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F I S C A L I M P A C T R E P O R T

SPONSOR: Aragon DATE TYPED: 2/24/03 HB

SHORT TITLE: Health Security Act SB 505

ANALYST: Dunbar

APPROPRIATION

Appropriation Contained		Estimated Additional Impact		Recurring or Non-Rec	Fund Affected
FY03	**FY04**	**FY03**	**FY04**		
			Significant See Narrative		

(Parenthesis ( ) Indicate Expenditure Decreases)

REVENUE

Estimated Revenue		Subsequent Years Impact	Recurring or Non-Rec	Fund Affected
FY03	**FY04**			
		(30,000.0)	Recurring	General Fund

(Parenthesis ( ) Indicate Revenue Decreases)

Duplicates HB 498

Relates to Appropriation in the General Appropriation Act

SOURCES OF INFORMATION

Responses Received From

Department of Health (DOH)
Health Policy Commission (HPC)
Human Services Department (HSD)
Children Youth and Families Department (CYFD)
Attorney General (AG)
New Mexico Public Schools Insurance Authority (NMPSIA)
Public Regulation Commission (PRC)
New Mexico Retiree Health Care Authority (NMRHCA)
General Services Department (GSD)

SUMMARY

Synopsis of Bill

Senate Bill 505 proposes the development of a statewide health care plan at a level of benefits mirroring the current state employees plan. Financing options are to be developed by the LFC, working with the Superintendent of Insurance. The LFC report on financing options is to be provided to the legislature by December 15, 2003. There are transitional steps for bringing in employees covered by private employers or collectively bargained plans. Public employees will be part of the plan on the date the health plan becomes effective.

The first meeting of the nominating committee will be held on or before June 15, 2004, with names of candidates to the governor no later than September 15, 2004. Committee members will use Department of Health staff. The chief executive officer will be responsible for administering the provisions of the Health Security Act.

Significant Issues

The information below summarizes the specific sections of the bill. Each section is followed by Comments and/or Technical Issues related to the section.

Section 2: explains that the purpose of the Act is to ensure coverage for all New Mexicans with a combination of public and private financing and to contain health care costs.

Section 3: delineates several definitions for use in the Act.

Comments and Technical Issues

Definitions are needed for "coalition" as used on p. 3 line 8, and "Consortia" as used in a similar context at p. 29, line 15. Are these words with truly different meanings or connotations?

Section 3, Part L (p 4) does not include all potential health care delivery organizations that could be covered under SB 505. For example, home care agencies are not facilities, but are an integral part of the delivery system of health care. Also the definition may want to enumerate specifically what is meant by outpatient facility, which might include a diagnostic and treatment center, ambulatory surgery center, alcohol and detoxification centers and other categories of licensure as defined by the DOH regulations.

Section 3, Part M (p 4) defines health plan, but does not include the word "insurance" anywhere in the definition. HPC assumes that the State of New Mexico is at risk for the provision and coverage of benefits, has exclusions, has defined who is and is not covered, how payments are made, ERISA coordination, waivers, how fraud is defined, etc. Therefore, the plan would likely be viewed as insurance.

Section 3, Part O (p 4) may want to define "operating budget" to be provided on an accrual basis of accounting, and would include a line item for facility depreciation.

Section 3,Part S (p 5) defines transportation services as "equipped with health care supplies and equipment." There are providers of medical transportation under the current Salud program that do not have medical supplies and equipment in the vehicle, but these providers do transport individuals for medical services.

Sections 4-10: The Health Care Commission:

- SB 505 forms the Health Care Commission to create the health care insurance coverage program. A health care nominating committee is created to make recommendations by September 15, 2004 to the Governor who will then make appointments to the Health Care Commission. The Governor is required to appoint the initial members of the Commission by November 15, 2004.
- Until the Commission is appointed, staff from the Department of Health shall assist the nominating committee.
- The 15 members of the commission are to include at least 10 members representing non-specific consumer interests, and 5 representing health care providers or facilities to represent different areas of the state.
- No Commission member can be appointed if he or she has a controlling interest in a healthcare provider or health insurer or vote on issues where he has a financial interest, with the exception of members representing health care facilities or providers.

