BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in New Mexico

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STRONG FAMILIES New Mexico

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ALLIANCE FOR A JUST SOCIETY

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Erik Lujan, Assistant Director, Health Education and Outreach, Native American Professional Parent Resources (NAPPR)

UPGRADING MEDICAL INSURANCE ENROLLMENT AND ACCESS TO HEALTHCARE IN NEW MEXICO

NEW MEXICO WAS THE SECOND STATE WITH A REPUBLICAN GOVERNOR to expand Medicaid. Citing an obligation to "provide an adequate level of basic health care services for those most in need in our state" Governor Susana Martinez said that the basis of her decision was "what is best for New Mexicans."[1] A 2012 report from the New Mexico chapter of the American College of Physicians projected that the expansion would both reduce the number of uninsured New Mexicans by as much as 46 percent and curb racial and ethnic disparities that are exacerbated by lack of insurance.[2]

The state's new health exchange website opened to a flurry of activity that was initially characterized by long waits and was soon bogged down with numerous website glitches. This report, jointly developed by Strong Families New Mexico and the Alliance for a Just Society, includes data from 196 individually administered bilingual surveys with new health insurance (Medicaid and marketplace) enrollees, interviews with health care advocates and professionals, and public data accessed from the New Mexico Health Insurance Exchange (NMHIX), the federal Centers for Medicare and Medicaid Services (CMS), the Kaiser Family Foundation (KFF), and Healthcare.gov. While this analysis does not attempt to capture all of the dynamics related to the enrollment process in the initial enrollment period that ended in April 2014, it does examine the major barriers to both enrollment and moving from coverage to care, making specific recommendations for systemic improvements in both areas.

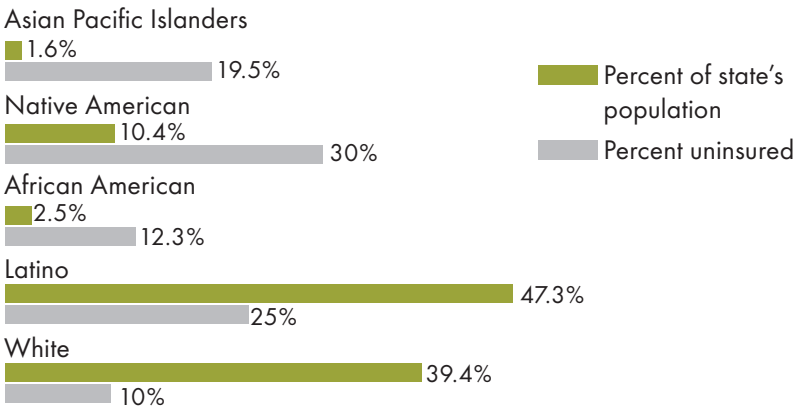
ENROLLMENT

"The website listed plans to apply for but if you didn't have the money to cover it you couldn't downgrade or select a plan that best fit family income. When we had a question and would call they would ask where we were from. When we said New Mexico, they would say you need to call Healthcare New Mexico. But when we got through to the NM line we were told to call the national line. I was on the phone for so many hours I had to plug in my phone to keep it charged."

SEVERAL FACTORS MARRED NEW MEXICO'S INITIAL ENROLLMENT PERIOD. Health advocates in the state cited, as reasons for low rates of enrollment, insufficient planning for outreach, lack of a comprehensive media campaign, underestimation of enrollment difficulties in rural areas, website and technology failure, and premium costs. According to Charlotte Roybal, Director of Policy Connections, "they didn't have a plan for outreach education and enrollment. They just kind of gave out money, mostly to the biggest city, Albuquerque, rather than the hard-to-reach populations in the rural areas. Just because our governor accepted Medicaid expansion doesn't mean we are enrolling people or making an effort to do so."[3] Says Kim Zamarin, Coordinator of Raise Up the Valley in Central New Mexico, "the state exchange didn't do any outreach or provide information on the exchange once they decided to promote Medicaid enrollment. They brought on a company to do outreach and another company to process applications. It was all a mess."[4] A report issued in June 2014 by the New Mexico Center on Law and Poverty and the Southwest Women's Law Center, entitled *Healthcare Coverage Under the Affordable Care Act: A Preliminary Report on Enrollment Barriers in New Mexico* (hereafter Enrollment Barriers Report), found that the exchange engaged in minimal outreach, suffered from a federal website that was non-functional for the first two months, and experienced significant technical problems when using new computer systems for Medicaid and other public benefits programs. Despite these barriers, by the end of the first enrollment period in March of 2014, New Mexico had lowered the percentage of medically uninsured by 5 percentage points, from 20.2 percent to 15.3 percent.

Chart 1 below examines state demographics and percent uninsured by race.

