SENATE BILL 225

48TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2008

INTRODUCED BY

Dede Feldman

AN ACT

RELATING TO HEALTH CARE REFORM; ENACTING THE HEALTH CARE AUTHORITY ACT; CREATING THE HEALTH CARE AUTHORITY; PROVIDING FOR POWERS AND DUTIES; REPEALING AND ENACTING SECTIONS OF THE NMSA 1978; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. SHORT TITLE.--This act may be cited as the "Health Care Authority Act".

Section 2. DEFINITIONS.--As used in the Health Care Authority Act:

A. "authority" means the health care authority;

B. "board" means the board of directors of the authority;

C. "health care services" means any services by a licensed provider included in the furnishing to any individual of medical, mental, dental, pharmaceutical or optometric care or hospitalization or nursing home care or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human physical or mental illness or injury;

D. "health coverage" means any system to finance health care services;

E. "health insurance" means any hospital or medical expense-incurred policy; nonprofit health care plan service contract or coverage of services; health maintenance organization subscriber contract or coverage of services; short-term, accident, fixed indemnity, specified disease policy or disability income insurance contracts and limited health benefit or credit health insurance; coverage for health care services under uninsured arrangements of group or group-type coverages, including employer self-insured, cost-plus or other benefits methodologies not involving insurance or not subject to New Mexico premium taxes; coverage for health care services under group-type contracts that are not available to the general public and can be obtained only because of connection with a particular organization or group; coverage by medicare or other governmental programs providing health care services; but "health insurance" does not include insurance issued pursuant to provisions of the Workers' Compensation Act or similar law, automobile medical payment insurance or provisions by which benefits are payable with or without regard to fault and are required by law to be contained in any liability insurance policy;

F. "health insurer" means a person duly authorized in the state pursuant to the New Mexico Insurance Code to transact the business of health insurance; and

G. "superintendent" means the superintendent of insurance or the superintendent's designee.

Section 3. HEALTH CARE AUTHORITY CREATED--MEMBERSHIP.--

A. The "health care authority" is created and is an adjunct agency within the meaning of the Executive Reorganization Act.

B. The board shall consist of eleven members, at least one of whom shall be a Native American, selected as follows:

(1) two members from each of the five public regulation commission districts:

(a) five of whom shall be appointed by the governor and subject to senate confirmation; and

(b) five of whom shall be appointed by the New Mexico legislative council; and

(2) the superintendent.

C. An appointed board member or any member of an appointed board member's immediate family or household shall not have any income derived from current or active employment, contract or consultation with the private health care delivery, financing or coverage sector while serving on the board and for twelve months preceding appointment to or service on the board.

D. Appointed board members shall have at least three years' experience in one of the following areas and shall be chosen as follows; provided that all areas are represented on the board:

(1) two members shall have executive-level experience in management or finance in a business not related to health care;

(2) one member shall have experience in the field of health or human services consumer advocacy;

(3) one member shall have executive-level experience in a business not related to health care that employs ten or fewer individuals;

(4) one member shall have executive-level experience in a business not related to health care that employs eleven or more individuals;

(5) one member shall have experience in health care management or finance;

(6) one member shall have experience related to health policy;

(7) one member shall have experience in health care economics;

(8) one member shall have experience in labor organization and advocacy; and

(9) one member shall have experience in public health.

E. Appointed board members initially shall have terms chosen by lot as follows: three members shall serve two-year terms; three members shall serve three-year terms; and four members shall serve four-year terms. Thereafter, members shall serve four-year terms. An appointed member shall not serve more than two consecutive terms. An appointed member shall serve until the member's successor is appointed and qualified.

F. A majority of board members constitutes a quorum. The board may allow members' participation in meetings by telephone or by other electronic media that allow full participation.

G. Every even-numbered year the board shall elect its chair and vice chair in open session from any of the members. A chair or vice chair shall serve no more than two consecutive two-year terms.

H. A vacancy shall be filled by appointment by the original appointing authority for the remainder of the unexpired term. The governor may request additional nominations from the legislature to ensure compliance with board qualifications pursuant to Subsection B of this section.