Comments and Technical Issues

Section7, Part A (p 11) is silent whether a director or board member of an entity providing health care or health insurance could be a commission member. HB498 language notes "officer of or has a controlling interest."

Section 11: Commission staff and responsibilities include:

- The Commission is to adopt a five-year plan to implement the Health Care Act, develop an educational program about the plan, and adopt as provisions of the plan methods to provide quality health care to all New Mexicans. This should include emphasis on preventive and primary care, provision of rural health care, in-home and community based alternatives to institutional care and case management services.
- Other directives for the Commission include the development of compensation methods, health plan budgets, capital budget for health facilities, a data collection system, establishment of an efficient health care delivery system and methods to evaluate the quality of health care delivered by the system.
- The Commission is to study and evaluate the cost of health care provider professional liability and liability insurance and is to establish and improve changes in coverage benefits and benefit standards.

Comments and Technical Issues

The Health Policy Commission (HPC) responsibilities under the HPC statute and Health Information System Act are, in part, either supplanted or duplicative to the responsibilities of the Health Care Commission. The bill does not acknowledge where or how the new Commission will receive its data; for example existing rules give the HPC the authority to collect capital assets data from hospitals and health facilities. Should this legislation pass, existing statutes may need to be amended or repealed.

Section 12 – 13: Commission's Authority and Advisory Boards

- Provisions are made to furnish the Commission with the necessary authority to carry out all duties related to the Health Care Act, including, approval of budgets and approving and making changes in the State health plan.
- The Commission is to establish a Health Care Provider Advisory Board and a Health Care Facility Advisory Board to provide expertise and knowledge to the Commission.

Section 14- 15: Health Care Delivery Regions and Regional Councils

- The Commission is to establish health care delivery regions, which may be assigned different fee scheduling or expenditure allocation designed to tailor and improve health care delivery for each region.
- The Commission is also to establish regional councils to report to and inform the commission.

Section 16: Rulemaking

- The Commission is to adopt rules necessary to carry out its duties and the provisions of the Health Care Act. Provisions are made for a public hearing for any adoption, amendment or repeal of rules.

Section 17-19: The Health Plan

- The health plan is to specify covered services and benefits. Categories of benefits the plan must include and benefits the plan may not include are listed.
- There are provisions for caps on administrative costs, the gradual phase in of beneficiaries, and the review of the five-year plan and other short and long term plans by the commission and regional councils.

Comments and Technical Issue

There exists confusion and a possible contradiction between the time provisions for getting long term care coverage functioning and operational, as found in Section 17 at p. 26 lines 11-14, and as found in Section 18 (p.26) line 20.

Sections 18 and 19 of the bill furnish descriptions of the specific long-term care and mental health services to be included in the health plan, provisions for service coordination and case management and the formation of a Long-term Care Committee and a Mental Health Services Committee to develop a plan to integrate these services into the State health plan. Mental health care is to be included in the inception of the plan and long- term care and dental care at the earliest time possible based on planning and budget constraints.

Section 20: Medicaid

- There should be agreements between the Commission and HSD, and other departments to provide for certain Medicaid services to be covered and administered by the Commission.

Comments and Technical Issues

Section 20 (p. 28) of the bill provides that the Commission "may enter into appropriate agreements with the Human Services Department … [to] provide for certain services provided pursuant to the Medicaid program to be administered by the commission to implement the health plan. " This could result in the Commission becoming the major Medicaid administrator, necessitating a change in the Medical Assistance Division's designation as the *single state agency.*

Medicaid claims are paid through a federally certified Medicaid Management Information System (MMIS). Enhanced federal funding at 75% is available for the MMIS. This needs to be considered when determining how the claims will be paid.

