

An Analysis of New Mexico's Health Security Act: Moving Forward within the Current Federal Legal Landscape

Sara Rosenbaum
Morgan Handley
The George Washington University

Thomas Barker
Ross Margulies
Haider Andazola
Alexander Somodevilla
Regina DeSantis
Foley Hoag and Elliot

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Executive Summary

The Health Security Act presents a comprehensive vision of universal, equitable health insurance for all state residents. This vision would be achieved through a publicly sponsored Health Security Plan overseen by a public commission. State policymakers recognize that in order to achieve such a goal, and to the maximum degree feasible, the Plan would need to be positioned as a health care financing replacement for most existing types of health insurance, including individually purchased private insurance, plans serving the state's public employees, the private employer-sponsored plan market, Medicare and Medicaid/CHIP. Such a sweeping replacement would necessitate the modification or waiver of federal laws to enable the Health Security Plan to operate as a successor and to receive the funding that now flows to these other forms of insurance.

This analysis examines the interaction of the Health Security Act with federal laws governing Medicare, Medicaid/CHIP, the private insurance market as regulated under the Affordable Care Act (ACA), and private employer-sponsored health plans governed by the Employee Retirement Income Security Act (ERISA). It concludes that existing federal laws do not offer the state a waiver mechanism powerful enough to allow New Mexico to replace public and private health insurance markets with the Health Security Plan and receive a single funding stream representing the combined value of these previous markets. To achieve such a result, the state would need an Act of Congress whose scope would eclipse anything previously enacted.

Our analysis is necessarily high-level. Although the HSA sets the broad parameters for the plan, many of the crucial details needed to conclusively determine the feasibility of implementation through various federal waiver authority have yet to be determined. Nonetheless, we believe that while a total replacement of federally regulated insurance markets with a single public market is not possible, many elements of the Act might move forward in modified form using the state's inherent powers to regulate insurance and design and administer its Medicaid program. This analysis also presents potential alternative approaches that attempt to meet key goals of the legislation while addressing the reality of the federal legal landscape around health coverage.

I. Introduction

This analysis, prepared at the direction of New Mexico’s Superintendent of Insurance,¹ examines federal laws and regulations relevant to HB 295 - The New Mexico Health Security Act (“HSA” or the “Act”) - that would create a comprehensive health plan in order insure all state residents, the single most important determinant of access to high quality health care.²

We begin with an overview of New Mexico’s population health insurance patterns along with the key provisions of HB 295. We then examine three legal questions that arise when considering the interaction of HB 295 with federal laws that together define and regulate existing forms of health insurance:

- First, to what extent would HB 295 replace other forms of public and private health insurance?
- Second, if HB 295 is intended as a replacement insurer, to what extent does implementation depend on the state’s ability to redirect funds that now support other forms of health insurance?
- Third, to what extent does federal law, through either waiver or demonstration authority, permit the state to seek redirection of these resources into its Health Security Plan?

We conclude by considering possible strategies that could enable the state to move toward the broad goal on which HB 295 rests – to assure that all state residents “have guaranteed health care coverage”³ – while accommodating federal laws that cannot be waived.

Any analysis of the interaction between the Health Security Act and federal law depends on a clear understanding of how HB 295 would operate if fully implemented as enacted. Thus, while we recognize that much of the law’s detail will subsequently be developed by the Commission established by the law, the Act is clear enough to allow us to ascertain its overall shape and structure. For this reason, we begin with a brief overview of the Act. We then consider the principal federal insurance laws whose provisions are implicated by HB 295: the Employee Retirement Income Security Act (ERISA); the Affordable Care Act (ACA); Medicare; and Medicaid/CHIP. We also consider the Dormant Commerce Clause of the Constitution, which outlaws certain types of state activities deemed to amount to an interference on interstate commerce.

II. Overview of Population Health Insurance Patterns in New Mexico

Health insurance statistics underscore the unique challenges New Mexico faces in terms of achieving near-universal insurance coverage for its residents. The Kaiser Family Foundation reports that the state’s population experiences an uninsured rate higher than the national average

¹ Contract No. 22-440-1000-00007.

² Rachel Garfield et al., *The Uninsured and the ACA: A Primer – Key Facts about Health Insurance and the Uninsured amidst Changes to the Affordable Care Act* (Kaiser Family Foundation, 2019), available at <https://www.kff.org/uninsured/report/the-uninsured-and-the-aca-a-primer-key-facts-about-health-insurance-and-the-uninsured-amidst-changes-to-the-affordable-care-act>.

³ Health Security Plan Summary (based on the 2019 Health Security Act).

(11.2 percent in 2020 compared to 10.4 percent for the U.S. population as a whole).⁴ Furthermore, the state's population is substantially more dependent on public insurance and considerably less likely to be insured through either employer-sponsored health plans or individual private policies.

In 2020, when 50.3 percent of the U.S. population was covered by employer insurance, only 35.7 percent of the New Mexico population reported workplace coverage – the lowest level of employer coverage of any state that year.⁵ By contrast, Medicaid and CHIP insured about 40 percent of the state's population⁶ compared to 24.9 percent of the U.S. – a 15-percentage-point difference⁷ that likely reflects elevated low income rates among state residents (42.1 percent with incomes below twice the federal poverty level compared to 30.4 percent nationally),⁸ as well as the generosity of the state's Medicaid program, which includes the ACA expansion population. New Mexico's population also shows greater reliance on Medicare (18.7 percent of the population versus 15.6 percent for the nation as a whole),⁹ likely associated with a somewhat higher proportion of elderly residents.¹⁰

Furthermore, New Mexico residents are less likely to be insured through individual policies bought in the nongroup market – 2.8 percent compared to 5.5 percent of the total U.S. population – and the state ranks 40th in the percentage of health insurance marketplace enrollees who receive

⁴ Kaiser Family Foundation, State Health Care Snapshots: New Mexico (2020)

<https://www.kff.org/statedata/election-state-fact-sheets/new-mexico/#:~:text=In%20New%20Mexico%2C%20there%20were,rate%20for%20the%20U.S.%20overall> (Accessed December 14, 2021).

⁵ Kaiser Family Foundation, Health Insurance Coverage of the Total Population (2020)

<https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (Accessed December 14, 2021).

⁶ Chiquita Brooks-LaSure et al, Evaluating Medicaid Buy-In Options for New Mexico (Manatt, 2018), available at https://www.nmlegis.gov/Entity/LFC/Documents/Health_Security_Act_Procurement_Library/Reports%20and%20analyses/New%20Mexico%20Medicaid%20Buy%20in%20Options%20-%20Manatt,%202018.pdf.

⁷ Centers for Medicare and Medicaid Services, May 2021 Medicaid and CHIP Enrollment Data Highlights

<https://www.medicare.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>; <https://www.census.gov/popclock> (Accessed December 14, 2021).

⁸Kaiser Family Foundation, Share of People without Health Coverage (2020) <https://www.kff.org/statedata/election-state-fact-sheets/new-mexico/#:~:text=In%20New%20Mexico%2C%20there%20were,rate%20for%20the%20U.S.%20overall>

(Accessed December 4, 2021).

⁹ Kaiser Family Foundation, Health Insurance Coverage of the Total Population (2020)

<https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (Accessed November 2, 2021).

¹⁰ PRB, Which U.S. States Have the Oldest Populations? <https://www.prb.org/resources/which-us-states-are-the-oldest/>

(Accessed December 4, 2021).

advance premium tax credits (APTCs)¹¹ and 41st nationally in terms of the percentage of subsidy-eligible people who actually are enrolled in a marketplace plan and receiving a subsidy.¹² With the increased generosity of ACA subsidies under the American Rescue Plan (a policy that will continue under the Build Back Better Act legislation, should it be enacted), the percentage of residents who qualify for subsidies and the generosity of those subsidies (especially for lower income residents) can be expected to rise.

III. The Health Security Act

A. Overview

HB 295 aims to overcome the problem of limited access to insurance through a publicly-sponsored Health Security Plan (the “Plan”) whose design and administration would be overseen by a government commission charged under state law with its establishment and operation. The Act would do so by creating a single, public insurer that would cover most state residents while offering a unified level of coverage to enrollees. It calls for the Plan to replace Medicare, the non-long term care portion of Medicaid (note, however, that Medicaid does not define long term care or acute care *per se*), insurance coverage for the state’s public employees, private insurance plans sold in both the individual and group markets, and (potentially) third-party-administered plans sold to self-insuring employers governed by ERISA.¹³

The Act envisions continuation of a “supplemental insurance” market that presumably refers to plans and policies that do not duplicate the Health Security Plan. It does not specify what types of insurance products would remain available for purchase, although presumably the Commission would make such a determination. It is not clear whether “supplemental insurance” signifies only coverage for services not covered under the Plan, or services covered in broader amount, duration, or scope (e.g. extra prescription drug coverage), or total replacement coverage such as short-term, limited duration policies as well.

B. Coverage Design

¹¹ Kaiser Family Foundation, State Health Facts: Marketplace Effectuated Enrollment and Financial Assistance (2020) <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Percent%20of%20Total%20Marketplace%20Enrollees%20Receiving%20CSRs%22,%22sort%22:%22desc%22%7D> (Accessed online October 21, 2021).

