

New Mexico Health Insurance Exchange Work Group Minutes

Work Group	Financial Sustainability	Date	12/13/2012
Facilitator	Andy Vallejos for Mark Padilla	Time	9:00 a.m. MT
Location	Conference Call/ In-Person	Scribe	Cicero Group

Agenda Item
 Discussion Item
 Conclusion
 Action Item

Attendees	
Name	Name
Andy Vallejos, HSD OGC	Lisa Shin, Optometrist
Milton Sanchez, HSD OHCR	Matthew Maes, Lovelace Marlene Baca, Lovelace
Jonni Pool, HSD OHCR	Karen Lucero, Physical Therapist
Kathryn Toone, Leavitt Partners	Stephanie Wright, <i>Cicero Group</i>
Dee Rush, Sierra Vista Hospital	Susan Loubet, New Mexico Women's Agenda
Sharon Finarelli, Sierra Vista Hospital	David Roddy, NMPCA

Agenda Item 1: Introduction

Name: Andy Vallejos

DISCUSSION ITEM 1 Welcome and Review

Mr. Vallejos excused Mr. Padilla from the proceedings and introduced himself as interim Group Lead for this meeting. He then briefly reviewed the challenges of creating a self-sustaining Exchange. He indicated that the guest speakers and attendees from the Health Insurance Alliance (HIA), the High Risk Health Pool, and the Division of Insurance (DOI) would assist in establishing an idea of costs from which the Work Group may proceed. He introduced Mr. Sanchez from the Office of Health Care Reform, and Mr. Nuñez from the HIA, and invited them to present a status review.

Mr. Sanchez announced that the Employer Participation Work Group had conducted an initial meeting, and the Blueprint was on schedule for submission. He said Requests for Proposal (RFPs) had been released, and introduced Mr. Nuñez, who described the RFPs for Project Management and IT infrastructure. Mr. Nuñez said responses to the Project Management RFP had been received and reviewed, with interviews scheduled for the following day. The hope is that the Project Manager will assist in the evaluation of IT proposals, which are also being reviewed. Preliminary responses for the IT RFP are due by December 21st, bids are due by December 28th, and interviews are to be conducted January 16-18th. All new parties for Exchange project management and IT are planned to be onboard by February 1, 2013.

Agenda Item 2: Items for Discussion

Name: Andy Vallejos

DISCUSSION ITEM 1

Presentation from Mike Nuñez, HIA

Mr. Vallejos indicated this was the 2nd meeting for the Work Group, and two subsequent meetings are to be held. The next scheduled meeting is December 20th at 9:00 a.m., in the same location. Ms. Pool gave details of the final meeting.

Mr. Nuñez then passed documents to the Work Group containing HIA information and history, including financial and other data. Mr. Vallejos indicated these documents would be available online for those participating by phone. Mr. Nuñez stated that, historically, for every dollar taken in by the HIA in premiums, \$1.30 has been paid out. He described the impact of the recession in 2008, and the resulting drop in claims, but said that things would recover. He said the HIA experienced a 132% loss ratio in 2011, with a projected loss ratio of 150% for 2012.

He explained that of total premiums received, 3.5% is applied towards HIA administrative costs; 1% is applied toward broker incentives; and to cover losses, an additional 12% withholding covers reinsurance for participating carriers; resulting in a 16% total withholding. The remaining 84% is returned to carriers on a monthly basis. He said that 75% of earned premiums are compared against incurred losses on a regular basis, with overage held in reserve against future expenses. In 2011, the HIA apportioned a loss of \$11.2 to carriers. There are currently four carriers participating in the HIA.

Mr. Vallejos asked how, statutorily, assessments were allowed and applied. Mr. Nuñez responded that the HIA was formed as an alliance of carrier members under the Establishment Act of 1994, and includes all those paying life and health insurance premiums in New Mexico, including roughly 300 businesses, that share in incurred underwriting losses. He explained that the HIA board exists as a construct under these carriers. Assessments are made against all those currently licensed to collect health and life insurance premiums in the state, not just the “big 4” member carriers, which were specified as Presbyterian, Lovelace, BlueCross BlueShield of New Mexico (BCBS), and United Healthcare (UHC). Mr. Nuñez stated there were some exemptions from assessments, and indicated that some carriers had withdrawn from the HIA.