Section 21-24: Eligibility for Benefits

- Individuals physically present in New Mexico for one year prior to the date of application are eligible for the plan. Otherwise ineligible individuals working in the state that came to the state because of offered employment could gain eligibility by paying a required premium.
- Those not to be brought into the plan are federal retirees, active duty military and those covered by federal health plans. There are provisions for retirees to switch from their employee sponsored health plan to the State health plan.
- Indian Health Service recipients are not brought into the plan except through agreement with individual tribes, consortia of tribes, or a federal IHS agency subject to approval by the tribes in that agency.
- Provision is made by rule for non-residents employed in the state to participate in the plan.
- Provisions are made for the purchase of coverage and assessment of fees by educational institutions for non-resident students.
- Provision is made for eligibility cards for beneficiaries and liabilities for misuse of the cards.

Comments and Technical Issues

Definitions are needed for "coalition" as used on p. 3 line 8, and "Consortia" as used in a similar context at p. 29, line 15. Are these words with truly different meanings or connotations?

Section 21C (p29) addresses incompletely the coverage of IHS beneficiaries since a significant portion of such persons are already Medicaid enrollees.

Section 25: Primary Care Provider

- The beneficiary has the right to choose a primary care provider. Stipulations are made for the assigning of a provider if one is not chosen by the health plan member, for responsibilities of the provider to the beneficiary, rules of referral, change of provider and selection of a specialist as a primary care provider.

Sections 26 - 29:Discrimination, Claims Review, Monitoring Providers and Facility Practices and Dispute Resolutions

- There are provisions against discrimination by providers and facilities. The Commission is to adopt a comprehensive claims review program and rules to implement a continuous quality improvement program, and is to establish procedures for dispute resolution.

Comments and Technical Issues

Section 28 (p 35) of the bill would establish health care monitoring programs to oversee providers. This could duplicate DOH's statutory responsibility to monitor health facilities and community providers.

Page 36, Paragraph #, line 22. "Administrative penalties shall be deposited in the current school fund". The meaning of "current school fund" is unclear.

Section 30: Health Plan Budget

- The Health Care Commission has the responsibility to develop an annual health plan budget for the approval of the State Legislature.

Sections 31-32: Payments to Health Care Providers and Facilities:

- The Commission is to prepare budgets and negotiate payments with health care providers and facilities. There are provisions for caps on the budgets, different and supplemental payment rates, co-payment schedules, and dispute resolutions when there is lack of agreement between the Commission and a provider or facility.

Sections 33 - 37: Health Resource Certificate, Audits, Standard Claims Forms, Computerized System, Reports

- A health resource certificate is required for capital expenditures, and other acquirements of capital projects, with some specified exceptions. The Commission is to report to the Legislature on capital needs of health facilities and geographic barriers by January 1, 2008.
- The Commission is to provide for an annual independent actuarial review of the health plan and of any funds of the Commission or of the plan.
- The Commission is to adopt standard claims forms for all providers and facilities.
- All health care providers and facilities are to participate in the health plan's computer network, which will provide for payment transfer, billing data and the transfer of other data and information.
- The Commission is to require reports by all health care providers and facilities of information enabling the commission to evaluate the health plan.

Comments and Technical Issues

DOH states that the "health resource certificate" procedure likewise is a potentially costly process that could generate significant additional administrative and litigation costs.

The provisions for "Standard claims forms" in Section 35 (p 44) or computer systems in Section 36 (p 45) does not specify that the Commission *must* comply with the federal HIPAA rule on Transactions and Code sets.

Sections 38-39: Consumer and Provider Assistance Program, Miscellaneous Reimbursements:

- The Commission is to establish a consumer and provider assistance program to take complaints and provide assistance.
- Provisions are made for payments for out of state services and determinations of liability for payment by third parties.

