

**MINUTES
of the
SIXTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**November 4-6, 2009
Room 322, State Capitol**

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Danice Picraux, chair, at 9:05 a.m. on Wednesday, November 4, 2009. A quorum was present.

Present

Rep. Danice Picraux, Chair
Sen. Dede Feldman, Vice Chair
Sen. Rod Adair (11/5)
Rep. Nora Espinoza
Rep. Joni Marie Gutierrez (11/5, 11/6)
Sen. Linda M. Lopez (11/5)
Rep. Antonio Lujan
Sen. Gerald Ortiz y Pino

Absent

Advisory Members

Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Eleanor Chavez (11/5)
Rep. Nathan P. Cote
Rep. Miguel P. Garcia
Rep. Keith J. Gardner (11/6)
Sen. Clinton D. Harden, Jr. (11/5, 11/6)
Rep. John A. Heaton
Rep. Dennis J. Kintigh
Rep. James Roger Madalena
Sen. Cisco McSorley
Rep. Bill B. O'Neill (11/5, 11/6)
Sen. Mary Kay Papen (11/5, 11/6)
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Mimi Stewart
Sen. David Ulibarri
Rep. Gloria C. Vaughn

Rep. Jose A. Campos
Sen. Gay G. Kernan
Rep. Rodolfo "Rudy" S. Martinez
Rep. Jeff Steinborn

Guest Legislators

Rep. Edward C. Sandoval
Rep. Nick L. Salazar (11/5)

(Attendance dates are noted for those members not present for the entire meeting.)

Staff

Michael Hely, Staff Attorney, Legislative Council Services (LCS)
Karen Wells, Researcher, LCS
Jennie Lusk, Staff Attorney, LCS
Mark Harben, Records Officer, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts are in the meeting file.

Wednesday, November 4

Welcome and Introductions

Representative Picraux welcomed everyone. She described the process by which she and Senator Feldman submitted bill requests on behalf of the committee.

Health Care Services Common Interest Report (SJM 1)

Ruby Ann Esquibel, director of policy, Human Services Department (HSD), introduced the members of the task force who collaborated on the memorial report. SJM 1 asked all public entities engaged in health care coverage in New Mexico to meet and identify common interests and opportunities to work together. She described the New Mexico Health Insurance Alliance (HIA) and the New Mexico Medical Insurance Pool (NMMIP) as quasi-public entities that were created by the legislature but do not receive legislative appropriations. She described the process by which the task force addressed the goals of SJM 1, identifying all the ancillary partners that were also brought into the project. The task force identified options for consideration, but did not make official recommendations due to the lack of actuarial analyses of the options.

All the entities together cover approximately 250,000 lives that represent almost \$1 billion in claims costs, \$46 billion in third-party administrator (TPA) costs and about \$12 million in administrative expenses. Information was provided to reflect measures in which all the entities are already engaged to contain costs. Options for consideration covered cost savings, enhanced coverage, modified pooling arrangements, plan and benefit design, pharmaceuticals and data and administration. Specific options were described and are included in the report and the detailed handout. Next steps that require funding include continued study of the options and actuarial analyses in order to develop specific recommendations. Implementation of some of the options

would require the creation of an authority or other overarching structure. The task force members were in agreement that additional actuarial analyses should be done.

Committee members asked for clarification or had comments in the following areas:

- how individuals are ensured continued coverage after losing group coverage under the federal Health Insurance Portability and Accessibility Act of 1996 (HIPAA); the NMMIP and the HIA are the current avenues in New Mexico to do this, though coverage may be costly;
- which individuals are not protected by HIPAA; those who do not have 18 months of creditable coverage before becoming uninsured;
- how the cost of the NMMIP compares with the cost of COBRA coverage that can be obtained through the HIA; the NMMIP rates are set by statute and include discounts for low-income individuals;
- whether the uninsured would be helped by implementation of these measures;
- whether estimates of cost savings for any of the options were done. The task force does not have aggregate estimates; however, individual agencies have done projections;
- what the Health Care Purchasing Act covers; it requires joint procurement for Interagency Benefit Advisory Committee (IBAC) agencies;
- clarification regarding self-insured entities and whether they participate in the IBAC;
- information regarding the potential for cost-savings and level of participation with wellness initiatives for IBAC agencies;
- the pros and cons of requiring a consolidated bid to serve all IBAC agencies and where resistance to that issue exists;
- why people have been transferred from the NMMIP into the state coverage insurance (SCI) program. The NMMIP has a six-month waiting period under some circumstances that would limit access to needed services while SCI does not have any waiting periods; additionally, less than one percent of SCI members qualify for the NMMIP;
- the potential for eliminating the six-month waiting period in the NMMIP;

- the effect that federal reform measures such as guaranteed issue and high-risk pool provisions would have in New Mexico;
- why NMMIP has (by statute) higher-than-average insurance premiums; losses in the high-risk pool are ultimately passed along to private insurance premiums;
- an observation that routinely reported administrative costs of health plans do not reflect the administrative costs of subcontracted providers;
- the potential cost-savings attributable to pooling;
- whether pharmaceutical cost-saving measures already in place in the NMMIP can be implemented by other state-funded insurance programs;
- opportunities to replicate throughout the system any cost-savings measures in any agency that are successful;
- whether decisions have already been made to contain costs in the Retiree Health Care Authority (RHCA); yes, changes were approved by the RHCA board and will be implemented in January and retirees have been notified;
- reasons why RHCA premiums are going up by 30 percent to 45 percent. Premiums are going up to address insolvency projections; however, options are available to keep premiums lower. The RHCA will work with retirees to help them identify the best options for them;
- a request for information regarding the RHCA reserves and solvency projections; currently, the RHCA projects it will remain solvent until 2026;
- whether market forces would take care of many of the issues and options raised in the report;
- a desire to identify and recognize unintended consequences of some of the options;
- the impact of reducing the annual claims cap in the SCI from \$100,000 to \$50,000; the re-submission of the SCI waiver contains a request for flexibility to do this;
- clarification regarding to whom the reported individual agency savings accrue; it appears that the recipients of coverage are not the beneficiaries of these savings; and
- a request for additional information regarding who TPAs are, what their corporate structure is, what their duties are and what the contracts with TPAs cost; the information will be provided.

Bulk Purchasing (SJM 5)

Sam Howarth, director, New Mexico Health Policy Commission (HPC), and Lisa Marie Gomez, management analyst, HPC, presented a report of SJM 5, which studied the potential of bulk purchasing of health care supplies. The goals of the memorial were to identify how departments are currently using bulk purchasing and to develop a plan for ways to use bulk purchasing in the future. The HPC was unable to convene a task force for this purpose; however, it conducted a literature review and requested input and review from state agencies. Ms. Gomez reviewed the experience of multi-state bulk purchasing pools in Medicaid and in the private market. New Mexico does not participate in any multi-state bulk purchasing for Medicaid, as virtually all of Medicaid is under a managed care contract, and the managed care organizations (MCOs) have an individual ability to obtain bulk purchasing discounts. A study conducted by the University of Maryland, Baltimore Campus, concluded that no additional savings are likely with participation in intra-state bulk purchasing in New Mexico under the existing structure. The report indicated that some additional savings could be realized with pursuit of additional rebates under the fee-for-services Medicaid program, measures to encourage greater use of generics, more intensive oversight of high-cost pharmacy products, redesigning the payment methodology for pharmaceuticals and implementing more cost-effective preferred drug lists. The report made recommendations for potential increased savings that are delineated in the report and the handout. Other suggestions for consideration were offered that derived from the experiences of other states and are contingent upon a return to a fee-for-service environment for Medicaid. New Mexico IBAC agencies also have opportunities for increased savings by participating in multi-state bulk purchasing arrangements.