Clarification on assessments followed, and Mr. Nuñez described how assessments are based on the total business done by each carrier, with some smaller carriers assessed less than \$10 on average. Mr. Vallejos summarized that assessments are billed to all carriers based on market share, and enquired whether the DOI provides the market share information. Mr. Nuñez responded that the HIA receives its information and conducts assessments in cooperation with the New Mexico Insurance Board.

Mr. Vallejos mentioned that Mr. Aaron Ezekiel from the DOI was present to address participants' questions. Mr. Roddy mentioned that the topic of shared losses and compensation, which may not be germane to Exchange operations, should perhaps not be dwelt on excessively.

Upon inquiry regarding broker incentives from Mr. Roddy, a small business owner and HIA participant, Mr. Nuñez explained that approximately 5-7% of total assessments are applied towards broker incentives, and carriers pay a standard commercial commission set by the carriers. Mr. Roddy felt this was a significant area of clarification in Exchange implementation, and that the structures of broker participation and reimbursement are areas that must be carefully examined. He pointed out the automated nature of the Exchange, which allows consumers to purchase insurance directly from the carrier, and that this may introduce changes in the market, as the industry currently requires the services of brokers in many cases. Mr. Nuñez suggested the assistance of Navigators might also affect plan selection and broker participation.

Members expressed a desire for more information, and were particularly interested in the portion of the insurance market that bears the brunt of current HIA assessments. Mr. Parra and Ms. Armstrong suggested they might be able to provide specific numbers at the next meeting.

Mr. Vallejos reviewed the documents provided by Mr. Nuñez, and asked for a summary of current HIA staffing and administrative expenses. Mr. Nuñez said the HIA has an overall budget of \$1.3 million and a staff of 7 employees; and IT, actuarial services, and software services are contracted to third parties. Upon questioning from participants, he further explained the HIA allocates approximately \$200K annually for marketing purposes, it uses an actuary to set DOI-approved rates, and it comprises roughly 4,500 enrollees and 12 fully insured plans. Mr. Ezekiel clarified that regulatory authority of the DOI is limited to approval of any plan of up to 50 participants, in both individual and small group markets.

Mr. Parra summarized his understanding of the rates: that they are capped by an index rate determined by an actuary, and that carriers can determine their own rates within this limit. Mr. Nuñez confirmed that this was correct. Ms. Loubet described her perception that, initially, some insurers hesitated to join the HIA, but now that it is established, they may find it more attractive. Mr. Nuñez explained that the niche market nature and guaranteed issue aspect of products offered by the HIA are now understood by carriers, and that they are accepting and responsive. Mr. Sanchez enquired whether participating carriers receive a tax credit for assessments, and Mr. Nuñez replied that they do, most recently in the amount of the \$11 million previously discussed, at a rate of 50 cents per dollar.

Mr. Vallejos asked for details on HIA plans for Exchange implementation: projected enrollees, expected growth, impact on administrative costs, etc. Mr. Nuñez replied that projections for enrollment in the first years following Exchange implementation range from an additional 50,000 to 80,000 enrollees. Most estimates from other states assume approximately 10% of those enrollees

will be in the Small Business Help Option Plan (SHOP) Exchange, and the remaining 90% in the Individual Exchange. Mr. Vallejos asked which outside studies were used to determine these projections, and Mr. Nuñez referenced the results of the Hilltop study which suggested 52,000 new enrollees, and the CBO study which estimate 62,000 new enrollees. Mr. Sanchez quoted the results of a Leavitt Partners study, which project the number at 82,000.

Ms. Baca asked for the expected impact of Exchange transition on existing carriers. Mr. Nuñez answered that current HIA enrollees are allowed to renew for January 2013, and by obligation, the HIA must offer a 12-month rate. Those enrollees will continue until 2014 under the HIA until the enrollment date anniversary, and then will transition to the Exchange. He said that HIA participants might terminate plans and transition earlier to the Exchange, if desired.