Chart 1

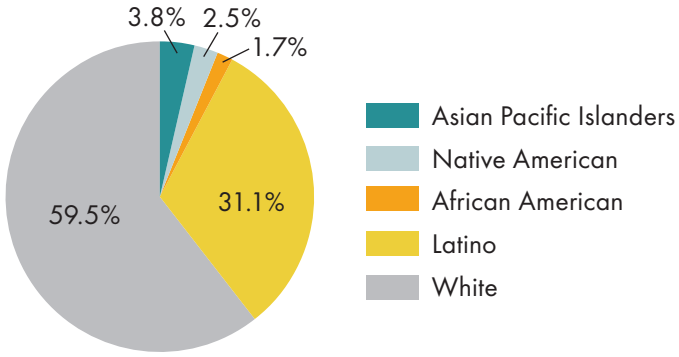


"They just kind of gave out money, mostly to the biggest city, Albuquerque, rather than the hard-to-reach populations in the rural areas. Just because our governor accepted Medicaid expansion doesn't mean we are enrolling people or making an effort to do so."

We have some problems in the Navajo Nation, because we have a lot of farmers and ranchers and people with seasonal homes. The main issue is the sheer distance involved in reaching people. The Navajo Nation is about 800 square miles with mostly dirt roads. And because of the lack of technology, you have to go back to offices in these areas 4-5 times to get people to fill out and correct paper applications.

Chart 2

Percent of new marketplace enrollees as of April 30, 2014



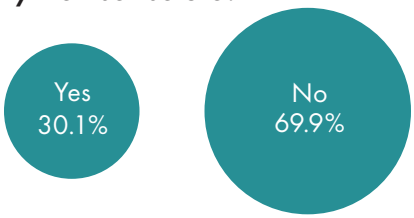
While whites make up less than 40 percent of New Mexico's population, they account for 60 percent of those enrolled. Latinos, on the other hand, make up nearly half of the state's population but account for only 31 percent of those enrolled. Native American enrollment is also well below what would be proportional, accounting for only 2.5 percent of those enrolled. The reasons? Many uninsured Native Americans use Indian Health Services and do not see a need for ACA enrollment. Other reasons relate to time, distance, and state resources allocated to the enrollment effort. As Erik Lujan, Assistant Director of Health Education and Outreach for Native American Professional Parent Resources, points out, "each community is different. We have some problems in the Navajo Nation, because we have a lot of farmers and ranchers and people with seasonal homes. The main issue is the sheer distance involved in reaching people. The Navajo Nation is about 800 square miles with mostly dirt roads. And because of the lack of technology, you have to go back to offices in these areas 4-5 times to get people to fill out and correct paper applications."[5] As for the low enrollment in other communities of color, Joseph Martinez, Consumer Outreach Coordinator of Health Action New Mexico, says that "not enough effort has been put into other communities beyond Native and Latino communities. The African-American community is very small and churches have been useful in outreaching to them. The Asian-American community is growing but there are very few organizations that have the capacity to conduct outreach in Asian languages."[6]

A high proportion of uninsured adults are Latino. Navigators often had the responsibility of language translation and translating insurance terms and concepts like co-pay, deductible, and essential benefits. These translations were not always readily available, even in Spanish. As Charlotte Roybal explains, "for enrollment they had an 800 number and things in Spanish, but most of the outreach was in English. The federal government did a lot of advertising on Telemundo, but it was national and not targeted. Because the Spanish language is spoken differently across the country, it wasn't as effective. And there wasn't a [local] phone number to call. A lot of people were confused about what the local and national news was saying about ACA and didn't know what to believe."[7]

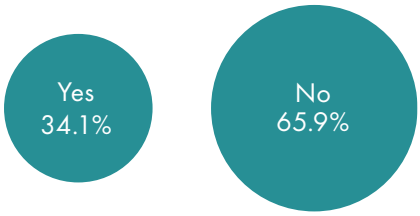
Immigration status also played a role in deterring Latino enrollment. "We run into trouble around this," says Jerald Montoya, Health Promotion Program Manager with the New Mexico State Public Health Department, "especially with mixed families where the children are born here and are eligible for Medicaid, but their undocumented parents are afraid to come in to sign up because of their immigration status. We also have the other element of racism in terms of policies and procedures that are complicated and cumbersome for people and unfriendly to recent immigrants."[8] Adriann Barboa, Field Director of Strong Families New Mexico, agrees: "Our communities just don't trust outsiders. There has been a huge conversation about how a mixed status family or mixed Indian certification status (e.g., mom is a tribal member and the kids aren't) aren't being served. Being a mixed family jeopardizes your eligibility. The process doesn't allow for the fact that there are many people who have multiple identities and status in a family. So once that is recognized it's a lot of work for the Navigator to figure out what they are eligible for. It's a long process."[9]

Access to Information about Insurance Coverage

Have you ever shopped for private health insurance for yourself or a family member before?



Survey Respondents Who Reported Shopping for Health Insurance Through the New Mexico Health Insurance Exchange



Did you apply for either Medicaid or a tax credit?

