MINUTES
of the
FIFTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

October 5-7, 2010
Room 322, State Capitol
Santa Fe

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by the chair at 9:24 a.m.

Present
Rep. Danice Picraux, Chair
Sen. Dede Feldman, Vice Chair
Rep. Nora Espinoza (Oct. 5)
Sen. Linda M. Lopez (Oct. 5, 6)
Rep. Antonio Lujan
Sen. Gerald Ortiz y Pino

Absent
Sen. Rod Adair
Rep. Joni Marie Gutierrez

Advisory Members
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Eleanor Chavez
Rep. Nathan P. Cote
Rep. Miguel P. Garcia
Rep. Keith J. Gardner (Oct. 6)
Sen. Gay G. Kernan
Rep. Dennis J. Kintigh (Oct. 5, 6)
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Mimi Stewart
Rep. Gloria C. Vaughn
Rep. Jose A. Campos
Sen. Clinton D. Harden, Jr.
Rep. John A. Heaton
Rep. Rodolpho "Rudy" S. Martinez
Rep. Bill B. O'Neill
Sen. Mary Kay Papen
Rep. Jeff Steinborn
Sen. David Ulibarri

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

Staff
Michael Hely
Karen Wells
Zelda Abeita

Guests

The guest list is in the meeting file.

Handouts

Handouts are in the meeting file.

Tuesday, October 5

Welcome and Introductions

The chair welcomed the committee and members of the audience. She reviewed the agenda for the day and reminded members that the meeting was being audiocast. Committee members introduced themselves.

Overview of Health Benefits Exchange Provisions in the Federal Patient Protection and Affordable Care Act (PPACA)

Marguerite Salazar, regional director, Region 8, United States Department of Health and Human Services (DHHS), provided a brief overview of the provisions in the PPACA regarding a health insurance exchange (exchange). She indicated that her office is available to assist New Mexico to establish an exchange, noting that if the state takes no action, the federal government will establish one for the state. Grant money is available to help states establish information technology systems. The exchange must be operated by either a state agency or nonprofit entity. The state will need to decide if it wants to have one exchange (combining both individual markets and small business markets) or two separate exchanges, or if it wants to participate in a regional exchange. Deadlines for having an operational exchange were identified. She noted that the Human Services Department (HSD) was recently awarded a grant of $1 million to engage in planning for an exchange. She highlighted a provision that will make Native Americans eligible for federal employee health benefits. She noted that exchange models are emerging in other states that may prove instructive for New Mexico. She acknowledged that the DHHS will recognize exceptions as it develops guidelines for an exchange.

Minutes and Miscellaneous Business

A quorum being present, the minutes of the September meeting of the LHHS and the minutes of the Disabilities Concerns Subcommittee were approved. Mr. Hely drew the committee's attention to several handouts in the members' packets.

Health Benefit Exchange Planning Grant

Kathryn "Katie" Falls, secretary, HSD, informed the committee about the details of the exchange planning grant received by the HSD. She reviewed the overall goals of a New Mexico exchange. The grant funds will be used to study issues and to provide information to the legislature and the governor to aid in the decision-making process regarding an exchange. She described activity that has already taken place, including obtaining stakeholder input, the work of the Executive Health Care Reform Leadership Team (leadership team) and the work of the SJM 1 Health Care Reform Working Group (SJM 1 HCRWG). She reviewed elements of a "decision tree" that is guiding much of the work that is now underway. The leadership team and the governor desire an exchange that is as transparent and accessible as possible. Details were provided about the primary activities of the grant, which are: to develop a financial modeling

tool; to study and begin to carry out the details of implementing an exchange; to explore the information technology needed to implement health care reform in New Mexico; to identify and develop the business operations of an exchange, such as necessary interfaces, eligibility determinations, plan qualifications and more; and to provide follow-up research and analysis, including recommended legislation that will be needed for health reform in the state. She noted that none of the grant funding will be used to support HSD funding. The HSD is moving as quickly as possible to accomplish the goals of the planning grant prior to the legislative session in January. The budget for use of the grant funds is as follows:

- $275,000 — financial modeling tool;
- $225,000 — oversight by experts;
- $200,000 — information technology assessment; and
- $300,000 — stakeholder involvement and input.

Secretary Falls recognized Ruby Ann Esquibel and Melinda Silver, who put the grant application together.

Western States Regional Exchanges: Lessons from Utah, Massachusetts, California and Florida

Cheryl Smith and Daniel Schuyler, directors, Leavitt Partners, LLC, identified their former roles in establishing an exchange for Utah. The importance of having a vision, developing a concrete plan, understanding the target demographic, engaging stakeholders in the process and developing a time line for important steps were identified as critical considerations. Ms. Smith emphasized that 2011 is an important year for passing authorizing legislation. Many details can be developed at a later time. She noted that the Utah exchange was established with a very limited budget, and experience is now available to other states as they struggle to build an exchange in difficult economic times. Mr. Schuyler noted that information technology challenges are large, but that numerous vendors are already developing products to meet the needs of an exchange. He described the way in which the Utah exchange functions. Ms. Smith highlighted the similarities and differences between the Utah and Massachusetts exchange models. The governance and the roles and responsibilities of the exchange are important to determine. The Massachusetts exchange is a quasi-governmental entity that serves as a contracting agent, while Utah's exchange is located in a state agency and serves a more limited role as a market facilitator. The ability of an exchange to accomplish risk adjustment is critical. Florida established a quasi-governmental exchange in 2008 that serves as a market facilitator.

Mark Reynolds, general counsel, HSD, shared key issues in implementing a state health insurance exchange within the requirements of the PPACA developed by the legal group of the leadership team. Possible approaches to addressing these key issues were described. The legal group feels that it will be critical to institute measures to avoid adverse selection and to minimize the number of people selecting products outside the exchange. In order for an exchange to be successful, to attract insurers and to achieve economies of scale, a sufficient number of people will need to be enrolled in the exchange. The cost of establishing an exchange could be significant, as will be the governance of the exchange. He identified some potential legal challenges should a private entity be selected to operate the exchange. Whatever model is chosen, the exchange must be employer-friendly to encourage the participation of small

businesses. The regulatory role of the exchange and rate health insurance plans will need to be determined, as well as the way in which the exchange will serve as an information clearinghouse. Finally, the exchange will be required to seamlessly facilitate public eligibility determinations; the interface between Medicaid and the exchange will be essential.

