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

SPONSOR	Armstrong D/ Gonzales/Chasey/ Roybal Caballero/ Ferrary	**ORIGINAL DATE** **LAST UPDATED**	1/28/19 3/4/19	**HB**	295/aHSEIC/aHFl#1
SHORT TITLE	Health Security Act			**SB**	
				ANALYST	Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY19	FY20	FY21	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		Indeterminate, but substantial	Indeterminate, but substantial	Indeterminate, but substantial	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

See Fiscal Impact, below

DUPLICATES Senate Bill 279, before amendment

SOURCES OF INFORMATION
LFC Files

Responses Received From
Public School Insurance Authority (PSIA)
Office of the Superintendent of Insurance (OSI)
New Mexico Medical Board (MB)
Board of Nursing (BN)
Indian Affairs Department (IAD)
University of New Mexico Health Sciences Center (UNM HSC)
Retiree Health Care Authority (RHCA)
Department of Health (DOH)
Human Services Department (HSD)

SUMMARY

Synopsis of HFl#1 Amendment

The House Floor Amendment #1 to House Bill 295 removes the phrase, “making an appropriation” from the long title of the bill; the appropriation itself had already been removed through the HSEIC amendment.

Synopsis of HSEIC Amendment

The House State Government, Elections & Indian Affairs Committee amendment to House Bill 295 has two effects:

1) It removes deadlines set in the original bill with the single exception of the date (now changed to) April 8, 2021 for changes in the Tort Claims Act, and
2) The appropriation in the bill is removed.

Synopsis of Original Bill

House Bill 295 enacts the Health Security Act to provide for a study of a comprehensive statewide health care, the development of a health security plan, and the creation of a commission to study the consequences that would occur from adoption of the framework put forward from the delayed creation of a Health Security Act. 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 2021. However, the Plan would require that the 2021 Legislature approve the implementation of the Plan; if it did not the act, except for the Tort Claims Act changes, 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, although individual tribal members could join. Other insurance entities, including Medicaid and Medicare, 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 include 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 select 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 and 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, as would their dependents. Excluded would be the following groups covered with other programs:

1) Federal retirees,
2) Active duty and retired military persons and their dependents and others covered by military medical coverage
3) Native Americans, unless their tribes or pueblos made an agreement with the plan or individual tribal members chose to join.

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.

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, other than preventive care, 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.

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 would seek any waivers 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, possibly 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 2021 Legislature.

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

FISCAL IMPACT

The Health Security Act as embodied in the original HB 295 made an appropriation of $375 thousand to LFC to "fund the legislative finance committee's performance of the fiscal analysis." It is unclear whether this amount would be sufficient; eight years ago, when a similar mandate to LFC was made in 2011 Senate Bill 5, the FIR indicated that

> The bill requires the LFC to develop financing recommendations for the plan and provide such to the legislature for approval or modification. The LFC is to be guided by benefit packages and cost of health care coverage provided to state employees and options may set beneficiary income-based premium payments, sliding scale premium payments, and Medicare credits and employer contributions. LFC will be required to seek partnerships among state agencies and private nonprofit persons to identify and apply for available grant funding and other in-kind and financial resources for its study of financing options. There is an appropriation of $375 thousand in the bill directed to the LFC for this effort; however, there may be more time and resources needed to complete this great task.

Other agencies' participation in this large project were and are not funded by the current bill, as amended.

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. Eventually, the many streams of funding for the Health Care Commission would pay these costs, but the up-front costs, before those streams would be forthcoming, would have to be absorbed in the interim between formation of the commission and the beginning of functioning of the Health Security Act.

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 would be required from the general fund, to be reimbursed by the commission once the plan was operational, until other funding options are decided by the Legislature.

SIGNIFICANT ISSUES

OSI indicates that "The exclusion of coverage for cosmetic surgery may be broadly applied in a discriminatory manner against transgender individuals seeking gender confirmation care. The proscription against orthodontics [coverage] may violate current ACA coverage requirements for minors." Further, OSI states that "The legislation does not appear to prevent balance billing of individuals covered by health security act coverage for out-of-network services," although "balance billing" is addressed in other bills before the Legislature, including Senate Bill 346 and House Bill 207/Senate Bill 279.

