

**HEALTH COVERAGE FOR NEW MEXICANS
COMMITTEE**



**REPORT TO GOVERNOR BILL RICHARDSON
AND THE NEW MEXICO LEGISLATURE**

AUGUST 9, 2007

TABLE OF CONTENTS

PREFACE BY LIEUTENANT GOVERNOR DIANE DENISH	3
EXECUTIVE SUMMARY	5
Summary of HCNMC's Policy Recommendations	7
I. CREATION AND CHARGE OF HCNMC	9
II. MEMBERS OF HCNMC	9
III. SUMMARY OF MEETINGS OF HCNMC	10
Components Considered for Inclusion in Models	10
IV. PROCESS OF HCNMC	12
V. PROCESS USED TO CONDUCT COST STUDY	16
VI. HIGHLIGHTS OF MATHEMATICA COST STUDY	18
Introduction to Mathematica Cost Study	18
Analysis of Current Coverage in New Mexico	19
Analysis of Current Health Care Expenditures	19
Key Assumptions for Analysis of Models	20
Change in Coverage Under the Reform Models	20
Change in Cost Under the Reform Models	21
Financing the Reform Models	22
Summary of Mathematica Cost Study	23
VII. HCNMC RECOMMENDATIONS	24
A. Recommendations for Policy Implementation	24
B. Recommendations for Process for Next Steps	25
C. Recommendations for Further Analyses	26
Cost, Financing and Fiscal Implications Analyses	27
Policy and Legal Analyses	27
VIII. CONCLUSION	28
ATTACHMENT A Committee Members	30
ATTACHMENT B HCNMC Timeline	31
ATTACHMENT C HCNMC Working Definitions	32
ATTACHMENT D Graphic Summary of Costs for Current Case and Models Studied	34
ATTACHMENT E List of Acronyms	35

PREFACE

From Health Coverage for New Mexicans Committee Chair, Lieutenant Governor Diane Denish

The Health Coverage for New Mexicans Committee was created in August 2006 and charged to systematically explore various reform options designed to improve health care coverage in New Mexico. The Committee adopted the following guiding principles and used these as a basis to conduct its work during the ensuing months:

1. The goal is universal coverage, that is to identify a model or models of health coverage for all people living in New Mexico to purchase or be provided health care coverage, whether public or private, and that are affordable for individuals, taxpayers, employers, and other payers.
2. Models analyzed must 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.
3. Models analyzed should consider the quality (including outcomes and wellness) and cost of health care for individuals, not just the cost of health coverage for payers.
4. Multiple approaches may be required to develop and finance the different coverage needs of different ages and types of populations within New Mexico.
5. A combination of public and private approaches may be necessary, with the state and federal government providing strong leadership and oversight roles; and government, employers, individuals/families and the clinical community sharing responsibility for health outcomes and the cost of health coverage.
6. Persons and families with low incomes or high health care needs should be assisted in purchasing, accessing or enrolling in available health care coverage.
7. Models must take into account that health, health coverage, and economic development are intrinsically linked with a) improved health of people living in New Mexico having a positive impact on economic development; b) strong economic development playing a role in improving the health status of people living in New Mexico; and c) health coverage impacting access to health care and health status and outcomes in New Mexico.

I wish to acknowledge the Committee members for their hard work and commitment. The members included Representative James Madalena, Representative Brian Moore, Representative Danice Picraux, Senator Dede Feldman, Senator Mary Jane Garcia, Senator Carroll Leavell, Charlotte Roybal, April Redbird, Mike Batte, David Scrase, M.D., Craig Keyes, M.D., Dennis Pena, Paul Sowards, Duane Trythall, Secretary Alfredo Vigil, M.D., Michelle Melendez, Carter Bundy, Robin Gould, Steve Altmiller, Charlie Alfero, James Tryon, M.D., Secretary Pam Hyde; advisory members Michelle

Welby, Chuck Milligan, Representative John Heaton, Senator Tim Jennings; and staff Raul Burciaga and Ruby Ann Esquibel.

The Health Coverage for New Mexicans Committee was pleased to have engaged in a proactive, well-defined process to engage with various stakeholder groups to understand their needs, create solutions, and maintain support throughout the design and development of health care reform recommendations for New Mexico. My hope is that these recommendations can be implemented to further increase the number of people in New Mexico with health coverage and greater access to quality health care.

Diane D. Denish

**Lieutenant Governor Diane Denish
Chair, Health Coverage for New Mexicans Committee**

HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE
Report to Governor Bill Richardson and the New Mexico Legislature
August 2007

EXECUTIVE SUMMARY

The Health Coverage for New Mexicans Committee (HCNMC) began study and deliberations in August 2006. Composed of 23 members and four advisory members, the task force was appointed by Governor Bill Richardson, Speaker Ben Lujan and Senate Pro Tem Ben Altamirano. HCNMC was chaired by the Lieutenant Governor. The membership included a cabinet secretary, legislators and representation from business, labor, insurance carriers, the health care industry (including providers and hospitals), and advocates to ensure a broad range of recommendations were designed specific to New Mexico.

HCNMC's charge was to develop or identify three to five different comprehensive universal health coverage models for New Mexico to be analyzed financially. Essential components that guided the work for models to be considered by HCNMC were:

1. Provide health coverage for all New Mexicans, regardless of ability to pay or income level;
2. Remove lapses in coverage because of unemployment, underemployment or changes in health status;
3. Identify ways of keeping costs in check;
4. Include coverage for those individuals with high health care needs or pre-existing conditions; and
5. Optimize the use of federal matching funds.

Several proposals were heard and considered. Three models were chosen for analysis and comparison to the status quo:

1. The Health Security Plan (HSP) would create a single statewide comprehensive health coverage plan similar to that provided to state employees and replace an array of the small group and individual health insurance carriers and programs in the state. All covered New Mexicans would be automatically enrolled in HSP. Individual premiums would be scaled to income. Employers would be required to pay into HSP as a percentage of payroll and self-insured employers could elect whether to participate. Individuals covered through plans offered to federal and military employees and retirees would not have to participate in HSP. HSP's governing board would negotiate lowered provider fees and facility budgets, and the state would seek federal waivers to integrate Medicaid and State Children's Health Insurance Program (SCHIP) beneficiaries and financing into HSP.
2. The New Mexico Health Choices Plan (NMHC) would create a single statewide risk pool to replace the individual and group health insurance markets as well as an array of state programs. Private insurers would continue to offer coverage

within the plan which would operate as a purchasing cooperative. All residents would be required to obtain coverage. In an alternative version of the model, all coverage through NMHC would be on an individual basis and all employers would contribute in the form of a payroll tax (version 1); or employers could continue to offer coverage and would be exempted from the payroll tax for any worker enrolled directly in the employer's health plan (version 2). The state would provide vouchers to all residents to cover the cost of a limited benefit plan, while employers and/or individuals could supplement these vouchers to purchase more comprehensive benefits.

3. The New Mexico Health Coverage Plan (HCP) would require all residents to obtain coverage and expand access to existing sources of coverage. The plan includes the following provisions: 1) all adults up to 100 percent of the federal poverty level (FPL) would be eligible for Medicaid or the State Coverage Insurance (SCI) program without cost-sharing; 2) SCI would be expanded to cover adults to 300 percent FPL, with cost sharing scaled to income; 3) nonprofit organizations with fewer than 100 workers could buy into SCI or the Small Employer Insurance Program (SEIP) without a waiting period if they are vendors for the state; 4) premium assistance would be provided to pregnant women and to children under age 18 who do not have coverage and are not otherwise eligible for public programs such as Medicaid; 5) a new state reinsurance program would remove the current annual limit on covered benefits under SCI; 6) parents could continue to cover their unmarried children as dependents under individual or group coverage up to age 30; 7) funding for federally qualified health centers (FQHCs) and primary care clinics would be increased; 8) incentives and subsidies would be developed to encourage the use of federal tax preferences for employer-sponsored coverage; and 9) employers would be required to pay into a Fair Share Fund for any worker for whom they did not directly provide coverage. The Fair Share Fund would pay claims for uninsured individuals and/or subsidize reinsurance.

