico did not apply for an MLR adjustment and informants did not expect insurers to have to issue rebates in 2012.

According to informants, there was little resistance among state leaders in taking on the PCIP because enrollees in the federal program likely would have enrolled in the NMMIP and, therefore, the PCIP saves money for the state.

Broker compensation appears to be of ongoing concern in New Mexico. Informants indicated that, in reaction to implementation of the heightened MLR standards, some carriers cut commissions in the individual and small group markets by about 50 percent and 20 percent, respectively. In addition, some insurers have removed the broker commissions from the premium entirely and are requiring brokers to establish separate contracts with clients. Informants also noted a trend of consolidation among independent brokers.

Rate Review. New Mexico had the authority to review and approve all rate requests in the individual and small group markets prior to the ACA.⁴⁹ Although informants suggested that New Mexico's existing rate review process would have met the federal rate review standard, the legislature passed enhanced rate review legislation in 2011 with new requirements that exceed the federal standard for an effective rate review program [Box 2].50 Informants reported that insurers lobbied against the legislation but the bill passed in part because of public outcry over past rate review controversies. To date, state officials reported that, as a result of the ACA and New Mexico's new rate review legislation, approved rate increases are significantly lower than those requested prior to the enactment of these laws, and three insurers recently agreed to reduce their rate filings to reflect only medical inflation, or close to it.

New Mexico also received two federal rate review grants of \$1 million and \$3 million. This funding has allowed the DOI to hire a rate review team – the Consumer and Business Taskforce Unit – which includes a hearing officer, an IT specialist, a management analyst, and a financial analyst to work with the DOI's actuaries. This unit serves as an extension of the existing rate review team and is dedicated to addressing rate review issues that need an elevated level of attention from regulators. New Mexico also used its

rate review grant funds to consult with an external actuary; establish a website devoted to rate review; and commission a study on consumer engagement.⁵¹ The state reported that it will use its second rate review grant to continue paying for an external actuary to conduct additional review of rate increases and additional stakeholder engagement through, for example, holding town hall meetings and media campaigns.⁵²

Rate Review in New Mexico: Exceeding the ACA's Requirements

In April 2011, the New Mexico legislature passed legislation granting the New Mexico DOI with additional authority to review health insurer rate increases. These requirements exceed the ACA's requirements for rate review and introduced a heightened standard of review of rates, improved transparency standards, and opportunities for public involvement in the rate review process. This legislation became effective January 1, 2012 and, among other new requirements, requires:

 Rates to be actuarially sound, reasonable, not excessive or inadequate, and not unfairly discriminatory and based on reasonable administrative expenses;

- Public web access to health insurance rate filings with a 30-day period for public comment; and
- Regulators to consider an insurer's financial position (including surplus and reserves), data to support compliance with state standards related to MLR, anticipated changes in an insurer's number of enrollees if proposed rate is approved, changes in covered benefits or plan design, compliance with certain state and federal requirements; and comments submitted by consumers; among other factors.

MEDICAID POLICY

Medicaid is a major insurer in New Mexico that covers some 560,000 New Mexicans, or more than one-fourth of the state's population. New Mexico's Medicaid coverage rate is well above the national average of 20 percent, reflecting the state's significant poverty. In 2010, 28 percent of New Mexicans had incomes below 100 percent of the FPL, the second highest poverty rate in the nation.⁵³ Reflecting the state's considerable poverty, New Mexico's federal Medicaid match was 69.8 percent in 2012, among the highest across the states.

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Even with this poverty, the scope of New Mexico's Medicaid program is generally consistent with that of the nation overall: It covers most but not all optional services, and, on a per person basis, its Medicaid spending is close to the national average. Similarly, New Mexico's Medicaid eligibility rules are consistent with those of other states: Between Medicaid and CHIP (which is fully integrated into Medicaid), children with an income up to 235 percent of poverty are covered and make up nearly 60 percent of the state's total Medicaid enrollment. The state also covers pregnant women and parents whose incomes are up to 185 percent and 85 percent of poverty, respectively.

As part of the Richardson administration's "Insure New Mexico!" effort, several initiatives were introduced to help

provide coverage to low-income adults. One initiative, which is part of the State Coverage Insurance (SCI) program, provides a limited benefit package through a Medicaid Section 1115 waiver to adults with and without children who have incomes up to 200 percent of FPL. While enrollment has been frozen since November 2010, some 40,000 adults are currently enrolled in Medicaid through the SCI program. Other initiatives included premium assistance programs for pregnant women with incomes above 235 percent of FPL and for children less than 12 years old with incomes above 235 percent of FPL. Both programs are financed with private, individual, and state and federal Medicaid funding, but enrollment closed in 2010. In 2012, enrollment in the two programs had dwindled to less than 200.

Budget Pressures and Medicaid

Like all states, New Mexico's Medicaid spending has steadily increased in recent years, putting pressure on the state's budget. In fiscal year 2013, New Mexico is expected to spend about 16 percent of its overall general budget on Medicaid, up from 12 percent the previous fiscal year. 55 This rapid spending growth is partly due to a rise in program enrollment, which grew 5 percent between 2008 and 2009, because of the sagging economy, but mainly due to the loss of the enhanced federal Medicaid match that was provided as part of the American Recovery and Reinvestment Act (ARRA), described by one informant as "saving us from tanking Medicaid." Under ARRA, New Mexico secured about a 10 percentage point bump in its match rate, receiving nearly an 80 percent match rate, up from its regular rate of about 70 percent. According to state officials, the loss of the enhanced ARRA match alone increased New Mexico's Medicaid spending about \$300 million, a considerable amount given the state's level of spending on the program.