Mr. Roddy asked whether the HIA would be going through the entire actuarial process to do business within the Exchange. Mr. Nuñez explained that carriers would submit plans, claims, and rates information to the DOI for approval. Mr. Ezekiel explained that the DOI had made minor revisions to the benchmark plans, which are under review by the Center for Consumer Information and Insurance Oversight (CCIIO); and he felt the approval process was soon to be completed. Once the benchmark plans for the state are federally approved, carriers can begin to submit compliant offerings to the DOI for inclusion in the Exchange.

Mr. Vallejos focused discussion on the administrative costs for the Exchange, and asked for forecasts from Mr. Nuñez. Mr. Nuñez explained that IT systems would comprise the largest expense. Estimates so far have ranged from \$40-80 million, and the HIA is expecting somewhere in the middle. Mr. Vallejos asked how much of the establishment grant was expected to be required by IT infrastructure. Mr. Nuñez responded that of the \$34 million received so far in grant money; perhaps \$30 million would be required, with a subsequent grant application to be made in mid-February 2013, which is expected to carry the Exchange into 2014.

Mr. Vallejos asked whether most IT expenses were expected to be one-time costs, and Mr. Nuñez responded that maintaining the Exchange over time would also incur significant costs. Mr. Vallejos inquired whether the HIA is currently setting aside money from the recurring budget to maintain future IT costs, and was told that the majority of costs will be incurred in the first 2 years of establishing the Exchange, with years 3-5 expected to primarily require maintenance and support only. Mr. Nuñez clarified that establishment of grant funding was expected to provide the IT structure, and Exchange revenue to generate sufficient revenue for ongoing support. Mr. Vallejos asked whether anticipated maintenance costs were built into the RFPs, and Mr. Nuñez responded that only establishment costs were included.

Mr. Roddy referred to the roughly \$60 million price tag for establishing the Exchange IT infrastructure, and gave a number of 60,000 individuals entering the Exchange, at a per person cost of \$1,000. He said that up to 20% of the budget might be required for ongoing support, at

additional consumer expense, and asked whether the HIA was coordinating with the Human Services Department in this regard. Mr. Nuñez responded that the system will detect and refer those eligible for Medicaid, and only those consumers ineligible will be enrolled in the Exchange, which will advise them of available benefits. It is expected that the system will be self-sustaining for those enrollees. He indicated that marketing costs are included in cost projections, based on existing healthcare marketing budget data.

Mr. Ezekiel advised that the policy decision to pursue a state exchange builds in certain costs, and options for Exchange design exist that can make a substantial difference in these costs. He gave as an example the decision of New Mexico to use the Oracle and PeopleSoft systems at one point, and the high costs involved with these expensive licenses. He explained that there are more economical open-source systems and processes for virtualization of machines that might result in significant savings. Mr. Vallejos asked whether, for purposes of the RFPs, New Mexico intends to build an entirely new system or to leverage and customize existing IT systems.

Mr. Nuñez responded that ground-up vs. existing technology approaches were considered in drafting the RFP. He felt there was insufficient time to create a new system, and leveraging existing systems and then tailoring them to suit the state's Exchange requirements was the most practical approach. He indicated that the \$40-60 million estimate for IT structure was intentionally broad until options were assessed, and may assume the building of a custom system from the ground up, but whether this would be necessary could not be determined at this stage. Mr. Vallejos asked for the anticipated budget once the Exchange was operational, and Mr. Nuñez said this number was still being determined. Mr. Vallejos pressed for an estimate for staffing, and Mr. Nuñez responded that based on estimates from other states, staffing levels for the Exchange are expected to fall between 25-50 employees, with hopes for the lower end of the scale.

Mr. Parra then referred to a spreadsheet listing estimated IT costs, ranging from \$4-90 million, from other states in various stages of implementation. Mr. Nuñez questioned whether the data was for IT structure or maintenance, and said the higher numbers of some estimates seem to indicate structure. Mr. Roddy said the numbers break down to a range of roughly \$33 to \$144 per enrollee per month. He and Mr. Vallejos asked for a breakdown of administrative, Navigator, marketing, training, oversight and actuarial costs.

