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

		ORIGINAL DATE	02/11/08		CS/CS/62/aHFL#1
SPONSOR	HJCS	**LAST UPDATED**	02/14/08	**HB**	/aHFL#2/aHFL#3/aSPAC
SHORT TITLE	Health Solutions New Mexico Act			**SB**	
				ANALYST	Hanika-Ortiz, Weber, Earnest, Francis, Geisler, Sallee

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Non-Rec	Fund Affected
FY10	**FY11**	**FY12**		
-0-	$7,600.0	$21,600.0	Recurring	(New) Healthy New Mexico Work Force Fund
-0-	($7,600.0)	($21,600.0)	Recurring	General Fund

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY08	FY09	FY09	FY11	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total	$1,300.0					Recurring	Various

(Parenthesis ( ) Indicate Expenditure Decreases)

See "Conflict, Duplication, Companionship, Relationship" section for listing of pertinent bills.

SOURCES OF INFORMATION
LFC Files
Taxation and Revenue Department (TRD)

SUMMARY

Synopsis of SPAC Amendment

The Senate Public Affairs Committee Amendment adds a provision within section 14 relating to "willful" or "fraudulent" misstatements made by an applicant that are used to void a policy or deny a claim. The new provision provides that if such a misstatement is not "fraudulent" or "willful", the insurer may collect from the insured premium fees from the date of issue, had such a misstatement not been made. The Amendment also changes the date the Health Policy

Commission transfers to the new authority, including all personnel, property, contracts and references in law, to July 1, 2008 (from July 1, 2009).

Synopsis of HFL#3 Amendment

The House Floor Amendment #3 will require that an employer need only offer its full-time employees, a pre-tax health coverage option. The Amendment further defines a "full-time employee" to mean an employee that works at least 35 hours per week for at least twelve consecutive weeks in a calendar year.

Synopsis of HFL#2 Amendment

The House Floor Amendment #2 raises the number of employees an employer has to 10 (from 5), that will require an employer to offer employees not provided a health insurance plan, a pre-tax health coverage option.

Synopsis of HFL#1 Amendment

The House Floor Amendment #1 removes the provision that would allow an individual who was an employee's dependent while the employee was actively employed, from the definition of "eligible retiree" as used in the Retiree Health Care Act.

Synopsis of Original Substitute

House Bill 62 enacts the health solutions New Mexico act; creates the health care authority; creates the healthy New Mexico work force fund; provides insurance reform initiatives; transfers administrative authority of certain health coverage programs to the new health care authority; and, provides for appropriations.

Specific provisions of the bill include:

Sections 1, 2 cite the act; and, provides for definitions as used within the act.

Section 3: creates the "health care authority" as an adjunct agency, pursuant to Section 9-1-6 NMSA 1978, consisting of eleven voting members and two nonvoting members with specific expertise, as defined in the bill, of which five voting members are to be appointed by the Governor, one from each of the five public regulation commission districts; five voting members appointed by the Legislative Council, one from each of the five public regulation commission districts; Secretaries from DOH and HSD as non-voting members; and, the Superintendent of Insurance as a voting member.

The board will be subject to the state Per Diem and Mileage Act, will meet at least once per quarter. The authority will not be allowed to promulgate rules unless specifically provided that power by the legislature.

The board is tasked with creating advisory councils to provide program recommendations at least once each year; a delivery system policy council; a cost containment and finance council; a benefits and services council; a federal issues review council; a health disparities council; and, a Native American health care council. Any recommendations made by an advisory council will have a time frame for public comment.

Section 4: requires the board to appoint an executive director of the new authority that will be exempt from the Personnel Act.

Section 5: allows for the employment and contracting of staff to be organized into "operational units", such as a health policy and research division; a plan management division; an outreach and education division; and, an administrative services division.