Committee members had questions and comments in the following areas:

- clarification of who is involved in negotiations for pharmaceuticals and medical supplies, and how much leverage the state actually has;
- clarification of the difference between the average wholesale price (AWP) and the average manufacturers price (AMP); AWP has always been the standard for negotiating discounts; this changed with the federal Deficit Reduction Act of 2005;
- recognition that a statute requires the HSD to collect information regarding the AMP; however, the law does not permit the information to be released;
- clarification of how Iowa saved \$100 million per year on prescription drug costs;
- clarification of how federal reform proposals address this issue;
- the ability of IBAC agencies to engage in bulk purchasing now; and

- opportunities for private market solutions.

Prescription Drug Importation (HM 80)

Wayne Propst, director, RHCA, and Mark Tyndall, deputy director, RHCA, reported on the study of the potential for importation of prescription drugs from Canada required by HM 80. Mr. Tyndall provided a description of the I-Save Rx program, initiated in Illinois and extended to seven other states. The federal Food and Drug Administration (FDA) continues to assert that this program is illegal, and all reviews by state attorneys general have concurred; however, no prosecutions have been pursued. Potential savings through instituting such a program are substantial to the individuals who use the program. Opponents of this program feel imported drugs may not be safe.

Committee members had questions and comments as follows:

- whether importation from Mexico has been explored; and
- whether any cost comparisons have been made of generic drugs.

Social Worker Study (HJM 55)

Senator Ortiz y Pino provided background information regarding the purpose of HJM 55. Romaine Serna, communications director, Children, Youth and Families Department (CYFD), Mark Dyke, Ph.D., New Mexico Highlands University, and Lynne Christiansen, L.I.S.W., Department of Health (DOH), presented the findings of the study. Ms. Serna noted that the original intention of the memorial was to study the need for social workers in the state and whether there was a need for a loan repayment program for social worker education. She noted that the information provided to the committee in addition to the memorial report includes a handout reflecting information not endorsed by the CYFD. The CYFD supports the position that persons with related degrees can be hired into social work positions.

Dr. Dyke conducted the research that is the basis of the findings of the report. A survey was conducted that asked about the current and projected need for social workers in the state. The survey found that 13 percent of current social workers intend to retire within the next five years. Given the current rate of population growth, social worker caseloads will increase by more than 50 percent by 2030. The cost of an undergraduate social work degree was found to be approximately \$70,000 when all costs are included, and the cost of a graduate degree is close to \$35,000. The average salary of a social worker who is repaying student loans is \$35,000 to \$40,000 per year. Survey respondents reflected that a loan forgiveness program for social workers would encourage more people to pursue social work as a career and would especially benefit minority students. The task force presented recommended criteria for a social worker loan repayment program; details are included in the full report and in an executive summary of the report. Ms. Christiansen noted that responses to the survey were dramatic; social workers expressed gratitude that their input was being sought. She also noted that respondents included many social workers not employed by state government. She described the difficulty in recruiting

and retaining social workers, especially in rural areas. Ms. Serna concluded by saying that the report shows that New Mexico does need social workers and that a loan repayment program is also needed.

Committee members had questions and comments as follows:

- recognition of the disparity between the national and state average wages for social workers;
- the unlikelihood that a loan repayment program would alter the low wages that social workers are paid in New Mexico;
- reasons why there are more unlicensed than licensed social workers in the state;
- whether obtaining a social worker license results in a pay raise in state government; no, it makes no difference;
- the percentage of minorities who are social workers; and
- the need to narrowly focus a loan repayment program to social workers in rural areas and in very challenging field positions for social workers such as child or adult protective services.

Health Insurance Exchange (HJM 57)

Morris "Mo" Chavez, superintendent, Insurance Division, Public Regulation Commission (PRC), and Melinda Silver, health care attorney, PRC, presented the findings of HJM 57, a memorial tasked with exploring the potential for establishing a voluntary health insurance exchange. Mr. Chavez noted that virtually all major health plans and health insurers participated in the task force and stated that the federal reform initiatives will likely require the state to form an exchange. Ms. Silver provided an overview of the federal landscape, describing common elements of the reform measures being considered in Congress and what to expect with regard to exchanges. She reminded the committee of the definition of an exchange as stated in the memorial, noting that there are variations in how an exchange can function. Mr. Chavez described an exchange as it currently exists in Massachusetts and the Utah model, which is a web-based exchange and a more limited model. Regarding an exchange, the Senate Finance Committee version of health reform requires states to establish an exchange; other senate bills allow states to establish an exchange, and the house measure requires the establishment of a national exchange. Mr. Chavez noted that the high-risk pool in New Mexico will likely serve as an element for transition as an exchange is developed. States may be responsible for accomplishing the necessary risk adjustments and reinsurance mechanisms. The establishment of an exchange could enhance access, choice, affordability and portability of insurance products in New Mexico. The task force envisions an exchange as a quasi-governmental body with diverse

membership on the board, including consumers as well as industry representatives. Individuals could access the exchange through brokers certified as navigators, employers or through a web site. The federal laws will mandate much of what the state is able to institute.

Committee members had questions and comments as follows:

- the potential for an exchange to get more people insured and for individuals to make informed choices;
- the opportunity to increase awareness about the NMMIP;
- whether an exchange could be started on a voluntary basis. It is possible; however, it is likely that very soon there will be federal mandates that direct the approach that will be taken;
- limitations and benefits of the Utah model;
- whether an exchange would help the uninsured. Currently, uninsured New Mexicans already have access to all these insurance products and are still uninsured; an exchange alone would not change that dynamic;
- whether an exchange would offer pre-tax benefits currently only afforded to employers;
- clarification of how Section 125 plans work; the federal tax code permits what are known as cafeteria plans allowing employees to purchase individual health insurance coverage with pre-tax dollars;
- the opportunity for the state to set up federal Section 125 plans through an exchange. It will depend on federal law parameters; New Mexico would need to get federal Internal Revenue Service approval to extend Section 125 plans to individuals;
- the anticipated ability of an exchange to facilitate an individual making health insurance purchases;
- an observation that an exchange, by itself, does not constitute health care reform, but does simplify the purchase of health insurance and promotes affordability;
- whether an exchange should include *all* insurance options, including a public option or the high-risk pool;

- whether an exchange makes insurance more portable; the exchange itself does not change portability laws;
- whether an exchange addresses affordability of health insurance; the cost of health insurance is driven by the cost of providing health care, and an exchange will not address that;
- an observation that exchanges are clearly beneficial to employers, but provide no obvious benefit to individuals with high medical costs;
- an observation that an exchange is part of a larger reform discussion; and
- the importance of including a discussion of the high-risk pool in any discussion of an exchange.