¹² Kaiser Family Foundation, Marketplace Enrollees Receiving Financial Assistance as a Share of the Subsidy-Eligible Population (2020) <https://www.kff.org/health-reform/state-indicator/marketplace-enrollees-eligible-for-financial-assistance-as-a-share-of-subsidy-eligible-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Percent%20of%20the%20Potential%20Subsidy-Eligible%20Population%20Enrolled%22,%22sort%22:%22desc%22%7D> (Accessed online October 21, 2021).

¹³ Staff of the Office of the Superintendent of Insurance (“OSI”) indicate that legislators may envision continuation of the self-insured ERISA market, although the Act does not appear to directly address the issue.

The Plan would adopt the coverage design applicable to ACA-compliant “essential health benefit”, or EHB, plans (presumably the full EHB standard applies, including covered benefit classes, actuarial value, and out-of-pocket annual spending limits). As such, the Plan also would represent a fundamental departure from the coverage design utilized by Medicare and Medicaid, both of which differ in significant respects, especially Medicaid. Although the Act would preserve Medicaid’s long term care component, the meaning of this preservation clause is unclear, since Medicaid does not define what constitutes “long term care.” Indeed, Medicaid’s “long term care” component includes not only distinct benefit classes (e.g., personal attendants, home and community based care) but also additional levels of coverage for certain benefits that the EHB benefit design also covers, at least to some degree (e.g., all medically necessary rehabilitation services, rather than a fixed number of days or visits), for children and adults with serious and chronic conditions.

C. Eligible and Exempt Populations

The Act specifies eligibility based solely on state residency; it imposes no legal status test. It would cover individuals who have been “physically present in the state for one year prior to the date of application for enrollment” into the Plan and who have a “current intention” to remain in New Mexico and not reside “elsewhere.” People who cannot meet the durational residency test could qualify for coverage by paying individual premiums until the date on which they fulfill the one-year residency period.

The Act also exempts certain populations, who, under the terms of the law would not be “brought into coverage.” These exempt populations include federal retiree health plan beneficiaries, active duty and retired military personnel, and individuals covered by the federal active and retired military health programs. People served through the Indian Health Service (IHS) system or tribally operated health care arrangements, which in New Mexico serves several hundred thousand people, would be covered through the Plan only upon agreement between the state and Indian nations, tribes and pueblos.

With the exception of these narrow exemptions, the Act appears to contemplate that the Plan will cover or, at a minimum, offer coverage to all persons meeting the residency requirement. Thus, the Plan would cover people who would otherwise be insured through public or private employer group plans (whether insured or self-insured) and residents whose coverage derives from individual insurance policies, Medicare, or Medicaid/CHIP.

The Act does not contain a coverage mandate such as that found in Massachusetts’ health plan, which served as the prototype for the Affordable Care Act. Enrollment thus appears to be voluntary. Reaching the bill’s goal of universal coverage will require some form of automatic enrollment or coverage requirement in order to achieve the universal coverage envisioned under the Act.

The Act specifies that the Plan “shall phase in eligibility for beneficiaries as their participation becomes possible through contracts, waivers, or federal legislation.” Exactly how the Plan would address the employer group market is not clear, even though eligibility of all residents is contemplated. For example, would the Plan back out people covered through employer group

plans and if so, all groups? Only groups that exceed a certain size? Presumably the Commission would determine the actual scope of enrollment, since eligibility appears universal to all residents. Presumably the Act does envision enrollment by groups (such as public employees) and individuals whose enrollment is not contingent upon federal exemptions and waivers (for example, people who purchase individual plans in the open market and perhaps people who select the Health Security Plan as a marketplace option). Again, precisely how the Plan would absorb various types of people is an issue that appears to be left to the Commission as part of a phase-in strategy. Phasing in thus emerges as a basic feature of the Plan, as opposed to a total replacement as of a certain date.

The Act does appear to explicitly envision cessation of some parts of the commercial market, which could be the individual market only or some subset of the employer group market. This presumption is signified by the fact that commercial insurance that duplicates the Health Security Plan is no longer permissible, and as of the date on which the Plan “begins operating” a beneficiary may purchase “supplemental health insurance benefits.”

Eligibility appears to be prospective; that is, the Act does not specify retroactive eligibility as a Plan feature, although it does not preclude retroactive eligibility either.

D. Enrollment

The Act does not specify the enrollment process. We assume this process is to be developed by the Commission. Presumably, anyone who is part of the eligible population and who wishes to enroll can do so, at least as of the time when that individual’s group becomes eligible for enrollment.

E. Appeals

The law requires the Commission to establish an appeals process for claims denials; it is not clear whether the same appeals process will also apply to eligibility and enrollment issues. A specific requirement of the claims appeals process is “a beneficiary’s right to continue to receive services that are the subject of the appeal and that the beneficiary was receiving before the beneficiary filed the appeal.”

F. Benefits, Cost-Sharing, and Coverage Standards

The Commission is responsible for coverage design within the legislation’s broad parameters. Those parameters specify “minimum essential health benefits as required under state or federal law” and a preferred drug formulary that would replace both Medicare Part D plans for outpatient prescription drug coverage as well as Medicaid’s prescription drug coverage and rebate system. The Act appears to contemplate a “minimum essential health benefits” design (presumably that used under the ACA) although it should be noted that § 47 indicates that the required fiscal analysis of the Act must project costs for a plan design that is “no less than the health care services afforded to state employees pursuant to the Health Care Purchasing Act.” (Presumably the state employee plan is at least as generous as the EHB coverage standard).

The Act further specifies “preventive and primary care that includes immunization and screening exams”, although how this specification would differ from the EHB standard (if at all) is not clear.

The Plan’s coverage standard appears to be a unified design – that is, the design would apply to all populations, whether previously covered through private individual policies or employer group plans (public or private), Medicare, or Medicaid/CHIP. The Plan would be required to conform to federal and state behavioral health services parity laws.

Services excluded by law would include cosmetic surgery, medical exams required pursuant to insurance applications or litigation involving claims for damages, and orthodontics and cosmetic dental care.

The Act further specifies that the Plan “shall ensure that beneficiaries receive comprehensive, high quality health care consistent within available revenue and budget constraints”. Presumably this limitation is included in order to allow the state to scale back and alter the coverage guarantee if necessitated by budgetary or revenue constraints.

The Act sets forth cost sharing parameters that the Commission is to follow; since cost-sharing design is to be developed by the Commission, this presumably means that the federal EHB parameters need not necessarily apply. Copayment policy is left to Commission discretion. As is true under the ACA, members of Indian nations, tribes, or pueblos under 300% FPL are exempt from cost sharing. The Act specifies that providers cannot waive cost sharing that is required and must demonstrate a good-faith collection effort. It further specifies that copayments “shall not be required for preventive health care services as the commission defines preventive health care services by rule and in accordance with state and federal law.” This provision suggests that the Act may go beyond the EHB and preventive coverage standard in defining what constitutes a preventive benefit exempt from cost sharing.

G. Beneficiary/Consumer Rights

In addition to appeals rights, the Act specifies that “within a reasonable time after enrollment and at subsequent times” designated by the Commission, beneficiaries must receive information about the Plan including covered services and exclusions, conditions of eligibility, prior authorization requirements, and the right to appeal adverse determinations. The Act specifies that the Commission must promulgate rules that provide for “a beneficiary’s right to emergency services that are immediately available without prior authorization” as well as “appropriate out-of-state emergency services that are not subject to additional cost to the beneficiary.” The notice from the state must also contain an explanation of emergency coverage (in-state and out-of-state), the right to review patient files, grievance and appeals rights, and other matters.

H. Provider Participation and Payment; Method of Care Delivery

The Plan appears to contemplate a form of primary care gatekeeping, specifying that “[e]xcept as provided in the Workers’ Compensation Act” (which appears to remain intact), beneficiaries have “the right to choose a primary care provider” who is responsible for providing patient care except for “medical emergencies” and “services for which a primary care provider determines that

specialist services are required.” The gatekeeping element of the law is further revealed in a provision stating that “nothing in this section prevents a beneficiary from obtaining the services of a health care provider specialist and paying the specialist for services”. This wording leaves unclear the extent to which specialist services may be excluded from coverage unless tied to a primary care referral. At the same time, the Commission is charged with developing a rule governing “the circumstances under which a beneficiary may not self-refer, provided that commission rules shall allow a beneficiary to self-refer to a chiropractic physician, a doctor of oriental medicine, or a behavioral service provider.”

The legislation appears to contemplate a direct relationship between the Plan and participating providers and describes due process rights for providers subject to sanction. At the same time, the Act does not appear to bar the use of third-party administrators (administration could conceivably be similar to Connecticut’s Medicaid program, which is publicly administered and does not use managed care organizations but also utilizes a third-party administrator).

The Commission is charged with developing a provider payment system using a “variety” of payment approaches. The Act does not specify the special payment methodologies that characterize the Medicare and Medicaid statute, such as the Medicare/Medicaid disproportionate share hospital payment methodologies, the various prospective payment methodologies required under both laws (e.g., rural health clinic and federally qualified health center payment rules, outpatient hospital payments, nursing facility payments), other designated payment systems for certain institutional providers, and the Medicare RBRVS system for physicians.