I. A member may be removed from the board by a majority vote of the members. The board shall set standards for attendance and may remove a member for lack of attendance, neglect of duty or malfeasance in office. A member shall not be removed without proceedings consisting of at least one notice of hearing and an opportunity to be heard. Removal proceedings shall be before the board and in accordance with rules adopted by the board.

J. A board member may receive per diem and mileage in accordance with the Per Diem and Mileage Act, subject to appropriation by the legislature and as travel policy is set by the board's bylaws.

K. The board shall meet at the call of the chair and not less than once monthly from July 1, 2008 until December 31, 2009. Thereafter, the board shall meet no less often than once per calendar quarter.

L. The board is subject to and shall comply with the provisions of the Administrative Procedures Act as well as other statutes and rules applicable to state agencies.

Section 4. AUTHORITY POWERS--DUTIES.--

A. The board may:

(1) identity procedures to carry out the duties identified in Subsections B and C of this section;

(2) create ad hoc advisory councils; and

(3) request assistance from other boards,

commissions, departments, agencies and organizations necessary to provide appropriate expertise to accomplish the authority's duties.

B. The board shall create the following expert advisory councils to provide the board with policy, program and analysis recommendations to maximize authority efficiency and effectiveness. At least once every calendar quarter, each council shall present its findings and recommendations to the board on issues described below or those requested by the board. The councils shall include, at a minimum:

(1) a finance council to study existing and prospective public and private health care system financing and cost-containment initiatives for a sustainable universal health care system;

(2) a federal impact council to:

(a) examine the impact of federal legal and administrative requirements on, and make recommendations for, reducing the number of New Mexicans without health coverage, improving access to affordable health care and removing barriers to reducing the number of uninsured New Mexicans; and

(b) recommend steps to maximize federal assistance and address federal requirements;

(3) a Native American health council consisting of members of Native American tribes, nations and

pueblos to examine Native American health care access needs and make recommendations on measures to improve access to health care for Native Americans;

(4) a health disparities council consisting of representatives from underserved populations who have expertise in the causes and elimination of health disparities to make recommendations, including but not limited to, recommendations on the following issues:

(a) disparities in the disease rates among and between racial and ethnic populations;

(b) language and cultural barriers to health care access; and

(c) enrollment strategies appropriate for diverse populations;

(5) a delivery system council to:

(a) examine prevention and wellness incentives and chronic disease management;

(b) make recommendations on new health care coverage and delivery systems and evidence-based health care quality and outcome indicators; and

(c) make recommendations on recruiting and retaining providers within the desired specialties or occupations; and

(6) a council of state-funded or state-created health care or health coverage agencies or other entities to

examine cost containment and benefit issues and make policy recommendations related to those issues.

C. By January 1, 2009, the authority shall develop a comprehensive plan for accessible and affordable health care for all people living in New Mexico. The authority shall develop proposals and recommendations to the legislature and the governor, including but not limited to proposals and recommendations on the following issues:

(1) the financing of a health care system that incorporates strategies from the public and private sectors;

(2) the evaluation of insurance reforms, including guaranteed issue, community rating, preexisting conditions provisions, health savings accounts, medical loss ratios, a health insurance exchange and portability measures;

(3) the definition of standards for a set of essential health care services;

(4) the administrative reorganization or consolidation of public sector programs and products, where feasible and beneficial, to increase the number of individuals covered and to restrain costs;

(5) the assessment of the impact of federal laws and regulations and any changes in the structure of health coverage or policies;

(6) the evaluation of statutory and regulatory initiatives to provide cost-effective health care services,

including the evaluation of:

(a) how to provide access to information that would enable providers, consumers and purchasers to fairly evaluate cost data, including contractual terms such as reimbursement rates and provider charges;

(b) how to implement a statewide uniform health care provider credentialing process;

(c) the costs and benefits of improving the transparency of provider services and health benefit plans; and

(d) the costs and benefits of bulk purchasing of health care services, durable medical equipment, health care supplies and pharmaceuticals;

(7) the evaluation of the current health care delivery services, including the evaluation of:

(a) the proper role of a comprehensive statewide system in providing acute medical care, behavioral health care, chronic medical care and disease management, preventive care and wellness, public health and patient education; and

(b) a system to realign provider and insurer incentives to use evidence-based care and to produce healthy outcomes;