A nationally recognized consultant — Mathematica Policy Research, Inc. — was competitively procured to conduct the analysis. Upon receipt of the final report in July 2007, HCNMC's charge was to make recommendations to the Governor and Legislature for next steps, including legislation to be considered during the 2008 legislative session. Those recommendations are contained in this report.

While there was consensus among HCNMC members that health reform is greatly needed in New Mexico, the members also recognized that discussions about how to expand health care coverage are difficult to separate from reforms in the health care system itself. If a choice is made to first focus on expanded health coverage offerings to the uninsured, these efforts may not be sustainable without eventually addressing the problems of cost, quality and inefficiency within and access to the system itself. The HCNMC arrived at a general consensus that increasing health care coverage is critical for all New Mexicans given our high rate of uninsured and low per capita income levels, and the correlation between coverage and improved access to health care.

Based on the findings in Mathematica's final report (http://insurenemexico.state.nm.us/documents/INM_MPR_Final_Report_070731.pdf), HCNMC concluded that the long-term cost of making **no change** in current health care coverage would be greater than moving forward with some type of reform. Rather than endorsing one particular model in the Mathematica study, HCNMC agreed that certain components of each model showed potential for inclusion in health coverage reform, and chose to recommend elements it considers vital to a statewide health coverage policy. While certain subjects require further study, many recommendations may be implemented without delay following the successful passage of legislation in 2008.

Summary of HCNMC's Policy Recommendations

1. Address a governance structure through a single statewide unified health care authority based on the guiding principles adopted by the HCNMC charged with implementing health care reforms regarding universal coverage, cost and quality controls, and oversight of health care delivery in New Mexico as described in the process recommendations below.
2. Maximize enrollment in Medicaid as soon as economically feasible including:
 - a. Enroll everyone currently eligible for Medicaid as state resources for federal match are available, focusing especially on children at all eligible income levels and on adults under 100 percent of the federal poverty level (FPL);
 - b. Expand Medicaid eligibility up to 300 percent FPL where allowed by federal law, regulation or U.S. Centers for Medicare and Medicaid Services (CMS) approval;
 - c. Expand Medicaid eligibility up to 200 to 300 percent FPL proportional to income, pending CMS approval.
3. Change New Mexico health insurance requirements including:
 - a. Require health coverage of everyone in New Mexico, incorporating affordability criteria and compliance procedures;
 - b. Institute minimum requirements for the medical loss ratio for insurance companies doing business in New Mexico;
 - c. Require guaranteed issue for all individuals and small groups in New Mexico;
 - d. Require coverage by insurance companies regardless of individuals' pre-existing conditions, and remove waiting periods;
 - e. Move toward combining the state's individual and small group markets;
 - f. Immediately reduce the small group mark-up for experience (currently allowable is 20 percent over/under the state average);
 - g. Eventually move towards community rating for all health insurance products, including within the small group market, thereby ending experience rating in that market;
 - h. Require standard data reporting for all insurance companies offering health insurance products in New Mexico;
 - i. Create a uniform statewide drug formulary;

- j. Require that all practitioners accept all public and private health care coverage options as a payment source. Ensure that public and private payment discrepancies do not disproportionately affect practitioner income based on location of service, catchment area and other geographical barriers;
 - k. Move towards implementing risk equalization strategies.
4. Allow employers and employees to buy into the state employee health risk pool and/or a Medicaid benefit plan.
 5. Move toward implementing portability to ensure that people's coverage follows them regardless of employment changes.
 6. Allow provider choice for consumers.
 7. Consolidate or create larger health insurance risk pools where beneficial.
 8. Require health information technology such as standard fee schedules, enrollment, medical records, diagnosis, billing, claims, provider payment and reimbursement.
 9. Increase provider recruitment and retention through incentives.
 10. Consider a state-operated reinsurance program to distribute risk and manage the effects of individuals' high cost medical procedures.

The comprehensive list of HCNMC recommendations including recommendations for the Process for Next Steps and Further Analyses is contained on page 24 of this report.

HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE
Report to Governor Bill Richardson and the New Mexico Legislature
August 2007

I. CREATION AND CHARGE OF THE HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE

The Health Coverage for New Mexicans Committee (HCNMC) is a 23-member Committee, plus four advisory members, appointed in August 2006 jointly by Governor Bill Richardson, the President Pro Tempore of the Senate, Ben Altamirano, and the Speaker of the House of Representatives, Ben Lujan. HCNMC's charge was as follows:

The Health Coverage for New Mexicans Committee will develop or identify three to five different health coverage models for which a financial analysis, including but not limited to actuarial analysis, will be conducted by national experts that have experience in the analysis of the costs of such models. The committee will hold an organizational meeting to discuss the process for determining the models to be analyzed. The analysis of the models determined by the committee will take into consideration current resources, projected needs, and public and private health care expenditures in the state, including the cost of the current system and the transitional cost to each different model analyzed, to achieve health coverage for all New Mexicans. The analysis will consider the costs of various models and appropriate roles for health care consumers and providers; publicly funded, operated or created health care programs; large and small businesses and nonprofit organizations; and managed care organizations and commercial insurers. The committee will review the consultants' work and make recommendations to the Governor and the Legislature for the next actions to be taken. The committee will actively solicit public input. All meetings of the Health Coverage for New Mexicans Committee or its subcommittees will be open to the public except when the committee is discussing or hearing information about potential bidders.

II. MEMBERS OF THE HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE

The members of HCNMC were appointed jointly by Governor Bill Richardson and the Legislative Leadership. HCNMC consists of 23 voting members and four advisory members, and is chaired by Lieutenant Governor Diane Denish. HCNMC included representation from the State Senate and House of Representatives, the cabinet, business, labor, insurance industry, health care providers, hospitals, and advocates. The members of HCNMC and the broad constituencies they represent are listed in **Attachment A**.

III. SUMMARY OF MEETINGS OF THE HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE

The Health Coverage for New Mexicans Committee met from August 2006 through June 2007. The Committee had 11 meetings and set out the comprehensive timeline indicated in **Attachment B**, with the Committee's guiding principles identified in the Preface to this report. HCNMC meetings focused on the following activities: 1) discussion of HCNMC's focus, work plan, and setting timelines; 2) determining what components to include in the models of universal coverage; 3) hearing from national experts to summarize the major issues of health care reform; 4) hearing presentations on models and receiving feedback from the public; 5) selecting the models to be studied; 6) procuring a vendor to conduct the cost study; 7) overseeing the cost study analysis; 8) hearing the initial cost study findings and providing feedback for adjustments prior to completion of the final report; and 9) recommending next steps to the Governor and the Legislature. All meetings of HCNMC were open to the public, electronically recorded, with public information collected and distributed regularly via email. The information associated with HCNMC's work is available on its website, <http://insurenemexico.state.nm.us/HCNMC>.

At its October 2006 meeting, HCNMC agreed that the following components noted in the section below would be required for all models chosen for inclusion in the cost study. **Attachment C** provides operating definitions used by HCNMC and associated with the model components selected by HCNMC.