Section 6: describes the duties of the health care authority to include:

- develop benefit guidelines and make recommendations regarding premium assistance subsidies by January 1, 2010;
- develop a comprehensive plan by July 1, 2010 that increases health care quality, coverage, access and health provider supply; addresses methods to control health care costs; and, addresses actions needed to implement plan;
- by September 1, 2011, submit a written report of findings and recommendations to the Governor and the Legislature about whether or how to consolidate actuarial pools, and whether to allow employees to purchase through certain pools or programs;
- conduct studies and gather information on health care coverage; and
- by July 1, 2010 submit a report and cost-benefit analysis to the Governor and the Legislature to include imposing a payroll tax to subsidize premiums; costs to the GF of full enrollment in Title 19 (Medicaid) or Title 21 (SCHIP); health insurer's cost for their administrative functions, and the amount of profit made by such health insurers; costs of allowing nongovernmental employers to buy into state risk pools; ERISA and other federal laws impacting health care coverage and delivery; costs of moving from a guaranteed issue in the individual market (insurer must issue but can underwrite) to a community rating system (everyone pays the same premium) for all health insurance products; adequacy of current provider reimbursement rates on access to health providers; and, other data collection and analysis as needed to include options for statewide health coverage for all New Mexicans through a combination of public and private financing;
- develop and administer transition health care products;
- conduct any procurement of health insurance coverage pursuant to the Procurement Code;
- provide for general consumer health education;
- collect and report on data of providers and health insurers ensuring patient confidentiality and that corporate proprietary information remains confidential;
- provides for an alternative dispute resolution process for both providers and health insurers;
- enters into agreements with Native American tribes or pueblos;
- reports quarterly on performance measures set by the authority; and
- by October 1, 2011 report to the Legislature on demographics of the uninsured; other states requirements for health coverage; availability and funding of public and private health coverage or insurance programs; and, recommendations for enforcement of required health coverage.

Section 7: establishes a healthy New Mexico work force fund consisting of money appropriated to the fund, employee's contributions, insurance or reinsurance proceeds and other funds, including refunds from health insurers. Subject to appropriation by the Legislature, money in the fund will be used to fund outreach and pay for health care premiums through publicly authorized programs.

Section 8: requires employers with five or more employees to offer employees not provided a health insurance plan, a pre-tax health coverage option.

Section 9: replaces the GSD Group Benefits Committee with the board of directors of the health care authority, and the director of the GSD/RMD with the executive director of the health care authority as used in the Groups Benefits Act.

Section 10: replaces the retiree health care authority with the health care authority, the board of the retiree health care with the board of the health care authority in the Retiree Health Care Act. Also, adds to the definition of an "eligible dependent" a person who would qualify as a dependent under the retiree's health plan had the employee not retired.

Section 11: allows the public school insurance authority to continue for the purpose of risk-related coverage, and the health care authority to assume the group health insurance administrative functions in the Public School Insurance Authority Act.

Section 12: provides that after July 1, 2011 the "public school insurance fund" is to be divided into two accounts: the "risk account" and the "group health insurance account" and all deposits/expenditures to be kept separate. On July 1, 2010 DFA and PSIA will determine the balance of each account.

Section 13: amends §59A-6-5, and will require the amount of revenue from insurance premiums taxes and related revenues in excess of the amount collected in calendar year 2009 that would otherwise go to the General Fund to be deposited into the new healthy New Mexico workforce fund beginning in January 2011.

Section 14: provides that, from the date of issue, only misstatements that are "willful" or "fraudulent" made by an applicant for comprehensive major medical coverage can be used to void a policy or deny a claim. This provision does not affect any initial two year period for policies other than comprehensive major medical.

Section 15: raises the maximum limit on the cost of healthcare services offered after January 1, 2009, to not less than $100 thousand for policies or plans issued pursuant to the Minimum Healthcare Protection Act.

Section 16: provides for a reduction in the "index rate" for health benefit plans pursuant to the Small Group Rate and Renewability Act, from 20% in FY08 to a final 10% in FY12 and each fiscal year thereafter to hold down cost increases for small employers by restricting the amount by which certain carriers can increase rates for a particular group due to its claims experience.

Section 17: states that with respect to enrolling any person under a group plan; extends the period of "creditable coverage" to a 95 day continuous period (from 63 days) during which the individual was not covered thereby increasing portability.

Section 18: replaces the board of directors of the Medical Insurance Pool with the board of the health care authority. Removes medical care programs of the Indian health service from the definition of "creditable coverage", relating to coverage of a person under plans pursuant to the Medical Insurance Pool Act; thereby, allowing an insuree to continue to receive care from IHS. Within the definition of "preexisting condition", clarifies that pregnancy is not considered a preexisting condition for a federally defined eligible individual.