Mr. Nuñez explained that current HIA marketing costs require about 17% of the budget, and board expenditures around 10%. General administrative procedures and salaries are the bulk of the budget. Mr. Vallejos asked how these numbers were expected to change. Mr. Nuñez informed members that the budgetary focus of the discussion should be operational costs of the Exchange after January 1, 2015, upon the termination of federal grant money. Mr. Ezekiel mentioned the necessity of establishing a capital improvement fund for the IT system and other considerations.

Mr. Vallejos pointed out that the Exchange may not be required to provide guaranteed issue, nor

participate in assessments established by the HIA to cover participant carrier losses. He asked whether the system of assessments against carriers should be discontinued in this context. Mr. Ezekiel reminded the group that these assessments are currently offset by a 50% premium tax credit.

Mr. Roddy stated that current per-enrollee costs in the HIA are approximately \$25 per month, and the budget for the system will not need to be ramped up so much as entirely revamped. He said that centering discussions around a start date of January 1, 2015 imply that no operational costs need to be addressed until then, but his understanding is that after implementation in October 2013, no Navigator costs are to be passed on to the federal government. He suggested as a result that the budget to be discussed by the group should assume a start date of October 2013.

Mr. Nuñez agreed that Exchange establishment and initial training costs will be federally absorbed, and that the costs of the Navigator program, which are left to each state to determine, are the biggest unknown factor. Ms. Toone clarified that while many aspects of the Navigator program are yet to be determined, the Outreach and Education Group had addressed some issues of the program.

Mr. Vallejos refocused the discussion on the agenda created by Mr. Padilla, and introduced Ms. Armstrong for a review of the New Mexico High Risk Health Pool.

DISCUSSION ITEM 2 | Debbie Armstrong Presentation, CEO NM High Risk Health Pool

Ms. Armstrong explained the role of the High Risk Health Pool. She said that premiums for this pool are set as a percentage of the standard risk rate, an actuarial calculation based on a new product for a healthy individual from the top 3-4 plans on the market. Premium rates for the high-risk pool are now 105% of this standard, and this is discounted for those under 400% of the federal poverty level. This pool has a self-insurance plan administered by BCBS, who receives an administrative fee for their services. There is one plan created by the High Risk Health Pool, which is modeled after those in the small group market and which varies only by deductible. The High Risk Health Pool pays all claims for covered individuals. Premiums received cover less than 25% of actual program costs, and administration is about 5% of the total. Losses, about 78%, were at \$100 million in 2011, and are projected to be higher in 2012.

Ms. Armstrong continued that the Medical Loss Ratio (MLR) in the High Risk Health Pool is over 400%, as it serves individuals with serious health problems unable to obtain insurance due to pre-existing conditions. Losses are compensated by assessments to state carriers based on their book of business, with market share information provided by the DOI. Reinsurance providers are excluded from these assessments, but Medicaid is included. Tax credit has averaged roughly 55% for the last 4 years, totaling approximately \$55 million in funding. The High Risk Health Pool currently covers approximately 8,400 enrollees, and costs per enrollee were given as roughly 5%, or \$650 per person.

Ms. Armstrong explained that enrollment in the high risk pool has recently leveled off and become flat, due to parallel federal program mandated by the ACA which funds a temporary high risk pool until the Exchange is active. As a result, the High Risk Health Pool currently administers two programs, one with state funding; and the ACA program, with federal funding. Recent growth has tended towards the federal program, resulting in decreased enrollment in the state-funded program. Mr. Vallejos asked whether Ms. Armstrong had any indication as to the permanency of the federal program, and she responded that this would become permanent under the ACA in 2013, as these individuals enter the Exchange. She explained that the assumption is that many in the state-funded high-risk pool will also eventually enter the Exchange.

Ms. Armstrong informed members on details of the state-sponsored plan, that there is currently no lifetime cap on reimbursement, and benefit coverage in the plan is close to meeting the standard for the state's Essential Health Benefits (EHBs). She said that potential enrollees are the very sick who try to get insured and are rejected for pre-existing conditions. Upon rejection, they are notified of the existence of the High Risk Health Pool by hospitals and other healthcare entities. She explained that recently a high number of the very sick had joined the federal branch of the program, in spite of a 6-month waiting period; but there was a high rate of dropping out as well, after enrollees' health concerns were addressed.