Components Considered for Inclusion in HCNMC's Models of Coverage

- a. A range of benefit options, including, but perhaps not limited to:
 - Comprehensive;
 - Basic; or
 - Limited, i.e., comprehensive range of benefits, but with annual limitation — for example, \$100,000 — and without vision or dental.
- b. Source of subsidies for low-income or high-risk individuals, for example:
 - Tax credits for employers or individuals;
 - Reduction in tax liabilities for employers or individuals;
 - Reduced premiums for low-income or high-risk/cost individuals;
 - Tax relief for insurance companies; or
 - State-funded/administered reinsurance funds.
- c. Source of "reserve", for example:
 - Premiums;
 - Commercial insurers;
 - Government funds;
 - One-time tax on insurance companies; or

- Contribution or tax from facilities and practitioners whose uncompensated care will be mostly eliminated.
- d. Types of revenue for public expenditures or subsidies, for example:
- Employer payroll tax;
 - "Play or pay" requirements on employers;
 - Gross receipts tax at state or county levels;
 - Medicaid funding to extent allowed by the federal government;
 - Reduction in tax relief for those who do not offer or purchase/enroll in a coverage option;
 - Savings from uncompensated care or administrative savings;
 - Unmatched local indigent funds; or
 - Personal income tax increase.
- e. Source of any projected savings, for example:
- Government controls on provider rates or rates of coverage;
 - Government controls on number and types of health care facilities or equipment, such as certificates of need;
 - Incentives on consumers to be smarter shoppers and better decision-makers regarding health care utilization;
 - Incentives on consumers and practitioners to engage in use of generics, use of physicians' offices rather than emergency rooms, etc.;
 - Incentives on consumers and practitioners to engage in or utilize prevention, wellness and health promotion activities;
 - Incentives to limit the use of defensive medicine and defensive testing procedures to reduce exposure to potential liability, e.g., tort reform or reduction in malpractice premiums;
 - Caps on administrative costs; or
 - Return to public use of a portion of uncompensated care savings.
- f. Methods to assure purchase of or enrollment into coverage, for example:
- Employer or individual mandates to require offer or take-up of coverage;
 - Employer or individual subsidies to reduce cost;
 - Required health plan or public program sign-up for employment, school, business, or professional or recreational licensure;
 - Aggressive outreach and education; or
 - Pools for uncovered individuals, e.g., newly eligible individuals.
- g. Governance and administrative structures to determine benefit designs and oversee quality and outcomes; for example:
- Existing state government entities with commercial policies or administrators;
 - Appointed or elected citizen commission with commercial policies or administrators;
 - Government- and/or commission-operated benefit plan with commercial administrator; or

- Government- and/or commission-operated benefit plan with government administration.
- h. Eligibility requirements, for example:
- Residency requirements;
 - Waiting or "crowd out" period before eligibility;
 - Exclusion of persons who have not lived in New Mexico for a defined period of time; or
 - Exclusion of persons already offered coverage through another source, such as an existing government program or an employer, etc.

IV. PROCESS OF THE HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE

HCNMC operated by consensus, with secret ballot utilized to choose the models to be included for analysis in the cost study and for the vendor selection process. HCNMC reached consensus and adopted the following criteria for determining the models to analyze in the cost study:

- a. The model will provide universal health coverage for all people living in New Mexico regardless of ability to pay or income level.
- b. The model will not exclude those with high health care needs or pre-existing conditions, but may propose existing publicly-subsidized programs for such individuals, e.g., New Mexico Medical Insurance Pool for high risk individuals, Medicaid or Medicare for elderly or disabled individuals. The model may include recommendations to combine certain public programs in order to remove duplication, to the extent it is in the power of the State to do so.
- c. The model will assure continuous health coverage and remove lapses in coverage due to unemployment, under-employment, or change in financial or health circumstances; will allow portability among or across providers; and will minimize uncompensated care and cost-shifting except for services not authorized under any defined benefit plan.
- d. The model may include roles for both public and private sectors, recognizing the role of Medicare, Medicaid, Tricare, Indian Health Service, and other federal, state or local public payers and providers as well as private insurance companies as insurers (managed care and/or indemnity), plan administrators or both. The plan shall optimize the use of available federal matching funds. The model may include elements from other health coverage models.
- e. The model will promote the delivery of high-quality health care in which evidence-based care will be provided for consumers through the application of the Institute

of Medicine (IOM) rules for safe, effective, patient-centered, timely, efficient and equitable care including:

- Care is based on continuous healing relationships;
 - Care is customized according to patient needs and values;
 - The patient is the source of control;
 - Knowledge is shared and information flows freely;
 - Decision-making is evidence-based;
 - Safety is a system priority;
 - Transparency is necessary;
 - Needs are anticipated;
 - Payment systems are aligned and incentives are provided toward health improvements;
 - Waste and inefficiency are continually decreased; and
 - Cooperation among clinicians is a priority.
- f. The model will be clear about the timeframe and steps for full implementation and the implications for transition to the model.
- g. The model will define or identify methods for encouraging accountability and tracking health outcomes on the part of the following:
- Individuals, families and organizations, as well as communities in promoting healthy behaviors;
 - Primary care providers to deliver preventive services at primary and secondary levels, and to emphasize evidence-based practices where these exist;
 - The relative impact of the cost of sub-specialty care on population health;
 - Health care workforce;
 - Governments, employers and other payers to fund health promotion, wellness, prevention, treatment, disease management, long-term and chronic care and research to generate evidence of positive outcomes through health promotion as well as treatment approaches; and
 - Private and academic sectors to invest in evidence-based long-term strategies that yield positive health outcomes for health care consumers.
- h. The model will include methods to collect and report data about at least the following health care indicators:
- Outcomes;
 - Improvements;
 - Critical incidents;
 - Trends by population types;
 - Care expenditures;
 - Administrative or overhead costs;
 - Timeliness of access; and
 - Impact on employers (small group and large group reported separately).

- i. The model will clearly identify its sources of funding, and how these are likely to change over time, including but not limited to:
 - Co-payments, co-insurance, deductibles or other cost-sharing, including limited or waived cost-sharing requirements for the most vulnerable or indigent populations;
 - Coverage limitations;
 - Adjustment of and innovative payment mechanisms for providers;
 - Available governmental and philanthropic funding;
 - Payments of premiums by payers assumed in the model;
 - Sales and payroll taxes;
 - Alcohol, tobacco, soft drink and food taxes;
 - Penalty for non-participation in the health coverage model;
 - Assessments on insurers, hospitals and employers; and
 - Indigent funds.

- j. The model will offer consumers and practitioners choices – balanced with patient or consumer accountability and sharing of responsibilities – including, but not limited to, choice about:
 - Benefits – level and services covered, inclusions and exclusions;
 - Practitioner/consumer relationships;
 - Practice settings and mechanisms;
 - Locations for service delivery;
 - Alternative and non-traditional healers;
 - Use of community health workers; and
 - Provision of services from a doctor in the patient’s local area.

- k. The model will have a method for identifying health care cost drivers and predicting trends and ways of addressing them to control the rising cost of health care and health coverage to achieve the goal of costs rising no greater than the consumer price index (CPI) or other reasonable price increase indicator, while adequately accounting for the full, reasonable cost of delivering care.

- l. The model will take into consideration New Mexico’s unique issues, including but not limited to:
 - Rural/frontier nature;
 - Large geographic service area;
 - High poverty/low median income economy;
 - Preponderance of small employers;
 - High percentage of individuals currently without coverage;
 - High percentage of employers not currently offering health coverage for employees or their families;
 - High rates of health disparities, particularly among minorities;
 - High numbers of Hispanics and Native Americans;
 - Partnerships with pueblos, tribes and the Indian Health Service;

- High numbers of individuals and households where English is not spoken or is the secondary language;
 - High rates of particular negative health outcomes (e.g., teen pregnancy, suicide, obesity, diabetes, hepatitis, asthma, etc., as reported by the New Mexico Department of Health);
 - New Mexico's safety net services, clinics and institutions;
 - Health professional training incentives;
 - New Mexico-specific statutes, regulations and case law about public health, medical malpractice, tort claims, consumer protections, insurance, tribal law, etc.;
 - Existing strengths of New Mexico's current health coverage market;
 - Mechanisms by which the state generates public funds;
 - State and local revenue;
 - Indigent funds; and
 - Premium costs.
- m. The model will consider prioritization of services delivered linked to principles of evidence-based health services.

The Health Coverage for New Mexicans Committee heard formal testimony regarding the following models:

1. Real Choice Insurance Market Reforms – Plan put forth by insurance brokers for a reduction in benefit mandates; reduction in regulations; health savings accounts, incentives or other mechanisms to encourage wise health care expenditure choices and discourage bad choices; wellness and prevention approaches; and utilizing no additional public funding.
2. American Medical Association (AMA) Health System Reform Proposal – Federally issued refundable tax credits inversely proportionate to income, and available only for use in purchasing a variety of commercially sold health insurance policies, with nationally set benefit standards and modified community rating, allowing somewhat higher costs for persons with higher risk, but greater tax credits for lower income regardless of health status.
3. Health Security Plan – A common benefit plan with one administrator and payer (with or without a commercial administrator) and ability to buy supplemental market-based policies.
4. New Mexico Health Choices – Publicly subsidized, individually purchased commercial insurance in a structured competition environment using payroll taxes to finance and vouchers to allow individuals and families to purchase portable market-based policies of their choice.
5. Build on Existing Public and Private Systems – Expansion of current public programs such as Medicaid, Indian Health Service, federally qualified health

centers (FQHCs), student health services, Medicare, etc., with use and engagement of commercial market as plan administrators or as vendors of policies subsidized for low-income residents.

