Governor Bill Richardson's Legislative Proposal to Achieve Universal Health Coverage for New Mexico

October 25, 2007

HealthSOLUTIONS New Mexico
Affordable, Accessible & Accountable

ACRONYMS

ALTSD – Aging and Long Term Services Department
APS – Albuquerque Public Schools
CYFD – Children, Youth and Families Department
DOH – Department of Health
EMR – Electronic Medical Record
FPL – Federal Poverty Level
GF – General Fund
GSD – General Services Department
HCA – Health Coverage Authority
HED – Higher Education Department
HIA – Health Insurance Alliance
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
HPC – Health Policy Commission
HSD – Human Services Department
IT – Information Technology
LFC – Legislative Finance Committee
LHHS – Legislative Health and Human Services Committee
MLR – Medical Loss Ratio
NMMIP – New Mexico Medical Insurance Pool
NMPRC-DOI – New Mexico Public Regulation Commission Division of Insurance
PAK – Premium Assistance for Kids
PAM – Premium Assistance for Maternity
PED – Public Education Department
PPO – Preferred Provider Organization
PSIA – Public Schools Insurance Authority
RHCA – Retiree Health Care Authority
RLD – Regulation and Licensure Department
RMD -- Risk Management Division (in the General Services Department)
SCHIP – State Children's Health Insurance Program
SCI – State Coverage Insurance
SEIP – Small Employer Insurance Pool

HealthSOLUTIONS New Mexico
Affordable, Accessible & Accountable

Governor Bill Richardson's Legislative Proposal to Achieve Universal Health Coverage

October 25, 2007

I. PRINCIPLES – To Achieve Universal Health Coverage and Improve Access, Cost and Quality of Health Care for New Mexicans

- Efforts over the last five years to move toward universal health coverage in New Mexico have resulted in agreed upon principles by multiple stakeholders.
- These guiding principles should be included in legislation creating a health care authority, insurance reform, and coverage mechanisms and responsibilities to clearly state the purpose and goals of New Mexico's health reform efforts.

Legislative Elements:

A. New Mexico's goal is access to universal health coverage through the identification of shared policies and comprehensive reform activities. All people living in New Mexico should have the opportunity to purchase or be provided with public or commercial health care coverage that is affordable for individuals, taxpayers, employers, and other payers.

B. These policies and activities should:
   1. Recognize the unique cultural and linguistic diversity in New Mexico;
   2. Be transparent and accountable, with sufficient information and data available for individuals, employers, payers and policy-makers to make reasonable choices among competing opportunities;
   3. 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;
   4. Consider the quality (including health outcomes and individual wellness) of health care provided for individuals living in New Mexico;
   5. Recognize that healthy people and a robust economy are intrinsically linked; health coverage for all people living in New Mexico will have a positive impact on economic development, and strong economic development will play a role in improving the health status of people living in New Mexico; and
   6. Improve access to health care and improve health status and outcomes in New Mexico.

C. To achieve universal coverage, multiple public and private policies and approaches will be required to develop and finance options for different ages, populations, employers, and circumstances within New Mexico.

D. Persons and families with low incomes or high health care needs will require assistance in purchasing, accessing and enrolling in available health care coverage.

E. Safety net services must be maintained for those individuals who experience significant barriers to accessing health care due to geography, language, culture, disability or personal situation.

F. Access to high quality health care that offers choices of providers, plans and treatment options for consumers is critical to improving individual and systemic health outcomes and to containing rising health care costs.

G. The state and federal government should provide strong leadership and oversight, with government, employers, individuals, families, providers and the clinical community sharing responsibility for health outcomes and the cost of health coverage.

H. The New Mexico Public Regulation Commission's (NMPRC's) role is critical to regulatory oversight of the commercial insurance industry and to assurance that consumer complaints about insurance are addressed. The NMPRC's Division of Insurance (NMPRC-DOI) should be a strong partner in health coverage reform efforts. Nothing in this legislation should preclude NMPRC or NMPRC-DOI from the performance of constitutional and statutory powers and duties.

