

Health Care Reform Policy Development in New Mexico



Resources for Change

June, 2011

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EXECUTIVE SUMMARY

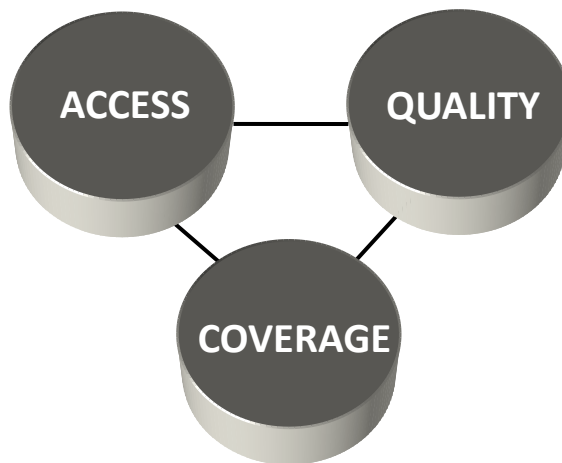
The W.K. Kellogg Foundation awarded Con Alma Health Foundation (CAHF) a six-month strategic planning grant to help guide New Mexico’s implementation of the federal Patient Protection and Affordable Care Act (PPACA). Building on a decade of bringing people and organizations together to improve health, CAHF serves as an unbiased and trusted convener of stakeholders to develop shared and realistic goals, and leverage federal funding. Findings and recommendations will serve as a strategic blueprint for New Mexico’s state-specific implementation of the PPACA requirements.

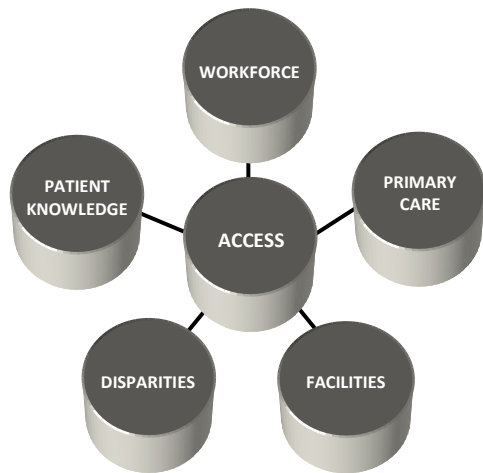
PPACA (PL 111-148), enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (PL 111-152), enacted March 23, 2010, are the culmination of more than 70 years of attempts (some successful, some not) by the federal government to expand health care access and coverage.

Reforms under PPACA (PL 111-148) have brought an end to some of the worst abuses of the insurance industry. These reforms have given Americans new rights and benefits, by helping more children get health coverage, ending lifetime and most annual limits on care, allowing young adults under 26 to stay on their parent’s health insurance, and giving patients access to recommended preventative services without cost.

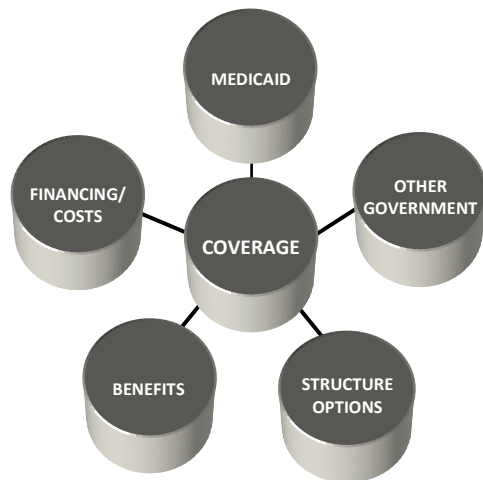
Many other new benefits of the law have taken effect, including 50% discounts on brand-name drugs for seniors in the Medicare “donut hole” and tax credits for small businesses that provide insurance to employees. More rights, protections and benefits for Americans are on the way through 2014, but it will take cooperation, coordination, and communication.

PPACA as enacted, and if fully funded, has the potential to dramatically improve overall health care for all New Mexico citizens. This document reviews the current status of consumer access to health care services; the coverage vehicles consumers use; and the quality of service delivered.





Consumer **access** to health care services encompasses workforce availability, access to primary care providers, and access to hospitals, facilities, and services. This access to health care can be restricted by lack of patient knowledge and easily accessible information. Consumer access to health care can only be accomplished by addressing the problems associated with health disparities.



Health care **coverage** vehicles include Medicaid, other Government coverage, structure options, benefits, and financing/costs.



Health care **quality** includes healthy lifestyles, continuous quality improvement, payments, transparency, and health information technology.

An inventory of Legislative Activity, Federal PPACA Grants and Other Implementation Activities were presented.

- During the 2011 Legislative Session 1591 bills, memorials and constitutional amendments were introduced. Out of those, over 100 in some way addressed health care issues and health reform concerns.
- Since enactment of PPACA on March 23, 2010, the Department of Health and Human Services has awarded \$62.3 million in new grant funding available in New Mexico, and helped many residents and employers take more control of their health care – from new patient protections to new coverage options.
- Due to the percentage of the New Mexico population with incomes below the Federal Poverty Line (FPL), concerted PPACA implementation efforts should be addressed for our vulnerable populations – children, families, and adults in need.
- Foundations have a role in bringing together leaders of various communities – Native American, African American, Children, Women, Seniors, Hispanics, Nonprofits, Healthcare, Education, Business – to create networks. A network could provide guidance and strategic planning, design, and advice to help implement health care reform in New Mexico.

If funding accompanies the law changes, by 2014 various components of access, coverage, and quality will be on the road to expansion and improvement. We have reviewed the initiatives envisioned by PPACA and how it may impact our health care system now and in the future.

INTRODUCTION

The federal Patient Protection and Affordable Care Act (PPACA) (PL 111-148) enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (PL 111-152), enacted March 23, 2010, are the culmination of more than 70 years of attempts (some successful, some not) by the federal government to expand health care access and coverage.

PPACA (PL 111-148) have brought an end to some of the worst abuses of the insurance industry. These reforms have given Americans new rights and benefits by helping more children get health coverage, ending lifetime and most annual limits on care, allowing young adults under 26 to stay on their parents' health insurance, and giving patients access to recommended preventative services without cost.

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PPACA as enacted, and if fully funded, has the potential to dramatically improve overall health care for New Mexico's vulnerable children, families and adults. This document reviews the current status of consumer access to health care services; the coverage vehicles consumers use; and the quality of service delivered.

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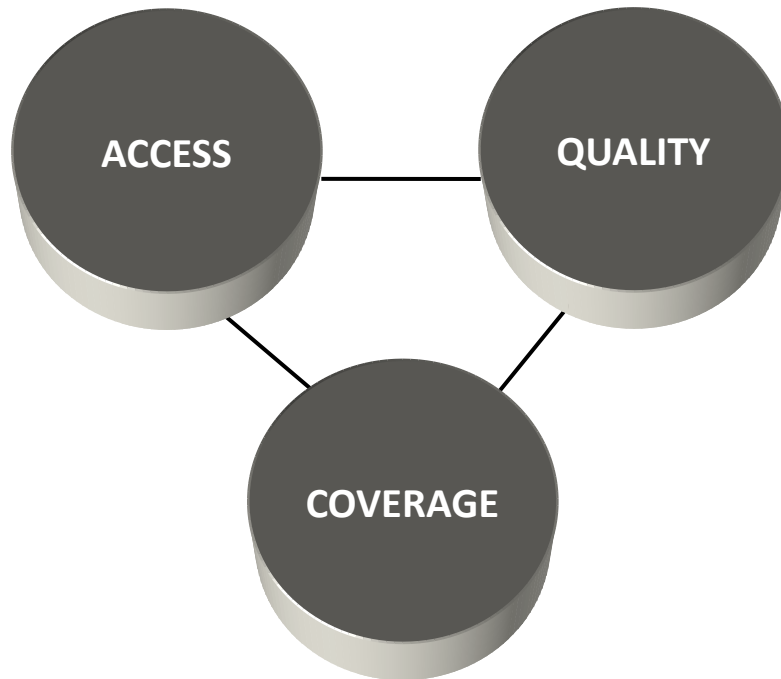
This document supports the W.K. Kellogg Foundation award to Con Alma Health Foundation (CAHF) for a six-month strategic planning grant to help guide New Mexico's implementation of PPACA.

Major references for this project include:

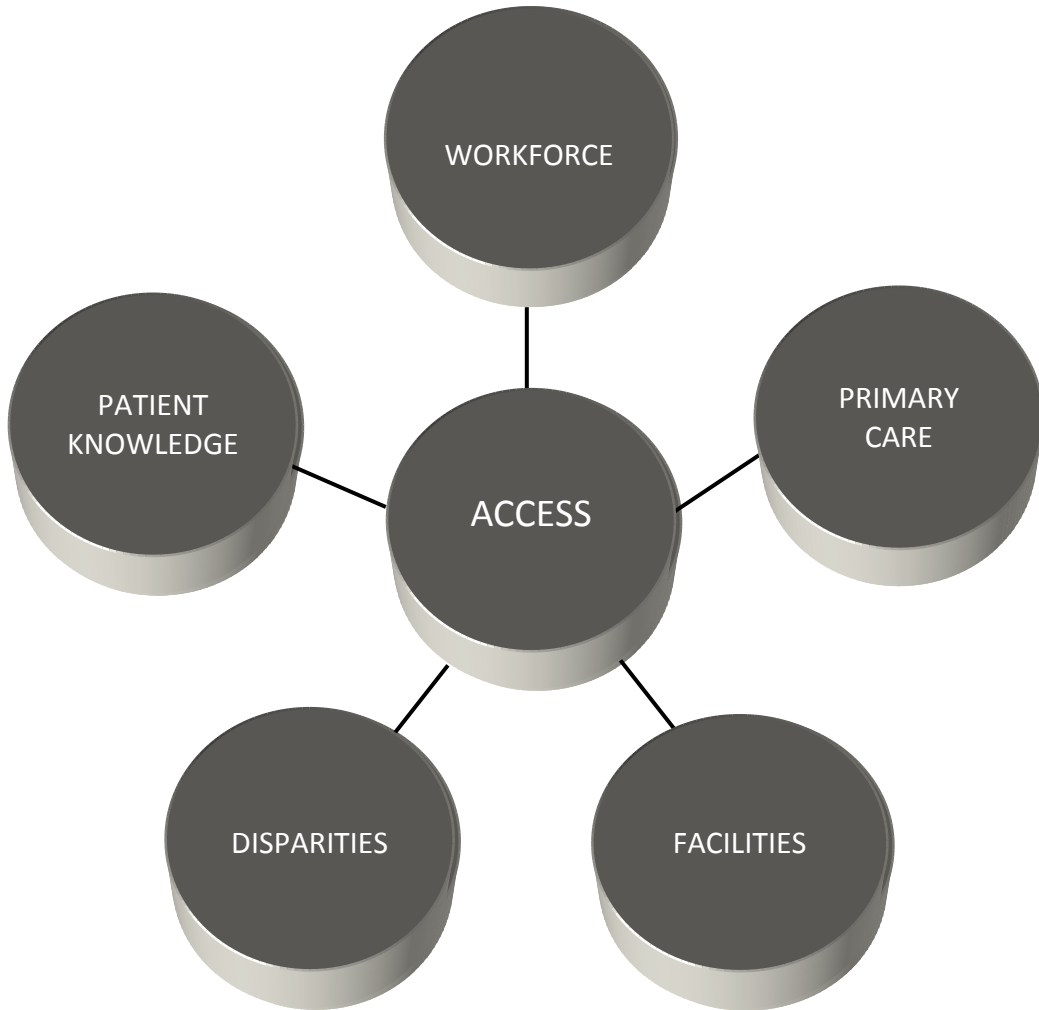
www.healthcare.gov, Washington: U.S. Department of Health and Human Services, 2011.

CCH's Law, Explanation and Analysis of the Patient Protection and Affordable Care Act Including Reconciliation Act Impact, Volumes 1 & 2. Boston: Wolters Kluwer Law & Business Aspen Publishers, 2010.

ACCESS, QUALITY, COVERAGE



ACCESS



ACCESS

PROVIDER WORKFORCE

TODAY	2014
<ul style="list-style-type: none"> • NM ranks 32nd in the U.S. with the number of licensed, registered physicians. • Nursing Shortage – New Mexico ranks 50 out of 51 states in the number of nurses per 100,000 people. • Advance Practice Nurse Shortage - nurse practitioners, certified registered nurse anesthetists and nurse midwives are critical providers in New Mexico whose numbers are also lower than national average. • Dentists Shortage – New Mexico ranks 49th in the number of dentists per capita. • Dental hygienists meet some of need, but do not practice independently. • New Mexico community colleges and universities cannot graduate enough physician or nursing students to meet our current need. • New Mexico has no dental school. • New Mexico has five dental hygiene schools meeting some of the current need. 	<ul style="list-style-type: none"> ⇒ Physician Shortage – PPACA will increase physician demand by 25%. ⇒ Reductions in state funding to our higher education system are impacting the ability of our schools to graduate additional health care providers. ⇒ PPACA funding though available may not flow to New Mexico in sufficient amounts to assist in our provider shortages. ⇒ PPACA expands federal student loans for primary care (Section 5201). ⇒ PPACA expands nursing student loans (Section 5202). ⇒ PPACA funds training in dentistry (Section 5302). ⇒ PPACA funds advanced nursing education grants for nurse practitioners and nurse midwives (Section 5308). ⇒ PPACA funds planning grants to establish Primary Care Extension Program State Hubs (Section 5405).

PROVIDER WORKFORCE TODAY

We have narrowed the review to a set of essential providers, but in no way does this discount the need for others providers groups in New Mexico.

Access to health care is not only dependent upon all New Mexicans having a means of health care coverage, but also access to appropriate health care providers. The supply and distribution of the health care professional workforce determines the adequacy of access to health care services. New Mexico has experienced a workforce shortage in the rural and frontier areas for many years. New Mexico's health care workforce ranks poorly when compared to the nation's health care workforce. (New Mexico Health Policy Commission, Recommendations to Address New Mexico Health Care Workforce Shortages, January 2011.)

Many factors contribute to health care workforce shortages. They include the state of the economy; mal-distribution of providers to primarily urban areas; enrollment in various health care plans; the capacity of educational institutions to admit students and graduate them; the aging of the baby boomer population; the availability of loans and scholarships to support students; and the aging of faculty teaching health care students, to name a few. (Derksen D, Whelan EM: Closing the Health Workforce Gap: Reforming Federal Health Care Workforce Policies to Meet the Needs of the 21st Century, Center for American Progress, 2010.) In addition, the number of health care providers involved in direct patient care and actually practicing in New Mexico is significantly less than the number with active licenses. This is true in every licensed profession. New Mexico licensing entities until the passage this year of SB14 (Health Care Data Collection) have not had the mandate to collect data on practice location, full- or part-time status, and other important workforce related data.

Physicians

In 2008 in the U.S. the data showed 254 active physicians (MD/DO) per 100,000. In New Mexico our numbers are lower at 227.6 per 100,000, ranking New Mexico 32nd in US. In 2006 7196 physicians were licensed by the New Mexico Medical Board or the New Mexico Osteopathic Examiners Board. Of those 2,348 (33%) practice exclusively outside of NM. Of the remaining 4,848, 946 (17%) were retired. Of the remaining 4002 physicians, 144 (4%) did not practice patient care. The remaining 3,858 provided actual patient care. (Physician Supply and Distribution in New Mexico, The Center for Health Workforce Studies, School of Public Health, University of Albany, State University of New York, 2006.)

In 2009, 30% of all New Mexico licensed physicians were between the ages of 55-64 and 17.9% over age 65 for a total of 47.9% over age 55 (New Mexico Health Policy Commission, Geographic Access Data System Report 2009). Only Los Alamos County, with a rate of 2.42 physicians per 1,000, came close to the national average of 2.42. All other counties are far below. Nearly half of all physicians practice in Bernalillo County and three quarters of New Mexico physicians come from other states. (Center for Workforce Studies Association of American Medical Colleges, Recent Studies and Reports on Physician Shortages in the US,

Albany, NY: 2011.)

As an example of the crisis in in number of physicians, in 2009, the American College of Emergency Physicians released the National Report Card on the State of Emergency Medicine, and access to physicians' emergency care in the U.S. received a "D." Too few emergency departments exist. Over the past 10 years, the number of people needing emergency care annually has increased 32%. At the same time, the number of hospital emergency departments has dropped nearly 7%. More and more patients turn to emergency rooms because they lack insurance or because of the limited provider options in rural communities.

Registered Nurses

New Mexico ranks 50th out of 51 states and territories in the number of Registered Nurses (RNs) per 100,000 – 600/100,000 versus the national average of 836/100,000. According to projections from the New Mexico Center for Nursing Excellence 2009 Annual Report, there is a current shortage of more than 1,000 RNs and LPNs in NM. Numbers increase to a shortage of 2,800 by 2015, and nearly 5,000 by 2020.