Mr. Reynolds covered the elements of the exchange law recently enacted in California, which requires the establishment of an independent, statewide public entity. Measures in the law to ensure state budget neutrality were described, as was the governance. California's law establishes a strong market facilitator model of an exchange. The exchange was given substantial regulatory authority.

Western States Regional Exchange

John Franchini, superintendent of insurance, Insurance Division, Public Regulation Commission (ID/PRC), spoke about the results of a meeting of the Western States Association of Superintendents of Insurance. Following the meeting, a number of western states all agreed to pursue the potential of establishing a multistate regional exchange that maximizes leveraging of resources while allowing for recognition of the unique needs and demographics of each individual state.

Questions and Comments for Morning Panelists

Questions and comments for all the morning panelists covered the following areas:

- ways in which the Utah plan manages to contain costs of the plans offered in the exchange: through risk adjustments and offering affordable plans such as health savings accounts;
- clarification regarding the functions that Superintendent Franchini identified as those that could be handled on a regional basis: underwriting, policy issuing, collections, cancellations, renewals and other functions;
- whether the federal Employee Retirement Income Security Act of 1974 (ERISA) considers it a conflict of interest for insurance companies to be included as board members of an exchange; the ERISA may consider exchanges as fiduciary entities;
- clarification regarding the federal poverty level (FPL) that will result in Medicaid coverage under the PPACA; including income disregards, it will be 138% FPL;
- clarification regarding the grants being awarded under the PPACA; some are competitive, but the exchange planning grant was not a competitive grant;
- concern regarding the establishment of an interstate regional exchange; western insurance superintendents are hoping to maximize economies of scale while preserving states' individual needs;
- clarification regarding what constitutes a sufficient number of participants to make an exchange successful; around 10,000 people are enough to avoid adverse selection;
- how Utah achieved the cooperation of health plans in instituting a defined contribution requirement;
- the role of the Utah exchange in handling customer service issues; one of the technology vendors provides this service at no cost to the state;
- clarification regarding tribal opportunities and challenges in the PPACA;

- the number of businesses and individuals in Utah that are enrolled in the Utah exchange; more than 200 businesses since September 1, 2010;
- whether the Utah exchange meets the requirements of the PPACA; the answer was no;
- whether insurance companies, under the PPACA, can choose not to participate in the exchange; insurance companies are not required to participate; however, the PPACA contains incentives for them to do so;
- whether the State Coverage Insurance (SCI) Program will still exist after implementation of the PPACA; this will need to be determined; the SCI Program could serve as the basis for a basic state plan option, in which case the tax subsidies available through the exchange would go to the state to manage that option; analysis of this and other options will be necessary;
- whether establishment of a quasi-governmental entity to operate an exchange would be problematic for the Risk Management Division of the General Services Department;
- concern regarding privacy issues with the broader use of information technology required in the PPACA;
- whether there will be an ongoing need for the federal high-risk pool; the answer was no, it is a temporary pool;
- clarification regarding important time lines in implementing an exchange;
- recognition of the importance of transparency and public awareness;
- a request for information regarding what other states are doing with regard to establishing an exchange; Ms. Salazar will provide that information;
- how the implementation grant money for stakeholders will be distributed; the Procurement Code will be followed, and the input will be analyzed by the HSD in an objective fashion;
- whether there is time to implement a state exchange if the state is not ready to make a decision in 2011; that is unlikely;
- concern regarding the amount of unknown details at this point in time;
- the pros and cons of allowing the federal government to establish an exchange for New Mexico;
- whether the rates and benefits for insurance are higher inside the exchange than outside the exchange in Utah; the answer was no, they are required to be the same; and
- whether what is required of the legislature now is enabling legislation to allow the process to go forward; the answer was yes; however, details about the major elements of an exchange can be determined by the legislature in the future.

Costs of Exchanges: Options for States

Mary Feldblum, executive director, Health Security for New Mexicans Campaign, provided information to the committee on the anticipated cost to the state of establishing a New Mexico exchange and some alternative approaches. She said that the state has the opportunity to decide whether or not to invest in a health insurance exchange. Two key questions that must be answered are how the cost of setting up an exchange will affect the general fund, and whether an exchange will be able to reduce the rising costs of health care. Federal grants are available through the PPACA to cover the costs of establishing an exchange, and New Mexico has already received a planning grant, but there is no guarantee that implementation costs, and especially information technology costs, will be funded through future grants. It is unknown whether after January 1, 2015, when the PPACA requires that the exchange be self-sustaining, the enrollment

or assessments on insurance companies will be sufficient to cover administrative costs of operating an exchange. Experts in the field have raised concerns about how exchanges will be funded and whether administrative costs will be sustainable. Ms. Feldblum contends that the PPACA does not contain strong enough provisions to hold down the rising cost of health insurance premiums. Continued reliance on a complex system that relies on health insurance ensures that cost shifting will continue to occur, and flaws in the current system will still contribute to the rising costs of health care. She noted that the experience in Massachusetts demonstrates that an exchange does not hold down health care costs. Ms. Feldblum presented an alternative to an exchange provided by the PPACA, called a waiver for state innovation, which is an option to be available in 2017. Work in Congress is underway to move that date up to 2014. A waiver such as this would be required to ensure coverage that is as comprehensive as that required by the PPACA and would cover as many people. She believes that New Mexico does not need to act in the 2011 session to establish an exchange; there is time to consider an alternative approach. Ms. Feldblum suggested that the legislature consider passing a memorial and/or writing a letter requesting the congressional delegation to remove the 2017 date from the waiver for state innovation option. She believes a legislative cost analysis, such as is underway in Vermont, is a critical step, and she emphasized the importance of determining the cost to the state before investing in an exchange.

