

## **EXECUTIVE PROPOSED LEGISLATION – NM HEALTH SOLUTIONS**

Revised Draft – September 17, 2007

### **I. PRINCIPLES – To Achieve Universal Health Coverage and Improvements in Access, Cost and Quality of Health Care Delivered in New Mexico**

- Efforts to move toward universal health coverage have resulted in agreed upon principles by multiple stakeholders.
- These guiding principles should be included in legislation creating a health care authority, insurance reform, and coverage mechanisms and responsibilities to keep New Mexico's direction clear.

#### ***Legislative Elements—Principles:***

- A. New Mexico's goal is universal health coverage, that is, to identify and implement policies and activities that will provide opportunities for all people living in New Mexico to purchase or be provided health care coverage, whether public or private, and that is affordable for individuals, taxpayers, employers, and other payers.
- B. These policies and activities should:
  1. Be financially viable and possible in New Mexico, taking into account costs, impact on New Mexico's economy, the health of its people, and the rising cost of health care;
  2. Consider the quality (including outcomes and wellness) of health care provided for individuals living in New Mexico;
  3. Recognize that health, health coverage, and economic development are intrinsically linked and that the improved health of people living in New Mexico will have a positive impact on economic development and that strong economic development will play a role in improving the health status of people living in New Mexico; and
  4. Impact access to health care and health status and outcomes in New Mexico.
- C. In order to achieve universal coverage, multiple public and private policies and approaches will be required to develop and finance options for different ages, populations, employers, and circumstances within New Mexico.
- D. The state and federal government should provide strong leadership and oversight, with government, employers, individuals/families and the clinical community sharing responsibility for outcomes and the cost of health coverage.
- E. Persons and families with low incomes or high health care needs will require assistance in purchasing, accessing and enrolling in available health care coverage.

### **II. HEALTH COVERAGE AUTHORITY (To Create A Single Point of Accountability)**

- New Mexico has multiple different departments, boards and commissions providing publicly-funded or subsidized health coverage programs or products, and/or conducting health care studies and analyses.<sup>1</sup> Each has its own mission, perspective, administrative infrastructure, data and oversight processes.
- Multiple pools and administrative infrastructures cannot achieve economies of scale in purchasing medical and pharmaceutical services or in administrative expenses and professional services.
- Consolidation of these entities and the creation of a *single point of accountability* will result in:
  - √ Consistent health issues analyses;
  - √ Economies-of-scale of multiple and separate entities;

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<sup>1</sup> These include: 1) New Mexico Medical Insurance Pool (NMMIP); 2) Health Insurance Alliance (HIA); 3) Human Services Department Medical Assistance Division (MAD) (including State Coverage Insurance (SCI), Small Employer Insurance Program (SEIP) and premium assistance for kids (PAK) and for maternity benefits for pregnant women (PAM); 4) Retiree Health Care Authority (RHCA); 5) General Services Department Risk Management Division (RMD); 6) Public School Insurance Authority (PSIA); Albuquerque Public Schools (APS) employee insurance pool; 8) Health Policy Commission (HPC). In addition, the Public Regulation Commission (PRC) Division of Insurance (DOI), the individual practitioner licensing boards, and the Department of Health (DOH) all have roles in overseeing, reporting, regulating and/or providing health coverage or health care.

- √ A streamlined administrative structure, which will be necessary to achieve health coverage pooling, and health care standard setting, as well as common and transparent data reporting in order to assure the best quality health care for the best price possible for New Mexicans.