Multiple pressures influence both the supply and demand for registered nurses. Although the nursing shortage has eased due to the recession, the shortage in the U.S. is projected to grow to 260,000 RNs by 2025. (www.aacn.nche.edu/Media/FactSheets/NursingShortage.htm.) The Bureau of Labor Statistics reports that RNs held about 2.6 million jobs in 2008. That number is expected to increase to 3.2 million by 2018. According to GADS data, 17,694 RNs were licensed in New Mexico in 2009, a 17.3 % increase from 2007. (New Mexico Health Policy Commission, 2009 Geographic Access Data System, 2010.)

In 2009, 39% of all RNs resided in Bernalillo County, 9.3% in Doña Ana County and 7.8% in Santa Fe County. According to the U.S. Department of Health and Human Services (HHS), "... fewer young nurses are entering the RN population ..., and older graduates from initial nursing education programs are leaving." Currently, over 49% of the New Mexico workforce is over the age of 50 while, at the same time, demand for health care services is increasing as baby boomers enter retirement.

Nurses practice in many settings including hospitals, homes, schools, health clinics, community and public health clinics, long-term care facilities, battlefields and private practices. As the largest group of health care professionals in the nation, nurses are essential in all health care delivery settings.

Advance Practice Nurses

Certified Nurse Practitioners (CNPs) are advance practice nurses with independent practice and prescriptive authority who provide healthcare services similar to primary care physicians. They diagnose and treat a wide range of health issues. CNPs are usually nationally certified in a specialty area. Currently 1,162 CNPs hold active licenses in New Mexico; however, 231 CNPs do not live in New Mexico.

In the last four decades, the number of nurse practitioners has risen to more than 140,000 nationwide. It is hard to say there is a shortage of CNPs because they are a fairly new profession first created in 1965. More and more CNPs are working on their own, especially in poor inner-city neighborhoods and rural areas where there are few doctors in private practice. In New Mexico we have 48 CNPs for 100,000 residents; the U.S. is 54 per 100,000. The scope of what nurses can do medically has also been growing for the past two decades, at a time when the pool of primary care or family practice doctors has been shrinking. The need for professionals to do basic family medicine and health care has never been greater.

Certified Registered Nurse Anesthetists (CRNAs) provide approximately 70% of the anesthesia in New Mexico. They are the only providers of anesthesia in most counties outside the Rio Grande Corridor. Rural hospitals could not provide surgery were it not for CRNAs. The Board of Nursing 2010 Annual Report indicates there are 380 licensed CRNAs; however, 215 live out of state.

Certified Nurse Midwives (CNMs) deliver approximately 36% of all vaginal birth babies in New Mexico – the highest percentage of deliveries in the nation. CNMs work independently in their own practices, in hospital settings, or in practice with obstetricians.

In 1989 a Congressionally-mandated review of maternal health care providers found that the U.S. was experiencing shortages in rural areas. Thirty-one percent of the states reported that a shortage of nurse midwives exacerbated the provision of prenatal care in rural areas. (Rooks, Judith Pence, Midwifery & Child Birth in America, Philadelphia: Temple University Press, 1997.) Though this data is two decades old, little has changed. A growing shortage of maternity care clinicians and an inadequate number of birth centers and hospital facilities equipped with labor and delivery units require some women in New Mexico to drive two to three hours to access delivery facilities. Eleven percent of New Mexico women do not have a hospital in their county that provides birthing services except on an emergency basis. A 2006 Health Policy Commission survey indicated that 17 counties in New Mexico lacked an obstetrician that provided delivery services.

Oral Care Providers

Dentists

New Mexico has 1223 licensed dentists. (www.Statehealthfact.org.) The median number of dentists to population in this state is 1 to 3,297, compared to the federal standard of 1 to 1,050. Inner-city and rural communities struggle to recruit and retain an adequate supply of dental providers. According to the New Mexico Oral Health Surveillance Systems Annual Report for 2006, three New Mexico counties did not have a dentist or other oral health provider. New Mexico ranks 49th in the number of dentists per capita. The Health Policy Commission's 2009 GADS report indicates that almost 32% of dentists are 55-64 and 19% are over 65 years of age. Sixty-three percent of dentists practice in Santa Fe, Albuquerque and Las Cruces, leaving a sparse number throughout the rest of the state. The demand for dental

services is expected to continue to increase because the population is aging and requiring more care.

Dental Hygienists

Dental hygienists remove soft and hard deposits from teeth, teach patients how to practice good oral hygiene, and provide preventative dental care. They check for disease and refer to dentists for further care.

According to the GADS report for 2009, 937 licensed dental hygienists practice in New Mexico. Because dental hygienists must have a collaborative relationship with a dentist or dentists, they often practice in the same areas as dentist. New Mexico continues to have difficulty finding providers in rural areas of the state.

Educational Institutions

Medical Doctors Education

The University of New Mexico (UNM) Medical School has currently enrolled 347 students according to The Association of American Medical Colleges 2010 report at www.aamc.org/data/fact. The Health Policy Commission's January 2011 Recommendations to Address New Mexico Health Care Workforce Shortages indicates that in 2009 that 1,769 UNM medical school graduates held an active license in New Mexico. Twenty-seven percent of UNM graduates have stayed to practice medicine in New Mexico. However, the retention rate for the Family Medicine Residency Program is anywhere from 50% to 75%. According to clinical staff at UNM, only 4% of all graduates choose to enter primary care, one of the areas of greatest shortage.

Doctors of Osteopathic Physicians Education

There is no Osteopathic medical school in New Mexico. The closest one appears to be in Arizona.

Dental Education

We do not have a dental school in New Mexico, although there has been much discussion and funding of studies to determine the viability of one. New Mexico residents use the WICHE program to fund their out-of-state education and promise to return to New Mexico for a period of time. Currently, 36 students use the program. UNM also has a Dental Residency Program which has a 59% retention rate with graduates remaining in New Mexico to practice. (New Mexico Health Policy Commission, Recommendations to Address New Mexico Health Care Workforce Shortages, January 2011.)

Dental hygienists in New Mexico can attend the following schools for degrees, including associates and bachelors: San Juan Community College; UNM; University of Phoenix; Dona Ana Community College; and Apollo College.

Nursing Education

Currently, 21 educational institutions in New Mexico offer registered nursing degrees. Two bachelor's degree programs are offered at public institutions, 15 public community colleges offer associate degrees as do four private colleges. Seven schools offer associate degrees to bachelor degrees – five public schools and two private colleges. Three schools offer advance practice nursing degrees including UNM, New Mexico State University (NMSU) and St. Francis, a private college. UNM and NMSU offer two doctorate in nursing degrees. In the 2009-10 fiscal year, public colleges and universities turned away 395 qualified students due to lack of space, instructors and funding, according to the New Mexico Center for Nursing Excellence's, [White Paper: Nursing in New Mexico 2011](#).

UNM and NMSU graduate approximately 25 CNPs/CNMs annually.

PROVIDER WORKFORCE IN 2014

The provisions of PPACA fully implemented in January of 2014 will provide health insurance and theoretically access to an estimated 350,000 to 400,000 currently uninsured New Mexicans. New Mexico ranks 49th out of 50 states in the highest percentage of uninsured. (<http://www.commonwealthfund.org/Maps-and-Data/State-Scorecard-2009/DataByState/State.aspx?state=NM>.) The following are summarized sections of PPACA that *may* impact New Mexico's ability to expand its workforce. This is by no means all of the PPACA workforce sections, but instead those with the most potential to improve New Mexico's workforce over the *long term*. Unfortunately, none of the provisions can assure an immediate increase in New Mexico's often insufficient provider networks, particularly in rural areas. In addition, it is impossible to determine which grants enumerated below have been submitted by any entity or awarded to New Mexico entities. The state does not keep a complete registry of submittals or awards.

Reductions in state funding to our higher education institutions is impacting programs in medicine, nursing, advance practice and nurse midwifery as well as the education of a variety of health care providers. Funding for New Mexico Health Services Corp; New Mexico Health Professional Loan Repayment Program; New Mexico Loan for Service Program; Primary Care Physician Conditional Tuition Waiver Program; Nursing Faculty for Services loans and others are flat or have been reduced. It is doubtful that federal funding, even if provided to New Mexico institutions, can significantly increase our provider workforce.

PPACA Workforce Sections

Section 5201. Primary Care Student Loans – The federal student loan program for primary care is modified to limit the service obligation to a maximum of 10 years and parental information is no longer required.

Section 5202. Nursing Student Loans – The maximum loan amounts under the federal nursing student loan program are increased.

Section 5203. Pediatric Specialty Loan Repayment Program – A loan repayment program is established that pays up to \$35,000 per year towards a physicians' education loan in exchange for at least two years of full-time pediatric subspecialty work in a shortage area.

Section 5205. Allied Health Workforce Recruitment and Retention Programs – An Allied Health Loan Forgiveness Program will be established to repay loans for allied health professionals working in public health agencies, acute care facilities, ambulatory care facilities, personal residences and other settings in areas with shortages or in medically underserved areas.

Section 5208. Nurse-Management Health Clinics – The Secretary of HHS will award grants to operate nurse-managed health clinics that provide primary care to underserved or vulnerable populations through 2014 (UNM has applied).

Section 5301. Training in Family Medicine, General Internal Medicine, General Pediatrics, Primary Care and Physician Assistantship – Funds will be allocated through 2014 to develop and operate accredited professional training programs. Financial assistance shall be provided for participants.

Section 5303. Training in General, Pediatric and Public Health Dentistry – Funds will be allocated through 2014 to plan, develop and operate training programs in the above dentistry fields with financial assistance provided to students.

Section 5304. Alternative Dental Health Care Providers Demonstration Project – The Secretary of HHS will award grants to 15 eligible entities to establish a demonstration program to increase access to dental health care services in rural and underserved communities through training programs for alternative dental health care providers.

Section 5305. Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education – Funds will be allocated through 2014 to entities that operate geriatric education centers that provide fellowship programs; chronic care management and long term care training.

Section 5308. Advanced Nursing Education Grants – Grants are available under section 811 of the Public Health Service Act for nurse midwifery programs (*UNM was awarded 8/5/10 \$38,333 for NPs and CNM programs*).

Section 5309. Nurse Education, Practice and Retention Grants – Authorizes funding of nursing education grants through 2014 for entities to initiate and maintain nurse retention programs.

Section 5311. Nurse and Faculty Loan Program – Funds are available for loans for the purpose of increasing nursing school faculty through 2014 (UNM awarded 8/5/10 \$406,078 & Western New Mexico University awarded 8/5/10 \$249,740).

Section 5313. Grants to Promote the Community Health Workforce – Funds will be available through 2014 to fund community health workers to educate, guide, and provide outreach, referral and home visitation services to populations in medically underserved areas. Authorizes grants for scholarships for individuals to upgrade their skills.

Section 5402. Health Care Professional Training for Diversity – Expands loan repayments for individuals who serve as faculty at eligible health professions institutions, scholarships for disadvantaged students and education assistance to recruit and retain disadvantaged students for health professions.

Section 5404. Workforce Diversity Grants – Expands grants and stipends for bridge or degree completion programs, student scholarships for accelerate nursing degree programs and retention activities.

Section 5405. Primary Care Extension Program – The Secretary of HHS will award funding for planning grants to establish Primary Care Extension Program State Hubs. Hubs will include the health department, Medicaid and health professions schools that train primary care providers. Hubs will assist primary care providers to implement patient-centered medical homes and support learning communities to disseminate research findings for evidence based practice. Funds will be available through 2014.

Section 5509. Graduate Nurse Education Demonstration – The Secretary will establish a graduate nurse education demonstration program under Medicare for up to 5 hospitals to provide clinical training to advance practice nurses through 2015.

Section 5606. Grants to Fund Programs for Medically Underserved – The Secretary will create a grant program to fund recruitment and training programs focused on underserved communities. States will be able to award grants to health care providers who treat a high percentage of medically underserved or other special populations.

Section 3114. Fees paid to a Certified Nurse Midwife – Fees paid to a CNM for the same service performed by a physician shall be equally reimbursed.

Section 10501. Amendments to Public Health Services Act in PPACA – Nurse Practitioners and Rural Physicians will be able to access training grants for those working in FQHC and nurse managed clinics.

If New Mexico institutions and government were to access every available grant indicated above, it still would not create the kind of workforce expansion we need in New Mexico.

ACCESS

PRIMARY CARE

TODAY	2014
<ul style="list-style-type: none">• Only 4% of UNM Medical School graduates choose primary care.• NM needs 400-600 new primary care providers immediately• Over 66% of primary care physicians live in the Rio Grande Corridor.• 55 Physician Assistants provide primary care services.• Many of the 931 CNPs provide primary care, but we don't know exactly how many.	<ul style="list-style-type: none">⇒ Reductions in state funding to our higher education system are impacting the ability of our schools to graduate additional health care providers.⇒ PPACA funding though available may not flow to New Mexico in sufficient amounts to assist in our provider shortages.⇒ PPACA expands federal student loans for primary care (Section 5201).⇒ PPACA funds advanced nursing education grants for nurse practitioners and nurse midwives (Section 5308).⇒ PPACA funds planning grants to establish Primary Care Extension Program State Hubs (Section 5405).

PRIMARY CARE TODAY

In 2008, New Mexico First conducted a forum on Health Care Needs in New Mexico. Their background report addressed the need to strike a balance between the number of primary care and specialty care providers in our state. Primary care doctors often earn less than their specialist colleagues, resulting in only 4% of UNM Medical School graduates choosing primary care. (New Mexico First, Health care Needs in New Mexico – Can New Mexicans Get the Healthcare They Need? 2008 Pipeline Forum Background Report, May 2008.) National estimates indicate that the country will need 45,000 more primary care providers by 2020. New Mexico has a shortage of 400 – 600 FTE in primary care providers according to Dan Derksen in a presentation to the Health Policy Commission ON October 14, 2010.

Most of what was discussed in the Workforce section applies to primary care. New Mexico simply cannot graduate or recruit a sufficient number of primary care physicians, physician assistants or certified nurse practitioners who will provide primary care.

PPACA's impact also will result in a shift from focusing on episodic treatment to emphasizing patient/family centered care, prevention and wellness. Of course that depends greatly on the ability to access primary care providers. The initial impact of PPACA likely will exacerbate the current shortage of primary care providers as indicated previously.

In 2009, New Mexico had 2,442 primary care physicians licensed in New Mexico. Thirty-two percent of them were between 55 and 64 years of age. Over 15% of primary care physicians were over 65 years of age. Forty-nine percent of these licensees reside in Bernalillo County. An additional 17% are in Santa Fe or Dona Ana Counties.

In 2009, approximately 55 of the 117 physician assistants (PAs) in the state, provided primary care services. PAs work under the supervision of a physician and often provide care in clinics in rural parts of the state. Of the 931 NPs who reside in the state, we cannot determine how many are providing primary care though anecdotally we know many NPs have their own clinics, particularly in less populated communities.

PRIMARY CARE IN 2014

Efforts continue in New Mexico to expand physician graduates, physician assistant graduates and nurse practitioner graduates to enter primary care and stay in New Mexico. PPACA funding, if it comes to fruition, will assist our universities in providing this education and training.

Impact of PPACA on Primary Care (see workforce PPACA sections):

- Primary Care Funding – PPACA increases the Medicaid reimbursement for primary care to 100% of Medicare rates in 2013 and 2014. For providers in shortage areas

with 60% of their Medicare billing in primary care, PPACA provides a 10% bonus in 2011 through 2015.

- Advance practice nursing education grants will be available.
- Nurse managed clinics may be expanded.
- Primary care extension programs will be created.

ACCESS

FACILITIES/SERVICES

TODAY	2014
<ul style="list-style-type: none"> • Forty-three hospitals in New Mexico 7 of which are designated trauma centers. • Hospitals provided \$384,000,000 in uncompensated care in 2006. • Ninety-five community based clinics serving over 300,000 patients with 1 million visits. • Seventy-nine home health and hospice agencies. • Seventy-one certified nursing homes serving 59% Medicaid residents. • Private providers' offices unknown. 	<ul style="list-style-type: none"> ⇒ PPACA allows states to amend state plans to provide home and community-based attendant services for those below 150% of FPL. ⇒ Value-Based Purchasing under PPACA may actually adversely impact hospitals, nursing homes and home health care in the short run. ⇒ Hospitals will see reduced payments for excessive readmissions. ⇒ Annual market updates will reduce hospital and home health care payments in the short run. ⇒ Grants of Trauma services will be available. ⇒ Medicare hospice demonstration projects will be funded. ⇒ PPACA reduces funds for hospital – acquired conditions. ⇒ Accountable Care Organizations may be created much like managed care. ⇒ Nursing homes and home health care will see Medicare cuts.