Committee members had questions and raised concerns in the following areas:

- support for the idea of waiting for another year in order to understand more fully what the potential cost to the state might be;
- concern regarding the potential cost of establishing an exchange when the state is facing a huge budget deficit; there is a desire to wait and see what other states do first;
- clarification that the losses experienced by Massachusetts are over a four-year period and are derived in part by state funding of subsidies;
- clarification that the potential for a larger pool of insured individuals in an exchange should lower the cost of insurance premiums; large pools do reduce administrative costs, but high health care costs are likely to continue;
- the likelihood of the 2017 date being removed, given the anticipated changes in the composition of Congress; Senator Ron Wyden of Oregon is reportedly planning to introduce a bill to do this, and the measure has bipartisan support;
- whether the state has the option to choose to allow the federal government to set up an exchange rather than electing to establish a New Mexico exchange; the answer was yes; however, not implementing an exchange brings its own costly risks;
- recognition that the change in the executive branch of government in New Mexico introduces more uncertainty into an already uncertain environment;
- clarification regarding the practical result of deferring a decision to establish an exchange, including a penalty for not establishing an exchange by 2014;
- clarification that federal implementation grants will be available in the spring of 2011 and that those funds will be able to be used for information technology costs; and
- a desire to move cautiously and examine other models besides an exchange.

Previous Models of Health Insurance Exchanges in New Mexico

Dr. J.R. Damron presented information about the history of bills previously introduced in New Mexico to create a health insurance exchange. Bills were introduced in 2007 and 2008; and in 2009, a joint memorial was introduced to create a task force to study the principles and parameters of an exchange. He identified the goals and principles inherent in all those pieces of legislation, many of which have been addressed through the PPACA, including the requirement for the establishment of an exchange. The state has the choice of determining whether to house such an exchange in a state agency or in a quasi-governmental entity such as the New Mexico Medical Insurance Pool (NMMIP) or the New Mexico Health Insurance Alliance (HIA). Dr. Damron highlighted elements of the bills formerly introduced in New Mexico, including a mandate for coverage or a demonstration of personal responsibility, governance issues, integration of public and private coverage offered through the exchange and other features. Morris "Mo" Chavez, Esq., former superintendent of insurance, ID/PRC, noted that New Mexico was far ahead of the curve in exploring the potential for establishment of an exchange. As a result of HJM 57 in 2009, a group of stakeholders, including health plans, brokers, consumers and the ID/PRC, was convened to study various elements of an exchange and what it would mean for New Mexico to have one. The report of this task force addressed such issues as governance, the type of entity to house an exchange and the duties and responsibilities of an exchange. The benefits of a quasi-governmental entity and the need for extensive outreach to consumers were identified. Guidance for New Mexico regarding an exchange is provided through the findings of this task force. Mr. Chavez noted that an exchange will potentially make available a great deal of useful data. The parameters of the exchange in the PPACA closely mirror those conclusions drawn by the task force.

Questions and comments by committee members covered the following areas:

- clarification regarding the provisions included in the 2007 bill that passed the senate; many of the provisions in the bill could be modified and adopted;
- a request for suggestions regarding provisions that should be included in an exchange at this time; it should meet the PPACA requirements and encourage participation by health plans; Dr. Damron supports enabling legislation that allows the state the flexibility to develop the details at a later time;
- whether exchange planning could proceed without enabling legislation; that is not known; however, there are many decisions that the PPACA requires a state to make; and
- an observation that the NMMIP and/or the HIA could serve as an exchange, which would require legislative amendments to existing statutes.

Exchange Recommendations from SJM 1 HCRWG

Deborah Armstrong, executive director, NMMIP, and chair, SJM 1 HCRWG, described the process and presented the conclusions of the SJM 1 HCRWG relative to an exchange. The SJM 1 HCRWG supports New Mexico establishing an exchange and that the exchange combine both the individual and small group markets, that it be implemented by a quasi-governmental entity and that the functions to be performed exceed what is required in the PPACA. The SJM 1 HCRWG rejected the idea of establishing multiple exchanges within the state but recommended that the door be kept open for participation in an interstate regional exchange. She reported that there was general concern that not all the details and requirements are now known; however, the SJM 1 HCRWG feels there is a higher risk in delaying the process. Support was expressed for

establishing an exchange utilizing existing quasi-governmental models such as the NMMIP and/or the HIA, which would allow the state to get started on essential planning with a low up-front cost, with the details to be filled in later.

Representative Picraux acknowledged the hard work of Ms. Armstrong in chairing the working group. She asked whether there was objection to a bill being drafted that reflects the suggested elements recommended by the SJM 1 HCRWG to be considered for endorsement at the November meeting. Questions were raised about whether such a request would reflect the reticence previously expressed by committee members regarding the establishment of an exchange. Clarification was offered that a bill draft simply puts into bill form what has been offered as a concept. It was noted that any committee member can request a bill draft to be considered in November. Requests were made to see bill drafts prior to the meeting so that members have the time to carefully review them prior to having to vote on them.

Public Comment

Dick Mason, Health Action New Mexico (HANM), commented that California, the only state that has passed legislation in response to the PPACA, concluded that the federal government would bear all of the costs to establish a state-run exchange. He noted that Massachusetts incurred substantial debt because it started its exchange without federal support.

Tara Sillers asked the committee to change the rules of the State Children's Health Insurance Program (SCHIP). The program does not allow coverage of a child if a parent has private insurance. Her husband is a disabled veteran who has coverage through CHAMP VA, which is inadequate to meet the needs of her special needs child. She would like the rule either removed or at least to allow the opportunity of a parent to appeal.

Marco Gonzales, lobbyist for Molina, suggested that an exchange provide for optional participation of health plans without negatively affecting the plans' ability to contract with a state to provide Medicaid benefits. Molina provides only public program coverage.

There being no further comment, the committee recessed for the day at 5:00 p.m.

Wednesday, October 6

The meeting was reconvened by the vice chair at 9:15 a.m. The agenda for the day was reviewed. Committee members introduced themselves.

