

Understanding Healthcare Reform

A Resource Guide
For New Mexico



NM center on law and poverty

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INTRODUCTION

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA) and President Obama signed it into law. This resource guide provides information about new healthcare options available for New Mexicans starting in 2014, with a focus on free and low cost coverage through Medicaid and the Health Insurance Exchange. On page 43 of this guide, you will find a list of resources that can provide information about other aspects of the law.

Special Rules: Immigrants

Many immigrants will have access to healthcare coverage under the law, but eligibility will depend on immigration status. While many immigrants can enroll in Medicaid right away, others must wait 5 years before they can get coverage. The Health Insurance Exchange will be open to immigrants with documented status. See page 25 of this guide for a full explanation of the special rules about immigrant eligibility and healthcare coverage under the law.

Special Rules: American Indians

When it passed the ACA, Congress also permanently reauthorized the Indian Health Care Improvement Act, which recognizes the federal government's obligation to provide healthcare to Native Americans. Together, these two laws provide American Indians and Alaska Natives with certain rights and consumer protections. These rules are highlighted throughout this guide.

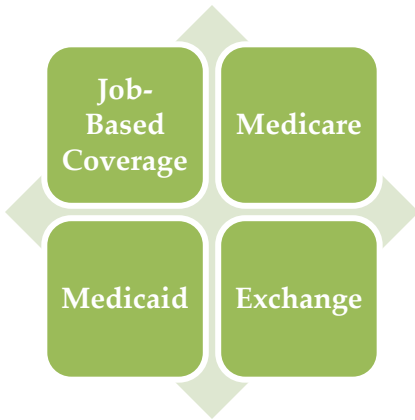
To qualify for these enhanced rights, a person must meet the definition of "Indian" under the ACA.

For Medicaid, an "Indian" means any person who (1) is an enrolled member of a federally recognized Indian tribe; (2) is considered an "Indian" under regulations promulgated by the U.S. Secretary of the Interior; (3) is considered an "Indian" for purposes of eligibility for Indian health care services by the U.S. Secretary of Health and Human Services; or (4) resides in an urban center and is a member of a tribe, band or other organized group of Indians or is an Alaska Native.¹

For the Exchange cost-sharing protections and special enrollment periods, an "Indian" is a person who can demonstrate membership, enrollment in, or affiliation with a federally recognized tribe.² However, under new federal rules, all people who are eligible for services through Indian health care providers (including Urban Indians) can receive tax penalty exemptions.³ If you have questions about these rules, please contact the New Mexico Center on Law and Poverty.

HOW WILL I GET HEALTH COVERAGE?

Starting in 2014, most people who are uninsured will qualify for new healthcare coverage for no costs or low costs. There are the four major ways you could get covered:



Job-Based Coverage: In 2011, about 38% of New Mexicans had job-based coverage. This number is expected to grow. Companies with more than 50 full-time employees will be required to provide coverage for certain employees or else pay tax penalties starting in 2015.⁴ Small employers are not required to provide coverage, but will have new opportunities to buy health plans for their employees.

Medicare: This federal program will continue to cover adults age 65 and older – about 14% of New Mexicans. There are no changes to Medicare eligibility rules under the healthcare law, though there are some positive changes to benefits and coverage levels. See page 19 of this guide for information about Medicare.

Medicaid: Medicaid is a public program that provides mostly free healthcare coverage for low-income people. On January 1, 2014, the program is expanded to over 150,000 more adults in New Mexico. About a quarter of New Mexicans get their health coverage through Medicaid now, but Medicaid will enroll about one in three New Mexicans in upcoming years. See page 4 for more information about Medicaid.

Exchange: The Exchange is a new marketplace where people who do not get job-based coverage, Medicare, or Medicaid can purchase health insurance. Most people who use the Exchange will qualify for financial assistance from the federal government to help with the cost of insurance. Small employers can also buy plans for their employees. See page 10 for more information about the Exchange and page 12 for information about who can get financial assistance.

THE FEDERAL POVERTY LEVEL – “FPL”

To qualify for the Medicaid Expansion and for financial help through the Exchange, a person’s household income must be below a certain level that is tied to the Federal Poverty Level (FPL). “FPL” is a standard set by the federal government and used for many public programs. The FPL amount changes every year.

“Household income” is how much the entire household earns each month before taking out taxes or any other costs. It generally includes income from **all** the people who are considered part of a household for tax filing purposes, and not just the people applying for health coverage.⁵

The tables below and on the next page provide rough information about the income rules for Medicaid and the Exchange. These charts are just a guide and do not guarantee you will meet the specific requirements when you apply. Note that the Medicaid income rules for certain groups, such as pregnant women and people with disabilities, are different than what is listed below – see page 6 of this guide for more information about the Medicaid income rules.

Adult Eligibility for Health Coverage⁶

<i>Adults ages 19 to 64 may qualify for:</i>			
MEDICAID <i>free healthcare coverage</i> (for adults under 138% FPL)		EXCHANGE <i>health insurance plans</i>	
		With financial assistance (for 139-400% FPL)	Without financial assistance (for over 400% FPL)
Household Size	<i>If their household income is this much each month:</i>		
1 person	Less than \$1,321	\$1,322-\$3,830	More than \$3,830
2 people	Less than \$1,783	\$1,784-\$5,170	More than \$5,170
3 people	Less than \$2,245	\$2,246-\$6,510	More than \$6,510
4 people	Less than \$2,708	\$2,709-\$7,850	More than \$7,850
5 people	Less than \$3,170	\$3,171-\$9,190	More than \$9,190
6 people	Less than \$3,632	\$3,633-\$10,530	More than \$10,530

Child Eligibility for Health Coverage⁷

<i>Children younger than 19 may qualify for:</i>			
MEDICAID <i>free healthcare coverage</i> (for children under 300% FPL)*	EXCHANGE <i>health insurance plans</i>		
	With financial assistance (for 300-400% FPL)	Without financial assistance (for over 400% FPL)	
Household Size	<i>If their household income is this much each month:</i>		
1 person	Less than \$2,872	\$2,873-\$3,830	More than \$3,830
2 people	Less than \$3,877	\$3,878-\$5,170	More than \$5,170
3 people	Less than \$4,882	\$3,883-\$6,510	More than \$6,510
4 people	Less than \$5,887	\$5,888-\$7,850	More than \$7,850
5 people	Less than \$6,892	\$6,893-\$9,190	More than \$9,190
6 people	Less than \$7,897	\$7,898-\$10,530	More than \$10,530

**Income rules are different for children depending on their age. Children ages 0-5 qualify if income is below 300% FPL. Children ages 6-18 qualify if income is below 240% FPL.*



MEDICAID



Medicaid is a public health coverage program that pays the medical bills of over 500,000 low-income New Mexicans. It is mostly free with some low costs in limited situations.

Medicaid is available to citizens and many immigrants.

See page 25 of this guide for more information about immigrant eligibility rules.

Who Qualifies for Medicaid After 2014?

Before 2014, only certain groups of people could qualify for Medicaid – including children, seniors, people with disabilities, extremely low income parents and pregnant women. On January 1, 2014, Medicaid will be expanded to include over 150,000 more low-income adults. The income rules will also be simplified for many people (using a new standard called “Modified Adjusted Gross Income”).⁸ This will result in some changes to the income rules for certain groups including children, parents and pregnant women. The state has also chosen to reduce the income threshold for family planning and for breast and cervical cancer services. After accounting for all these changes, Medicaid will provide healthcare coverage to low-income people who are:

- **Adults between ages 19 to 64** with a household income less than 138% FPL.⁹ Most of these adults are new to the program – they qualify for the Medicaid Expansion starting on January 1, 2014. This group also includes low-income parents who were qualified for Medicaid before 2014. These parents have access to more healthcare benefits than the new group of adults, but they must have extremely low incomes (meeting both a gross income test of 85% FPL and a “standard of need” test that often requires making less than \$4,500 per year).¹⁰ The state is developing a new income standard that combines the gross income and standard of need tests.
- **Children under age 19** with a household income less than 300% FPL if they are between 0-5 years old, and income less than 240% FPL if between 6-18 years old.¹¹
- **Pregnant women** with incomes up to 235% FPL qualify for pregnancy-related services.¹² The state is developing new income guidelines that may

reduce eligibility levels. Pregnant women with incomes below 85% FPL qualify for a more comprehensive range of services.¹³

- **People who are elderly, blind or disabled and receive SSI** with a household income of less than 75% FPL.¹⁴
- **Working disabled individuals** with incomes less than 250% FPL.¹⁵
- **People in nursing homes** with incomes under 250% FPL.¹⁶
- **People with disabilities** with household income less than about 250% FPL may also qualify for home and community-based “waiver” programs that provide alternatives to institutional care.¹⁷ These are limited programs and have long waitlists for enrollment.
- **Medicare recipients who are low-income** qualify for assistance to pay for Medicare premiums if their income is under 135% FPL, and for assistance with both Medicare premiums and co-pays if their income is under 100% FPL.¹⁸

Medicaid Eligibility by Income Level¹⁹

<i>You may qualify for:</i>			
	Medicaid for Adults 138% FPL	Medicaid for Pregnant Women, Disabled or Elderly 250% FPL	Medicaid for Children 300% FPL*
Household Size	<i>If your monthly income is less than:</i>		
1 person	\$1,321	\$2,393	\$2,872
2 people	\$1,783	\$3,231	\$3,877
3 people	\$2,245	\$4,068	\$4,882
4 people	\$2,708	\$4,906	\$5,887
5 people	\$3,170	\$5,743	\$6,892
6 people	\$3,632	\$6,581	\$7,897

** Note that the income rules for children depend on their ages. Children ages 0-5 years old will qualify for Medicaid if household income is below 300% FPL whereas children ages 6-18 qualify if income is below 240% FPL.*

What Is Happening to SCI?

As of December 2012, nearly 40,000 New Mexican adults were covered by the State Coverage Initiative, or “SCI”, program. SCI is a limited health insurance program that provides coverage to adults. SCI will no longer be available in January 2014 and nearly all enrollees (an estimated 94%) will qualify for more comprehensive coverage through the Medicaid Expansion.²⁰ The remaining 6% will qualify for Exchange coverage with financial assistance.

What Healthcare Services Are Covered by Medicaid?

Medicaid pays for a wide range of healthcare services unless a person is enrolled in a limited program such as family planning or treatment for breast or cervical cancer. Under the new healthcare law, most Medicaid plans must cover a set of Essential Health Benefits that include services like preventive care, maternity and newborn care, prescription drugs, and mental health services (see page 20 for the full list of benefits).

In addition, federal law requires Medicaid to cover certain mandatory services. Some examples include:

- Transportation services (to and from healthcare providers)²¹
- Laboratory and X-ray services²²
- Federally Qualified Health Centers and rural health clinic services²³
- Family planning services and supplies²⁴
- Nurse midwife services²⁵
- Nursing facility services for individuals over 21 years of age²⁶
- Home health care for people eligible for nursing facility services²⁷
- Medical and surgical services of a dentist²⁸
- Comprehensive services for children and adolescents called “Early and Periodic Screening, Diagnosis, and Treatment” (EPSDT) that includes early intervention services, and screening and treatment for medically necessary services, including vision, dental, and mental health services²⁹

Every state can also choose to cover other services. For example, Medicaid in New Mexico covers services like prescription drugs, eyeglasses, hearing aids, mental health services, and nutrition services.³⁰ **Starting in 2014, adults enrolled in Medicaid will be able to get preventive dental services.**

What Is “Centennial Care” and Managed Care?