The Act specifies that annual payment increases are to be no higher than the M-CPI, although the Commission is authorized to adjust this limitation “based on a showing of special and unusual circumstances in a hearing before the commission.” The Act also specifies that “supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care in rural and other underserved areas throughout the state.” (§ 31). The law specifies that the Plan must make full payment pursuant to negotiated rates for the services it covers and bars providers from charging Plan members additional amounts for services covered by the Plan.

A separate provision specifies a payment methodology for health care facilities that is “based on a base operating budget of past performance and projected changes in costs and services” adjusted for the upcoming year. As with provider payments, payment increases are to be no higher than M-CPI, unless there is a showing of “special and unusual circumstances.” Further, the Act also permits the Commission to negotiate supplemental payments to healthcare facilities “to help ensure the delivery of needed health care services in rural and other underserved areas throughout the state.”

In the case of both provider and facility payments, the Act envisions a negotiated process, with “dispute resolution” access in cases in which payment terms cannot be reached.

I. Financial Administration

The Act describes annual budget development and rate-setting activities to determine both individual and employer group premiums. It specifies that the Commission must develop an annual

plan budget reflecting a global spending level for the next fiscal year. Based on this budget, the Superintendent of Insurance is to develop premium rates and employer contribution rates proposed by the Commission. The Act further specifies that the annual plan budget is also to reflect federal revenues received.

J. Changes to Insurance in New Mexico and Federal Waivers

The Act contemplates that the Plan will replace Medicare and the non-long-term care portion of Medicaid; it is unclear regarding whether the Marketplace structure will remain as the means by which people and groups will enroll in the Plan and secure affordability assistance.

The Plan presumably would replace the state and local insurance programs for public employees. Whether the Plan would replace the private employer group market remains unclear; this market consists of employers that purchase insurance as part of their plans as well as those that self-insure.

In sum, HB 295 aims to fundamentally restructure how New Mexico residents acquire health insurance coverage and how they are covered. Multiple public and private insurance markets would be merged into a single public insurance market that covers all residents for a wide range of services with the exception of long term care and supplemental insurance. Coverage would follow the general contours of the ACA's essential health benefit package; whether the marketplace would remain the mechanism for enrolling in the Health Security Plan and for addressing issues that arise in connection to payment and coverage is not clear.

Achieving this vision necessitates displacing existing public and private insurance and repurposing the federal funds (and presumably private premium payments from employers and individuals) that are used for these other forms of coverage. Even if the Plan ultimately does not replace the private employer group market (both insured and self-insured), the reality in New Mexico is that this part of the state's insurance system plays a much smaller role than is the case in most other states.

In order to implement the Plan, the Act authorizes the Commission to “apply for program waivers from any governmental entity ... necessary to ensure the participation by the greatest possible number of beneficiaries.” Specifically, the Act directs the Commission to apply to the United States Department of Health and Human Services (HHS) “for all waivers of requirements under” the Medicaid and Medicare programs necessary to “receive federal payments for services rendered to Medicaid and Medicare beneficiaries.” The Act further directs the Commission to “identify other federal programs that provide federal funds for payment of health care services” (although the law explicitly excludes federal civilian and military insurance as well as the Indian Health Service) and apply for any waivers necessary for payment of services covered under the Plan.¹⁴ Additionally, the Act directs the Commission to “seek an amendment” to the ERISA statute to

¹⁴ It is not clear whether the Act contemplates folding in, if possible, federal programs that directly fund health care, such as community health centers, the Ryan White Care Act, the Title X Family Planning Program; while these programs provide federal funds for health care services, their purpose is to support costs associated with establishing and operating clinical care access points for medically underserved and vulnerable populations and communities, and we therefore assume that these funds would not be included in a waiver strategy.

exempt the state from provisions that relate to health care services or insurance, or to alternatively apply for any waivers of ERISA requirements.

IV. Federal Laws Relevant to the Health Security Act

A. The Employee Retirement Income Security Act (ERISA)

The Employee Retirement Income Security Act establishes a comprehensive federal regulatory framework for pension and “health and welfare” plans that private employers choose to sponsor.¹⁵ ERISA applies to all private employers and employee organizations¹⁶ regardless of size¹⁷ and exempts only plans established and operated by churches within the meaning of the Internal Revenue Code.¹⁸ Enacted to further nationwide uniformity while assuring that employers and employees have broad discretion over matters of plan design and administration, ERISA exerts a powerfully preemptive impact on state laws that may “now or hereafter relate to any employee benefit plan.”¹⁹ Although the Affordable Care Act amends ERISA in certain key respects to ensure that many of its reforms apply to ERISA plans, the law also preserves ERISA preemption principles as a core feature of American health law.

ERISA preemption is a dense and complex subject and includes two forms of preemption. The first is a provision (29 U.S.C. § 1144, entitled “Other Laws”) that is intended to supersede the vast body of state laws that regulate health benefits offered by employer plans. The second (29 U.S.C. § 1132) establishes an exclusive civil enforcement mechanism for plan participants and beneficiaries whose claims arise under an ERISA plan; this mechanism completely preempts all state law remedies (including damages for injuries) that might also apply to a claim alleging injury as a result of the operation of an ERISA plan.²⁰ This analysis focuses on the first form of preemption – that is, preemption of state regulatory laws.

¹⁵ Sara Rosenbaum, David Frankford, Sylvia Law and Rand Rosenblatt, *Law and the American Health Care System* (Foundation Press, 2012); 2021 Supplement.

¹⁶ Plans can be sponsored by both employers and unions. See U.S. Department of Labor, Health Plans and Benefits. <https://www.dol.gov/general/topic/health-plans> (December 4, 2021).

¹⁷ Certain federal regulatory laws applicable to employer plans, such as laws barring discrimination based on pregnancy or laws establishing mental health parity as a requirement of ERISA plans, limit their applicability to plans whose size exceeds a certain threshold. ERISA itself applies to all employer health and welfare plans. See, e.g. United States Department of Labor, Mental Health Parity, <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/parity-of-mental-health-and-substance-use-benefits-with-other-benefits.pdf> (December 6, 2021); United States Equal Employment Opportunity Commission (EEOC), Pregnancy Discrimination <https://www.eeoc.gov/pregnancy-discrimination> (December 6, 2021).

¹⁸ 29 U.S.C. § 1003(b)(2) In *Advocate Health Care Network v. Stapleton* (2017), https://www.supremecourt.gov/opinions/16pdf/16-74_5i36.pdf the United States Supreme Court broadened the meaning of church plans to include plans that may not have been established by a church as long as it is maintained by an organization whose principal purpose falls within the meaning of the church exemption.

¹⁹ 42 U.S.C. § 1144; see, generally, *Law and the American Health Care System*.

²⁰ *Pilot Life Insurance v. Dedeaux*, U.S. 481 U.S. 41 (1987). Note that complete preemption has been held not to apply to other types of claims in connection with acts that potentially trigger liability for substandard medical care rather than actions that lead to injury because they involve the denial of a claim or the withholding of benefits. *Dukes v. U.S. Healthcare*, 57 F. 3d 350 (1995). See, also *Aetna Health v. Davila*, 542 U.S. 200 (2004).

ERISA § 1144 preemption analysis involves a three-step analysis that can be summarized as follows:

First, ERISA “supersedes” – that is, sets aside – any state law that “relates to” an employee benefit plan, meaning that the state law “acts directly”²¹ on the plan by attempting to regulate its design or administration. Under this sweeping standard, ERISA does not preempt only state insurance laws such as the Health Security Act; it also can sweep aside state civil rights laws and²² state family and consumer laws.²³ ERISA also preempts state public health laws that stand in conflict with specific federal ERISA reporting requirements.²⁴

At the same time, supersedure does have its stopping point: ERISA does not displace state laws that regulate health care quality and costs directly, such as state laws that impose a sales tax on hospital services furnished to participants and beneficiaries covered under ERISA plans (regardless of whether the plan is insured or self-insured).²⁵ Nor does ERISA preempt state laws regulating the price that pharmacy benefit managers must pay to dispensing pharmacies.²⁶ However, there is no doubt that ERISA would preempt – that is, its federal shield would supersede -- a state law such as the Health Security Act that aims to replace private employer-sponsored plans with a public plan that insures nearly all state residents.

Second, even as its provisions supersede state laws that act directly on ERISA plans by mandating plan design and administration, ERISA also “saves” state laws that regulate insurance,²⁷ meaning that state insurance laws continue to be in effect in the case of insured ERISA plans that purchase group health insurance policies for their employees. However, the saving clause has a relatively modest impact on states’ ability to regulate the employer group market, since the percentage of insured plans is small; indeed, the U.S. Department of Labor reports that as of 2018, more than 80 percent of employer plans self-insure in whole or in part.²⁸ The saving clause does ensure the continued applicability to the ERISA group insurance market of state regulations governing benefits, provider networks, or other requirements going to the structure and administration of employer-sponsored group insurance.

Third, despite the insurance saving clause, ERISA’s “deemer clause” exempts from state insurance laws employer plans that self-insure, fully shielding such plans from state laws that regulate insurance within ERISA’s meaning.²⁹ The ERISA shield for self-insured plans applies even to

²¹ The first-step preemption analysis applies to both fully insured plans and health plans that self-insure. See *New York State Conference of Blue Cross and Blue Shield Plans v Travelers Insurance Co.*, 514 U.S. 645 (1995); *DeBuono v NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

²² *Shaw v Delta Airlines Inc.*, 463 U.S. 85 (1983).