II. HEALTH COVERAGE AUTHORITY (To Create A Single Point of Accountability for Data, Analysis, Plan Management, and Policy; To Increase Coverage and Access, and Control Costs)

- New Mexico has multiple departments, boards and commissions providing publicly-funded or subsidized health coverage programs or products, or conducting health care studies and analyses.[1] Each has its own mission, perspective, infrastructure, data and oversight processes.
- The New Mexico Public Regulation Commission, through its Division of Insurance (NMPRC-DOI) plays a critical role in the regulatory oversight of the commercial health insurance industry. This regulatory role needs to be continued and utilized as a tool to assist in accomplishing the purpose of achieving universal health coverage.
- Multiple pools and administrative infrastructures cannot achieve economies-of-scale in purchasing medical and pharmaceutical services or in administrative expenses.
- Cost and affordability are major factors in whether individuals, families and employers have coverage and receive health care. Costs are driven by service utilization; provider rates; profits or reserves maintained by insurance carriers, health maintenance organizations and preferred provider organizations; investments in technology; expectations about services; health plan benefit designs and exclusions; costs of supplies and materials; and individual life style choices.
- There needs to be a single point of accountability – an entity – that has the capacity and authority to address the design of the current service delivery and health coverage systems.
- Access to healthcare services and healthcare workforce availability are crucial if universal coverage is to make a difference in people's lives.
- Targeted recruitment and retention of healthcare practitioners throughout New Mexico, particularly in border, rural and frontier counties is crucial to increase access.
- Consolidation of multiple administrative entities and the creation of a *single point of accountability* will result in consistent health issues analyses; economies-of-scale for multiple and separate entities; and streamlined administrative structures that lower overhead costs of separate pools.
- A concentrated and coordinated effort to achieve health coverage pooling, standard setting, common and transparent data reporting in order to assure the best quality health care for the best price possible for New Mexicans.

Legislative Elements:

A. Create the New Mexico Health Coverage Authority (HCA) with responsibility and power to:
   1. *Set standards* for:
      1. Benefits (including preventive services) and plan choices that will count as coverage for participation requirements and assuring that publicly offered programs are included as coverage for purposes of participation requirements;
      2. Affordability guidelines (including average amount or percentage of household income that should have to be spent on health coverage;
      3. Performance by insurance carriers, health maintenance organizations (HMOs), preferred provider organizations (PPOs), practitioners, facilities and other provider organizations (in

[1] These include: 1) New Mexico Medical Insurance Pool (NMMIP); 2) Health Insurance Alliance (HIA); 3) Human Services Department (HSD), including State Coverage Insurance (SCI), Small Employer Insurance Program (SEIP) and premium assistance programs for Kids (PAK) and for maternity benefits for pregnant women (PAM); 4) Retiree Health Care Authority (RHCA); 5) General Services Department /Risk Management Division Benefits Bureau (RMD); 6) Public School Insurance Authority (PSIA); Albuquerque Public Schools (APS) employee insurance pool; 8) Health Policy Commission (HPC). In addition, the New Mexico Public Regulation Commission, Division of Insurance (NMPRC-DOI), individual practitioner licensing boards, and the Department of Health (DOH) all have roles in overseeing, reporting, regulating, analyzing and/or providing health coverage or health care.

conjunction with NMPRC-DOI, licensing boards, certifying agencies such as CYFD, DOH and HSD); and

4. Processes for provider complaint resolution, without intrusion into the contractual relationship between payers and providers.
5. HCA shall operate in collaboration with NMPRC-DOI, DOH, CYFD, HSD, ALTSD, RLD and other state agencies with statutory authority in these matters. HCA's authority and activities will neither limit nor duplicate the NMPRC-DOI's regulatory oversight of commercial insurers and brokers, nor the authority of licensing boards and certifying agencies to set criteria for the licensing or certification of practitioners and providers/facilities, pursuant to state law and federal or other funding requirements.