FACILITIES/SERVICES TODAY

Hospitals

New Mexico has 43 hospitals, seven of which are designated trauma centers. A trauma center hospital is specially equipped and staffed to treat patients who have sustained complex, life-threatening injuries such as multiple gunshot wounds or severe internal injuries. In the United States, a hospital can receive trauma center verification by meeting specific criteria established by the American College of Surgeons (ACS) and passing a site review by the Verification Review Committee. Official designation as a Trauma Center is determined by individual state law provisions. Trauma centers vary in their specific capabilities and are identified by "Level" designation: Level 1 being the highest and Levels 3 and 4 being the lowest. Higher levels of trauma centers will have a trauma surgeon available as well as highly sophisticated medical diagnostic equipment. Lower levels of trauma centers may only be able to provide initial care and stabilization of a traumatic injury and arrange for transfer of the victim to a higher level of trauma care.

Designated trauma centers include:

- UNM Hospital - Level 1
- Gerald Champion Regional Medical Center Alamogordo – Level 3
- San Juan Regional Medical Center – Level 3
- Eastern New Mexico Medical Center Roswell – Level 3
- Carlsbad Medical Center – Level 3
- Christus St. Vincent Regional Medical Center – Level 3
- Roosevelt General Hospital Portales – Level 4

Only the largest hospitals provide obstetric services. In rural areas, women often have to drive up to two hours to reach a facility offering birthing services.

New Mexico has 2 beds for each 1,000 in population slightly below the national average of 2.6 per 1,000 population. (www.statehealthfacts.org.) New Mexico actually spends more per hospital adjusted expenses per in-patient day at \$1,989 compared to the national average of \$1,853. Hospitals in New Mexico admitted 160,792 patients; treated 4,344,119 outpatients; saw deliveries of 24,275 babies and provided 777,671 emergency services. They also provided \$384,000,000 of uncompensated care in 2006. (NM Hospital Association, New Mexico Hospitals' State of Economic Impact Report, 2010.)

Clinics

New Mexico has worked for the last 20 years to build a system of community-based primary care centers in areas of the state chronically underserved. Currently, primary care clinics operate in 95 communities, servicing over 300,000 patients through more than 1 million visits each year. Fifteen of these sites are Federally Qualified Health Clinics (FQHCs). Roughly 88% of these are patients with annual incomes below 200% of FPL and 43% have no health insurance coverage. (State of Health in New Mexico 2011, Department of Health New

Mexico Health Trends, 1998-2009.)

Home Health Agencies

Seventy-nine private pay and Medicare / Medicaid certified home care agencies operate in New Mexico. Seniors and people with disabilities who prefer to live independently in their own homes or stay with a family member have access to these outside supportive care and assistance services. Home health and home care agencies provide two main types of services: medical (skilled) and non-medical (unskilled) care.

Non-Medical: Supportive services, provided by non-medical home care agencies, offer assistance with personal care such as bathing, grooming and dressing, in addition to help with meal preparation, housekeeping, and shopping. Staff also may provide assistance with self-administered medications, ambulation and exercises, and transportation to medical appointments. These supportive services can be arranged for any amount of time needed including up to 24/7 or on a respite or temporary basis.

Medical: Skilled services provided by medical home health agencies offer nursing care, physical, occupational, speech, and respiratory therapy as well as social services and hospice care. Following a specific plan of care and under the supervision of a nurse or therapist, a certified home health aide may provide personal care for a limited time. These skilled services are provided on an intermittent basis, with scheduled home visits to homebound clients only, under a plan of treatment ordered by a physician.

Nursing Homes

New Mexico's 71 certified (Medicare/Medicaid) nursing home facilities have 6,800 beds and serve 5,570 residents. (www.statehealthfacts.org.) Payer sources are: 59% Medicaid; 14% Medicare; 27% private pay or other. The national average of Medicaid as the payer source is 64%.

Private Provider Offices

It is not known at this time how many physician and advance practice nurses operate private offices.

HEALTH FACILITIES/SERVICES IN 2014

At various phases in the legislative process, representatives from rural states were able to insert provisions in PPACA that specifically address rural needs. Many of the sections below are a result of those actions. Most of the new spending proposed in this legislation is through authorizing sums (typically "such sums as necessary") to be appropriated. Therefore, funds are not yet available because Congress would need separate action to complete an appropriation. In some instances, the Secretary of Health and Human Services may be able to initiate spending from "such sums not otherwise spent," using authority in this legislation to transfer funds from programs not using full appropriations. (Mueller, Keith J., PhD. The Patient

Protection and Affordable Care Act – A Summary of Provisions Important to Rural Health Care Delivery, RUPRI Center for Rural Health Policy Analysis, University of Iowa, College of Public Health, June 2010 Paper #2010-4.)

The following are sections of PPACA that offer grant funding and/ or changes in law that will affect health care facilities in New Mexico. It is currently unclear if New Mexico entities have applied for or received funding in the areas below.

Section 2401. In Home Care and Attendant Services – States can amend their state Medicaid plans to provide home and community-based attendant services for persons at 150% of FPL or below.

Section 3001. Value-Based Purchasing Program (VBP) – VBP will be instituted by October 2012 affecting prospective payments to hospitals including sole community provider hospitals and critical access hospitals. VBP covers acute myocardial infarction; heart failure; pneumonia; surgeries and healthcare associated infections.

Section 3002-3007. VBP for others – VBP is also incorporated into payment to physicians, skilled nursing facilities and home health care.

Section 3022. Accountable Care Organizations – Allows Medicare Demonstration projects beginning in January 2012. (The director of the New Mexico Hospital Association indicates that very few New Mexico hospitals will participate because it is so confusing.)

Section 3023. National Pilot Program on Payment Bundling – The Secretary shall include rural hospitals.

Section 3024. Independence at Home Demonstration – This program will test a payment incentive and service delivery model that uses physician- and nurse practitioner-directed home-based primary care teams designed to reduce expenditures and improve health outcomes. The program will test whether an “independence at home” model reduces preventable hospitalizations; prevents hospital readmissions; reduces emergency room visits; improves health outcomes commensurate with the beneficiaries’ stage of chronic illness; improves efficiency of care; reduces the cost of health care services; and achieves beneficiary and family caregiver satisfaction. The demonstration program is to begin no later than January 1, 2012 and will test services provided to approximately 10,000 beneficiaries.

Section 3025. Payments for Readmission – Payments for excessive readmissions to hospitals will be reduced October 2012. This of course could have an adverse affect on hospitals.

Section 3125. Hospital Payment Adjustment - Lowers the mileage and discharge requirement to provide an increased adjustment in payments.

Section 3131. Payment Adjustments for Home Health Care – A 3% rural home health add-on is extended to January 1, 2016.

Section 3132. Hospice Reform – Beginning January 1, 2011, the Secretary will collect additional data and information as appropriate to revise payments for hospice care. Data may include information on charges and payments; number of days of hospice care for Part A beneficiaries; number of days attributed to each type of service; cost of each type of service; and other issues. By October 1, 2013, the Secretary will implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care. Revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing care and services during the entire episode of care. Beginning January 2011, a hospice physician or nurse practitioner will be required to have a face-to-face encounter with a patient to recertify hospice care in order to extend services beyond 180 days.

Section 3137. Hospital Wage Index Improvement – A new hospital wage index will be created. This could positively or negatively affect rural hospitals.

Section 3140. Medicare Hospice Concurrent Care Demonstration Program - PPACA establishes a three-year demonstration program that will allow hospice beneficiaries to receive all other Medicare-covered services while in hospice care. The demonstration will be open to 15 hospice programs in both rural and urban areas. The Secretary will evaluate the potential for improved patient care, quality of life and cost-effectiveness in, contractors and other agents.

Section 3401. Reduces Annual Market Updates – Reduces the updates for hospitals, skilled nursing facilities, home health care and hospice care by a “productivity adjustment.”

Section 3503. Trauma Supports – Grants available for innovative models of regionalized, comprehensive and accountable emergency care and trauma services especially in medically underserved areas.

Section 4102. School-Based Health Centers - Directs the Secretary to award grants to support the operation of school-based health centers through 2013.

Section 7102. Drug Purchasing Program – Sole community hospitals are added as eligible for the 340B drug purchasing program.

Section 10324. Floor Payment – Floor payments are established on the area wage index for hospital in frontier state (50% counties frontier counties).

Section 10326. Pilot Testing Pay For Performance Programs of Certain Medicare Providers – Hospice programs in rural states will be eligible for this VBPP.

Section 10503. Community Health Centers and the National Health Services Corps Fund – A CHC Fund is created to provide enhanced funding for community health centers - \$10 billion over 5 years.

Section 3021. Impact of PPACA on Hospitals:

- Bundled payments for episodes of care – PPACA establishes a five-year Medicare voluntary pilot program beginning January 1, 2013 for integrating care through hospitals, providers and post-acute care providers during an episode of care for certain medical conditions. If successful, the law allows for expansion of this program in January of 2016.
- Pay for Performance – PPACA establishes a value-based purchasing (VBP) (see Sec. 3001) program for Medicare to pay hospitals based on performance compared to quality measures. Under the VBP, a percentage of payments to hospital will be tied to a hospital's performance on these quality measures. If a hospital does not meet the quality measures, the base operating DRG (diagnosis related group) payment amount is decrease by a percentage in the next fiscal year.
- Market Basket Updates and Reductions – PPACA (Sec. 3401) modifies the market basket updates for hospitals beginning in 2012. The update incorporates a productivity adjustment. This adjustment may result in a negative market basket update resulting in a deduction in payment rates. In addition, a failure by the hospital to report required data will result in a reduction of the annual market basket update.
- Medicaid Expansion – PPACA requires the Medicaid program to significantly expand. Medicaid will cover individuals up to 133% of FPL. This expansion is to help reduce the difference in state-by-state eligibility. States will have an option to expand eligibility to individuals with higher incomes with a state plan amendment. Federal funding is available from 2014 through 2016. The feds will pay 100% of the costs of coverage for newly eligible individuals. In 2017, the states will receive 95% FMAP, reducing to 90% by 2020.
- DSH Payments – Beginning in 2014, payments to disproportionate share hospitals (DSH) will be reduced. The first reduction is 75%. After this reduction, increases in payments will be based on the percentage of the population that is uninsured and the amount of uncompensated care provided.
- Accountable Care Organizations (ACOs) – PPACA allows providers to organize as ACOs that will voluntarily meet quality thresholds to share in cost savings realized in Medicare. To qualify as an ACO, organizations must agree to be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care providers, define processes to promote evidence-based medicine, report on

quality and costs, and coordinate care. If these work, hospital utilization *should* decline and providers will be incentivized to reduce hospital admissions.

- Hospital-Acquired Conditions – PPACA reduces Medicare payments to certain hospitals for hospital acquired conditions by one percent beginning in 2015. This will incentivize hospitals to improve their infection control programs. Hospitals are worried that “conditions” are ill defined, potentially resulting in unjustified cuts to reimbursement.
- Preventable Readmissions – PPACA (Sec. 3025) reduces Medicare payments by specified percentage amounts to account for excess/ preventable hospital readmissions effective October 2012.
- Trauma Center Development – PPACA establishes a new trauma center program with funding to strengthen emergency department capacity.
- (Main, David C. and Starry, Melissa M, Pillsbury, Winthrop, Shaw, Pittman LLP, [The Effect of Health Care Reform on Hospitals: A Summary Overview](#), June 23, 2010.)

Impact of PPACA on Home Health Agencies:

- A three percent rural add-on effective for Medicare episodes ending on or after April 1, 2010, and before January 1, 2016.
- Indefinite continuance of the agency-specific 10 percent outlier payment cap.
- A two and one-half percent 2011 reduction to the Medicare home health PPS base rates due to realigning outlier budget of five percent versus outlier spending target of two and one-half percent.
- A one percent reduction in the annual Medicare home health market basket update for the years 2011 through 2013.
- Rebasement of payment rates to better approximate costs over a four-year phase-in beginning with 2014, with a maximum reduction of three and one-half percent per year.
- Reduction of the annual Medicare home health market basket update by a productivity adjustment, beginning in 2015

Impact of PPACA on Nursing Homes:

- Reimbursement Cuts in Medicare – Nursing homes receive the bulk of their revenues from Medicare and Medicaid. PPACA will cut reimbursements and encourage patients to receive care in their homes. Such cuts may adversely impact nursing home business.

ACCESS

PATIENT KNOWLEDGE

TODAY	2014
<ul style="list-style-type: none">• Numerous advocacy websites are available to research general information on health insurance reform.• State government websites enable consumers to determine which state benefits for which they are qualified.• Various health insurance plans are available via the internet.• Advocacy groups and organizations provide information on their websites.• Consumers without internet access have a more difficult time finding complete information.	<ul style="list-style-type: none">⇒ PPACA requires the creation of a state health insurance exchange of some type by January 2014 or the federal exchange must be used.⇒ An exchange must have a “portal” for consumer access.⇒ The portal may not be accessible to those without Internet access or Internet knowledge.⇒ The exchange must “educate” consumers as well as enable them to review different insurance plans and compare costs.⇒ Navigators must be used to assist consumers.

PATIENT KNOWLEDGE

WHERE TO FIND HEALTH INSURANCE INFORMATION TODAY

Consumer access to health insurance information is extremely difficult without the use of the Internet. Consumers can call various agencies or organizations if they know their names or use advocacy organizations throughout the state. Information is particularly difficult to access in Indian Country without the support of tribal organizations and the tribes themselves.

- Human Services Department eligibility website www.yes.state.nm.us enables one to determine eligibility for numerous State services including Medicaid. It is fairly user friendly.
- Public Regulation Commission Division of Insurance website www.nmprc.state.nm.us provides general information about insurance of all types.
- Federal health care website www.healthcare.gov under *Find Insurance Options* will provide a consumer with multiple priced options for private health insurance coverage.
- Consumers' Union website www.consumersunion.org/health.html provides information about all types of health care, insurance, Medicare, Medicaid, prescription drug issues, long-term care and other issues.
- New Mexico Health Insurance Plans website www.nmhealthinsurance.com allows a consumer to compare certain plans, get rates and apply for coverage.
- New Mexico Health Insurance Alliance website www.nmhia.com is an alliance of independent health insurers who have agreed to offer a full range of health plans to companies with 50 or fewer eligible employees. Their website can lead a consumer to an agent.
- New Mexico Medical Insurance Pool website www.nmmip.org provides information and rates on insurance for individuals denied health coverage because of preexisting conditions.
- Insure New Mexico website www.insurenwemexico.state.nm.us provides information on the now capped SCI program.
- Families USA website www.familiesusa.org provides general information on health insurance issues.
- Any New Mexico broker can be located with an Internet search.

- All current insurance companies and products can be accessed on the Internet by using the company name.
- Consumers without access to the Internet currently have a difficult time finding information on health insurance issues and health insurance plans. There are local phone numbers for most of the above entities.

WHERE TO FIND INFORMATION AFTER PPACA 2014

- PPACA requires the creation of a state, regional or use of the federal exchange by January 2014. States may create a business exchange, an individual exchange or combine the two.
- HHS regulations will govern the standards for the exchange, the offering of qualified health plans, reinsurance and other areas.
- The exchanges shall create an easy access “portal” for consumers to research different health plans.
- The exchanges shall be designed to attract and educate consumers on the available health plans in the exchanges. PPACA requires a “navigator” to provide the information and access to help identify appropriate plans for consumers. (Section 1311)
- Navigators must do the following:
 - ⇒ Conduct public education activities to raise awareness of the availability of qualified health plans;
 - ⇒ Distribute fair and impartial information on plans, tax credits and cost-sharing reductions;
 - ⇒ Facilitate enrollment in qualified plans;
 - ⇒ Provide referral to any office of health insurance consumer assistant or health insurance ombudsman or other state agency for any enrollee with a grievance, complaint or question about a plan; and
 - ⇒ Provide information in a culturally or linguistically appropriate manner.
- It is unclear if brokers will have a role in the exchanges. They can serve as navigators but cannot be paid by the insurer.
- The exchanges must use information technology that at a minimum requires the website to educate site visitors on qualification for subsidies, compare plan designs, compute premiums and model cost sharing. The site must also be able to connect the consumer with their insurance carriers, agents and perhaps providers.
- Navigators will be required to provide information to difficult to access populations throughout the state.

ACCESS

DISPARITIES

TODAY	2014
<ul style="list-style-type: none">• Thousands of New Mexicans have limited or no access to health care services creating health disparities.• Life expectancy and quality of life are impacted by health disparities. The Native Americans under 65 die at higher rates than whites under 65.• Health care can come too late because of cultural barriers or language issues.• New Mexico has the highest number of uninsured women in the country.• Over 20% of children live in poverty.• Teenage pregnancy is higher among Hispanics than any other group.• Undocumented people are still in the health systems especially the emergency system. Many wait till conditions are dire before entering hospitals.	<ul style="list-style-type: none">⇒ Medicaid will be expanded to serve adults up to 133% of FPL.⇒ PPACA requires expansion of primary care coverage.⇒ PPACA requires training of providers on diversity.⇒ PPACA requires the collection of data to determine if programs are working.⇒ Undocumented people are not covered under PPACA.