Rate Review: Factors, Procedures and Administration

Sondra Roberto, staff attorney with Consumers Union, was joined by Michael Murray, chief actuary, Presbyterian Health Plan, to present a general overview of the health insurance rate-setting process. Ms. Roberto discussed elements of the PPACA relative to rate review, which include a provision for the DHHS to review "unreasonable" increases and requirements for insurers to post a public justification for rate increases. She emphasized that responsibility and authority for rate review, process and transparency still will reside primarily with the states. She

identified statistics regarding the individual insurance market, which historically pays higher out-of-pocket costs for health insurance. Ms. Roberto described various elements that contribute to higher rates for the individual market, including rising medical costs, adverse selection, fragmented individual markets and lax oversight of rate setting. Traditionally, rate review involves prior approval for a rate increase, rate filing, a desk review by the ID/PRC and a comparison against standards for approval. She described the phenomenon of "death spirals" in which an individual market block becomes limited to the individuals with the highest medical expenses and then is ultimately closed by the insurer so that no more people may buy policies within that block. Limits of actuarial justification were described. New Mexico's standards are considered to be very discretionary, with many factors not fully described in law or regulation. The New Mexico law does not consider the end effect on the consumer and lacks transparency. In order to have effective rate review, the entire financial position of the insurer should be reviewed, including the insurer's profitability. Ms. Roberto described elements of modern rate review as demonstrated in Oregon, Colorado and Rhode Island statutes that could be incorporated in New Mexico. Strong laws have the potential to promote reimbursement reform and an overall reduction in the cost of medical care. Several states were highlighted for particular elements of their rate review process, such as actuarial projections, affordability, risk pooling and transparency. She concluded by suggesting several steps that New Mexico could pursue to strengthen its rate review process, including a thorough examination of current weaknesses, legislative changes, a study of provider reimbursements and market conditions, development of a finite, allowable surplus range for insurers and an examination of insurer charters and missions.

Mr. Murray noted that the new state law regarding medical loss ratios limits an insurer's ability to have flexible pools. He described an industry view of the basics of insurance rating, including that insurance rates must be low enough to be competitive and affordable and high enough to cover losses. Premiums must cover projected claims, projected administrative costs and a target margin of profitability. He described the typical components of health insurance costs and market dynamics that can affect costs. He contrasted the current rate regulation process with the anticipated effect of changes in such factors as the minimum loss ratio, which was made more strenuous by legislation passed during the 2010 New Mexico legislative session and by the PPACA. Mr. Murray noted that in setting premium rates, insurance companies are more driven by their ability to attract more members than by their profit margins. He commented that Presbyterian Health Plan would support a more rigorous and transparent rate-setting process.

Committee members had questions and comments in the following areas:

- whether the industry believes the process should be more transparent; the answer was yes, within limits; Mr. Murray feels that the actual rate filings would not be useful as they are very complex;
- clarification regarding how pools become more and more unhealthy over time;
- clarification regarding the administrative structure of the Presbyterian Health System and Presbyterian Health Plan, including the long-term viability of the system;
- clarification regarding the effect of personal health choices on rating the risks of individuals;

- concern regarding the suggestion that rate setting be used as a vehicle for provider reimbursement reform;
- the anticipated effect on premiums of the inclusion of individuals with high risks being included in the same pool with healthier individuals in exchanges in the future;
- clarification regarding the tenure of rate review reforms in the states mentioned by Ms. Roberto; it varies; however, the process of reform in this area is relatively new;
- whether there are inherent dangers in the self-regulation of actuaries as a profession;
- whether standardized and more detailed documentation should be required from insurance companies; and
- which recommendations Mr. Murray would agree should be included in a reformed rate-setting process; Mr. Murray stated that his opinions are his own and not the industry's or his employer's; he feels that transparency and limits regarding reserve funds and all steps in the actuarial process should be included in the filing.

Rate Review in New Mexico: Existing Law and Procedures and Potential Changes

Superintendent Franchini commented on the importance of the PPACA. Thomas Bowling, chief life and health actuary, ID/PRC, provided background information regarding the actuarial process in rate review in New Mexico as provided in law and by regulation. He noted that New Mexico traditionally uses the National Association of Insurance Commissioners (NAIC) guidelines, and he commented on the effect of changes in the medical loss ratio in New Mexico. He identified anticipated legislative actions pursuant to the awarding of a grant under the PPACA to review the premium rate review process. Christine Baca, bureau chief, Managed Health Care Bureau, Life and Health Bureau, ID/PRC, clarified the definition of "small employer" as provided in the PPACA. She spoke about the process of rate review, and she identified deadlines and requirements for insurers seeking premium rate increases not already described by Mr. Bowling. She noted that the PPACA grant will allow the ID/PRC to strengthen the process and make it more transparent and consumer-friendly.

Brian Harris, assistant attorney general and consumer advocate, provided details about the process of holding a hearing on rate review. Once a consumer requests a hearing, a hearing must be held, and the process becomes quite adversarial. He acknowledged the complexity of actuarial data and the difficulty the general public has in understanding rate filings. He commented that he welcomes the opportunity to participate in rate review reform.

Superintendent Franchini reviewed steps that the ID/PRC has taken to address rate increase requests since he became superintendent. He described changes that have been made to change the hearing process to better serve the needs of the public. Kimberly Scott, ID/PRC, reviewed in detail the rate review project underway thanks to a $1 million grant received through the PPACA. She described prior efforts of the ID/PRC to research what other states have done to strengthen rate review, and she described four rate review models from other states that were obtained as a result of this research. The ID/PRC is using these best practices in considering reform in this area with the PPACA grant. She believes Oregon's model has emerged as the best model after which New Mexico should pattern its model. The ID/PRC would like to develop a web portal that will make information much more available to consumers. Other changes for which the ID/PRC will be seeking legislative support involve development of a consumer and business services bureau with four staff positions, a stakeholder advisory committee, actuarial

and web development contracts and other enhancements to the current system. Ms. Scott described data collection efforts that are currently underway as part of the grant process. A time line was presented with key activities highlighted. Activities will be pursued as funding increments are received. She concluded by reviewing common questions and answers provided by the DHHS.