2. *Engage in activities to control costs and increase access and quality* by:
   a. Identifying, analyzing, recommending and implementing methods to address cost drivers, for example, diagnostic and treatment technologies; delivery of higher cost services to address illness or injuries rather than investing in prevention; health care delivery expectations; provider/facility errors and quality control failures; rising cost of health care services such as medications and hospital care; and individual behaviors such as smoking, inadequate exercise and poor diet choices;
   b. Developing "pay for performance" programs and policy recommendations that will identify quality of care standards and tie reimbursement ranges to better health outcomes, including but not limited to infection control and reduction of readmissions or return visits due to practitioner errors or omissions (in conjunction with DOH and practitioner and provider representatives);
   c. Working with NMPRC-DOI and appropriate health and human services agencies and the Legislature to require coverage of prevention services and disease management (especially for chronic conditions), as defined by HCA; and promote wellness through incentives and other approaches;
   d. Promoting appropriate consumer access to innovative, efficacious and cost-effective pharmaceuticals to control symptoms and assist in disease management; reviewing prescribing practices;
   e. Increasing additional practitioner recruitment and retention activities and incentives, in conjunction with DOH, HED, RLD and practitioner representatives;
   f. Requiring and monitoring quality data (including but not limited to adverse incidents reporting) from providers, facilities and individual practitioners, including but not limited to hospital infection rates, using the National Healthcare Safety network operated by CDC or other approaches to protect privacy of individual patients;
   g. Posting quality, cost and access data, analyses and plans on a public web site;
   h. Setting of reasonable and appropriate ***ranges*** for provider rates within New Mexico and those contracted to provide services for New Mexicans, which will include incentives for preventive services; HCA will consider rates in surrounding states within the Southwest region and will address payment rates for out-of-state services for New Mexicans;
   i. Negotiating common contracts for HCA administrative supplies and services; and
   j. Identifying and implementing opportunities for collaborative and cost-effective purchasing of health care delivery supplies, materials, pharmaceuticals, and/or services by plans administered by HCA and by state departments, including but not limited to public-private purchasing collaborative models with
      i. uniform performance standards;
      ii. cost and quality reporting requirements; and
      iii. appropriate use of technology to improve quality and improve efficiencies.

3. *Manage and consolidate public sector programs and products* to increase coverage and reduce costs.
   1. **Phase 1 (FY08 & FY09)** – Create an interim transitional advisory group consisting of the Directors and/or board chairs or other board members of the programs and pools that will

be managed under the auspices of HCA, along with the Director of the HSD Medical Assistance Division and the Superintendent of NMPRC-DOI; establish HCA by appointing board members; select chair and vice-chair; appoint and confirm Executive Director; prepare FY10 budget request taking into account existing administrative costs and resources of pools to be administered by HCA; set standards for benefits that will count as coverage and affordability guidelines; identify and implement insurance reforms possible through NMPRC-DOI's regulatory authority.

2. **Phase 2 (FY10)** – Combine under the auspices of HCA management of: HIA, NMMIP, HPC, GSD/RMD/Group Health Benefits for state and local public body employees, PAK, PAM, SEIP and SCI (subject to federal approval); maintain purposes and financing mechanisms of each program, eliminating administrative duplication where possible.
3. **Phase 3 (FY11)** – Include within HCA the management of the RHCA, PSIA and APS pools, maintaining each as a separate actuarial and benefits pool and assuring the funding streams (premiums paid by beneficiaries and employers, General Fund appropriations, and other revenue streams) for each are accounted and used for the service needs of the beneficiaries of each pool; implement a single point of entry and referral for coverage options for individuals, employers and other purchasers
4. **Phase 4 (Summer 2010 through end of FY11)** – After public and stakeholder input, submit a written plan to the Governor and the Legislature (Summer 2010) about whether and how to consolidate all or parts of actuarial pools managed by HCA, where appropriate and cost-effective for pool members and public payers; include analyses and recommendations regarding future management and location of Medicaid (and SCHIP).
5. **Phase 1 (FY09) and Forward** – HSD will enroll as many eligible children under 300 percent of the federal poverty level (FPL) and low-income adults under 200 percent FPL as possible within the state and federal funding provided for the Medicaid and SCHIP programs (including SCI), with the goal of achieving full enrollment of all Medicaid eligible children and low-income adults no later than the end of FY13 (five years).