Section 19: amends language within the New Mexico Medical Insurance Pool to require the entity to operate subject to the new health care authority.

Section 20: requires an individual who voluntarily terminates a "pool" policy (including for nonpayment of premium) to have a six month waiting period for preexisting conditions. Also provides that persons terminated from a qualified state high-risk pool policy due to non-residency in another state may apply for coverage under the pool within ninety-five days (from thirty-one days) after termination.

Section 21: provides that a small group policy not include a lifetime maximum benefit.

Section 22: in the case of a small group policy under the Medical Insurance Pool Act, allows covered family members to continue the policy upon the death or legal separation of the insured. Removes medical care programs of the Indian health service from the definition of "creditable coverage"; thereby, allowing an insuree to continue to receive care from IHS.

Section 23: replaces the board of directors of the New Mexico Health Insurance Alliance with the health care authority. Removes medical care programs of the Indian health service from the definition of "creditable coverage" relating to coverage of a person under plans pursuant to the Health Insurance Alliance Act; thereby, allowing IHS and tribal providers to continue to be part of an insuree's provider network.

Section 24: requires the New Mexico Health Insurance Alliance to operate subject to the authority of the health care authority.

Section 25: increase portability by raising the maximum break in coverage for policies issued under the Alliance to 95 days (from 63 days).

Section 26: enacts a new section of the New Mexico Insurance code:

a) a health insurer shall spend no less than 85% collected from premium fees across all product lines on direct health care services over the preceding three calendar years, but not earlier than FY09. If a health insurer makes reimbursement for direct services at a rate less than 85%, the difference between the amount reimbursed for direct services and 85% of premiums received shall be paid into the healthy New Mexico work force fund;
b) a health insurer must issue coverage without exclusions of preexisting conditions effective January 1, 2010;
c) a health insurer may impose a waiting period not to exceed six months before payment for any service related to a preexisting condition;
d) a health insurer must offer or make a referral to a transition product during a waiting period due to a preexisting condition; and
e) a health insurer may continue a policy in existence on July 1, 2009 that has a permanent exclusion of payment for preexisting conditions until renewal.

Section 27: enacts a new section of the New Mexico Insurance code to require a health insurer to allow a qualified IHS provider to participate in the health insurer's provider network.

Section 28: enacts a temporary provision and transfers personnel, property, contracts and references in law for the New Mexico Health Policy Commission to the new health care authority on July 1, 2009.

Section 29: enacts a temporary provision; and,

a) transfers the administrative functions of the New Mexico Health Insurance Alliance, the Retiree Health Care Authority, health coverage programs pursuant to the Group Benefits Act, state-sponsored premium assistance programs and the New Mexico state coverage insurance program administered by HSD to the health care authority by July 1, 2010; and, provides that financing mechanism of these programs be maintained separately; and
b) by July 1, 2011 combines the management of the Medical Insurance Pool, the Public School Insurance Authority as it relates to group insurance, and the publicly funded health care program of any public school district (greater than 60,000 students); and, provides that each program's actuarial and benefit pool and funding streams be maintained separately.

Sections 30 through 36 provides for temporary provisions requiring the transfer of personnel, property, contracts and references in law of additional entities to the new authority, including:

- the GSD's Group Benefits Committee on July 1, 2010;
- the Retiree Health Care Authority (RHCA) on July1, 2010;
- the Public School Insurance Authority's group health insurance program on July 1, 2011;
- certain School District's public funded health care systems with a student enrollment in excess of 60 thousand students on July 1, 2011;
- the New Mexico Medical Insurance Pool on July 1, 2011;
- the New Mexico Health Insurance Alliance on July 1, 2009; and
- any insurance programs of HSD related to the state-sponsored premium assistance programs and the NM state coverage insurance program on July 1, 2010.

FISCAL IMPLICATIONS

To achieve universal access and coverage:
The bill establishes a healthy New Mexico work force fund to fund outreach activities and pay for health care premiums or services through publicly authorized programs to expand coverage. The fund will consist of certain balance transfers from the insurance department suspense fund; and amounts received from a health insurer for direct services provided at a rate less than 85% of premiums received. The fund will also consist of employee's contributions, insurance or reinsurance proceeds and other funds, including refunds from health insurers.