²³ See discussion in *Travelers Insurance*, *supra*.

²⁴ *Gobeille v Liberty Mutual Insurance Co.*, 577 U.S. 312 (2016).

²⁵ *Travelers Ins.* *supra*; *DeBuono v NYSA-ILA*, *supra*.

²⁶ *Rutledge v Pharmaceutical Care Management Asso.*, 140 S. Ct. 474 (2020).

²⁷ *Metropolitan Life v Massachusetts*, 471 U.S. 724 (1985).

²⁸ See <https://www.dol.gov/sites/dolgov/files/EBSA/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2021-appendix-b.pdf>

²⁹ *Metropolitan Life Insurance*, *supra*.

plans that also purchase reinsurance to protect against the financial risks created by high-cost cases (as most would do).³⁰ As a result, within the limits of federal law, self-insured plans are free to design coverage as they choose.

As noted, while the ACA amends ERISA to apply certain provisions to ERISA plans, whether insured or self-insured, the ACA also preserves ERISA preemption. As noted, laws that regulate the price or quality of health care remain in force; to be preempted by ERISA, a state law needs to act directly on the plan itself rather than indirectly on the health care that a plan purchases. This limitation on preemption would not save the Health Security Act insofar as it seeks to regulate insurance.

What does this mean for the New Mexico law? Under ERISA preemption principles, to the extent that the Health Security Act would replace private group insurance policies with a public plan, the state presumably could do so, and employers that purchase insurance could be limited to the Health Security Plan. For these employers, commercial group products would remain available to the extent that they meet the Act's definition of supplemental plans. However, New Mexico employer plans that *self-insure* would be insulated by virtue of their self-insurance. This would be true even for self-insured plans whose coverage falls below the level established under the Act. These employers presumably could voluntarily opt into ERISA by contracting with a plan administrator for a product that tracks the coverage offered under the New Mexico plan.

Finally, it is important to note that ERISA contains no federal waiver authority. That is, the Labor Secretary cannot waive ERISA preemption. While Congress could of course amend ERISA to permit states to experiment with alternatives to the private group plan market, it has never done so in the nearly 50 years since ERISA's 1974 enactment; indeed, the Affordable Care Act represents a clear Congressional statement of intent that ERISA preemption continue as federal policy. The single statutory waiver exception was the waiver granted to Hawaii, whose Prepaid Health Care Act of 1974, enacted months before ERISA, mandates that employers insure certain employees. Other than the special dispensation given Hawaii, Congress has consistently rejected proposals to create ERISA waivers to permit state-based health reform of the type that New Mexico has enacted.³¹ For this reason, ERISA acts as a continuing limitation on the power of states to establish comprehensive coverage schemes for their populations.³²

B. The Dormant Commerce Clause

While ERISA's saving clause preserves states' broad latitude to regulate insurance sold in the private employer group market, it is worth briefly considering the constitutionality of a law that outlaws the sale of certain insurance products to New Mexico residents and employers. Supreme Court precedent makes clear that health insurance constitutes interstate commerce within the

³⁰ *American Medical Security, Inc. v Bartlett*, 111 F. 3d 358 (4th Cir. 1996).

³¹ Elizabeth McCuskey, *ERISA Reform as Health Reform: The Case for an ERISA Preemption Waiver*, 48 *Jour. Law Med. & Ethics* 450 (2020).

³² National Academy of State Health Policy, *ERISA Preemption Primer* https://www.nashp.org/wp-content/uploads/sites/default/files/ERISA_Primer.pdf.

meaning of the Constitution for purposes of Congress’s Article I powers,³³ and therefore, the question could arise as to whether such a law could be characterized by the industry as a violation of the “Dormant Commerce Clause,” a constitutional law principle established in very early Supreme Court cases³⁴ that bars states from regulating commercial activities within their borders in ways that impede the free flow of commerce across the states.

The Dormant Commerce Clause has served as the basis for prohibiting states from enacting protectionist tax laws that favor in-state producers of commercial products.³⁵ In this instance, however, favoritism of in-state businesses does not appear to be a factor. The purpose of the Health Security Act is not to give the edge to in-state commercial insurers; it is, instead, a classic exercise of a state’s inherent powers to safeguard its residents’ health through legislation designed to make it possible to achieve near-universal access to health care by means of a public insurance plan. To the extent that the legislation is grounded in the state’s exercise of its inherent police powers to protect public health, the Health Security Act should withstand challenges to its displacement of the commercial insurance market in favor of a public approach that achieves greater efficiency and near-universality. In this regard, contemporaneous statements of legislative intent regarding the Act’s purpose – to promote near-universal access to health care – would be of significant value.

C. Section 1332 of the Affordable Care Act

i. *Overview*

Section 1332 of the ACA allows states to seek waivers of key requirements under the ACA in order to test different healthcare coverage models. Of particular importance to states seeking to undertake coverage expansions, § 1332 permits states that qualify for a waiver to also receive an aggregate payment equal to what residents would otherwise have received in premium tax credits and cost-sharing reduction subsidies, referred to as “pass-through funding.”

Under current guidelines, as of 2021, sixteen states have been approved for § 1332 waivers and will receive pass-through amounts to fund innovations ranging from \$9.8 million (Rhode Island) to \$334.5 million (Maryland).³⁶ Recognizing that states may have as their goal broader health reform initiatives, § 1332 and its implementing regulations explicitly recognize that states may wish to coordinate their § 1332 waiver requests with other waiver processes, including § 402 (Medicare), § 1115A (Center for Medicare and Medicaid Innovation (CMMI)), and § 1115

³³ *United States v South-Eastern Underwriters Association*, 322 U.S. 533 (1944).

³⁴ *Gibbons v Ogden*, 22 U.S. 1 (1824).

³⁵ *West Lynn Creamery, Inc. et al v Healy*, 512 U.S. 186 (1984).

³⁶ Current approved 1332 waivers include: Alaska, Colorado, Delaware, Georgia, Hawaii, Maine, Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, and Wisconsin. These amounts do not include additional funding received as a result of enhanced subsidies under the American Rescue Plan. See <https://www.hhs.gov/about/news/2021/09/10/biden-harris-administration-invests-20-million-in-american-rescue-plan.html> (accessed November 18, 2021).

(Medicaid), into a single application to the Department of Health and Human Services (HHS) and/or the Department of Treasury.³⁷

Section 1332 waiver authority is broad, but at the same time, the statute limits approval to state innovations that comply with four statutory “guardrails.” In order to qualify for approval, a state § 1332 waiver must:

1. Provide coverage that is at least as comprehensive as coverage defined under the ACA’s essential health benefit statute would be absent the waiver.
2. Provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable as ACA coverage absent the waiver;
3. Provide coverage to at least a comparable number of residents as would be covered absent the waiver; and
4. Not increase the federal deficit.

The § 1332 waiver process is jointly overseen by the Departments of Health and Human Services and Treasury.³⁸

The Biden Administration recently finalized updated regulations for § 1332 waivers.³⁹ These regulations generally set forth the application procedures for § 1332 waivers (including a requirement for authorizing State legislation),⁴⁰ state public notice requirements,⁴¹ Federal public notice and approval processes,⁴² requirements for monitoring and compliance,⁴³ eligibility for pass-through funding,⁴⁴ state reporting requirements,⁴⁵ authority for periodic evaluations,⁴⁶ and the procedures for waiver approvals and amendments.⁴⁷

ii. Section 1332 – Potential Applicability to the Health Security Act

States with approved § 1332 waivers currently utilize the law’s broad authority for an array of reforms including: (1) reinsurance programs which reimburse insurers for incurred claims for high-risk enrollees (thereby keeping premiums stable); (2) market-led alternatives to the federal Exchange system;⁴⁸ (3) waivers of the ACA’s Small Business Health Options Program (SHOP)

³⁷ See 45 C.F.R. § 155.1302 and 31 C.F.R. § 33.102.

³⁸ See CMS, Section 1332 Waivers, https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers- (December 5, 2021)

³⁹ 86 Fed. Reg. 53,412 (September 27, 2021) (note that portion of this regulation take effect on November 26, 2021).

⁴⁰ 45 C.F.R. § 155.1308 and 31 C.F.R. § 33.108.

⁴¹ 45 C.F.R. § 155.1312 and 31 C.F.R. § 33.112.

⁴² 45 C.F.R. § 155.1316 and 31 C.F.R. § 33.116.

⁴³ 45 C.F.R. § 155.1320 and 31 C.F.R. § 33.120.

⁴⁴ 45 C.F.R. § 155.1322 and 31 C.F.R. § 33.122.

⁴⁵ 45 C.F.R. § 155.1324 and 31 C.F.R. § 33.124.

⁴⁶ 45 C.F.R. § 155.1328 and 31 C.F.R. § 33.128.

⁴⁷ 45 C.F.R. § 155.1330-2 and 31 C.F.R. § 33.130-2.