**Legislative Elements:**

A. Create the Health Coverage Authority (HCA) which would have responsibility to:

1. *Set standards* for:
  - a. Minimum benefits (including preventive services) that will count as coverage for participation requirements;
  - b. Affordability (including average percentage of household income that should be spent on health coverage and health care by income level); and
  - c. Performance by insurance carriers and health maintenance organizations, practitioners, facilities/providers (in conjunction with PRC, licensing boards, certifying agencies such as HSD and DOH).
2. *Manage and consolidate public sector programs and products* to increase coverage and reduce costs.
  - a. **Phase 1 (FY09)** – Administratively combine in the Health Coverage Authority the following: HIA, NMMIP, HPC, GSD/RMD Group Health Benefits for state and local public body employees, PAK, PAM, and SCI and SEIP (in consultation with HSD and subject to federal approval); maintain purposes and financing mechanisms of each program and eliminate administrative duplication where possible.
  - b. **Phase 2 (FY 10)** – Include in the HCA the administration of RHCA, NMPSIA and APS, maintaining each as a separate pool and assuring the funding streams for each are dedicated to the use of the beneficiaries of each pool.
  - c. **Phase 3 (FY 11)** – Begin to consolidate pools as possible and appropriate, after public and stakeholder input and after submission of a written plan to the Governor and Legislature.
  - d. **Phases 1-3 (FY09, 10 and 11) and on-going** – HSD enrollment of as many eligible children and low-income adults under 200 percent of the federal poverty level (FPL) as possible within the appropriation provided for the Medicaid and SCHIP programs (including SCI).
3. *Conduct health care/coverage studies and analyses*, including but not limited to who in New Mexico has health coverage, of what type, and at what cost.
  - a. Report to Legislature, Governor and public; and
  - b. Request and receive non-proprietary aggregate data for such analyses from providers, insurance carriers and payers within New Mexico, to the extent not otherwise reported or available elsewhere;
4. *Educate the public* re health care coverage requirements and options; serve as a referral source and connector.
5. *Engage in activities to control quality, access, and costs* through:
  - a. Setting of appropriate ranges for provider rates within New Mexico and those contracted to provide services for New Mexicans, over or above which payers would have to request permission from the HCA; rate ranges will include incentives for preventive services.
  - b. Budget negotiations for HCA administrative activities;
  - c. Bulk purchasing for HCA administrative supplies, materials and services;
  - d. Consideration of opportunities for collaborative purchasing of health care delivery supplies, materials, pharmaceuticals, and/or services; and
  - e. Development of “pay for performance” programs or recommendations including but not limited to infection control and reduction of readmissions or return visits due to practitioner errors or omissions (in conjunction with DOH and practitioner and provider representatives).
6. *Make recommendations to Governor and Legislature* for policy and legislative changes necessary to increase health care coverage, access and quality and/or to control costs.

B. Public Participation

1. *HCA’s activities will be open to the public*, subject to the Open Meetings Act, State Rules Act, Inspection of Public Records Act and Public Records Act.
2. *HCA will include the public* and make opportunities for public input in as many activities and processes as possible, including but not limited to public input processes at public meetings of the HCA governing body and special meetings called for purposes of hearing input from the public.

C. Structure of the HCA Governing Body

1. *15 members, all appointed by the Governor, seven (7) of whom would come from nominees provided to the Governor (three for each available position) by the Legislature.*
2. *Governor and Legislature seek input from interested stakeholder groups before deciding on appointees or nominees.*
3. *Members collectively represent the best interests of New Mexico*
  - a. *Expertise, knowledge and experience in the areas of consumer advocacy, management, finance, actuarial analysis, labor, health economics, health care delivery and payment;*
  - b. *Represent the geographic and population diversity of the state; and*
  - c. *Majority of members do not receive (within the last 12 months) more than 50 percent of the individual's income or the income of the individual's immediate family living in the same household from the health care industry or the health insurance industry.*
4. *All 15 appointed members confirmed by the Senate (unless otherwise previously confirmed by the Senate for a health-related position).*
5. *Each member serves up to two consecutive four-year terms (staggered for continuity).*
6. *Authority convenes ad hoc or permanent advisory group(s) to represent key stakeholders such as consumers (including but not limited to retirees, educators, Native Americans and union representatives); employers; insurance companies and health maintenance organizations; payers; practitioners; and health facilities.*

D. Selection of Staff

1. *Director shall have experience in the delivery and/or finance of health care or health coverage.*
2. *Director appointed by the Governor and confirmed by the Senate.*
3. *All other staff selected by the Director with input from the HCA governing body.*