Despite increasing costs, the Martinez administration has not made significant Medicaid cuts over the last two fiscal years.

Despite increasing costs, the Martinez administration has not made significant Medicaid cuts over the last two fiscal years. Indeed, since taking office, the governor has requested larger budget increases for Medicaid than proposed by the legislature's finance committee. In the just-passed budget for fiscal year

2013, the legislature approved a 3 to 4 percent increase in state Medicaid spending. According to informants, the governor recognizes that Medicaid is an important payer in the state's fragile health care system, that the need for Medicaid continues to be high given the state's economic condition and the number of uninsured New Mexicans, and that large program spending cuts would have significant and far-reaching consequences. In addition, New Mexico had a small budget surplus this fiscal year, which helped to protect Medicaid from cuts, according to informants.

During the 2011 fiscal year, New Mexico observed an unexpected "flattening out" in Medicaid enrollment, which also eased program budget pressures. Some informants attributed the drop to an improving economy while others credited a decline in enrollment "churn" because of passive Medicaid recertification New Mexico implemented in 2007. Still others suggested that the drop reflected the state's scaling back on outreach and enrollment efforts beginning in 2009.

While Medicaid has been largely spared in the last two budget cycles, New Mexico has made some program cuts and changes beginning in 2009. These include reducing provider payment rates and capitation rates, changing payment methodology for hospital outpatient services, changing methodology for determining service hours for personal case services, making changes to the pharmacy benefit, and freezing enrollment in the SCI and premium assistance programs described above. In addition, New Mexico has tried to better manage its Medicaid program. For example, while not eliminating benefits, they have "tightened" some benefits such as limiting the number of eyeglasses or panoramic x-rays. The state also tried to improve cost settling with "border" hospitals in other states where Medicaid beneficiaries may seek care because of New Mexico's rural nature.

Although the Martinez administration has not made major Medicaid cuts over the past two budget years, it believes that maintaining the program in its current incarnation is "not sustainable." In February 2012, the administration unveiled a Medicaid modernization plan called Centennial Care. In April, New Mexico submitted a formal Medicaid Section 1115 waiver request to the Centers for Medicare and Medicaid Services to implement the plan. The goals of Centennial Care are to create a comprehensive service delivery system that provides cost-effective care; slows

the rate of Medicaid cost growth without cutting services, eligibility or provider rates; and streamlines the program to prepare for the ACA Medicaid expansion in 2014.⁵⁷ One informant described Centennial Care as necessary to "put some sanity back in the program." New Mexico hopes to realize savings from Centennial Care's up-front investments in medical and health homes to produce a healthier population as well as back-end savings to promote quality care. The state estimates that it could reduce the rate of program spending growth between 2.75 and 4 percent over the five-year demonstration period.⁵⁸

To achieve these goals, Centennial Care has several guiding principles:

- Managing care through comprehensive care delivery;
- Combining all services into a "second generation" of managed care that offers the full array of benefits from prenatal care to nursing home care;
- Improving personal responsibility by rewarding for healthy behaviors and introducing selected costsharing strategies;
- Reforming provider payment to focus on outcomes rather than process; and
- Simplifying program administration by merging nearly all current Medicaid waivers into a single 1115 waiver, and reducing the number of contracted managed care plans.

With Centennial Care, New Mexico hopes to revamp its existing managed care program in a number of ways. For one, it hopes to realize program efficiencies by carving in virtually all services that would be provided by health plans under a capitated payment arrangement. This would include behavioral health services, community-based and institutional long-term care services, which are currently carved out of New Mexico's physical health managed care program. As part of combining these different services, New Mexico anticipates collapsing several of its 12 existing waivers into a single Section 1115 Research and Demonstration waiver. Under its current system of waivers, New Mexico contracts with six health plans, with the bulk of enrollees in Presbyterian, Lovelace and Molina health plans. As part of Centennial Care, the state would like to reduce the number of health plans it contracts with. The hope is to achieve administration savings but also to improve quality by providing care on a more systemic basis, which should also generate savings.

Subject to securing waiver approval from the federal government, New Mexico hopes to release a request for

proposals from managed care plans in June 2012, award plan contracts in September 2012, and have Centennial Care operational by October 2012.

Provider Taxes in New Mexico's Medicaid Program.

New Mexico does not rely heavily on provider taxes to finance its Medicaid program. The state, however, does impose a premium tax on all managed care plans. In the last two budget cycles, the nursing home industry had pushed for provider taxes as a way to help increase Medicaid reimbursement but the effort failed because the governor is opposed to raising taxes, including provider taxes. Given the state's modest use, informants were not concerned about possible limits being placed on Medicaid provider taxes, a topic that has been part of recent federal Medicaid policy discussions.

