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

SPONSOR Picraux **ORIGINAL DATE** 01/23/08 **LAST UPDATED** 02/05/08 **HB** 147/aHGAC/aHAFC/aHFl#1/aHFl#2

SHORT TITLE Health Care Authority Act **SB**

ANALYST Weber

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY08	**FY09**		
	NFI		

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Health Policy Commission
Public Education Department (PED)
Public Regulation Commission (PRC)

SUMMARY

Synopsis of House Floor Amendment #2

On page 6, between lines 19 and 20, insert a new subsection as follows:

M. "Any binding decisions by the board shall require seven out of eleven members voting in favor."

Synopsis of House Floor Amendment #1

1. On page 5, line 23, strike "The governor may request additional and strike lines 24 and 25 in their entirety. See H. below.

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 sect~~ion.

2. On page 13, lines 11, 12 and 13, strike "except where patient-specific data is necessary to provide unduplicated information". See B. below.

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.

Synopsis of HAFC Amendment

The House Appropriations and Finance Committee amendment strikes Section 9 that contains the appropriation of $600 thousand for this purpose. The amended bill does not include an appropriation.

Synopsis of HGAC Amendment

The House and Government Affairs Committee made the following changes to House Bill 147:

1. On page 3, line 15, after the comma, insert "one of whom shall be a physician licensed pursuant to the Medical Practice Act and one of whom shall be a nurse having a graduate-level education in nursing;".
2. On page 4, line 2, strike "delivery,".
3. On page 4, between lines 4 and 5, insert:

"D. Board members shall comply with the provisions of the Governmental Conduct Act and the Financial Disclosure Act.".
4. Reletter succeeding subsections accordingly.
5. On page 4, strike lines 5 through 25, and on page 5, strike lines 1 through 4, and insert in lieu thereof:
"E. Each appointed board member shall have at least three years' experience in at least one of the following areas; provided, however, that all areas are represented on the board:

1. executive-level experience in management or finance in a business not related to health care;
2. experience in the field of health or human services consumer advocacy;
3. executive-level experience in a business not related to health care that employs ten or fewer individuals;
4. executive-level experience in a business not related to health care that employs eleven or more individuals;
5. experience in health care management or finance;
6. experience related to health policy;
7. experience in health care economics;
8. experience in labor organization and advocacy; and
9. experience in public health.".

6. On page 14, line 12, strike "September" and insert in lieu thereof "July".
7. On page 14, line 19, strike "and".
8. On page 14, line 22, strike the period and insert in lieu thereof "; and"
9. On page 14, between lines 22 and 23, insert a new
Subsection D as follows:

D. the executive director of the New Mexico health policy commission shall be appointed as interim executive director of the health care authority until the board of directors of the health care authority appoints an executive director.".
10. On page 15, line 6, strike "September" and in lieu thereof insert "July".,

The changes primarily are directed at the qualification of the board members. Also, the Executive Director of the Health Policy Commission is designated as the interim director of the Authority until a permanent director is appointed. In addition, the Health Policy commission is transferred under the direction of the Authority July 1, 2008 rather than September 1, 2008.

Synopsis of Original Bill

House Bill 147 appropriates $600 thousand from the general fund to establish the Health Care Authority, an adjunct agency that is to collect data and evaluate the information to develop a comprehensive plan for accessible and affordable health care for all people living in New Mexico.

An adjunct agency is defined in statute as:

- "Adjunct agencies" are those agencies, boards, commissions, offices or other instrumentalities of the executive branch, not assigned to the elected constitutional officers, 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.

The bill has 10 sections.
Section 1 is the title, “Health Care Authority Act”.
Section 2 defines certain words and phrases used in the act.

Section 3 creates the Health Care Authority and defines the membership of the board.

- The board will consist of 11 members. Two members from each of the five Public Regulation Commission districts (five appointed by the governor and subject to senate confirmation, five appointed by the New Mexico legislative council) and the Superintendent of Insurance. At least one of the 11 members shall be Native American.
- In addition, Section 3 establishes qualifications for the board members.
- The terms for the members are noted.
- Other general rules are set forth.

Section 4 outlines the authority and power of the act.

- The board is to create expert councils to provide analysis and recommendation. The councils should include at minimum:

- a finance council
- federal impact council
- a Native American health council
- a health disparities council
- a delivery system council
- a council of state-funded or state-created health care or health coverage agencies and other entities

- January 1, 2009, the authority shall develop a comprehensive plan for accessible and affordable health care for all New Mexicans. The authority shall develop proposals and recommendations to the Legislature and Governor, including but not limited to the following: (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; (7) the evaluation of the current health care delivery services; (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.

Section 5 describes the Health Care Authority staff.

- There is to be an executive director of the authority to employ the persons necessary and implement policies that will complete the functions of the authority.
- The employees are to be covered by the state Personnel Act.

Section 6 defines the reporting and use of data collected.

Section 7 is a sunset clause terminating the authority July 1 2013 but will continue to operate until July 1, 2014 under the provision of the Sunset Act.

Section 8 transfers the New Mexico Health Policy Commission to the Health Care Authority.

FISCAL IMPLICATIONS

The appropriation of $600 thousand contained in this bill is a recurring expense to the general fund. Any unexpended or unencumbered balance remaining at the end of FY10 shall revert to the general fund.

SIGNIFICANT ISSUES

The purpose of the transfer of the Health Policy Commission to the Authority is unclear but presumed to be resources to perform the duties of the Authority. This may require other statutory changes to redefine the mission of HPC.

OTHER SUBSTANTIVE ISSUES

The health Policy Commission offers the following regarding experiences of other states with Health Care Authorities.

Source for state information below is *Universal Health Coverage Research on States and Unresolved Issues* completed by the Health Policy Commission in August 2007.