DISPARITIES TODAY

Research and public health practice literature reports substantial disparities in life expectancy, morbidity, risk factors and quality of life of people based upon race/ethnicity, sex, income, geographic location and disability status. (Centers for Disease Control and Prevention, MMWR Morbidity and Mortality Weekly Report, CDC Health Disparities and Inequalities Report- United States, January 14, 2011.) Health disparities are defined as the differences in health outcomes and their determinants between segments of the populations based upon the list above.

Many Americans too often do not receive the care they need. Care can come too late or not at all because of lack of insurance, language barriers, cultural barriers or even geographic barriers. New Mexico's our health care system distributes services inefficiently and unevenly across our rural state. All Americans should have equal access to high-quality care. Instead, racial and ethnic minorities and poor people often receive poorer quality care and face more barriers when trying to access care. Women without health insurance are less likely to have adequate access to and use of preventative and specialty care, resulting in poorer health outcomes. (New Mexico Governor's Women's Health Advisory Council, New Mexico Women's Health Profile, 2009.)

Some of our communities have been left behind:

- The death rate for African American infants was double the national rate in 2002.
- In 2005, the prevalence of diabetes remained two times higher amount non-Hispanic blacks than among whites.
- In 2002, high blood pressure was controlled in only 18% of Hispanics compared to 30% of whites.
- In 2003, only 45% of Hispanics age 65 or older receive a flu vaccine, compared to 69% Whites.
- According to the federal Indian Health Services, suicide is the second leading cause of death behind unintentional injuries among Native American children and youth adults. Native Americans commit suicide at a rate more than three times the national average. (REACH, Reaching Across the Divide – Finding Solutions to Health Disparities, U.S. Department of Health and Human Services, CDC, 2007.)
- New Mexico ranks 50th in the nation for the percent of women living in poverty. Almost 20% of New Mexican women and 10.6% of New Mexican men are living in poverty. Research shows that poverty is linked to ill health. (Cacari, Lisa Stone, PhD., WK Kellogg Disparities Scholar, Harvard School of Public Health; and Vicky Howell, PhD,

New Mexico Department of Health. Women's Health Inequalities in New Mexico: Challenges and Policy Options.)

- Teenage pregnancy among Hispanics continues to be higher than any other racial/ethnic minority. New Mexico's teen birth rate for females ages 15-17 remains more than 60% higher than the national rate.
- Rates of death for Native Americans are higher than Whites for all age groups under the age of 65.
- Accidents (unintentional injuries) are the second leading cause of death for Native Americans and the third leading cause of death for Hispanics. New Mexico has alcohol and drug-related death rates double the national rates.
- Many women of color do not avail themselves of health screening tests such as Pap smears and mammograms on a regular basis due to a variety of factors including availability of insurance coverage, accessibility of facilities, cultural beliefs, and lack of information. (Women of Color Data Book, Office of Research on Women's Health, Office of the Director, National Institutes of Health, 2006.)
- Science Daily Aug. 19, 2009 (www.sciencedaily.com), reports that research indicates that the social stigma that surrounds lesbian, gay, bisexual, and transgender (LGBT) teens leads to a variety of health risks such as substance abuse, risky sexual behaviors, eating disorders, suicidal ideation, and victimization.
- In 2009 Indian Health Services per capital spending was \$2,696 for its constituents while Medicare spent an average of \$11,018 per beneficiary. (www.officeofminorityhealth.hhs.gov).

DISPARITIES IN 2014

PPACA contains many sections that if funded will reduce the health disparities that exist throughout the state and country. PPACA makes significant advances for all minority groups in health care coverage, quality of care and access to health care services. If fully funded and enacted, it will positively impact and mitigate the health disparities throughout our state and the country.

Numerous provisions of PPACA should greatly improve the factors that lead to health disparities.

Section 2001. Universal Health Insurance Coverage — Creates an exchange to afford almost universal health insurance coverage. Requires Medicaid to cover all adults up to 133 % of FPL.

Section 1201. Coverage Denial — Prevents insurers from denying coverage based on preexisting conditions.

Section 3501. Medical Homes — Seeks to improve primary care and create “medical homes” to assure continuity of care and care coordination.

Section 5313. Community Health Centers — Seeks to expand access to community health centers. PPACA seeks to focus on disease prevention and health promotion.

Section 5402. Workforce — Seeks to improve the health care workforces distribution and cultural competency.

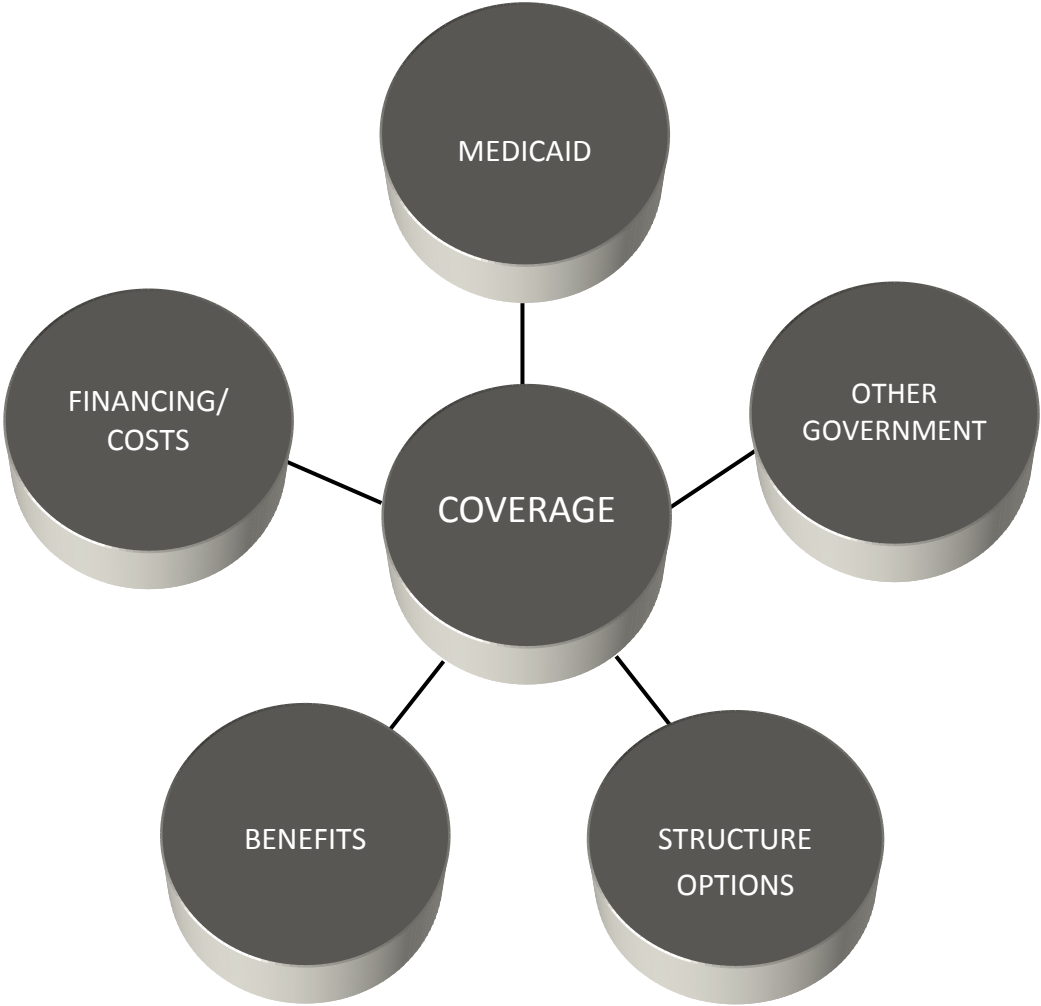
Section 3015. Data Collection — Seeks to collect data to better measure the effectiveness of all initiatives. PPACA plans will be required to offer 100% coverage of approved preventative services such as immunizations, cancer screenings and diabetes testing.

Section 5201. Primary Care — Seeks to expand primary care capacity. PPACA seeks to expand funds for community health centers.

Section 5402. Cultural Competency — Seeks to provide grants to train health care workers to better serve underserved and hard-to reach populations and improve cultural competency. PPACA seeks to increase the number of health care professionals from minority communities.

Section 1507. Discrimination — Prohibits discrimination under any federal or federally funding health program. PPACA requires federally funded programs to collect and report data on race, ethnicity, socioeconomic status, health literacy and primary language. PPACA creates the Office of Minority Health at the Department of Health and Human Services.

COVERAGE



COVERAGE

MEDICAID

TODAY	2014
<p>There are approximately 40 categories of eligibility within New Mexico Medicaid. Some of these include the following:</p> <ul style="list-style-type: none"> • The Human Services Department’s Medical Assistance Division is responsible for all Fee for Service (FFS) provider payments as well. • Salud! - Services are provided by contracted Managed Care Organizations (MCOs) to provide Medicaid services to eligible and enrolled citizens. • Children's Health Insurance Program (CHIP) – expands Medicaid coverage guidelines for children up to age 19 in households with family income between 185%-235% FPL. • Family Planning & Pregnancy - covers pregnant women in families for pregnancy related services only and whose income is below 185% of the FPL. • JUL Medicaid - covers families with dependent children who also qualify for TANF. • New MexiKids - provides no cost or low cost health care coverage for children 0-12 in households with incomes up to 235% FPL. • New MexiTeens - provides no cost or low cost health care coverage for children 13-19 in households with incomes up to 235% FPL. • Working Disabled Individuals (WDI) - covers disabled working individuals who, because of earnings, do not qualify for Medicaid under any other programs. • Native Americans -Native American Medicaid recipients who are otherwise eligible for Salud! will receive Medicaid coverage or have the ability to opt out. 	<ul style="list-style-type: none"> ⇒ PPACA (PL 111-148) expands Medicaid to cover low-income adults and children with incomes up to 133 percent of FPL. (Section 2001) ⇒ Millions of low-income parents, non-disabled adults who do not have dependent children (and who are generally ineligible for Medicaid today except in a small number of states) will become newly eligible for health coverage through Medicaid as a result. ⇒ In some instances, children now covered through the Children’s Health Insurance Program (CHIP) will become newly eligible for health coverage. ⇒ The coverage expansion to individuals with incomes up to 133 percent of the FPL represents a sharp increase in coverage and the state increase in spending will be 3.0% in NM. ⇒ Increase in adult Medicaid enrollment relative to New Mexico baseline with lower participation rate assumption is 28.3% with a state cost of \$194 million and a \$4.5 billion federal match or an increase in adult Medicaid enrollment relative to New Mexico baseline with the higher participation rate is 39.4% with a state cost of \$278 million and a \$5.6 billion federal match. ⇒ Basic match from federal government for existing enrollees remains at 66-75%. ⇒ Federal government enhancement match for expansion enrollees will be 100% for 2014-2016, 95% for 2017, and 90% for 2020 on.

MEDICAID TODAY

There are approximately 40 categories of eligibility within New Mexico Medicaid. Some of these include the following. The Medical Assistance Division is responsible for all Fee for Service (FFS) provider payments as well. Enrollment through February 2011 was 503,000 individuals in New Mexico.

- **Salud!** is the umbrella name for New Mexico's Medicaid managed care program. Salud! Services are provided by contracted Managed Care Organizations (MCOs) to provide Medicaid services to eligible and enrolled citizens.
- **Children's Health Insurance Program (CHIP)**, formerly known as the State Children's Health Insurance Program (SCHIP), expands Medicaid coverage guidelines for children up to age 19. Through CHIP, children in households with family incomes between 185%-235% of FPL may be eligible for Medicaid coverage. Unlike traditional Medicaid coverage, CHIP requires nominal co-payments for some services received (10,884 enrolled as of 5/31/11).
- **Family Planning & Pregnancy** covers women in families whose income is below 185% of the FPL. Pregnant women may be eligible for pregnancy-related services only. Women of childbearing age may be eligible for family planning services. (24,276 enrolled as of 5/31/11)
- **JUL Medicaid** covers families with dependent children. The income eligibility mirrors that of the Temporary Assistance for Needy Families (TANF) program, known as New Mexico Works. There is no resource test for this category.
- **New MexiKids** provides no-cost or low-cost health care coverage for children ages 0-12. Health care coverage helps pay for regular check-ups, doctor visits, dental visits, hospital care, prescriptions, glasses and hearing and vision exams. The program covers children in families with household incomes up to 235% of the FPL.
- **New MexiTeens** - provides no cost or low cost health care coverage for children ages 13-19. Health care coverage helps pay for regular check-ups, doctor visits, dental visits, hospital care prescriptions, glasses and hearing and vision exams. The program covers teens in families with household incomes up to 235% of the FPL.
- **Working Disabled Individuals (WDI)** covers disabled working individuals who, because of earnings, do not qualify for Medicaid under any other programs. Individuals must meet the Social Security Administration's (SSA) criteria for disability without regard to "substantial gainful activity." The program also covers

individuals with a recent attachment to the work force. An individual is considered to have recent attachment to the work force if he/she has enough earnings in a quarter to meet the SSA's definition of a qualifying quarter or has lost SSI and Medicaid due to the initial receipt of Social Security Disability Insurance (SSDI) benefits until Medicare entitlement.

- **Native Americans** Native American Medicaid recipients who are otherwise eligible for Salud! will receive Medicaid coverage on a fee-for-service basis unless the recipient chooses to enroll with one of the four Salud! managed care organizations contracted with the state.
- **Qualified Medicare Beneficiaries (QMB)** entitles individuals to payment of Medicare premiums as well as the deductible and co-insurance amounts on Medicare-covered services. To be eligible, the applicant must already have or be conditionally eligible for Medicare Part A (Hospital Insurance).
- **Qualified Individuals 1 (QI1) & Specified Low-Income Medicare Beneficiaries (SLIMB)** entitle individuals to payment of their Medicare Part B premiums if their income is below 120% of the FPL. The SLIMB category was expanded to cover an additional group of individuals known as Qualified Individuals 1 (QI1's), if their income is between 120-135% of the FPL. The applicant must be enrolled in Medicare Part A. Medicaid does not pay the Medicare Part A premium. Since payment of the Medicare Part B premium is the only benefit, no Medicaid card is issued.

MEDICAID IN 2014

Section 2001. To provide individuals and families access to affordable, high-quality health care, PPACA expands Medicaid to cover low-income adults and children with incomes up to 133 percent of FPL. Millions of low-income parents, non-disabled adults who do not have dependent children (and who are generally ineligible for Medicaid today except in a small number of states) and, in some instances, children now covered through the Children's Health Insurance Program (CHIP) will become newly eligible for health coverage through Medicaid as a result.

The New Income and Household Size Definitions

PPACA establishes a new definition of income, Modified Adjusted Gross Income (MAGI), which will be used in determining eligibility for premium credits. MAGI is Adjusted Gross Income as determined under the federal income tax, plus any foreign income or tax-exempt interest a taxpayer receives. Assets will not be considered in determining eligibility.

Furthermore, in determining income eligibility for premium credits, an individual's family size

will be based on the number of personal exemptions an individual claims in his or her tax return (the tax filing unit). A household's income thus is the MAGI of the taxpayer, the spouse (if any), and any child or other person the individual claims as a tax dependent, including the income of any person who must report his or her income on a separate return but is still claimed as a dependent by the taxpayer. A taxpayer's family size thus would be four if the taxpayer claimed himself or herself, a spouse, and two children as exemptions on his or her tax return. In order to be eligible for the premium credit, married couples are required to file a joint tax return.

Starting in 2014, eligibility for most Medicaid and CHIP beneficiaries under age 65 will also be determined using MAGI, and family size will also be based on the tax filing unit. The family's assets will not be considered in determining eligibility. These new income eligibility rules generally will apply to all children except foster children, who automatically qualify for Medicaid, and to all adults under 65 except those who qualify for Medicaid as a disabled individual. The health reform law does *not* change Medicaid eligibility rules for beneficiaries age 65 or older or those in eligibility categories based on disability.

Implications of New Rules for Medicaid and Future Policy Considerations

Under the health reform law, states will need to make major changes to the way they conduct Medicaid eligibility determinations for individuals and families. The use of a new national standard for counting income and family size will help simplify eligibility rules and processes over the long term and help reduce the administrative cost burden of determining eligibility for Medicaid and CHIP. At the same time, however, using a tax-based definition of income and family size will bring a set of new challenges.

One such challenge involves reconciling the use of income from a prior year's tax return in determining eligibility with Medicaid rules that require eligibility determinations based on current or point-in-time income. This is particularly important since many low-income individuals do not file tax returns and/or have fluctuating incomes that may cause them to move in and out of eligibility over time.

In addition, MAGI is calculated on an annual basis, whereas Medicaid typically looks at income on a monthly basis. Thus, a process may need to be established for "projecting" the average monthly equivalent of income that is reported to individuals annually, such as interest or dividend income earned over the course of a tax year.