The ACA and New Mexico Medicaid

Like many states, New Mexico enrollment under the ACA could be considerable. Recent state estimates indicate that by 2014 about 80,000 uninsured New Mexicans will gain Medicaid coverage.⁵⁹ The state also projects that an additional 12,000 to 30,000 individuals currently eligible for Medicaid but not enrolled will enroll in the program in 2014.⁶⁰ By 2020, state estimates show that as many as 750,000 individuals could be insured by Medicaid, up from 550,000 in 2012. Thus, New Mexico's Medicaid enrollment could increase by some 36 percent between 2012 and 2020.

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Some of the newly eligible will be individuals currently enrolled in the SCI Program. The state estimates that roughly half of SCI enrollees, about 20,000 individuals, will transition to traditional Medicaid in 2014. While a formal decision has not yet been made, informants suggested it was unlikely that SCI enrollees with incomes above 138 percent of poverty would remain on Medicaid and would, instead, receive coverage through the exchange. In addition, no decision has yet been reached on what benefit package would be provided to newly eligible Medicaid enrollees. Some informants, however, indicated that the newly eligible

will likely not receive the full Medicaid package but instead a benefit package comparable to what is offered in the state's small group market.

Eligibility and Enrollment Systems. Before the ACA was enacted, New Mexico was already working on replacing its Medicaid eligibility and enrollment IT system, which is more than 20 years old and described as a largely paper-based system. Although New Mexico made several past attempts to overhaul its systems, the state faced a number of challenges including financing in particular. With the enhanced federal Medicaid match made available to states to improve HIT systems under ARRA, New Mexico began a new IT overhaul effort. The under-construction Medicaid eligibility system, ASPEN, is being built by Deloitte. A pilot ASPEN system is expected to be ready to test in one county by June 2013, with a statewide launch anticipated in 2014.

At the time of our site visit, informants acknowledged that no ACA outreach or enrollment campaigns had been formally initiated but viewed this as an activity to be undertaken at a later time. At the same time, informants emphasized the state's administrative and financial experience in operating the SCI program for low-income adults who had previously been uninsured. This experience places New Mexico among a handful of states and will aid in the state's planning and outreach to those newly eligible for Medicaid under the ACA. In addition, according to the state's grant proposal, New Mexico intends to use \$1.3 million of its level one exchange funds to contract with UNM to promote enrollment of individuals eligible for the exchange and Medicaid in 2014.

ACA Demonstration Options. New Mexico is taking advantage of several of the ACA demonstration options. For example, the state received a Section 2703 planning grant to design health homes and is initially focusing on health homes for individuals with behavioral health conditions. Selected mental health agencies will serve as the homes and coordinate behavioral and physical health services for Medicaid enrollees with high utilization of redundant services. Health homes will be piloted in local mental health services agencies in Albuquerque - with four such homes expected to be operational by early 2013 and eventually expanded to other areas of the state over time. New Mexico's hope is to eventually establish health homes for individuals with other chronic health conditions. The state also submitted a proposal to HHS in May 2012 to participate in the capitated integrated care model demonstration for dual eligibles.

The Basic Health Program Option. At the time of our visit, New Mexico, like most other states, had not reached a

decision on whether to implement the Basic Health Program (BHP) option. Some informants were supportive of a BHP because it could make health care more affordable for low-income individuals compared to the exchange as well as help mitigate critical transitions on and off of Medicaid since, by exercising the BHP option, Medicaid coverage would extend to 200 percent of poverty.

However, other informants noted many concerns about a BHP. One questioned how the BHP would affect the viability of the exchange because about 100,000 individuals - half of those expected to participate in a New Mexico exchange -would qualify for the BHP. According to informants, leaving only 100,000 individuals in the exchange could threaten its viability in terms of risk, plan participation, and premiums. Informants also were concerned about the potential financial risk that a BHP poses for New Mexico. Since New Mexico has a very favorable Medicaid match rate (70 percent), if it implemented the BHP it would be assuming a federal risk but only receiving 95 percent of what would be received if individuals were instead covered under the exchange. Others noted concerns about the costs of administering a BHP and recommended "wait[ing] until the smoke clears" before the state moves forward, especially because the state does not have to make a decision about the BHP by 2014. Finally, informants noted that some view the BHP as a quasi-Medicaid expansion, which the current administration would likely not support.

Notwithstanding these concerns, the legislature recently called for a study of the BHP option with an emphasis on affordability issues.⁶¹ Thus, New Mexico may continue to explore the possibility of the BHP.

Financial Impact of the ACA on New Mexico

Medicaid. Informants suggested that New Mexico may initially realize some savings, albeit modest, with the ACA. First, New Mexico estimates that about 20,000 or so SCI enrollees with incomes under 138 percent of poverty will be newly eligible for Medicaid under the ACA. Thus, New Mexico will no longer have to pay its full state Medicaid share for this population. Second, New Mexico will likely realize savings by shifting SCI enrollees with incomes above 138 percent of FPL into the exchange. Third, informants suggested that the state could reap some cost savings through the shared savings component of the financial alignment demonstration for dual eligibles if selected as a demonstration state. Finally, New Mexico could realize some savings through the enhanced Medicaid match provided as part of the health homes initiative.