Dr. J.R. Damron was invited to make comments as a long-standing proponent of exchanges. He noted that the federal employee health benefit plan is a model of an exchange; 26 other states are looking at the exchange concept; and federal reform efforts place an exchange as a framework to provide one-stop shopping for consumers to help them identify available products. Additionally, an exchange acts as an administrator for an employer that participates in the exchange and removes the responsibility for an employer to make health insurance choices for its employees.

Substance Abuse: Interagency Behavioral Health Purchasing Collaborative Report on Memorials

Substance Abuse Strategic Plan (SM 71)

Michael Coop, president, Coop Consulting, Christine Wendel, chair, Behavioral Health Planning Council, and Yolanda Cordova, chair of the Substance Abuse Subcommittee of the Behavioral Health Planning Council, presented information about efforts to develop a statewide plan to address substance abuse in New Mexico. The work they have done establishes a permanent process for examining the needs of New Mexico in addressing substance abuse in the future. Mr. Coop described the statutory requirement for the Substance Abuse Subcommittee and the work of the subcommittee to address prevention, treatment, harm reduction and law enforcement elements of substance abuse. He reviewed statistics about the extent of substance abuse as a problem in New Mexico, which shows the seriousness of the work of the subcommittee and the recommendations it is making. Two specific legislative recommendations were highlighted: first, a recommendation that prevention be included in health education as a graduation component; second, that judges be allowed discretion, in cases of possession of small amounts of illegal substances, to send a person to treatment rather than incarceration upon the recommendation and assessment of a licensed behavioral health provider. Mr. Coop noted all of the recommendations will be presented to the Interagency Behavioral Health Purchasing

Collaborative (IBHPC). He briefly highlighted some of the most important recommendations of the report in each of the key areas.

Committee members had questions and comments in the following areas:

- the extent to which youth are screened for substance abuse issues;
- the degree to which existing programs could be consolidated or enhanced to improve efficiency or effectiveness;
- whether OptumHealth was involved in the subcommittee, and the critical need to include it in the future;
- what the ultimate goal of all these recommendations is;
- whether the recommendations include rehabilitation of young alcohol or drug addicts;
- the recognition of the need for a better continuum of care for adolescents; school-based health centers are part of the solution;
- an observation that the report does not emphasize enough the lack of services; and
- the number of treatment facilities in the state.

Opioid Addiction Treatment Barriers (HM 9)

Dr. Karen Armitage, medical director, DOH, Olin Dodsens, opioid treatment program, DOH, and Jeanne Block, advocate, presented the findings of HM 9. The memorial called for the DOH to put together an expert panel to identify the most important treatment methodologies and barriers to treatment of opioid addictions. Dr. Armitage described the scope of the problem in New Mexico. Methadone is a treatment for addiction that is administered under medical supervision. A new treatment modality, suboxone, is a combination of buprenorphine and naloxone that is available in pill form. Opioid overdose is a serious problem; at least half of the deaths are a result of prescription drug overdose. Barriers to treatment include a limited number of treatment programs and limited insurance coverage for that treatment. There are only a few providers who are trained in treatment of this addiction and, except for the University of New Mexico (UNM), all are for-profit entities. Finally, most people with opioid addiction have multiple other medical problems. The memorial called for a plan to reduce the barriers to treatment. Numerous recommendations were presented targeting actions to be taken by the IBHPC and member agencies; actions for communities, health councils and local collaboratives; actions for local detention facilities and law enforcement; and miscellaneous other recommendations. Overall, the recommendations seek to focus system changes and allocations of

dollars to ensure that the best and most effective treatments are identified and used. Dr. Armitage noted that many of the recommendations can be accomplished with very little money.

Committee members asked questions and had comments in the following areas:

- the number of people in the state with opioid addictions;
- reasons why OptumHealth and other payers do not cover suboxone treatment;
- acknowledgment that very few providers or collaborative members have experience with heroin users;
- a comment that most methadone patients are self-paying and receive no assistance to cover the cost of their treatment; and
- a need to introduce suboxone opioid treatment in prisons.

Breastfeeding Student Mother Needs (HM 58) and Pregnant Substance Abuse Services (SM 19)

Giovanna Rossi Pressley, executive director, Office of the Governor's Council on Women's Health, provided a report of the findings of HM 58, which addressed the needs of breastfeeding student mothers. Data regarding the incidence of breastfeeding student mothers show that breastfeeding rates drop dramatically nine weeks postpartum. The report identified needed support for breastfeeding student mothers and recommendations to extend the duration and improve the initiation of breastfeeding among student mothers. New Mexico law mandates that a mother be permitted to breastfeed her child in any public or private location and requires employers to provide a clean and safe environment in which a mother may breastfeed her child. Neither law is enforced. Recommendations were divided into direct services, outreach and education, leadership development and research.

Committee members sought clarification regarding whether students are not being allowed to breastfeed or are not being provided a location in which to breastfeed. Students are not provided an appropriate space; only a handful of schools have programs in place to accommodate pregnant or breastfeeding students.

Ms. Rossi Pressley next addressed SM 19, which looked at substance abuse treatment and prenatal care for pregnant women with substance abuse problems. She noted that a task force identified goals and a proposed work plan, but that the full work of this task force is not completed. The final report will be completed in 2010. Ms. Rossi Pressley identified the goals of the task force, which reflect federal Substance Abuse and Mental Health Services Administration (SAMSHA) guidelines. The chair asked whether the office has adequate funding to conduct these

studies. Ms. Rossi Pressley stated she is not requesting any funding for this work, but would appreciate the committee's support in keeping the office open.

There being no public comment, the meeting was recessed for the day at 6:00 p.m.

Thursday, November 5

The meeting was reconvened by the chair at 8:55 a.m.

Update on Statewide Entity Implementation: IBHPC Overview and State Actions to Address Problems

Linda Roebuck Homer, CEO, IBHPC, was joined by Alfredo Vigil, secretary of health, Dorian Dodson, secretary of children, youth and families, and Katie Falls, acting secretary of human services. Secretary Vigil indicated the presentations of the day would include a brief description of the structure of the IBHPC and actions taken by it since the last meeting of the LHHS. Secretary Dodson provided a time line for the actions taken, noting that much more work has been done than can be reflected here. She also noted that the contract with OptumHealth, the statewide entity (SE) for behavioral health services, requires that the IBHPC provide certain opportunities for the SE to respond. Although payments are going out, she acknowledged that the system is still not working well and is in need of improvement. As a first step, OptumHealth agreed to relax edits in order to bypass billing system problems; an off-cycle payment was issued to get payments to providers quickly. Despite these changes, only a small number of outstanding claims had been paid by October 26; after meeting with the governor, it was determined that sanctions would be imposed and a letter to that regard was sent to OptumHealth on October 29. Critical contract requirements were reviewed, including maintenance of a working claims management system, prompt payment of claims, reductions of administrative burdens on providers and development and use of "user-friendly" forms and procedures. Secretary Falls provided details about the components of the sanctions that have been imposed: a directed corrective plan is required; civil monetary penalties in the amount of \$1.2 million were imposed as well as one percent of the total contract amount until such time as the plan is implemented to the state's satisfaction (fines will be allocated to providers); actual damages were assessed in the amount of 1.5 percent interest on unpaid claims; OptumHealth will be held responsible for all costs incurred by the IBHPC to identify and remedy contract noncompliance; and a state monitor has been appointed and will be paid for by OptumHealth. Ms. Roebuck Homer reported on claims that have been paid since October 14 following the LHHS meeting. She identified the number of providers who have received expedited payments, but noted that steps taken to pay claims quickly will result in more complicated reconciliation of claims at a future date. The IBHPC is conducting a weekly sampling of providers to validate that payments are being received. She provided a clarification regarding denials. OptumHealth was requested to reprocess all denied claims; OptumHealth is resisting due to legal concerns; however, the IBHPC attorneys feel there are no legal impediments to reprocessing previously denied claims. A graph