4. *Conduct studies and analyses of health care and health coverage functions and trends*, including but not limited to who in New Mexico has health coverage, of what type, and at what cost, with a long-term trend analysis for all health care practices.
   a. Report to Legislature, Governor and public.
   b. Request and receive non-proprietary aggregate data for such analyses from providers (including facilities, practitioners and other providers), employers, insurance carriers and payers within New Mexico, to the extent not otherwise reported or available elsewhere.
   c. To the extent funding is available, conduct bi-annual household and employer surveys to ascertain extent of coverage offered and coverage participation rates.
5. *Make recommendations to the Governor, Legislature* and other bodies such as NMPRC-DOI for policy, budgetary, regulatory and legislative changes necessary to increase health care coverage, access and quality and/or to control costs.
6. *Develop and publish a comprehensive health care cost, quality and access plan*, working with DOH, HSD and other state agencies to incorporate specific goals, activities, targets and responsible parties, including but not limited to
   a. efforts to address chronic diseases and prevention management efforts; and
   b. short and long-term approaches to implementing additional health coverage reforms.
7. *Educate the public* about health coverage requirements and options; serve as a referral source and connector.

B. Public Participation

1. *HCA's activities will be open to the public,* subject to the Open Meetings Act, State Rules Act, Inspection of Public Records Act and Public Records Act.

2. *HCA will include the public* and make opportunities for input in as many activities and processes as possible, including but not limited to open meetings of HCA's governing body and special meetings called for purposes of hearing public input.

C. Structure of HCA Governing Body
   1. *Eleven (11) members representing those who purchase or utilize health coverage or services:*
      a. Four (4) members appointed by the Governor and confirmed by the Senate;
      b. Four (4) members nominated by the Legislature (two from the Senate and two from the House) and appointed by the Governor;
      c. The Secretary of the Department of Health, or his/her designee;
      d. The Secretary of the Human Services Department, or his/her designee; and
      e. The Chair of the New Mexico Public Regulation Commission (NMPRC), or his/her designee.
   2. *Members collectively shall represent the best interests of New Mexico, by*:
      a. Each appointee shall have significant experience in at least one of the following areas: health care management or reimbursement; medical or behavioral health practice; health care policy development and implementation; health care delivery and finance; business or government finance; actuarial analysis; labor; economics; and/or health care consumer advocacy;
      b. Represent the geographic and population diversity of the state;
      c. Represent purchasers and consumers of health coverage and health care such as employers, labor, and public employees and/or retirees; and
      d. Majority of members do not receive (within the last 12 months) more than 50 percent of the individual's income or the income of the individual's immediate family living in the same household from the health care industry or the health insurance industry.
   3. *Each member may serve up to two consecutive four-year term*s (staggered for continuity, with the exception of the ex officio members).
   4. *No member may be removed during his/her appointed term except for lack of attendance or participation or for cause,* as determined by HCA board by-laws, until the term of his/her appointment is completed.
   5. *Creation of standing policy advisory councils with clear review and recommending authority:*
      a. Native American Health Care Council – consisting of tribal, pueblo and off-reservation Native American representatives – to advise and recommend analyses, policies and programs regarding Native American health coverage and health care delivery, working with tribal and pueblo health care planning processes.
      b. Delivery System Policy Council – consisting of providers (facilities and individual practitioners), health care consumers and payers – to advise and recommend analyses, policies, and practices regarding reform of the health care delivery system, including but not limited to access and quality issues; standardization of processes that are duplicative and time-consuming such as credentialing; development of a sustainable and transparent delivery system that includes prevention, public health, evidence-based and best practices, physician-directed treatment guidelines, formulary standardization, community-based medical home models, expansion of primary care, proper integration of information technology, other system changes and innovations necessary for comprehensive care.
      c. Cost Containment and Finance Council – consisting of members of the insurance and HMO industries; employers and other payers; providers and practitioners; individuals with expertise in high risk pool management and fiscal operations; managers of public and private insurance funds; and individual consumers as payers – to advise and recommend analyses, policies, and practices regarding healthcare cost and reimbursement issues and approaches to achieve cost containment.

d. Benefits and Services Council – consisting of public and private program consumers, advocates, employees, retirees, educators, high risk and other plan members and coverage purchasers, as well as NMPRC-DOI staff serving as ex officio members – to advise and recommend analyses, policies and practices regarding services, plans and benefits to be offered, affordability guidelines, and other issues affecting health care consumers. Some members of this Council may be selected to work specifically with individual funds or pools administered within the auspices of HCA.
e. Other Advisory and Review Councils – as needed, with members or participants invited by HCA – to advise and recommend analyses, policies, and practices regarding special identified issues, such as high risk pool management, rate analysis and rate setting, risk equalization processes, insurance carrier assessments, evaluation of federal and state statutory and regulatory barriers and opportunities, and effects of federal programs on coverage, cost, and providers.

