

MINUTES
of the
SIXTH MEETING
of the
HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE
April 26, 2007
Central New Mexico College, Workforce Training Center
Albuquerque

The sixth meeting of the Health Coverage for New Mexicans Committee (HCNMC) was called to order by Lieutenant Governor Diane Denish, chair, on Thursday, April 26, 2007, at 9:15 a.m. in the Workforce Training Center at Central New Mexico College.

Committee Mmbers Present

Lt. Governor Diane Denish, Chair
Sec. Pamela Hyde, Vice Chair
Steve Altmiller
Mike Batte
Carter Bundy
Sen. Dede Feldman
Sen. Mary Jane M. Garcia
Robin Gould
Craig Keyes
Michelle Melendez
Dennis S. Pena
Rep. Danice Picraux
Charlotte Roybal
David Scrase
Paul Sowards
James Tryon
Duane Trythall
Alfredo Vigil

Absent

Charlie Alfero
April Redbird

Advisory Members Present

Rep. John A. Heaton
Sen. Timothy Z. Jennings
Chuck Milligan
Rep. Brian K. Moore
Chuck Milligan
Michelle Welby

Absent

Sen. Carroll H. Leavell
Rep. James Roger Madalena

Staff

Ruby Ann M. Esquibel, Human Services Department
Betina Gonzales McCracken, HSD
Raúl E. Burciaga, Legislative Council Service
Tim Crawford, LCS

Guests

The guest list is in the meeting file.

Welcoming remarks

Lieutenant Governor Diane Denish, chair, welcomed committee members and public guests. She reviewed the work of the HCNMC over the last year and the day's agenda. She discussed the proposed meetings for May 16 and June 21. Lt. Gov. Denish welcomed Ms. Deborah Chollet and Ms. Su Liu from Mathematica and advised that they would review the study design, specifications for costing analyses, cost results for New Mexico and results to date.

The committee approved the October 19 meeting minutes.

Discussion of Study Design (and How It Differs From Other Approaches to Costing of Models)

Ms. Deborah Chollet provided an overview of microsimulation modeling and its components. Microsimulation mimics the operation of a program or system and considers responses to alternative opportunities and factors affecting response. Microsimulation provides for estimation, consistent application, flexible analyses, sensitivity analyses and identification of other issues that may otherwise be overlooked.

Ms. Chollet discussed the population module and the data used from the Current Population Survey (CPS), the New Mexico population sample and "borrowed" population samples from rural and small metro areas in Arizona, Colorado, Nevada and Texas, which were re-weighted to reflect prevalent characteristics in New Mexico. New Mexico-specific program data was also used in looking at certain health coverage programs. Eligibility and enrollment information was also used in developing the population module.

The cost module was used to assign to individuals expenditure patterns based on certain characteristics as well as place and type of service characteristics. Mathematica used national Medical Expenditure Panel Survey data and calibrated it to state-specific program data. Information from the Insurance Division was also used. Ms. Chollet reviewed additional sources of data used for the population and cost modules.

Projections to 2007 through 2011 were estimated and calculated for each separate program based on historical information. Administrative and non-medical costs were extracted, i.e., what is not directly related to health care delivery. The University of New Mexico's Bureau of Business and Economic Research (BBER) is being used for information on projected population changes as opposed to CPS data.

Upon comments and questions from the committee, the following issues were discussed:

- The seven categories of expenditures identified in the presentation should actually have an eighth category for prescription drugs.