⁴⁸ On November 1, 2021 the Trump Administration approved Georgia’s 1332 waiver entitled the “Georgia Access Model.” In light of the different policy goals of the Administration, HHS is currently requesting comments from the

requirements;⁴⁹ and (4) waivers that enable states to fund a Basic Health Program for people with household incomes between 138 percent of poverty and twice the federal poverty level and otherwise eligible for Exchange coverage. Currently § 1332 waiver authority was designed to enable states to pursue alternative models to that created by the ACA where waivers or modifications of specific ACA provisions would be required. However, New Mexico retains the power to determine what types of insurance entities can lawfully function in the state so long as those that do comply with ACA structural and coverage provisions. Thus, the decision as to whether to limit ACA-compliant health insurance to a single public insurance plan is the state's to make, and no waivers would be needed.

The only reason New Mexico would pursue a § 1332 waiver with respect to coverage in the individual market might be if the state sought to use savings potentially resulting from substitution of public insurance for private coverage in order to improve coverage without having to support the cost of additional benefits solely out of state funds. At the same time, the state should be aware that the deficit neutrality requirement of § 1332 means that not only would the state have to comply with the level of coverage it offers under its plan for the life of the waiver (and not reduce coverage as potentially possible under the Health Security Act) but furthermore, the state would also have to maintain deficit neutrality – that is, a cap on the total level of federal spending under the ACA on coverage subsidies for state residents.

To be sure, § 1332 might be a useful tool for enabling New Mexico to implement many of its desired reforms, since it offers states the flexibility to modify enrollment procedures, replace or modify the employer mandate,⁵⁰ and make changes to both benefit design and subsidies as long as such changes align with the statutory guardrails noted above. The Act appears to contemplate these guardrails in terms of the scope of coverage, which is pegged to the essential health benefit model as at least a floor, and we assume that the premium and cost sharing structure of the new law would be at least as generous as that utilized under the ACA. Again, we assume that the state would pursue a § 1332 waiver with the understanding of the need to commit to preserving an ACA-level entitlement over the life of the alternative state plan.

The key question however is whether the state wants to submit to the deficit neutrality requirement of § 1332. Because deficit neutrality effectively caps federal ACA subsidy spending, the state faces a key challenge if the requirement effectively imposes an aggregate limit on federal expenditures tied to its current spending levels, which, as noted in the publicly available data used in this report, New Mexico's individual market spending appears to be quite low in relation to the potential eligible population. The gap between enrollment and eligibility might be even greater if the subsidy restructuring now pending in the Build Back Better legislation is enacted into law. A key question, therefore, is whether the state can accomplish desired reforms without having to undergo the § 1332 waiver process and commit to aggregate budget restrictions. For example, would any waiver be needed before the state uses its own authority over the state regulated

public on the Georgia waiver through January 9, 2022. *See* <https://www.cms.gov/files/document/depts-letter-comment20period.pdf> (Accessed November 18, 2021).

⁴⁹ *See* <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Hawaii-1332-Waiver-Fact-Sheet-12-30-16-FINAL.pdf>.

⁵⁰ The 2017 federal Tax Cuts and Jobs Act effectively repealed the individual mandate by zeroing out the penalty on individuals who fail to purchase affordable insurance.

individual insurance market to restructure its market and the products sold in the marketplace? Is there any reason to operate under waiver authorities in the case of the individual market? Given the potentially adverse effects of a deficit neutrality cap given low enrollment rates, the state presumably would need to consult with federal agency staff regarding whether it is feasible to measure the cap against projected higher enrollments resulting from the state's insurance reforms and additional outreach efforts.

Finally, § 1332 must be read in light of ERISA preemption. That is, while § 1332 can be used to reformulate the insurance market, including employer group insurance, it provides no authority to set aside ERISA preemption, meaning that a state cannot use § 1332 to set aside the federal ERISA shield for self-insured plans. Thus, for example, a § 1332 waiver would not permit the state to regulate third-party administered products sold to self-insured plans.

D. Section 1115 of the Social Security Act

i. Overview

Section 1115(a) of the Social Security Act (SSA) authorizes the HHS Secretary to waive compliance with certain statutory requirements of the Medicaid statute in order to allow “any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of” Medicaid.⁵¹ Beyond the basic authority to approve certain departures from the statutory provisions of the program, § 1115(a)(2) also allows the Secretary to fund approved federal experiments by expending federal Medicaid funds in ways that normally would be considered impermissible under the terms of the statute. (For more than 40 years, however, it has been federal policy to hold § 1115 demonstrations to a “budget neutrality” standard meaning that the cost of the demonstration cannot exceed what the state would have spent in the absence of its approved § 1115 experiment).⁵²

Under this broad authority, the Secretary may allow a state to test new approaches to eligibility, enrollment, and coverage.

Although the HHS Secretary's authority under § 1115 is broad,⁵³ it is not unlimited. First, the Secretary must determine that the demonstration will “further the objectives of” the Medicaid

⁵¹ Social Security Act § 1115(a) (codified as 42 U.S.C. 1315(a)).

⁵² See, State Medicaid Director Letter 18-009 (August 22, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf> Despite the budget neutrality rule, many demonstrations have used as their budget neutrality measure what a state might have spent had it made alterations in its program that are permissible as part of normal state plan operations, rather than the expenditures that the state makes under its current plan. This ability to hypothesize broader state plan spending as the measure of budget neutrality as opposed to spending under current state policy enabled Arkansas, for example, to implement the ACA expansion through the purchase of marketplace plans that are considerably more expensive than Medicaid managed care because they pay higher rates. See GAO, Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns (2014) <https://www.gao.gov/products/gao-14-689r>.

⁵³ See *Crane v. Matthews*, 417 F. Supp. 532, 540 (N.D. Ga. 1976) (affirming the Secretary's broad waiver authority in the context of upholding copayment requirements); see also *Cal. Welfare Rights Org. v. Richardson*, 348 F. Supp. 491, 496 (N.D. Cal. 1972) (same).

program.”⁵⁴ Second, the provisions that are waived must be codified in a specific part of the Medicaid statute (42 U.S.C. § 1396a). Third, as would also be the case with ACA § 1332 waivers, the Secretary’s approvals of § 1115 applications are considered agency actions, and thus governed by the Administrative Procedure Act (APA) and subject to judicial review.⁵⁵ Courts that have reviewed the Secretary’s approval of § 1115 demonstrations have described the Medicaid program’s primary objective to be to “furnish ... medical assistance” to individuals “whose income and resources are insufficient to meet the costs of necessary medical services.”⁵⁶ Put another way, “the principal objective of Medicaid is providing health care coverage” for those who are eligible and cannot afford it.⁵⁷ Any demonstration approval in this context will be governed by this basic standard.

As noted, § 1115 demonstrations must be budget neutral to the federal government.⁵⁸ This means that CMS will not approve demonstrations that would “result in Medicaid costs to the federal government that are greater than what the federal government’s Medicaid costs would likely have been absent the demonstration.”⁵⁹ In practice, each § 1115 demonstration is subjected to a budget neutrality test, “which results in limits ... placed on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval.”⁶⁰ This budget neutrality expenditure limit is calculated by projecting “the amount of FFP [Federal Financial Participation] that the state would likely have received in the absence of the demonstration” for the population covered and services provided by the demonstration.⁶¹ This involves forecasting future spending and enrollment trends.⁶²

ii. *Section 1115 – Potential Applicability to the Health Security Act*

The essential health benefit design used by the Health Security Act would represent a fundamental alteration of Medicaid for many beneficiaries. Although the ACA Medicaid expansion population is guaranteed essential health benefits, traditional beneficiaries (pregnant women, children, exceptionally poor parents and children and adults who receive SSI benefits) are entitled to benefits that go well beyond EHB coverage limits. This is true even if one sets aside indisputably “long term care” benefits that the Health Security Act would exempt. Furthermore, most ACA expansion states go beyond the essential health benefit standard in covering the expansion

⁵⁴*Pharm. Research & Mfrs. of Am. v. Concanon*, 249 F.3d 66, 75 (1st Cir. 2001) (quoting 42 U.S.C. § 1396 (2000)), *aff’d*, 538 U.S. 644 (2003); *see also Price v. Medicaid Dir.*, 838 F.3d 739, 742 (6th Cir. 2016); *see also Univ. of Wash. Med. Ctr. v. Sebelius*, 634 F.3d 1029, 1031, 1034–35 (9th Cir. 2011).

⁵⁵ *See* 5 U.S.C. §§ 701-706 (2012); *see also Beno v. Shalala*, 30 F.3d 1057 (9th Cir. 1994); and *Wood v. Betlach*, 922 F. Supp. 2d 836 (D. Ariz. 2013).

⁵⁶ *Gresham v. Azar*, 950 F.3d 93, 99 (D.C. Cir. 2019) (quoting 42 U.S.C. § 1396-1).

⁵⁷ *Gresham*, 950 F.3d at 99.

⁵⁸ U.S. Gov’t Accountability Office, GAO-14-689r, *Medicaid Demonstrations: 173 HHH’s Approval Process Arkansas’s Medicaid Expansion Waiver Raises Cost For Concerns* (2014).

⁵⁹ State Medicaid Director Letter, *Budget Neutrality policies for Section 1115(a) Medicaid Demonstration Projects*, Centers for Medicare and Medicaid Services (Aug. 22, 2018), <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18009.pdf>.

⁶⁰ *Id.* at 2.