New Mexico has proposed saving costs in Medicaid by changing the way services are provided. The plan is called “Centennial Care” and it will impact everyone who gets Medicaid including new adults who enroll in 2014. The plan is available at: www.hsd.state.nm.us/CentennialCare/index.html.

As part of Centennial Care, nearly everyone who receives Medicaid will be enrolled into “managed care” plans. These are health insurance plans paid for by Medicaid. In New Mexico, four managed care organizations (MCOs) have been selected to provide Medicaid managed care plans: Blue Cross Blue Shield of New Mexico, Molina, Presbyterian, and UnitedHealth. Each MCO offers its own network of doctors, clinics and other healthcare providers. If you are approved for Medicaid, you can choose which MCO you would like to use for healthcare services. See page 36 for more information on selecting an MCO.

Most people with Medicaid, including children and parents, are already enrolled in managed care plans (through a program called “Salud!”), so these changes will not be new. However, the state will soon require nearly everyone, including seniors and people with disabilities, to also enroll in managed care. The only exception is for Native Americans – the federal government has determined that **Native Americans in New Mexico do not have to enroll in managed care unless they receive long-term care services**.³¹ If you are Native American, you can continue to have your medical bills paid directly by Medicaid to the healthcare provider of your choice (a system called “fee for service”).

What Will Happen to the Disability “Waiver” Programs?

Medicaid covers healthcare for certain people with disabilities, including those who receive SSI (Supplemental Security Income), working disabled individuals, and people who need nursing home care. In addition, Medicaid in New Mexico provides home and community-based “waiver” programs. These include programs for Developmental Disabilities (“DD” waiver), Mi Via (a self-directed program), AIDS, Medically Fragile, and “CoLTS” for long-term services. Under Centennial Care, all of these programs except for the DD waiver and the Mi Via program will be consolidated and run by managed care organizations. There are currently very long waitlists for nearly every program. However, many people will qualify for the Medicaid Expansion in 2014 and will be able to get some healthcare covered while waiting for an opening in a waiver program.

Emergency Medical Services for Aliens (EMSA)

If you have a medical emergency, you have the right to get medical help at a hospital emergency room or urgent care center. There is a Medicaid program called Emergency Medical Services for Aliens (also known as “EMSA”) which covers the emergency medical bills of immigrants who do not qualify for regular Medicaid (including if you are undocumented). You have the right to apply for EMSA to cover your medical bill.

To receive EMSA, you must qualify under all the other standards for Medicaid other than immigration status. You must reside in New Mexico, meet the income rules, and be part of a group that can get Medicaid (for example, children, parents, pregnant women, or people with disabilities). **When Medicaid expands in 2014 to cover more low-income adults, EMSA will also expand to cover more adults (with incomes under 138% of the poverty level).** See page 6 for information on the income rules for Medicaid.

If you did not apply for EMSA at the hospital before you left, you must apply for EMSA at your local Income Support Division (ISD) office within three months after you got care at the emergency room.³² To apply at the ISD office, you will need to get a form from the hospital Admissions or Billing office and bring it to ISD. That form is called an **EMSA Referral for Eligibility form**.³³

Once you apply for EMSA, you will receive a letter within 45 days stating whether you are approved. **This letter does not guarantee that EMSA will pay the bills.** You must take this letter to the hospital and ask them to seek payment from Medicaid. Otherwise, you will still be responsible for the bill.

If EMSA does not cover the emergency medical bill, there are other options for having the bills paid. **After you have been treated, you should ask at the hospital if you qualify for Section 1011 funds, charity care, or a self-pay discount, and what you need to do to qualify.**

EMSA COVERS LABOR AND DELIVERY

If you are having a baby, EMSA will cover the labor and delivery costs. Ask the hospital or clinic if you qualify and what you should do to get free care or a discounted bill when you go in for check-ups before your baby is born or before you leave the hospital with your baby. Once your baby is born, you should apply for Medicaid for your child.



THE EXCHANGE

The Exchange is a new “marketplace” where uninsured people will be able to compare and sign up for health insurance sold in the private market. Most people will also receive financial help to buy coverage, including over 200,000 people in New Mexico.³⁴

The Exchange will make it easier to shop for health insurance by providing clear information about health plans and how much they cost. People can also enroll on the spot into the health plan of their choice. The Exchange is required to:

- Offer health insurance plans for individuals and small businesses;³⁵
- Provide plain language descriptions of the insurance plans to make it easy to compare benefits and costs;³⁶
- Operate a website where people can compare plans and sign up for health coverage;³⁷
- Make the application available online, in person, by postal mail, and by telephone;³⁸
- Screen applicants for financial assistance in the Exchange, Medicaid, and other public health programs;³⁹
- Operate a toll-free telephone hotline to help applicants understand coverage options and sign up for coverage;⁴⁰ and
- Provide free in-person outreach, education and application assistance through a statewide “navigator” program.⁴¹

The Exchange is often compared to websites like amazon.com or Travelocity because applicants will be able to compare the costs and benefits of different health plans. But buying a DVD or a plane ticket is a much easier decision than selecting a health insurance plan. Many – if not most – of the people who get health insurance through the Exchange will have no experience selecting an insurance plan. It will be critical for the Exchange to provide consumer assistance and support to make it easier to sign up for coverage. See page 37 for more information about assistance that will be available to Exchange applicants.



Levels of Coverage

Every health plan that offers coverage on the Exchange must cover a minimum level of healthcare services called “Essential Health Benefits”.⁴² See page 20 for a list of these benefits.

In addition, every plan will be rated according to its level of coverage. There are two major costs you must pay when you have health insurance. One is the **premium** that you pay every month for your plan. The other costs are **copays and deductibles** that you pay each time you receive healthcare – like the \$15 copay that you must pay when you fill a prescription or the bill you get for 15% of the costs of an emergency room visit. Deductibles are amounts you must pay out of pocket (such as \$500 or \$1000) before your health insurance begins to pay for costs. You may have to pay the entire costs of visits to the doctor, even though you have insurance, until your deductible has been paid for the year.

Every health plan on the Exchange will be rated according to these costs, or in other words by something called **actuarial value**. Health plans typically do not pay the entire costs of healthcare services that are covered by the plan. Instead, enrollees in the plan must pay a portion of costs. “Actuarial Value” is the percentage the insurance company pays on average. If your plan has an actuarial value of 85%, the plan will pay an average of 85% of your covered health costs and you will be responsible for an average of 15% of the costs in the form of copayments and deductibles, in addition to your monthly premiums.



Under the healthcare law, plans will be given one of four ratings based on their actuarial value – platinum, gold, silver or bronze.⁴³ There is also a fifth category – catastrophic coverage – available to people who are young or low-income. See page 16 of this guide for more information about catastrophic plans. Platinum plans have the most expensive premium fees, but also the lowest copays and deductibles. Bronze plans have the lowest monthly premium fees but have the highest copays and deductibles. They will cost a lot more out of pocket each time you must see a doctor, get prescription drugs, or go to the hospital.

Sample Exchange Health Plans and Their Costs

Type of Plan	Actuarial Value	Monthly Premium	Prescription Drug Copay	Emergency Room Visit
Platinum	90-100%	\$500	\$10	Patient pays 5%
Gold	80-90%	\$425	\$15	Patient pays 10%
Silver	70-80%	\$350	\$25	Patient pays 20%
Bronze	60-70%	\$200	\$45	Patient pays 40%

Healthcare costs in this table are examples. They are intended to make actuarial value and cost-sharing easier to understand. They do not represent precise dollar amounts for costs on the Exchange.

Premium Tax Credits

The federal government will help people buy health insurance through the Exchange by providing two types of financial assistance. The first is a **tax credit** to help with monthly premiums. The second is a **cost-sharing subsidy** to help with the costs of copays and deductibles. See page 14 for more information about cost-sharing subsidies.

Depending on your household income, you may be qualified for tax credits to help pay for the monthly costs of insurance. These credits are “refundable”, which means that you can use them even if your income is low enough that you pay no or very low taxes. They are also “advanceable” – they are available throughout the year and are applied immediately through the Exchange to help lower your monthly insurance premiums. You don’t have to wait until the end of the year to get them. The credits are provided on a sliding scale – the lower your income, the more financial help you will receive. Some people may not have to pay anything at all depending on the type of plan they choose. However, health plans with lower premium costs will also have higher copays and deductibles.

The amount you must pay for coverage will be different for each household because it depends on both your income and the costs of your health plan. The Exchange will have an online calculator to tell you the actual costs for coverage under each health plan after accounting for financial assistance.⁴⁴ The amount of financial help is calculated in the following way:

Step 1: The federal government will look at the cost of coverage to obtain a certain “Silver” plan on the Exchange.⁴⁵

Step 2: The federal government will cap the amount you would be expected to pay if you bought the Silver plan. This is called your “expected premium contribution” and it is capped at a percentage of your household income.⁴⁶

Expected Premium Contribution in Exchange⁴⁷

Household Income	Expected Premium Contribution
Below 138% FPL	2% of income
138% to 150% FPL	3-4% of income
150 to 200% FPL	4-6.3% of income
200% to 250% FPL	6.3-8.05% of income
250% to 300% FPL	8.05-9.5% of income
Above 300% FPL	9.5% of income

Step 3: The Exchange will issue you a tax credit that pays the difference between the cost of the Silver plan and your expected premium contribution.

You can use your tax credit to buy any plan in the Exchange. For example, if you are a single person with an income of \$28,725 (or 250% of the federal poverty level), your expected premium contribution would be \$193 per month (or 8.05% of income). If a Silver Plan cost \$350, then the tax credit you would receive is \$157. You could use that tax credit to instead buy a Platinum Plan that costs \$500 each month. After your \$157 tax credit, you would have to pay \$343 each month. On the other hand, you could choose to buy the Bronze Plan. If the monthly cost is \$200 per person, most of the cost would be covered by the tax credit and you would only pay \$43 per month for monthly premiums.

Remember that lower premiums also mean higher copayments and deductibles. So while a Bronze plan might seem like a good deal, you will have to pay more each time you need to fill a prescription or see a doctor. **It is very important that families carefully consider all of the costs before making a decision about which Exchange plan to buy.**

Cost-Sharing Subsidies

The second type of financial assistance provided by the federal government is called a **cost-sharing subsidy**. The subsidies put a cap on the total copayments and deductibles a person can be required to pay. While the law limits these costs for everyone who buys a plan through the Exchange regardless of their income level, the cap is the lowest for lower-income families.

Annual Out-of-Pocket Limit, by Income⁴⁸

Income Level	Maximum Annual Copayments/Deductibles, Individual	Maximum Annual Copayments/Deductibles, Family
Below 200% FPL	\$2,083	\$4,167
200-300% FPL	\$3,125	\$6,250
300-400% FPL	\$4,167	\$8,333
Above 400% FPL	\$6,250	\$12,500

For low- and middle-income families, the law also lowers costs by guaranteeing a certain actuarial value (for more on actuarial value, see page 11). If a family buys a Silver plan, the federal government will make payments directly to their insurance company so that the family has lower copayments and deductibles.⁴⁹ The family will still have to pay some costs, but less – in some cases, much less. For example, if a Silver plan usually has a \$20 prescription copay, a family with income below 150% FPL might pay \$3 and the federal government might pay \$17. The family does not have to pay up front. The government makes a payment directly to the insurance company, and the family is just charged less for a prescription or a doctor’s visit.