D. Selection of HCA Governing Board Chair and Staff
1. *Chair and Vice Chair of the HCA board selected by a majority vote of the HCA board, in open session, to serve no more than two consecutive one-year terms.*
2. *Executive Director shall have experience* in the delivery and/or finance of health care or health coverage – appointed by the Governor and confirmed by the Senate.
3. *Such other staff selected by the Executive Director* with input from the HCA governing body, as necessary to conduct the business and activities of HCA, subject to available funds.
4. *One permanent staff person will be a Tribal Liaison and advisor on Indian health care issues.*

E. Administrative Infrastructure of HCA as a State Agency
1. *Health Policy and Research Division* – to conduct studies, research and other data analyses and assist HCA in setting standards and guidelines and in recommending policy and legislative changes to the Governor and the Legislature.
2. *Plan Management Division* – to manage various pools and programs administered by HCA.
3. *Outreach and Education Division* – to interact with the public, conduct outreach and education activities, respond to inquiries, and help staff policy advisory functions and groups.
4. *Administrative Services Division* – to manage the budget, funds, premiums, contracting, accounting, information technology, human resources, and other administrative activities; HCA will be exempt from personnel and procurement requirements to the extent necessary to effect its purposes.

III. INSURANCE REFORM (To Make Coverage More Affordable and Accessible)

- The insurance industry in New Mexico is not currently required to cover everyone who wants an insurance policy (provide guarantee issue for individuals). Small groups do get protections afforded by the federal HIPAA legislation such as guaranteed issue and renewal protection, but their premiums can be rated-up due to the group's initial health status upon purchase and claims experience on renewal.
- Currently, insurance companies are not required to spend a set amount of premiums collected for direct medical services or a minimum "medical loss ratio" (MLR).
- Insurance reforms must be enacted such that: 1) anyone who wants coverage can get it; 2) services for pre-existing conditions are not permanently excluded from claims payments; 3) those covered pay a reasonable price; 4) all coverage includes preventive services; and 5) a set minimum amount of premiums paid is invested in direct care.
- These and other insurance reforms may be implemented through NMPRC-DOI regulation to the extent allowed by law.
- As more coverage options are available, practitioners and provider organizations must be accessible to covered individuals by accepting Medicaid, SCI and SCHIP as payment sources for those individuals that have coverage through these programs. The implications of requiring practitioners to accept assignment of payment from other commercial funding sources also need to be considered, which will assist in increasing access and choice of practitioners as well.
- While these reforms are being implemented, there needs to be a moratorium on new benefits (services) required to be covered by various commercial products.

Legislative Elements:

A. Require minimum spending on direct services
   1. *85 percent of premiums* collected across product lines.
   2. *Calculated across three years*, *after exclusion of premium taxes*.
   3. *Direct services may include* case management, disease management, health education and promotion, preventive services and any other health-related service only if they are designed to improve the health or health outcome of covered individuals and are provided directly to covered individuals, regardless of whether through subcontracts or by company staff.
   4. *Direct services shall not include* care coordination, utilization review or management or any other activity designed to control costs for the payer or to limit utilization of services.

B. Guarantee issue without exclusion of pre-existing conditions in the individual market beginning January 1, 2009; require insurance companies to offer coverage to any individual who requests it (subject to rules regarding payment and fraud), without permanent exclusion of pre-existing conditions (although a waiting period of up to six months may be imposed before payment for any service related to a pre-existing condition).
   1. *Continue the current statutory provision that allows access to the New Mexico high risk pool (NMMIP) for any individual whose rate is quoted at more than 125 percent of the NMMIP's standard rate; require carriers to make the choice of NMMIP known to all eligible applicants and assist in the referral.*
   2. *Consider allowing HCA to offer a transition product through NMMIP to cover the waiting period due to a pre-existing condition.*
   3. *Allow carriers six months from time of issuance to retroactively cancel a policy for failure to disclose complete medical history, subject to carrier's rules regarding payment and fraud.*
   4. *Continuation or renewal of individual policies* currently in existence that have permanent exclusion of payment for pre-existing conditions will remain in effect until HCA makes and publishes decisions about what constitutes coverage for purposes of compliance with coverage requirements during Phase 1 (see II.A.3.a. above).
   5. *Work to bring protections afforded groups under federal HIPAA law to individual policies.*

