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

SPONSOR Feldman **ORIGINAL DATE** 1/30/09 **LAST UPDATED** 2/18/09 **HB**

SHORT TITLE Patient Choice for Medical Services **SB** 104

ANALYST Hoffmann

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY09	**FY10**		
	See Narrative		

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY09	FY10	FY11	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		See Fiscal Impact			Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Health Policy Commission (HPC)
Human Services Department (HSD)

No Response
Retiree Health Care Authority (RHCA)
Department of Health (DOH)
General Services Department (GSD)

SUMMARY

Synopsis of Bill

Senate Bill 104 proposes to amend Section 59A-22A-4 NMSA 1978 and Section 59A-57-6 NMSA 1978 of the Insurance Code. Section 59A-22A-4 NMSA 1978 is amended to determine that any health care insurer may enter into preferred provider arrangements with any physician, hospital, or outpatient surgery center meeting specific requirements. Section 59A-57-6 NMSA 1978 is amended to specify that a managed health care plan shall not prohibit any physician,

hospital, or outpatient surgery center meeting certain requirements from entering into a contract. This type of arrangement is often referred to as "any willing provider."

Both amended sections in Senate Bill 104 note that arrangements and contracts for physician payments shall be equivalent to the pay schedule for other physicians in that specialty and practice setting. A health care insurer and a managed health care plan have the ability to terminate an arrangement or contract once a federally designated physician peer review organization concurs with the insurer or managed health care plan.

Senate Bill 104 also amends Section 59A-57-6 NMSA 1978 to replace all gender inferences (his) with the term "provider's."

FISCAL IMPLICATIONS

There are potential increased costs to the state through the health insurance programs it operates: Medicaid MCO rates, Medicaid cost of care, health benefits to state employees provided by the Health Benefits Bureau of the General Services Department, and the Retiree Health Care Authority. Only Presbyterian Health Plan (PHP) was able to provide an estimate of the impact. Though outside of the scope of the state's budget, PHP's comments indicate that Senate Bill 104 could produce an increase in the cost of all health insurance plans available in New Mexico.

The HSD reports that the ultimate fiscal impact for Medicaid is unknown at this time. However, this could lead to significantly higher costs for some of the organizations with whom HSD contracts for Medicaid managed care services. The end result could be higher Medicaid rates and costs.

In the Legislative Finance Committee report "Department of Human Services Program Evaluation: Medicaid Managed Care (Physical Health)" published January 14, 2009, the potential fiscal impact of "any willing provider" on Medicaid costs is addressed in the following two paragraphs.

Historically, New Mexico has not fully exercised its authority to increase price competition and has limitations placed on it to assure the benefits of competitive procurement. For the FY09-FY12 procurement HSD awarded contracts to all four bidders that in practice served as an "any willing provider" procurement. These procurement arrangements limit the effectiveness of competition because HSD did not exclude higher priced bidders from being awarded a contract. Clients have no price sensitivity (no co-pays or premiums) when choosing "free health care" and are not given the opportunity to examine comparative cost information when choosing an MCO. Medicaid clients have been choosing to enroll in the plan with the highest costs. When the state has the choice through autoassignment, it has not, up until November 2008, given preference to lower cost MCOs either.

Managed care limits choice of provider and helps direct clients to certain providers in their health care networks. This is intended to infuse competition on provider pricing and thus contain unit costs through pricing and other volume discounts. Using more market-based approaches for network development is intended to expand the range of quality service providers.

According to Presbyterian Health Plan (PHP), one of the state's health care providers, this bill could cause health care costs and premiums to increase, and thereby increasing the need for

General Fund appropriations. The increase in cost would be the result of the elimination of competition between health care providers due to the "similar terms" called for among provider payments contained in Senate Bill 104. Presbyterian Health Plan estimates that "The general fund impact to the state is expected to be $9.6 million annually for IBAC (the General Services Department's Risk Management Division's Insurance Benefit Advisory Committee) members, and they would expect to see a similar cost effect as PHP would on our 180,400 commercial/ASO members."

SIGNIFICANT ISSUES

The HSD comments that managed care companies typically extend contracts with qualified providers in order to ensure access to services in a given geographical area. They may well have legitimate reasons to limit the number of contracts. By removing an insurer's flexibility to contract in a way that best meets its needs and the needs of the members that it insures, there could be resultant quality issues that would have negative financial implications in the long term.

The coordination between an insurer and its provider network is one of the greatest benefits of managed care. This bill could jeopardize that relationship, causing fragmentation within an insurer's provider network and ultimately causing degradation in care coordination and health outcomes.

The Health Policy Commission offers the following observations of the impact of this bill on patient choice. Typically, a patient's choice of physicians is limited by the managed care plan's gatekeepers who try to refer patients only to health care facilities and physicians who are members of the plan's network. Often, these gatekeepers are offered financial incentives to limit a patient's access to expensive medical services. For example, some gatekeepers receive a bonus at the end of the year from their managed care plans if they keep the number of patients who are hospitalized or who are sent to specialists below a certain number that has been set as a limit for that year.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

The HSD states that by not enacting Senate Bill 104, managed care entities and insurers will be able to maintain the integrity of their provider network.

The HPC claims that by not enacting Senate Bill 104 there would be limits to patients' choice and access to qualified physicians, hospitals, or outpatient surgery centers.

CH/mt