depicted the nature of claims payments since July 2009. An explanation was provided regarding lost claims; some occurred due to OptumHealth connectivity problems. The IBHPC is analyzing reasons why additional claims appear to have been lost. Secretary Vigil concluded by reiterating that the IBHPC is taking the situation very seriously. From this point forward, the IBHPC will be considering whether the contract with OptumHealth should be terminated. An emergency meeting of the IBHPC is scheduled to discuss the SE on November 10, from 8:30 a.m. to 11:30 a.m. at the State Capitol. Progress has been made, but additional work remains to be done.

Committee members had questions and made comments as follows:

- whether recoupments of denied claims will occur; no, the state monitor is calling providers to discuss what arrangements can be made versus dunning calls; the IBHPC has directed OptumHealth to not dun providers;
- clarification regarding the time line for corrective action, including early actions taken prior to October 14;
- a request for a record of the calls to providers and information regarding the consultants and what they accomplished;
- a strong statement that the problems with OptumHealth are the responsibility of the executive and not the legislature;
- clarification regarding what the IBHPC is doing differently with OptumHealth to avoid problems experienced with the previous SE, ValueOptions;
- whether there were services that were interrupted or providers that went out of business as a result of the payment problems; some providers decided to no longer accept Medicaid clients;
- the seriousness of ensuring that all behavioral health clients in need of services are able to access services;
- clarification regarding the monetary penalties and a recognition that OptumHealth may not use the money contractually required to go to patient care;
- the consequences should OptumHealth decide to no longer continue its contract;
- issues with specific contracts for drug courts that were previously being provided, but have not yet been executed, under OptumHealth;

- when a state monitor will be in place and functioning. Monitoring is occurring daily by staff and consultants; an emergency procurement is underway to hire a specific state monitor, and the IBHPC hopes to have one in place within two weeks;
- whether there are any outstanding claims from ValueOptions;
- appreciation and acknowledgment that the measures taken are a giant step forward, but that much remains to be done;
- clarification regarding claims denied and which ones were legitimate denials;
- the priority placed on reconciling the number of denied claims and paying providers quickly;
- clarification regarding premium taxes paid by OptumHealth and the amount that is returned to OptumHealth through a premium tax credit;
- recognition of the enormity of the dollar amounts in the contract and that the amount is growing annually; legitimate tax and other revenues should not be lost to the state;
- clarification regarding whether claims are still being denied and whether there has been instituted a "hold harmless" provision for the time being;
- the implication of re-institution of a one-twelfth draw method of reimbursement to providers;
- whether OptumHealth or its parent company, United Health Care, is ultimately in charge of decisions. OptumHealth is in charge of day-to-day operations; however, when disputes arise such as with the information technology (IT) system or regarding recoupments, United Health Care is in charge;
- a request for clarification regarding the total budget for behavioral health services in New Mexico;
- what preparations are needed and/or underway to manage the system of behavioral health should the contract with OptumHealth be terminated;
- how much of the current problem is attributable to a faulty IT system;
- the importance of being vigilant in protecting providers from retaliation;

- a recognition that the IBHPC is required by law to contract with an entity or entities to provide behavioral health services;
- accountability of OptumHealth in managing the money that the state pays it for the SE contract; if OptumHealth does not comply with the sanctions, payments to it would be withheld as well as payments to providers made directly by the state; mechanisms are being developed to do that if needed;
- a suggestion that a contractual relationship with an entity under sanctions is adversarial and should be terminated;
- an acknowledgment that in the midst of system failures, safeguards were not sufficient to protect human interests, but that lessons have been learned and measures taken to correct that;
- assurances that the situation will be kept "under a microscope" and providers communicated with constantly as the IBHPC goes forward with this issue;
- whether the contract allows for a reduction of the amount of OptumHealth profits for noncompliance; the sanctions prohibit service dollars being used to pay penalties;
- recognition that OptumHealth has incentives to keep as much of the state's money as it can, while still finding a way to be in compliance with its contract;
- whether the state has the option of contracting with a New Mexico nonprofit or bringing the operations in-house;
- a request that the leadership of the LHHS be kept apprised of the situation as it unfolds and not only during the interim;
- recognition of the huge ongoing costs of lawsuits in which the state is engaged. A request was made for an accounting of the hours charged to the *Jackson* lawsuit and how that affects the ability of the DOH to provide services; staff is working on that;
- clarification of the amounts and reasons for sanctions that were imposed on ValueOptions. There were 12 corrective actions; more detailed information will be provided;
- an update regarding the protest and a lawsuit filed by ValueOptions; these are not yet resolved; and

- a suggestion that the IBHPC develop a proposal to transition out of the current contract with OptumHealth.

Patsy Romero, representing providers in Espanola, testified that although some progress has been made, providers are putting clients on a waiting list and have not received the technical support and training from OptumHealth that was promised.

Brent Earnest, Legislative Finance Committee (LFC), clarified that premium taxes are paid in lieu of all other taxes; insurers receive premium tax credits based on the amount they are assessed to support the NMMIP.

Update on Statewide Entity Implementation: Provider Perspective

A panel of providers addressed the adequacy of measures taken to address OptumHealth problems. Dr. David Ley, director, New Mexico Solutions, stated that things are still pretty bad, but improvements are being made and providers feel they are being heard. He stated that the IT system is so integrated with human systems in OptumHealth that the solution will lead to greater problems later. The flawed system is still being used to fix the flawed system. A large number of providers across the state are still not being paid. Children and youth providers have many examples of Medicaid clients that are not being reimbursed. Significant data problems are anticipated down the road. The Children and Youth Alliance has no confidence in OptumHealth's ability to fix the problems. It is working with the state to identify better solutions to get providers paid.