C. Analyze the best method for risk equalization processes to be created by HCA (in consultation with NMPRC-DOI and insurer representatives) to spread costs among insurance companies due to adverse selection as a result of guaranteed issue.

D. Limit rating up or down based on initial health status or claims experience on renewal of small groups to no more than 10 percent above or below average, phased in over five years.
   1. *Now – 20%; FY09 – 18%; FY10 – 16%; FY11 – 14%; FY12 – 12%; FY13 – 10%.*
   2. *Retain rating variations by age and geography* until after HCA has made policy recommendations to the Governor and the Legislature.

E. Require through law or as a condition of licensure that all New Mexico practitioners and providers/facilities accept any state funded public source of payment for eligible individuals (e.g., Medicaid, SCHIP, SCI, etc.); move toward requiring acceptance of assignment of payment from commercial insurance offered within the state at least for the amount the commercial plan pays.
   1. *Allow insurers to maintain networks* based on facility/provider and practitioner agreements concerning performance and payment.
   2. *Allow practitioners and facilities to accept or refuse any individual client* based on limitations of size, capacity or expertise of the individual's practice or facility/provider organization's mission (subject to admissions or acceptance policies set by contract with payers.)
   3. *Allow practitioners and facilities/providers to charge the patient/client (within state and federal law) an amount above what commercial coverage pays* for those services for which additional charges can be levied or for those services not covered (so long as the total rates charged to the coverage source and the patient/client are within the ranges set by HCA for that procedure or service).
   4. *Phased in* to allow time for adjustment by insurers, practitioners and facilities and to allow time for introduction of standardized electronic billing and claims payment processes.

F. Require insurance carriers to allow Indian Health Services (IHS) and tribal 638 providers that meet quality and credentialing standards to be part of a carrier's provider network, permitting them to serve only the federally defined user populations for these providers.

G. Strengthen coverage for state, municipal and public education retirees by:
   1. Assuring the *RHCA trust fund is dedicated to the health care needs of retirees* and their families covered by the RHCA; and
   2. Allowing RHCA to *cover partners of retirees under conditions set by the RHCA board and subsequently by HCA's board* as recommended by the policy advisory body set up by HCA to address state employee and retiree benefits.

H. Increase transparency and accountability by requiring common data reporting for
   1. *All insurance companies*, health maintenance organizations and preferred provider organizations *for all products*, required data to be defined by NMPRC-DOI, in consultation with HCA; and
   2. *All employers, practitioners, and health care facilities*, to the extent not otherwise reported, required data to be defined by HCA in conjunction with DOH, HSD and other licensing or certifying entities.

I. Work with brokers/agents to obtain their on-going input, and provide them education and opportunities to offer state funded public products, with limited immunity from liability if certified to offer such products.

J. Impose a moratorium on additional insurance benefit mandates until after December 31, 2010.

IV. COVERAGE MECHANISMS AND PARTICIPATION (To Assure Everyone Has Coverage)

- New Mexico must create a culture of coverage so that every resident knows they have an opportunity and obligation to participate in coverage either through commercial insurance options or publicly offered programs.
- This requires an adequate number and variety of mechanisms and public funding and capacity is available for individuals and employers to fulfill their participation responsibilities.
- New Mexico must maximize its public programs and make them and commercial insurance affordable based on an individual's or household's percentage of income used for coverage.
- Employers should contribute in some way to the public goal of a Healthy New Mexico Workforce, with a dollar-for-dollar offset for their expenditures toward their own employees' health coverage. This assures that employees and employers who are satisfied with the way their current employer-sponsored insurance can keep it. It also assures that employers who offer health coverage for employees are not paying more because some employers are not paying anything.
- One of the mechanisms to assure affordable coverage is to expand existing risk pools to allow those without access to or who are unable to afford commercial insurance to buy into them. These pools are often administered and in part subsidized by the state and federal governments. This includes maximizing the role of the New Mexico Medical Insurance Pool (NMMIP) as an option for those for whom coverage in the traditional commercial market would cost more than the NMMIP coverage, due to health conditions or history.