Ms. Armstrong then referred to documentation on the state-funded program, provided to attendees. She reviewed charts with information on income, assessments, program growth, enrollment, medical and drug expenses, and operating costs. She indicated that the pool has been in existence and stable since 1986, with enrollment dropping after the introduction of the ACA high-risk program. She explained that growth indicated for 2013 is expected to be a result of the trend in medical claims costs, and not increased enrollment. She explained a spike in growth indicated on the charts as a trend that began after the introduction of significant discounts offered to low-income enrollees. She described chart data as reflecting actual amounts for 2009-11, and projections for 2012 and 2013. Projected losses for 2013 are at \$123 million. A member asked for the enrollment numbers in the federal program, and Ms. Armstrong answered that it was roughly 1,500 insured, totaling nearly 10,000 individuals between the two programs.

Ms. Armstrong explained the two fundamental missions for a high-risk pool: 1) to make sure the high risk population has continual coverage; and 2) to stabilize the rest of the insurance market by separating out the high risk population, spreading risk evenly, and thus lowering premiums for the healthier population. The mandate of the ACA to increase coverage to every uninsured in the nation creates a concern to existing high-risk pools, as to whether the large pool created by the mandate makes their existence redundant. However, they are expected to play some role due to concern about possible premium shock during the transitional period, before there is a high enough Exchange enrollment to economically absorb all high-risk patients.

She continued that the HIA Board does not currently intend to close down the state High Risk Health

Pool upon Exchange implementation, although the federal program will be absorbed. It was believed that many people in the state program may migrate to the Exchange, and possible Medicaid expansion will affect the pool as well; but whether premium discounts will be equivalent to current levels of tax credit remains to be seen.

The High Risk Health Pool desires to coordinate closely with the Exchange to accomplish a smooth transition, and expects that some enrollment – metastatic cancer patients, AIDS patients, etc. – will be ongoing. Other important factors that remain to be determined are the behavior of low-income individuals, and plan portability within the Exchange. She stated that her office was proceeding with the assumption that the state high-risk pool will never be entirely transitioned to the Exchange, mentioning the preservation of premium stability as a priority.

Mr. Vallejos agreed, and described the complexity of the issue. He mentioned the influx of high-risk individuals entering the Exchange, and the desirability of increasing the size of the risk pool as quickly as possible. He felt, however, that if all high-risk pool individuals were to enter the Exchange at implementation, it might create an atmosphere of adverse selection and increase costs. He restated the importance of careful integration of high-risk migration into the Exchange to avoid instability.

DISCUSSION ITEM 3

Should Carrier Assessments Continue in the Exchange?

Mr. Vallejos thanked the guest speakers, and reintroduced the topic of carrier assessments, asking whether they should be continued in the Exchange, and what other revenue options might exist. Mr. Parra indicated his belief that, between state, federal, and ACA assessments, carriers are “tapped out,” and that new assessments from the state Exchange will unfairly increase the burden on carriers.

Mr. Ezekiel reminded participants of the existence of undocumented immigrants, and wondered how their access to healthcare will be addressed. Ms. Armstrong indicated that the Medigap policy might apply here. She pointed out that one group of high-risk individuals will already be in the Exchange pool upon implementation, as the Department of Health (DOH) already pays premiums for many of the most vulnerable population: hemophiliacs, medically challenged children, etc.

Mr. Roddy stated that of 4,500 individuals enrolled in the HIA at a cost of \$6,200 per year, 42% are subsidized through assessments; but that the high-risk pool contains 8,400 individuals at a cost of \$13,600 per year, with 75% subsidization. He said that inevitably premiums would rise. He pointed out that the federal government decides caps on premiums for low-income individuals, but small businesses are subject to all rate increases. He felt that assessments should continue, as costs will go up for everyone.

Mr. Nuñez explained that assessments have both a claims component and an administrative component. The current intent of the HIA is to keep current assessments, and eventually apply all

revenue towards administrative needs, with no assessment funds used towards carrier losses. He reminded Mr. Vallejos that the SHOP Exchange offers a tax credit to carriers, and the goal is affordability for all parties involved.