Despite the large overall increases in total Medicaid spending, the increase in state spending relative to the baseline is still low, i.e. 3.0% in New Mexico. The coverage expansion to individuals with incomes up to 133% of the FPL represents a sharp increase in coverage and the state increase in spending will be 3% in New Mexico. (Holahan, John and Irene Headen, [Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL](#), Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, 2010)

The increase in adult Medicaid enrollment relative to the New Mexico baseline with lower participation rate assumption is estimated at 28.3% with a state cost of \$194 million and a \$4.5 billion federal match, or an increase in adult Medicaid enrollment relative to New Mexico baseline with the higher participation rate is 39.4% with a state cost of \$278 million and a \$5.6 billion federal match.

The basic match from the federal government for existing enrollees remains at 66-75%. The federal government enhancement match for expansion enrollees will be 100% for 2014-2016, 95% for 2017, and 90% for 2020 on.

Angeles, January. Explaining Health Reform: the New Rules for Determining Income Under Medicaid in 2014. Washington, D.C.: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2011)

COVERAGE

OTHER GOVERNMENT COVERAGE

TODAY	2014
<ul style="list-style-type: none"> • New Mexico Medical Insurance Pool (NMMIP) – 8,200 enrollees The Pool was created to provide access to health insurance coverage to residents of New Mexico who are denied health insurance and considered uninsurable. • State Employee Benefits – 33,000 enrollees An eligible employee of state government or local public body includes anyone hired as classified, exempt, probationary, temporary, term or hourly and working at least 20 hours per week. • State Retirees (RHCA) – 48,000 enrollees Provides medical, pharmacy, dental, and vision plans to members in both Medicare and non-Medicare plans. These may overlap. • State Coverage Insurance (SCI) – 43,000 enrollees and 32,000 on waiting list Program offers affordable health care coverage to low-income working adults primarily through an employer-based system and is available to uninsured, low-income adults, ages 19 through 64, with countable family incomes of up to 200% of FPL. • Medicare – 309,000 enrollees. • Other Government Coverage – Military, VA, & Federal Employees – 51,000 enrollees. 	<ul style="list-style-type: none"> ⇒ Federal Insurance Pool – will be incorporated into state exchange offerings. State and federal pool could be phased in. (Sections 1101 & 1105) ⇒ State Employee Benefits and Retiree Health Care Authority – Allowed to continue as self insured plans. One year after enactment of PPACA, the Secretary of the Department of Labor will prepare an aggregate annual report on self insured plans. (Section 10101 amending Section 1253 as Section 1255) ⇒ SCI - could be converted to a premium assistance program for children and families who have access to employer sponsored insurance that is cost effective. Could also be included in a basic health plan. (Section 2003) ⇒ Medicare Improvements for Patients and Providers – all provisions of the Health Care and Education Reconciliation Act (PL 111-152) have repealed provisions in PPACA and are under current consideration by Congress. ⇒ Other Government Coverage – will be eligible for participation in state exchange.

OTHER GOVERNMENT COVERAGE TODAY

NMMIP – 8,200 enrollees

The New Mexico Medical Insurance Pool (NMMIP) was established by the 1987 New Mexico State Legislature. The Pool was created to provide access to health insurance coverage to residents of New Mexico who are denied health insurance and considered uninsurable.

NMMIP also provides health benefit portability coverage to New Mexicans who have exhausted COBRA benefits and have no other portability options available to them.

NMMIP is administered by Blue Cross and Blue Shield of New Mexico, which handles eligibility, enrollment, member services and claims processing.

State Employee Benefits – 33,000 enrollees

An eligible employee of state government or local public body includes anyone hired as classified, exempt, probationary, temporary, term or hourly if the employee is scheduled to work at least 20 hours per week and whose term of employment when hired is for six or more months.

Dependents may also be covered under the State's benefit plan if they are one of the following:

- A lawful spouse;
- Unmarried, natural children up to the age of 25;
- Adopted children;
- Stepchildren; and
- Domestic Partners (must complete Affidavit of Domestic Partnership).

State Retirees (RHCA) – 48,000 enrollees

RHCA provides medical, pharmacy, dental, and vision plans to members in both Medicare and non Medicare plans.

State Coverage Insurance (SCI) – 47,000 enrollees and 24,000 on waiting list

SCI offers affordable health care coverage to low-income working adults primarily through an employer-based system. One may enroll through his/her employer group or as an individual. SCI is available to uninsured, low-income adults, ages 19 through 64, with countable family incomes of up to 200% of FPL and who are not eligible for certain government health insurance benefits such as Medicaid (Title XIX), Medicare, private health insurance, TRICARE, and other public or private health insurance programs. There are no asset requirements required for eligibility or preexisting condition limitations.

Premium Assistance for Kids (PAK)

Pak is now available for children who are uninsured but not eligible for Medicaid coverage due

to income. PAK is an *Insure New Mexico!* Solution to expand health care coverage.

Premium Assistance for Maternity (PAM)

PAM is now available for pregnant women who are uninsured, but not eligible for Medicaid coverage due to income. Premium Assistance for Maternity (PAM) is an *Insure New Mexico!* Solution to expand health care coverage.

Medicare – 309,000 enrollees

Other Federal Coverage – Military, VA, & Federal Employees – 51,000 enrollees

OTHER GOVERNMENT COVERAGE IN 2014

Federal Insurance Pool will be incorporated into state exchange offerings. This program will provide protection for people with pre-existing conditions until 2014, when insurance companies can no longer deny coverage based on health. State and federal pool could be phased in. (Section 1101 & Sec. 1105)

State Employee Benefits and Retiree Health Care Authority will be allowed to continue as self-insured plans. One year after enactment of PPACA, the Secretary of the Department of Labor will prepare an aggregate annual report on self-insured plans. (Section 10101 amending Section 1253 as Section 1255)

This type of plan is usually present in larger companies where the employer collects premiums from enrollees and takes on the responsibility of paying employees’ and dependents’ medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered.

SCI could be converted to a premium assistance program for children and families who have access to employer- sponsored insurance that is cost effective. (Section 2003) SCI Could also be included in a basic health plan.

Medicare Improvements for Patients and Providers – The life of the Medicare Trust fund will be extended to at least 2029, a 12-year extension as a result of reducing waste, fraud and abuse, and slowing cost growth in Medicare. This will provide future cost savings on your premiums and coinsurance.

Medicare will take strong action to reduce payment errors, waste, fraud, and abuse in Medicare. The President has made a commitment to reduce Medicare fraud 50 percent by 2012. PPACA makes an historic, ten-year, \$350 million investment to prevent, detect and fight fraud in Medicare, Medicaid and the Children’s Health Insurance Program including criminal efforts to exploit the new law.

COVERAGE

STRUCTURE OPTIONS

TODAY	2014
<ul style="list-style-type: none"> • New Mexico Medical Insurance Pool (NMMIP) – 8,200 enrollees The Pool was created to provide access to health insurance coverage to residents of New Mexico who are denied health insurance and considered uninsurable. • New Mexico Health Insurance Alliance (NMHIA) - The Alliance has been providing access to small businesses and qualified individuals for more than 16 years. In recent years, the Alliance serves between 4,000–6,000 members annually. • Medicaid -There are approximately 40 categories of eligibility within New Mexico Medicaid. Some of these include the following. The Medical Assistance Division is responsible for all Fee for Service (FFS) provider payments as well. Enrollment through February 2011 was 503,000 individuals in New Mexico. • Brokers/Agents – Approximately 1000 licensed selling health products directly to consumers in the state. • Self Insured Employers – i.e. governmental bodies pooling. • Co-ops – State statute allows a nonprofit corporation to organize as a private health insurance cooperative to purchase health insurance. • Small employer group insurance – An employer who employed an average of at least two but not more than fifty employees on business days during the preceding calendar year. 7 companies and 72 plans listed on the federal website. • Large employer group insurance - An employer who employed an average of at least fifty-one employees on business days during the preceding calendar year. 	<ul style="list-style-type: none"> ⇒ Basic Health Program: In a state that implements BHP, eligible consumers may not obtain subsidized coverage in the exchange. Instead, they are covered through state contracts with health plans or providers. ⇒ American Health Benefit Program: By January 1, 2014, each state must establish a state-based exchange administered by a governmental agency or nonprofit organization, through which individuals can purchase qualified coverage. (Section 1311) ⇒ SHOP Exchange: Each state is required by PPACA to establish a Small Business Health Options Program, designed to assist small employers (i.e. with 100 or fewer employees) in the state in enrolling their employees in qualified health plans in the state’s small group market. ⇒ Insurance Co-Op: A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners. ⇒ Combined Exchange for Individuals and Small Employers -A state may elect to provide for only one state Exchange that would provide both American Health Benefit Exchange services and SHOP exchange services to both qualified individuals and qualified small employers. (Section 1311)

STRUCTURE OPTIONS TODAY

New Mexico Medical Insurance Pool (NMMIP) The Pool was created by the legislature in 1987 to provide access to health insurance coverage to residents of New Mexico who are denied health insurance and considered uninsurable.

NMMIP also provides health benefit portability coverage to New Mexicans who have exhausted COBRA benefits and have no other portability options available to them.

NMMIP is administered by Blue Cross and Blue Shield of New Mexico, which handles eligibility, enrollment, member services and claims processing.

New Mexico Health Insurance Alliance (NMHIA) The Alliance has been providing access to small businesses and qualified individuals for more than 16 years. In recent years, the Alliance has served between 4,000 – 6,000 members annually. The Alliance provides customer service while actively working statewide with Chambers of Commerce, small business development centers, and community organizations.

The Alliance is governed by a Board of Directors representing small business owners, employees and insurance carriers and was established by the State as a 501C (4) nonprofit. It does not receive any direct federal or state funding but is funded in part through assessments to insurance carriers doing business in New Mexico. The assessments are taken as 50% tax credits against premium taxes due to the State.

Medicaid There are approximately 40 categories of eligibility within New Mexico Medicaid. Some of these include:

Co-ops (SB 89) allows a nonprofit corporation to organize as a cooperative to purchase health insurance. A person may form a cooperative to purchase employer health benefit plans. A cooperative shall be organized as a nonprofit corporation and has the rights and duties provided by the Nonprofit Corporation Act. Two or more large employers or small employers or any combination of large employers and small employers with an aggregate of fifty or more full-time-equivalent employees may purchase group health benefit plans pursuant to Chapter 59A, Article 23 NMSA 1978.

Self Insured Employer (NMSA 3-62) Two or more municipalities or other political subdivisions or local public bodies may provide insurance for any purpose by any one or more of the methods specified in Chapter 3, Article 62 NMSA 1978. Self-insurance or the pooling of self-insured reserves, claims or losses among subdivisions or bodies as authorized pursuant to Sections 3-62-1 and this section NMSA 1978 shall not be construed to be transacting insurance or otherwise subject to the provisions of the laws of this state regulating insurance or insurance companies.

Small employer group insurance (NMSA 59A -23) "Small employer" means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but not more than fifty employees on business days

during the preceding calendar year and who employs at least two employees on the first day of the plan year; seven companies and 72 plans are listed on the federal website.

Large employer group insurance - (NMSA 59A-23) | “Large employer” means, in connection with a group health plan and with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.

The Medical Assistance Division is responsible for all Fee for Service (FFS) provider payments as well. Enrollment through February 2011 was 503,000 individuals in New Mexico.

STRUCTURE OPTIONS IN 2014

Basic Health Program: In a state that implements BHP, eligible consumers may not obtain subsidized coverage in the exchange. Instead, they are covered through state contracts with health plans or providers. To support these contracts, the state receives 95 percent of what the federal government would have spent if BHP enrollees had received tax credits and subsidies for out-of-pocket (OOP) costs in the exchange. The federal dollars are placed in a state trust fund and may be used only “to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in” BHP. The U.S. Department of Health and Human Services (HHS) makes one BHP payment to a state before a federal fiscal year begins, based on the best available projections. If the amount is too high or too low, HHS makes an offsetting correction in the next year’s payment. Although the issue has not been resolved by HHS, it seems likely that federal BHP funds may be used to pay BHP administrative costs. (Dorn, Stan: The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States. The Urban Institute for State Coverage Initiatives, 2011)

Section 1311. American Health Benefit Program — By January 1, 2014, each state must establish a state-based exchange administered by a governmental agency or nonprofit organization, through which individuals can purchase qualified coverage.

Section 1311. SHOP Exchange — Each state is required by PPACA to establish a Small Business Health Options Program (SHOP Exchange), designed to assist small employers (i.e. with 100 or fewer employees in the state in enrolling their employees in qualified health plans in the state’s small group market.

Section 1311. Insurance Co-Op — A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners. (Section 1311)

Section 1311. Combined Exchange for Individuals and Small Employers — A state may elect to provide for only one state Exchange that would provide both American Health Benefit Exchange services and SHOP exchange services to both qualified individuals and qualified small employers.

COVERAGE

BENEFITS

TODAY	2014
<p>No companies in New Mexico currently offer all ten essential health benefits for small employer groups or to individuals.</p> <p>Companies offering health plans to Small Employer Groups in NM:</p> <ul style="list-style-type: none"> • Blue Cross Blue Shield of New Mexico • John Alden Life Insurance Company • Lovelace Health System, Inc. • Lovelace Insurance Company • Presbyterian Health Plan • Presbyterian Insurance Plan • Time Insurance Company • Trustmark Life Insurance Company • United Healthcare Insurance Company <p>Companies offering health plans in New Mexico to individuals:</p> <ul style="list-style-type: none"> • Blue Cross Blue Shield of New Mexico • Celtic Insurance Company • Humana • Lovelace Insurance Company • Presbyterian Insurance Plan • DOL Study: Selected Medical Benefits <p>Type of plan and overall plan limits: Of employees covered by an employer health benefits plan, 79 percent received benefits under a fee-for-service arrangement (PPOs) in 2009, the remaining 21 percent were covered by a health maintenance organization (HMO).</p> <p>Covered services and cost-sharing Nearly everyone who has employment based health benefits has: medical, dental, and vision services such as hospital room and board, inpatient and outpatient surgery, and physician office visits.</p>	<p>Qualified Health Plan: (Section 1301) Under PPACA, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.</p> <p>Essential Health Benefits: (Section 1302) A set of health care service categories that must be covered by certain plans including at least the following general categories:</p> <ul style="list-style-type: none"> ⇒ ambulatory patient services; ⇒ emergency services; ⇒ hospitalization; ⇒ maternity and newborn care; ⇒ mental health and substance use disorder services, including behavioral health treatment; ⇒ prescription drugs; ⇒ rehabilitative and habilitative services and devices; ⇒ laboratory services; ⇒ preventative and wellness services and chronic disease management; and ⇒ pediatric services, including oral and vision care. <p>Levels of Coverage: (Section 1302) Qualified health plans must provide coverage of the essential benefits at either the “bronze”, “silver”, “gold”, or “platinum” levels.</p>

BENEFITS TODAY

Type of plan and overall plan limits

Of employees covered by employer health benefits plans, 79% received benefits under a fee-for-service arrangement in 2009, where payment wasn't made until services were received. The remaining 21% were covered by a health maintenance organization (HMO), generally characterized by a fixed set of benefits provided for a prepaid fee, often with restrictions on available providers. Most of those in fee-for-service plans were in the sub-category of plans known as preferred provider organizations (PPOs), where enrollees are provided medical services at a higher level of reimbursement if they receive care from designated providers.

Covered services and cost-sharing

Information on coverage and cost-sharing for roughly two dozen medical, dental, and vision services is captured as part of the ongoing survey. For certain common services, such as hospital room and board, inpatient and outpatient surgery, and physician office visits, nearly everyone who has employment-based health benefits has coverage. Other services are provided less often. For example, in 2008, hospital room and board was covered for 99% of plan participants while home health care was covered for about 73% of plan participants. In the following section, coverage and cost-sharing information is provided for many of the services included in the survey.

Coverage for hospital room and board charges is nearly universal. Twenty-nine percent of participants have such charges covered in full, with no required cost sharing. The remaining participants are subject to some limits on coverage, such as a copayment per admission. In fee-for-service plans, 92 percent of covered workers are subject to limits; only 7% have charges covered in full. Limits in fee-for-service plans include both overall plan limits, such as deductibles and coinsurances discussed previously, and separate limits imposed on the specific service, such as a copayment per hospital admission. The median copayment per admission was \$250 in both fee-for-service plans and HMOs.

Selected Medical Benefits: A Report from the Department of Labor to the Department of Health and Human Services, Washington, DC: Dept. of Labor, 2011.

BENEFITS IN 2014

Section 1301. Qualified Health Plan — Under PPACA, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Section 1302. Essential Health Benefits — A set of health care service categories that must be covered by certain plans, starting in 2014. PPACA defines essential health benefits to “include at least the following general categories and the items and services covered within the categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventative and wellness services and chronic disease management; and
- pediatric services, including oral and vision care.”

Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid State plans must cover these services by 2014. Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

Section 1302. Levels of Coverage — Qualified health plans must provide coverage of the essential benefits at either the “bronze”, “silver”, “gold”, or “platinum” levels. For bronze level plans, the level of coverage must provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan. For silver level plans, the percentage increases to 70%, the gold to 80%, and the platinum to 90% respectively.