Legislative Elements:

A. Require individuals to have coverage through enrollment and participation in public programs or commercial insurance, or show proof they can cover their own health care costs, beginning January 1, 2010 (tax year 2009; one-half of state FY10).
   1. *FY10 – Identify those not yet covered through various processes such as licensure applications and renewal processes, school and university enrollment processes, tax return submissions, initiation of employment and during open enrollment periods.*
   2. *FY11 – Begin the requirement to show proof of coverage by starting with those individuals living in households over 400 percent of the federal poverty level (FPL), children in households under 300 percent FPL* who are eligible for Medicaid (as public funding is available to enroll all eligible children); at initiation of employment and during employer open enrollment periods, and out-of-state students applying for admission to New Mexico colleges and universities.
   3. *Individuals in households with incomes below 300 percent FPL will not be required to purchase coverage unless coverage is offered by an employer, a public program or is otherwise affordable* for that income group based on guidelines set by HCA.

B. Require employers with six or more employees to contribute to a Healthy New Mexico Workforce by contributing toward that public health goal an annual fee per employee, offset dollar-for-dollar by the amount the employer contributes to its employees' health coverage.
   1. *Beginning tax year 2009* (one-half of state FY10).
   2. *Require all employers with six or more employees which have been doing business in New Mexico for at least three years to offer employees a pre-tax health coverage option*, whether the employer chooses to contribute to that health coverage plan or not.
   3. *Consider allowing small businesses to purchase coverage with pre-tax dollars*, based on HCA analysis of costs and potential impacts.
   4. *Require employers who offer health coverage to employers to collect information* about coverage from those employees who do not accept employer-sponsored insurance.

5. *Exempt tribal and pueblo employers from the Healthy New Mexico Workforce contribution* requirement, while encouraging such employers to offer coverage for their employees and their families in accordance with HCA guidelines.
6. *Use the Healthy New Mexico Workforce Fund contributions to fund outreach and public programs to expand coverage* (Medicaid, premium assistance, etc.).
7. *Annual appropriation of Healthy New Mexico Workforce fund* through state budget process.

C. Expand and/or allow buy-in to existing public risk pools where appropriate and cost-effective.
   1. *HCA will be charged with developing and presenting to the Governor and the Legislature a written plan* for the most appropriate and cost-effective approach to consolidating risk pools among programs and plans managed by HCA, considering the role of Medicaid and SCHIP.
   2. *Appropriately expand the New Mexico Medical Insurance Pool (NMMIP) by:*
      a. Addressing coverage of pregnancy during the six-month waiting period for payment of claims for pre-existing conditions;
      b. Continuing the current statutory provision that allows access to NMMIP for any individual whose rate is quoted in the commercial individual market at more than 125 percent of the NMMIP standard rate;
      c. Requiring individuals who lose insurance coverage for non-payment or due to voluntary cancellation of coverage to apply for other coverage prior to applying for coverage through NMMIP;
      d. Requiring individuals who are not eligible for HIPAA continuation after being covered through groups that voluntarily cancel health coverage previously offered to employees to apply for individual or other coverage prior to applying for coverage through NMMIP; and
      e. Offering more than one option for individuals covered by the NMMIP.
   3. *HSD along with HCA will be charged with analyzing the possibility of allowing buy-in to Medicaid – with premium based on income – for individuals* who need assistance according to HCA's affordability guidelines and who are:
      a. Not currently covered by commercial products;
      b. Not otherwise eligible for publicly subsidized programs such as NMMIP, SCI, HIA, PAK and PAM; and
      c. Without an employer or other source of subsidy for the premium; cost based on income.
   4. *HCA will be charged with analyzing the possibility of allowing buy-in to the state and local public bodies insurance pool* for some employers (for example, those not eligible for HIA or NMMIP), at rates based on their own group's health status or claims experience but within the experience rating limitations for the small group market; criteria for employers eligible to buy-in to this pool may be set by HCA.