6. Combination of approaches.

HCNMC ranked each of the proposed plans against the following prioritized criteria:

- #1: Insures All People Living in New Mexico
- #2: Identifies Sources of Funding
- #3: Uses Evidence-Based Practices
- #4: No Exclusion for High Need
- #5: Role for Public and Private Sector
- #6: Method for Identifying Cost Drivers
- #7: Provides Continuous Coverage and Reduces Uncompensated Care

Voting was based on the prioritized criteria and resulted in the selection of three models that became HCNMC's plans for inclusion in the cost study: the Health Security Plan (HSP); the New Mexico Health Choices Plan (NMHC); and the New Mexico Health Coverage Plan (HCP, initially described as Building on Public and Private Systems).

V. SUMMARY OF PROCESS USED TO CONDUCT THE COST STUDY

HCNMC adopted the following criteria to be used in the analysis of its selected health coverage models as time and resource constraints permitted. The analysis of the models was to include:

- a. The quantitative and qualitative economic impacts on government, businesses, and people living in New Mexico when the model is 1) implemented, 2) in the transition from the current system to the new model, and 3) over time, including but not limited to the impact on:
 - The cost of proposed coverage models or the cost of components of coverage models over a five-year period;
 - Pooling of populations that are currently served/funded by the State of New Mexico;
 - The health care provider industry (facilities, organizations, employees);
 - Payment incentives;
 - The impact of physician specialty mix on health care cost and outcomes;
 - The health insurance industry;
 - The financial impact of contracted public coverage models, e.g., Medicare, Medicaid and public employees on the private insurance and pharmaceutical industries;

- State revenue and local taxes, including funding of health care provided to indigent patients and the federal disproportionate share hospital (DSH) funding;
 - State gross receipt taxes;
 - Business and employer costs, including self-employed individuals, large group employers and small group employers, associated with insurance premiums and wages;
 - Non-profit funding needs and costs;
 - Minimizing cost shifting;
 - Interdependency between payer and provider and its impact on cost increases and practice mandates;
 - Cost transparency, i.e., determining the “real” cost of health care;
 - Cost of employer and individual mandates;
 - Cost and savings of health promotion, wellness, prevention, disease management, and chronic or long-term care;
 - Costs to individuals;
 - Impact of residency limits;
 - Development and funding of an uncompensated care pool/fund;
 - Potential impact of merging the group and non-group insurance markets; and
 - Creation of a “connector”, i.e., an office or authority to work with individuals and employers to connect them with coverage options and manage the implementation of the model.
- b. The anticipated economic impacts from expected changes in health status and health outcomes including the anticipated social benefits from fewer health disparities, increased immunization rates, earlier diagnosis and treatment of chronic conditions and general preventive care.
- c. The analysis of each model will be compared against a continuation of the status quo policies and insurance market (known as the “base case”).

A request for proposals (RFP) was let by the Legislative Council Service (LCS) in collaboration with the Human Services Department (HSD) requesting bids from proposers to study the cost of each model selected by the Committee. A team consisting of staff from LCS, HSD and Division of Insurance (DOI) reviewed the four proposals received for technical aspects and proposed three offerors for the HCNMC to consider.

HCNMC heard oral presentations from the three finalists to conduct the financial analysis of the three health coverage models chosen by the Committee. The successful vendor was chosen on behalf of HCNMC, with LCS (in consultation with HSD) entering into a contract with Mathematica Policy Research, Inc. (Mathematica), to conduct an extensive quantitative and comparative analysis of three health coverage models, against each other and the base case, to bring universal health coverage to New Mexico.

The analysis was to consider the costs to employers, the state, individuals and families, and health care companies compared to taking no action with the current system. HCNMC was clear that before it could proceed on recommending and ultimately adopting recommendations for a model of universal coverage for New Mexicans, it needed to understand the ultimate benefits of bringing health care reform to New Mexico. HCNMC clearly articulated that cost alone would not be the determining factor for any final model proposed and ultimately adopted by the state's policy-makers.

VI. HIGHLIGHTS OF THE COST STUDY CONDUCTED BY MATHEMATICA POLICY RESEARCH, INC.

The cost study report produced by Mathematica Policy Research, Inc., *Quantitative and Comparative Analysis of Reform Options for Extending Health Care Coverage in New Mexico*, can be found in its entirety at

http://insurenemexico.state.nm.us/documents/INM_MPR_Final_Report_070731.pdf.

The following are highlights excerpted from that report.

Introduction to Mathematica Cost Study

HCNMC requested that Mathematica Policy Research, Inc. estimate the cost of the current health care system in New Mexico and the relative cost of three alternative models to ensure that all New Mexicans become and remain covered.

To develop estimates that would help HCNMC compare reform models on the same basis, it was necessary to develop relatively precise specifications for key components of the three models. Implicit in the specifications are a number of key decisions, including:

- A focus exclusively on the non-institutionalized civilian population under age 65 who are not enrolled in Medicare.¹
- Premium schedules for coverage in each reform model.
- Specification of employer roles and contributions, including employer payroll taxes in HSP and NMHC, and the Fair Share amount that employers would pay under HCP.
- Specification of benefits or services available for individuals under NMHC and HCP.

It should be noted that any of these specifications – especially premiums, employer contributions and services/benefits available – could be adjusted in any of these models, thereby affecting the overall cost and the distribution of costs to various parties (e.g., employers, individuals/families, state General Fund, etc.)

¹ Almost all individuals over age 65 are covered by Medicare and some individuals under age 65 who are disabled are covered by Medicare.

In addition, each of the reform models envisions various strategies to ensure compliance with a state requirement that all New Mexicans have coverage, as well as strategies to control health care costs and improve the quality of care. Because any of the models could devise “best practice” approaches to achieve these goals, the estimates and projections assume that they all do so with equal success.

Analysis of Current Coverage in New Mexico (As of 2006)

Coverage is not static—in every state, people move in and out of different coverage from various sources, and gain and lose coverage during the year. An estimated 432,000 New Mexicans are predominantly uninsured (i.e., without coverage more than six months in a year), accounting for 26 percent of the non-institutionalized civilian population under age 65. Under the eligibility rules that were authorized in the 2007 legislative session, more than half of uninsured New Mexicans would be eligible for Medicaid or SCHIP *if* sufficient state general fund was appropriated to allow for matching of federal dollars *and if* all eligible individuals were required to enroll.

Employer-sponsored plans are the predominant source of coverage for an estimated 42 percent of the state’s non-institutionalized civilian population under age 65. Of those with employer-sponsored coverage offered, 26.5 percent do not take up that coverage, even though it is available to them. The number of small employers who offer health insurance is strikingly low. However, the overall percentage of employees in New Mexico covered by large employer-sponsored insurance is higher than previously thought, given the low number of small employers offering insurance. More than one-third of those New Mexicans with employer-sponsored coverage are enrolled in self-insured employer plans, i.e., employer plans that are protected by the federal Employee Retirement Income Security Act (ERISA) statute. Public health coverage programs – primarily including Medicaid and SCHIP, but also the SCI program – cover an additional 30 percent of the non-institutionalized civilian population under age 65 in 2006.

Analysis of Current Health Care Expenditures in New Mexico

Expenditures for personal health care services in New Mexico for the non-institutionalized population under age 65 are projected to exceed \$6 billion in FY07. Privately-insured expenditures account for 44 percent of total health care spending, while state and federal expenditures account for 37 percent. New Mexicans are projected to pay 18 percent of health care expenditures out-of-pocket. (See **Attachment D** for a graphic summary of the cost of the current case and the three reform models.)