The chart on the next page shows how these cost-sharing protections change the actuarial value of a Silver plan, which usually has an actuarial value of 70%. Note that the protections **do not apply if a family buys a Bronze plan**. This means that purchasing a Silver plan, even if it costs a little bit more, can make a very big difference in the cost of a prescription or visit to the hospital.

Actuarial Value of Silver and Bronze Plans, by Income, after Federal Payments⁵⁰

Income Level	Effective Actuarial Value of Silver Plan	Effective Actuarial Value of Bronze Plan
Below 150% FPL	94%	60%
150-200% FPL	87%	60%
200-250% FPL	73%	60%

Special Rule: Costs for Native Americans

Under the law, any Native American who enrolls in a health plan through the Exchange and has income below 300% of the federal poverty level cannot be charged copayments or deductibles.⁵¹ In addition, Native Americans, regardless of income, cannot be charged copayments or other fees for any healthcare they receive through the Indian Health Services, a Tribal Organization, an Urban Indian Organization or through a referral from Contract Health Services.⁵² Native Americans must still pay a share of monthly Exchange premiums according to the chart on page 12. However, they will receive financial help if their incomes are below 400% of the federal poverty level. As a result, Bronze plans could be a very good deal – the monthly premium payments would be low cost or even free and Native Americans would not be charged any deductibles or copayments if their income is below 300% of the federal poverty level. In addition, **Tribes, Tribal Organizations, and Urban Indian Organizations can choose to pay the monthly premium fees for their member** to get health plans in the Exchange.⁵³

See page 1 of this guide for information about who qualifies as an “Indian” under the ACA.

Special Rule: Tobacco Users

In general, the healthcare law does not allow insurance companies to charge people more for health insurance based on their health status. But there is one big exception: people who use tobacco products or have used them in the last six months. They can be charged up to 50% more for coverage.⁵⁴ Premium tax credits are calculated based on the premium cost **before** any additional charge for tobacco use.⁵⁵ This means the federal tax credit is **not** increased for people facing higher premiums because of their tobacco use. The effect is that **all** Exchange coverage is likely to be unaffordable for low-income tobacco users. As one example, a single adult who does not use tobacco will be expected to pay an estimated \$59 per month for health coverage in 2016. By contrast, a single adult that is the same age but who uses tobacco could be expected to pay up to \$276 a month for coverage – 19% of household income. While costs this high will mean that the person will not be required to buy insurance under the law because it is unaffordable (see page 23 of this guide for more information), the result is that many tobacco users will be unable to access healthcare coverage. Note that the rules for Medicaid are **not different** based on tobacco use; adults with incomes up to 138% FPL can qualify for Medicaid regardless of whether they use tobacco.

Special Rule: Catastrophic Plans

The Exchange will also offer “catastrophic” plans with lower actuarial value than Bronze coverage. Catastrophic plans will have the lowest monthly premiums costs. However, the federal government will not provide financial help to pay these costs.⁵⁶ These plans are also only open to people who are younger than age 30 or who are exempt from the law’s mandate to get healthcare coverage due to hardship or affordability reasons.⁵⁷ See page 23 of this guide for more on the mandate to get coverage.

The major difference between catastrophic plans and other plans is that catastrophic plans can charge a large, up-front deductible before the plan will cover most services. This means the person with the catastrophic plan will have to pay the **full cost** of most medical services up to the maximum out-of-pocket limit before the plan will pay for healthcare costs. See page 14 of this guide for a list of maximum out-of-pocket limits.

Development of the NM Health Insurance Exchange

Under the ACA, all states are required to decide whether they will develop and run their own Exchange, let the federal government run the state's Exchange, or partner with the federal government to share Exchange responsibilities.⁶⁶ In March 2013, the New Mexico Legislature passed and the Governor signed the New Mexico Health Insurance Exchange Act (NM Exchange Act).⁶⁷

The NM Exchange Act sets up an independent nonprofit corporation, the New Mexico Health Insurance Exchange.⁶⁸ While the Exchange is not part of the state government, it is subject to certain transparency and public accountability requirements.⁶⁹ The Exchange is run by a thirteen member board of directors: six members are appointed by the Governor, six are appointed by the legislative leadership,⁷⁰ and the last member is the Superintendent of Insurance.⁷¹

The Exchange board does not have the power to determine which health plans will be offered to individuals and small employers.⁷² That power is given to the Superintendent of Insurance.⁷³ The Exchange board is charged with the administration of Exchange operations, including establishing a statewide consumer assistance program,⁷⁴ establishing consumer complaint and grievance procedures,⁷⁵ creating various advisory committees,⁷⁶ and establishing at least one walk-in customer service center.⁷⁷

The federal government has made significant grant funding available to states to help them set up and start Exchange operations.⁷⁸ By 2015, however, Exchanges must be “self-sustaining” – that is, they must generate enough funds to support their own operations.⁷⁹ In New Mexico, the Exchange board has the authority to charge fees to all health insurance issuers in the state, regardless of whether they offer a plan on the Exchange.⁸⁰

Special Rule: Native American Consultation

Federal law requires the Exchange to consult with Indian tribes.⁸¹ State law also requires the New Mexico Exchange to have a Native American advisory group and to appoint a Native American liaison.⁸² The Exchange board must also implement policies that promote effective communication between the Exchange and Indian Nations, Tribes and Pueblos, and that promote cultural competency in providing services to Indians.⁸³

MEDICARE

Medicare is a public health coverage program that serves senior citizens age 65 and older and certain people with disabilities. For enrollees, Medicare remains largely unchanged under the ACA. There are no cuts to benefits and enrollees are still free to choose their own doctor. However, there are several new benefits and consumer protections for seniors:

- **The ACA establishes the Federal Coordinated Health Care Office to streamline administration and access to comprehensive health care coverage for people who receive both Medicare and Medicaid.**⁸⁴ These individuals are known as “Dual Eligibles”. They receive Medicare (for people with disabilities and people who need institutional care) but they also receive Medicaid.
- **The ACA closes the “donut hole” by 2020.** Right now, there is a gap in Medicare prescription drug coverage. With Medicare Part D, you must pay 100% of the costs of prescription drugs until your deductible amount is reached. After that, drug costs are 75% covered by Medicare until you reach another threshold (\$2,970 in 2013). There is then no coverage for prescription drugs until total spending hits a third limit (\$4,750 in 2013). After that, about 95% of drug costs are covered.⁸⁵ This \$2,000 gap with no prescription coverage is referred to as the “donut hole.” The ACA started phasing out the donut hole in 2011 and will completely close it in 2020.⁸⁶ The law also provides a combination of government subsidies and manufacturer discounts to help reduce out-of-pocket costs in the donut hole before 2020.
- **Medicare now covers certain preventive services with no copayment or deductible.**⁸⁷ These services include a free annual wellness exam; screenings including mammograms, some cancer screenings, diabetes screenings, and others screenings; and vaccinations for the flu, pneumonia, and hepatitis B. For a full list of services, visit www.medicare.gov/coverage/preventive-and-screening-services.html.



INSURANCE CONSUMER PROTECTIONS

The ACA introduces a set of insurance “market reforms” to improve the quality of health insurance. This section reviews and provides basic information about the most important of these reforms.

Essential Health Benefits

Beginning in 2014, all health insurance plans offered in the individual and small group markets, including all Medicaid and Exchange plans, must cover a core set of benefits called the “Essential Health Benefits.” Plans will be required to include coverage of the following categories:

1. Ambulatory patient services (walk-in services that do not require admission or hospitalization);
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.⁸⁸

Currently, many plans in the individual and small group markets exclude some of these services, or require you to buy an expensive “rider” to add the coverage to a basic plan. The Essential Health Benefits ensure that every health plan provides a standard level of coverage and quality, making it easier for people to understand their coverage and compare plans to one another.

Improved Access to Preventive Care

The healthcare law also increases access to certain preventive services by requiring insurance plans to cover them without charging a copayment or deductible.⁸⁹ These rules apply to most insurance plans and are not limited to plans in the Exchange or even to plans in the individual and small group markets.

Preventive services with no copayment or deductible include:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on topics like quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use
- Regular well-baby and well-child visit, from birth to age 21
- Routine vaccinations against diseases such as measles, polio or meningitis
- Counseling, screening and vaccines to ensure healthy pregnancies
- Flu and pneumonia shots

A full list of covered preventive services is available at www.healthcare.gov/news/factsheets/2010/07/preventive-service-list.html.



Other Consumer Protections

- ❖ **The right to buy and keep insurance.** Before the ACA, insurance companies could deny health coverage based on a preexisting condition. This meant that if someone with diabetes, for example, lost her job, it was often impossible to get a health plan that would include coverage for diabetes. Under the ACA, health plans must provide coverage to anyone who signs up for coverage, regardless of their health status.⁹⁰ Plans are also prohibited from cutting off coverage once someone is enrolled.⁹¹
- ❖ **The right to fair insurance premiums.** Under the ACA, insurance companies are also prohibited from charging people more because they have or are at risk for a particular health condition.⁹² Before the ACA, women paid more for health insurance than men and people with a history of illness paid much more for health insurance than people who had not been sick. Now, insurance companies are only permitted to charge different insurance rates to people based on: (1) whether the plan covers an individual or a family; (2) geographical area; (3) age; and (4) current tobacco use or tobacco use in the past 6 months.⁹³ See page 16 of this guide for more information about how these rules will affect people who use tobacco.
- ❖ **The right to keep your child on your insurance plan.** Parents can keep their children on their insurance plan until the child turns 26.⁹⁴
- ❖ **No more annual or lifetime limits.** Before the ACA, people with insurance and who were diagnosed with serious conditions such as cancer often found their benefits would “run out” when they hit annual or lifetime caps for covered services. Now, insurance companies cannot impose annual or lifetime dollar value caps on benefits for anyone who enrolls in a plan.⁹⁵



THE REQUIREMENT TO HAVE HEALTH COVERAGE

The purpose of the ACA is to expand access to healthcare by ensuring that nearly everyone has access to health coverage. The consumer protections and insurance reforms described in the previous section only work well if nearly everyone actually gets coverage – either through public programs like Medicaid or Medicare, through their job, or through the Exchange.

Insurance prices could become very high if only the people who have health conditions get coverage. Young and healthy people must also be added to the pool to keep prices low for everyone. To make sure that happens, the ACA requires most people to buy insurance and requires some employers to provide insurance for their employees.

The Individual Mandate

The ACA requires most people to pay a tax penalty if they are uninsured for more than 3 months of the year beginning in 2014.⁹⁶ **Some people are exempt from this requirement and will not have to pay tax penalties if they do not maintain coverage,⁹⁷ including:**

- People with income below the tax filing threshold;
- **Native Americans** (see page 1 of this guide for more information about who is a “Native American” under the ACA);
- Undocumented immigrants;
- People who are incarcerated;
- People who obtain a “religious conscience exemption”;
- Individuals who do not have access to a health plan that costs less than 8% of their income; and
- Individuals who are found to have a “hardship” with obtaining coverage as determined by the Secretary of the U.S. Department of Health and Human Services.

The Exchange is required by law to determine whether a person qualifies for one of these exemptions.⁹⁸

Employer Responsibility

The ACA also requires some employers to provide coverage to their employees. Large employers – those with 50 or more full-time employees (or the equivalent of 50 full-time employees when adding up part-time and full-time employees) – must offer health coverage to their employees who work 30 hours or more per week, or else pay a penalty.⁹⁹ In addition, to avoid a penalty, the coverage must be “affordable” for employees (the employee’s share of premiums must be less than 9.5% of household income for an individual policy) and it must have at least 60% actuarial value. See page 11 for more information about actuarial value.