	Percent
Yes	35.6
No	44.3
I don't know	20.1

If you are still waiting for a notification about your Medicaid and or NM Health Insurance Exchange eligibility, how long ago did you apply?

	Percent
About five months ago	40.0
About one month ago	20.0
About two months ago	40.0

"There has been a huge conversation about how a mixed status family or mixed Indian certification status (e.g., mom is a tribal member and the kids aren't) aren't being served. Being a mixed family jeopardizes your eligibility. The process doesn't allow for the fact that there are many people who have multiple identities and status in a family."

"[R]ural and low-income communities don't have Internet access in the first place and the availability and functionality of the federal website was a problem. After a first (unsuccessful) attempt, a lot of people got frustrated and walked away. This problem was compounded for the immigrant population."

Seven of ten survey respondents had never before shopped for health insurance; two-thirds who did apply did not use the New Mexico Health Insurance Exchange. A little over a third of respondents applied for either Medicaid or a tax credit and, as a lawsuit filed by the Southwest Women's Law Center and the New Mexico Center on Law and Poverty as well as our survey responses indicate, the backlog meant that decisions on many applications were not issued within the 45 days required by federal law.

Who helped you shop for coverage?

	Percent
Health coverage guide (the professional at an enrollment office or event)	14.5
NMHIX BeWellNM call center	2.7
On-line chat (healthcare.gov)	0.5
An insurance agent or broker	1.1
Both call center and online chat	2.2
I did not receive help	39.3
Other	39.8

What help did you need?

Translation help tied with other services for what most survey respondents reported that they needed. In addition, limited Internet access, website glitches, and limited rural access combined with applicants' low health care literacy to make the New Mexico enrollment process very complicated. Says Paige Duhamel, staff attorney at the Southwest Women's Law Center, "(w)e have a state that has little or no access to the Internet, especially in the rural areas. Twenty-three percent of the population accesses the Internet less than once every two weeks."[10] Joseph Martinez of Health Action New Mexico added, "rural and low-income communities don't have Internet access in the first place and the availability and functionality of the federal website was a problem. After a first (unsuccessful) attempt, a lot of people got frustrated and walked away. This problem was compounded for the immigrant population."[11] As the Enrollment Barriers Report found, "Immigrants were unable to verify their identities with the Exchange if they did not have credit histories. Instead, they had to wait on the phone to talk with Experian, and then either wait for processing to complete the application, or mail in the documentation to a Kentucky processing center."[12] "The whole identity verification was a major issue for folks who don't have credit. We couldn't confirm identity in the Exchange," said Kim Zamarin. "We had to get on the phone and go through a long process to confirm identity. It was difficult."[13]

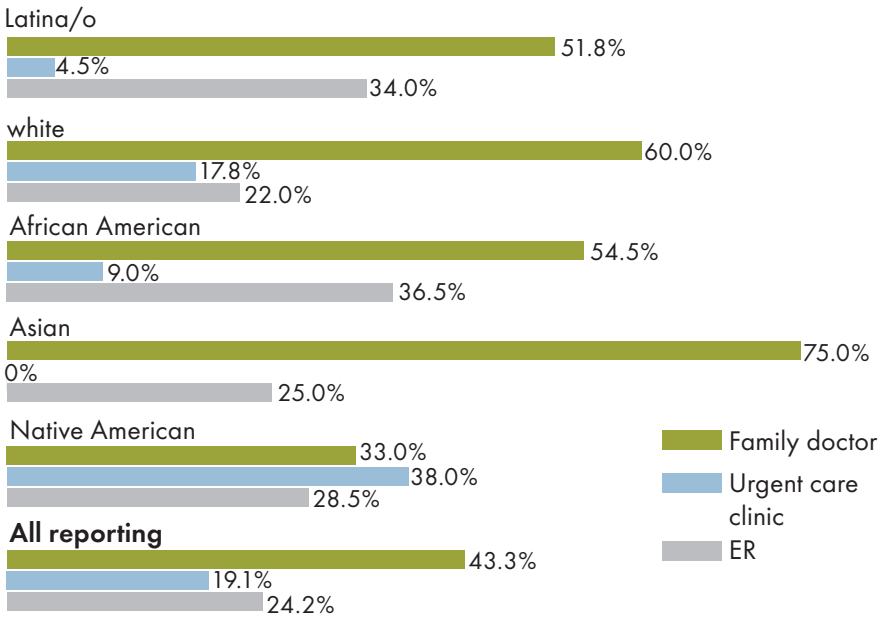
Although nearly 70 percent of survey respondents had never shopped for health insurance and were thus unfamiliar with the process, only 14.5 percent

were assisted by a health coverage guide; less than 3 percent used either a call center or an insurance broker, while nearly 40 percent got no help at all. Of the 186 respondents to questions about website utility, exactly half (93) did not use the enrollment website to apply. Of those who did, 44 percent felt that the website did not provide adequate information on the monthly premium, 46 percent were dissatisfied with the information on copayments and deductibles, 47 percent were dissatisfied with the information provided about the medical services covered by the plan, while 48 percent felt they did not have adequate information about the medications covered.