Donald Naranjo, chair of the Adult Behavioral Health Provider Association, testified that quality is being damaged as providers are not able to provide the same amount of services. Adult providers continually have to deal with decisions that are made and then passed along to them; they need to be involved up front. Communication with OptumHealth is unreliable. Shannon Freedle, C.E.O., Teambuilders, feels that actions taken by the state prior to October 14 were inadequate. Although OptumHealth is now moving cash through the system, providers will still be subject to recoupment in the future, which will put providers at risk once again. The prior authorization system is not working; inaccurate authorizations are being approved, while some appropriate authorizations are not being approved. Roque Garcia, director, Rio Grande Behavioral Health Services, thanked the committee for putting the pressure on the IBHPC to address the problems. He also thanked Secretary Falls for the dialogue that is now occurring with providers. He contends that although the IT system is the largest part of the problem, there are many other problems that are not being addressed in the interest of getting providers paid. His organization supports the concept of the IBHPC, but feels the implementation of it has been poor. He feels that the current system is inefficient and input from providers is critical.

Questions and comments from committee members addressed the following:

- clarification regarding the long-term approach to recoupment and conditions under which denied claims will be reprocessed; the IBHPC has already told OptumHealth that its announced approach to recoupment is unacceptable;
- whether best practices exist for recoupment;
- a suggestion that discussions such as this are less valuable without the presence of OptumHealth;
- clarification regarding the impact on clients. For the most part, providers have continued to provide services; however, their ability to continue to do that is now dramatically diminished;
- a sense that OptumHealth is not supportive of the solutions and is not a cooperative partner in fixing the problems;
- the extent of the interaction with OptumHealth prior to July 1, 2009; providers offered to work with OptumHealth in advance to test the system, but this did not occur;
- acknowledgment that OptumHealth has become more reticent about working with providers; a provider request to be part of the transition team and to participate in the readiness review was not granted;
- the avenues pursued by providers to address problems with ValueOptions; there is current litigation on this issue;
- a feeling by providers that things are worse under OptumHealth than they were under ValueOptions;
- a sense that there is dialogue among providers, the state and OptumHealth, but that there is not meaningful dialogue;
- whether providers are being paid or denied for contracted services;
- the number of services and clients represented by the two provider associations: approximately 24,000 consumers and about 70 percent of all the providers; and
- clarification of the process by which clients get enrolled in the OptumHealth system.

Consumer, Family, Native American and Advocate Panel

Ms. Wendel, Carol Brusca, family member, Mark Simpson, project coordinator, New Mexico Connection to Wellness, Susie Trujillo, local collaborative perspective, Regina Roanhorse, chair, Local Collaborative 15, and Nancy Koenigsberg, Disability Rights New

Mexico (DRNM) advocate, convened as a panel to present various perspectives of the behavioral health system in New Mexico.

Ms. Wendel, representing consumers with substance abuse problems, spoke to the committee as a recovering alcoholic. She told her personal story about growing up in an alcoholic family. At a significant point in her life, when depressed and suicidal, she admitted herself to a small rehabilitation center. She learned the incredible importance of peer support, regained hope for a productive life and realized that she needed to live a life of service. She has now been sober for 20 years, but her disease is still with her. She believes her personal understanding of these issues demonstrates the importance of the consumer voice in the system. Ms. Brusca, vice president of the National Alliance for the Mentally Ill (NAMI), Albuquerque, addressed a family perspective, noting that the NAMI's objective is to ensure that mentally ill family members have the same quality of life as everyone else. Prevention, medication management, availability of housing in the least restrictive environment and employment opportunities are critical. The NAMI wants to see money spent wisely and well to provide the above mentioned opportunities. Family members would like to be involved in choices and decisions for their family members. The NAMI every year conducts a grading of the states; New Mexico regularly gets graded "F". Mr. Simpson addressed the consumer perspective, stating that he has several health problems in addition to bipolar disorder. He expressed great appreciation to the committee for taking the time to listen to these various perspectives. He noted that there are many aspects in treating mental illness, from self-medication to inpatient care. He participates in an organization called Life Link and sees a therapist once a month. His mental illness is well under control, and he is productive in a career and in his life. He made the point that in small communities around the state, consumers are working with consumers to encourage self-sufficiency and prevention. He would like to see additional funding for medical management of mental illness.

Ms. Trujillo identified herself as a community health worker and the chair of Local Behavioral Health Purchasing Collaborative 6 in Silver City. She provided a brief history of local collaboratives, which were established to elicit community input. They are made up of consumers, family members, advocates and providers and reflect the unique and particular needs of sections of the state. There are 13 local collaboratives that are aligned with the 13 judicial districts; additionally, there are five Native American collaboratives. Previously, the delivery system was fragmented and duplicative; the input of the local collaboratives helps to ensure a continuum of care. She identified some successes of her local collaborative. The collaborative serves as a vehicle for counties to work together. She emphasized that something in the system redesign does work, and it is the local collaboratives.

Ms. Roanhorse identified herself as one of the original directors of a local collaborative. She represents four counties in the northwest part of the state. She noted that Native Americans do not have language to describe mental illness. She thinks of herself as an unofficial monitor. On the reservation, teen suicide, alcohol, drug abuse and poverty are huge issues. The 22 tribes,

nations and pueblos are now represented by five collaboratives. It took a great effort to increase the number of Native American collaboratives. She feels the system is not serving Native Americans well, and she feels that her suggestions are discounted. She would like to see the IBHPC and the Behavioral Health Planning Council listen to consumers and families more, especially Native Americans.

Ms. Koenigsberg spoke representing the advocacy community. She stated that the original intention of the IBHPC was to have braided, bundled services and payment streams; however, it has been structured and funded as a Medicaid program and is pathology-based. Head Start; Family, Infant, Toddler Program (FIT); and other early education programs can prevent mental illness problems later on. Her hope is that the IBHPC will begin to emphasize that factors such as substance abuse, poverty, child abuse and others are needed for children. Additionally, she reported on a letter she wrote to the LFC on October 9 on behalf of providers who were afraid to speak out due to a fear of retaliation. Since 1988, she has noticed a devolution of the system; with every system change, some part of the system is lost. She feels that now the system is in a very precarious situation and is in danger of falling apart. This lack of stability in treatment leads to far greater problems. She recommends that the original statute be revisited to require the IBHPC to report statistics on the number of people served, the status of contractors and providers, waiting lists and how long contractors and providers stay in service. She endorses the concept of the IBHPC and the community-based focus; however, it is not materializing in the manner envisioned.

Committee members had questions and comments as follows:

- appreciation for the perspectives of consumers and family members, and a recognition of a need for more data on how system changes affect them;
- a request was made for data as described by Ms. Koenigsberg to be provided quickly to committee members;
- an observation of how the transformation to OptumHealth has resulted in reduced services as reported by the NAMI;
- a suggestion that some LHHS members participate in the evaluation of the data; and
- the importance of preventing retaliation.

Public Comment

Ms. Trujillo stated that with no new money, local collaboratives are learning how to utilize the natural and community support systems better. Funding cuts have led to new creative approaches at the community level.

Deb Dennison testified as the mother of a 19-year-old son who died a few months ago. He spent six years on the waiting list for the developmental disabilities waiver. Ms. Dennison said that she was deeply grateful that he was on the Mi Via waiver when he died. She noted the difficulty of navigating the system. Unless the agencies that are responsible for people with disabilities become more accountable, more and more people will die. She requested the creation of a disability task force as an agency liaison to assist people navigating the system, a complaint line and more money appropriated to remove people from the waiver waiting lists. She commented on some of the recommendations in the memorial report for SJM 1. Waiver waiting lists should be acuity-based, so that the people with the greatest need are served first.