What if I Don’t Get Insurance?

If you are not eligible for an exemption and you don’t get coverage – through Medicare, Medicaid, the Exchange, your job, or by buying a policy on your own – you must pay a tax penalty at the end of the year. The tax penalty is either a flat dollar amount per member of your family or a percentage of taxable income, whichever is more.

Annual Penalties for Failure to Get Insurance¹⁰⁰

Year	Flat Dollar Penalty	Percentage Penalty
2014	\$95 per uninsured adult and \$47.50 per uninsured child	1% of taxable income
2015	\$325 per uninsured adult and \$112.50 per uninsured child	2% of taxable income
2016 and later	\$695 per uninsured adult and \$347.50 per uninsured child	2.5% of taxable income

If you have 3 or more months without insurance in a given year, you pay a penalty for each month that you did not have insurance. So, for example, if you are a single adult and are uninsured for the first six months of 2014 but then you get a new job that provides you with coverage, your penalty would be \$47.50 or 0.5% of taxable income for the year, whichever is more. You will pay any penalties that you owe at the end of each year when you file your taxes.

SPECIAL ELIGIBILITY RULES: IMMIGRANTS

Many immigrants will have access to new health coverage under the ACA. However, some immigrants must wait five years before they can get certain benefits, and others are excluded from coverage options under the law.

Citizens in “Mixed Status” Households

Many immigrants live in “mixed status” households, where citizens and people with different immigration statuses live together. Immigrants in “mixed status” families have a right to apply for coverage for qualified family members. For example, an undocumented mother has a right to apply for Medicaid for her U.S. citizen children even though she cannot seek coverage for herself. If her children qualify for the Exchange and not Medicaid, she has a right to access tax credits to help pay for their insurance through the Exchange. The Exchange must have “child-only” plans for immigrant families where only the children qualify for Exchange coverage.

There are special rules for immigrant families that apply for coverage. The state **cannot** require Social Security Numbers or immigration status information for non-applicant family members, but can require this information for the family members who will be receiving coverage.¹⁰¹ All application forms should make clear that Social Security Number and immigration status information for non-applicant family members is **optional** and is not required to complete the application. **If you are applying for health coverage for your family (but not for yourself) and someone asks for your Social Security Number or immigration status information, contact the Center on Law and Poverty using the information at the end of this guide.**

Immigrant families **must** provide information about income from all household members, whether or not they are applying for coverage. If Medicaid or the Exchange cannot verify income electronically (see page 30 of this guide) and traditional paper-based proof (such as pay check stubs) is unavailable, the state must work with immigrant families to provide alternate proof of income. See page 35 for more information on ways to prove income.

If you are supplying proof of income for a household member who is not

seeking health coverage for himself or herself, you should black out any Social Security Number that appears on the check stubs or other paperwork that is being used to verify income.

Lawfully Present Immigrants

The Medicaid Expansion **does not change** immigrant eligibility rules for Medicaid. This means that some immigrants may still have to wait 5 years before they can qualify for Medicaid, including many lawful permanent residents (“green card” holders). These individuals must be in a “qualified” immigration status for five years.¹⁰² However, many immigrants in New Mexico can get Medicaid coverage **with no waiting period**. Immigrants who can get Medicaid right away include:

- **Any lawfully residing child or pregnant woman.** This includes lawful permanent residents (“green card” holders) and many other “qualified”¹⁰³ immigrants. It also includes any immigration status (other than undocumented), including those with temporary authorization like a student visa or a temporary work visa.
- **Lawful permanent residents** who can be credited with 40 quarters of work.
- **Refugees and asylees.**
- **Victims of trafficking.**
- **Cuban and Haitian entrants.**
- **Persons granted withholding of removal or deportation.** This category does **not** include deferred action for child arrivals (DACA or “DREAM” beneficiaries).
- **Iraqi and Afghan Immigrants granted special status.**
- **Active duty military and veterans.**
- **Certain American Indians born abroad.**
- **Battered spouses and children.**
- **Lawfully residing immigrants** who are receiving SSI, members of a federally recognized Indian tribe, or who entered the U.S. prior to August 22, 1996 and are permanently residing under color of law (“PRUCOL”).
- **Lawful permanent residents, persons paroled into the U.S. for at least one year, and conditional entrants** who entered the U.S. prior to August 22, 1996 and (1) remained continuously in the U.S.

until obtaining “qualified”¹⁰⁴ status, (2) are Amerasian immigrants, or (3) are PRUCOL.

Lawfully present immigrants who cannot get Medicaid (because they do not have a qualifying immigration status or they must wait for 5 years) do have access to coverage through the Exchange. They can get the tax credits and cost-sharing reductions described on pages 12 and 14 of this guide to help pay for insurance coverage. If the household income is below the Medicaid threshold (138% FPL), the person or family will receive special enhanced financial assistance in the Exchange. Their expected premium contribution is limited to 2% of household income and, if they purchase a Silver plan, they are guaranteed a plan with at least 94% actuarial value.¹⁰⁵

In addition, lawfully present immigrants in this income group will qualify for Emergency Medical Services for Aliens (EMSA), a health coverage program through Medicaid that pays only for the cost of emergency services, including labor and delivery. Immigrants who have emergency medical expenses can apply for EMSA by submitting an application at the hospital or through an Income Support Division (ISD) office within 90 days of the date of receiving the emergency care. See page 9 for more information about EMSA.

Undocumented Immigrants

Undocumented immigrants are excluded from benefits under the healthcare law. They cannot qualify for regular Medicaid. They cannot qualify for financial assistance in the Exchange and they are barred from buying coverage through the Exchange even if they are willing and able to pay full price.¹⁰⁶ They are also exempt from the individual mandate of the law,¹⁰⁷ which means they are not required to buy health insurance.

Undocumented immigrants who meet income and state residency requirements for Medicaid can qualify for Emergency Medical Services for Aliens (EMSA). EMSA is a health coverage program through Medicaid that pays only for the cost of emergency services, including labor and delivery. Immigrants who have emergency medical expenses can apply for EMSA by submitting an application at the hospital or through the ISD office within 90 days of the date of the emergency care. See page 9 for more information about EMSA.

THE APPLICATION PROCESS

The ACA envisions a new enrollment system for both Medicaid and the Exchange. There are two major principles that should transform the application process, making it much easier for applicants to get and keep health coverage in both Medicaid and the Exchange:

- **The “paperless” application.** New Mexico is developing new websites and information technology systems to help connect people to healthcare. With these new systems, Medicaid and the Exchange are supposed to move to a paperless application system to the greatest extent possible.¹⁰⁸ This means verifying your identity, citizenship or immigration status, income, and state residency information with “third-party data sources” that may already have your records, such as the Internal Revenue Service, the Department of Labor, and the Department of Homeland Security. You should only be asked to provide paper proof if information is not available from these electronic sources or if you disagree with the information that is available.



- **No wrong door access.** Under the healthcare law, Medicaid and the Exchange must provide “no wrong door” access to coverage – you should be able to fill out one application for both programs and be enrolled into the right coverage regardless of where you apply.¹⁰⁹ The Exchange is supposed to help enroll people into Medicaid, and vice versa, and people should not be directed to another location to submit their applications.¹¹⁰ This is especially important because so many New Mexico families will have some members who qualify for Exchange coverage while others qualify for Medicaid.

Applicants with Limited English Proficiency (LEP) have a right to receive application assistance and information in a language they understand.¹¹¹ All Medicaid and Exchange materials, including the websites, will be available in both English and Spanish. If you speak a language other than English or Spanish, you have a right to request an interpreter – at no cost to you – to help with the application process or if you want to appeal a decision.¹¹²

When to Apply for Coverage

The Medicaid Expansion and coverage through the Exchange both take effect on **January 1, 2014**. The rules for when you can enroll in coverage are different for the two programs.

- You can sign up for Medicaid coverage by **October 1, 2013** and enrollment is open **year-round**.
- Most people can only sign up for Exchange coverage during a special **open enrollment period**. The first open enrollment period starts **October 1, 2013** and closes **March 31, 2014**.¹¹³ After the first year, enrollment will be open from October 15 to December 7 each year.¹¹⁴ Coverage then begins on January 1 of the following year. In general, once the open enrollment period ends, you can't sign up until the next year. However, if a change happens (like you get a new job or have a baby) that affects your eligibility, it may trigger a "special enrollment period."¹¹⁵ If you are Native American, you have an opportunity to enroll in or change coverage each month.¹¹⁶ See page 1 of this guide to find out who qualifies as a Native American under the ACA.

Where to Apply for Coverage

While the full list of locations to apply for the Exchange and Medicaid is not yet available, you will be able to apply for coverage:¹¹⁷

- **Online** from your home or any other computer, such as a computer at the public library. Apply at either of these websites: www.yes.state.nm.us or www.bewellnm.com.
- By filling out a paper application and sending it by **fax** or **mail**. A "streamlined application" for both the Exchange and Medicaid is available online at: www.hsd.state.nm.us/isd/apply.html.
- At **Income Support Division** offices throughout the state. See page 46 of this Guide for a full list of ISD offices in New Mexico.
- With the help of "**healthcare guides**". These people will be stationed throughout New Mexico at community agencies and health clinics. To find a guide near you, visit www.bewellnm.com or call the Exchange hotline at 1-855-99-NMHIX.

- At a walk-in **Exchange service center**. There will also be a special **Native American service center**. Call 1-855-99-NMHIX for information or visit www.bewellnm.com.

What You Will Need to Apply

To apply for Medicaid or Exchange coverage, you will be required to prove three basic things for every household member who is applying for coverage:

1. **Identity (including age)**
2. **New Mexico residency**
3. **U.S. citizenship or qualifying immigration status**



In addition, there may be people in your household who are not seeking coverage – because they have employer-based coverage, or qualify for an exemption for the individual mandate, or are ineligible due to their immigration status. For all household members, whether or not they are applying for coverage, you must prove:

4. **Income** (Note that while Medicaid eligibility is based on current income, Exchange financial assistance eligibility is based on expected income for the whole year.)

Because of the new “paperless application” rules, you may not need to provide any documents to enroll in Medicaid or the Exchange. Instead, Medicaid or the Exchange will match up what you say with information that is already stored in government databases.¹¹⁸ However, it is possible that the Exchange will not be able to find your records or the data will be outdated or inaccurate. In these cases, you will still need to provide paper proof to complete your application.

If you need to provide paper proof, you have 90 days to get it to the Exchange.¹¹⁹ During this 90 day period, you have a right to be enrolled in a health plan with financial assistance while you search for your records. You can also ask for an extension if you have been making a good faith effort to find your records but need more time.¹²⁰ However, if you cannot provide

the proof by the end of the time period you may be dis-enrolled and owe money back to the federal government.¹²¹

The rules for Medicaid are different. You may not be enrolled simply based on what you say except in two situations. One is if you do not have proof of citizenship. The Medicaid agency must enroll you anyway based on your declaration of citizenship and give you 90 days to provide documents.¹²² If you cannot provide the proof in that timeframe, you will be dis-enrolled.