Sections 40 – 43: Insurance

- After the implementation of the plan no private insurance is to be provided to a beneficiary for any service covered by the plan, except for retiree insurance plans not entering into agreements with the health plan. Nothing in the act is to affect coverage pursuant to the federal Employee Retirement Income Security Act of 1974 (ERISA).
- The Commission, in conjunction with HSD, is to apply for any waivers necessary to enable the State to utilize federal payments for the health plan, negotiate with employers offering health coverage regarding the deposit of their contributions into the health plan, and is to seek an amendment to ERISA to exempt New Mexicans from any part of the act pertaining to health care. The Commission is also to seek payment to the health plan from Medicaid, Medicare or any other federal or other insurance plan for any reimbursable payment provided under the plan.
- No person included by this bill in the health plan is to insure himself or his employees after January 1, 2006.
- The Superintendent of the Division of Insurance (DOI) should work with the LFC to identify premium costs and shall lower insurance premiums as soon as the health plan is implemented.

Comments and Technical Issues

DOH points out that the authority granted to the superintendent of insurance in Section 43 B (p51) to unilaterally "lower insurance premiums associated with medical benefits on all types of insurance policies." – without going through the usual procedures for establishing rules governing the regulation of insurance – is possibly unconstitutional.

Section 44: Financing the Health Plan

- The Legislative Finance Committee (LFC) is to determine financing options for the plan.
- Benefits considered when determining these financing options will be no less than the benefit package offered State employees.
- Options may include minimum and maximum levels of premium payments, sliding scale premium payments, Medicare payments and employer contributions and shall include a system for reasonable co-payments, except for preventive care.
- A report will be submitted by the LFC to the Legislature of recommendations and options no later than December 15, 2003.

Comments and Technical Issues

DOH notes that a mechanism needs to be created to integrate federal and state categorical health program funding with the benefits of the Plan.

DOH notes that SB 505 does not fully describe how revenues sufficient for supporting proposed benefits will derived. The department states that the bill does not fully address how the State Health Plan will be integrated with other State and Federal program payments to health care providers and health facilities.

Section 45: Temporary Provisions

- On the date the health plan is implemented, those individuals receiving health care benefits under a private contract or collective bargaining agreement prior to January 1, 2006 will receive them until the contract expires or is renegotiated to provide participation in the State health plan.
- Any individual covered by a health care services plan with premiums paid for in any part by public money, "including money from the State, a political subdivision, State educational institution, public school or other entity that receives public money to pay health insurance premiums" will be covered by the health plan upon its implementation.

Section 46: Effective Dates

- Sections 43-44 are effective July 1, 2003.
- Sections 1-42 and 45 are effective June 1, 2004.

FISCAL IMPLICATIONS

The bill does not contain an appropriation.

Financing options are to be developed by the LFC, working with the Superintendent of Insurance. The legislation proposes that the LFC determine in FY 04 financing options to include:

- The cost of the plan
- Individual premiums and employer contribution
- Public Funds
- Payment Process

Expertise in the field is required to conduct the study. Therefore, the LFC would need to bid a contract for this study at an estimated cost of $250.0 to $300.0. Previous studies have had a price tag of $200.0. Another option would be to have staff members from other state agencies assist the LFC in conducting the study.

In the next fiscal year, the Health Care Commission would develop and submit to the legislature a health plan budget that would be the total amount to be spent by the plan for covered health care services. The budget would be established within projected annual revenues.

A study done for the HPC by the Lewin Group in 1996, involving only public health sector spending, showed the State would receive greater value for what it spent on health care by consolidating the purchase of health services programs to maximize purchasing power through the creation of a larger risk pool, and elimination of duplicative administrative costs associated with separate purchasing. If the plan had been adopted as suggested by the Lewin Group for State employees, retired employees, Medicaid and the Health Insurance Alliance, it was estimated that the State would have reduce health care spending by $108 million over five years, with an esti-

mated direct saving to the State of $50 million for that period.