- Approximately 25% of data is "borrowed" from other states but it will be flagged to check and weight accordingly for New Mexico.
- CPS data identifies immigrant population but it is not clear about which are undocumented.
- Private insurance numbers are reported separately. Premium information is provided to the Insurance Division, subsequently to the National Association of Insurance Commissioners and then reviewed in consultation with the division.
- The rationale for borrowing information from other states is that the number of observations from the New Mexico household survey is very small. Each New Mexico household is used to represent many other households. While no metropolitan area in the state looks like Phoenix or Denver, many rural households in Arizona or Colorado look like those in New Mexico.
- It is surprising how often people in the state fall in and out of insurance.
- The level of take-up by employees is high when offered by employers but the take-up has dropped off a few percentage points over the last decade. Employers are offering coverage at about the same rate as previously offered. There is some winnowing of eligibility and thus slightly eroding.
- Re-weighting and built-in characteristics are used to ensure population and cost modules "look like New Mexico".
- History does not necessarily predict medical cost trends but modeling by these assumptions is transparent and if the trends are wrong, recalculation is possible.
- Out-of-pocket expenses are observed using MEPS data since there is no other place to understand those expenses. They are scaled to make them reasonable for the state.
- There has been a marginal decline in coverage, some due to workforce changes. However, most of the decline is attributable to employee contribution increases, especially in small firms.
- Efforts to identify undocumented immigrants will depend in part on the state's experience with use of emergency rooms and similar providers, CPS estimates although whether documented or undocumented is unknown and census efforts to identify documented and undocumented populations.
- None of the models is differentiated by incentives that would result in cost reductions.
- Take-up assumptions took into account that an employee may take up insurance but not for dependents. Some of this discussion is dependent on observations regarding income and health status at single or multiple points in a year.
- The employer survey was not used because of insufficient data. The biggest decline is in take-up, not in the offer of insurance. Eligibility has changed but if an employee is likely to take-up coverage then it will probably continue. The difference appears to be in how the coverage is offered.
- Although some health care costs have exceeded 12% growth, there are areas where it has been in the 4% to 6% range, probably because programs are varied, but numbers have been combed thoroughly and to the extent that there is an error in that projection, all models start at the same base and use of historic trends.

Specifications for Coverage and Cost Analyses

Ms. Chollet thanked those persons that had reviewed the specifications for the models. She discussed the similarities, differences and the focus on cost "drivers" in each model.

A number of key elements were reviewed to understand coverage, costs and thus estimate and project costs. The key elements included eligibility, private insurers, employers, benefits, cost sharing, provider reimbursement, per member per month costs, contributions or subsidies and revenue sources.

For comparability across models, estimates assume the same target population, covered services, compliance with individual mandates, control of medical cost trends, other sources of saving and quality improvement. The estimates assume different Medicaid and SCHIP eligibility, roles of private insurers, roles of employers, incentives, medical cost differences, administrative cost differences, premium or contribution levels, sources and losses of revenue and other potential drivers.

Upon comments and questions from the committee, the following issues were discussed:

- Budget neutrality may be a component to consider since loss of disproportionate share hospital funding or availability of Medicaid waivers may be premature.
- There is a good handle on ongoing costs but startup and implementation costs may be more difficult. The assumption is immediate full implementation but it will be important to look at the significance of costs and time frames.
- Institutionalized populations are those in skilled nursing facilities, intermediate care facilities for the mentally retarded, prisons and similar institutions.
- Medicaid cost sharing is currently limited to the State Coverage Insurance (SCI) program and SCHIP. There may be some implications on when contributions are collected since they may be made only when illness or injury occur and not necessarily when individual is well. Driver assumptions change source of payment, not overall costs.
- Dual eligibles (Medicare and Medicaid) are a special population, like the institutionalized population. The growth of that segment affects the models equally.
- Each model calls for some governing body to collect information, work with providers, carriers and employers. There are legislative implications on costs, incentives, reimbursement and best practices in the management of the health care system.
- The models include the indigent population if they are medically indigent, not necessarily if they are simply transient.
- Consideration of the Employee Retirement Income Security Act (ERISA) in costing out models was based on preliminary estimate of costs; self-insured employers can decide whether to participate based on incentives.
- The legislature may need to consider provider payments, centralized systems, administration and other decisions implicit in the respective program model.

- Administrative costs may be affected by how a provider deals with the payer or administrative services organization. Presumably, a centralized administration or plan has lower administrative costs.
- There are significant federal-state law and policy considerations on how to deal with the Native American population and the impact on financing coverage. If tribes choose to pay for their individual members' contributions, then potential adjustments may be made on how the funding is collected. Indian Health Service is the payer of last resort, as a matter of policy, and their payments are not as large as providers anticipate.
- Whether there will be enough information to understand transitional costs to monitor data and quality will depend largely on the system's components. The governing structure is critical.