The other situation is if you are found to be “presumptively eligible” for Medicaid. In New Mexico, certain clinics, hospitals and providers can decide that you are qualified for Medicaid based on what you declare about your identity, citizenship, residency and income. This is only allowed for children, pregnant women, adults who qualify for the Medicaid Expansion, and people who need family planning or breast or cervical cancer treatment.¹²³ You will be enrolled in Medicaid for a limited time (starting in the month you enroll and lasting through the end of the next month). You must complete a regular application with the Income Support Division (ISD) in order to continue receiving Medicaid past the temporary period.

You have the following rights during the application process:

- You do not have to verify information that does not change if it has already been verified in a previous application, such as: date of birth, address, SSN or citizenship.¹²⁴
- You do not have to verify information that the ISD or Exchange worker can find in other government data systems.¹²⁵
- You do not have to verify a negative: for example, if you do not have a car or a bank account, you do not have to prove this.¹²⁶
- Documents should be used as proof for more than one eligibility factor if possible: for example, your driver’s license can be used to verify your identity, date of birth and address.¹²⁷
- The Exchange and Medicaid cannot use your immigration status to disprove state residency.¹²⁸ For example, the fact that you have a “temporary” authorization to be in the country (such as a student visa or work permit) cannot be used as evidence that you are not a state resident. The test is whether you live in the state now and intend to remain here.¹²⁹

Proof of Identity¹³⁰

Regulations in New Mexico describe the following documents that may be used to prove identity. The rules for the Exchange are still under development but are likely to be similar.

- Driver's license or other identification card issued by federal, state, or local government with the same information as driver's license
- U.S. passport
- Certificate of U.S. Citizenship (DHS Form N-560 or N-561)
- Certificate of Naturalization (DHS Form N-550 or N-570)
- Birth certificate or letter from a hospital (for newborns)
- Certificate of Indian Blood
- Native American tribal document with picture or other personally identifying information
- U.S. Military card or draft card; Military dependent's identification card, or U.S. Coast Guard Mariner card
- School identification card with a picture of the person
- A cross match with federal or state governmental, public assistance, law enforcement or corrections agency's data systems, if the agency establishes and certifies the true identity of the individual
- Affidavit by a residential facility director or administrator on behalf of an institutionalized applicant/recipient
- School records for children
- Clinic, doctor or hospital records for children

Parents can sign a sworn statement (called an affidavit) for their children who are under 16, but only if other documents are not available.

Proof of New Mexico Residency¹³¹

- Driver's license
- Rental agreement, mortgage papers, or letter from landlord
- Utility bills
- Employment records or statement from employer
- Records from school, tax office, post office, church or synagogue
- Proof of ownership of property
- Any other items listed by the Income Support Division (ISD)

A sworn statement can be made if you cannot provide documents or if you do not have a "collateral contact" (a person outside the household who knows your circumstances).

Proof of Citizenship¹³²

- U.S. Passport (proves both citizenship and identity)
- Certificate of U.S. Citizenship (DHS form N-560 or N-561) (proves both citizenship and identity)
- Certificate of Naturalization (DHS form N-550 or N-570) (proves both citizenship and identity)
- Birth certificate (*note: your ISD caseworker can do a computer match with a state's vital statistics agency to verify your citizenship, but if you have your birth certificate, it is a good idea to bring it in when you apply*)
- Certificate of Birth issued by State Department (Form DS-1350 or FS-545), Report of Birth Abroad (Form FS-240), U.S. Citizen ID Card (DHS Form I-179 or I-197), or Northern Mariana identification card (I-873)
- U.S. Military record of service showing U.S. place of birth
- Evidence of civil service by U.S. government before June 1, 1976
- American Indian Card with code "KIC" for Texas Band of Kickapoos (DHS Form I-872)
- Final Adoption Decree with child's name and U.S. place of birth

- Data verification with the SAVE program for naturalized citizens if conducted consistent with a memorandum of understanding with DHS
- Adopted or biological children born outside of U.S. establish citizenship automatically if all of the following are true: 1) at least one parent is U.S. citizen; 2) child is under age 18; 3) child resides in U.S. under physical custody of U.S. citizen parent; 4) child was admitted to U.S. for lawful permanent residence; and 5) if adopted, child satisfies immigration law rules pertaining to adoption
- Official religious record by religious organization in U.S. within three months of birth, and showing birth in U.S.
- Early school record showing U.S. place of birth, date of birth, name of child, date of admission to school, and the name and place of birth of the applicant/recipient's parents
- Documents showing U.S. place of birth and created near time of birth or five years before date of initial application:
 - U.S. Hospital record on hospital letterhead
 - Life, health, or other insurance
 - Medical record (except for immunization records)
 - Seneca Indian Tribal Census Record;
 - Bureau of Indian Affairs Tribal Census Records of the Navajo Indians;
 - U.S. state Vital Statistics Official Notification of Birth registration;
 - A delayed U.S. public birth record that is recorded more than five years after the person's birth;
 - A statement signed by a physician or midwife who was in attendance at the time of birth.
 - The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.
 - Institutional admission papers from a nursing facility, skilled care facility or other institution
- Federal or State Census Record showing U.S. place of birth

Written affidavits signed under penalty of perjury and notarized can be used, but only if no other document is available. You must submit an affidavit explaining why other documents are not available, and must also submit two documents from individuals who can prove their own citizenship and who have knowledge of the your citizenship (one of whom cannot be related to you).

Proof of Immigration Status (for Non-Citizens)¹³³

If you are not a U.S. citizen, you must have a valid Department of Homeland Security U.S. Citizenship and Immigration Services document (unless you are applying on behalf of another person, in which case, proof is only needed for the person who will be receiving healthcare coverage). Your immigration status will be verified through the United States Department of Homeland Security database system, called “SAVE”.

Proof of Income¹³⁴

- Check stubs
- Letter from your boss
- Records of other government benefits you are receiving (such as SSI or TANF)

If you do not have check stubs and cannot get a letter from your boss, there are other ways to prove your income. You can choose somebody to be a “collateral contact.”¹³⁵ This is a person that your caseworker can call, with your permission, to verify where you work and how much you earn. The “collateral contact” person cannot live with you and should be someone who knows your situation. Some examples of a “collateral contact” are employers, landlords, co-workers, social service agency workers, and neighbors.

If there is no one that your caseworker can ask about your income information you can write a statement, which must be sworn and signed “under penalty of perjury,” explaining how much you earn.¹³⁶ The caseworker must accept this statement if you have an explanation for why you cannot supply other proof. Some examples might be that your employer doesn’t want to talk to anybody about it, or you are afraid you might lose your job.

Help Getting Documents

If you cannot get any of the above documents, you should ask for help – your ISD caseworker is supposed to help you get the documents you need.¹³⁷ The healthcare guides with the Exchange (see page 37 for more information) should also be able to help you.

If the Exchange or Medicaid needs more information, you have a right to receive a notice that clearly explains what information is still missing.¹³⁸ If you apply at an ISD office, this could be in the form of a “What You Still Need” form (which you are given at the time of the application) or a “Help Us Make A Decision” form (which you receive in the mail later). It is very important to have a correct, current address on file with your application. If you move, be sure to contact ISD or the Exchange to tell them that your address has changed so that you will be sure to receive any notices about your health coverage.

What Happens After I Apply?

Both Medicaid and the Exchange are supposed to move toward “real time” eligibility determinations.¹³⁹ This means that most applicants should be able to complete their application and get enrolled as soon as all your information has been provided and verified. In reality, it may be awhile before “real time” eligibility determinations happen for many Medicaid and Exchange applicants.

If you do not receive a Medicaid decision at the time you apply, your application should be processed within 45 days.¹⁴⁰ If you qualify for Medicaid, you will be sent a notice of approval and your Medicaid card will be sent to you. If you are denied Medicaid, you have the right to be informed why.¹⁴¹ If you think a mistake was made, you should appeal by requesting a hearing. See page 38 for details on how to request a hearing.

After you are approved for Medicaid you will get a letter telling you to pick a managed care organization (MCO): Blue Cross Blue Shield, Presbyterian, Molina, or UnitedHealth. You should pick the MCO that your doctor uses. If you don't respond to pick an MCO, then Medicaid will pick one for you. **If you are Native American, you are not required to select an MCO. You can choose to stay in “fee for service” where Medicaid pays all your bills directly or you can choose to enroll in MCO coverage – it's up to you.**

If you are approved for Exchange financial assistance at the time you apply, you will be able to immediately select a health insurance plan as part of the application process. However, if you are required to supply additional

documents, you have 90 days to do so. During those 90 days, you have a right to be enrolled in Exchange coverage with financial assistance based on what you say your income is.¹⁴² See page 30 for more details. If you disagree with the final decision about how much financial assistance you qualify for, you should appeal by requesting a hearing (see page 38 for details).

Where to Get Help – Consumer Assistance Resources

If you need help with your application for Medicaid or the Exchange, there are several resources available to provide you with assistance. If you have questions about the application process and your health coverage options, you can contact:

1. Your **local Income Support Division (ISD) office**. See page 46 for a list of ISD office locations.
2. The state **Medical hotline** at 1-855-637-6574.
3. The toll-free **Exchange hotline** at 1-855-99-NMHIX.
4. **A healthcare guide** in your community. These guides can provide information about the application process and assist you with enrollment. To find a guide near you, call the Exchange hotline at 1-855-99-NMHIX or visit www.bewellnm.com.
5. The Exchange **walk-in customer service center**. The locations will be announced at www.bewellnm.com.
6. The **Native American service center**. The locations will be announced at www.bewellnm.com.
7. If you are having trouble with the application process or with getting the healthcare services you need, you can get legal assistance from the organizations listed on p. 44 of this guide. You can also call the state's **Health Insurance Consumer Assistance Program** at 1-888-427-5772.

HEARINGS



If you do not agree with the decision about your eligibility for Medicaid or Exchange financial assistance, you can request a hearing.¹⁴³ You might request a hearing because you never hear from Medicaid or the Exchange about the decision, or because you disagree with the decision once it is made.

Medicaid Hearings

After you are told (or get a letter) that your Medicaid benefits are being stopped or reduced, or you have not heard anything from ISD after applying, you then have 90 days to tell your caseworker that you want a hearing.

You should request the hearing in writing. You can ask for a hearing request form from the ISD receptionist or your caseworker, or you can just write your request for hearing on a blank piece of paper. Give the request to your caseworker or the receptionist and make sure you get a receipt when you turn it in. You can also call 1-800-432-6217 (toll free) to request a hearing, but you should **also** give the written request to an ISD caseworker and get a receipt.

Your hearing will be held within 60 days from the date ISD received your request for a hearing.¹⁴⁴ You should get a notice not less than 10 days before the hearing telling you the time and place of the hearing.¹⁴⁵

You have the right to bring someone with you to help you through the hearing, and that person does not have to be an attorney.¹⁴⁶ See page 43 for resources for legal help and advice.

Exchange Hearings

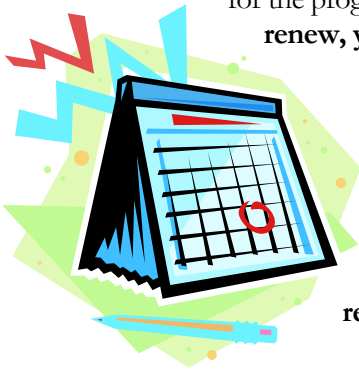
The Exchange must set up a dispute resolution and appeals process under federal and state law. The process has not been set up yet, but information about how to appeal will be included in all Exchange notices as well as on the Exchange website.