⁶¹ *Id.*

⁶² *Id.*

population, for example offering additional rehabilitation care and prescribed drugs.⁶³ Thus, in terms of its coverage, cost-sharing, and provider payment features, the Health Security Act could have a major impact on the federal Medicaid entitlement.

Furthermore, it is not clear that § 1115 is broad enough to enable the HHS Secretary to give the state a defined contribution toward a successor health insurance program, operated wholly under state authority, that would replace a major portion of the Medicaid program. In short, § 1115 allows the Secretary to authorize and fund a modified Medicaid plan but not replace Medicaid with something else that is separately operated under a separate legal authority. Such a complete shift in the legal basis for a program appears to be beyond the limits of federal demonstration powers.

Assuming that the Health Security Plan could be structured to include a separate Medicaid component, it might be possible to move forward within the confines of § 1115. As part of the § 1115 application process, the state would need to identify each eligibility group it intends to move into Health Security Plan coverage and also would have to explain with particularity how the coverage and cost-sharing for each demonstration eligibility group would compare to the Medicaid entitlement under current law. For example, in proposing to substitute the Health Security Plan for the ACA expansion population (adults ages 18-64 ineligible for any form of creditable coverage including any eligibility category under New Mexico's traditional Medicaid state plan), the state would be expected, in its application, to identify with particularity how the Health Security Plan compares to the benefits to which members of the expansion population are now entitled under the state plan (i.e., alternative benefit plans plus other state plan benefits the state has elected to cover for the expansion population, such as additional levels of behavioral health care). This level of granular detail would be required for each eligibility category included in the state's § 1115 demonstration proposal.

It remains unclear however, whether the scope of the actual Medicaid modifications the state envisions would be permissible under § 1115. In profound ways – some visible to the naked eye, others less so – Medicaid's coverage reach extends beyond the most generous form of private health insurance. This is true even if the state carves out what it terms "long term care" from the reform package, since, as noted, there is no separate "long term care" component to Medicaid. Rather, Medicaid addresses the extensive and ongoing health care needs of seriously ill or disabled people in myriad ways, some of which fall into what might be thought of as a "long term care" category (e.g., home and community-based care), and others of which are part of a standard benefit design but are covered in far greater amount, duration and scope (e.g., speech and physical therapy for children with developmental disabilities).

Furthermore, states are entitled to federal Medicaid payments only for expenditures made as part of their state plan. Thus, to the extent the state is seeking to replace the entire Medicaid market and eliminate some or all of its Medicaid plan in favor of a separate Health Security Plan and receive federal funding that otherwise would have flowed to the state under its Medicaid plan, such

⁶³ A deep dive into whether New Mexico supplements Medicaid coverage for the expansion population is beyond the scope of this analysis.

a request appears to exceed the Secretary’s § 1115 powers. The Secretary, in other words, has the power under § 1115 to modify Medicaid, not entirely replace it.

Assuming the state actually envisions an altered Medicaid program as part of its Health Security Plan, it is difficult to know how a waiver proposal would fare, since the Commission has not yet developed the extensive Plan detail needed to ascertain prospects for approval. Even if New Mexico succeeds in framing its plan as a Medicaid modification, much of the Plan would appear to require waivers that the Secretary is not empowered to authorize under § 1115(a). Many of the Medicaid’s most significant features that appear not to have a counterpart in the New Mexico Plan – exceptionally comprehensive prescription drug coverage; provider payment rules for disproportionate share hospitals, federally qualified health centers, and rural health clinics; Vaccines for Children; cost-sharing safeguards – are codified in other parts of the statute. Furthermore, even if the Plan could be viewed as a modification of Medicaid for federal funding purposes, and even if the HHS Secretary could claim the power to waive provisions not codified in § 1902(a), the New Mexico Plan appears to envision the ability to alter coverage as budget constraints arise. This flexibility could be viewed by the HHS Secretary as seeking a waiver of the Medicaid legal entitlement itself, the right to apply for assistance whenever coverage is needed, retroactive eligibility, and the full benefit guarantee. Whether the HHS Secretary would consider such a request as promoting the objectives of Medicaid – the basic standard that must be met in order to qualify for § 1115 approval -- cannot be known, but it is reasonable to expect significant resistance from the agency for the reasons described above.

In sum, New Mexico’s § 1115 request may be unprecedented in scope and design, going well beyond anything attempted before. Understood to its fullest degree, the Health Security Act would be an outright replacement for much of Medicaid, with funds flowing to the Plan rather than a modified Medicaid program. This proposal exceeds the scope of § 1115, and even were the Plan to be presented as a modified Medicaid program, it is not clear that the Secretary can waive key provisions of the Medicaid Act. Not only is the legal authority to waive certain key aspects of federal Medicaid law in relation to the plan (particularly prescription drug coverage) open to question, but there is a serious risk that the HHS Secretary would not consider such waivers as promoting Medicaid’s purpose – the basic criterion for determining whether to approve a demonstration.

E. Section 402 of the Social Security Act

i. Overview

Section 402 of the Social Security Act Amendments of 1967,⁶⁴ which was further amended by the Social Security Act Amendments of 1972,⁶⁵ authorizes the HHS Secretary to conduct significant demonstration projects relating to alternative methods for financing and delivering care to Medicare and Medicaid beneficiaries. Specifically, section 402(a)(1) provides that the Secretary may, “either directly or through grants to public or private agencies, institutions, and organizations

⁶⁴ Pub. L. No. 90-248 (Jan. 2, 1968).

⁶⁵ Section 222, Pub. L. No. 92-603 (Oct. 30, 1972).

or contracts with public or private agencies, institutions, and organizations, [] develop and engage in experiments and demonstration projects” for purposes specifically enumerated in the statute.

To facilitate the demonstration projects under section 402(a), section 402(b) also provides the Secretary of HHS with broad waiver authority to alter the requirements ordinarily applicable to Medicare *and* Medicaid for the purposes of testing the demonstration. Specifically, section 402(b) authorizes the Secretary of HHS to waive:

“compliance with the requirements of Title XVIII [Medicare] and Title XIX [Medicaid] insofar as such requirements relate to reimbursement or payment on the basis of reasonable cost, or (in the case of physicians) on the basis of reasonable charge, or to reimbursement or payment only for such services or items as may be specified in the experiment.”

Prior to implementing any demonstration under the authority of § 402, however, § 402(b) requires the Secretary of HHS to ensure an appropriate research protocol and evaluation process that can assess the results of the demonstration project. In particular, § 402(b) requires the Secretary of HHS to:

“obtain[] the advice and recommendations of specialists who are competent to evaluate the proposed experiment or demonstration project as to the soundness of its objectives, the possibilities of securing productive results, the adequacy of resources to conduct the proposed experiment or demonstration project, and its relationship to other similar experiments and projects already completed or in process.”

Finally, CMS has generally required § 402 demonstration projects to be budget-neutral.⁶⁶

Historically, CMS has exercised its § 402 demonstration authority both to test novel financing/delivery models and to address Medicare programmatic needs. Furthermore, even more than § 1115 in practice, § 402 is structured to authorize true demonstrations, although, as the examples below suggest, § 402 demonstrations ultimately can emerge as long term alternative programs rather than time-limited experiments. To a lesser extent, CMS has also used § 402 demonstration authority to test demonstrations under both the Medicare and Medicaid programs. Below are examples of various ways CMS has proposed or has exercised its § 402 authority in the past:

- Waiving Medicare and Medicaid requirements to allow Massachusetts to implement a state-wide, comprehensive and integrated managed care option for persons 65 years of age and older who are dually eligible.⁶⁷ The demonstration project continues to exist today.⁶⁸

⁶⁶ Section 402 Medicare Waiver Application, *available at* <https://innovation.cms.gov/files/x/medicareappwaiver.pdf>.

⁶⁷ 62 Fed. Reg. 43541 (Aug. 14, 1997).

⁶⁸ <https://www.mass.gov/senior-care-options-sco>.

- Waiving Medicare requirements prohibiting coverage and payment for certain preventive services to test whether coverage of preventive services improves health outcomes.⁶⁹
- Waiving application of payment consequences associated with the Medicare Merit-based Incentive Payment System (MIPS) under § 1848(q)(6)(E) of the Social Security.⁷⁰
- Waiving application of prohibition on payment to certain DME suppliers within moratoria areas to maintain operation of previously existing CMS demonstration project that allowed need-based exceptions to the moratoria requirement to test whether targeted anti-fraud strategies have merit.⁷¹
 - CMS had previously waived its own regulations and certain statutory provisions using § 402 to test the initial demonstration project.⁷²

ii. Section 402 – Potential Applicability to the Health Security Act

Like § 1115, § 402 does not offer New Mexico a legal basis for seeking a complete replacement to Medicare and Medicaid. But, in combination with § 1115, § 402 might offer the state flexibility to implement the Health Security Act as a “Health Security Plan” that effectuates coverage under both programs, much as the Plan would be the means by which coverage is effectuated for individuals receiving ACA subsidies. Each market – Medicare, Medicaid, and the ACA subsidy market – would continue as the legal authority for coverage rather than being merged into a single Health Security Plan. At the same time, the Plan would take the place of the Medicaid managed care and the Medicare Advantage markets and would also be the means by which the traditional Medicare program operates. Put another way, rather than acting as the prime source of coverage, the Health Security Plan would operate as the administrator of coverage across the Medicare, Medicaid, ACA premium subsidy, and (possibly) the employer markets. Separate sources of insurance coverage would continue to exist, but all sources of insurance coverage would be implemented through a single public administrator. This approach might be feasible. Indeed, Vermont appears to be doing something similar with its Medicaid program under a recently-submitted § 1115 proposal, and Connecticut has historically operated its Medicaid program by means of a public organizational structure that effectively functions as a state-wide managed care plan (Connecticut does appear to use a private third party administrator, much as a self-insuring employer might do).