Public comment

General comments from the public included the following issues:

- The cost of doing nothing, i.e., maintaining the status quo, will also be projected as part of the analyses.
- There are studies that have demonstrated that wellness programs help reduce costs. The ultimate cost of health care has a significant impact on the costs of goods and services.
- It is important that the HCNMC recognize that health care for uninsurable or high-cost/high-risk patients is increasingly unaffordable.
- The costs associated with treating undocumented immigrants is substantial and need to be taken into consideration.
- There are numerous issues impacting Native Americans and their participation in the proposed models, some of which is complicated by issues relating to tribal sovereignty.
- The assumption that the SCI program can be used to enroll participants up to 300% of the federal poverty level (FPL) or that others can be enrolled in Medicaid up to 100% FPL may be problematic and should be reviewed carefully by the committee.
- Concern expressed that the state employees health care benefit package may be used for some of the modeling since it is a fairly rich package.
- The consideration given to rural issues is impressive and important.
- The study must consider the financial impact on the health care industry if a single payer system is selected.
- That universal coverage will be achieved should be presented as a question, not as an assumption. If certain groups are excluded such as the Medicare population then the model may not reflect what it was intended to do. It is important to figure out the costs before determining how the models are to be financed. The methodology based on an insurance premium model may not reflect what the proposed model can do if non-medical costs are excluded. Various items such as subsidies, caps, administration, overhead and quality must be examined.

- Concern that only one benefit design, the state employees program, is being used since that program is more expensive. An analysis of medical pricing would be helpful as part of this process. The effect of a single payer system that may level pricing for all providers should be examined. Administrative cost savings, uncompensated care, cost-shifting and one fee schedule should be more closely examined, particularly with respect to a single payer system.
- County indigent programs and their role as both providers and health care expenditures should be examined with an examination of how these may impact counties.
- Appropriate comparisons among the models is key, particularly since one benefit package is being used.

Ms. Chollet addressed some of the issues raised during the public comment period and indicated that most of those issues would be more formally addressed in the next meeting or the final report.

Current Coverage and Cost and Coverage in the Reform Models

Ms. Chollet provided an overview of how the current case was developed through an examination of predominant sources of coverage, self-insured coverage among workers, part- and full-year uninsured persons, and current expenditures and sources of payments. The current case would be updated based on anticipation of eligibility changes for SCI and Medicaid, with corresponding first-year enrollment projections.

Health coverage in New Mexico is dynamic in that many residents have part-year coverage, with an average of about seven months in Medicaid and SCHIP. Ms. Chollet reviewed various graphs that illustrated:

- approximately one in four New Mexicans under age 65 are predominantly uninsured;
- half of the predominantly uninsured New Mexicans are Medicaid or SCHIP eligible but are not enrolled;
- New Mexicans under age 65 will spend approximately \$6.1 billion in 2007 for health care;
- large and small firm employees comprise approximately 34% each of the labor workforce;
- almost 40% of New Mexico workers are enrolled in self-insured employer plans;
- more than 50% of New Mexicans under age 65 are uninsured at least part of the year; and
- 12% of children are uninsured during the entire year and 54% of children are uninsured during part of the year.

Upon comments and questions from the committee, the following issues were discussed:

- Some studies consider Native Americans uninsured because the Indian Health Service is not a traditional health insurance or coverage program and there are numerous limitations on the provision of service to Native Americans.
- New Mexico has higher than national rates of part-year coverage.
- State and federal employees comprise about 10% of the total and local government employees are included in the employer-sponsored breakdowns.
- The seven-month average for coverage may be due to the Medicaid and SCHIP six-month recertification process that was subsequently changed to twelve months.
- SCI enrollees are included as part of the "other public" 4% covered and are not included in the Medicaid/SCHIP percentage since SCI is not a strictly Medicaid eligibility group. SCI enrollees are not counted as private employer members.
- For the most part, the \$6.1 billion spent for health care does not include Medicare beneficiaries or the institutionalized population since those over 65 are excluded from those statistics.