Mr. Sanchez stated that at some point, all high-risk individuals will enter the Exchange pool, and rates will inevitably rise. His opinion is that the Exchange should accomplish this step promptly. He feels that assessments will be necessary to offset implementation costs, but did not feel assessment revenue should be used strictly for administration. He felt that assessments might also need to be applied, as now, towards premiums in the SHOP Exchange. He believed that current HIA assessments offsetting carrier losses should decrease as this expense decreases.

Participants discussed the possibility of change to the current system of assessments, and the multifaceted nature of the policy. Mr. Roddy pointed out that only businesses would be affected by premium raises, as rates for individual premiums, particularly for low-income individuals, are federally regulated. Mr. Parra called attention to the likelihood that some businesses may opt to not offer coverage and will find it more affordable to take the tax penalty for noninsurance. Another member pointed out that some predictions for the Exchange assume an expansion in Medicaid, and much of the increased costs may be federally compensated. A guest pointed out that Medicaid is currently reassessing their pregnancy policy for the transitional period.

Mr. Vallejos returned questioning to Ms. Armstrong, and the way assessments, caps, benefits, and administrative costs are handled by the High Risk Health Pool. Ms. Armstrong responded that the assessment process within the High Risk Health Pool was relatively easy to administer but restricted in who could be assessed. She said that because of ERISA statutes, no assessments are levied against self-insured businesses. She mentioned that a creative approach in some states is to levy assessments against hospitals, but wasn't sure how this might work in New Mexico.

Mr. Roddy pointed out the differences in assessments for the high-risk market, as opposed to those that might be used in the Exchange: that the high-risk market uses a specialized assessment to compensate for the medical losses among a fragile segment of the market; and Exchange assessments would be applied primarily towards administrative costs. He recommended ensuring receipt of the maximum amount eligible in funding from the federal government as one measure to defray costs.

Mr. Parra stated his preference that administrative costs be fairly distributed among all parties and not exclusively borne by carriers, but Mr. Roddy mentioned that consumers could not be charged more than a fixed amount based on income. Mr. Parra suggested that perhaps a \$5-10 user fee based on transactions might be instituted. Mr. Roddy was concerned that caps on totals charged to consumers might make this unfeasible, but Ms. Toone clarified that transaction fees are not considered part of the premium cost.

A member asked whether federal subsidies can be applied towards user fees, but this was determined as perhaps outside the scope of eligibility. Mr. Parra added that transaction fees have the benefit of transparency, as they allow consumers to see the cost of the Exchange. Ms. Loubet pointed out the value inherent in broad assessments for individuals and carriers not involved in the Exchange, as costs of uninsured consumers are not unfairly passed on to the insured.¹

Mr. Vallejos discussed the ramp-up in administrative costs, particularly in the first years of the Exchange. He called the attention of the group to a document provided by Ms. Loubet entitled State of Women and Assistor information, containing bullet points on the in-person assistance and Navigator programs. It was recommended that provisions for assistors and Navigators be considered in the next grant application.

Mr. Vallejos reviewed how current HIA assessments are billed to carriers offering life and health policies, based on market share. He asked whether the current assessment structure was broad enough, and whether it should include vendors of all insurance products. Members discussed the option, with Mr. Parra expressing a preference to broaden assessments. Mr. Roddy noted that eventually all costs are passed on to the consumer, and he felt it was unfair to charge life insurance companies, for example, to assist in carrying costs for Exchange plans. Ms. Armstrong² gave an example of revenue that would be excluded in assessments, saying that if half of Presbyterian's business is comprised of state employees, only half of their business would be assessed.

Mr. Vallejos explained that in setting up a system of assessments, mandatory DOI requirements facilitate receipt of payment from insurers, as they must pay to get a license to do business. He wondered whether broadening assessments to include hospitals might introduce problems with collections. Mr. Ezekiel also mentioned the possible complication of legislative intervention being required in changing assessments. Mr. Parra questioned whether Work Group members could presume that statutory change will follow group recommendations, or whether they should proceed only with recommendations compatible with existing regulation.

DISCUSSION ITEM 4

Participant Comments and Questions

Mr. Vallejos opened the discussion for questions or additional topics from audience members.

