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

SPONSOR Senate **ORIGINAL DATE** 02/12/08 **LAST UPDATED** **HB**

SHORT TITLE Health Care Authority Act **SB** CS/225/aSFL#1 /aSFL#2

ANALYST Weber

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY08	FY09	FY10	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		See Narrative				

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

SUMMARY

Synopsis of SFl#1 Amendment

Senate Floor Amendment 1 deletes Section 6 and renumbers the subsequent sections.

Synopsis of SFl#2 Amendment

On page 11, between lines 19 and 20, insert the following new paragraph:

(10) the development of provider networks that always allow the consumer a choice of health car providers;"

Synopsis of Substitute Bill

The Senate Floor Substitute for Senate Bill 225 has nine sections.

Section 1 is the Short Title: Health Care and Policy Commission Act.

Section 2 states the definitions of important terms used in the act.

Section 3

The "health care and policy commission" is created and is an adjunct agency.

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 board shall consist of eleven members, at least one of whom shall be a Native American, 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, selected as follows: two members from each of the five public regulation commission districts: five appointed by the governor and subject to senate confirmation; and five appointed by the New Mexico legislative council with at least two appointments being made by council members from the minority party; and the superintendent of insurance.

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.

The board is subject to the State Per Diem and Mileage Act as well as the Government Disclosure Act and the Financial Disclosure Act.

Section 3 also outlines other general procedural matters common to any board.

Section 4 outlines the Commission powers and duties.

The board is charged with:

(1) identifying procedures to carry out the duties identified in Subsections B and C of this section;
(2) creating ad hoc advisory councils; and
(3) requesting assistance from other boards, commissions, departments, agencies and organizations necessary to provide appropriate expertise to accomplish the commission's duties.

The board is to create at minimum the following advisory councils:

(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:
(3) a Native American health council;
(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:

(5) a delivery system council to: 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.

By January 1, 2009, the commission shall develop a comprehensive plan for accessible and affordable health care for all people living in New Mexico.

The board shall appoint an executive director of the commission with 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 commission. The executive director shall be exempt from the provisions of the Personnel Act.

Section 5 outlines the commission staff.

The executive director of the commission:
(1) shall employ and fix the compensation of those persons necessary to discharge the duties of the commission, including regular, full-time employees;
(2) shall propose an annual budget for the commission;
(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 commission's work.

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

Section 6 discusses the reporting and use of data.

Health insurers and providers are to report about health coverage, services delivered, incident and infection rates and outcomes achieved in a format required or approved by the commission. Data should be reported in aggregate form and electronically to the extent possible. The commission is not to release any individual-identifying or corporate proprietary information except as provided by state or federal law or by court order. The commission 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 terminates the agency.

The commission is terminated July 1, 2013 but will continue to operate according to the provisions of the Health Care and Policy Commission Act until July 1, 2014. Effective July 1, 2014, the Health Care and Policy Commission Act is repealed.

Section 8 is a temporary provision transferring The Health Policy Commission under the authority of the Health Care and policy Commission effective July 1, 2008.

Section 9 repeals Section 9-7-11.2 NMSA 1978 that creates the health policy Commission, effective July 1, 2008.

FISCAL IMPLICATIONS

There are no direct fiscal implications but it must be assumed the new commission will operate under the existing Health Policy Commission budget. Additional operating expenses must be assumed since there is a new Executive Director and per diem and mileage expenses related to the board members. The exact amount is not determined but the costs could be substantial with contractual services needed to evaluate programs beyond the expertise of the existing Health Policy Commission.

SIGNIFICANT 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.

MW/bb