The federal government finances nearly three-fourths of approximately \$2.3 billion spent by federal and state government to finance health care in New Mexico. Medicaid accounts for approximately two-thirds of all federal funds for health care in the state – nearly \$1.1 billion.

Key Assumptions for Analysis of the Three Reform Models

To compare the estimation results across the reform models in a meaningful way, a number of assumptions about implementation and behavioral responses were applied consistently to each model. Key assumptions underlying the coverage estimates include the following:

- Every New Mexican becomes covered. Moreover, the reform models are immediately and fully implemented, with immediate savings gained if they are expected to occur at full implementation.²
- Both the Medicaid and SCHIP programs continue, although they may be incorporated into new programs. In addition, every individual eligible for Medicaid or SCHIP enrolls unless already enrolled in an employer plan that continues to be available.³
- Self-insured employer decisions are driven by consideration of premiums, and individuals always choose coverage that entails the lowest cost to them.
- When the reform model folds Medicaid and SCHIP into a new program, waiting periods and other crowd-out provisions are suspended.
- Coverage decisions are made at the family level, and family coverage is preferred when it is available. New Mexicans not living with a spouse or children make coverage decisions as individuals.
- Young adults first seek coverage on their own, accepting coverage from their own employers if offered before taking coverage as their parents' dependent.

Change in Coverage Under the Reform Models

The Mathematica study delineated the essential impacts on coverage for each model:

- Under the Health Security Plan (HSP), nearly 1.6 million New Mexicans—94 percent of the non-institutionalized civilian population under age 65—would enroll in the new HSP. Of this population, nearly half (46 percent of the non-institutionalized civilian population under age 65) would be Medicaid or SCHIP enrollees. Responding only to lower premiums, most workers and dependents currently enrolled in self-insured plans would become enrolled in HSP.

² Perhaps obviously, no reform model is likely to be adopted and immediately implemented. Therefore, the cost estimates determined by Mathematica would be affected by the amount of time it takes to implement any model adopted.

³ The take up and impact of Medicaid depends on the model. See the Mathematica final report.

- New Mexico Health Choices Plan (NMHC) would expand Medicaid and SCHIP the most, and rely most heavily on federal financing. Assuming that self-insured employers terminate their plans in New Mexico in response to a payroll tax with no exemptions, nearly 1.6 million New Mexicans would enroll in coverage through the Alliance in version 1 of NMHC. Medicaid and SCHIP would account for nearly 60 percent of total enrollment in NMHC, and 57 percent of the total non-institutionalized civilian population under age 65. Version 2 of NMHC would enroll 529,000 New Mexicans in coverage through the NMHC Alliance, with Medicaid and SCHIP accounting for 64 percent of Alliance enrollment and 56 percent of all non-institutionalized civilian New Mexicans under age 65. Approximately 150,000 New Mexicans would remain in employer-sponsored coverage in version 2, including 119,000 in self-insured plans.
- The New Mexico Health Coverage Plan (HCP) would expand all current sources of coverage in New Mexico; it does not envision creation of a new plan. Approximately 122,000 workers and dependents would newly enroll in employer-sponsored coverage increasing enrollment by 14 percent. Medicaid and SCHIP enrollment would expand (but only to the extent that uninsured New Mexicans are currently eligible but not enrolled) covering 39 percent of non-institutionalized New Mexicans under 65. In addition, SCI would enroll 80,000 now-uninsured adults under expanded eligibility for the program. Finally, nearly 11,000 New Mexicans would enroll in individual coverage of various types, including HIA and NMMIP.

Change in Cost Under the Reform Models

The *most crucial findings* regarding the costs of the three reform models are:

- It will cost just as much or more to do nothing and have increasing numbers of New Mexicans without coverage than it would to implement any of the reform models; and
- It would cost relatively little beyond what New Mexicans are paying now to cover all New Mexicans.

The Health Security Plan (HSP) would generate the least new total cost for insuring all New Mexicans. The low estimated cost of HSP is due primarily to its low estimated non-medical cost and to a reduction in rates paid to providers. Expenditures under HSP would be lower than expenditures in the current case. Because NMHC would layer new administrative costs over an essentially private system of insurance—and makes no provision for constraining private insurers' non-medical costs—it would be more costly overall than either HSP or HCP.⁴

⁴ Note, the primary differences in the costs of the three models studied are in the non-medical or administrative costs and the rates paid to providers. There was considerable discussion by HCNMC members about whether the assumptions about the reduction in HSP non-medical costs was realistic and whether the rates paid to providers would actually be able to be reduced as assumed. There was also discussion about whether the relatively higher non-medical costs assumed in NMHC could be lowered by alternative approaches to voucher eligibility

Any reform model that would reduce provider payments from current levels would, of course, be less costly than a reform model that maintained or increased provider payment levels. HSP assumes provider administrative savings associated with fewer payers in the system, and it anticipates negotiating provider payment rates down to capture those savings. However, HSP would not likely be the only payer in New Mexico. Members of the Committee questioned whether there is much provider administrative savings to be captured. Nevertheless, even at current average payment levels (estimated as HSP version 2), lower non-medical costs would translate into lower per capita cost under HSP compared with either the current case or the other reform models.

Because each of the reform models entails different relative amounts of medical and non-medical cost, and because these components of cost would grow at different rates in each of the reform models, their total costs are likely to grow at different rates over time. Mathematica projected the slowest cost growth for HSP (even assuming higher Medicaid and SCHIP payment increases than in the current case), followed by HCP which Mathematica assumed would update Medicaid and SCHIP reimbursement at historic rates. However, because all of the reform models would attempt to address medical cost growth, it was presumed that all would succeed at least modestly in doing so. By reducing medical cost growth just one percentage point below projected current-case rates, all of the reform models would either reduce total costs absolutely by 2011 or come within a few percentage points of the projected total cost of health care in the current case.

Financing the Reform Models

Both HSP and NMHC would put in place pure community-rated systems of coverage—with no variation for personal characteristics or location. None of the reform models would require that self-insured employers, in particular, participate in new coverage programs. To avoid potentially severe adverse selection from self-insured employer groups, it would be necessary to minimize premiums (so that lower cost groups would come into the new programs, as well as high-cost groups). However, these reform models would then rely heavily on payroll tax financing.

Mathematica estimated that the payroll tax necessary to support these programs, assuming relatively low premium levels, could be as high as eight percent of payroll (under NMHC version 1, which would rely solely on payroll tax financing) but probably not less than four percent of payroll (under HSP version 1).

Under HCP, the Fair Share Fund paid into by employers that did not offer coverage to employees would accrue an estimated \$93 million in 2007. This amount would be earmarked to cover services for New Mexicans who are temporarily uninsured

determination (e.g., through the NM Taxation and Revenue Department rather than through a traditional eligibility determination process). In any case, it is clear that these assumptions are not cast in stone and could change, thereby changing the relative cost of these two models in particular.

(including homeless and transient persons) but are in need of health care services. However, the state would also incur additional cost related to significantly greater enrollment in Medicaid, SCHIP and SCI; this additional liability—estimated at \$34 million in 2007 (after federal match) would likely come from state General Fund, but could also come from employer payroll taxes or other state revenue-generating sources.

The *most crucial findings* of the Mathematica study in terms of the financial impact on employers were:

- For employers currently contributing to the cost of coverage for employees, their costs under any of the models are likely to be less than those costs of offering and providing coverage now.
- For employers not currently offering health coverage, their costs would be more than currently expended, but generally less than what would be required for these same employers to begin offering coverage for their employees in today's insurance market.

Summary of Mathematica Cost Study

HCNMC was presented a new perspective regarding New Mexico's uninsured populations based on the cost study completed by Mathematica Policy Research, Inc. After July 1, 2007 and when adequate state General Fund is appropriated to match available federal dollars, more than 228,000 of the state's over 400,000 uninsured residents could have coverage through public programs at little or no cost. About 26 percent of working New Mexicans are offered insurance through their employers, but do not take it up largely because of cost, obtaining coverage elsewhere or other reasons.