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

- the necessity for balancing the interests of the public's desire for the lowest possible rates and the fiscal viability of the insurance companies; both must be considered in the rate review process;
- whether the process of rate review should be altered pursuant to the PPACA; the federal government, through the PPACA, has already given the ID/PRC more tools to accomplish this;
- whether the superintendent supports standardization of filing forms; the answer was yes, using NAIC guidelines;
- whether health insurance rate filings are subject to the same requirements as utilities; the answer was no, insurance companies are not regulated as a monopoly and are not entitled to any set profit;
- whether physicians are participating in the grant stakeholder group; they have been invited and will be involved in a formal advisory group in the future;
- clarification regarding the meaning of "actuarially sound"; it differs in private and public settings, but it basically means the premium is sufficient to pay claims that arise;
- whether the concept of protecting consumers is included in the model that the ID/PRC is proposing;
- clarification regarding the information that is needed to best determine the reasonableness of rate increases; specific justification of submitted information;
- clarification regarding which changes can be accomplished by regulations and which will require legislation; much will be done by regulations, but legislative requests will be brought forward at a later time;
- clarification regarding the ID/PRC's remedial plan to address the poor audit review and probationary status under which it is currently operating; the ID/PRC is currently accredited, but must address four specific areas to be taken off probation; the process of complying is anticipated to take about one year;
- whether the Workers' Compensation Administration definition of "small employer" and the ID/PRC's definition should be in alignment; the superintendent will explore this;
- whether it is a goal of the ID/PRC to attract more competition; the answer was yes; and
- whether there is an appropriate role in the ID/PRC in regulating hospital reimbursement; the superintendent is in dialogue with the secretary of health on this issue.

Overview: the PPACA and Health Insurance Reforms; Potential Changes to the New Mexico Insurance Code

Superintendent Franchini was joined by Melinda Silver, Esq., Melinda Silver Enterprises, Mr. Reynolds and Marisela Chavez, legal intern, University of New Mexico (UNM) School of Law, to discuss the insurance provisions in the PPACA and changes to the New Mexico Insurance Code that may be required as a result of this new federal law. Ms. Chavez began by

describing a chart she created while serving as an intern to the Legislative Council Service that compares the insurance provisions of the PPACA to the New Mexico Insurance Code. Ms. Silver provided a very brief history of health insurance in the United States, noting that each time Congress passed insurance reform laws, states needed to examine their own insurance laws and amend them to align with federal law. She commented that some insurance reforms in the PPACA have already gone into effect. She described "grandfathered plans" that do not need to comply with the requirements of the PPACA. New Mexico has already implemented some measures that will not need to be changed to align with the PPACA requirements. New Mexico's consumer protection law is quite strong and probably does not need any revision. Ms. Silver identified numerous measures in New Mexico law that differ from the PPACA, particularly those that are effective in 2010 and 2011, and time lines for implementation.

Superintendent Franchini stated that the ID/PRC is already in the process of informing New Mexico residents about their rights under their health insurance coverage. Insurers have been informed through a formal bulletin. He distributed a list of potential changes to the New Mexico statutes and New Mexico Administrative Code as a result of the PPACA. He identified four specific areas of law that he believes will need to be changed, including Chapter 59A, Article 22 NMSA 1978, individual health insurance contracts; Chapter 59A, Article 23 NMSA 1978, group blanket health insurance contracts; Chapter 59A, Article 46 NMSA 1978, health maintenance organizations; and Chapter 59A, Article 47 NMSA 1978, nonprofit health care plans.

Mr. Reynolds presented an alternative approach that he called a "catch-all" provision to allow the ID/PRC to implement insurance reforms to ensure compliance with the PPACA. He provided information about three states that have already enacted such legislation, as well as a discussion draft of a bill that could suffice as a catch-all solution in New Mexico. Mr. Hely clarified that the bill was drafted at the request of the leadership team and loosely mirrors Maryland's approach. Superintendent Franchini stated that he supports a measure like this. Ms. Silver noted that if New Mexico does nothing, the federal law will prevail, and consumers with questions would have to seek guidance from federal statutes.

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

- an observation that the Government Restructuring Task Force (GRTF) is considering changes to the PRC, and that if these changes are adopted, it could affect the superintendent and the responsibilities of that position;
- clarification regarding whether the suggested statutory changes to the New Mexico Insurance Code would be affected by a restructuring of the PRC; the superintendent thinks not;
- an observation that recently released bulletins related to the internal claims appeal process and external review process should be closely reviewed to evaluate the possible conflict should the PRC be reorganized; these rules are being promulgated by the Consumer Relations Division of the PRC;
- whether moving the health insurance regulatory responsibilities of the ID from the PRC to another entity would require a constitutional amendment;
- an observation that proposed legislation seeking to align state and federal law could include a successor provision to circumvent problems that arise from restructuring;

- whether the catch-all language will address those New Mexico provisions that are stricter than the federal law; the answer was yes;
- whether the ID/PRC is prepared to issue rebates to consumers who are affected by an insurance company's violation of the federal medical loss ratio provision;
- a suggestion that the draft bill covering catch-all language be amended to change "may" to "shall"; a quorum being present, a motion was made to instruct Mr. Hely to make that change; the motion carried;
- a motion was made and seconded to adopt the discussion draft bill 202.182097, as amended, as a committee-endorsed bill; a roll call vote was requested and the vote was unanimous; and
- clarification that the stricter of the two laws prevails when there is a conflict between state and federal law.

Public Comment

Albert Dugan, M.D., National Alliance for the Mentally Ill (NAMI), objected to the earlier discussion regarding risk pools and the position that healthy individuals should not be burdened by bearing the risk of those who do not take personal responsibility for health. He contends that all individuals are at risk of illness regardless of whether they have taken good care of themselves. Members of the NAMI desire robust and fair risk pools.

A request was made for handouts in advance of the next day's meeting. No handout materials are currently available. A suggestion was made that in the future, materials be requested prior to the meeting.

Representative Kintigh clarified his position regarding risk pools and personal responsibility for health care in response to earlier public comment.

There being no further comment, the committee recessed for the day at 3:05 p.m.

Thursday, October 7

The meeting was reconvened by the chair at 9:05 a.m. She reviewed the agenda for the day and for the November meeting. She reminded the committee that the meeting is being audiocast.