COVERAGE

FINANCING/COSTS

TODAY	2014
<ul style="list-style-type: none"> • Medical Loss Ratio (MLR) - The Superintendent adopted the 80% MLR contained in PPACA for individually underwritten health care policies, plans, and contracts. For rate filings affecting small and large group markets, the 85% MLR as well as the definitions of market classifications contained in the Insurance Code apply. • Rate Review – A rule that requires insurers to justify unreasonable premium rate increases and post that information on the web for the public to see. Selected states reviewed in September 2011. • Waiver grants – Companies with limited benefits plans could apply for waivers and extensions through 2013. Applications will cease for these waivers on Sept. 22, 2011. • Grants – Funding for states to study, plan, and implement parts of PPACA, i.e. HIE Planning grant, RHCA early retirees, Rate Review grant, Consumer Protection grant, workforce planning grant, etc. • Medicaid – dual eligibles - Alignment initiative to effectively integrate benefits under Medicaid and Medicare. • Premiums – Over ten years, premiums more than doubled, rising by more than \$7,500 for the average family with employer sponsored insurance. 	<ul style="list-style-type: none"> ⇒ Medical Loss Ratio (MLR) – no further waivers enabled that were granted to states. MLR will be 85% for large group plans and 80% for small group plans and individual market while states may be more stringent. (Section 1001) ⇒ Rate Review – Will have been implemented. (Section 1003) ⇒ Accountable Care Organizations - A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. (Section 3022) ⇒ Bundling of Payments - A payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. (Section 3021) ⇒ Cost sharing - This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums. (Section 1402) ⇒ Review of Rules – Operating rules for two electronic health care transactions – whether a patient is eligible for coverage, and the status of a health care claim submitted to a health insurer. (Section 1104) ⇒ Premiums – In 2014, annual premiums are projected to fall and savings could be as much as \$2,300 for middle income families purchasing through exchanges.

FINANCING/COSTS TODAY

Medical Loss Ratio (MLR) A basic financial measurement used in the Affordable Care Act to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The PPACA sets minimum medical loss ratios for different markets, as do some state laws.

Prior to the enactment of PPACA, New Mexico passed its own MLR law which went into effect May 19, 2010. The Superintendent deferred enforcement of New Mexico's MLR law until after federal MLR regulations were published. The Superintendent adopted the 80% MLR contained in PPACA for individually underwritten health care policies, plans, and contracts. For rate filings affecting small and large group markets, the 85% MLR as well as the definitions of market classifications contained in the Insurance Code apply.

The provisions of PPACA that relate to MLR requirements affect policies and plans for calendar year 2011 and subsequent years and allow states to have more stringent MLR requirements.

Rate Review: A rule that requires insurers to justify unreasonable premium rate increases and post that information on the web for the public to see.

Waiver grants: Companies with limited benefits plans could apply for waivers and extensions through 2013. Applications will cease for these waivers on Sept. 22, 2011.

Grants: Funding for states to study, plan, and implement parts of PPACA. i.e. HIE Planning grant, RHCA early retirees, Rate Review grant, Consumer Protection grant, workforce planning grant, etc.

Medicaid – dual eligible: Alignment initiative to effectively integrate benefits under Medicaid and Medicare.

Premiums: From 1999 to 2009, health insurance premiums skyrocketed while Americans' wages and cost of living grew at a much slower rate. Premiums more than doubled, rising by over \$7,500 for the average family with employer-sponsored insurance. The cost of an employer-based family coverage plan rose from 12 to 22% of family income over the decade. Health insurance costs jumped as a percentage of private sector compensation from 5.4 to 7.3% from 1999 to 2009, eroding workers' wages. Small businesses were particularly hard hit. The proportion of small employers offering health insurance dropped from 65 to 59% between 1999 and 2009. Part of the reason for rising costs has been reduced competition. These

increases occurred at a time of tremendous consolidation in the insurance markets, both national and local.

PPACA increases insurance company accountability by supporting states' review of premium increases, setting standards for the amount of premiums spent on benefits versus overhead (i.e., medical loss ratios), and posting insurance price information for transparency. A Small Business Health Care Tax Credit, reinsurance for early retirees, and premium assistance for uninsured people with pre-existing conditions have already provided targeted relief for millions of insured and uninsured Americans, and these changes are making a difference. Preliminary evidence suggests that rate increases for 2011 may be lower than in previous years. In addition, roughly 16.6 million workers are eligible for the tax credits, which the Congressional Budget Office values at \$6 billion for 2010 and 2011. Several insurers are reporting a rise in small businesses offering coverage. Furthermore, tens of thousands of early retirees and thousands of uninsured people with pre-existing conditions have already gotten relief from high and often unaffordable premiums as a result of the new law's assistance.

FINANCING/COSTS IN 2014

Section 1001. Medical Loss Ratio (MLR) — No further waivers enabled that were not already granted to states. MLR will be 85% for large group plans and 80% for small group plans and individual market while states may be more stringent.

Section 1003. Rate Review — A rule that requires insurers to justify unreasonable premium rate increases and post that information on the web for the public to see.

Section 3022. Accountable Care Organizations — A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Section 3021. Bundling of Payments — A payment structure in which different health care providers who are treating patients for the same or related conditions are paid an overall sum for taking care of the condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

Section 1402. Cost Sharing — This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums. (Act Sec. 1402)

Section 1102. Review of Rules — The interim final rule issued requires compliance by health

plans, health care clearinghouses, and certain health care providers by January 1, 2013, and implements part of Section 1104 of the PPACA. It puts in place operating rules for two electronic health care transactions, making it easier for providers to determine: 1. Whether a patient is eligible for coverage, and 2. The status of a health care claim submitted to a health insurer. The new operating rules will provide greater uniformity of information and transmission formats so that physicians and other health care providers can use one type of information request for all insurers rather than being required to use multiple systems. For example, if a physician submits an electronic inquiry to a health plan about a patient's eligibility, some plans may simply respond yes or no, while others provide information that the physician needs to know at the point of service, such as patient co-pays and deductibles. Under the proposed rules, physicians will get a more detailed response when they ask about the status of a claim they have submitted to a health plan.

The new rules save an estimated \$12 billion for physicians, other health providers, and health insurance companies by reducing transaction costs in the form of fewer phone calls between physicians and health plans, lower postage and paperwork costs, fewer denied claims for physicians, and a greater ability to automate health care administrative processes.

Premiums: In 2014, annual premiums are projected to fall and savings could be as much as \$2,300 for middle income families purchasing through exchanges. These savings could be as much as \$2,300 for middle-income families purchasing through exchanges. A low-income family of four with an income of \$33,525 could save as much as \$9,900 in premiums and \$5,000 in cost sharing due to the extra help from new tax credits and cost sharing assistance. Small businesses, on average, could save up to \$350 per family policy due to lower costs in the exchanges and could get tax credits for up to 50 percent of their premiums. Even large businesses will likely see lower premiums of \$200 per family due to an increase in healthier enrollees. After 2014, analysts predict that premium growth should slow because of the PPACA, adding another \$2,000 to family savings by 2019.

The Congressional Budget Office (CBO) produced estimates of the impact of PPACA on premiums. For people purchasing non-group coverage through the exchanges, it estimated savings of 7 to 10% resulting from the increase in the size of the insurance pool as well as the nature of the new enrollees who, in light of the premium tax credits and the individual responsibility provisions, are likely to be healthier than existing enrollees. An additional 7 to 10% savings would result from providing the same set of services to the same group of enrollees – primarily because of the new rules in the market such as eliminating insurance underwriting. CBO also credits some of the savings to increased choices and competition. Together, these savings range from 14 to 20%. CBO also assumed that individuals and families would have, on average, coverage that is more comprehensive than what they have now, meaning that the savings would be offset by higher premiums due to better coverage. It is important to note that this benefit enhancement is a choice, not a requirement.

Assuming 20% premium savings, families purchasing insurance through exchanges could save

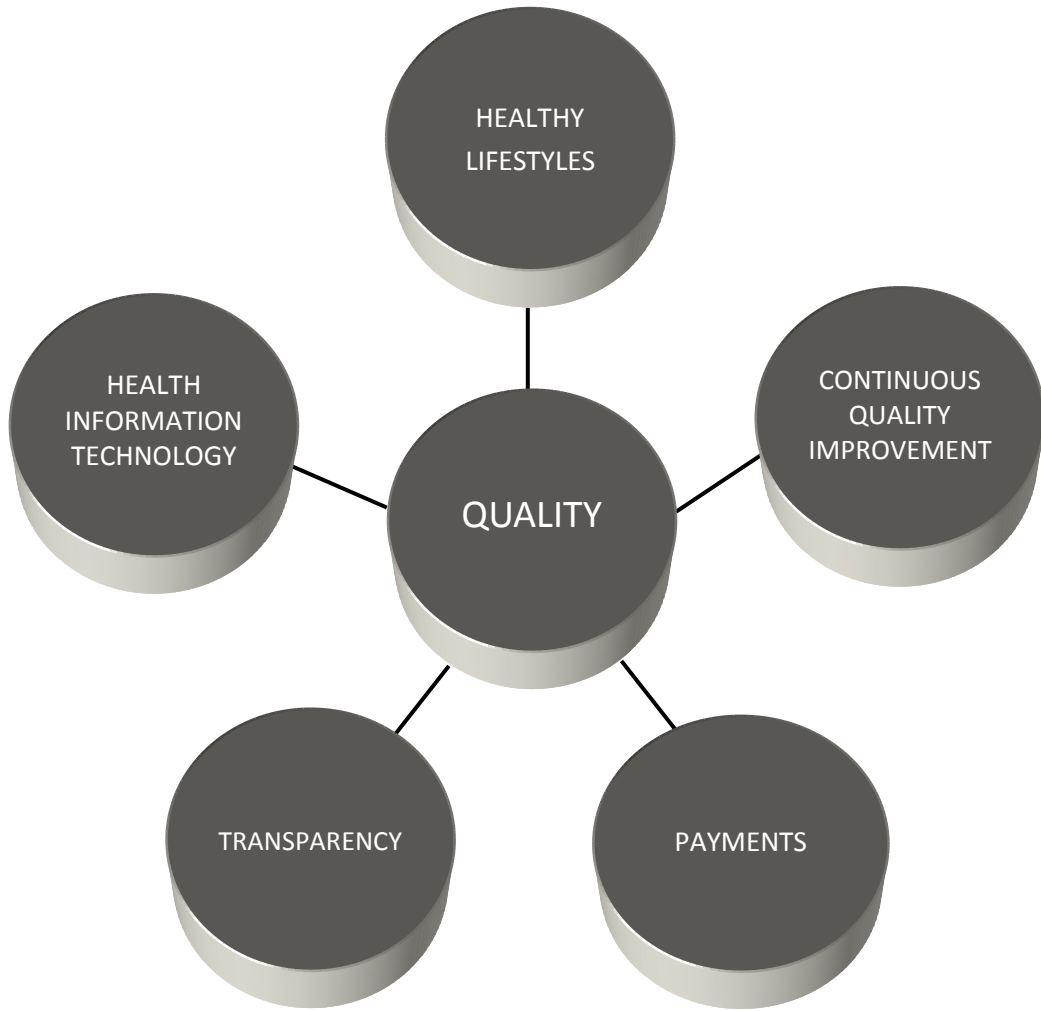
as much as \$2,300 per year and individuals could save up to \$800 in 2014 compared to individual market coverage with the same level of benefits without the law. With premium tax credits, the savings from health reform range from \$9,900 for a family of four with income of \$33,525 to \$3,500 for a family with an income of \$78,225. Premium savings are only part of the picture for low-income individuals and families. They also may qualify for reduced cost sharing under PPACA. For the same families with incomes of \$33,525 and \$78,225, this could add \$5,000 and \$1,500 respectively to the premium savings.

Cost Savings over the long term: A high priority of PPACA is not just lowering premiums, but slowing their growth over time. As such, a number of its policies aim to keep premiums affordable, including:

- **Lowering uncompensated care and administrative costs:** By insuring over 30 million Americans not now covered, the new law lowers the “hidden tax” of uncompensated care that often gets passed along to already-insured people. The law also accelerates, standardizes, and regularly updates operating rules for electronic transactions and requires health plans to certify compliance. This will make the health system more efficient by reducing the clerical burden on providers, patients, and health plans.
- **Limiting the incentive for high-cost group health insurance plans:** In order to encourage insurance plans to target efficient plan designs and reduce administrative costs, an excise tax on insurance companies and plan administrators will start in 2018 for any health coverage plan that is above the threshold of \$10,200 for single coverage and \$27,500 for family coverage (subject to phase-ins and exemptions).
- **Building rate review into Exchanges:** The law requires each Exchange to consider excessive premium increases and the reasonableness of proposed rate hikes when determining a health plan’s participation in the Exchange.
- **Targeting areas of underlying cost growth:** The law has numerous policies to test and implement ideas to coordinate care, develop innovative payment systems, reward quality and prevent medical errors, reduce waste, fraud and abuse, and empower patients and providers with information to best guide their treatments. It also makes a significant investment in evidence-based prevention. While quantifying savings over the short term is difficult, there are long term benefits to lessening preventable illness. The effects of these policies will directly and indirectly slow private premium growth.

Independent analysts suggest that the combination of these policies could slow the growth of health spending by 1 percentage point a year starting in 2014. By 2019, this could save 9% or \$2,000 for a family policy, in addition to the savings that come from the policies implemented in 2014.

QUALITY



QUALITY

HEALTHY LIFESTYLES

TODAY	2014
<ul style="list-style-type: none">• Individual businesses sometime offer wellness programs.• Health insurance plans encourage healthy lifestyles.• NM Department of Health supports creating worksite prevention programs.• NM Department of Health funds numerous prevention programs.• State employee benefits program offers a discount on deductibles when employee participates in a Health Risk Assessment.• Interagency Benefits Purchasing Collaborative (IBAC) coordinates prevention services.	<ul style="list-style-type: none">⇒ PPACA created the National Prevention Council and requires the development of a National Prevention Strategy.⇒ PPACA requires Medicaid coverage for tobacco cessation for pregnant women and funding for obesity.⇒ PPACA has funds for workplace wellness programs; healthy aging projects and prevention.⇒ PPACA requires creation of risk assessment tools.⇒ PPACA requires that Medicare pay 100% of prevention services.

HEALTHY LIFESTYLES SERVICES TODAY

Many large employers offer workplace healthy lifestyle programs which may include health risk assessment with services depending upon the results of the assessment. The State of New Mexico through the Risk Management Division offers \$100 off of the deductible if employees take the Health Risk Assessment. Once completed, health information and tips will be provided the employee as well as information on insurance coverage available for such conditions. As another example, UNM has created an Employee Health Promotion Program which emphasizes tobacco cessation, stress management, healthy eating and exercise for participating employees. Various health insurance plans have web-based health risk assessments for participant completion followed by advice and tips. According to the Albuquerque Chamber of Commerce, economic down turn has impacted employers' ability and willingness to provide such workforce programs.

The New Mexico Department of Health has a worksite health program which encourages businesses, nonprofit organizations and other government agencies to adopt new worksite wellness programs that are designed to prevent, detect and reduce modifiable risk factors for heart disease, stroke, diabetes, cancer, lower respiratory diseases and arthritis. (www.nmhealth.org/PHD/prevention.shtml 2011.) In addition, DOH's funds HIV prevention, diabetes prevention, cancer prevention, tobacco prevention and cessation, harm reduction and injury prevention through state budget cuts have significantly reduced these programs.

HEALTHY LIFESTYLES SERVICES IN 2014

PPACA created the National Prevention Council and called for the development of a National Prevention Strategy to realize the benefits of prevention to American's health. PPACA legislation looks to the federal, state, tribal, and local governments to join with business, health care, education, community and faith-based organizations to support a healthy environment and health lifestyles for America's citizens.

Numerous provisions of PPACA attempt to address prevention services and improving the health of our nation's citizens:

Section 4107. Medicaid coverage for tobacco cessation services to pregnant women – This went into effect October 2010 requiring state to provide counseling and drug therapy for pregnant women without cost sharing.

Section 4306. Childhood obesity demonstration project funding – PPACA appropriates \$25 million for obesity demonstration projects.

Section 4202. Healthy Aging, Living Well pilot programs — The Secretary will award grants to governments to conduct five-year pilots programs using interventions, screening and clinical referral to improve the health of 55 to 64 citizens.

Section 4002. Prevention and Public Health Fund – Provided \$750 million to expand prevention and public health programs.

Section 4205. Nutritional Labeling of Menu Items at Chain Restaurants – The Secretary will promulgate regulations requiring nutrition labeling for standard menu items of restaurants with 20 or more locations.

Section 4103. Health Risk Assessments – The Secretary in 2011 will establish guidelines for health risk assessments and standards for telephone and web-based risk assessment.