The Mathematica study analyzed New Mexico's uninsured population using a different methodology than does the U.S. Census Current Population Survey (CPS). The CPS indicates New Mexico has an uninsured rate of 21.1 percent using the CPS definition of uninsured for at least an entire year. Mathematica's analysis indicates the rate of uncovered New Mexicans is approximately 26 percent when the over 65 and institutionalized populations are excluded, using a part-year coverage definition. Mathematica estimates 432,000 residents go without health coverage at least six months of the year. These residents "churn" in and out of the system, which adds to the high administrative costs of our state system. This population also tends to be less healthy than the population that is covered all year.

The Mathematica analysis drew the following conclusions:

- 26 percent of those under age 65 and not in institutions are uninsured six months or more in a year.
- 46 percent are uninsured some part of the year (70 percent of children lose coverage at some time during the year).
- 11 percent are uninsured for the full year.

- \$6.11 billion will be spent in New Mexico on health care for this population in 2007, excluding spending on Medicare and a few other programs not included in the study's analysis.
- It would cost \$5.93 billion (HSP), \$6.3 billion (HCP) or \$6.7 billion (NMHC) to cover all under 65 non-institutionalized New Mexicans, given the assumptions of the models studied.
- The cost of each model might be lowered (or increased) by changing the assumptions about rates paid to providers, type and amount of services or benefits offered, wellness and public health initiatives, and actions to reduce non-medical costs.
- Each of the models has positive impacts on the state's economy, with NMHC having the greatest positive economic impact. These impacts have to do with increased spending on health care and increased federal dollars in the state.
- The positive impacts on the economy are even more pronounced in rural areas.
- Within five years, it will cost more to do nothing and have the number of uninsured New Mexicans grow than to implement health reform changes in the state.
- Many New Mexicans are currently or will soon be eligible for employer-sponsored or public programs of health coverage, if adequate state General Funds are appropriated to draw available federal match and if efforts are made to require those eligible to enroll.
- ERISA and federal tax laws may impact (but not necessarily impede) implementation of some aspects of each of the models and need to be considered to avoid unintended consequences of any reform model adopted.

VII. HEALTH COVERAGE FOR NEW MEXICANS COMMITTEE RECOMMENDATIONS

At its meeting on June 22, 2007, HCNMC decided on the following recommendations:

A. Recommendations for Immediate Policy Implementation

1. Create a governance structure to include a single statewide unified health care authority based on the guiding principles adopted by the HCNMC charged with implementing health care reforms regarding universal coverage, cost and quality controls, and oversight of health care delivery in New Mexico as described in the process recommendations below.
2. Maximize enrollment in Medicaid as soon as economically feasible including:
 - a. Enroll everyone currently eligible for Medicaid as state resources for federal match are available, focusing especially on children and adults under 100 percent of the federal poverty level (FPL);
 - b. Expand Medicaid eligibility up to 300 percent FPL where allowed by federal law, regulation or CMS approval;

- c. Expand Medicaid eligibility up to 200 to 300 percent FPL proportional to income, pending CMS approval.
3. Change New Mexico health insurance requirements including:
 - a. Require universal health coverage for all New Mexicans incorporating affordability criteria and compliance procedures;
 - b. Institute minimum requirements for the medical loss ratio for insurance companies doing business in New Mexico;
 - c. Require guaranteed issue for all individuals and small groups in New Mexico;
 - d. Require coverage by insurance companies regardless of individuals' pre-existing conditions, and remove waiting periods;
 - e. Move toward combining the state's individual and small group markets;
 - f. Immediately reduce the small group mark-up for experience (currently allowable is 20 percent over/under the state average);
 - g. Eventually move towards community rating for all health insurance products, including within the small group market, thereby ending experience rating in that market;
 - h. Require standard data reporting for all insurance companies offering health insurance products in New Mexico;
 - i. Create a uniform statewide drug formulary;
 - j. Require that all practitioners accept all public and private health care coverage options as a payment source;
 - k. Move towards implementing risk equalization strategies.
4. Allow employers and employees to buy into the state employee health risk pool and/or a Medicaid benefit plan.
5. Move toward implementing portability to ensure that people's coverage follows them regardless of employment changes.
6. Allow provider choice for consumers.
7. Consolidate or create larger health insurance risk pools where beneficial.
8. Require health information technology such as standard fee schedules, enrollment, medical records, diagnosis, billing, claims, provider payment and reimbursement.
9. Increase provider recruitment and retention through incentives.
10. Consider a state-operated reinsurance program to distribute risk and manage the effects of individuals high cost medical procedures.

B. Recommendations for Process for Immediate Next Steps

1. Create a single statewide unified health care authority that consolidates current state and quasi-state health coverage and health policy agencies' administrative

structures (e.g., initially HIA, NMMIP, HPC, GSD/RMD, SEIP, and eventually Medicaid, SCI, the IBAC agencies of RHCA, NMPSIA, APS and other programs). The authority would have the ability to set a minimum or base benefit package of services for residents; rates; medical management programs; comprehensive quality and preventive incentives; performance standards; uniform reporting; fraud and abuse detection and intervention; as well as customer service and coverage linkage/connecting. The authority would work in conjunction with professional licensing boards and the state's Division of Insurance as appropriate.

2. Charge the authority to do further analysis, including development of minimum or base benefits/services up to a comprehensive benefit plan structure. This could include single or multiple defined benefit offerings for fully insured individuals, including a standard "base benefit package".
3. Draft legislation to be reviewed by the Legislative Health and Human Services Committee (LHHS), the Legislative Finance Committee (LFC), other interim legislative committees, the executive branch and other stakeholders, for consideration during the 2007 legislative interim process.
4. Consult with Indian Health Service (IHS), tribes and rural and urban Indian interest groups to further identify and address health coverage needs for Native Americans (see *Insure New Mexico! Barriers to Obtaining Health Insurance Among Native Americans in New Mexico* study at <http://insurenemexico.state.nm.us/In%20Brief.pdf>).
5. Create HCNMC report with Mathematica study findings and highlights, and Committee discussion and recommendations including issues that were discussed but lacked consensus or agreement.
6. Present HCNMC recommendations to the Governor.
7. Require effective prevention, wellness and chronic disease management programs and incentives (e.g., Regional Diabetes Centers of Excellence).
8. Consider reform of end-of-life legal and medical issues with the goals of managing costs and promoting individual choice.

C. Recommendations for Issues Needing Further Analyses

HCNMC recommends further information should be obtained in the areas outlined below. Concurrently, HCNMC is aware that several coverage studies have been performed in New Mexico over the years, and recommends an action-oriented agenda wherever possible. Further analysis relates to on-going needs for additional information in order to consider, adopt or implement aspects of universal health coverage approaches.

Cost, Financing and Fiscal Implications Analyses Needed

1. Further study the savings and net cost to employers, for example, the impact of payroll taxes versus premium reductions, including the cost to employers who are currently not offering coverage to their employees.
2. Analyze the cost of varying benefit or service plans and different cost-sharing options for each of the models.
3. Project the cost to the state General Fund of full Medicaid enrollment at the current (post July 2007) eligibility levels. This recommendation arises given that many New Mexicans are currently eligible, but not enrolled, in Medicaid or SCHIP.
4. Provide further analysis that separates insurers' profit from their administrative expenses to provide more complete information on non-medical costs.
5. Further analyze the cost of allowing employers and employees to buy into Medicaid or the state employee plan administered by the Risk Management Division of the General Services Department. The Mathematica study stressed that the larger the risk pool, the larger the potential savings.
6. Provide a financial analysis on the potential savings that could be realized by pooling the medical component of residents' workers compensation and auto insurance benefits, while ensuring the state's workers compensation structure stays robust and strong.
7. Associated with the analysis above, HCNMC would require information on the cost and impact of changing the state's workers compensation structure.
8. Analyze the cost and savings of establishing an independent health care authority based on HCNMC's guiding principles. HCNMC achieved consensus regarding establishment of an independent or quasi-independent body to develop a structure and method for achieving the recommendations in this report and ultimately the desired system reforms, and possibly define the components of a benefit or service plan that should be available for all New Mexicans.
9. Study effective methodologies to improve and enhance Medicaid/SCHIP outreach and enrollment and the associated funding needs.

