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

SPONSOR HHHC **ORIGINAL DATE** 2/09/17 **LAST UPDATED** 2/27/17 **HB** 101/HHHCS

SHORT TITLE Health Security Act **SB**

ANALYST Chilton/Chabot

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	5 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$100.0-$200.0	$100.0-$200.0	$500.0-$1,000.0*	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

*Since a five-year analysis is required, estimated LFC costs would range from $500 thousand to $750 thousand. Participating board member costs are estimated at $25 thousand annually.

SOURCES OF INFORMATION
LFC Files

Responses Received From
Indian Affairs Department (IAD)
New Mexico Medical Board (MB)
Health Security for New Mexicans Campaign
University of New Mexico Health Sciences Center (UNM HSC)
Board of Nursing (BN)
Department of Health (DOH)

Responses not Received From
Human Services Department (HSD)

SUMMARY

Synopsis of Health and Human Services Committee Substitute

House Bill 101 enacts the Health Security Act to provide for comprehensive statewide health care, the development of a health security plan, and the creation of a commission. The Tort Claims Act is amended.

The bill proposes to enact the Health Security Act to create a program that ensures health care coverage to virtually all New Mexicans through a combination of public and private financing, control escalating health care costs, and improve the health care of New Mexicans, to begin in December 2019. However, the Plan would require that the 2019 Legislature approve the

implementation of the Plan, the act, except for the Tort Claims Act, would be repealed. Exceptions to universal coverage would be made for citizens with federal retirement health coverage, covered by ERISA-covered health insurance plans that did not choose to join the overall system, active and retired military service members, and by Indian tribes and pueblos that did not contract with the system. Other insurance entities would be subsumed into the new plan, with the exception that supplemental insurance products would be permitted to cover expenses that would otherwise be borne by the consumer.

Definitions are specified for twenty-two key terms as used in the Health Security Act. Of note, Section 3, Subsection M defines "health security plan" as the program that is created and administered by the health care commission for provision of health care pursuant to the act.

An extensive section, Section 5, sets up a ten-member nominating committee, to be appointed by leadership of both houses of the Legislature. This nominating committee would then create a slate of knowledgeable New Mexicans to be considered for the eventual governing body of the Health Security Plan by the governor. It would also nominate additional persons when needed to fill vacancies on the commission.

The commission itself would be comprised of fifteen members; the nomination procedures, appointment formulas, conflicts-of-interests, code of conduct, and member removal are detailed. Members would be geographically dispersed through the public education commission districts, and would five persons representing health care providers or health facilities, four members representing employer interests, and six persons representing consumer interests.

Eight state laws are specified as applicable to the commission and regional councils. The extensive general duties of the commission's members are enumerated in Section 11 and Section 12 establishes the authority to carry out the powers and duties of the act. The commission would be authorized to adopt, amend or repeal rules necessary to carry out their duties and the provisions of the act. The commission would then appoint a chief executive officer. The law specifies that as much as possible, work on all aspects of the Health Security Plan would be done in New Mexico, though the commission would have the authority to enter into agreements with entities outside New Mexico for "the performance of common administrative functions."

Section 10 addresses the selection and subsequent authority and responsibilities of the chief executive officer and the chief executive officer's staff in implementing the Health Security Act. If the chief executive officer determines staffing or state agency resources or expertise are inadequate to perform a necessary task, contract personnel could be employed. Further expertise and knowledge assistance to the commission would be available through designated advisory boards, including a long-term care committee, a mental and behavioral health services committee, Native American advisory board, and a health care practice advisory committee and others found to be necessary by the commission. The commission would also be authorized to enter into appropriate agreements with the human services department, another state agency or a federal agency to further the goals of the act.

In addition to the advisory committees mentioned above, a long-term care committee and a mental and behavioral health services committee would be established shortly after implementation of the plan.

The commission would be charged with creating a code of conduct and procedures for assuming there would be no conflicts of interest among its members.

The commission establishes health care delivery regions in the state, overseen by regional councils, based on geography and health care resources. These regional councils receive public information and comments regarding regional health care needs. The regional councils would recommend to the commission fee schedules, budgets, capital expenditure allocations or other features tailored to the region to encourage health care provision, recognizing that there might be differences among regions in order to provide incentives for service provision in currently underserved areas.