Governance of Health Care Finance and Administration: Restructuring Opportunities

James Tryon, M.D., described his background in medicine and his significant contributions to health policy in New Mexico. Background information was offered about the cost of the current system of health care. The system is complex, difficult to control, dynamic and constantly changing. In general, it can be seen as a social structure not inclined to be self-organizing or self-correcting. He contends that there is really no such thing as competition or a free market in health care. The primary financing mechanism is based on a private, competitive approach. The problem is not in the financing model. The problem is that health care delivery has evolved into a more and more fragmented system. The mechanism to bring order to this fragmented system is the exchange. An exchange allows pooling of resources and efficiency of scale, but it must be established and implemented very carefully. A properly governed exchange

can accommodate the continually changing aspect of health care delivery; can focus on cost, quality and disparities in health care; and can deal with persistent public fears about the system. It is critical to keep in mind the "control knobs" of the health sector, which include finance, payment, organization, regulation and behavior. Change to one control knob can result in changes to all the others. Governance should be subject to constant evaluation to determine its ongoing effectiveness, particularly with regard to responsiveness to stakeholders. A well-governed exchange will have a process for consultation with stakeholders and regularly consider changes to policy based on their input. Properly set up and governed, an exchange will operate as a business. The PPACA requires an exchange to be self-sustaining by 2015. Dr. Tryon concluded by noting that a well-designed exchange will serve to simplify the administrative aspects of managing a physician practice in such areas as prior authorization. Unbridled health care costs demand that action be taken. Doing nothing is not a choice.

Brent Earnest, senior fiscal analyst, Legislative Finance Committee (LFC), provided a different approach to the discussion of restructuring by focusing on opportunities for a health care financing agency. Goals of a health care financing agency could include health care cost containment, improvement in health outcomes, delivery system design, a data clearinghouse and consumer education. Such an agency could consolidate and manage the public purchasing of health care and serve as the center for research and data collection to inform policy for the state. Other key legislative considerations include governance, the relationship of such an entity to an exchange, legislative oversight, reporting requirements, evaluation and the possibility of a sunset clause. Mr. Earnest described two models for a health care authority, including Oklahoma and Kansas. Oklahoma's authority is charged with controlling health care costs, ensuring appropriate standards of care and ensuring access to care. It does not include state employees. The governing board is made up of seven members appointed by each legislative chamber and the governor. The duties and responsibilities of the board and the organizational structure were described. The Kansas Health Policy Authority was established in 2005 as the principal health care agency for the state. All public programs, including state employees, are under this authority. Its purpose combines the effective purchasing and administration of health care with public health strategies. Its governing board has nine members appointed by the governor and the house and senate leadership. The Oregon Health Authority is the newest of the described models, having been established in 2009. Its purpose is to organize most health-related programs into a single agency and to maximize its purchasing power. The establishment of the authority is to be phased in over two years, and the authority will be charged with establishing an exchange. The Oregon Health Authority is Organized within the state's Department of Human Services, and it will be governed by a nine-member board appointed by the governor and approved by the senate. Mr. Earnest described a possible New Mexico health care financing authority that could consolidate data collection and planning, behavioral health services, the Interagency Benefits Advisory Committee (IBAC) and Medicaid under a board. It holds the potential for incorporating an exchange into the authority or as an adjunct to the authority. He concluded by identifying a phased approach to consolidation of the IBAC that was presented to the GRTF. It would begin with consolidated purchasing and lead to administrative and risk pool consolidation over a three-year period.

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

- the net cost to the state of creating a new state agency through consolidation; whether consideration has been given to the effect on existing agencies; major savings would probably not be seen in the short run, but efficiency would improve in the delivery and outcomes of health care;
- whether credentialing and recoupment would be helped by establishment of an exchange; credentialing might be simplified; it is unknown whether recoupment would be improved;
- the overall penetration of health insurance in New Mexico;
- whether Oklahoma, Kansas and Oregon operate their Medicaid programs through managed care;
- whether the ID/PRC would have a role in a health care authority in New Mexico; it would depend on how an exchange fits into the picture;
- the amount that could be saved through consolidation of IBAC agencies; consolidation of the pharmacy formulary alone is estimated to realize $5 million to $10 million per year; Mr. Earnest will provide the LFC estimate for combined estimated savings from purchasing a similar benefit package, which could total $10 million to $50 million;
- ways in which an exchange could affect the health care delivery system; over time, benefit packages will reflect evidence-based practice, prevention and wellness on a greater scale;
- whether a health authority would have a role in future planning as in a certificate of need process; this is a critical issue for New Mexico to consider;
- differences between health care delivery in rural and urban areas and how to address both in a coordinated fashion;
- the potential benefits of standardization; and
- whether restructuring would provide opportunities to expand the health care provider supply through more clinics or better use of telehealth; the development of mid-level practitioners is vital, especially in rural areas.

Public Comment Regarding Restructuring

Liz Stefanics reminded the committee that the New Mexico Health Policy Commission could be amended in statute to serve as a health care authority.

Nandini Kuene, independent health policy consultant, commented on the impact of rising health insurance premiums. She noted that more than 40% of the uninsured in New Mexico are working people who cannot afford health insurance. She contended that a primary goal of an exchange should be to ensure that health insurance is affordable. She urged the committee to consider the benefits of a robust exchange such as the Massachusetts model.

Bill Wiesel, M.D., Center for Health Policy, UNM, noted that the current system of health care delivery does not focus on quality of care or patient care but unduly emphasizes the quality of care provided. The primary focus of health reform should be on the causes of the rising cost of health care. The key is accountability.

Mr. Mason reported that HANM has been conducting forums on health reform around New Mexico. An exchange will have a vital role in representing individual consumers. HANM

believes in the four major elements of an exchange: it is quasi-governmental; it has an availability of plans; it is transparent and accountable; and it is a strong purchaser.

Ellen Pinnes, health policy consultant, offered a correction to information previously provided about the Medicaid budget. The shortfall referenced should not accrue to Medicaid as the enhanced federal medical assistance percentages (FMAP) go away. The enhanced FMAP allows the state to divert Medicaid funds to other programs, and those dollars should now come back to Medicaid. She stated that reform should incentivize providers to provide good care rather than more care. She noted that funding health and wellness efforts in the short term will have great cost savings in the long run. The Commonwealth Fund has done research on this topic. She encouraged the members to look more at where the state can do better and less at where cuts can be made.

Becky Becket, former chair of the Behavioral Health Planning Council, spoke as a parent of a child with mental illness. She commented that the original lofty goals of the Interagency Behavioral Health Purchasing Collaborative (IBHPC) have not been realized. The system is not working and has lost sight of patient needs.

Patsy Romero, Romero and Associates, represents rural behavioral health providers. She commented that restructuring of the behavioral health system is resulting in many mental health care providers closing their doors, thereby limiting services to consumers. Core service agencies are not benefiting New Mexico. She contends that it will not reduce costs.