Section 10408. Workplace Wellness Program Grants – The Secretary will award grants to employers with comprehensive workplace wellness programs who employ less than 100 employees.

Section 4104. Removal of Cost Sharing for Medicare Prevention Services – Effective in 2011, Medicare will cover 100% of costs for preventative services.

Premium Reduction for Wellness Participation Starting January 1, 2014, PPACA enhances wellness discounts by permitting group health plans to give reductions of up to 30 percent of the cost of premiums to employees who participate in such wellness programs.

Section 4207. Break Time for Nursing Mothers - PPACA also provides that, effective immediately, employers covered by the Fair Labor Standards Act must provide reasonable break time and a private space – other than a restroom – for a nursing mother to pump breast milk for up to one year after the birth of a child.

Section 4303. Centers for Disease Control (CDC) Employer-Based Wellness Programs – The CDC will provide employers with technical assistance, consultation and resources to evaluate workplace wellness programs.

Not all of PPACA's wellness initiatives are discussed above. The enactment of PPACA signifies a heightened emphasis on personal accountability for health and wellness. While the expansion of health care screenings, vaccinations and preventative care is argued to initially result in an increase in health care costs, the goal is preventing illnesses and diseases – before they become difficult and costly to treat – will ultimately reduce spending and create a healthier America.

QUALITY

CONTINUOUS QUALITY IMPROVEMENT

TODAY	2014
<ul style="list-style-type: none"> • Increased Access to Health Care – Expansion of services offered by Community Health Centers (mental health, substance abuse, and oral health treatment) with federal grants. • Increase health insurance coverage for clinical preventative services. • Increase counseling about health behaviors. • Increase core competencies in health provider training to include health promotion and health disparities. • Medicaid managed care. • Medicare financial bonuses – Experiment with coordinating care for Medicare patients. Pre cursor to accountable care organizations. • Coalitions for quality improvement (AF4Q) – Measuring outcomes of physician and nursing care in hospitals and outpatient settings. 	<ul style="list-style-type: none"> ⇒ Accountable Care Organizations - A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. (Section 3022) ⇒ (Many other initiatives discussed Sections 3001 - 3026; 10308; 10321: 10330 – 10337) ⇒ Delivery system research – AHRQ grants. ⇒ Partnership for Patients ⇒ Continued increase in Medicaid Managed Care ⇒ Independence at Home ⇒ Hospital readmissions reduction program ⇒ Community based care transitions program ⇒ Patient navigator ⇒ Hospital value based purchasing program ⇒ Public reporting of physician performance information ⇒ Adjustment to payment for hospital payments for hospital acquired conditions

CONTINUOUS QUALITY IMPROVEMENT TODAY

There is increased access to health care and expansion of services offered by Community Health Centers (mental health, substance abuse, and oral health treatment) with federal grants.

With federal grants, New Mexico has increased health insurance coverage for clinical preventative services and increased counseling for healthy behaviors.

Grants are assisting in increasing core competencies in health provider training to include health promotion and health disparities.

Medicaid managed care is used as a tool to monitor quality improvement

Experimental Medicare financial bonuses are being used for providers to coordinate care for Medicare patients. This is a precursor to accountable care organizations.

Local initiatives, i.e. coalitions for quality improvement (AF4Q) are measuring outcomes of physician and nursing care in hospitals and outpatient settings.

CONTINUOUS QUALITY IMPROVEMENT IN 2014

PPACA seeks to increase access to high-quality, affordable health care for all Americans. To that end, the law requires the Secretary of HHS to establish a National Strategy for Quality Improvement in Health Care (the National Quality Strategy) that sets priorities to guide this effort and includes a strategic plan for how to achieve it.

The National Quality Strategy will promote quality health care in which the needs of patients, families, and communities guide the actions of all those who deliver and pay for care. It will incorporate the evidence-based results of the latest research and scientific advances in clinical medicine, public health, and health care delivery. It will foster a delivery system that works better for clinicians and provider organizations—reducing their administrative burdens and helping them collaborate to improve care. It is guided by principles (www.ahrq.gov/workingforquality) that were developed with input by stakeholders across the health care system, including federal and state agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers. Most importantly, the implementation of this Strategy will lead to a measurable improvement in outcomes of care, and in the overall health of the American people.

The National Quality Strategy will pursue three broad aims. These aims will be used to guide and assess local, State, and national efforts to improve the quality of health care.

- **Better Care:** Improve the overall quality, by making health care more patient-centered,

reliable, accessible, and safe.

- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

The six priorities of the National Quality Strategy have great potential for rapidly improving health outcomes and increasing the effectiveness of care for all populations:

- Making care safer by reducing harm caused in the delivery of care;
- Ensuring that each person and family are engaged as partners in their care;
- Promoting effective communication and coordination of care;
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- Working with communities to promote wide use of best practices to enable healthy living; and
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

These priorities can only be achieved with the active engagement of clinicians, patients, provider organizations, and many others in local communities across the country, something the National Quality Strategy supports. Since different communities have different assets and needs, they will likely take different paths to achieving the six priorities. This Strategy will help to assure that these local efforts remain consistent with shared national aims and priorities. Over time, their goal is to ensure that all patients receive the right care, at the right time, in the right setting, every time.

QUALITY

PAYMENTS

TODAY	2014
<ul style="list-style-type: none"> • \$1 Billion in federal resources appropriated for Implementation of PPACA • Early Retiree Reinsurance Program until 2014 (Section 1102) • Pre-existing Condition Insurance Plan until 2014 (Section 1101) • Payment Suspension during Fraud Investigation (Section 6402) • Productivity Increase or Decrease Adjustment for: <ul style="list-style-type: none"> ◊ Ambulatory Surgical Centers, ◊ Durable Medical Equipment, ◊ Medical Devices, ◊ Renal Dialysis Services, ◊ Hospice Care, ◊ Inpatient Acute Hospitals, ◊ Hospital Outpatient Services, ◊ Inpatient Rehabilitation Facilities, ◊ Laboratory Services (Section 3401) • Med PAC Study on Medicare Payments in Rural Areas (Section 3127) 	<ul style="list-style-type: none"> ⇒ Productivity Increase or Decrease Adjustment to Rates for: <ul style="list-style-type: none"> ◊ Ambulance Services ◊ Long Term Care Hospitals ◊ Psychiatric Hospitals (Section 3401) ⇒ New Center for Medicare and Medicaid Innovation to Test New Payment Models (Section 3021) ⇒ Accountable Care Organization Rewards (Sections 3022 and 10307) ⇒ Pilot Program on Payment Bundling (Section 3023)

PAYMENTS TODAY

Section 1002. Early Retiree Reinsurance Program – The Program provides much-needed financial relief for employers so retirees can get quality, affordable insurance.

Rising costs have made it difficult for employers to provide quality, affordable health insurance for workers and retirees while also remaining competitive in the global marketplace. Many Americans who retire without employer-sponsored insurance and before they are eligible for Medicare see their life savings disappear because of exorbitant rates in the individual market.

Section 1101. Pre-existing Condition Insurance Plan – The Plan creates a new program – the PCIP - to make health coverage available if a person has been denied health insurance by private insurance companies because of a pre-existing condition.

Section 6402. Payment Suspension during Fraud Investigations – On January 24, 2011, HHS announced new rules authorized under PPACA that will help keep bad actors from defrauding the Medicare, Medicaid and CHIP programs while protecting both patients and legitimate doctors and other providers. These new rules will help HHS do less “paying-and-chasing” fraudulent health care claims and do more proactive fraud prevention by stopping criminals from getting into the system in the first place through new provider screening. The new rules also give HHS new enforcement tool to fight fraud, such as suspending payments in cases of suspected fraud. The new rules will:

- **Create a rigorous screening process** for providers and suppliers enrolling Medicare, Medicaid and CHIP to keep fraudulent providers out of those programs. Certain types of providers and suppliers that have been identified in the past as posing a higher risk of fraud. For example, durable medical equipment suppliers will be subject to a more thorough screening process.
- **Require a new enrollment process for Medicaid and CHIP providers.** States will have to screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding government. Providers that have been kicked out of Medicare or another State’s Medicaid or CHIP will be barred from all Medicaid and CHIP programs.
- **Temporarily stop enrollment of new providers and suppliers.** Medicare and state agencies will be on the lookout for trends that may indicate health care fraud – including using advanced predictive modeling software, such as that used to detect credit card fraud. The program can temporarily stop enrollment of a category of providers or of providers within a geographic area that has been identified as high risk, as long as that will not impact access to care for patients.

- **Temporarily stop payments** to providers and suppliers in cases of suspected fraud. Under the new rules, if there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

Earlier this year, the Administration announced other rules implementing PPACA provisions to help fight fraud, including:

- Requiring all fee-for-service Medicare and Medicaid applications and claims to include the National Provider Identifier;
- Requiring physicians and eligible professionals who order or refer certain supplies, items, or services to be Medicare enrolled;
- Requiring physicians and suppliers to maintain and provide access to documentation of written orders for DME, home health or other items and services; and
- Requiring providers and suppliers file fee-for-service claims within 12 months of providing the item or service.

Section 3127. MedPAC Study on Medicare Payments in Rural Areas – The Medicare Payment Advisory Commission must review payment adequacy for rural health care providers and suppliers serving the Medicare program, including an analysis of the rural payment adjustments.

PAYMENTS IN 2014

Section 3401. Productivity – Rates will increase or decrease based on productivity for Productivity :

- Ambulance Services
- Long Term Care Hospitals
- Psychiatric Hospitals (Section 3401)

Care transitions refer to the movement of patients from one health care provider or setting to another. For people with serious and complex illnesses, transitions in setting of care, for example from hospital to home or nursing home, or from facility to home- and community-based services, have been shown to be prone to errors.

Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days. This translates to approximately 2.6 million seniors at a cost of over \$26 billion every year. Readmission rates are also high for patients covered by Medicaid and private insurance.

Medication errors, poor communication, and poor coordination between providers from the

inpatient to outpatient settings, along with the rising incidence of preventable adverse events, have drawn national attention. Health care providers and community-based organizations are aware of the negative effects of poor patient care transitions. But many struggle with fragmentation and lack of collaboration across settings, limited resources, and an expanding aging population with multiple chronic conditions.

The Department of Health and Human Services is committed to promoting high quality health care and improving patient outcomes. For example, PPACA calls for progressive reduction in Medicare payments to hospitals beginning in fiscal year 2013 based on high rates of 30-day readmissions for Medicare beneficiaries. The goal is to ensure that the hospital discharges are accomplished appropriately and that care transitions occur effectively and safely. The goal is not to avoid re-hospitalizations that are the best treatment option for an individual.

Section 3021. New Center for Medicare and Medicaid Innovation to Test New Payment Models —The Innovation Center is different from what CMS has done before. The Innovation Center will rigorously and rapidly assess the progress of its programs and work with caregivers, insurers, and employers to replicate successful innovations in communities across the country.

The initial work of the Center will focus on three areas:

- **Better Care for People:** Improving care for patients in hospitals, nursing homes, and doctors' offices, and developing ways to make care safer, more patient-centered, more efficient, more effective, more timely, and more equitable;
- **Coordinating Care to Improve Health Outcomes for Patients:** Developing new models that make it easier for doctors and nurses and other caregivers to work together to care for a patient; and
- **Community Care Models:** Exploring steps to improve public health and make communities healthier and stronger by fighting the epidemics of obesity, smoking, and heart disease.

Sections 3022 and 10307. Accountable Care Organization Rewards — An Accountable Care Organization (ACO) is a group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. PPACA includes a number of policies to help physicians, hospitals, and other caregivers improve the safety and quality of patient care and make health care more affordable. By focusing on the needs of patients and linking payments to outcomes, these delivery system reforms will help improve the health of individuals and communities and slow cost growth.

On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new rules to help doctors, hospitals, and other providers better coordinate care for Medicare patients through ACOs. ACOs create incentives for health care providers to work together to

treat an individual patient across care settings – including doctor’s offices, hospitals, and long-term care facilities.

The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

Section 3023. Pilot Program on Payment Bundling — “Bundling” is a payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

QUALITY

TRANSPARENCY

TODAY	2014
<ul style="list-style-type: none">• Aligning Forces for Quality are working in New Mexico on quality and transparency.• Numerous websites exist to help consumers compare providers and facilities.• DOH has a complaint website.	<ul style="list-style-type: none">⇒ Consumers must have access to information about health plans.⇒ Funding is available for expanding consumer assistance programs.⇒ Physicians and other providers and manufacturers must reveal financial relationships.⇒ Nursing homes/ home health agencies have new transparency requirements.

Although PPACA focuses on expansion of health insurance coverage and controlling costs, it also contains a number of provisions designed to require “transparency” on providers and financial relationships as well as information for consumers to determine the quality of providers and facilities.

TRANSPARENCY TODAY

The Robert Wood Johnson Foundation has been working with organizations in New Mexico since 2009 to bring transparency and improved care to patients through the Foundation’s Aligning Forces for Quality effort. The program has four main goals:

- To help doctors and nurses improve the quality of the care they give;
- To help patients make informed choices about their health care;
- To make data on doctors’ and hospitals’ performances available to the public; and
- To reduce the inequality of care for patients in different racial and ethnic groups.

New Mexico’s project is being headed by the Albuquerque Coalition for Healthcare Quality, an umbrella group of hospitals, health plans, primary care physicians, nurses, consumers and employers.

Websites currently exist to compare hospitals like www.hospitalcaomapre.hhs.gov or other types of health care through www.healthcare.gov/compare/. Consumer Reports also has hospital and provider rankings. Information about nursing homes in New Mexico can be seen on www.memberofthefamily.net/registry/nm.htm. The Department of Health has a website <http://dhi.health.state.nm.us/imb/imbirform.php> where complaints about health facilities may be filed. Many consumer oriented websites exist to provide health care comparisons. Angie’s List web site (www.angieslist.com) will also provide consumer-derived information about health care providers.

TRANSPARENCY IN 2014

One of the most significant realities of PPACA is the expectations for transparency. Not only will physicians have to reveal any fiduciary interest in companies with whom they do business, but nursing homes, home health agencies and other providers will have a whole new level of data collection and reporting.

Section 1001. Consumer Information – PPACA requires the Secretary to work with the National Association of Insurance Commissioners to develop standard definitions of insurance related terms and a summary form for applicants.

Section 1002. Grants for Consumer Information – PPACA appropriated \$30 million for expanding or establishing State offices of health insurance consumer assistance.

Section 1103. Information Regarding Coverage Option – The Secretary must help states create the mechanisms to assist residents and small businesses to identify affordable insurance.

Section 1311. Health Plan Transparency – PPACA requires health plans seeking certification under the Exchange laws to provide specified information.

Section 6002. Manufacturers Reporting of Payments – Manufacturers will have to begin reporting in 2013 all payments and other transfers of value given to physicians and teaching hospitals. Physicians must report ownership or investment in a manufacturer or group purchasing organization.

Section 6003. In-Office Ancillary Services Exception – PPACA will require patient notification of alternative suppliers of enhanced diagnostic imaging services other than the referring physician.

Section 6005. Pharmacy Benefit Manager Transparency – A benefit manager who manages prescription drug coverage must provide certain specific information.

Section 6101. Nursing Home Reporting – Each facility must make available to state and federal governments and eventually the public information about ownership and management of the facility.

Section 6103. Nursing Home Compare Website –The Nursing Home Compare website must include information on staffing, complaints and the number of adjudicated criminal violations by a facility or its staff.

Section 6106. Reporting of Expenditures – Nursing homes must begin reporting the wages of direct care staff broken out by RNs, LPNs, nursing aides and other staff. This information must be electronically submitted with resident census and other information.

Section 6105. Standardized Complaint Form – The Secretary must establish a standardized complaint form for use by consumers.

Section 9007. Tax Exempt Hospital Transparency – Non-profit hospitals will have to conduct a community health needs assessment every three years to determine and meet the community health needs and show they are addressing charitable needs.