The lack of communication between the state's Medicaid enrollment apparatus and the exchange was also problematic. Without an adequate interface an applicant who is eligible for Medicaid but ends up going to the exchange can get lost in the system. The regularly occurring violation of the 45-day limit for issuing a decision on a Medicaid application, coupled with lost applications, inordinate waits at application offices, random terminations, and other barriers, led the New Mexico Center on Law and Poverty to file a lawsuit in May 2014 in federal district court. The judge suspended the New Mexico Human Services Department's automatic closure of cases and ordered the Department to resolve processing delays.

FROM INSURANCE COVERAGE TO HEALTH CARE

If you or a member of your family needed non-life threatening medical attention, where would you most likely go?



Responses show clear racial differences. While 43 percent of respondents reported visiting a family doctor for regular care, whites and Asians are significantly more likely to do so than are Native Americans or Latinos. Conversely, 36.5 percent of African Americans, 34 percent of Latinos, and 28.5 percent of Native Americans rely on an emergency room (ER) for primary care, in contrast to the still substantial 25 percent of Asians and 22 percent of whites.

Preventive services are, of course, key to keeping people healthy, but enrollees with co-payments and burdensome deductibles are unlikely to seek these services if they believe they will incur significant cost. The lack of knowledge about preventive care is further evidenced by the particularly low rates at which respondents indicated they would access preventive care services.

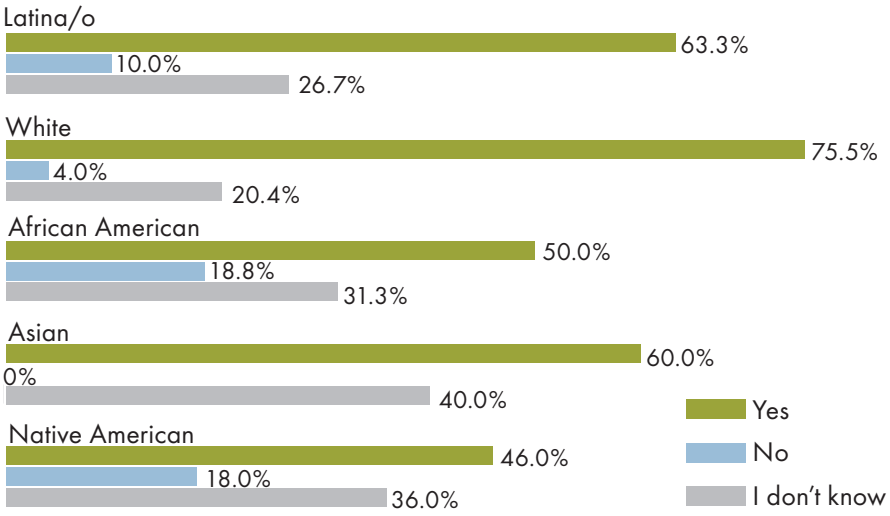
Provider can always provide services in my primary language.

	Latina/o	White	African American	Asian	Native American
Percent Yes	65.0	89.8	60.0	60.0	38.5

Language is as dominant an issue in the delivery of care as in enrollment, and studies have found that language is a significant component of cultural competence. Our survey results indicate that whites are served in their primary language at a rate 25 to 65 percentage points higher than people of color. Significantly, Native Americans get the lowest rate of service in their primary language. Language barriers not only lead to communicative misunderstandings; they cause misdiagnosis. Coupled with cultural bias, language difficulties can also lead to errors in prescriptive treatment.

Does the coverage you signed up for provide coverage for preventative care like well-child visits and annual check-ups?

By race



ACCESS TO CONTRACEPTIVES AND ABORTION CARE

The November 2013 election campaign marked an important victory in Reproductive Health and Rights for New Mexico's women and families. Defeating a ballot measure that proposed a 20 week cutoff on abortions in Albuquerque by a 10 point margin—55 percent to 45 percent, reproductive justice advocates pointed to grassroots organizing as a key factor in defeating the proposal. In 2011, 94 percent of New Mexico counties, home to 60 percent of New Mexico's women, had no health care facilities that performed abortions. In general, 46 percent women survey participants supported the provision of coverage for contraceptives or birth control, 19 percent did not, and 36 percent did not know. Fifty-two percent of women versus only 45 percent of men thought it was important to cover abortion care. When respondents were asked if they strongly agree, somewhat agree, somewhat disagree, strongly disagree, or have no opinion about whether women should be able to make their own decisions about abortion, in consultation with their family and doctor, **83 percent either strongly or somewhat agreed** while only 8 percent strongly or somewhat disagreed. Similarly, when asked if women should be able to make their own decisions about the use of contraception, in consultation with their family and doctor, **84 percent strongly or somewhat agreed while less than 5 percent disagreed**. Of 194 respondents to the question "Does the coverage you signed up for cover abortion care?" only 10 (5.15 percent) thought that it did and 129 respondents (66.49 percent) did not know.