This bill creates a new fund and provides for appropriations. The LFC has concerns with including continuing appropriation language in the statutory provisions for newly created funds, as earmarking reduces the ability of the legislature to establish spending priorities.

Section 13 will require the amount of revenue from insurance premiums taxes in excess of the amount collected in calendar year 2009 that would otherwise go to the General Fund, to be deposited into the new healthy New Mexico workforce fund beginning in January 2011. The estimate in the revenue table above is based on the forecast by the Consensus Revenue Estimating Group of the amount of revenue from insurance premiums taxes and related revenues. While there is a negative impact to the general fund, the new fund will be appropriated by the legislature and there may be overlap in spending particularly in Medicaid programs. To the

extent that the authority increases enrollment in private insurance, insurance premium taxes will increase more than projected.

The new substitute also provides that if a health insurer makes reimbursement for direct services at a rate less than 85%, the difference between the amount reimbursed for direct services and 85% of premiums received shall be paid into the healthy New Mexico work force. Any amounts this provision generates cannot be determined at this time; and, should not be counted on as a significant source of revenue for the new fund without further analysis.

Containment of health care costs through various initiatives including insurance reform:
The NM Medical Insurance Pool (NMMIP), established by Chapter 54 of the Insurance Code, is a non-profit corporation operating a high-risk health insurance pool. The premiums charged to members are not sufficient to cover the costs, and this shortfall is assessed to health insurance industry. Assessed insurers then receive a 50 percent premium tax credit for full premium plan losses and a 75 percent premium tax credit for certain plans and programs. Under the bill, eligibility for the NMMIP may be expanded. In addition, it appears NMMIP is the default plan for higher risk individuals, including those with preexisting conditions. The NMMIP assessment to its providers may increase as its membership grows. The premium tax credits taken on any increased assessments will likely reduce the amount of revenues in the healthy New Mexico workforce fund. Estimating the amount of the tax credit is difficult without projected growth in NMMIP membership.

The bill does not change any of the parameters of any of the Medicaid programs but the cost study and presentations related to the Health Solutions proposal in the fall of 2007 indicated that expansion of Medicaid was critical to the goal of universal coverage. A federal waiver for SCHIP has allowed funding for adults in the State Coverage Insurance (SCI) program, which has been an important component in current state efforts to expand insurance. However, continuation of the funding source is uncertain and there is continuing disagreement at the federal level about whether SCHIP funds should be used for adults. To date there is no resolution of the issue as Congress extended SCHIP funding under current law.

Creation of a health care authority collapsing administratively various entities to create a single point of accountability:
No appropriation was included in the bill to support the new authority in fulfilling its mission. The estimated $1.3 million for the additional operating budget impact noted in the box above is only an approximate amount at this point; but, with the transition costs to the new authority for an executive director, perdiem expenses and mileage, etc. it is expected that there will be a need for an annual appropriation from the General Fund.

The Executive recommendation within the General Appropriation Act included $1.3 million for start-up funding for the health care authority proposed in the original bill.

The fiscal impact to the new authority for its human capital needs is difficult to estimate and will be determined by how many executive and other positions are eliminated or added to the authority. Agency responses in this area failed to provide sufficient detail on how much in appropriations and staff will actually transfer to the new authority.
It is expected that any coordinated procurement and benefits administration by the new authority may create administrative savings for these state agencies and programs; including overhead costs, consultant and administrative contracts and fees, and leased office space. HSD reports that

that the first 15 months rent for the new authority was to be absorbed by HSD, HPC and/or DOH and has not been decided.

The substitute bill does not specifically address the disposition of the NMRHCA $180 million fund or the amount of subsidy towards insurance premiums that will be provided for retirees who are currently members or will become members of the NMRHCA. Costs to add additional beneficiaries as defined in the bill are unknown.

SIGNIFICANT ISSUES

To achieve universal access and coverage: Health coverage is never static as people move in and out of different coverage from various sources, and gain and lose coverage during the year. Employer-sponsored plans are the main source of coverage for an estimated 42 percent of the state's non-institutionalized civilian population under age 65. More than one-third of these New Mexicans are enrolled in self-insured employer plans. Public health insurance programs (Medicaid, SCHIP, and SCI) cover an additional 30 percent of the non-institutionalized civilian population under age 65. (Mathematica Policy Research, Inc.)