Delphy Roach, director, Brain Injury Association, urged committee members to think about easy access to family support services. She would like to propose some changes to the Children's Code to protect the rights of children. She desires to give input on the CYFD child protective services system.

Della Garlitz provided the perspective of recovery support service providers. Her program serving methadone users was completely eliminated retroactive to June 1 with the transition to OptumHealth. Other services and the level of care were substantially changed and reduced. Funding was reduced by one-half and staff have been let go. Services that were not medically oriented were eliminated. Her agency's program had worked successfully for 18 months, and it had been assured that no services would change, but that has not occurred. Thanks to the intervention of Senator Harden, barriers it was unable to overcome were eliminated. The previous SE understood the value of the program, but OptumHealth is not supportive.

Albert Dugan, NAMI New Mexico, noted that many NAMI concerns have already been addressed. He has served on several OptumHealth committees. He has major concerns about inpatient beds and inpatient care, premature discharge and recidivism to the state behavioral health institute. He is hopeful that data will begin to be produced that will lead to positive change to this system.

Ginny Wilson expressed appreciation for the generous sharing of time by the committee to try to improve the behavioral health system of care in New Mexico. She addressed concerns regarding the local hospital's study to see whether it will close the psychiatric unit. She also urged the committee to keep in mind the individual needs and gifts of people with mental illness. She was critical of the state's decision to change from ValueOptions to OptumHealth and is sad to see that the situation is worse than it was a year ago. Gainful employment, supportive housing and careful moderation of medication are all essential to the successful lives of people with mental illness.

Senator Harden thanked the chair and the committee for the very good work done over the interim.

The chair reminded the committee members that legislative endorsements will be considered tomorrow. There being no further business, the meeting was recessed for the day at 5:25 p.m.

Friday, November 6

The meeting was reconvened by the chair at 9:10 a.m.

Proposed Executive Legislation: Assisted Outpatient Treatment

Paul Ritzma, Esq., deputy chief of staff, Office of the Governor, presented the concept of Kendra's Law, now called assisted outpatient treatment (AOT), stating that the governor is interested in introducing a consensus bill. The bill is intended to provide for mandatory treatment for mentally ill individuals who are considered a danger to society. There are many controversial aspects of the bill.

Brian Stettin, Esq., policy director, Treatment Advocacy Center, Virginia, presented information about the original Kendra's Law enacted in New York and sought to clarify some of the policy issues inherent in the bill. New Mexico is one of only seven states without some provision for court-ordered treatment. He highlighted some of the reasons for opposition to mandated treatment, including those who generally oppose any medical treatment and are in opposition to coercive, rather than voluntary, treatment choices. The chair requested that the opponents be permitted to identify their own reasons for opposition. Mr. Stettin noted that the population of people who would be affected under this law is small and only includes those who have been hospitalized or incarcerated for their conditions. Some people who suffer from severe mental illness lack the ability to make treatment choices or accept treatment choices that are offered to them. Proponents of the bill include family members who are genuinely fearful for the lives of their loved ones. The proposed law requires an individualized treatment plan before a court order would take effect. He referenced a report that was distributed to committee members that summarizes the results of Kendra's Law in New York. An independent program evaluation, which came out in 2005, demonstrated very positive outcomes and reductions in hospitalizations, incarcerations and homelessness, and a greater sense of engagement and higher rates of compliance after initial treatment. It appears that the experience of going to court makes a deep impression on patients and causes them to take their treatment more seriously. Patients do not report feelings of coercion.

Committee members requested to be reminded about the specifics of the proposal and whether a bill has been drafted; no specific bill has yet been drafted. Mr. Ritzma noted that House Judiciary Committee Substitute for HB 609, introduced in 2007, is the rough template for the bill, but that the comments offered today and in other settings will influence any draft to be introduced in 2010. Mr. Stettin provided a brief overview of the concept, wherein a petition is made to the court for court ordered-assisted treatment. The patient would be represented in court by a psychiatrist as would the petitioner. Mr. Ritzma identified the criteria that would be required

for a petition to be made to the court, which include episodes of violent behavior, repeated hospitalizations or incarceration and a history of noncompliance with treatment. A very limited list is typically included of who can make a petition for a court order. A treatment plan would be developed by a treating psychiatrist or psychologist. The sequence of events in which a person is referred to the court was described.

Committee members asked for clarification regarding whether funding will be sufficient for an adequate array of services to be available. It was clarified that this bill is intended for people who refuse to get treatment and does not address access to services for all mentally ill people. A question was asked about military people returning from combat who do not seek services at the Veterans' Administration Hospital and how this law would interface with the military. Military personnel would be eligible to receive court-ordered services. Issues that would need clarification were identified, including the consequences of noncompliance with court-ordered treatment; whether an individual could be committed to inpatient hospitalization on a long-term basis; recognition of the difficulty of identifying an effective treatment plan for a mentally ill individual; and the current lack of sufficient community-based services, acknowledging that New York's success is in part attributable to a significant infusion of new service dollars. It was noted that AOT is not a panacea for an underfunded system, but that there is a cost to doing nothing as well. On request, Mr. Ritzma summarized the case of John Hyde, a mentally ill person whose situation led to the death of two police officers. Ms. Koenigsberg observed that the tragic case of Mr. Hyde would not have been altered by a law such as this. He had been in a successful treatment program for 10 years. He sought treatment at a local hospital and was turned away because he did not have an appointment. He and the five people he killed were the victims of a failed system. A committee member described her personal experience with the serious mental illness of a family member. She contended that Mr. Hyde should not be the poster boy for this law; the law targets people who refuse treatment, not those who are turned away from treatment. This committee member advocated for crisis intervention team (CIT) training for all police officers. An AOT bill should be carefully crafted to protect not only the public, but the individual with mental illness. She asked whether the bill would be accompanied by the necessary funding so that the program will work well, observing that, currently, New Mexico lacks the hospital beds to perform the evaluations required in AOT. Mr. Ritzma was asked if the governor plans to have an appropriation in the bill. He acknowledged that a lack of funding could result in failure of the concept, and that he will bring this concern to the governor. He reiterated that AOT is not a panacea, but is one tool for treating serious mental illness. Questions were asked about the legislative history of this measure; amendments that were previously added gained the support of the opposing advocates and should be included in any new iteration of this measure. A question was asked whether other states have passed similar legislation without appropriations. The answer was yes; however, only anecdotal information is available about the success of measures in those states.