Asked if women should be able to make their own decision about abortion, survey respondents replied:

Abortion is a woman's choice, no matter who you are. It is their choice to make and that's how it should be.

I don't believe in abortion personally but I don't think that I have the right to tell someone they can't have an abortion. If it is not an option then they don't have anywhere to go. This option should be there for people.

My insurance plan has no abortion coverage and explicitly says that. Abortions are really expensive and being more open about abortions as a healthcare need is very important. There is sometimes coverage in cases of rape or incest but only with some insurance companies. There's a couple of places nearby to here including Planned Parenthood, UNM Reproductive Health. They are pretty accessible for people that live in Albuquerque. The biggest issue is paying and the counseling that comes with it. It takes courage to go to those places.

Everybody has their own rights, so women should have their own choice as well.

Personally I have no experience. However, if someone wants it, it shouldn't be a barrier for them. It really depends on the person.

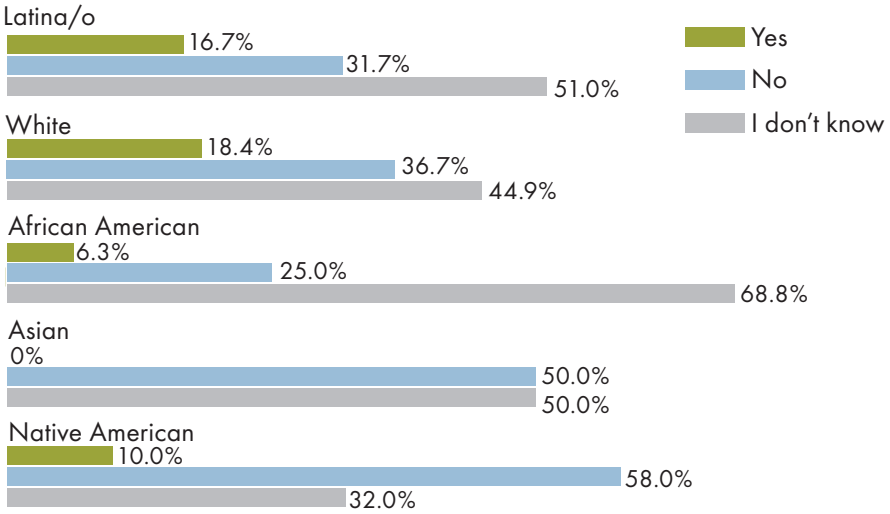
Which preventative care services is your family likely to access in the next 12 months?

	Percent
Annual physicals	24.6
Annual cancer screenings	1.0
Annual dental care	7.7
Well-baby/well-child visits	5.6
None	11.8
Physicals + cancer screenings	4.1
Physicals + dental care	15.4

Among the most significant aspects of the ACA is the *requirement* that health plans cover preventive care *without any cost-sharing or co-pay and regardless of whether a deductible has been met (*ACA § 2313(a), 42 U.S.C. 300gg-13). Nonetheless, as these figures show, signifcant numbers of new enrollees do not know whether their coverage includes preventive services or believe that these services are *not* covered. Preventive services are, of course, key to keeping people healthy, but enrollees with co-payments and

burdensome deductibles are unlikely to seek these services if they believe they will incur significant cost. The lack of knowledge about preventive care is further evidenced by the particularly low rates at which respondents indicated they would access preventive care services. Only a quarter (24.6 percent) said that they would seek an annual physical. Physicals were the top response followed by physicals and dental care at 15.4 percent. These responses demonstrate a significant gap between coverage and care. Misunderstanding about the benefits that every health plan must offer are a dimension of network accountability that should be clarified and regularly reiterated in accessible language.

Does the coverage you signed up for provide coverage for holistic health care options like massage, chiropractic, or acupuncture? By race



An examination of holistic health coverage by race reveals that Native Americans, Asian-Pacific Islanders, and African Americans are less likely to be covered than whites or Latinos. Almost half of survey respondents (49 percent) did not know whether they were covered for holistic care. Some responses when asked if holistic health coverage was important are cited below:

Children need traditional medicine but it's not covered. Would be great if massage and acupuncture were covered as most of the time it is NOT covered.