A study done by the Lewin Group in 1994 showed even greater savings when considering both the public sector health spending and private sector participation. In that study, the State of New Mexico would have saved in health care costs by the year 2002 a total of $2.3 billion if a Single Payer Plan would have been implemented in 1997. Lewin indicated that the savings would have doubled by the year 2004 to $4.6 billion dollars.

The effect of this legislation on some state agencies is described below. However, there are no actual dollar savings to the general fund since the revenue will be placed into a "pool" to be use in the Health Plan budget.

- The benefits budget of the New Mexico Public Schools Insurance Authority would be significantly reduced, from $199 million to less than $10 million. The $10 million will be used for life insurance or other similar policies.

- The group health budget of Risk Management Division in GSD would be significantly reduced from the approximately $150 million to less than $10 million. The $10 million will be used for life insurance or other similar policies.

- The PRC collects over $30 million in premium taxes and fees associated with the regulation of private medical insurance. Approximately $500.0 to $1 million of general fund appropriation supports the regulation of this industry. It is estimated that beginning in FY 06, general fund revenues would be reduced approximately $30 million due to the elimination of this industry. (Reflected in Revenue Table)

- The NMRHCA projects a fund balance of at the end of FY06 of $113,989.5; at the end of FY07, $113,860.2; at the end of FY08, $112,619.7. SB 505 does not address what would become of this fund, which contains contributions from participating employers and employees of those participating employers (as well as contributions from retirees, Taxation & Revenue Suspense Fund, and investment income) in trust for their future benefit.

ADMINISTRATIVE IMPLICATIONS

SB 505 would have some immediate administrative impact upon the Department of Health. The Department of Health is directed to staff the initial Health Care Commission Membership Nominating Committee.

After implementation, the PRC's Insurance Division will no longer need to regulate comprehensive major medical insurance or managed care plans. Fewer personnel will be needed in this division.

The AG believes that because of the fundamental and comprehensive change proposed by the bill, legal challenges from those with a vested interest in the existing health care financing and delivery systems should be expected. The staggered effective dates of the bill creates the opportunity to discuss points of conflict with the stakeholders of the existing system, but it is not possible to predict the precise legal challenges that might be brought as the result of unsuccessful discussion with stakeholders nor the ultimate judicial outcomes. Much of the policy success of the proposal will be determined by the willingness of the federal government to grant waivers

permitting federal health care financing dollars to be used in the New Mexico program, and the willingness of corporate employers to cooperate and support the program.

OTHER SUBSTANTIVE ISSUES

At least 60% of all health care spending in New Mexico now comes from public monies in the form of Medicaid and Medicare, health insurance for employees and retirees of Federal, State, municipalities, teachers, Federal and State contractors, and tax deductions for employer insurance. The rationale behind placing most New Mexicans in a single public insurance plan is to simplify the multiple public components of health insurance coverage, and to realize the significant cost savings that could result from the elimination of duplicative administration.

HPC notes that:

- The last seven years have seen significant progress in reducing the number of uninsured citizens in New Mexico. The percentage of people not insured has dropped from 25.6% of the New Mexico population in 1995 to 20.7% in 2001. Despite this progress, New Mexico remains the state with the highest percent of people without health insurance. (*Quick Facts, 2003*-NMHPC).

- According to the US Census Current Population Survey of March 2000, as reported in *HPC Quick Facts, 2001*, affordability is the primary reason cited for lack of insurance coverage. New Mexicans without health insurance coverage do not generally receive the benefits of medical care for treatable or chronic illnesses.

- According to the HPC 2000 Employer Survey, 58% of NM establishments offer health insurance, and that number drops to 52% outside of the Albuquerque MSA area. The current study found that NM workers contribute a higher percentage of their income to health insurance premiums than the national average.

- Health insurance premiums nationally rose an average of 11% last year, and are expected to rise another 13% this year, after several years of very modest growth.

BD/njw