Containment of health care costs through various initiatives including insurance reform: The two most significant insurance reforms are in Section 26. This new section of the Insurance Code will require 85 percent of premiums collected be spent for direct medical services; and, guarantee health insurance coverage without permanent exclusion of pre-existing conditions.

The 85 percent of premiums target for direct medical services is considered appropriate for large groups or block purchases like Salud! However, it may create problems for insurers who only write individual or small employer groups. Economies of scale work against individual and small group coverage. Several insurers who currently offer only individual and small group coverage could be forced to leave the market. A more appropriate target could be developed for individual and small employer groups. HSD reports that most providers operating in the state already meet or exceed the ratio.

While the bill eliminates an insurer's ability to decline coverage due to health status and exclude certain medical conditions, insurers may still set higher substandard premiums based on health status. The bill allows insurers to impose a six month waiting period before payment for any service related to a preexisting condition, but requires the insurer to provide a referral for coverage during the waiting period, not a significant change from current law. The "transition product" would seem to be plans offered by NMMIP, which under current law allows these so-called high risk individuals to acquire insurance.

According to the NMMIP, their plans offer coverage with a six-month wait period but with premium protections and a low-income program with reduced premiums for persons under 400% of the Federal Poverty Level. NMMIP plans are specifically designed to meet the health care needs of this population while reducing the cost of a traditional plan. Specifically, NMMIP states: "Clarification and coordination between guaranteed issue under the bill and NMMIP program will be critical in reducing confusion and maximizing resources."

Section 14 raises the standard of proof for insurers of material misstatements or omissions by individuals in applications for major medical health insurance during the first two years after a policy is issued. The more stringent standards of proof are intended to add more consumer protections.

Section 15 raises the minimum cap for policies issued under the Minimum Healthcare Protection Act from $50,000 to $100,000 after January 1, 2009.

Section 16 amends NMSA 1978, Section 59A-23C-5, and narrows the premium rating bands for small employer insurance from plus or minus 20% to plus or minus 10% over a five year period. This will lower the surcharges for health status and claims experience in the small employer market. By shrinking the bands (i.e., the variation in premiums for groups), this section is intended to reduce the rise in medical premiums.

Section 17 is intended to increase portability by raising the maximum break in coverage to 95 days (from 63). This will increase the time period individuals are given to apply for insurance after leaving a group to retain guaranteed issue rights under the law.

Creation of a health care authority collapsing administratively various entities to create a single point of accountability:
The temporary provisions of the bill will require that appropriations for certain existing agencies will follow the transfer of state-administered purchasing pools to the new health care authority in either FY09 or FY10; and, “financing mechanisms” and “funding streams” for each of the programs will be accounted for separately. These programs include the New Mexico Medical Insurance Pool (high risk), the Albuquerque Public School self-insurance functions, the Public Schools Insurance Authority and the Retiree Health Care Authority. There most likely will be some statutory changes needed to state law if any future commingling of funds will occur.
Albuquerque public school self-insurance functions

The bill will require the Albuquerque Public Schools (APS) health care self-insurance functions to be folded into the new authority. The State’s largest school district operates as a self-insured government entity. APS states it is unclear how the bill will transfer administration of health care benefits from APS to the new authority. APS only recently created an internal service fund to deposit employer/employee contributions and make health care expenditures. A recent LFC program evaluation estimated that APS employer/employee contributions exceeded health care expenditures which should have created a balance to apply to future premiums or be returned to the sources of revenue, but were not. As a result of these issues, establishing an accurate beginning balance for APS health care may prove difficult.

In previous analyses, the Public School Insurance Authority (PSIA), the NMRHCA and APS have stressed the importance of requesting a comprehensive analysis of the short and long term objectives of any proposal for consolidation. PSIA has also in the past noted concerns relating to board representation; and, that advocacy for educational employees not be lost do the diverse makeup of any board.

Even though the details have not been worked out regarding governance by the new authority, the rights of the retirees within the RHCA should not be affected. The agency should be able to realize savings in administrative costs over time due to natural attrition in the work force; however, a recommendation has been made by the RHCA to allow the twenty-two existing employees retain their jobs.