I believe it has a great impact on my health…

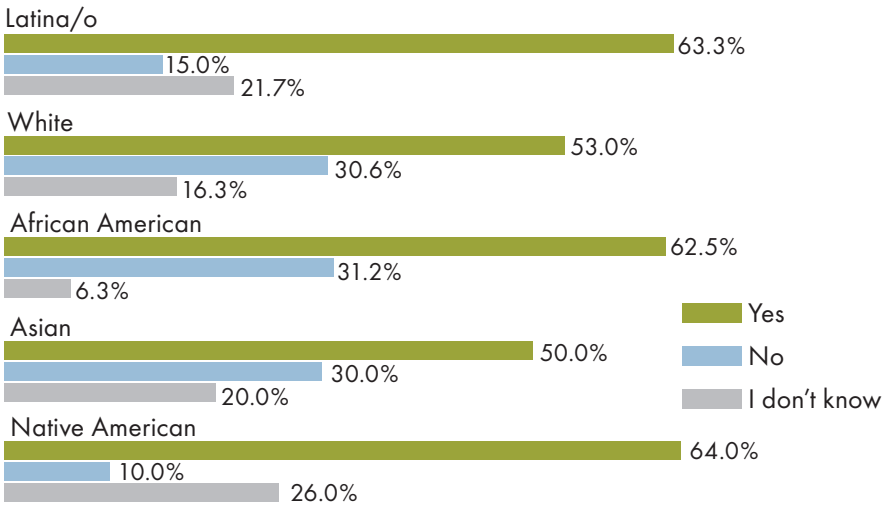
Massage helped with depression and to get through a tough couple of weeks. This in turn contributed to my overall wellbeing not just the physical. It made me feel more assertive.

Holistic healthcare is important in helping people to deal with stress. This can lead to more serious things like diabetes and heart health. I think this would be helpful for a lot of people.

The use of traditional medicine (sweat lodge) is a high priority for me.

Acupuncture is important – it's able to kill pain in my arms, shoulder, and hand.

Does the coverage you signed up for include dental care? By race



Over 60 percent of Latino, African American, and Native American survey respondents have dental insurance, compared with approximately half for whites and Asians. Significantly, 18 percent of respondents of color and 16.3 percent of whites did not know if their coverage included dental care.

Costs

The monthly insurance premium is either very important or somewhat important to over 81 percent of survey respondents, with some variations by race.

How important was the monthly health insurance premium?

Race/Ethnicity	Percent who responded "very" or "somewhat"
Latina/o	86.4
white	87.5
African American	64.3
Native American	72.3
Asian Pacific Islander	80.0
Total	**81.7**

Survey respondents' comments on costs raised several dimensions of unaffordability: premiums, deductibles, and prescription drugs. Below is a small sample of replies to an open-ended inquiry about health care costs in New Mexico:

Affordable? I have to pay a deductible with one of my doctors. My budget is not very good. Sometimes I didn't know how to pay.

There were about 10 plans with Molina-Blue Cross Blue Shield what we qualified for on healthcare.gov; they are based on your income. They don't take into account the bills that we pay, medical bills and what we can really afford; our "real" income. We ended up picking a plan that we couldn't afford but we were like "we've got to afford it". We had to put off getting some of my husband's medication so we could pay the insurance. He would be off of his

In 2014, the second lowest-cost individual silver plan, with subsidies, cost a New Mexico resident an average of $194 per month. While this amount is on par with premium costs nationally, New Mexico is the second poorest state in the country, with an overall poverty rate of almost 22 percent and one in ten residents in "deep poverty," living at less than 50 percent of the federal poverty level.

medication until we were able to pay the insurance and what money we had left we would use for his medication. The plans didn't give you the option to downgrade to another plan you maybe could afford.

The plan noted that we had to pay a certain percentage for the deductible, but we don't know what the deductible is going to be. We have to pay a certain amount before the insurance plan even kicks in. Some of the plans were just ludicrous. We had to pick a plan that covered a lot of my prescriptions. We had to know how much it is to see the doctor. Different doctors charge different amounts to use their services so I don't know what I am going to be paying. Now we, and others, are not able to go to the doctor to get preventative healthcare because we haven't been able to pay our bill.

Sometimes it's deciding between medication and food. I can get food in other ways – like go to the food pantry. But if my care and medication is not covered in my plan I have to figure out how to pay the bill. My life insurance got cancelled. I have bad credit because of my medical bills. If Medicaid won't pay for it we can't access healthcare.

I have been told that I will be receiving a $348 bill for medical supplies. I don't know how to pay for this bill and still be able to pay my lights and utilities. I only get $267 a month from my pension.

We have insurance but it is still very expensive because of the administrative fees. Billing process for MRIs, blood tests and x-rays are contracted out and billing is processed separately. It is especially expensive to get an MRI or x-ray. Many of these tests are urgent and needed.