Ms. Koenigsberg made numerous comments in response to previous comments and questions by legislators. She agrees that CIT training should be offered to police officers. She

feels strongly that this bill is an unfunded mandate, that the behavioral health system is currently in tremendous disarray and that these provisions actually already exist in New Mexico law. The New Mexico Mental Health and Developmental Disabilities Code provides that most people admitted to a psychiatric hospital are discharged with a treatment guardian; this discharge planning tool is therefore already in place. If the person does not comply, the treatment guardian can bring the person in for readmission to the hospital. The Mental Health and Developmental Disabilities Code identifies who may petition the court to have a treatment guardian appointed. Finally, the services currently available are poorly managed and there are an inadequate amount of them. There is no continuum of care for behavioral health in New Mexico, which remains at the bottom of rankings in states' funding of behavioral health services. In order for a program like this to be successful, statewide availability of intensive case management services should be available. This service has been eliminated in lieu of comprehensive community support services that are limited to six hours and must be routinely reauthorized. New Mexico does not have the services in place to minimally support AOT. Current New Mexico law has all the elements to allow the state to do what AOT provides; however, New Mexico does not have the funds or the infrastructure to make it work. Ms. Koenigsberg recommends that New Mexico deal with the current crisis, ensure that the service delivery system does not erode any further and consider a modification of the IBHPC law to permit, rather than require, a contract with an SE.

Questions from committee members addressed the paucity of services in the New Mexico behavioral health system. Mr. Stettin contends that in an environment of inadequate services, AOT puts the sickest of the sick at the front of the list and has the potential to save dollars that would otherwise be spent in the most expensive settings. An observation was made that most of the people in need of AOT are already in the system and are imminently dangerous to themselves or others. A court order results in needed treatment being provided and episodes of violence being averted. A personal story was offered about a suicide that could have been prevented with a law such as is being presented today.

Representative Gutierrez, the intended sponsor of the bill, provided some history of this measure and why there is not a bill draft ready for the committee to look at today. She urged the committee to consider this bill and not be distracted by the important, but not essential, funding issue.

It was noted by a committee member that a very small percentage of people account for a large percentage of the behavioral health costs to Medicaid in particular, and the health care system in general. Consumers are already paying for the high cost of these seriously mentally ill individuals; this measure could reduce the overall cost to the system and the Medicaid program in New Mexico. Additionally, this law could provide for a better quality of life for mentally ill individuals and a safer society. A comment was offered that the committee cannot support a bill when a bill draft is not available. The chair noted that if the New Mexico Legislative Council approves an extra day for the committee to meet, a bill could be reviewed at that time.

Steven Randazzo, HSD, offered clarification regarding New Mexico's ranking for behavioral health services. Most recently, the NAMI ranked New Mexico at a "C", and SAMSHA ranked New Mexico's behavioral health funding at twenty-fourth in the nation, in part because of the IBHPC and partly due to legislative support for behavioral health services. A request was made for this information to be provided in writing and incorporated into the minutes. One committee member recalled previous testimony from former Secretary of Human Services Pam Hyde that the calculation that ranked New Mexico last in the nation did not include money spent in Medicaid for behavioral health.

A quorum being present, the chair noted a motion to accept the minutes of the October meeting of the LHHS, with a correction offered by Senator McSorley that he attended all three days. The minutes were approved as amended. The minutes of the Disability Subcommittee of the LHHS were presented for approval. Representative Espinoza requested that the minutes include specifically what was presented to the subcommittee about funding and waiting lists that has now been submitted to the LHHS by her in writing. The motion to accept the minutes was so amended to reflect the additional handout. A motion to accept the minutes as amended was passed unanimously. Attention was drawn to a written statement regarding a controversy about job coaching that the Disability Subcommittee wished to have distributed to the LHHS. Senator Harden noted that the comments in the distributed statement might provide an opportunity to free up additional money for other purposes in the developmental disabilities waiver.

Ms. Koenigsberg stated that the DRNM is opposed to the AOT bill in concept for the reasons she previously stated.

Public Comment

Veronica Garcia raised provider concerns about OptumHealth. Her agency, Esperanza New Mexico, has received payments, but does not know for what the payments have been made, whether they are subject to future recoupment and whether they might in the future be denied. Mr. Randazzo noted the information and will report it to Ms. Roebuck Homer.

Dick Mason, chair of the Legislative Committee of Health Action New Mexico, provided a handout and comments regarding federal health reform initiatives now being considered. He requested that the committee consider legislation to form a working group to ensure alignment of state laws and regulations with federal reform as it occurs.

Jim Ogle, president, Albuquerque NAMI, told committee members a story of a young man who developed mental illness after a bright beginning. Despite numerous psychotic breaks and episodes of hospitalization, this young man believes he is cured and routinely goes off his medication and treatment. Mr. Mason spoke in favor of a carefully constructed AOT bill. He asserted that the cost of multiple hospitalizations in this young man's life far exceeds any community-based treatment he could have received. The existing system of treatment guardians is cumbersome and not working.

Diane Wood, American Civil Liberties Union (ACLU), spoke in opposition to the AOT bill; the ACLU's position aligns with the DRNM position. The civil rights of the individual should be respected and protected.

Sherry Patridge spoke as the mother of a mentally ill daughter. After describing her situation, she spoke in favor of AOT as an approach that would preserve the long-term stability of treatment. AOT serves as a hospital without walls.

Dan Matthews, psychologist and legislative chair of the New Mexico Psychological Association, noted that previously the association took a position to not support the AOT bill without sufficient funding. Without seeing a draft, the association has not taken a position yet on this year's bill. He fears that implementation of AOT without funding would have the effect of prioritizing AOT candidates to the exclusion of other people who also need treatment, but who are not refusing services. Mental health advanced directives, which have not been mentioned today, could serve as a vehicle for mentally ill persons to identify future treatment options during a period when their mental illness is under control.

Jim Jackson presented the position of DRNM and noted that the controversy around this issue highlights the inadequacy of the mental health system in New Mexico. He contends that the bill as previously introduced has the potential to cover a very large group of individuals with mental illness in the state. The qualifying criteria is too broad, going well beyond what he believes most people want. He reiterated the variety of solutions that are already in place to address this problem; in any case, more funding is greatly needed.

Nancy Bailey, NAMI, related her personal experience with the mental illness of her granddaughter who has had hospitalizations too numerous to count. Ms. Bailey has been largely unable to get her the services she needs due to the fact that as an adult, she has civil rights that permit her to make decisions for herself. She urged the committee to enact a version of AOT to help people like herself and her granddaughter and to keep families like hers from being destroyed.

Carol Woleta spoke as a police officer who was shot by a mentally ill individual. She believes that an AOT law would make things safer for police officers.

Mr. Dugan, a retired doctor of internal medicine, believes that early intervention, diagnosis and treatment of mental illness will result in lower costs to the state, families and community. He spoke in support of AOT; however, he noted that virtually all perspectives presented today are accurate. He believes all mentally ill individuals should have treatment, whether or not they seek it. He disagreed with the position of the ACLU and stated that a person who is incarcerated due to mental illness does not have civil rights. Multiple problems exist with New Mexico's current treatment guardian program due in part to the inconsistent application and availability of treatment guardians around the state.

Glen Ford, advocate for people living with brain injuries, stated his appreciation for the committee's support for brain injury programs. He highlighted the incidence of brain injury in the military and in the general population. More funding and infrastructure are needed to address this invisible and often silent condition. Without the support system, mandated treatment will do nothing.