(8) the setting of affordability standards for individuals and families, particularly uninsured individuals,

relating to purchasing insurance coverage for the defined essential health services;

(9) the implementation of a program that partners public health coverage programs with private health coverage plans to provide health insurance coverage that meets affordability standards;

(10) the design of measures to make health insurers and health benefit plans accountable to the public and to state government;

(11) the assessment of strategies for reducing racial and ethnic health care disparities and identifying underserved populations;

(12) the evaluation of incentives for providers to utilize information technology to deliver efficient, safe and quality health care and to encourage the development of individual electronic medical records that protect patient privacy;

(13) the evaluation of the feasibility of implementing programs to deliver local community-based health care services;

(14) the examination of measures, targeted at local and statewide levels as appropriate, to improve health care outcomes while containing costs; and

(15) the operation of a health care system that provides a primary care medical home to individuals and

provides information about the range, cost and quality of services offered by providers and plans.

D. The board shall appoint an executive director of the authority. The executive director shall have at least five years' experience in health care policy, management, delivery, financing or coverage. The board shall develop a process for evaluating the executive director's performance. The executive director shall carry on the day-to-day operations of the authority. The executive director shall be exempt from the provisions of the Personnel Act.

Section 5. HEALTH CARE AUTHORITY--STAFF.--

A. The executive director of the authority:

(1) shall employ and fix the compensation of those persons necessary to discharge the duties of the authority, including regular, full-time employees;

(2) shall propose an annual budget for the authority;

(3) shall report to the board no less than once monthly from July 1, 2008 until July 1, 2009 and no less than once quarterly after July 1, 2009;

(4) may contract with persons for professional services that require specialized knowledge or expertise or that are for short-term projects; and

(5) may organize the staff into operational units as the executive director sees fit in order to facilitate

the authority's work.

B. The authority's staff is subject to the provisions of the Personnel Act.

Section 6. REPORTING AND USE OF DATA.--

A. Health insurers, providers and employers shall report to the authority data about health coverage, services delivered, incident and infection rates and outcomes achieved in a format required or approved by the authority after consultation with other state entities authorized to collect related data.

B. Data reported shall be in aggregate form except where patient-specific data is necessary to provide unduplicated information. Data shall be reported electronically to the extent possible. The authority shall use and report data received only in aggregate form and shall not use or release any individual-identifying information or corporate proprietary information for any purpose except as provided by state or federal law or by court order.

C. In developing data reporting requirements, the authority shall seek and consider input from health insurers, providers, employers, advisory councils created pursuant to Section 4 of the Health Care Authority Act and the public regarding the format, timing and method of transmission of data to prevent duplicative reporting and to make the reporting of data the least burdensome possible.

D. The authority may use data collected by provider associations or other entities and shall not request data already collected by and available from other state agencies.

Section 7. TERMINATION OF AGENCY LIFE--DELAYED REPEAL.--The health care authority is terminated July 1, 2013 pursuant to the Sunset Act. The authority shall continue to operate according to the provisions of the Health Care Authority Act until July 1, 2014. Effective July 1, 2014, the Health Care Authority Act is repealed.

Section 8. TEMPORARY PROVISION--NEW MEXICO HEALTH POLICY COMMISSION--TRANSFER OF PERSONNEL, PROPERTY, CONTRACTS AND REFERENCES IN LAW.--On September 1, 2008:

A. all personnel, appropriations, money, records, equipment, legislative requests, supplies and other property of the New Mexico health policy commission shall be transferred to the health care authority;

B. all contracts of the New Mexico health policy commission shall be binding and effective on the health care authority; and

C. all references in law to the New Mexico health policy commission shall be deemed to be references to the health care authority.

Section 9. APPROPRIATION.--Six hundred thousand dollars ($600,000) is appropriated from the general fund to the health care authority for expenditure in fiscal years 2009 and 2010 to

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establish and implement the authority. Any unexpended or unencumbered balance remaining at the end of fiscal year 2010 shall revert to the general fund.

Section 10. REPEAL.--Section 9-7-11.2 NMSA 1978 (being Laws 1991, Chapter 139, Section 2, as amended) is repealed effective September 1, 2008.

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