As with § 1115 demonstrations, § 402 poses a threshold issue that would determine whether New Mexico could utilize this special authority to implement the Health Security Act as a publicly-sponsored managed care arrangement, if not as a primary insurer. This threshold question is whether the Health Security Act can properly be characterized as a demonstration that is consistent with at least one of the enumerated purposes under § 402(a)(1). New Mexico arguably satisfies the following purpose under paragraph (C):

⁶⁹ 48 Fed. Reg. 36660 (Aug. 12, 1983).

⁷⁰ 83 Fed. Reg. 59452, 59890 (Nov. 23, 2018).

⁷¹ 83 Fed. Reg. 42037 (Aug. 20, 2018).

⁷² See generally 81 Fed. Reg. 51116 (July 29, 2016).

“(C) to determine whether the rates of payment or reimbursement for health care services, approved by a State for purposes of the administration of one or more of its laws, when utilized to determine the amount to be paid for services furnished in such State under the health programs established by the Social Security Act, would have the effect of reducing the costs of such programs without adversely affecting the quality of such services;”

Although Massachusetts’ Senior Care Options (SCO) waiver request is not publicly available, we presume that Massachusetts relied on subparagraph (C) when requesting such a waiver because subparagraph (C) is predicated on enabling legislation by the requesting state. The Federal Register Notice announcing Massachusetts’s § 402 application expressly referenced state enabling legislation as a necessary condition for approval of Massachusetts’s waiver request.⁷³ Likewise here, the HSA would enable New Mexico to “determine whether the rates of payment or reimbursement for health care services...when utilized to determine the amount to be paid for services furnished in [New Mexico] under [Medicare and Medicaid], would have the effect of reducing the costs of such programs without adversely affecting the quality of such services.”

We note that although the language of § 402(a)(1)(C) above could be read to contemplate a proposed demonstration which would only modify the “rates of payment” for health care services that would otherwise be “paid for” under Medicare and Medicaid, the statute as a whole can be read to authorize the proposed demonstration to cover and pay for *different* items and services than would ordinarily be covered by the Medicare and Medicaid programs. This is because although the “purpose” of a § 402 demonstration is defined by subsection (a) of § 402, subsection (b) provides the Secretary of HHS with the ability to waive *any* requirement under Medicare or Medicaid necessary to accomplish the goals of the demonstration. Thus, it is arguably possible to waive any Medicare or Medicaid requirements that may conflict with the HSA’s proposed approach to cover and pay for items and services based on the design of the state’s choosing.

As alluded to above, however, there may be some potential limitations to § 402 demonstration authority. The first is that it only allows for the waiver of Medicare and Medicaid program requirements, not requirements applicable to commercial coverage in the state of New Mexico. These waiver authorities will need to be invoked separately, and they must comply with their own applicable requirements as discussed elsewhere.

Second, related to the first limitation, and as noted elsewhere, § 402 demonstrations do not appear to change the underlying legal status of Medicaid and Medicare beneficiaries: they continue to technically be “Medicaid” and “Medicare” beneficiaries. As we also discussed in our § 1115 review, the requirement that Medicare and Medicaid remain separate – and separately covered by program-specific demonstration authorities – means that the program-specific structure of federal laws would effectively bar a demonstration approach in which various markets are replaced with a single Health Security Plan that operates as a single payer and presumably a single risk pool. It does not seem possible that CMS could use § 402 to commit the funding attributable to Medicaid

⁷³ 62 Fed. Reg. at 4351 (“In addition to Federal demonstration waivers, enabling legislation in Massachusetts is also necessary.”).

and Medicare beneficiaries residing in New Mexico to the state for expenditure on an entirely different form of insurance, that is, the Health Security Act. CMS may require New Mexico to segregate any funding for the § 402 demonstration from funding used in other markets (to the extent that CMS commits to any block-style financing, which is a reasonably questionable assumption), which may affect New Mexico's ability to implement the Health Security Act as designed.

Finally, § 402 demonstrations generally require budget neutrality. Again, in the context of New Mexico's goal to shift most state residents to coverage under the Health Security Plan, CMS may resist incorporating budget impact calculations attributable to dynamics occurring outside of the Medicare and Medicaid markets, which could pose challenges for New Mexico's compliance with the budget neutrality requirement.

We note that the Massachusetts SCO will be a helpful precedent for New Mexico to leverage as it considers requesting a § 402 demonstration for the implementation of the Health Security Act. Regrettably, there is limited public information about the Massachusetts SCO, and, in any event, the Massachusetts SCO is comparatively limited relative to what the Health Security Plan would attempt to achieve. We anticipate that most information on the Massachusetts SCO will have to be provided by CMS itself in discussions with the agency. Alternatively, New Mexico could reach out to the Executive Office of Health and Human Services (EOHHS) of Massachusetts to request additional information directly from the State.

F. Section 1115A of the Social Security Act

iii. Overview

The Center for Medicare and Medicaid Innovation (CMMI) was established and funded by the ACA⁷⁴ and is codified at § 1115A of the SSA. Per the statute, the purpose of CMMI is “to test innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care furnished to individuals under [Medicare and Medicaid].”⁷⁵ Congress also provided CMMI with broad waiver authority over the Medicare program and select provisions of the Medicaid program for purposes of testing and implementing its models.

Section 1115A(b)(2)(A) requires CMMI to prioritize the development and testing of models where the Secretary determines that there is “evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures” and where the models would be expected to “reduce program costs” while “preserving or enhancing the quality of care” received by Medicare and/or Medicaid beneficiaries. The statute goes on to outline illustrative examples of potential models that could meet the standard mentioned above.⁷⁶

⁷⁴ Section 3021. Patient Protection and Affordable Care Act Pub. L. No. 111-148 (March 23, 2010).

⁷⁵ Social Security Act, § 1115A(a)(1).

⁷⁶ See generally *id.* at § 1115A(a)(2)(B).

Of the models specifically illustrated in statute, several stand out for our purposes here. More specifically, section 1115A contemplates models that:

- “[T]est and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.”⁷⁷
- “[T]est and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.”⁷⁸

In addition to outlining potential models, § 1115A(b)(2)(C) also provides CMMI with additional discretionary factors to consider in developing a model. Of particular relevance here is a factor that considers “whether the model demonstrates effective linkage with other public sector payers, private sector payers, or statewide payment models.”⁷⁹

Models selected by CMMI must adhere to certain procedural and evaluation requirements. First, Congress contemplated CMMI models to be tested in “phases.” Under Phase I, the Secretary is *not* required to ensure that the model is budget neutral.⁸⁰ During this initial implementation phase, however, the statute requires the Secretary to terminate or modify the design of a model *unless* the Chief Actuary of CMS determines that the model will:

- “(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;
- (ii) reduce spending under the applicable title without reducing the quality of care; or
- (iii) improve the quality of care and reduce spending.”⁸¹

Following the implementation of the model during Phase I, the Secretary must evaluate the model and make publicly available an analysis of the quality of care furnished under the model and the changes in spending under Medicare and Medicaid “by reason of the model.”⁸² To expand the model to “Phase II,” the Chief Actuary of CMS must certify that expansion “would reduce (or would not result in any increase in) net program spending under [Medicare or Medicaid].”⁸³

Importantly, although CMMI has the authority to waive any requirement under Medicare, CMMI has limited authority to waive requirements under Medicaid. However, CMMI may only waive sections 1902(a)(1) (relating to uniform benefits throughout the state), 1902(a)(13) (relating to processes for setting facility-based payment rates), 1903(m)(2)(A)(iii) (relating to Medicaid

⁷⁷ *Id.* at § 1115A(b)(2)(B)(x).

⁷⁸ *Id.* at § 1115A(b)(2)(B)(xi).

⁷⁹ *Id.* at § 1115A(b)(2)(C)(viii).

⁸⁰ *Id.* at § 1115A(b)(3)(A).

⁸¹ *Id.* at § 1115A(b)(3)(B).

⁸² *Id.* at § 1115A(b)(4)(A).

⁸³ *Id.* at § 1115A(c)(2).

managed care), and 1934 (except subsections (b)(1)(A) and (c)(5) of such section) (relating to Program for All-Inclusive Care for the Elderly).⁸⁴

iv. Section 1115A – Potential Applicability to the Health Security Act

Section 1115A may be a potential waiver authority which New Mexico could leverage to implement the HSA, but there may be too many limitations to § 1115A authority relative to other available waiver authorities discussed in this paper such that § 1115A may not be an effective use of New Mexico’s resources. Although the HSA could arguably align with the stated purpose of CMMI, § 1115A imposes more conditions than other waiver authorities, and is better suited to supporting targeted demonstrations rather than system-wide transformations.