ONCE YOU HAVE COVERAGE

Once you are enrolled in Medicaid or the Exchange, you generally will keep that same coverage for a full year. There are certain things you should know about what happens during that year or at the end of the year, when you have to renew coverage.

Medicaid Renewals

If you are on Medicaid, then once per year you must prove that you still qualify for the program. This is called renewal. **If you do not renew, you will lose your Medicaid benefits.**



After 11 months of being on Medicaid, you **should** receive a letter from ISD telling you how to renew for Medicaid. But ISD does not always send these letters, or the letter may not reach you. **If you have been on Medicaid for about 11 months and do not receive the renewal letter, do not wait - contact ISD.**

If you attempt to renew Medicaid and are cut off, request a hearing right away. You have the right to stay on Medicaid while you wait for your hearing if you request a hearing soon after you get a denial notice. Your Medicaid coverage should continue if ISD receives your request for a hearing by the end of the 13th day after the date on the notice.¹⁴⁷ See page 38 for more information on hearings and contact one of the legal resources on page 43 to get legal advice about your situation.

Medicaid: Changes in the Middle of the Year

Starting on January 1, 2014, there will be important changes to the rules about reporting your income for Medicaid. Adults will be able to stay enrolled in Medicaid for an entire year (called “continuous eligibility”) up until the time of renewal. **This means that after you are approved for Medicaid, you do not need to notify Medicaid if your income changes in the year. You can stay enrolled for a full year.** Medicaid already provides “continuous eligibility” for children.

Exchange Renewals

Once you have signed up for a health plan on the Exchange, you will not be able to change plans until the next “open enrollment period.” The initial open enrollment period is six months long, **from October 1, 2013, to March 31, 2014.**¹⁴⁸ In later years, the open enrollment window will be shorter, **from October 1 to December 7** each year.¹⁴⁹ Coverage then begins on January 1 of the following year.

However, there are exceptions. If you have a change in circumstances in the middle of the year (like you get a new job or have a baby) it may trigger a “special enrollment period.”¹⁵⁰ **If you are Native American, you may also sign up for new plans or change plans during special enrollment periods** that happen every month of the year. The days of these enrollment periods will be determined by the Exchange.¹⁵¹ See page 1 of this guide to find out who qualifies as a Native American under the law.

You should receive a letter from the Exchange or your insurance company telling you about the upcoming open enrollment period. If you do not receive a letter, you should keep track of the open enrollment dates in your calendar to be sure you can change insurance plans if you want to.

Exchange: Changes in the Middle of the Year

If you are enrolled in the Exchange with financial assistance, you should report **all household and income changes immediately** to the Exchange as they happen. This includes both changes to earnings (for example, you lose a job or get a raise) and changes to household composition (for example, you have a new baby or you get a divorce). You may then qualify for a different level of financial assistance through the Exchange, or you may become eligible for Medicaid.¹⁵² This will also open up a special enrollment period for you to sign up for a new health plan. You will not have to wait until the end of the year for the regular open enrollment period. **If you don’t report these changes, you may have to pay back some of the financial assistance you received at the end of the year when you file taxes.** The law requires that you report these changes in circumstance within 30 days if you have coverage through the Exchange.¹⁵³

What Happens if I Don't Pay My Premiums On Time?



If you miss your monthly payments and you have not notified the Exchange of a change in circumstances (for example, you had a pay cut), your coverage in an Exchange plan can be terminated for nonpayment. Under the law, you get a three month grace period to pay your premiums.¹⁵⁴ If you don't pay by the end of the grace period, your coverage will end. The termination will be effective on the last day of the first month of the

grace period.¹⁵⁵ This means that if you have any medical bills during the second and third month of the grace period, the insurance plan will not pay them. You will be responsible for the bills and could get sent to collections if they remain unpaid.

Another consequence of not paying the premiums is that you may not be able to enroll again into coverage right away. Normally, you can sign up for coverage again through a special enrollment period if you have had a change in life circumstances. However, termination of coverage for nonpayment is not included and does not trigger a special enrollment period.¹⁵⁶ The regulations are not yet clear, but this could mean that if your coverage is terminated due to nonpayment you may have to wait until the next open enrollment period in order to sign up again. As a result, you could be left without coverage and may also have to pay the tax penalty for the months you do not have insurance.

Health Coverage & Your Taxes

Your health coverage will now be tied to your tax return at the end of the year in two major ways. First, if you or someone in your household did not have coverage for more than three months of the year, you will have to pay the tax penalty described on page 24 of this guide (unless you are exempt from the requirement). Under the law, your insurance company must provide everyone they cover with information that will help them show that they had coverage.

Second, if you or anyone in your household received Exchange financial assistance (tax credits or subsidies) during the year, you must make sure that the amount you received matches up with the amount you should have qualified for, based on your annual income. This process is called “reconciliation”. You may end up owing money or getting a payment from the federal government when you file your taxes. This is why it is so important to immediately report income changes to the Exchange as they happen during the year.

If you are receiving Exchange financial assistance, and then someone in your household has an upward change in income (through a raise, a new job, or a bonus), you will end up receiving more financial assistance than you qualify for if you don’t report the change. At the end of the year, you will have to pay back the difference. On the other hand, if you experienced a pay cut, you may receive too little financial help, and the federal government may have to pay you money during the reconciliation process.

The amount you have to repay the federal government will be capped at a certain level according to your income. No matter how large the overpayment by the federal government, individuals and families with incomes below 500% FPL are only responsible to pay back a certain maximum amount at the end of the year.

Maximum Tax Credit Repayment by Income Level

Household Income	Maximum Repayment Amount (Individual)	Maximum Repayment Amount (Family)
Below 200% FPL	\$300	\$600
200-250% FPL	\$500	\$1,000
250-300% FPL	\$750	\$1,500
300-350% FPL	\$1,000	\$2,000
400-450% FPL	\$1,500	\$3,000
450-500% FPL	\$1,750	\$3,500
Above 500% FPL	Full amount	Full amount

If you were on Medicaid for the full year, you are not subject to reconciliation because you did not receive any financial assistance in the Exchange.

RESOURCES

GENERAL INFORMATION & ASSISTANCE

Medicaid

Medicaid Hotline: 1-855-637-6574

Medicaid Online Applications: www.yes.state.nm.us

Medicaid Paper Applications: www.hsd.state.nm.us/isd/apply.html

Medicaid General Information: www.hsd.state.nm.us/mad

NM Health Insurance Exchange (“NMHIX”)

Exchange Hotline: 1-855-99-NMHIX

Exchange Online Applications: www.bewellnm.com

Healthcare Guide Locations: www.bewellnm.com

New Mexico Resources

New Mexico Center on Law and Poverty

505-255-2840 • www.nmpoertylaw.org

Health Action New Mexico

505-867-1095 • www.healthactionnm.org

Southwest Women’s Law Center

505-244-0502 • www.swwomenslaw.org

National Resources

Healthcare.gov – www.healthcare.gov

CuidadoDeSalud.gov – www.cuidadodesalud.gov

HealthInsurance.org – www.healthinsurance.org

Kaiser Foundation – www.kff.org

Enroll America – www.enrollamerica.org

Families USA – www.familiesusa.org

LEGAL RESOURCES

Law Access New Mexico

Call Law Access New Mexico first for legal advice over the phone. They can tell you whether you have a legal issue. They can also make referrals to some legal offices statewide. www.lawhelp.org/Program/3577/index.cfm

Telephone Helpline: 1-800-340-9771 or 505-998-4LAW (4529)

New Mexico Legal Aid

Legal Aid provides legal representation for low-income New Mexicans.

www.nmlegalaid.org

Albuquerque: 1-866-416-1922 or 505-243-7871

Clovis: 1-866-416-1921 or 575-769-2326

Gallup: 1-800-524-4417 or 505-722-4417

Las Cruces: 1-866-515-7667 or 575-541-4800

Las Vegas: 1-866-416-1932 or 505-425-3514

Roswell: 1-866-416-1920 or 575-623-9669

Santa Fe: 1-866-416-1934 or 505-982-9886

Silver City: 1-866-224-5097 or 575-388-0091

Taos: 1-800-294-1823 or 575-758-2218

Migrant Worker Unit: 1-866-515-7667 or 575-541-4800

Native American Program (All Pueblos except Zuni): 1-866-505-2371 or 505-867-3391

Law Help New Mexico

A useful website hosted by NM Legal Aid: www.lawhelpnewmexico.org

DNA People's Legal Services

DNA provides legal services for low-income New Mexicans in San Juan County and the Navajo Nation in the following offices:

www.dnalegalservices.org / 1-800-789-7287

Crownpoint: 505-786-5277 / 1-800-789-7936

Farmington: 505-325-8886 / 1-800-789-7992

Shiprock: 505-368-3200 / 1-800-789-8894

Disability Rights New Mexico

DRNM protects, promotes and expands the rights of persons with disabilities.

www.drnrm.org / 1-800-432-4682

Albuquerque: 505-256-3100

Las Cruces: 575-541-1305

Las Vegas: 505-425-5265

Lawyer Referral for the Elderly Program

This program provides legal advice, brief services and referrals to New Mexico residents 55 years and older.

www.nmbar.org/Public/lrep.html / 1-800-876-6657 or 505-797-6005

Native American Disability Law Center

The Native American Disability Law Center provides advocacy, referral information, and educational resources to Native Americans with a disability, regardless of income. www.nativedisabilitylaw.org

Gallup: 505-863-7455

Farmington: 800-862-7271

New Mexico Center on Law and Poverty

The New Mexico Center on Law and Poverty is dedicated to advancing social and economic justice through education, advocacy and litigation, improving living conditions, and protecting the rights of people living in poverty.

www.nmpovertylaw.org / 505-255-2840

Senior Citizen's Law Office

SCLO assists persons 60 years and over in **Bernalillo, Torrance, Valencia and Sandoval Counties.**

www.sclonm.org / 505-265-2300

Southwest Women's Law Center

SWLC is a law and research organization dedicated to creating greater opportunities for women and girls in New Mexico to fulfill their personal and economic potential.

www.swwomenslaw.org / 505-244-0502

ISD OFFICES STATEWIDE

ALAMAGORDO

2000 Juniper Drive
Alamogordo, NM 88310
Mon-Fri 8:00 AM to 5:00 PM
(575) 437-9260
(800) 826-4468

ALBUQUERQUE

Northeast Albuquerque
4330 Cutler NE
Albuquerque, NM 87176
Mon-Fri 7:30 AM to 5:00 PM
(505) 222-9600

Northwest Albuquerque
1041 Lambertton Place NE
Albuquerque, NM 87125
Mon-Fri 7:30 AM to 5:00 PM
(505) 841-7700

Southeast Albuquerque
17111 Randolph Rd SE
Albuquerque, NM 87106
Mon-Fri 7:30 AM to 5:00 PM
(505) 383-2600
(800)432-6217

Southwest Albuquerque
3280 Bridge St. SW
Albuquerque, NM 87121
Mon-Fri 7:30 AM - 5:00 PM
(505) 841-2300