Policy and Legal Analyses Needed

1. Further analyze the federal Employee Retirement Income Security Act (ERISA) legal implications associated with implementation of any statewide health reform model considered for adoption. HCNMC suggested requesting assistance with ERISA issues from the Congressional Research Service and other sources.

2. Further review the Section 125 (U.S. Internal Revenue Service Code) legal implications associated with implementation of any new statewide health plan considered for adoption. Again, assistance from Congressional Research Service and other sources may be helpful.
3. Analyze the fiscal impact associated with increasing Medicaid enrollment and eligibility in the state, while examining the cost to the General Fund of such enrollment, building on current use of public and private partnerships.
4. Examine the current and future roles of the New Mexico Public Regulation Commission (PRC) and its Division of Insurance as they would relate to the proposed statewide health care authority.
5. Study the value of contracting or out-sourcing Medicaid and other public programs to the private sector, with focus on the impact to beneficiaries and the impact on costs.
6. Examine the feasibility of obtaining a waiver from the U.S. Centers for Medicare and Medicaid Services (CMS) for increasing Medicaid eligibility for persons with incomes above state's current FPL levels.
7. Compare the historical cost implications of the Medicaid and Medicare programs by examining Medicare reimbursement methodologies as a reimbursement benchmark before and after implementation of Medicare Advantage Plans.
8. Analyze the concept of realigning the payment and physician training system to favor primary and preventive services as opposed to more expensive subspecialty health care.

VIII. CONCLUSION

While some New Mexicans may feel that the current state health system functions reasonably well for the estimated 80 percent of the population that has coverage and access to some level of health care, at least 20 percent of New Mexicans do not have health care coverage. Health care costs continue to be prohibitively high for many residents of the state to afford care or coverage. Many people with health coverage have stated that they do not have access to or cannot get a particular treatment paid for by their current coverage mechanism. Additionally, the quality of care is questioned by many. The striking differences between New Mexico and other states that have tried to improve health care coverage are the state's high percentage of uninsured, its large minority population and the fact that the state's health care system is substantially financed by the federal government.

HCNMC represented a wide range of policy makers and stakeholders to focus on ideas, strategies and resources that can help the state overcome common challenges and barriers which may impede efforts to cover the uninsured. While all participants shared

in the goals of increasing the effectiveness and potential success of health care reform initiatives, the group was unique in the variety of vantage points that were represented. Physicians, hospitals, payers, large and small employers, unions, and health consumer advocates joined leaders and policy makers, creating a rare opportunity to share a wide variety of experiences and perspectives on how best to expand coverage and improve the efficiency of New Mexico's health system.

HCNMC members discussed at length the need for all parties in the health coverage equation to give a little in order to achieve universal coverage in New Mexico. This means individuals and families may have to give up their choice to not obtain coverage or not enroll in coverage options. Employers may have to give up their choice to not provide or contribute to coverage. Practitioners may have to give up their option to refuse to accept certain coverage options. Hospitals may have to return to the public domain savings generated from previously uncompensated indigent care. Insurance carriers may have to give up their practice of rating coverage products at different amounts for different types of individuals or groups, and they may have to give up their ability to refuse to cover some individuals based on their medical history or age. Labor may have to give up its choice to negotiate individual products with individual employers. Large groups may have to give up their choice to have and set the parameters for their own groups' services and benefits. The state may have to give up its historical multiple administrative infrastructures for multiple publicly-funded or supported coverage programs. Brokers may have to give up their choice regarding which coverage products and programs they will learn about and offer to their clients. Only by everyone giving something will New Mexico obtain coverage for everyone.

Mathematica's analysis indicates that covering New Mexico residents in some manner would require the redistribution of resources and increase demand for services, but would also improve health and get people care in more appropriate settings such as using physicians' offices or other primary care providers instead of emergency rooms for non-emergency care. Changes in health care utilization and access would reduce costs and improve health services and outcomes overall in the state's health care system.

The Mathematica report also indicates that affordability for high-cost individuals and groups would be improved through the use of larger insurance pools. Having coverage for all residents of New Mexico would also help more health care providers stay in business by reducing or eliminating uncompensated care. Critics of the analysis indicate the study assumes savings would happen in New Mexico which have not happened elsewhere; for example, an ability to slow the continuing rise in medical costs.

Perhaps the most compelling finding in the Mathematica cost study is not that any one financing model might be less expensive than another, but that providing coverage for every New Mexican may not be as costly a prospect as is assumed by many, and that not moving toward universal coverage is a more costly proposition than any option of achieving that coverage. Therefore, the time for action is now.

ATTACHMENT A**Health Coverage for New Mexicans Committee Members**

CATEGORY	NAME	ORGANIZATION
CHAIR	Diane Denish	Lieutenant Governor
House Members	James Madalena	House
	Brian Moore	House
	Danice Picraux	House
Senate Members	Dede Feldman	Senate
	Mary Jane Garcia	Senate
	Carroll Leavell	Senate
Health Care Advocate	Charlotte Roybal	Health Action New Mexico
Uninsured	April Redbird, LMSW	Affirmations Counseling Center
Division of Insurance	Mike Batte	NM Public Regulation Commission
Insurance Industry	David Scrase, M.D.	Presbyterian Health Plan
	Craig Keyes, M.D.	United Healthcare
Employers	Dennis S. Peña, R.P.H.	Pharmacist, Retired
	Paul Sowards	Bank of Albuquerque
	Duane Trythall	Excel Staffing Companies
	Alfredo Vigil, M.D.	Secretary, Department of Health; formerly El Centro Family Health
Nonprofit	Michelle Melendez	St. Joseph's Community Health Services
Labor	Carter Bundy	AFSCME
	Robin Gould	Communications Workers of America
Hospital Representative	Steve Altmiller	San Juan Regional Medical Center
Provider/ Physician	Charlie Alfero	Hidalgo Medical Services
	James Tryon, M.D.	NM Medical Society
Human Services Department	Pam Hyde	Secretary
Advisory Member	Michelle Welby	Office of the Governor
Advisory Member	Chuck Milligan	University of Maryland, Baltimore County
Advisory Member	John Heaton	House
Advisory Member	Tim Jennings	Senate
Staff	Raul Burciaga	Legislative Council Service
Staff	Ruby Ann M. Esquibel	Human Services Department

ATTACHMENT B**Health Coverage for New Mexicans Committee****Timeline**

2005	Legislative Health and Human Services Committee and Governor Richardson's <i>Insure New Mexico!</i> Council call for financial analysis of universal health coverage models
1/06 – 2/06	Legislature in session
7/20/06	Governor Richardson announces Five Point Plan to help extend health coverage to more New Mexicans, including creation of Health Coverage for New Mexicans Committee
7/20/06-8/10/06	Governor and Legislative Leadership appoint members of Health Coverage for New Mexicans Committee (HCNMC)
8/10/06	HCNMC Organizational Meeting
9/7/06	HCNMC Discussion of Potential Models to be Analyzed by National Expert(s)
9/27/06	HCNMC Public Input Meeting
10/2/06	RFP for Selection of National Expert(s) Released
10/19/06	HCNMC Approves Models for Analysis by National Expert(s)
11/13/06	Vendor Proposals Due
11/14/06 – 11/17/06	Technical Review of Proposals Completed by State Staff
11/20/06	Finalists Notified
11/30/06	HCNMC Hears From Finalists and Selects Vendor(s)
12/1/06	Successful Vendor Notified
12/15/06	Contract Begins
1/07-3/07	Legislature in Session
5/07	Presentation by Vendor of Preliminary Report
6/07-8/07	Presentation by Vendor of Final Report & HCNMC's Recommendations on Next Steps
7/07-11/07	Report of Vendor and HCNMC Recommendations Considered & Discussed by Interim Legislative Committees, Executive and Stakeholders
1/08-2/08	Legislature in Session