Informants suggested that there may be some potential savings for New Mexico counties if services currently provided through county-run indigent care programs, such as behavioral health and substance abuse services, are covered under the ACA. Whether that occurs and the extent to which that occurs hinge on how the state's essential health benefits package is defined. However, any of these savings would accrue to county government, not the state. Informants did not express optimism that uncompensated care costs would diminish even with increased insurance coverage under the ACA because between 100,000 and 150,000 New Mexicans will remain uninsured in 2020 and the health care system will continue to have to pay for services provided to these individuals.

Informants recognize that the federal government will fully pay for newly eligible Medicaid enrollees until 2017 but expressed concern about 2017 and beyond when the state must contribute towards the newly eligible Medicaid population. This is a particular concern given the expected growth of Medicaid under reform in New Mexico. Informants were also concerned about health reform's so-called "woodwork effect"—that is, New Mexico would have to pay its standard [I] Medicaid share (which is about 30 percent) for any of the 60,000 individuals who are currently eligible for Medicaid but not enrolled in the event that these individuals choose to enroll. Recent state projections estimate that between 12,000 and 30,000 currently eligible but not enrolled individuals could enroll in Medicaid in 2014.

Although most informants agreed that the ACA will not generate cost savings for the state, some acknowledged that reform might change the "slope of health care costs and rate of growth of increases" in the long-term, particularly if the state is successful with the efficiency and quality components included in the Centennial Care Medicaid modernization plan.

Provider and Plan Capacity in New Mexico's Medicaid Program. Almost universally, informants thought

that the state had sufficient health plan capacity to absorb the expected Medicaid enrollment increase in 2014. This may be because the Medicaid program already accounts for 31 percent of covered lives in New Mexico. In addition, New Mexico has a long history of operating a Medicaid managed care program dating back to 1997. Currently, about 80 percent of New Mexico's Medicaid enrollees are enrolled in managed care, including dual enrollees.

Given that New Mexico's overall population is only about 2 million and Medicaid accounts for nearly one-third of covered lives in the state, little distinction exists between the Medicaid market and the commercial market. Informants noted that most providers have to take Medicaid enrollees to survive. The same is true for managed care plans: the large commercial plans are also the large Medicaid plans. Informants do not expect to see much change in the Medicaid managed care or commercial market, largely because New Mexico's insurance market was described as very competitive, with new plans unlikely to enter the market. Further, the state has long-standing contracts with managed care plans for Medicaid and informants suggested that it would be difficult for a new issuer to come into the state, particularly if the state goes forward with its Centennial Care plan, which calls for reducing the number of Medicaid plans as a way to generate program savings and improve administration.

Owing to the nature of New Mexico's managed care market, informants thought that plans participating in Medicaid would be the same as those participating in the exchange (and the commercial market). Indeed, informants suggested that state officials are considering making participation in the exchange a requirement for being a Medicaid contractor. While informants were confident about the state's managed care capacity to handle the influx of new Medicaid enrollees, virtually all were less sanguine about the strength of its primary care capacity.

PROVIDER AND INSURANCE MARKETS

Once the ACA is implemented and individuals obtain health insurance, the success of the reform hinges to a great extent on the reaction of local health care providers and insurers which will directly affect coverage, access to care, premiums, subsidy costs, and, ultimately, the sustainability of health reform.

Informants noted several unique and challenging aspects of New Mexico's health care market. First, New Mexico struggles to maintain a robust provider network, which is largely attributed to the difficulty in recruiting and retaining providers willing to practice in rural areas. New Mexico is the nation's fifth largest state in terms of land mass

but has a population of only two million. While the state has undertaken numerous efforts to strengthen its health workforce, it continues to fall short of demand, making access to health care services challenging. Indeed, in a 2009 ranking of states' access to care, New Mexico placed the lowest among states.⁶²

Informants noted several unique and challenging aspects of New Mexico's health care market. First, New Mexico struggles to maintain a robust provider network, which is largely attributed to the difficulty in recruiting and keeping providers practicing in rural areas. New Mexico is the nation's fifth largest state in terms of land mass but has a population of only two million. While the state has undertaken numerous efforts to strengthen its health workforce, it continues to fall short of demand, making access to health care services challenging.

Second, there is tremendous pressure on New Mexico's health care system because of its underlying funding structure and poverty level. About two-thirds of insured New Mexicans have public coverage under Medicaid, Medicare or as a state employee which makes it difficult for providers to shift costs to private payers who only account for one third of the insured market. Overlaying this is New Mexico's high rate of uninsurance (28 percent for those under 65) and high rate of poverty (26 percent of the overall population have incomes below 100 percent of poverty). On both measures, New Mexico is ranked as the second highest state in the nation. In short, there is tremendous pressure on New Mexico's health care system.

At the same time, informants noted some positive attributes about the state's health care system. One was that Medicaid enrollees typically had access to the same health care system as other insured New Mexicans. While access is a general problem in the state, it affects everyone, not just Medicaid enrollees. In addition, Medicaid was described as being a relatively generous payer. This in part because the state has been responsive to providers' demands that the program, with such a significant market

presence, maintain adequate reimbursement levels. Informants also suggested that the market is fairly well managed, as evidenced by Medicare outcomes.