III. **INSURANCE REFORM (To Make Coverage More Available And Affordable)**

- The insurance industry in New Mexico is not currently required to cover everyone who wants coverage (provide guarantee issue for individuals). Small groups do get protections afforded by the federal legislation HIPAA such as guaranteed issue and renewal protection, but their premiums can be rated-up due to health status and claims experience.
- Currently, insurance companies are not required to spend a set amount of premiums collected for direct medical services or a minimum "medical loss ratio" (MLR).
- Insurance reforms must be enacted, i.e.: 1) anyone who wants coverage can get it; 2) pre-existing conditions are not excluded; 3) those covered pay a reasonable price; 4) all coverage includes preventive services; and 5) a set minimum amount of premiums paid is invested in direct care.
- As more coverage options are available, practitioners and provider organizations must be accessible to covered individuals by accepting assignment of payment from those funding sources to the extent possible. This assists in increasing choice of practitioners as well.
- While these reforms are being implemented, there needs to be a moratorium on new benefits (services) required to be covered by various commercial products. The HCA can take up these issues again, after the transitions envisioned by this legislation have taken place.

**Legislative Elements:**

A. Require minimum spending on direct services

1. *85 percent of premiums collected across product lines.*
2. *Calculated across three years, after exclusion of premium taxes from numerator and denominator.*
3. *Direct services may include disease management, health education and promotion, preventative services and any other health-related service only if they are designed to improve the health or health outcome of covered individuals and are provided directly to covered individuals, regardless of whether through subcontracts or by company staff.*
4. *Direct services shall not include care coordination, utilization management or any other activity designed to control costs for the payer or to limit utilization of services.*

B. Guarantee issue without exclusion of pre-existing conditions, i.e., require insurance companies to quote and offer coverage to any individual who requests it, without permanent exclusion of pre-existing

conditions (although a waiting period of up to six months may be imposed before payment for any service related to a pre-existing condition).

1. *Continuation or renewal of policies* currently in existence with permanent exclusion of payment for pre-existing conditions will remain in effect until the HCA makes and publishes decisions about what constitutes coverage for purposes of compliance with coverage requirements.
  2. *Work to bring protections afforded by groups under federal HIPAA to individual policies.*
  - C. Risk equalization process created by the HCA (in consultation with PRC and insurer representatives) of a risk equalization process to spread costs among insurance companies.
  - D. Move toward community rating by limiting rating up or down based on experience of individuals or groups to no more than 10 percent above or below average, phased in over four years (currently  $\pm$  20 percent in small group market).
    1. *FY09 – 17.5 percent; FY10 – 15.0 percent; FY11 – 12.5 percent; FY12 and forward – 10 percent*
    2. *Retain rating variations by age and geography* until after FY12 and after HCA has recommended to the Governor and the Legislature appropriate next steps in the move toward community rating.
  - E. Require through law or as a condition of licensure that all New Mexico practitioners and providers/facilities accept assignment of payment from any public or private insurance/coverage offered within the state at least for the amount the coverage will pay (to the extent the payment is not required to be the whole payment (such as in Medicaid or Medicare)).
    1. *Allow insurers to maintain networks* based on facility/provider and practitioner agreements re performance and payment.
    2. *Allow practitioners and facilities/providers to accept or refuse any individual client* based on limitations of size, capacity or expertise of the individual's practice or facility/provider's mission).
    3. *Allow practitioners and facilities/providers to charge the patient/client an amount above what the coverage pays* for those services for which additional charges can be levied or for those services not covered (so long as the total rates charged to the coverage source and the patient/client are within the ranges set by the HCA for that procedure or service).
    4. *Phased in* to allow time for adjustment by insurers, practitioners and providers/facilities and to allow time for introduction of standardized electronic billing and claims payment processes.
  - F. Require common data reporting by all insurance companies and health maintenance organizations for all products, required data set by HCA in consultation with PRC.
  - G. Require brokers/agents to offer public products, with limited immunity from liability once certified as trained to offer such products.
  - H. Allow adult dependents up to age 30 to continue on parents' individual or group insurance policies.
  - I. Moratorium on additional insurance benefit mandates until after December 31, 2010.
- IV. COVERAGE MECHANISMS AND PARTICIPATION (To Assure Everyone Has Coverage)**
- New Mexico must create a culture of coverage so that every resident knows they have an obligation to participate, either through commercial insurance or through publicly offered programs.
  - This requires an adequate number and variety of mechanisms and public funding and capacity is available for individuals and employers to fulfill their participation responsibilities.
  - New Mexico must maximize our public programs and make them and commercial insurance affordable based on an individual's or household's percentage of income used for coverage.
  - Employers should contribute in some way to their employees' coverage, based on their ability to do so. This assures that employees and employers who are satisfied with the way their current coverage works can keep it. It also assures that employers who offer health coverage for employees are not paying more because some employers are not paying anything.
  - One of the mechanisms to assure affordable coverage is to create bigger pools to allow those without access to or who are unable to afford commercial insurance to buy into larger pools already subsidized by the state and federal governments.