Mr. Ezekiel said that the DOI had requested he provide information on Navigator training. He explained that initial costs for Navigator materials, training, and certification were estimated at \$100 per person, with a \$50 annual recertification fee. How these fees will be covered is yet to be determined. Mr. Roddy asked whether certification would occur in a classroom setting, taught by the DOI or a third party; or through self-study. Mr. Ezekiel assumed the low cost implied self-study.

Mr. Sanchez asked Mr. Ezekiel to address DOI policy, if any, for carriers and plans that do not initially enter the Exchange. Mr. Ezekiel said the DOI could possibly impose³ a lockout period of up to 24 months, which may constitute a penalty. It was unknown whether the DOI has statutory authority

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to impose this lockout.

Ms. Finarelli advised the group that should hospital assessments be enacted, there would be backlash, due to the existing environment of increased financial challenges, discounted reimbursements, staff layoffs, and the uncertainties inherent in Exchange implementation. Mr. Ezekiel suggested that the increase in insurance coverage might be of benefit to hospitals by providing increased revenue. Ms. Finarelli stated that up to 75% of Sierra Vista Hospital's admissions are covered by Medicare, and there are a significant number of uninsured patients.

Audience member John Adkins, representing New Mexico Health Connections, stated that the approach of Exchange assessments depends largely on whether it is expected to be the focal point for all insurance purchases. If so, they should spread the operational burden as broadly as possible. He advocated for assessments covering fixed costs, with built-in funding for capital improvements. Mr. Roddy asked whether there would be a premium tax, and a member responded that there would be a new business tax.

Mr. Sanchez asked Mr. Ezekiel whether the Commissioner was open to making changes if required. Mr. Ezekiel responded that there was continual pressure to do so. His understanding was that the purpose of the benchmark plan was as a floor, and not a ceiling, suggesting the intention for ongoing change.

CONCLUSIONS

Mr. Vallejos advised that time was up for the meeting, and suggested ongoing discussion be continued separately. The next scheduled meeting is December 20th at 9:00 a.m., in the same location. Mr. Vallejos thanked those in attendance and adjourned the meeting.

Dr. Shin indicated her presence by teleconference at the end of the meeting. She subsequently submitted the following questions to Mr. Padilla for consideration, and requested their inclusion in the minutes.

Item 3: Additional Questions from Work Group Member Submitted to Mr. Padilla

Name: Dr. Lisa Shin

DISCUSSION ITEM 1

Submitted Via Email for Inclusion in the Minutes

Dear Mark: I have scheduled to be at the meeting next Thursday, the 20th; I was only able to hear most of the meeting today by telephone. My questions/comments:

1. In technical terms: "explore architecture and code re-use from pre-existing implementation"; in other words - can we look to IT systems & software from other states & modify it for NM? My understanding is that the Federal Government will have its Exchange for those states

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that choose not to establish one themselves. Will the Feds make IT systems & software available for states to use? This could significantly decrease cost for NM.

2. Open source: in my small business - we have changed from closed source to open source operating systems & software. "Open source does not mean free" but it can mean lower "total cost of ownership" than closed source & there is much more flexibility/options when it comes to troubleshooting; there would still be maintenance required. Using open source at various levels of the system might also decrease cost.
3. Assessments to fund the Exchange should be "broad-based on the health care market" & "shared" - providers, hospitals that receive patients from the Exchange; consider all carriers, regardless of participation in the Exchange.
4. How do we maximize number of insurance carriers & participants in our Exchange? If we end up with low numbers of insurance carriers & low numbers of participants - our Exchange will be less financially sustainable. Lower number of participants also increases risk of "adverse selection"; Leavitt Partners "Risk Adjustment" & Reinsurance" information is helpful.
5. Has there been discussion of the role of advertisement in means of revenue for Exchange?

AMENDMENTS

Amendments Requested December 20, 2012

¹In the unamended version of these minutes, an inaccurate attribution of agreement with a participant's comments was included. Indication of agreement was subsequently removed.

²Speaker's name changed from Ms. Loubet to Ms. Armstrong.

³Verbiage changed from "had proposed a possible lockout period" to "could possibly impose..." as clarified by Mr. Ezekiel.