Three Reform Models and What Will Come Next

Ms. Chollet provided an overview of the major assumptions, sources of coverage in the reform models, potential legal considerations and the production of a final report. She discussed the assumptions regarding universal coverage for the state; implementation; maximum enrollment in Medicaid and SCHIP; employer and individual decisions driven by cost; crowd out; family coverage preferences; and young adults seeking coverage. She provided a breakdown of the percent of New Mexicans covered under the current case, the three models and the type of program as well as projected sources of coverage for uninsured residents. Potential legal issues included mandate enforcement, Medicaid waiver authority, self-insured plan and tax consequences. Ms. Chollet indicated that the final report would include expenditures under the reform models, financing, economic impacts, fiscal impacts and consideration of institutionalized persons, costs savings, public health impacts and access to services in medically underserved areas.

Public comment

General comments from the public included the following issues:

- It is important to maintain what is working in New Mexico, e.g., the SCI program rather than making wholesale changes.
- It would be helpful for the study to address how overhead expenses impact providers.
- Models may need to address those persons not working full-time.
- Whether employers will be able to purchase coverage for undocumented employees should be considered as part of the legal analysis.
- Employees that work part-time to maintain public program eligibility should be addressed to allow full-time employment while maintaining coverage.

- Lack of coverage leads to lack of care but it does not guarantee access. There are numerous implications including primary care providers, greater demand, impact on rural areas, economic impact, displacement and economies of scale.
- All counties except Los Alamos are designated as health care work force underserved counties.
- By 2020, it is estimated that there will be a shortage of 85,000 physicians and 200,000 nurses. If health care providers are lost in rural areas, then facilities are similarly lost. There are significant financial and economic impacts on physicians, other providers, the private sector, insurers and hospitals.
- The governing board discussed in Health Choices would not set provider rates. It may be helpful to obtain a legal analysis on provider rate setting, particularly as it impacts hospital operating costs and capital budgets. Contributions to premiums may be based on income.
- Mathematica has done a considerable amount of work with limited time and resources. Issues that may still need to be addressed include household patterns of expenditures, employer contributions, caps on premiums, caps on employer premiums and administrative costs.

Ms. Chollet addressed some of the issues raised during the public comment period and indicated that most of those issues would be more formally addressed in the next meeting or the final report.

Upon comments and questions from the committee, the following issues were discussed:

- The final report will address cost drivers and differential costs.
- How the coverage of undocumented immigrants in emergency rooms will be financed by the various models should be addressed.
- Coverage-based denials may impact what is needed for high quality health care.
- Under the Health Coverage Plan, there is no expected administrative savings by source of coverage but program expansion will have a commensurate rise in administrative costs.
- With respect to access and disparities, the rural health network may be underestimated in terms of its fragility. Extensive analysis may be needed since in many areas, competition destabilizes the safety net.
- It is necessary to determine what waivers are needed for the coverage models and their associated costs since waivers require budget neutrality. In the Health Security Act, the Medicaid package is kept the same. The final cost figures cited do not include the full Medicaid costs because of dual eligibles and others over 65 that are not included, accounting for approximately two-thirds of the Medicaid budget. SCHIP money is capped since it is similar to a block grant, which should be reflected in the analysis of the models. The analysis of ERISA appeared to be somewhat lacking.
- Undocumented workers are residents of New Mexico and thus presumably covered under the models.
- Federal tax incentives are under consideration but numerous issues make its impact limited.

- The final report should address what is or is not possible with Medicaid, e.g., expansions, waivers and financing, all of which have economic impacts.
- Higher rates paid under Medicaid or SCHIP in other states have an impact on the amount of money that goes for out-of-state provider reimbursement.
- Consideration should be given to a lawsuit against the federal government to ensure that it meets its obligations to provide health care under treaties with tribal governments.

Next steps

The committee discussed possible next steps as outlined in a handout regarding process, analysis and policy content. Members commented that sufficient time would be needed for consideration and analysis, final report information must be shared with the public in a timely fashion, consideration of potential legislation may be needed, some continuation of the committee's efforts may be necessary beyond June 30, building of consensus is key for change to occur and the concept of universal coverage is "huge" requiring a lot of work and commitment. Some members requested that time be provided at the May meeting to begin a discussion of potential next steps and how the committee will arrive at these recommendations, even though the committee will not have heard all the analyses from Mathematica at that point.

The next meetings are scheduled for May 16 in Albuquerque and June 21 in Santa Fe.