ATTACHMENT C

Health Coverage for New Mexicans Committee Working Definitions

a. General terms:

- Universal Coverage: Realistic opportunity for all people living in New Mexico to purchase or be provided health care coverage, whether public or private.
- People Living in New Mexico: People who are physically present, domiciled, or a legal resident of New Mexico; and who have been in New Mexico for at least six consecutive months.
- Coverage: Different types of benefit options offered under a public or private plan or insurance contract.
- Uninsured: No coverage of any kind over previous calendar year (U.S. Census definition).
- Underinsured: Coverage that is: a) interrupted during a year; b) does not cover all the basic insurance plan services; c) is for catastrophic coverage only; and/or d) has high deductibles or co-insurance and does not provide first dollar coverage.
- Continuity of coverage: Continuity = consistency; not interrupted over time; not only available for part of the year.
- Single Payer System: Health coverage for all people living in New Mexico paid for out of one publicly administered fund replacing the current multi-payer system and eliminating commercial insurance companies, except perhaps as contracted administrators of the publicly administered fund; could be one or multiple benefit options; practitioners could be publicly or privately employed.
- Social Insurance or “Socialized Medicine”: Health care provided by publicly employed or contracted practitioners for all persons living in or citizens of a particular jurisdiction.

b. Levels of coverage:

- Basic Insurance Plan or Policy: Includes the following services or benefits:
 - ⇒ Inpatient Hospital
 - ⇒ Durable Medical Equipment (DME)
 - ⇒ Physicians’ Services, Inpatient And Outpatient
 - ⇒ Primary/Preventive/Early Detection, Including Family Planning and Oral Health
 - ⇒ Emergency Room Services
 - ⇒ Diagnostic And Assessment Services
 - ⇒ Therapeutic And Diagnostic Radiological Services
 - ⇒ Laboratory Services
 - ⇒ Prescription Drug Coverage
 - ⇒ Behavioral Health (Mental Health and Substance Abuse) Inpatient and Outpatient provided on a parity basis
 - ⇒ Organic Eye and Natural Tooth Injury Treatments

The amount of services available in a basic plan (i.e., limitations on the benefits and co-pays) can vary.

- *Comprehensive Insurance Plan or Policy*: A Basic Policy/Plan to which any of the following services are added:
 - ⇒ Chiropractic/Massage/Acupuncture
 - ⇒ Other Practitioners' Services, Including But Not Limited to Traditional Medicine Men/Healers
 - ⇒ Dental
 - ⇒ Vision
 - ⇒ Hearing
 - ⇒ Home Health
 - ⇒ Hospice
 - ⇒ PT/OT/ST
 - ⇒ Rehabilitation Services
 - ⇒ Nutritional Services
 - ⇒ Crystal Therapy, Aromatherapy, Herbal Therapy
 - ⇒ Non-Medically Necessary Elective Services
 - ⇒ Any of the Long-Term Care Policy Services

- *Long-Term Care Insurance Policy or Plan*: Includes any of the following services:
 - ⇒ Habilitation services
 - ⇒ Home Health
 - ⇒ Assisted Living
 - ⇒ Skilled Nursing Facility
 - ⇒ Intermediate Care Facility for Mental Retardation
 - ⇒ Individual Living/Personal Care/Attendant Care

- *Catastrophic Insurance Policy or Plan*: One in which the amount of deductible or premium and co-pays paid by the insured before the coverage pays for services is significantly higher than most basic or comprehensive coverage policies/plans.

- *Minimum Insurance Policy or Plan*: One in which:
 - ⇒ Benefits are significantly less than in a basic plan/policy; and
 - ⇒ All services are capped annually and/or over insured's lifetime at a significantly lower amount than most policies/plans; or
 - ⇒ There are limitations to or no legally mandated services and legal rights protections for the insured.

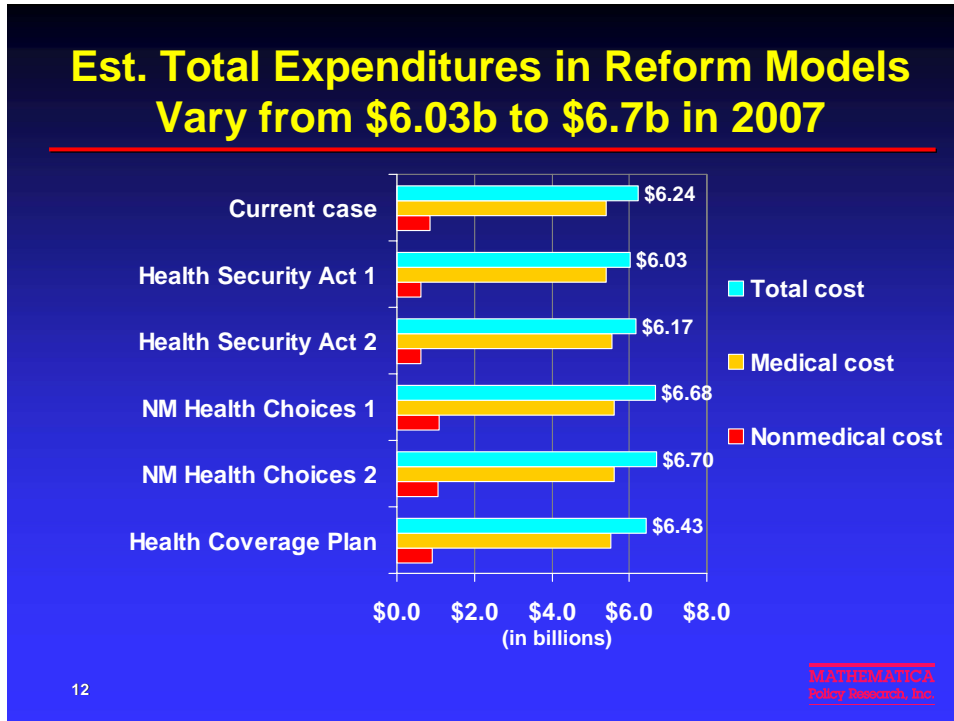
In a minimum policy or plan, there may or may not be co-payments, co-insurance and/or deductibles once coverage begins.

 - The covered benefits of each of the above described policies/plans may or may not be evidence-based.

ATTACHMENT D

GRAPHIC SUMMARY OF COSTS FOR CURRENT CASE AND MODELS STUDIED

[Note: The assumptions behind these estimates are crucial to understanding the numbers. The reader is encouraged to look to Mathematica's final report found at http://insurenwemexico.state.nm.us/documents/INM_MPR_Final_Report_070731.pdf before quoting these numbers or the results suggested by these numbers.]



ATTACHMENT E – ACRONYMS

BBER	University of New Mexico’s Bureau for Business and Economic Research
CMS	U.S. Centers for Medicare and Medicaid Services
CPS	U.S. Census Current Population Survey
DOI	New Mexico Division of Insurance
FPL	U.S. Federal Poverty Level
GSD/RMD	New Mexico General Services Department/Risk Management Division
HCNMC	Health Coverage for New Mexicans Committee
HIA	New Mexico Health Insurance Alliance
HRA	Health Reimbursement Account
HPC	New Mexico Health Policy Commission
HSA	Health Savings Account
HSD	New Mexico Human Services Department
HSD/MAD	New Mexico Human Services Department/Medical Assistance Division
IBAC	Interagency Benefits Advisory Committee groups joined to improve insurance purchasing power: GSD, Retiree Health Care Authority (RHCA), Albuquerque Public Schools (APS) and Public Schools Insurance Authority (NMPSIA)
IHS	Indian Health Service
IPL	University of New Mexico’s Institute of Public Law
LCS	New Mexico Legislative Council Service
LHHS	New Mexico Legislative Health and Human Services Committee
MCO	Managed Care Organization
NMMIP	New Mexico Medical Insurance Pool
PRC	New Mexico Public Regulation Commission
RFP	Request for Proposals
SCHIP	U.S. State Children’s Health Insurance Program
SCI	New Mexico State Coverage Insurance Program
SEIP	New Mexico Small Employer Insurance Program
TRD	New Mexico Taxation and Revenue Department