ANTHONY

220 Crossett Lane
Anthony, NM 88021
Mon-Fri 8:00 AM to 5:00 PM
(575) 882-5781

ARTESIA

108 N. 16th
Artesia, NM 88210
Mon-Fri 8:00 AM to 5:00 PM
(505) 748-3361

BELEN

100 S. 5th Street
Belen, NM 87002
Mon-Fri 8:00 AM to 5:00 PM
(505) 864-5200

CARLSBAD

3604 San Jose Blvd.
Carlsbad, NM 88220
Mon-Fri 8:00 AM to 5:00 PM
(575) 885-8815

CLAYTON

834 Main Street
Clayton, NM 88415
Mon-Fri 8:00 AM to 5:00 PM
(575) 374-9401

CLOVIS

3316 North Main Street, Suite A
Clovis, NM 88101-3756
Mon-Fri 8:00 AM to 5:00 PM
(575) 762-4751

DEMING

910 E. Pear
Deming, NM 88031
Mon-Fri 8:00 AM to 5:00 PM
(575) 546-0467

ESPAÑOLA

228 Paseo de Oñate Street
Española, NM 87532
Mon-Fri 8:00 AM to 5:00 PM
(505) 753-2271
(800) 231-2835

FARMINGTON

101 W. Animas
Farmington, NM 87499
Mon-Fri 8:00 AM to 5:00 PM
(505) 566-9600, (800) 231-6667

GALLUP

3006 E. Hwy 66
Gallup, NM 87301
Mon-Fri 8:00 AM to 5:00 PM
(505) 726-7600
(800) 825-7422

GRANTS

900 Mount Taylor Ave.
Grants, NM 87020
Mon-Fri 7:00 AM to 5:00 PM
(505) 287-8836

HOBBS

2120 N. Alto, Suite D
Hobbs, NM 88240
Mon-Fri 8:00 AM to 5:00 PM
(575) 397-3400

LAS CRUCES

East Doña Ana Area
2121 Summit Court
Las Cruces, NM 88011-8238
Mon-Fri 8:00 AM to 5:00 PM
(575) 524-6568

West Doña Ana Area
655 Utah Ave.
Las Cruces, NM 88001-6006
Mon-Fri 8:00 AM to 5:00 PM
(575) 524-6500

LAS VEGAS

2536 Ridge Runner Rd.
Las Vegas, NM 87701
Mon-Fri 8:00 AM to 5:00 PM
(505) 425-6741
(888) 456-0037

LORDSBURG

109 Poplar St.
Lordsburg, NM 88045
Mon-Fri 8:00 AM to 5:00 PM
(575) 542-3562

LOS LUNAS

445 Camino Del Rey
Los Lunas, NM 87031
Mon-Fri 8:00 AM to 5:00 PM
(505) 222-0800

MORIARTY

109 Tulane Ave
Moriarty, NM 87035
Mon-Fri 8:00 AM to 5:00 PM
(505) 832-5026
(800) 335-7293

PORTALES

1028 Community Way
Portales, NM 88130
Mon-Fri 8:00 AM to 5:00 PM
(575) 356-4473

RATON

1233 Wittier Street
Raton, NM 87740
Mon-Fri 8:00 AM to 5:00 PM
(575) 445-2308

Rio Rancho

4363 Jagar Drive
Rio Rancho, NM 87144
Mon-Fri 7:30 AM to 5:00 PM
(505) 383-6300
(800)926-9425

ROSWELL

1701 S. Sunset
Roswell, NM 88203
Mon-Fri 8:00 AM to 5:00 PM
(575) 625-3000
(800) 824-8971

RUIDOSO

26387 Hwy 70
Ruidoso, NM 88346
Mon-Fri 8:00 AM to 5:00 PM
(575) 378-1762

SANTA FE

37 Plaza la Prensa
Santa Fe, NM 87504
Mon-Fri 7:30 AM to 5:00 PM
(505) 476-9200
(800) 231-8081

SANTA ROSA

620 Historic Route 66
Santa Rosa, NM 88435
Mon-Fri 8:00 AM to 5:00 PM
(575) 472-3459
(800) 523-6643

SILVER CITY

3088 32nd Street
Bypass Road, Suite A
Silver City, NM 88061
Mon-Fri 8:00 AM to 5:00 PM
(575) 538-2948
(800) 331-7311

SOCORRO

1014 N. California Street
Socorro, NM 87801
Mon-Fri 8:00 AM to 5:00 PM
(575) 838-8700
(800) 245-9571

T O R C

102 Barton Street
T or C, NM 87901
Mon-Fri 8:00 AM to 5:00 PM
(575) 894-3011
(800) 560-3011

TAOS

145 Roy Road
Taos, NM 87571
Mon-Fri 8:00 AM to 5:00 PM
(575) 758-8804

TIERRA AMARILLA

17345 Chama Highway
Tierra Amarilla, NM 87575
Mon-Fri 8:00 AM to 5:00 PM
(575) 588-7103

TUCUMCARI

421 W. Tucumcari Blvd.
Tucumcari, NM 88401
Mon-Fri 8:00 AM to 5:00 PM
(575) 461-4627 or (800) 283-4465

LEGAL CITATIONS

- ¹ 42 C.F.R. § 447.50 (Medicaid regulation on definition of Indian).
- ² Affordable Care Act (hereinafter “ACA”) § 1311(c)(6)(D)(on special enrollment periods), referring to Indian Health Care Improvement Act § 4; ACA § 1402(d)(1)-(2)(on cost-sharing exemptions), referring to the Indian Self-Determination and Education Assistance Act, codified at 25 U.S.C. § 450b(d); ACA § 1501(b)(on tax penalty exemptions), referring to I.R.C. 5000A(e)(3), referring to I.R.C. 45A(c)(6).
- ³ 45 C.F.R. 155.605(g)(6) and 45 C.F.R. 155.615(f)(3).
- ⁴ ACA § 1513(a) (codified at 26 U.S.C. § 4980H).
- ⁵ 42 C.F.R. 435.603(f).
- ⁶ U.S. Department of Health and Human Services, 2013 Poverty Guidelines, aspe.hhs.gov/poverty/13poverty.cfm.
- ⁷ *Id.*
- ⁸ ACA § 2002(a) (codified at 42 U.S.C. § 1396a(e)(14)).
- ⁹ ACA § 2001(a) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)) requires a new Medicaid category of adults with incomes under 133% FPL. ACA §2002(a) (codified at 42 U.S.C. §1396a(e)) adds 5% to the income standard increasing it to 138% FPL.
- ¹⁰ NMAC § 8.202.500.9(B) and NMAC § 8.102.520.8 through 8.102.520.15.
- ¹¹ NMAC § 8.232.500.11 through 8.232.500.12.
- ¹² NMAC § 8.235.500.11.
- ¹³ NMAC § 8.230.500.12.
- ¹⁴ NMAC § 8.215.600.9 (providing Medicaid benefits to SSI eligible individuals).
- ¹⁵ NMAC § 8.243.500.18.
- ¹⁶ NMAC § 8.200.520.16.
- ¹⁷ NMAC § 8.200.520.16.
- ¹⁸ NMAC § 8.240.400 through 8.245.600.
- ¹⁹ U.S. Department of Health and Human Services, 2013 Poverty Guidelines, aspe.hhs.gov/poverty/13poverty.cfm.
- ²⁰ New Mexico Human Services Department, Medicaid Under Healthcare Reform by State Fiscal Year with Different Up Take Rates (May 2012).
- ²¹ 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 431.53.
- ²² 42 U.S.C. § 1396d(a)(3); 42 C.F.R. § 440.335(b)(3); ACA § 1302(b)(1)(H).
- ²³ 42 U.S.C. § 1396d(a)(2)(C); 42 C.F.R. § 440.365.
- ²⁴ 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 440.335(b)(6); ACA § 2303(c).
- ²⁵ 42 U.S.C. § 1396d(a)(17); 42 C.F.R. § 440.165; NMAC § 8.305.7.11(G).
- ²⁶ 42 U.S.C. § 1396d(a)(4)(A); 42 C.F.R. § 440.40; NMAC § 8.312.2.9.
- ²⁷ 42 U.S.C. § 1396d(a)(7); 42 C.F.R. § 440.70; NMAC § 8.325.9.9.
- ²⁸ 42 U.S.C. § 1396d(a)(5)(B); NMAC § 8.310.7.
- ²⁹ 42 U.S.C. § 1396a(a)(43)(A); 42 U.S.C. §1396d(a)(4)(B); 42 C.F.R. § 441.55; ACA § 1302(b)(I), (J).
- ³⁰ NMAC § 8.310.6 (vision), §8.310.8 (behavioral health), §8.324.4 (pharmacy), §8.324.6 (hearing aids), §8.324.9 (nutrition services).

³¹ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Letter to Julie Weinberg (March 5, 2013), www.hsd.state.nm.us/pdf/Medicaid%20Modernization/Cindy%20Mann%20Letter%20to%20NM.PDF.

³² NMAC § 8.325.10.12(B)(1).

³³ NMAC § 8.285.600.10.

³⁴ New Mexico Human Services Department, New Mexico Additional Level One Health Insurance Exchange Establishment Grant 10 (2013).

³⁵ ACA § 1311(d)(2) (codified at 42 U.S.C. § 18031(d)(2)).

³⁶ ACA § 1311(d)(4)(E) (codified at 42 U.S.C. § 18031(d)(4)(E)).

³⁷ ACA § 1311(d)(4)(C) (codified at 42 U.S.C. § 18031(d)(4)(C)).

³⁸ ACA § 1413 (codified at 42 U.S.C. § 18083(b)(1)(A)(ii)).

³⁹ ACA § 1311(d)(4)(F) (codified at 42 U.S.C. § 18031(d)(4)(F)).

⁴⁰ ACA § 1311(d)(4)(B) (codified at 42 U.S.C. § 18031(d)(4)(B)).

⁴¹ ACA § 1311(d)(4)(K) (codified at 42 U.S.C. § 18031(d)(4)(K)).

⁴² ACA § 1301(a) (codified at 42 U.S.C. § 18021(a)).

⁴³ ACA § 1302(d)(1) (codified at 42 U.S.C. § 18022(d)).

⁴⁴ ACA § 1311(d)(4)(G) (codified at 42 U.S.C. § 18031(d)(4)(G)).

⁴⁵ ACA § 1402(a) (codified at 26 U.S.C. § 36B(b)(2)(B)).

⁴⁶ ACA § 1401(a) (codified at 26 U.S.C. § 36B(b)(3)(A)).

⁴⁷ ACA § 14019a) (codified at 26 U.S.C. § 36B(b)(3)(A)(i)).

⁴⁸ ACA § 1402(c)(1)(A) (codified at 42 U.S.C. § 18071(c)(1)(A)), using Health Savings Account out-of-pocket limits for 2013.

⁴⁹ ACA § 1412 (codified at 42 U.S.C. § 18082(c)(2)(A)).

⁵⁰ ACA § 1402(c)(2)(A)-(C) (codified at 42 U.S.C. § 18071(c)(2)(A)-(C)).

⁵¹ ACA § 1402(d)(1) (codified at 42 U.S.C. § 18071(d)(1)).

⁵² ACA § 1402(d)(2) (codified at 42 U.S.C. § 18071(d)(2)).

⁵³ Indian Health Care Improvement Act Reauthorization § 152, codified at 25 U.S.C. § 1642; 45 C.F.R. § 155.240.

⁵⁴ ACA § 1201 (codified at 42 U.S.C. § 300gg(a)(1)(A)(iv)).

⁵⁵ ACA § 1401(a) (codified at 25 U.S.C. § 36B(b)(2)).

⁵⁶ ACA § 1401(a) (codified at 26 U.S.C. § 36B(c)(3)).

⁵⁷ ACA § 1302(e) (codified at 42 U.S.C. § 18022(e)); 42 C.F.R. § 156.155(a).

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ 45 C.F.R. § 156.155(b).