As a threshold matter, the HSA must align with the “purpose” of CMMI’s statutory mandate. Section 1115A expressly contemplates the testing of all-payer models, but not single-payer models, and CMMI has not approved any statewide single-payer programs. This said, the statute makes clear that selected models “may include, but are not limited to, the models described [in the statute].”⁸⁵ As such, New Mexico could draw attention to the HSA’s focus on establishing an “effective linkage” across public and private sector payers, which is a factor Congress expressly encourages CMMI to consider in testing models.⁸⁶ Thus, there may be an argument that nothing expressly *precludes* the single-payer approach envisioned by the HSA.

However, even if the single-payer approach envisioned by the HSA could be characterized as a model that CMMI could test, the limitations associated with § 1115A waiver authority may encumber New Mexico with significant legal and practical challenges to ensure compliance with the statute. For instance, as noted above, the HSA contemplates times where benefits may be rolled back when New Mexico experiences budgetary pressures. But arguably, such a rollback would directly contravene § 1115A’s strict access requirements. Furthermore, because § 1115A requires at least two “phases” to a model’s implementation, it is unclear how an initial implementation phase could be distinguished from a subsequent phase in the context of the HSA, which makes no such distinctions in its own provisions. Moreover, as § 1115A only considers expenditures under Medicare and Medicaid when assessing budget impact for purposes of expansion of the model, the HSA’s achievement of savings in the commercial market would bear no impact on CMS’ Chief Actuary’s assessment of the model. Finally, as is the case with § 402 demonstrations, it is not clear that § 1115A allows for the block-granting of funds that would otherwise be expended for Medicare and Medicaid beneficiaries, thereby potentially impeding HSA’s hopes to unify available funding from all markets to implement a single-payer model.

V. Conclusion and Recommendations

The Health Security Act represents an ambitious and innovative effort to replace the fractured public and private insurance system with a stable, affordable coverage framework for virtually all state residents that gives residents better control over the quality and price of their coverage

⁸⁴ *Id.* at § 1115A(d)(1).

⁸⁵ *Id.* at § 1115A(b)(2)(A).

⁸⁶ *Id.* at § 1115A(b)(2)(C)(viii).

through a unified, publicly-administered, accountable system. At the same time, however, the Health Security Plan is highly dependent on federal funding to be financially viable. For this reason, the Act directs state officials to investigate the feasibility of repurposing the federal revenues that flow into coverage via Medicare, Medicaid, and ACA insurance subsidies to support implementation of the Health Security Plan. Additionally, the Act inquires about the feasibility of modifying the approach to employer-sponsored group health plans that would enable the Health Security Plan to effectively capture employer and employee premiums.

The feasibility of such an ambitious transformation of public and private coverage in New Mexico obviously implicates political and policy questions that go beyond the proposal's legal feasibility. Here, however, we consider only the question of whether the Health Security Plan implementation, and specifically its goal of repurposing federal funding streams, may be legally feasible. The Plan itself, of course, is only in its infancy, since extensive Commission work is needed to develop its detailed contours where eligibility, enrollment, coverage, benefits, cost sharing, provider payment, and other key aspects of the plan are considered. Therefore, any conclusions we reach are necessarily preliminary and based only on a high-level overview of the law as it may relate to various federal laws.

Our high-level analysis can be summarized as follows:

ERISA-Governed Plans. The Employee Retirement Income Security Act (ERISA) permits the state to regulate the private employer group insurance market while shielding self-insured employer plans from state regulation. Unless there is a state law that bars this, New Mexico could, without running afoul of ERISA, replace its ACA-compliant commercial group insurance market with the public Health Security Plan and could encourage self-insuring employers to purchase the Plan as their administered product. The state also could encourage selection of the HSP by the state's church plans (to the extent they exist), which are exempt from ERISA regulation and (customarily in many states), state regulation as well.

Furthermore, ERISA governs only the private employer health benefit plan market. This means that, depending on state law and possible collective bargaining considerations, the state faces no ERISA barrier to utilizing the HSP as its public employee plan.

The Individual Insurance Market. Nothing in the ACA alters states' regulatory powers over the insurance market except to the extent that federal law sets certain minimum standards for policies subject to ACA standards and sold in the individual and group markets. New Mexico could fundamentally restructure its individual insurance market, eliminating the sale of ACA-compliant individual commercial plans in favor of the ACA-compliant HSP. People purchasing the HSP through the Marketplace would qualify for premium tax credits and cost sharing subsidies, and given the apparently low take-up rate among state residents eligible for the subsidy, the state might significantly extend the reach of its public insurance model, essentially replacing commercial ACA-compliant plans with the HSP. Given the low penetration rate of the ACA tax credit system in relation to the potentially eligible population, New Mexico may consider the state's power to regulate insurance and its exchange to pursue HSP implementation rather than seeking a §1332 waiver. The need for a § 1332 waiver is unclear, and the deficit neutrality cap ultimately could impede coverage expansion rather than help it, unless the waiver process permits the state to set

the cap in anticipation of expanded enrollment, just as the 1115 budget neutrality cap allows a state to set the cap based on total potential expenditures under the state's normal state plan authority. The types of proactive outreach reforms to boost marketplace enrollment, as well as reforms to further streamline alignment between the Medicaid and the HSP-configured marketplace, may be accomplished without § 1332 waivers, however, although a closer look at potential streamlining reforms to achieve greater alignment a new HSP Marketplace and Medicaid certainly would be merited. (This type of deep dive into issues of alignment is beyond the scope of this project).

Medicare and Medicaid. As we noted, federal demonstration and waiver authorities specific to Medicare and Medicaid (§ 1115, § 1115A, § 402) are designed to allow the federal and state governments to test and evaluate modifications to these programs to achieve certain specified statutory goals. In our view, none of these waiver authorities would permit the HHS Secretary to end Medicare and (at least portions of) Medicaid for New Mexico residents, replace these programs with the HSP, and redirect to the HSP the federal Medicare and Medicaid financing that flows to the state or to Medicare providers, suppliers, and Medicare Advantage plans. (Presumably the state would want to redirect not only direct federal program outlays into the HSP but also, presumably, employer and employee Medicare payroll taxes along with Medicare beneficiary premiums). Federal law simply does not give the HHS Secretary the power to literally replace these programs, nor could the Secretary do so, in our view, without raising constitutional nondelegation concerns about waiver powers exercised in such a complete replacement fashion. Congress would need to enact new authority authorizing the New Mexico HSP as a successor program to Medicare and Medicaid, while redirecting federal funding to support the state's public plan. Lawmakers considered this type of sweeping replacement in the ACA, and 1332 was the compromise. We believe that this remains a legislative non-starter.

The state could, however, consider the use of § 1115 as a means of redesigning its Medicaid managed care market. Under such a demonstration (similar to one that Vermont appears to be pursuing now) the state would offer a single public Medicaid MCO covering all Medicaid populations not exempt from HSA. Whether the state could do this unilaterally or would require demonstration authority would depend on a close read of the federal Medicaid managed care authority as well as consideration of the design of the HSP. For example, does the New Mexico Act envision the use of provider networks or, instead, a fee-for-service system allowing access to any HSP-participating provider for all services? Does the state envision coverage and cost sharing criteria for HSP that are sufficiently aligned with the Medicaid program requirements to enable the state to move forward?

We note, furthermore, that the state could potentially redesign the HSP to operate as a Medicaid managed care organization meeting federal requirements and could align this public Medicaid model with the marketplace HSP, thereby creating an HSP enrollment continuum across both sources of subsidies. To the extent that such an innovation would require § 1115 and /or § 1332 waivers (a closer examination would be required once the HSP details are developed), the result would be to effectively extend Medicaid-level coverage across both markets. Through this approach, the state could effectively unify its two publicly subsidized markets by offering the same plan in both and would retain full ACA premium tax credits and achieve Medicaid-level coverage at the 100 percent federal funding level that governs marketplace tax credits. In this way – by aligning plan markets rather than eligibility itself – New Mexico would succeed in effectively

expanding Medicaid to people whose incomes exceed the ACA 138 percent income threshold. Federal law allows the state to expand its state plan to include this optional group, but at normal federal funding levels.⁸⁷ By offering the HSP to both Medicaid beneficiaries and marketplace purchasers, New Mexico effectively would extend Medicaid-level coverage (presumably an alternative benefit plan model) to all people whose coverage is funded either through Medicaid or marketplace tax credits and cost sharing subsidies

Finally, with respect to Medicare, there are serious questions regarding New Mexico's ability to repurpose federal dollars that would otherwise pay for Medicare-eligible residents of New Mexico and instead use those dollars to support a state-run Health Security Plan. That being said, the state could conceivably explore creating a Medicare Advantage plan that could be aligned with Health Security Plan models in other markets (e.g., individual market, Medicaid manage care, etc.) and marketed to Medicare-eligible beneficiaries for enrollment. However, in the absence of waiving Medicare beneficiaries' freedom of choice, which to the best of our knowledge has never been granted before, a Health Security Plan-based Medicare Advantage plan would have to compete with commercial plans and other Medicare Advantage plans.

⁸⁷ 42 U.S.C. § 1396a(a)(10)(A)(ii)(XX)