Ms. Roach spoke in opposition to AOT. She lost a husband to suicide and has a son who is bipolar. She recognizes this is a difficult decision, but she thinks attention should first be given to improving the system currently in place.

Representative Cote noted that next week, the interim Military and Veterans' Affairs Committee (MVAC) will hear testimony regarding pre- and post-deployment screening and what the military is doing to identify brain injury and mental illness. Representative Cote would like committee support for a bill he carried for two years to fund safe houses.

Approval of Proposed Legislation

A voting quorum was recognized. Representative Picraux described a way of counting Representative Lujan's votes. He had to leave early; however, he marked the matrix to indicate the measures he supports. If amendments to the bill drafts are made, his vote will not be counted. If the bill is endorsed by the committee without amendments, his vote will be counted.

Mr. Hely and Ms. Wells presented the bills and memorials in the numbered order in which they were listed on the matrix (attached). Expert testimony was provided by Ms. Esquibel concerning HSD bills; Jack Callaghan provided expert testimony for the DOH bill requests.

A motion to endorse bill number 1, to exclude gender as a premium rating factor, generated debate. Questions were asked about how this would affect other factors upon which rates are generally based. Ms. Rossi Pressley stated that national information reflects that women are routinely charged up to 20 percent more than men for the same insurance; this bill is intended to provide gender equity. State law permits insurance companies to charge up to 20 percent more than a male is charged and most do. Clarification was sought regarding whether women cost more to cover. Susan Loubet, the Women's Agenda, contended it is only a perception that women cost more to cover; over their lifetime, they do not cost more, but they do use more health services. An observation was made that this bill would not prevent insurers from raising all premiums to achieve equity and that the overall effect would not be to lower the cost of insurance. Deborah Armstrong, executive director, NMMIP, stated that women are charged higher premiums in the individual market only. A committee member stated a preference for simply eliminating the word "gender" as a rating factor. The motion for committee endorsement was supported by Senators Feldman and Ortiz y Pino and Representatives Picraux and Gutierrez. Senator Adair opposed the measure.

A motion to endorse bill number 2, to redefine "small employer" to permit a group to be one person, passed with no opposing votes.

A motion to endorse bill number 3, to require insurers to utilize at least 85 percent of premium revenues for direct services, generated debate. A committee member felt the bill as written would have no real impact as there are no consequences or sanctions for noncompliance. It was mentioned that sanctions would or could be in contract language. The motion to endorse the bill was unanimously adopted.

A motion to endorse bill number 4, which mandates guaranteed issue of insurance to individuals, generated debate about whether the bill allows insurance companies to charge higher premiums to people who engage in unhealthy lifestyles. Ms. Esquibel clarified that the bill allows all individuals to be offered a policy; however, it allows rating based on rating factors. It does not address the cost of the policy. A committee member observed that guaranteed issue already exists in New Mexico through the NMMIP. Another committee member noted this bill eliminates the possibility of an insurance company rescinding a policy for a lack of disclosure of a pre-existing condition. The motion to endorse the bill passed, with Senator Adair opposing it.

A motion was made to endorse bill number 5, which establishes premium rate limits in the small group market. Questions were asked about whether this would prevent insurers from responding to inflation, and why only small group rates were addressed. The motion to endorse the bill passed, with Senator Adair opposed.

Bill number 6, which gives Native Americans and others more time to meet the requirements and become licensed as alcohol and drug abuse counselors, was endorsed with no opposition.

Bill number 7 would create a mid-level scope of practice called dental auxiliaries. The bill reflects amendments offered in the last session by dental hygienists. A motion to endorse the bill was opposed by Senators Ortiz y Pino and Lopez and by Representatives Picraux and Lujan, and therefore did not receive the committee's endorsement.

A motion to endorse bill number 8, to allow for notification of partners considered at risk of HIV, generated debate. Mr. Callaghan described the bill as a public health intervention; the DOH does not disclose the name of the infected person. The bill was endorsed with no opposing votes.

Bill number 9 to expand the rural health care practitioner tax credit to other providers was endorsed with no opposition.

Senator Feldman asked for an amendment to bill number 10, to tax alcohol, to earmark the increase in revenues to all parts of the Medicaid program. Clarification was sought regarding the

amount of the increase for beer and how this compares to taxes on neighboring states. The bill was endorsed, with Senator Adair opposing it.

Mr. Hely described bill number 11, to create a disabilities task force, that was previously presented to the Disabilities Subcommittee. Mr. Jackson commented that the DRNM made recommendations for language changes, as did others. Senator Feldman noted that it would require a message and suggested that the LHHS request a message for all bills endorsed that need a message. A suggestion was made to add an appropriation for per diem and mileage of committee members. A motion to endorse the measure was unanimously adopted.

Bill number 12 also was discussed by the Disabilities Subcommittee and calls for improved executive agency communication with deaf individuals. It was noted that it would be expensive and difficult for very small agencies such as the Commission on the Status of Women to comply. Clarification was sought about whether this was already required by the federal Americans with Disabilities Act. The bill was not endorsed.

A motion was made to endorse bill number 13 that seeks to align New Mexico law regarding the rights of individuals with disabilities with federal law. The bill was unanimously endorsed.

Bill number 14, to amend the current statute regarding medical homes adding osteopaths, was amended to provide a more technically correct definition of osteopath and to add osteopathic physician assistants. The bill was unanimously endorsed with the amendment.

Bill number 15, to raise taxes on cigarettes and tobacco products, generated debate. The bill was drafted according to American Cancer Society recommendations and previously presented to the Tobacco Settlement Revenue Oversight Committee. Senator Feldman requested the increase in revenues to go to Medicaid programs. The bill received the committee's endorsement, with Representative Gutierrez and Senator Adair opposing it.

A motion to endorse bill number 16 to remove the food tax exemption for soft drinks was passed, with Senator Adair opposing it.

Memorial number 17, calling for an expansion of medical homes, passed with no opposition.

Memorial number 18, calling for a central credentialing process and a task force, passed with no opposition.

Senator Adair moved that all remaining memorials be voted upon as one. The motion passed, and the remaining memorials, providing for tracking of nurse education funding, tracking of hospital-acquired infections, forming of a health reform work group and encouraging private

managed care programs to support medical homes, were all endorsed. Senator Adair asked to be shown in opposition to all four memorials.

Senator Feldman notified the LHHS that she and Representative Picraux have written a letter to the governor asking that Medicaid not be cut as was the legislative intent.

Disabilities Subcommittee Meeting Report

Mr. Hely and Ms. Wells provided a report of the meeting of the Disabilities Subcommittee. The subcommittee met for two days, October 29 and 30, in Room 307 of the State Capitol. LHHS members who attended were identified. The meeting was well attended by the public. The agenda was reviewed briefly. Mr. Hely observed that much public comment was offered throughout the meeting regarding the need for improvements to the education system and employment sector to accommodate disability and foster independence. Medicaid waiver programs generated extensive discussion, particularly policies relating to waiting lists. Because of this interest, an extra LHHS meeting day was requested. The importance of having all the departments present to answer questions was recognized.

There being no further business, the committee was adjourned at 5:15 p.m.