In 2014, the second lowest-cost individual silver plan, with subsidies, cost a New Mexico resident an average of $194 per month. While this amount is on par with premium costs nationally, New Mexico is the second poorest state in the country, with an overall poverty rate of almost 22 percent and one in ten residents in "deep poverty," living at less than 50 percent of the federal poverty level. The cost of health insurance is fundamental to access. As one advocate observed, "Medicaid expansion has been a wonderful thing for NM. But on the whole, affordable healthcare really isn't affordable. When folks started doing enrolling and seeing the cost, many felt that they were out of reach. Added to the basic expenses, out of pocket costs add to both the unaffordability … and the uncertainty."[14]

SUMMARY OF FINDINGS

Racial Disparities in Enrollment: Though whites make up less than 40 percent of New Mexico's population and Latinos nearly half of the state's population, whites account for 60 percent of those enrolled and Latinos only 31.4 percent of enrollees. Native American enrollment is also well below what would be proportional. These outcomes are built, at least in part, on three factors:

1. **Insufficient Targeted Outreach:** Survey responses showed that while only 30 percent of respondents had ever shopped for health insurance before, only 15 percent received assistance from a Health Coverage Guide. As advocate interviews indicate, lack of resources (especially in communities whose first language

was neither English nor Spanish) combined with the difficulties in conducting outreach in hard-to-reach rural areas hindered outreach efforts.

2. **Lack of Internet Access:** Both survey respondents and advocates mentioned lack of Internet access, particularly in rural areas; only a third of survey respondents (34.5 percent) said they compared plans on the New Mexico Health Insurance Exchange; half of respondents did not use the website to apply. These issues of access were compounded by general website difficulties and particular failures on the Spanish language website.

3. **Legal, Language, and Cultural Barriers:** While Spanish language outreach may not have been an overwhelming barrier, the combination of language, fear of legal reprisals for mixed status families, and lack of familiarity with culturally-specific insurance and medical terms combined to form a formidable barrier to enrollment.

Racial Disparities in Access: Of our survey respondents, 36.5 percent of African Americans, 34 percent of Latinos, and 28.5 percent of Native Americans relied on the ER for primary care, in contrast to 25 percent of Asians and 22 percent of whites. Native Americans had the lowest rate of service in their primary language, while whites were served in their primary language at a rate 34 percentage points higher than people of color.

Costs: The survey question that elicited the most open responses was the cost of insurance premiums, co-pays, and medication. In general, respondents felt that choices were insufficient to make their health access truly "affordable."

RECOMMENDATIONS FOR IMPROVEMENT

Both survey respondents and advocates articulated ideas for improvements to both the enrollment process and access to quality care. These recommendations, combined with relevant recommendations from the Alliance for a Just Society's national report, are listed below.

I. SAFEGUARDING ACCESS TO HEALTH INSURANCE

Enhance and expand language access. Advocates noted "real language and cultural barriers in the Native American and Hispanic community" and a failure to "use culturally appropriate approaches." Asian-Pacific Islanders and Latinos have uninsured rates that are significantly higher than whites, and culturally appropriate language access is still not an everyday reality. Complete multilingual application materials and website access are still not readily available. To address these issues, the state should: establish a right to enroll in the enrollee's primary language; require plans to give enrollees notice of their right to language services, as California does (Cal. Code Regs. tit. 10 § 2538.3); regularly assess plans' compliance with language access requirements, as New York mandates (N.Y. Pub. Health Law § 4403); and expand its pool of interpreters. The state should also require plans to

continually update information about which providers are in their networks, and provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties.

Improve the Medicaid enrollment system. Numerous advocates reported problems with Medicaid enrollment. Said one, "The separation between the Exchange and Medicaid process is problematic. This should be about getting people covered. They need a 'no wrong door' approach. We could do more around Medicaid expansion, especially with our population who are overwhelmingly eligible for Medicaid."[15] The state should automatically enroll in Medicaid people who already receive need-based benefits like SNAP (food stamps), Supplemental Security Income (SSI), WIC, or free or reduced-price school meals, as well as people released from incarceration with no immediate source of income or assets.

Personalize and localize the insurance-shopping experience. Given the general lack of Internet access in poor and rural communities and the problems of long lines and significant wait times at public enrollment centers, trust between potential enrollees and those assisting them is critical. The New Mexico Health Insurance Exchange should a) take the suggestion of Health Access New Mexico to develop locally staffed regional technical assistance centers charged with enrollment in both Medicaid and the ACA; b) increase access to in-person assistance outside of hospitals and clinics and beyond standard hours of 9 to 5 Monday through Friday (New Mexico Center on Law and Poverty and Southwest Women's Law Center) [16]; and c) simplify print and electronic descriptions of plans and benefits, making cost information transparent and communicating information about deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network to allow for easy comparisons of different plans.

Reduce premium costs. The biggest barrier to continuous coverage for our survey respondents was the cost of insurance. The state of New Mexico should authorize and fund an independent external study (not conducted by insurance companies) to assess ways to lower premium costs for the plans most selected by low-income enrollees.

Require faster decisions on applications. Besides cost, the biggest complaint survey respondents articulated about the enrollment process was the amount of time it took for an application to be approved. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

II. MOVING CONSUMERS FROM COVERAGE TO CARE

I feel like I am left behind, because (there are) not enough doctors for the patients that come in for mental health. I get scheduled so far out—not until the end of the year.