Maine
The Dirigo Health Plan created the Maine Healthcare Authority to oversee and administer the Plan, which will be funded by streamlining and simplifying the many ways Maine residents currently pay for healthcare. The Maine Health Care Reform Commission (MHCRC) recommended that the Authority board be comprised of healthcare providers, government appointees, hospital administrators and representatives of the business community as well as private citizens. The Authority will oversee the healthcare program as well as steward the education of healthcare professionals.
Massachusetts
The Massachusetts Commonwealth Health Insurance Connector Authority is run by an independent agency with a 10- member board. The Connector will make health insurance portable by allowing employees to keep the same plan even if they leave an employer. The Connector will also allow employees to aggregate the contributions of multiple employers, e.g. if they are part-time workers or work for multiple employers, and apply them to one insurance plan. The Connector is designed as a clearinghouse for insurance plans and payments. It performs the following functions- it runs the Commonwealth Care program for low-income residents (below 300% of the poverty level) who do not qualify for MassHealth; it offers for purchase health insurance plans for individuals who are not working, are employed by a small business (less than 50 employees) that uses the Connector to offer health insurance. are not qualified under their large employer plan, are self-employed, part-time workers, or work for multiple employers, it sets premium subsidy levels for Commonwealth Care, and it defines "affordability" for purposes of the individual mandate.

Vermont
The administrative centerpiece of the law is the Vermont Health Care Authority (VHCA), which began its work in August 1992. The VHCA acts under the direction of a three-member administratively powerful board appointed by the governor and confirmed by the Senate. The

board's responsibilities include program design (typically requiring legislative approval), data collection, advisory work with other agencies involved in implementing reform, and working with existing public organizations to encourage local and regional health plans and primary health care systems and to negotiate with provider groups. The board represents one of the nation's most highly centralized and potentially powerful health care agencies.

Colorado

The Blue Ribbon Commission for Health Care Reform is studying health care reform models to expand health care coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. The Commission is charged with examining health coverage and reform models designed to ensure access to affordable coverage for all Colorado residents; soliciting comprehensive reform proposals from interested parties; selecting between three and five proposals for in-depth technical assessment by an independent contractor; and completing a final report with recommendations to the General Assembly by January 31, 2008.

Maryland

There is a State Board of Governors within the Maryland Universal Health Care Plan. The Board is to administer, implement and monitor the operation of the plan; establish a global budget for the total amount that may be expended for the provision of health care under the plan each year; develop and recommend to the governor and the general assembly funding sources for the plan; set reimbursement rates for non-hospital outpatient services which are not regulated by the Health Services Cost Review Commission; administer the Maryland Universal Health Care Trust Fund; establish reasonable and effective means of cost containment, quality assurance and promotion of access to services; establish a system to promote continuity of care, including the use of case managers for plan members with multiple health care problems; establish a prescription drug formulary; and administer payments for the provision of covered services to participating health care providers.

Minnesota

The Minnesota Universal Health Board is legislatively proposed for the purpose of providing a single, publicly financed, statewide program to provide comprehensive coverage for all necessary health care services for residents of Minnesota. The board may implement and administer the Minnesota universal health program; estimate the current cost of universal coverage for all Minnesotan residents; establish statewide and regional budgets; approve budgets for each region, establish fee schedules, which may vary to reflect regional differences; approve budgets for institutional providers; approve capital expenditures for freestanding outpatient facilities; monitor compliance with all budgets and fee schedules and take action to achieve compliance to the extent authorized by law; issue requests for proposals for a contract to process claims submitted by individual providers; provide technical assistance to the regional boards; administer the Minnesota Health Care Trust Fund; monitor the operation of the Minnesota universal health program through consumer surveys and regular data collection and evaluation activities, including evaluations of the adequacy and quality of services furnished under the program, the need for changes in the benefit package, the cost of each type of service, and the effectiveness of cost containment measures under the program.

Oregon

The Oregon Health Fund program would be established under proposed legislation. The goals of the program would be to provide coverage of the defined set of essential health services for all residents; reduce unsustainable health care cost increases in Oregon; shift to a system of public and private health care partnerships that integrate public involvement and oversight, consumer

choice and competition within the private market; use proven models of health care benefits, service delivery and payments that control costs and over-utilization, with emphasis on preventive care and chronic disease management within a primary care environment; provide services for humane and dignified end-of-life care; restructure the health care system so that payments for services are fair and proportionate among various populations and health care programs; and fund a high quality and transparent health care delivery system that allows users and purchasers to know what they are receiving for their money. The Boards will
also manage the Oregon Health Fund; oversee the actuarial process to define the set of essential health conditions; conduct public hearings to determine the adequacy of the defined set of essential health conditions and report the findings to the Governor and the Legislative Assembly; and contract with privately and publicly sponsored health care organizations.

Washington State
The Washington State Health Care Authority would work with contracting health carriers and health care providers, and a nonproprietary public interest research group and/or university-based research group, to implement practical and usable models to demonstrate shared decision making in everyday clinical practice. The demonstrations would be conducted at one or more multi-specialty group practice sites providing state purchased health care in the state of Washington, and may include other practice sites providing state purchased health care. The Health Care Authority and the Department of Social and Health Services shall also develop a five-year plan to change reimbursement within state purchased health care programs to reward quality health outcomes rather than simply paying for the receipt of particular services or procedures; pay for care that reflects patient preference and is of proven value; require the use of evidence-based standards of care where available; tie provider rate increases to measurable improvements in access to quality care; direct enrollees to quality care systems; better support primary care and provide a medical home to all enrollees; and pay for e-mail consultations, telemedicine, and tele-health where doing so reduces the overall cost of care.

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