Committee Discussion and Direction: Health Care Financing and Restructuring Opportunities

Mr. Hely noted that the GRTF has asked for input from the LHHS on this topic and that this is an opportunity to discuss this and other options. Senator Feldman noted that this discussion need not repeat the discussion that occurred around the establishment of an exchange.

Comments were offered on this topic as follows:

- whether the GRTF has considered an actual bill; the answer was yes; it primarily addresses phase one of the proposed consolidation of IBAC agencies;
- a reminder that the SJM 1 HCRWG report reflected numerous points of agreement to consolidate and simplify certain administrative functions, including an all-payer claims database; one third-party administrator; a common enrollment process; common data reporting and plan year; linked web sites; joint outreach and marketing; a common contract for actuarial services; and a cost-benefit analysis;
- a suggestion that the LHHS consider this bill at the November meeting;
- recognition that consideration of IBAC consolidation would be highly controversial and generate a lot of fear;
- a belief that there is not much more savings that can be achieved through more IBAC consolidation;
- interest in moving forward on establishing a health care authority as a quasi-governmental body that could house the exchange;

- whether a new health care agency would carve out current employees from existing departments; the agency would have to be cost-neutral in order to pass;
- the extent to which information technology is, or is not, already consolidated;
- efforts should be focused on whether New Mexico is getting the best service for its dollar and whether health care needs are being met;
- instruct staff to draft a bill creating a health care financing and administration agency; use goals of health care cost containment, improved health outcomes, delivery system design, data clearinghouse and consumer education;
- the bill should give the agency the ability to redo managed care contracts; accountability should be ensured, especially in the mental health managed care contracts; and factors of shared risk and wellness should be added;
- consider a previous bill of Senator Timothy M. Keller to create an open bidding process to save 5% of the cost of the contract; Mr. Earnest clarified that this concept refers to an open rate-setting process versus an open rate-negotiation process;
- suggestion that a previous bill that was developed by the committee with a facilitator serve as a starting point;
- a process should be considered to negotiate directly with providers;
- the authority should be focused on state-run programs;
- whether county indigent fund programs should be included; this would be controversial;
- the lack of providers is a recurring theme with the LHHS this interim; a suggestion was offered that a bill could be drafted to work with a private medical school in Arizona to fund 20 slots for dental students; this approach would be more affordable than starting a New Mexico dental school; admission should be tied to a guarantee of service in rural New Mexico;
- pursue enhancing mid-level providers, particularly in the behavioral health area;
- clarification: re-embolden the New Mexico Health Policy Commission and all of its functions; this entity would combine Medicaid and other New Mexico public program oversight and contracting; it could be a health care planning and financing entity;
- whether a defined contribution concept should be included; it should have broad direction and leave responsibility for details to the board;
- consider using the Oklahoma authority as a model for New Mexico; and
- an authority must interact with an exchange.

Mr. Hely noted that bills may have overlapping functions and that prior bills have focused on health care reform in the state; he has questions before he can draft. He requested that the committee appoint a person or persons with whom to work out the details. The committee agreed that the chair and the vice chair should serve that function.

Behavioral Health Caucus: Early Detection and Treatment of Schizophrenia; Telehealth in Behavioral Health Treatment; Causes and Prevention of Suicide in New Mexico

A meeting of the legislative behavioral health caucus was conducted during the lunch hour. Jim Ogle, Albuquerque NAMI, reminded committee members of the role and function of the caucus. He announced that the presentation was intended to be educational and the NAMI would like feedback about its usefulness. He introduced Steven Adelsheim, M.D., director, Center for Rural and Community Behavioral Health, UNM, who presented information regarding

a public health approach to decreasing the incidence of mental illness. Three topics were covered, including the EARLY program, designed to provide treatment to youths with early signs of serious mental illness; youth suicide, with a special focus on Native American youth suicide; and the emerging importance of behavioral telehealth programs. Dr. Adelsheim introduced Dr. Braveheart, who has been hired to focus specifically on mental health issues among Native Americans.

Committee members had questions and comments in the following areas:

- whether the NAMI has bill requests that could be brought before the committee for endorsement;
- the extent of efforts to address mental health issues with the Mescalero Apache Tribe; Dr. Braveheart will be working to develop and enhance existing programs that are culturally appropriate;
- clarification regarding the extent of need among middle school students and how student needs can be met; if students are reached early enough, they do not need the same level of service as when needs go unrecognized;
- how telehealth expands access to services at a lower cost;
- whether the OptumHealth contract could be reconfigured to optimize mental health benefits for youths;
- the severity of the heroin overdose problem, which far exceeds DWI incidents; marijuana use may be an even bigger problem; prescription drugs can also be gateway drugs to heroin addiction;
- whether the IBHPC has been a successful venture;
- a recommendation to look at treatment models in other states;
- the importance of offering programs in public schools; and
- the challenge of increasing funding for these vital behavioral health programs in such an austere budget year; establishing budget priorities will be more critical than ever.

Mr. Ogle offered thanks all around for the opportunity and reiterated the request for feedback on this format of this educational approach.

Long-Term Care: the PPACA and Restructuring

Matthew Onstott, Ph.D., deputy secretary, Aging and Long-Term Services Department (ALTSD), introduced Emily Kaltenbach, director of policy and planning, ALTSD, and outlined the format of the presentation. He highlighted the growth in population for individuals over the age of 60 over the next five years. By the year 2030, it is expected that there will be more people over the age of 65 than under the age of 18. He briefly described long-term services currently available in New Mexico through the ALTSD. He noted that New Mexico is first in the nation in the proportion of Medicaid long-term services dollars for home- and community-based services compared to nursing home care. Statistics were provided regarding the number of people enrolled in the various programs overseen by the ALTSD.