PERFORMANCE IMPLICATIONS

The bill creates the "health care authority" as an adjunct agency under Section 9-1-6 NMSA 1978 which states "Adjunct agencies are those agencies…of the executive branch…which are excluded from any direct or administrative attachment to a department, which retain policymaking and administrative autonomy separate from any other instrumentality of state government".

ADMINISTRATIVE IMPLICATIONS

The bill proposes to allow the authority to absorb the Health Policy Commission which was established by statute (9-7-11.2) in l991 to provide independent research, guidance, and recommendations on health policy issues that impact the planning of health care and health systems for New Mexico.

Administrative costs to other participating state agencies and committees to provide information to the new authority on issues that impact the state's health policies could require moderate staff effort beyond current activities.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Relates to: HB 37 and SB 305, Electronic Medical Records
Conflicts with: HB 147 and SB 225, Health Care Authority Act
Relates to: HB 182, Simplify Medicaid Eligibility
Conflicts with: HB 205, Health Insurance Exchange Act
Conflicts with:HB 214 and SB 3, Health Security Act
Relates to: SB 14, Health Professional Recruitment & Retention
Relates to: SB 37, Require College Student Health Insurance
Relates to: SB 38, Non-Resident College Student Health Insurance
Conflicts with: SB 39, Health Insurance Tax Credit
Relates to: SB 40, Health Insurance in College Scholarships
Relates to: SB 62, Health Education Cultural Task Force
Conflicts with: SB 115, Employee Health Insurance Premium Tax Credit
Relates to: SB 129, Healthy New Mexico Task Force
Conflicts with: SB 228, Health Insurance Exchange Act

OTHER SUBSTANTIVE ISSUES

The New Mexico State Coverage Initiative (NMSCI) administered by HSD uses unspent SCHIP funding to provide managed care coverage for uninsured employed adults with incomes up to 200 percent FPL. New Mexico's funding model incorporates employee and employer contributions to obtain managed care coverage plans selected through a competitive bid process. Cost sharing is on a sliding scale basis, with the premium and co-payment amounts corresponding to three income groupings (1-100 percent FPL, 101-150 percent FPL, and 151-200 percent FPL). Employers pay $75 per employee per month, and the employee pays from zero to $35 per month. Individuals not affiliated with an employer pay the $75 employer premium in addition to the employee premium. Sliding scale co-payments are due upon the delivery of medical services. There is an out-of-pocket limit on cost sharing that represents five percent of the program participant's countable income (after all income exclusions and

disregards are applied). NMSCI implementation was effective July 1, 2005, and the demonstration will last until July 1, 2010.

The New Mexico Medical Insurance Pool (NMMIP) was established by the 1987 New Mexico State Legislature. The Pool was created to provide access to health insurance coverage to residents of New Mexico who are denied health insurance and considered uninsurable. NMMIP also provides health benefit portability coverage to New Mexicans who have exhausted COBRA benefits and have no other portability options available to them. NMMIP is administered by Blue Cross and Blue Shield of New Mexico who handles eligibility, enrollment, member services and claims processing.

The Health Insurance Alliance was created in 1994 by the State Legislature to provide increased access to health insurance for small businesses, self-employed and qualified individuals. The Alliance is administratively attached to the PRC/ID and is comprised of independent health insurers who have agreed to offer similar health plans to companies with 50 or less eligible employees.

ALTERNATIVES

The Health Coverage for New Mexicans Committee (HCNMC) was created by the Legislature and the Governor to study three models of universal health coverage. The HCNMC charged a consulting firm with costing out three different approaches to universal coverage in New Mexico. The Health Security Act (HB213 and SB3) was one of the models that were part of the cost study conducted. The report was presented to the public and the committee in the summer of 2007. Each of the reform models promised cost savings, but it remained unclear whether they included real cost controls.

AMENDMENTS

Consider requiring all appropriations to the healthy New Mexico work force fund be subject to budget review through DFA and LFC.

Consider deleting or clarifying language within Pg 9, Section 6 (A) regarding "… develop guidelines for affordability of coverage…make recommendations regarding premium assistance or other subsidies..." It is uncertain as to what this language refers to as the bill no longer references universal health care.

AHO/mt:bb