BN comments on the bill's discussion of compliance of providers with best practices:

> The bill provides for the commission to refer or report matters to licensing boards such as the NM BON. The matters reported relate to a health care provider's compliance with practice guidelines established by the commission. Generally, the failure of an advanced practice registered nurse to comport their practice to meet guidelines established by an insurer or payor does not mean they are subject to discipline by the board unless public safety or fraud are implicated.
>
> Section 28 of the act is designed to implement measures to ensure that effective, high-quality, cost-efficient and appropriate health care is provided under the health security plan. This section creates a health care practice advisory committee that will "provide to the commission recommended standards and guidelines to be followed in making determinations on practice trends". The commission will establish a system of peer education for health care providers that do not meet the guidelines established by the commission. It may refer to a licensing board a matter where the commission determines peer education has failed.
>
> Section 28 also allows the commission to suspend or revoke a health care provider's authorization to be paid from the plan if they engage in a pattern of practice which does not meet the practice guidelines.
>
> It is unclear if the intent of these provisions are to require licensing board to take disciplinary action against health care providers who do not follow the commission's practice guidelines.

RHCA comments that "The New Mexico Retiree Health Care Authority (NMRHCA) provides comprehensive core group health insurance to more than 63,000 retirees of certain public employment in the state. NMRHCA collaborates with the State of New Mexico, the New Mexico Public Schools Insurance Authority and Albuquerque Public Schools to form the Interagency Benefits Advisory Committee (IBAC). The IBAC uses its collective bargaining power to negotiate health insurance plans with the richest benefits at the lowest cost possible.

"NMRHCA constantly seeks out ways to control health care costs for its members and would serve as an available source of information for the Health Security Commission. However, it is not clear whether the purpose seek to replace or add to the duties already assigned under the Retiree Health Care Act."

DOH speaks to some of the financial implications of the Health Security Act:

According to the Health Security for New Mexicans Campaign, there is currently a segmented system of hundreds of insurance plans that create a costly and complex administrative system. The HSP combines the young, old, healthy, and not so healthy in one large insurance pool. The risk is shared, while administrative costs are reduced. A 1994 New Mexico study by the independent think tank The Lewin Group estimated that $4.6 billion could have been saved by 2004 had all New Mexicans been under one plan by 1997. While not all New Mexicans would be covered by the HSP, even if half that amount is saved, that is significant. Mathematica Policy Research, Inc., concluded in 2007 that the Health Security Act was the only proposal that would significantly reduce health care costs, even in its first year of operation. Other state studies have also shown that covering all or most state residents through one insurance plan controls rising health care costs…

Almost 1 in 5 New Mexicans have no health insurance (Health Equity in New Mexico, January 2018). Individuals without health care coverage are much less likely than those with coverage to receive recommended clinical preventive services, are less likely to have access to regular care by a personal physician, and are less able to obtain needed medication or health care services. Consequently, the uninsured are more likely to develop preventable illnesses, more likely to suffer complications from those illnesses, and more likely to die prematurely. (NMDOH Indicator Based Information System).

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 for those agencies, the agencies would have to determine how to provide personnel hours to meet these requirements.

OSI, for example, estimates its additional costs as follows:

OSI currently does not have sufficient staff to meet the required duties under the Health Security Act. OSI would need the following staff to meet these needs.

- Actuarial services to review premium rates and coverages – 1 FTE accredited actuary and 1FTE actuarial assistant - $275,000 = salary plus benefits
- Data collection staff to assist in commission reporting – 1 FTE - $80,000 salary plus benefits
- Actuarial services and analyst to identify impacts on premiums on worker's compensation rates and automobile insurance rates = 1 FTE actuary - $140,000
- Staff to handle external appeal processes – 8 FTE at $70,000 each = $560,000
- Legal staff to handle rulemaking on premium rates and employer contribution rates – 1 FTE attorney and 1 FTE paralegal - $180,000 salary + benefits.

RELATION to Senate Bill 346 and House Bill 207/Senate Bill 279, which address "balance billing" and "surprise billing," respectively.
Duplicates Senate Bill 279, prior to the amendment.

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.

IAD recommends that the term "off-reservation" be replaced with "urban areas" in Section 13, paragraph 3a of subsection A.

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 percent of New Mexico's population, or approximately 227,000 New Mexicans. Between 2010 and 2015, the percentage of New Mexico residents without insurance declined from 19.6 percent to 10.9 percent (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.

LAC/sb/gb