New Mexico's Hospital Market

New Mexico has 32 acute care hospitals of which 16 are non-profit, nine are for-profit and seven are publiclyowned. Given New Mexico's vast geographic size and low population density, many of the hospitals have fewer than 50 beds and are located in rural areas. Indeed, 24 hospitals have been designated by the state as sole community providers and are eligible for additional Medicaid funding. These sole community hospitals generally offer very little specialty care. UNM is the state's only level one trauma hospital and was consistently identified by informants as New Mexico's main safety net hospital, particularly for inpatient care and outpatient specialty services. A large majority of inpatient care (up to 40 percent overall and 50 percent of Medicaid according to informants) is concentrated among five to six hospitals, with UNM accounting for the biggest share. Given the rural nature of the state and the travel distance between communities, informants also noted that it is not uncommon for New Mexicans living outside of the Santa Fe-Albuquerque corridor to go to neighboring states for hospital care, particularly trauma and inpatient care.

The state's two largest hospital systems are Presbyterian Health Care Services (Presbyterian) and Lovelace Health System (Lovelace). Presbyterian is the largest and the state's only fully integrated health system with its own health plans, eight hospitals, and employing 50 percent of its physicians. Recently acquired by Ardent Health Services, Lovelace is a partially integrated system that has its own health plans and six hospitals but no medical group following a divestiture a few years ago. Lovelace Health Plan which offers several different network tiers for enrollees contracts with over 7,000 health care providers across the state.

Despite the divestiture of Lovelace's physicians, New Mexico hospitals employing physicians is an ongoing trend. At the same time, New Mexico has experienced provider consolidation, especially in the urban areas such as Albuquerque where 50 percent of the state's physicians practice. Physicians are typically moving away from operating as single private practitioners to operating through a more corporate-based model in which large practices prevail. As one informant put it, "independent physicians are a dying breed." Often these groups have strong alignments with particular hospitals. One informant

noted that large hospital-based systems own "basically everything" in New Mexico's health care market. Another informant noted that this trend is a particular burden for smaller rural hospitals faced with the need to recruit physicians but without the patient volumes to pay them.

The combination of the hospital-physician alignment and physician consolidation has made for a "very competitive" health care market in New Mexico, according to informants. Informants described considerable struggles among hospitals and insurers to capture market share and to maintain a robust network of committed physicians.

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New Mexico Hospitals and the ACA. According to informants, New Mexico hospitals have had a mixed reaction about the ACA, and have embraced some of the reforms such as Medicaid eligibility expansions but not others, such as the cuts in Medicaid disproportionate share hospital (DSH) funding. Further, while New Mexico is a "low" Medicaid DSH state, the ACA DSH cuts come on top of Medicaid hospital reimbursement cuts the state implemented in 2009 and 2010. Also, New Mexico recently cut Medicaid managed care rates, which ultimately "trickles down to tougher contracts and less payments" for hospitals.

Informants also expressed concerns about the ACA tying payment to outcomes because this could potentially reduce hospital payments, especially in areas where the state is already low such as hospital readmissions. Another major issue for New Mexico hospitals links to the state's lack of primary care. ⁶⁴ Informants noted that newly insured individuals are going to seek out care but that the state's already strained primary care system is not going to be able to absorb them all and they will instead come to hospitals for care. On balance, informants indicated that the ACA would have a negative impact on New Mexico hospitals.

Though not directly tied to the ACA, informants raised concerns about the effect of the state's current push to expand Medicaid managed care on Medicaid add-on payments, in particular add-on payments made to sole community hospitals and hospital upper payment limit payments. In 2011, these payments totaled more \$200 million, far exceeding New Mexico's Medicaid DSH payments. The worry is that these add-on payments are tied to Medicaid fee-for-service payments. If Centennial Care, which calls for increased use of managed care, is adopted as currently envisioned, New Mexico's fee-for-service program may largely cease to exist, jeopardizing Medicaid add-on payments. However, the Centennial Care proposal would continue these add on payments through new delivery system reform pools.

New Mexico's Primary Care Market

By many measures, the supply and distribution of New Mexico's health care workforce is inadequate. Go Of New Mexico's 33 counties, 32 are designated as Health Professional Shortages Areas or Medically Underserved Areas. In 2010, there were six counties with fewer than three doctors and one with no doctor. Recent estimates suggest that New Mexico is short 400 to 600 full time equivalent primary care physicians, and the shortage is expected to grow to 950 over the next 10 years.

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This long-standing problem plagues both the Medicaid and the commercial populations and was widely identified as critical. Moreover, informants had little optimism for improvement in the near future. Although New Mexico has supported several initiatives to recruit and train physicians such as loan repayment programs, training stipends, and establishing a BA/MD degree program, the rate of medical student and resident retention at UNM is just 27 percent. 68 Like many other states, New Mexico has to recruit physicians from out of state, which informants noted as a challenge because many physicians do not want to practice in rural areas, where the need is greatest. Further,

informants felt that, with reform, New Mexico is at an even greater disadvantage in recruitment because the state is now in competition with other states also looking to fill gaps in primary care physicians.

In addition to trying to address the shortage of primary care doctors, New Mexico has undertaken efforts to recruit mid-level practitioners such as physician assistants and nurse practitioners to work in rural areas. These efforts have not been widely successful, largely because these professionals, like their physician counterparts, were described as reluctant to practice in isolated areas.