The commission is charged with designing the health security plan to provide comprehensive, cost-effective and necessary and appropriate health care services, to include primary health care and specialty services, as well as emergency and intensive care. It would be required to maintain adequate reserves to cover unforeseen circumstances. The content areas of the health security plan are specified, including the amount, scope and duration of health care services, control mechanisms for health care costs, and the eligibility for beneficiaries. As noted, all New Mexicans, resident in the state for at least one year and intending to remain in New Mexico would be eligible for the plan. Students at New Mexico educational institutions but coming from outside New Mexico could be covered by their policies from other states, or by coverage purchased from the Health Security Plan by their institution. Those in their first year in New Mexico and intending to remain here would be able to purchase coverage through the commission.

The commission would be charged with overseeing capital and annual operating budgets for health facilities and giving or denying prior approval for major health facility capital expenditures. It would recommend premium rates to the superintendent of insurance. Also in the interest of cost efficiency, the commission would be required to collect data that would help to assure good health care at an effective cost, as well as data to assess the adequacy of the state's health care workforce. Also to that end, administrative expenses would be capped, and the commission would be charged with negotiating prices with health facilities and with pharmaceutical companies. Additionally, the commission is charged with looking at the effect of medical malpractice costs on health security plan expenditures and recommending remedies to the legislature. Annual increases in provider payments would be constrained to the national rate of rise of the consumer price index, unless unusual circumstances were documented.

Except as provided in the Workers' Compensation Act, beneficiaries would have the right to choose a primary care provider who is responsible for providing health care provider services, The commission would determine referral requirements for specialty care, including direct access to specialists in emergency situations. If it were to be found that co-payments were an effective means of controlling costs, they could be assessed of patients for services through the commission's action. However, providers with negotiated contracts with the Health Security Plan would be prohibited from "balance" or "surprise billing." An extensive section of the bill, Section 27, specifies claim and benefit determination procedures. The Superintendent of Insurance would be required to establish an external review process to deal with grievances of consumers or providers.

The commission would be required to provide beneficiaries with prompt and fair grievance procedures for resolving patient complaints and concerns relating to any aspect of the health

security plan. The commission shall provide beneficiaries with full disclosure of the health security plan's covered services, conditions of eligibility, and beneficiary rights. Procedures would also be set in place to address grievances of health care providers and facilities.

The commission is charged with establishing a quality improvement program that monitors the health care provided by the health security plan, but would not supplant providers' and facilities' quality improvement activities. The commission would set standards, adopt professional practice guidelines as it deemed necessary to promote the quality and cost-effectiveness of health care provided through the health security plan. Task forces or subcommittees would be appointed to address practice issues of a health care provider or health facility and to indicate corrective measures or penalties.

An annual health security plan budget would be developed by the commission, and annual reports would be provided to the legislature and the governor. The commission would also provide for annual independent fiscal and actuarial reviews of the health security plan and any funds of the commission or the plan. The legislative finance committee would be required to undertake a fiscal analysis relating to the first five years of the establishment and operation of the proposed health security plan. The fiscal analysis would include a projection of plan costs and a review of financing options for the proposed health security plan over subsequent years. The legislative finance committee would seek partnerships among state agencies and private nonprofit persons to obtain grant funding and other in-kind and financial resources for the health security plan. The commission would be charged with obtaining necessary waivers from the federal government and with seeking payment to the health security plan from medicaid, medicare or any other relevant federal program to maximize federal contributions and payments, avoiding their diminution due to achieved health care efficiencies and improvements achieved by the Plan.

As soon as allowed under federal law, the secretary of the human services department shall seek the waiver needed to allow the state to suspend operation of any health benefits exchange or health insurance exchange and to allow the commission to administer the federal premium tax credits, cost-sharing subsidies and small business tax credits available under federal law. Any personal property used in the operation of a state health insurance exchange would be transferred to the commission's use in implementing the provisions of the Health Security Act.

The Legislative Finance Committee would be charged with obtaining a fiscal analysis of the first five years of the Plan, probably from an outside agency. It is envisioned that this plan be reviewed by the Legislative Health and Human Services Committee and possibly other interim committees in time for action to be taken (or repeal of the Act) by the 2019 Legislature.

The staff and members of the health care commission would be added to those covered by the Torts Claims Act.