Ms. Kaltenbach described long-term care provisions in the PPACA and the opportunities that may arise as a result of this. The emphasis on home- and community-based services is considered the most significant since the passage of the federal Olmstead Act of 1999. She highlighted several opportunities, beginning with the Medicaid Community First Choice Option,

which provides incentives to states to provide personal attendant services as a state plan benefit with an enhanced FMAP. This program is similar to the personal care option program already in effect in New Mexico. The Medicaid State Plan Benefit somewhat mirrors the Coordination of Long-Term Services "C" Waiver, with some exceptions. Originally developed under the federal Deficit Reduction Act of 2005, it has a more robust service package than the Community First Choice Option. Individuals do not have to meet the same level of care as in the current waivers, and the eligibility criteria must be less stringent than the institutional level of care determinations. This option allows states to target populations, and some states are considering using it to serve individuals with mental health or substance abuse issues. A state could have multiple programs of this sort serving different targeted populations. States may not establish waiting lists or cap enrollment for the eligible populations in this option. Money Follows the Person is an existing demonstration program that has been extended to 2015, with additional dollars appropriated to cover the cost. The program is intended to offer the opportunity for individuals in nursing facilities to receive services in the home and community. Then the state has an opportunity to target specific populations and will receive an enhanced FMAP for one year for individuals transitioned into the community. Requirements for eligibility have been relaxed. New Mexico has applied for and will receive planning grant funds in the amount of $200,000 to engage stakeholders, analyze current system capabilities, develop a programmatic and fiscal impact report, identify target populations and develop operational protocols.

Ms. Kaltenbach described a voluntary, new long-term care insurance program called the federal Community Living Assistance Services and Support (CLASS) Act. Regulations are under development. Medicare changes enhance prescription drug coverage, preventive care and improved health outcomes. Higher payments to Medicare Advantage plans will be phased out. Within the PPACA is the Elder Justice Act, which authorizes grants to states to enhance protection and provide support for adult protective services. Mr. Onstott described the federal Nursing Home Transparency and Improvement Act of 2009, which makes information about the quality of nursing home care more easily accessible to consumers. Other grants enhance aging and disability resource centers (ADRC) (the ALTSD received $500,000), healthy aging and living well projects and work force development. A summary slide highlighted funding opportunities within the PPACA. He concluded by briefly discussing the work that is underway to respond to HM 43, which calls for the ALTSD to work with area agencies on aging to develop a new business model of service delivery for federal Older Americans Act of 1965 services. Changes are suggested not only to respond to funding constraints and restructuring potential, but to address the changing demographics with the aging of the baby boomer generation.

Ms. Kaltenbach presented recently published data and policy recommendations emerging from the Elder Economic Security Initiative. The ALTSD is partnering with Wider Opportunities for Women and the University of Massachusetts, Boston, on this project. On average, seniors need between $17,000 and $18,000 per year to be economically secure in New Mexico, an amount that exceeds the FPL by $7,000 to $8,000 per year. Policy recommendations were derived directly from interviews with elders.

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

- clarification regarding the resources provided in the Elder Economic Security Initiative;
- clarification regarding grants that have been awarded and may yet be awarded for long-term care;
- clarification regarding the impact of cuts to Medicare Advantage plans; it appears that premiums have not substantially increased yet, but there are 14 Medicare Advantage plans in New Mexico, and information is not known about all of them at this time;
- a request for follow-up on changes to Tricare; ADRC counselors are well-versed in this area;
- a request for the telephone number of the ADRC: 1-800-432-2080; and
- recognition that in-migration to New Mexico may decline in the coming decade due to the poor economy.

Office of Ombudsman: Consumer and Business Outreach

Jane Wishner, Esq., executive director, Southwest Women's Law Center (SWWLC), spoke about the importance of outreach to consumers. She described three legislative proposals as follows: 1) establish in statute and adequately fund an office of health care reform implementation; 2) establish an independent consumer health assistant program (CHAP) for consumer education and assistance that utilizes community-based agencies, community health workers and health care and social services providers and advocates; and 3) require the public dissemination of key data regarding health care coverage and services obtained by the HSD, the ID/PRC and any exchange that is created. Ms. Wishner noted that Barbara Webber, HANM, provided a handout that summarized the input of consumers obtained during public education meetings conducted by HANM.

Ms. Scott described the process of external review currently available to consumers who have unresolved complaints regarding coverage through managed care plans. Jill Janov provided a personal story about her experience of erroneous denials and a complicated appeals process and made recommendations for improvements in New Mexico. Her recommendations include: establishment of a statewide public awareness campaign about the right of appeal; funding of advocates in the community to help navigate the appeals process; funding of a wide network of providers to serve on managed care appeal hearings; and creation of an emergency appeals process.

Ms. Scott presented information about the consumer assistance grant application submitted by the ID/PRC. If awarded, $226,436 will be awarded to create an ombudsman position and a consumer telephone hotline to establish a language line to serve culturally diverse populations and to partner with consumer advocates, health care professionals and other state agencies with existing consumer assistance services.

Comments and questions from committee members covered the following areas:

- clarification regarding an existing ombudsman program; the ALTSD operates an ombudsman program to assist with nursing home complaints;
- whether insurance companies should be penalized for making bad-faith denials;
- whether a statutory change is needed to allow the ID/PRC to serve as the office of the ombudsman; it might help to clarify that in the PPACA;

- whether the ID/PRC could intervene in Medicaid complaints if this statutory change is made; Medicaid has a separate appeals and fair hearing process;
- whether the current ID/PRC appeals process is efficient;
- a suggestion to include in state regulations a requirement that health insurers notify members of the availability of the ID/PRC avenue of appeals;
- whether there is overlap between the recommendations of the SWWLC and the responsibilities of the Consumer Division of the Office of the Attorney General; and
- whether there is PPACA funding for the navigator program; the HSD requested funding for this in the exchange planning grant.

Public Comment

Ed Steller spoke representing the disability community, most of whom were attending the Southwest Disability Conference in Albuquerque. He commented that the Mi Via program is in need of funding and oversight. It is an important program, but it does not have adequate services or support. Written comments will be provided.

Eric Buckley, New Mexico Society for Acupuncture and Asian Medicine, contended that New Mexico does not have enough primary care providers to meet anticipated needs. Doctors of oriental medicine are trained and capable of helping the state to meet that need. Their profession is predicated on minimal intervention, which is at the heart of preventive medicine. Written comments were provided.

Ms. Pinnes noted that most of the recommendations regarding consumer outreach, appeals, complaints and other items are included in the state's Patient Protection Act, which was passed 12 years ago. An ombudsman bill was passed in 1999 but was vetoed by Governor Gary Johnson.

There being no further business, the meeting was adjourned at 4:40 p.m.