Informants did highlight some ways the state is trying to mitigate the effects of the shortage include the various Medicaid initiatives aimed at endorsing preventative care or improving integrating and coordinating care such as primary care medical homes and health homes. Indeed, such measures are one of the cornerstones of the Centennial Care plan. Another is that the state is considering building on its existing tele-health programs to try and bring care into rural areas, particularly specialty care. Also, according to one informant, at least one health plan is expected to introduce a strategy with case managers at the office level to help unburden primary care doctors and enable them to fully practice at their skill level.

In addition, informants highlight that New Mexico has a fairly robust primary care safety net for its uninsured, primarily because of its large network of FQHCs, which has been growing in recent years. At present, there are 15 centers located across the state with 100 medical sites, which function as the safety net in both urban and rural areas, according to informants. The FQHCs have increasingly been sponsoring school-based health centers, which for some communities is the only medical site. Because of the FQHCs, primary care was described as adequate, but all residents - whether insured or not - face difficulty in obtaining specialty care. This may result in doctors "beg[ging]" to get a referral in the local area or sending a patient to UNM which was described as the provider for specialty care for low-income populations. According to informants, this lack of access results in the state's dismal rankings for access to care.

New Mexico's Insurance Market

As noted above, Presbyterian and Lovelace are dominant insurers in both the commercial market and the Medicaid managed care market. In 2011, Presbyterian covered 33

percent of the Medicaid market and about 25 percent of the commercial market. For Lovelace, these statistics were, respectively, 17 percent and 11 percent. Blue Cross Blue Shield of New Mexico (BCBSNM) was the dominant commercial insurer, particularly in rural areas, covering 42 percent of lives. BCBSNM also participates in Medicaid but covered fewer than 5 percent of enrollees in 2011. ⁶⁹ Though much smaller, other players in the commercial market include United Healthcare and Humana; in the Medicaid market, Molina Healthcare is a major player.

In the individual and small group markets, competition among insurers was described as being "very robust" and "fierce" largely because of the state's small provider community and the integrated nature of Presbyterian and Lovelace.

In the individual and small group markets, competition among insurers was described as being "very robust" and "fierce" largely because of the state's small provider community and the integrated nature of Presbyterian and Lovelace. According to informants, the relationship between plans and hospitals varies by location. In rural areas where there is often only a single hospital, plans complain that hospitals have a competitive advantage. And in the state's principal urban area, Albuquerque, Presbyterian and Lovelace dominate and contract largely with their own hospitals, making contracting difficult for other insurers. In addition, since Presbyterian and Lovelace own their hospitals, they were described as being effective in holding down costs. Because of the degree of competition in the market and because Presbyterian and Lovelace command such a large share of the market making it difficult for new entities to enter market, informants did not expect new insurers to come to New Mexico in the near term.

According to informants, New Mexico insurers were opposed to the 2011 exchange bill that the governor eventually vetoed. While generally being supportive of the idea of an exchange, insurers were described as concerned that the industry would not be represented on the board and that the exchange would be an active purchaser.

New Mexico's Business Community and the ACA

As indicated above, informants report that the small business community has had limited involvement in ACA implementation to date. For example, although the OHCR established a small business stakeholder group to encourage input during the exchange development process, the group met only twice. Findings from a survey commissioned by the OHCR also indicated that "most small employers were uninformed of the

specifics of the ACA and the exchange."⁷⁰ The survey results further suggested that small businesses have "little understanding" of the benefits of the ACA's tax credits and who is eligible for such credits.⁷¹ This is true even though 88 percent of New Mexico's small businesses are estimated to be eligible for such benefits.⁷² Informants, however, noted that small business input is "critical" to ACA implementation. Indeed, OHCR is expected to request funding in its level two establishment application to conduct outreach to small businesses.

CONCLUSIONS

New Mexico has taken several important steps to implement the ACA. Although it has yet to pass new legislation or otherwise establish the legal authority to authorize an exchange, the governor is committed to implementing one that meets the state's unique needs. To that end, New Mexico has capitalized on all available federal funding, including a federal exchange planning grant and, most recently, a level one establishment award to complete planning tasks essential to operationalizing an exchange by 2014.

New Mexico also passed multiple pieces of legislation that adopted a new MLR standard, enhanced its rate review process, and allowed its state high risk pool to administer the federal PCIP. Although New Mexico did not pass legislation to implement the ACA's early market reforms, the state is helping to ensure that consumers benefit from these protections by reviewing policy forms for compliance with these requirements. New Mexico has not yet passed new legislation implementing all of the federal standards that apply to private insurers under the ACA, but informants were confident that the state would come into full compliance with these market reforms by 2014, if only to avoid a regulatory takeover by the federal government.

In addition, New Mexico has made significant progress in achieving its vision of a "no wrong door" approach to its exchange IT development and may leverage its existing eligibility system for Medicaid and other human services programs. With the use of federal Medicaid funds, the state is also overhauling its eligibility and enrollment IT, and building a state-of-the-art system that will be launched by 2014.

In Medicaid, New Mexico is pursuing several of the ACA demonstration opportunities including health homes and

the capitated integrated model for dual eligibles, which may help the state partly address some of its provider capacity issues. The state is proposing a major overhaul of its Medicaid program as set out in its Centennial Care plan. The plan is designed to both prepare the state for the substantial Medicaid expansion under the ACA and drive delivery reform aimed at slowing the rate of program spending growth and introducing cost-effective care.