Expand and extend the role of health guides. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with either the medical system or the insurance system and may need to be introduced and acclimated. As advocate Jordon Johnson of Place Matters in Gallup, New Mexico points out,

"People need to have an understanding around the need for regular check ups and monitoring your health. We need to expand this educational work."[17] Navigators are in an ideal position to perform this role. The state should extend the role of health guides to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. The New Mexico Health Insurance Exchange should enforce ACA statutory provisions that require insurers to act to reduce racial disparities. The exchange should continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes, and impose penalties, including exclusion from exchanges, on insurers that do not succeed in reducing disparities within required timeframes.

Require plans to adopt geographic access standards. When asked about ways to improve health access in New Mexico, one survey respondent replied, "*More specialists in rural communities, especially spinal cord, eye doctors, and classes. More dental coverage in rural communities as well.*" The New Mexico Health Insurance Exchange should adopt geographic access standards ensuring that, for at least 90 percent of enrollees, primary care providers are available within 10 miles or 30 minutes average driving or public transit time and specialists within 45 miles or one hour, whichever is less, as New Jersey does (N.J. Admin. Code § 11:24A–4.10). Vermont imposes similar requirements. Enrollees who live farther from providers should be offered free transportation.

Access during non-working hours. The New Mexico Health Insurance Exchange should require plans to include in their networks primary care providers that offer appointments during non-standard hours (e.g., California, Cal. Code Regs. tit. 10 § 2240.1), to meet the needs of low-income workers who, because their employers do not offer sick leave, must seek treatment outside of work hours.

Standardize introductory care. Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests and other preventive care within 60 days of enrollment. Expand and standardize preventive services, ensuring that non-grandfathered plans offer services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost,* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Enforce the ACA-mandated women's right to no-cost "well-woman preventive" care by ensuring that all plans available through the marketplace include reproductive health care services, including all FDA-approved forms of contraception.

Assess and publicize outcomes. Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation, and publish results annually.

III. BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Expand medical-legal partnerships, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness in low-income communities (e.g., mold in housing, utility service terminations, domestic violence) and work jointly to remove the barriers. While effective, there are a relatively small number of these programs nationally. Expanding this infrastructure, especially in rural areas, would strengthen a holistic approach to prevention and general wellness.

Invest in innovative treatment options. Seek funds from HHS' Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities, to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

Align incentives to address social determinants of health. Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. New Mexico is a state with more than 20 percent of its residents living in poverty. Insurance is one step toward better health but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health – particularly in poor rural communities.

ENDNOTES

1. Young, Jeffrey, "New Mexico Medicaid Expansion Will Move Forward, Republican Gov. Susana Martinez Announces," Huffington Post, January 9, 2013, accessed at: http://www.huffingtonpost.com/2013/01/09/new-mexico-medicaid-expansion_n_2442640.html

2. "How Will the Medicaid Expansion Benefit New Mexico?" American College of Physicians New Mexico Chapter, accessed at: http://www.acponline.org/about_acp/chapters/nm/medicaid.pdf

3. Interview with AJS staff, July 2014.

4. Interview with AJS staff, July 2014.

5. Interview with AJS staff, August 2014.

6. Interview with AJS staff, July 2014.

7. Interview with AJS staff, July 2014.

8. Interview with AJS staff, July 2014.

9. Interview with AJS staff, August 2014.

10. Interview with AJS staff, August 2014.

11. Interview with AJS staff, July 2014.

12. "Healthcare Coverage Under the Affordable Care Act: A Preliminary Report on Enrollment Barriers in New Mexico," New Mexico Center on Law and Poverty & Southwest Women's Law Center, June 2014, accessed at: http://nmpovertylaw.org/WP-nmclp/wordpress/WP-nmclp/wordpress/wp-content/uploads/2014/06/Report-on-Healthcare-Enrollment-Barriers-2014-06-16.pdf

13. Interview with AJS staff, July 2014.

14. Interview with AJS staff, August 2014.

15. Interview with AJS staff, July 2014.

16. Op. cit. "A Preliminary Report on Enrollment Barriers in New Mexico"

17. Interview with AJS staff, August 2014.

The NM Breaking Barriers Report on the state of healthcare in New Mexico was jointly developed by Strong Families New Mexico and the Alliance for a Just Society. Research and data partners for the report include Robert Wood Johnson Foundation Center for Health Policy at UNM and the Kaiser Family Foundation (KFF). The report uses original research from nearly 200 healthcare surveys, 16 in person interviews, as well as data provided by healthcare.gov and the Centers for Medicaid and Medicare Services (CMS).

New Mexico Health Care Partner Organizations

- Equality New Mexico
- Health Action New Mexico
- Native American Voters Alliance
- NM Asian Family Center
- Southwest Women's Law Center
- Tewa Women United
- UNM Community Engagement Center