⁶¹ ACA § 1311(b)(1)(B) (codified at 42 U.S.C. § 18031(b)(1)(B)).

⁶² ACA § 1304(b)(2) (codified at 42 U.S.C. § 18024(b)(2)).

⁶³ ACA § 1304(b)(3) (codified at 42 U.S.C. § 18024(b)(3)).

⁶⁴ ACA § 1421(a) (codified at 26 U.S.C. § 45R(b), (d)).

⁶⁵ *Id.*

⁶⁶ ACA § 1311(b)(1) (codified at 42 U.S.C. § 18031(b)(1)); ACA § 1321(c) (codified at 42 U.S.C. § 18041(c)); Center for Consumer Information and Insurance Oversight,

Centers for Medicare and Medicaid Services, “Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges” (updated Nov. 9, 2012), www.cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf.

⁶⁷ New Mexico Senate Bill 221/589 (2013) [hereinafter “NM Exchange Act.”]

⁶⁸ NM Exchange Act § 3(A).

⁶⁹ NM Exchange Act § 3(A), (M).

⁷⁰ NM Exchange Act § 3(E)(2)-(3).

⁷¹ NM Exchange Act § 3(E)(1).

⁷² NM Exchange Act § 3(B)-(D).

⁷³ NM Exchange Act § 7.

⁷⁴ NM Exchange Act § 5(D)(1).

⁷⁵ NM Exchange Act § 5(D)(2).

⁷⁶ NM Exchange Act § 3(S)(2)-(4).

⁷⁷ NM Exchange Act § 3(S)(6).

⁷⁸ ACA § 1311(a)(1) (codified at 42 U.S.C. § 18031(a)(1)).

⁷⁹ ACA § 1311(d)(5)(A) (codified at 42 U.S.C. § 18031(d)(5)(A)).

⁸⁰ NM Exchange Act § 4(B).

⁸¹ 45 C.F.R. § 155.130(f).

⁸² NM Exchange Act § 3(S)(4)-(5).

⁸³ NM Exchange Act § 5(D)(4).

⁸⁴ ACA § 2602. (codified at 42 U.S.C. § 1315b).

⁸⁵ AARP, Medicare Prescription Drug Coverage Guide, Part 3: Moving and Out of the Doughnut Hole, Updated Fall 2012, http://www.aarp.org/health/medicare-insurance/info-11-2009/part_3_the_doughnut_hole.html.

⁸⁶ ACA § 3301 (b) (codified at 42 U.S.C. §§ 1395w-153, 114a, 102).

⁸⁷ ACA § 1001 (5) (codified at 42 U.S.C. § 300gg-13).

⁸⁸ ACA § 1302(b)(1) (codified at 42 U.S.C. § 18022(b)(1)).

⁸⁹ ACA § 1001 (codified at 42 U.S.C. § 300gg § 2713(a)).

⁹⁰ ACA § 1201 (codified at 42 U.S.C. § 300gg §§ 2702, 2704(a)).

⁹¹ ACA 1001 (codified at 42 U.S.C. § 300gg § 2712).

⁹² ACA 1201 (codified at 42 U.S.C. § 300gg § 2705(a)).

⁹³ ACA § 1201 (codified at 42 U.S.C. § 300gg § 2701(a)(1)(A)).

⁹⁴ ACA § 1001 (codified at 42 U.S.C. § 300gg § 2714(a)).

⁹⁵ ACA § 1001 (codified at 42 U.S.C. § 300gg § 2711(a)(1)).

⁹⁶ ACA § 1501 (codified at I.R.C. § 5000A(a)).

⁹⁷ ACA § 1501 (codified at I.R.C. § 5000A(d),(e)).

⁹⁸ ACA § 1311(d)(4)(H) (codified at 42 U.S.C. § 18031(d)(4)(H)).

⁹⁹ ACA § 1513 (codified at I.R.C. § 4980H(a)).

¹⁰⁰ ACA § 1501 (codified at I.R.C. § 5000a).

¹⁰¹ 42 C.F.R. § 435.910; *See also* Triagency Letter, Dep’t of Health and Human Services and Dep’t of Agriculture, Dear State Health and Welfare Officials, <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/tanf/triagencyletter.html> (last visited May 24, 2013).

¹⁰² *Id.*

¹⁰³ “Qualified immigrants” are defined by federal law. They include lawful permanent residents (LPRs or “green card” holders), refugees, asylees, persons granted withholding of deportation or removal, conditional entrants, persons paroled into the U.S. for at least one year, Cuban/Haitian entrants, and battered spouses and children with a pending or approved self-petition or immigrant visa or application cancellation of removal or suspension of deportation. 8 U.S.C. § 1641(b). Parents and children of battered spouses/children are also “qualified.” 8 U.S.C. § 1641(c)(1)-(3). Victims of trafficking and Iraqi and Afghan immigrants with special status are eligible for public benefits programs to the same extent as “qualified” immigrants. 8 U.S.C. § 1182(a)(9)(B)(iii)(v); 45 C.F.R. § 1522(3).

¹⁰⁴ *Id.*

¹⁰⁵ ACA § 1401 (codified at 26 I.R.C. § 36B(b)(3)(A)(ii)); ACA § 1401 (codified at 42 U.S.C. § 18071(c)(2)(A)).

¹⁰⁶ ACA § 1312(f)(1) (codified at 42 U.S.C. § 18032(f)(1)).

¹⁰⁷ ACA § 1501(b) (codified at I.R.C. § 5000A(d)(3)).

¹⁰⁸ ACA § 1413(c) (codified at 42 U.S.C. § 18083(c)).

¹⁰⁹ ACA § 1413(a)-(b) (codified at 42 U.S.C. § 18083(a)-(b)).

¹¹⁰ ACA § 1413(c)(1) (codified at 42 U.S.C. § 18083(c)); ACA § 2201(b) (codified at 42 U.S.C. § 1396w-3(b)); 45 C.F.R. 155.302(a)-(b); 45 C.F.R. 155.305(c)-(d); 45 C.F.R. 155.345(a),(d),(g).

¹¹¹ ACA § 1557 (codified at 42 U.S.C. § 18116) (prohibiting discrimination in health programs or activities; ACA § 1001 (codified at 42 U.S.C. § 300gg-15(b)(2) (requiring health insurance issuers to provide linguistically appropriate explanations of benefits and coverage); ACA § 1311(e),(i) (codified at 42 U.S.C. § 18031(e),(i) (requiring the Exchange to provide descriptions of health plans in “plain language” that is understood by limited-English proficient individuals and for navigators to provide linguistically appropriate information).

¹¹² 42 U.S.C. § 18031(i)(3)(E); 45 C.F.R. § 155.205(c)(2).

¹¹³ ACA § 1311(c)(6)(A) (codified at 42 U.S.C. § 1803(c)(6)(A)); 45 C.F.R. § 155.410(b).

¹¹⁴ ACA § 1311(c)(6)(B) (codified at 42 U.S.C. § 1803(c)(6)(B)); 45 C.F.R. § 155.410(e).

¹¹⁵ ACA § 1311(c)(6)(C) (codified at 42 U.S.C. § 1803(c)(6)(C)); 45 C.F.R. § 155.420(d).

¹¹⁶ ACA § 1311(c)(6)(D) (codified at 42 U.S.C. § 1803(c)(6)(D)); 45 C.F.R. § 155.420(d)(8).

¹¹⁷ ACA § 1413(b)(1)(A) (codified at 42 U.S.C. § 18083(b)(1)(A)(ii)).

¹¹⁸ ACA § 1413(c) (codified at 42 U.S.C. § 18083(c)); 45 C.F.R. § 155.315.

¹¹⁹ ACA § 1411(e)(4)(A)(ii)(II) (codified at 42 U.S.C. § 18081(e)(4)(A)(ii)(II)); 45 C.F.R. § 155.315(f)(2)(ii).

¹²⁰ 45 C.F.R. § 155.315(f)(3).

¹²¹ 45 C.F.R. § 155.315(f)(2).

¹²² ACA § 1411(e)(3)(codified at 42 U.S.C. § 1396a(ee)).

¹²³ *See* 42 U.S.C. § 1396r-1 (for pregnant women and Medicaid Expansion adults) and NMAC 8.200.400.11 (pregnant women); 42 U.S.C. § 1396r-1a and NMAC §

8.200.400.12 (children); 42 U.S.C. § 1396r-1b and NMAC § 8.200.400.13 (breast and cervical cancer); 42 U.S.C. § 1396r-1c and NMAC 8.235.400.18 (family planning).

¹²⁴ See NMAC § 8.100.130.9(c). See also 42 C.F.R. 435.1200; 45 C.F.R. 155.345(a),(d),(g) (requiring Medicaid and the Exchange to transmit and accept application information).

¹²⁵ NMAC § 8.100.13.9(D).

¹²⁶ NMAC § 8.100.130.10(e).

¹²⁷ NMAC § 8.100.130.9(E).

¹²⁸ 42 C.F.R. § 435.956(c)(2)

¹²⁹ 42 C.F.R. § 435.403(i)(1)

¹³⁰ NMAC § 8.100.130.13.

¹³¹ NMAC § 8.100.130.17.

¹³² NMAC § 8.100.130.16(B).

¹³³ NMAC § 8.100.130.16(C) and (D).

¹³⁴ NMAC § 8.100.130.25.

¹³⁵ NMAC § 8.100.130.25(A)(4) and § 8.100.130.9(E).

¹³⁶ NMAC § 8.100.130.9(G).

¹³⁷ NMAC § 8.100.130.8(A)(3).

¹³⁸ ACA § 1411(e)(3)-(4) (codified at 42 U.S.C. § 18081(e)(3)-(4)).

¹³⁹ Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010, 76 Fed. Reg 51,168 (proposed Aug. 17. 2011).

¹⁴⁰ NMAC § 8.100.130.11.

¹⁴¹ NMAC § 8.200.430.12(B).

¹⁴² ACA § 1411(e)(4)(A)(ii)(II) (codified at 42 U.S.C. § 18081(e)(4)(A)(ii)(II)); 45 C.F.R. § 155.315(f)(2)(ii).

¹⁴³ NMAC § 8.100.970.

¹⁴⁴ NMAC § 8.100.970.9(B)(2) .

¹⁴⁵ NMAC § 8.100.970.10.

¹⁴⁶ NMAC § 8.100.970.8.

¹⁴⁷ NMAC § 8.100.970.8(C)(6).

¹⁴⁸ 45 C.F.R. § 155.410(b).

¹⁴⁹ 45 C.F.R. § 155.410(e).

¹⁵⁰ ACA § 1311(c)(6)(C) (codified at 42 U.S.C. § 1803(c)(6)(C)); 45 C.F.R. § 155.420(d).

¹⁵¹ ACA § 1311 (c)(6)(D) (codified at 42 U.S.C. § 1803(c)(6)(D)); 45 C.F.R. § 155.420(d)(8).

¹⁵² 45 C.F.R. § 155.330(e) (referring to 45 C.F.R. § 155.305).

¹⁵³ 45 C.F.R. § 155.330(b)(1).

¹⁵⁴ ACA § 1412(c)(2)(B)(iv) (42 U.S.C. § 18082(c)(2)(B)(iv)).

¹⁵⁵ 45 C.F.R. §156.270(g) (referring to 45 C.F.R. § 155.430(d)(4)).

¹⁵⁶ ACA § 1311(c)(6)(C) (codified at 42 U.S.C. § 1803(c)(6)(C)); 45 C.F.R. § 155.420(e)(1).

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