While New Mexico is engaged in several health reform activities, there are many challenges it will need to address as it moves forward. In establishing and operationalizing an exchange, the state faces two main issues. First, New Mexico still has many policy decisions to make, such as the governance structure of the exchange board, and tasks to be completed ahead of 2013. Second, much of New Mexico's exchange planning efforts, including its plans to apply for a level two establishment award, are contingent on whether the state has the legal authority to establish an exchange. Because Governor Martinez vetoed exchange legislation in 2011 and did not allow exchange legislation to be considered in 2012, she will likely issue an executive order establishing an exchange. This executive order, however, is unlikely to be issued ahead of a decision by the Supreme Court which is not expected until June 2012. And as noted above, recent developments since the time of our site visit suggest that the state has largely slowed its implementation efforts and is taking steps to reevaluate its current approach to exchange development. Despite this shift, New Mexico has signaled that it intends to move forward in implementing an exchange and faces many important policy decisions ahead.

Informants were in broad agreement that New Mexico has a significant challenge in preparing its health care system for

reform, particularly its health care safety net. The state has one of the highest uninsured rates in the country as well as one of the highest rates of poverty, a combination that puts considerable stress on the health care system. It is also a combination that suggests demand for services will be high with reform. Further, the state faces a seemingly intractable problem of how to deliver care in a state which is composed of vast frontier areas where the population density is low and it is difficult to recruit and maintain health care providers. These issues are not new for New Mexico, and the state continues to work towards viable solutions.

About the Authors and Acknowledgements

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NOTES

- New Mexico Human Services Department, "HSD Selects Contractor to Assist in Exchange Development" (May 10, 2012), available at http://www.hsd.state.nm.us/pdf/newsroom/nr/Leavitt%20Partners%20Exchange%20-%20Release%20FINAL.pdf.
- New Mexico Office of Health Reform, New Mexico's Office of Health Reform Transition Plan, December 27, 2010.
- Dan Derksen, Provider Stakeholder Meeting, New Mexico Hospital Association, New Mexico Office of Health Care Reform. February 20, 2012.
- Governor Susana Martinez, Senate Executive Message No. 53 (Apr. 8, 2011), available at http://www.governor.state.nm.us/uploads/FileLinks/1ea6 5343013a47f9a948cb019fc237b5/SenateExecutiveMessage53.pdf.
- Trip Jennings, "Health Care Official Resigns Over Perceived Lack of Progress," New Mexican (Mar. 23, 2012).
- State of New Mexico, State Health Insurance Exchange (NMEXCHANGE) Establishment Consulting Services, Request for Proposals (Mar. 29, 2012), available at: http://www.hsd.state.nm.us/pdf/rfps/FY12%20NMEX-CHANGE%20Establishment%20RFP%203_29_12.pdf.
- New Mexico Human Services Department, "HSD Selects Contractor to Assist in Exchange Development" (May 10, 2012), available at http://www. hsd.state.nm.us/pdf/newsroom/nr/Leavitt%20Partners%20Exchange%20 -%20Release%20FINAL.pdf.
- Commonwealth Fund, State Scorecard on Health System Performance, 2009: New Mexico, available at: http://www.commonwealthfund.org/~/ media/Files/Chart%20 Maps/2009%20State%20Scorecard/New_Mexico_ combined_tables_v2.pdf.
- Kaiser Family Foundation, Distribution of Total Population by Federal Poverty Level, states (2009-2010), U.S. (2010), available at: http://www.statehealthfacts.org/comparetable.jsp?ind=9&cat=1&sort=1803.
- 10. See, e.g., 2007 N.M. H.B. 1045; 2007 N.M. S.B. 976.
- New Mexico House of Representatives, House Joint Memorial 57 (2009), available at: http://www.sos.state.nm.us/09Bills/HJMem57.pdf.
- 12. Dan Boyd, "Gov. Signs Letter on Health Reform," *Albuquerque Journal* (Jun. 17, 2011).
- 13. Governor Susana Martinez, supra note 4.
- Governor Susana Martinez, CFDA No. 93.525 Cooperative Agreement to Support Establishment of State Operated Health Insurance Exchanges, Letter to Sec. Kathleen Sebelius (Sept. 27, 2011).
- 2011 N.M. S.B. 38. The bill passed both chambers on March 20, 2011 but was vetoed on April 8, 2011. See Governor Susana Martinez, supra note 2.
- 16. 2011 N.M. S.B. 38.
- 17. Governor Susana Martinez, supra note 4.
- 18. 2012 N.M. S.B. 6; 2012 N.M. S.B. 278.
- See Taylor v. Johnson, 125 N.M. 343, 96 P.2d 768 (1998); Clark v. Johnson, 120 N.M. 562 (1995).
- Governor Bill Richardson, Press Release, New Mexico Receives \$1 Million Grant to Plan Implementation of a Health Insurance Exchange(s) (Sept. 30, 2010)
- 21. New Mexico Office of Health Care Reform, Fiscal Year 2012 First Quarterly Report Project Summary for CCIIO (Jan. 31, 2012).