D. Educate the public, in conjunction with DOH, HSD, NMPRC-DOI and other relevant entities, about:
   1. The *benefits of wellness and prevention* activities and services.
   2. The *benefits of health coverage* for individuals, families and employers.

V. ELECTRONIC HEALTH TRANSACTIONS AND INFORMATION (To Help Control Costs and Increase Quality)

- Efficiency, accuracy of transactions and some costs can be improved by moving from paper to electronic billing and claims processing. This will require standardizing forms and processes.
- Electronic medical and health records utilized by all practitioners and owned by the individual receiving health care can increase the quality of health care practice and allow for greater coordination of care among various practitioners serving one individual.
- These technological improvements will also help in tracking utilization and in identifying opportunities for quality improvements among specific high risk populations.
- Individuals' privacy and other rights must be protected as New Mexico moves forward with these initiatives.

Legislative Elements:

A. Require electronic claims submission by all practitioners and facilities/providers and electronic processing and remittance by all insurance companies doing business in New Mexico.
   1. *Telehealth Commission will be charged with developing and submitting a detailed plan* to HCA by July 1, 2009, with specific action steps and implementation dates.
   2. *HCA and Telehealth Commission jointly make recommendations* to Governor and Legislature about legislation or appropriations required for implementation of the plan.
   3. The plan must include steps to *standardize forms and processes necessary for electronic claims submission and payment*.

B. Require use and exchange of electronic medical records in use by all healthcare practitioners, facilities and organizational providers.
   1. *Telehealth Commission will be charged with developing and submitting a detailed plan* to HCA by January 1, 2010, with specific action steps and implementation dates.
   2. *HCA and Telehealth Commission jointly make recommendations* to Governor and Legislature about legislation or appropriations required for implementation of the plan.
   3. The plan must include steps to *standardize forms and processes necessary for use and exchange of electronic medical records*.

C. Protect patient's privacy and right to information by authorizing the creation, maintenance and use of electronic records; providing individual rights with respect to disclosure of information, including but not limited to the following:
   1. *Legal recognition* of electronic records;
   2. Requirements for *electronic signatures*;
   3. *Attribution and effect* of electronic health records;
   4. *Notarization and acknowledgement*;
   5. *Retention of information*; and
   6. Patient authorization and protection of *privacy upon disclosure of information*.

VI. EVALUATION (To Assure Policy and Structures Are Accountable in Meeting Identified Goals)

- A change of this nature and magnitude needs to be evaluated to determine if the policies and structures are working to achieve the goals intended.
- This evaluation needs to be collaborative with the Governor, the Legislature, HCA and existing executive and regulatory departments working together.
- The evaluation should be timely enough to allow for mid-course corrections, but with adequate time allowed to give the new structure and policies opportunity to be implemented and effective, and for data useful to the evaluation to be available.

Legislative Elements:

A. External evaluation conducted:
   1. *Jointly by* Legislative Finance Committee (LFC), Legislative Health and Human Services Committee (LHHS), and HCA, in collaboration with HSD, DOH, and NMPRC-DOI
   2. *No sooner than four (4) years and no later than seven (7) years* after the effective date of the legislation.

B. Evaluation mechanism will be subject to funds available to the evaluating entities.

C. Evaluation shall include, but not necessarily be limited to:
   1. *Functioning and capacity* of HCA;
   2. *Progress toward achievement of identified goals* toward universal access to coverage and barriers to meeting those goals, if any, including but not limited to the impact of;
      a. “Guarantee issue” policies;
      b. Requirements for individuals to show proof of coverage; and
      c. Employer contributions toward a Healthy New Mexico Workforce;
   3. *Medical and non-medical costs* of health care and health coverage offered by commercial carriers and public programs;
   4. *Progress toward electronic claims submission and payment transactions and electronic medical records;*
   5. *Access to quality health care throughout the state*, with particular emphasis on rural and low-population areas, including but not limited to Native American reservations and border areas, and urban areas with concentrations of low-income individuals and off-reservation Native Americans; and
   6. *Quantifiable progress toward enhancing the health outcomes* of people living in New Mexico.