***Legislative Elements:***

- A. Require individuals to have coverage through enrollment in public programs or commercial insurers, or show proof they can cover their own health care costs by no later than December 31, 2009 (tax year 2009;  $\frac{1}{2}$  of FY2010).

1. *Identify those not yet covered through various licensure applications and renewals, school and university enrollment processes, tax return submissions, and other state mechanisms.*
  - B. Require employers (with six or more employees) to offer insurance or contribute to a fair share fund.
    1. *Consider allowing small businesses to purchase coverage with pre-tax dollars, based on HCA analysis of costs and potential impacts.*
    2. *Fair share fund amount used for outreach and public programs to expand coverage (Medicaid, premium assistance, etc.).*
    3. *Annual appropriation of fair share fund through the state budget process.*
  - C. Create larger risk pools.
    1. *Allow buy-in to Medicaid for individuals in households up to 400 percent FPL and who are not otherwise eligible for public programs, not currently covered by commercial products, and without an employer or other source of premium subsidy with the premium cost based on income.*
    2. *Allow buy-in to state employee insurance pool or other pools managed by the HCA – for employers not currently offering coverage and not eligible for public subsidies, at rates based on their own group experience but not rated up or down more than the established amount by law.*
  - D. In conjunction with DOH, HSD, PRC and other relevant entities, HCA will educate the public about:
    1. *The benefits of wellness and prevention activities and services.*
    2. *The benefits of health coverage for individuals, families and employers.*
- V. **ADDRESS HEALTH CARE COST, ACCESS AND QUALITY (To control and increase . . .)**
- Cost is a major factor in preventing individuals, families and employers from having coverage. Costs are driven by utilization of services, rates paid to providers; profits or reserves obtained by insurance carriers and health maintenance organizations; investments in new technology; expectations about health care services; costs of health care supplies and materials such as pharmaceuticals; and individual life style choices. The HCA needs to have the capacity and the ability to address these cost drivers by identifying opportunities for bulk purchases across programs, controlling provider rate ranges, and addressing prevention efforts.
  - Some costs can be contained by moving from paper to electronic billing and medical records and by standardizing forms and processes. These technological improvements will also help in tracking utilization and in identifying opportunities for quality improvements.
  - Access to health care services and workforce availability are crucial if universal coverage is to make a difference in people's lives.
  - Targeted recruitment and retention of practitioners and providers throughout New Mexico, particularly in border, rural and frontier counties is crucial to increase access.

***Legislative Elements:***

- A. Standardize forms, credentialing processes, utilization review criteria, and data collection processes.
- B. Require electronic claims submission by all practitioners and facilities/providers and electronic processing and remittance by all insurance companies doing business in New Mexico.
  1. *Telehealth Commission develop and submit a detailed plan to HCA for achieving this requirement, with specific action steps and implementation dates, by January 1, 2010.*
  2. *HCA and Telehealth Commission jointly make recommendations to Governor and Legislature about legislation or appropriations required to implement the plan.*
- C. Require electronic medical records in use by all health care practitioners and facilities/providers
  1. *Telehealth Commission develop and submit a detailed plan to HCA for achieving this requirement, with specific action steps and implementation dates by January 1, 2011.*
  2. *HCA and Telehealth Commission jointly make recommendations to Governor and Legislature about legislation or appropriations required to implement the plan.*
- D. Require coverage of prevention services, as defined by HCA.
- E. Increase practitioner recruitment/retention activities and incentives, in conjunction with DOH and practitioner representatives.