FISCAL IMPACT

The Health Security Act as embodied in HB 101 does not make an appropriation, nor does it anticipate revenue. However, in the words of the IAD, it represents an "unfunded mandate," as there would be need for extensive preparation during the first year of the program that would not be covered by anticipated future income; work on this preparation would fall to the Legislative Finance Committee, the Office of the Superintendant of Insurance, the Legislative Council

Service, the Indian Affairs Department, and other agencies. In addition, per diem and daily payments to a nominating committee and then the Health Care Commission would be required, as would a salary for the chief executive officer and his/her staff and funds found to pay for these would be needed. Sponsors of the bill (and of the committee substitute) indicate that they expect that private foundation grants might be available to pay for the study to be done prior to the 2019 Legislature taking up the Plan or repealing it; the committee substitute notes that the Legislative Finance Committee would "obtain" (i.e., contract for) the study rather than be asked to perform the study itself.

While estimated costs from other agencies were not provided. For a commission of 15 members, costs are estimated at $25 thousand or more, the LFC staff estimates three performance evaluators would need to do the fiscal analysis required by this bill. The staff probably would devote approximately 50 percent of their time for this effort. This is estimated at $75 thousand. However, if it were determined that the analysis were to be contracted, estimated costs would at least double. In addition, other planned evaluations may have to be deferred because of the equivalent of a full-time position would not be available. The LFC currently has 5 vacancies that will continue to be unfilled because the current fiscal situation.

Once the Health Security Act was in operation, costs would be covered by a combination of federal funds (Medicaid and Medicare and others), employer contributions, and enrollee premiums. At that point, it is anticipated that the Health Security Plan would pay for itself and have no further impact on the state budget. However, funding will be by general fund until other funding options are decided by the Legislature in the 2019 session for fiscal year 2020.

SIGNIFICANT ISSUES

Although the Health Security Act establishes a Native American advisory board, IAD notes the complexity of negotiating with twenty-one tribes with frequently changing leadership, and the need for cultural sensitivity in doing so. The bill addresses the need to preserve Native Americans' insurance portability – i.e., if New Mexico Native Americans were to leave the state, the availability of Indian Health Service treaty-rights coverage outside the purview of the New Mexico Health Security program.

Section 42, B (3) indicates that minimum and maximum costs to a beneficiary would be established, making cross-subsidies necessary. This is not discussed in the bill.

ADMINISTRATIVE IMPLICATIONS

There would be major administrative implications for many agencies, including, but not restricted to DOH, HSD, IAD, RLD, and OSI. As no funding is included in this bill, the agencies would have to determine how to provide personnel hours to meet these requirements.

DUPLICATION

The Board of Nursing comments that there is a possible duplication of effort with the University of New Mexico Health Sciences Center's stewardship of statewide planning efforts, as mandated by the New Mexico Health Care Work Force Data Collection, Analysis and Policy Act of 2011.

TECHNICAL ISSUES

It appears as if most of those charged with implementation of the Act would receive little or no pay (e.g., members of the nominating committee, regional councils, and to a lesser extent, the commission). That would necessarily limit the ability of many New Mexicans to take part and might increase the likelihood of special interest influence.

BN notes "In the definition of primary care provider, nurse practitioner is appropriately listed, but clinical nurse specialist is omitted (Page 5, line 2-11). Clinical nurse specialists are also independently licensed primary care providers," although the nature of the term "specialist" would seem to exclude clinic nurse "specialists" from the ranks of primary care providers.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Payments for medical care in New Mexico would continue to be made by private insurance companies, federal insurance programs (principally Medicaid and Medicare) and by individuals without insurance, estimated in 2015 to be 10.9% of New Mexico's population, or approximately 227,000 New Mexicans. Between 2010 and 2015, the percentage of New Mexico residents declined from 19.6% to 10.9% (from 46th among the states to 39th among the states), with an estimated 178,000 New Mexicans gaining coverage; New Mexico had the fifth highest percentage increase in coverage, but the proposed repeal or dismantling of the Affordable Care Act makes prediction of future effects on New Mexicans difficult.

POSSIBLE QUESTIONS

How, in the presence or absence of the Health Security Act will New Mexico deal with partial or total repeal of the Affordable Care Act?

LAC/sb/al/jle