- Governor Susana Martinez, Press Release, Governor Susana Martinez Announces Appointment of Director of Office of Healthcare Reform (Aug. 31, 2011), available at: http://www.governor.state.nm.us/uploads/PressRelease/191a415014634aa89604e0b4790e4768/110831_1.pdf.
- 23. Governor Susana Martinez, Press Release, Governor Susana Martinez Announces Award of Health Insurance Exchange Grant (Nov. 2011).
- 24. New Mexico Office of Health Care Reform, Fiscal Year 2012 First Quarterly Report Project Summary for CCIIO (Jan. 31, 2012).
- 25. N.M.S.A. §§ 59A-56-2, -4.
- 26. See N.M.S.A. § 59A-56-4(D).
- 27. New Mexico Office of Health Care Reform, Fiscal Year 2012 Second Quarterly Report Project Summary for CCIIO (Apr. 15, 2012).
- Center for Consumer Information and Insurance Oversight, New Loan Program Helps Create Customer-Driven Non-profit Health Insurers, Press Release (Mar. 20, 2012).
- State of New Mexico, New Mexico Level I Health Insurance Exchange Establishment Grant (Sept. 2011).
- 30. Ibid.
- 31. New Mexico Human Services Department, New Mexico Health Insurance Exchange Project (NMEXCHANGE) Information Technology Eligibility, Shop and Compare. (Feb. 3, 2012).
- 32. <u>Ibid.</u>
- 33. Ibid.
- 34. Ibid.
- 35. Ibid.
- State of New Mexico, Level I Establishment Grant: CFDA #93.525. Available at: http://www.hsd.state.nm.us/pdf/hcr/NM%20Health%20Insurance%20 Exchange%20Establishment%20Grant.pdf.
- 37. 2010 N.M H.B. 12; 2011 N.M. S.B. 208.
- Resources for Change, Rate Review Report: PRC DOI Health Insurance Rate Review Grant (Sept. 2011).
- 39. 2012 N.M. H.J.R. 17.
- 40. 2012 N.M. S.B. 290; 2011 N.M. S.B. 608.
- New Mexico Bulletin No. 2010-005 (Sept. 14, 2010); New Mexico Bulletin No. 2010-006 (Sept. 23, 2010) (replaced by New Mexico Bulletin No. 2011-012 (Nov. 21, 2011)).
- 42. 75 Fed. Reg. 37188, 37235 (June 28, 2010).
- 43. 2012 N.M. S.B. 290.
- 44. 2010 N.M. S.B. 148.
- New Mexico Medical Insurance Pool, Semi-Annual Packet (01/10/10-06/30/10) (June 2010).
- 46. 2010 N.M. H.B. 216.
- 47. 2010 N.M. H.B. 12.

- 48. New Mexico Public Regulation Commission, *Medical Loss Ratios and Related Rate Filing Requirements* (Apr. 8, 2011).
- 49. N.M.S.A. § 59A-18-14.
- 50. 2011 N.M. S.B. 208.
- 51. Final DOI Health Insurance Rate Review Grant September 2011.
- New Mexico Health Insurance Rate Review Project Narrative, available at: http://www.nmhealthratereview.com/Documents/Cyclell_Project_Narrative_clean.pdf.
- 53. Kaiser Family Foundation, supra note 9.
- 54. In February 2012, New Mexico received approval from CMS to expand the SCI program by about 5,000 individuals currently on the waiting listing as part of patient-centered medical home pilot project. The initiative is led by the University of New Mexico which will provide the state share for the coverage expansion through an inter-governmental transfer. New Mexico Human Services Department. 2012. Press release, January 10.
- New Mexico Human Services Department. 2012. Centennial Care: Ensuring Care for New Mexicans for the Next 100 years and Beyond. February.
- New Mexico Human Services Department, Letter to Secretary Sebelius (Apr. 25, 2012), available at: http://www.hsd.state.nm.us/pdf/Medicaid%20 Modernization/Waiver%20Submission%20to%20CMS.pdf.
- New Mexico Human Services Department. 2012. Centennial Care: Ensuring Care for New Mexicans for the Next 100 years and Beyond. February.
- 58. Ibid.
- New Mexico Office of Health Care Reform. Provider Stakeholder Meeting, New Mexico Hospital Association, February 20, 2012.
- 60. Authors' communication with New Mexico Office of Health Care Reform.

- New Mexico House of Representatives, House Memorial 38, available at: http://www.nmlegis.gov/Sessions/12%20Regular/memorials/house/ HM038.pdf.
- 62. Commonwealth Fund, supra note 8.
- 63. Kaiser Family Foundation, supra note 9.
- New Mexico Health Policy Commission. 2011. Recommendations to Address New Mexico Health Care Workforce Shortages, January 2011.
- 65. ibid.
- 66. Ibid.
- 67. Ibid.
- 68. Ibid.
- New Mexico Office of Health Care Reform. Provider Stakeholder Meeting, New Mexico Hospital Association, February 20, 2012.
- Judith M. Espinosa & Charlotte Roybal, New Mexico Small Employers (June 30, 2011), available at: http://www.hsd.state.nm.us/pdf/hcr/Small%20Employer%20Final%20Report%20June%202011.pdf.
- 71. Ibid.