QUALITY

HEALTH INFORMATION TECHNOLOGY

TODAY	2014
<ul style="list-style-type: none"> • Project Echo - Extension for Community Healthcare Outcomes is an innovative healthcare program developed to treat chronic and complex diseases in rural and underserved areas of New Mexico. • SBIRT – Screening, Brief Intervention and Treatment Program of Sangre de Cristo Community health Partnership. • NM Telehealth Alliance - Dedicated to promoting telehealth solutions to deliver quality healthcare throughout the state. • NM Primary Care Association – Pilot project to set up approximately 1/3 of the FQHCs with electronic medical records. • NM Telehealth Commission housed in the Department of Health. • Medicaid support of electronic medical records within provider groups. All reporting and billing completed electronically. • The Health Information Technology Regional Extension Center Program - New Mexico HITREC is a consortium of three nonprofit organizations: LCF Research, the New Mexico Medical Review Association (NMMRA), and the New Mexico Primary Care Association (NMPCA). • New Mexico Health Information Collaborative –The state’s designated health information exchange (HIE) network and the community collaborative that has supported its development with time and funding. • New Mexico Medical Review Association – NMMRA is the federally contracted Medicare Quality Improvement Organization (QIO) for New Mexico and the state contracted Medicaid External Quality Review Organization (EQRO). 	<ul style="list-style-type: none"> ⇒ Accountable Care Organization Rewards (Sections 3022 and 10307) - A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. ⇒ Administrative Simplification for Electronic Health Care Transactions (Section 1104) ⇒ Streamlined Health Program Enrollment (Sections 1311 & 1413) - Access and Continuity of Care requires Exchanges to evaluate and determine eligibility for applicants in Medicaid, the Children’s Health Insurance Program (CHIP), and other health programs. ⇒ Presumptive Eligibility determinations by Hospitals (Section 2202) – Allows hospitals to determine whether children, pregnant women, and certain other populations, based on preliminary information, are eligible for medical assistance under the state plan. ⇒ Improving Health Care through Health Information Technology (Section 2450) Widespread adoption of health information technology ensures patients and providers have access to accurate, private, and secure information. It can improve care quality, prevent medical errors, cut paperwork, and reduce costs—all goals of the Affordable Care Act. The American Recovery and Reinvestment Act invests nearly \$20 billion over five years for health information technologies

HEALTH INFORMATION TECHNOLOGY TODAY

Project Echo (ECHO): Extension for Community Healthcare Outcomes is an innovative healthcare program developed to treat chronic and complex diseases in rural and underserved areas of New Mexico. Through the use of technology, ECHO bridges the gap between urban healthcare specialists and providers in rural settings.

Collaboration between specialists and rural providers enables patients to receive state-of-the-art healthcare from the professionals they know and trust in their own communities. For providers, co-management of the often lengthy and involved treatments brings added depth and technical competencies and reduces professional isolation. With continued involvement providers become highly skilled in the treatment of these chronic and complex diseases, thus creating a center of excellence in their community.

ECHO has also developed relationships with Bernalillo Community Health Center, Pojoaque Primary Care, Hidalgo Medical Services, Ben Archer Community Health Centers and Health Centers of Northern New Mexico.

In addition to the partnerships already involved in ECHO, New Mexico Technet and The New Mexico Telehealth Alliance have also agreed to serve roles in the project by helping manage ongoing relations with the rural communities to adequately support the telemedicine initiative, and to promote and assist in leveraging other telemedicine applications across this network.

SBIRT: Screening, Brief Intervention and Treatment Program of Sangre de Cristo Community health Partnership.

New Mexico Telehealth Alliance: The New Mexico Telehealth Alliance is a tax-exempt 501(c)(3) non-profit corporation dedicated to promoting telehealth solutions to deliver quality healthcare throughout the state. The Alliance is a network of members representing a broad spectrum of public and private healthcare organizations. They provide technical and program support to our members and enable them to effectively share resources.

New Mexico Primary Care Association: A pilot project to set up approximately 1/3 of the FQHCs with electronic medical records.

New Mexico Telehealth Commission: Housed in the Department of Health.

Medicaid: Supports electronic medical records within provider groups. All reporting and billing is completed electronically.

The Health Information Technology Regional Extension Center Program (NM HITREC) NM HITREC is a consortium of three nonprofit organizations: LCF Research, the New Mexico

Medical Review Association (NMMRA), and the New Mexico Primary Care Association (NMPCA). Each organization brings a special expertise to this collaborative effort to assist priority primary care providers throughout the state meet the challenges in embracing the national commitment to reach "meaningful use" of electronic health records (EHRs) to improve patient care.

NM HITREC will enroll more than 1,000 priority primary care providers working in small practices and underserved areas and provide technical assistance for adopting, implementing and upgrading EHRs to improve care.

NM HITREC is able to provide direct, individualized technical assistance to priority primary care providers to guide them in adopting, implementing or upgrading certified EHR systems. Practices may be eligible for New Mexico HITREC assistance if they are primary care practitioners (such as family practice, general internal medicine, ob-gyn, and pediatrics) in small practices or serving rural and medically underserved areas.

New Mexico Health Information Collaborative (NMHIC): NMHIC is the name of New Mexico's state designated health information exchange (HIE) network and the community collaborative that has supported its development with time and funding. The collaborative includes important New Mexico stakeholders representing health care providers, payers, employers, state agencies and consumers. NMHIC was created in 2004, and continues to be fully staffed and operated by LCF Research. LCF Research is a 501(c)(3) non-profit applied health research organization.

New Mexico Medical Review Association (NMMRA): NMMRA is the state's premier and independent healthcare consulting organization dedicated to the facilitation of positive changes in the delivery of health care. NMMRA's exceptional staff, comprised of analytical, communications, medical coding, and clinical and quality improvement professionals, is widely recognized for providing education and training, technical assistance, quality of care review, and project management expertise to a variety of audiences in a number of areas. NMMRA has a well-earned reputation for working with community leaders to provide innovative solutions to healthcare challenges.

As a not-for-profit healthcare organization that has served New Mexico since 1984, NMMRA offers a wide array of services to its clients. NMMRA is the federally contracted Medicare Quality Improvement Organization (QIO) for New Mexico and the state-contracted Medicaid External Quality Review Organization (EQRO).

While NMMRA provides quality improvement expertise and services through its federal and state contracts, it also assists organizations outside of New Mexico in quality improvement initiatives. NMMRA partners with stakeholder organizations and uses a client-focused and collaborative approach in working with providers, Medicare beneficiaries, consumers, payers and others to improve care.

HEALTH INFORMATION TECHNOLOGY IN 2014

Sections 3022 and 10307. Accountable Care Organization Rewards

A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

PPACA includes a number of policies to help physicians, hospitals, and other caregivers improve the safety and quality of patient care and make health care more affordable. By focusing on the needs of patients and linking payments to outcomes, these delivery system reforms will help improve the health of individuals and communities and slow cost growth.

On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new rules to help doctors, hospitals, and other providers better coordinate care for Medicare patients through ACOs. ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities.

The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary.

Sections 1311 and 1413. Streamlined Health Program Enrollment

Access and Continuity of Care requires Exchanges to evaluate and determine eligibility for applicants in Medicaid, the Children's Health Insurance Program (CHIP), and other health programs. Exchanges must also comply with all applicable federal statutes relating to nondiscrimination. The federal government will provide critical building blocks and financial support for achieving an efficient enrollment process including verification of eligibility for tax credits. Successful Exchanges will use those building blocks to streamline access for consumers, while also promoting seamless access for applicants eligible for other health programs beyond the Exchange coverage options. Successful Exchanges will upgrade information technology (IT) systems and other business operations, and improve continuity of care across health programs.

Accountability requires transparency and requires public reports on Exchange activities, additional reporting, which should include standardized data reporting on price, quality, benefits, consumer choice and other factors that will help measure and evaluate performance. Successful Exchanges must ensure public accountability in areas such as objective information on the performance of plans; availability of automated comparison functions to inform consumer choice; fair and impartial treatment of consumers, plans and other partners; and prohibitions on conflict of interest.

Section 2202. Presumptive Eligibility determinations by Hospitals

This section allows hospitals to determine whether children, pregnant women, and certain other populations, based on preliminary information, are eligible for medical assistance under the state plan.

Section 2450. Improving Health Care through Health Information Technology

Widespread adoption of health information technology ensures patients and providers have access to accurate, private, and secure information. It can improve care quality, prevent medical errors, cut paperwork, and reduce costs—all goals of the PPACA. The American Recovery and Reinvestment Act invests nearly \$20 billion over five years for health information technologies

INVENTORY OF PAST STATEWIDE HEALTH CARE REFORM IMPLEMENTATION ACTIVITIES

Legislative Health & Human Services Committee Report for 2011 (attachment)

This is the final legislative report written by LHHS staff following the conclusion of the 2011 Legislative session.

<http://www.nmlegis.gov/Sessions/InterimCommittees/LHHS/2010/Endorsed%20Legislation/MATRIX%20-%20LHHS%20Proposed%20Bills%202011.pdf>

SJM 1 Report

SJM1 created a working group comprised of legislators and consumers who met over a period of 6 months to receive input and recommendations from the public and advisory groups concerning the implementation of PPACA in New Mexico.

http://www.nmprc.state.nm.us/insurance/pdf/SJMI_TASKFORCE/SJM1%20Final%20Report%20of%20Healthcare%20Reform%20Working%20Group.pdf

Governor's Health Care Reform Task Force – Transition Report

Governor Richardson by executive order appointed a cabinet task force to work on health care reform. The group provided a transition document to the new administration.

<http://www.hsd.state.nm.us/pdf/hcr/OHCR%20Transition%20Plan%20122710.pdf>

2011 Legislative Session Report (attachment)

This report highlights all health reform legislation from the 2011 Legislative Session. NMLR Report from Resources for Change

PPACA funding to New Mexico (attachment)

The Human Service Department keeps track of all available grants through PPACA and other federal legislation. It includes some information on which entities in New Mexico responded to grant RFPs, but it is incomplete.

<http://www.hsd.state.nm.us/pdf/hcr/HCRSpreadsheet6-30-11.pdf>

Governor's Letters to HHS (attachment)

In February of this year, Governor Martinez signed a letter along with 20 other Republican governors requesting more flexibility with PPACA.

<http://www.kaiserhealthnews.org/Stories/2011/February/10/Text-GOP-Governors-Letter-To-Sebelius.aspx>

Health Care Reform (including insurance) (2011 Reg)

Bill: HB33
Sponsors: Picraux (D25); Feldman (D13)
Title: NEW MEXICO HEALTH INSURANCE EXCHANGE ACT
Summary: (For the Legislative Health and Human Services Committee) (Identical to SB38) Creates a nonprofit public corporation, the New Mexico Health Insurance Exchange, to offer qualified health plans to qualified individuals and small groups by January 1, 2014. "To the extent possible," operationally and under law, the Exchange is intended to assume the functions of the N.M. Health Insurance Pool (Sec. 59A-54-1 through 59A-54-21) and the N.M. Health Insurance Alliance (Sec. 59A-56-1 through 59A-56-25). The Pool now offers health insurance to residents considered uninsurable; the Alliance offers health insurance to eligible small businesses and individuals.
History: 02/24/2011—H Withdrawn from House Calendar.
02/24/2011—H Referred to House Health & Government Affairs.

DEAD

Bill: HB34
Sponsors: Picraux (D25); Feldman (D13)
Title: MANAGED CARE, MEDICAL-HOME PROGRAM REQUIRED
Summary: (For the Legislative Health and Human Services Committee) Amends the Public Assistance Act to provide that, beginning FY2012, the Human Services Department include contractual specifications in all Medicaid, State Children's Health Insurance Programs, and State Coverage Initiative Program contracts with managed-care organizations to allocate funds to establish and maintain a medical home program (MHP).
History: 03/25/2011—H Enrolled and engrossed.
03/25/2011—H Signed by Officers of House.
03/25/2011—S Signed by Officers of Senate.

POCKET VETO BY GOVERNOR

Bill: HB37
Sponsors: Picraux (D25)
Title: INTERIM LEGISLATIVE COMMITTEES ON HEALTH AND HUMAN SERVICES
Summary: Restructures interim legislative committees relating to health and human services. Changes the name of the Legislative Health and Human Services Committee to the Legislative Health Committee. Creates an interim Human Services Committee and abolishes the interim Welfare Reform Committee, transferring its duties and responsibilities into the new creation.
History: 01/27/2011—H Reported Do Pass by House Health & Government Affairs.

DEAD

Bill: HB94
Sponsors: Picraux (D25)
Title: HEALTH POLICY AND FINANCE DEPARTMENT
Summary: Establishes a cabinet-level Health Policy and Finance Department to be headed by a secretary appointed by the governor with the consent of the Senate. The administration of medical assistance programs is transferred to the new department over a three-year period.
History: 01/19/2011—H Also referred to House Appropriations & Finance.

DEAD

Bill: HB99
Sponsors: Espinoza (R59)
Title: DEFINITIONS OF "ANESTHESIOLOGIST" AND "ANESTHESIOLOGIST ASSISTANT"
Summary: Changes the definitions of "anesthesiologist" and "anesthesiologist assistant" to remove the requirement that the qualifying candidate be employed by The Department of Anesthesiology at The UNM Medical School.
History: 02/10/2011—H Reported Do Pass by House Health & Government Affairs.
DEAD

Bill: HB103
Sponsors: Chavez, Eleanor (D13)
Title: HIGHER ED: STATEWIDE NURSING PROGRAM
Summary: Requires the Higher Education Department to develop a statewide nursing program to be used by all public post-secondary institutions with a nursing program. The new program would provide for a common curriculum; shared use of nursing faculty; plan for dual credit among post-secondary institutions; and between them and secondary schools, shared use of clinical sites and other operational considerations.
History: 03/10/2011—S Reported Do Pass by Senate Public Affairs.
DEAD

Bill: HB187
Sponsors: Sandoval (D17)
Title: COMMUNITY DENTAL HEALTH PROVIDERS
Summary: Amends the NM Drug, Device and Cosmetic Act and the Dental Health Care Act to provide for expanded-function dental auxiliaries and community dental health coordinators and reconciles multiple amendments enacted in Laws 2003.
History: 04/07/2011—**G Signed by the Governor (Ch. 113, Laws 2011).**

Bill: HB223
Sponsors: Chavez, Eleanor (D13)
Title: CAP ON HOSPITAL CHARGES FOR UNINSURED PATIENTS
Summary: Based on a legislative finding that uninsured, state resident hospital patients are more likely to pay for hospital services when they feel that a fair price is being charged, this bill limits those charges to no more than 115 percent of the federal Medicare rate.
History: 01/27/2011—H Introduced and referred to House Health & Government Affairs.
01/27/2011—H Also referred to House Labor & Human Resources.

Bill: HB240
Sponsors: Stapleton (D19)
Title: INSURANCE SUPERINTENDENT TO SEND ORDERS AND NOTICE BY CERTIFIED MAIL
Summary: Requires that the Superintendent of Insurance, or designee, send orders and notices in person or by certified mail, return receipt requested. If mailed, the order or notice is to be deemed given ten days after mailing; and the affidavit of the person who mailed it shall be prima facie evidence that notice was given.
History: 03/17/2011—S Reported Do Pass by Senate Judiciary.
DEAD

Bill: HB245
Sponsors: Gonzales (D42)
Title: PRIVATE HEALTH INSURANCE PURCHASING COOPERATIVES
Summary: Proposes to enact the Private Health Insurance Purchasing Cooperative Act, pursuant to which large or small employers in the state could form cooperatives organized as nonprofit corporations in order to purchase employer health benefit plans or health insurance from carriers.

organizations, nonprofit health care organization or other entities providing health insurance or benefit plans.

History: 03/17/2011—H Passed 66-0.
03/17/2011—S Received in the Senate.
03/17/2011—S Introduced and referred to Senate Finance.

DEAD

Bill: **HB246**
Sponsors: Gonzales (D42)
Title: AMENDING THE HEALTH INSURANCE ALLIANCE ACT
Summary: Amends the Health Insurance Alliance Act to provide membership in the Health Insurance Alliance to companies with more than 50 employees (current law limits participation to small companies with 50 or fewer workers). The determination of whether an employer is small or large is based on whether the company employed at least 50 workers during either one of the previous two years. For employers that have not been in business for a calendar year, the determination is based on how many workers the company may reasonably be expected to employ.

History: 01/31/2011—H Introduced and referred to House Health & Government Affairs.
01/31/2011—H Also referred to House Business & Industry.

DEAD

Bill: **HB257**
Sponsors: Chavez, Eleanor (D13)
Title: LFC HEALTH BENEFITS PLAN DESIGNS AND ANALYSIS
Summary: (For the Legislative Finance Committee) Requires the LFC, in collaboration with the Governor's office, the Human Services Department, the Department of Health, the PRC's Insurance Division, the LCS and other experts, to perform a fiscal impact analysis of certain health care finance and administration plan designs. Appropriates \$100,000 from the General Fund to the Legislative Finance Committee to meet the federal requirement for cost sharing.

History: 02/28/2011—H Opened for floor debate.
02/28/2011—H Failed to pass 32-36.

DEAD

Bill: **HB266**
Sponsors: McMillan (R37)
Title: HEALTH CARE SCOPE OF PRACTICE
Summary: (Similar to SB 161) Provides a procedure for an objective review of proposed changes in the scope of practice of licensed health care professionals, and for submitting findings to the governor and Legislature. Cited as the Scope of Practice Act, the bill authorizes a member of the licensing board, a licensee, or any other person seeking a change in the scope of practice of a health profession to notify the appropriate licensing board and request a hearing. The licensing board must collect data, conduct a technical assessment, and report findings and recommendations to the New Mexico Health Policy Commission.

History: 02/22/2011—H Reported Do Not Pass but Do Pass as substituted without recommendation by House Health & Government Affairs.

DEAD

Bill: **HB267**
Sponsors: Trujillo (D45)
Title: LIMITS ON MEDICAL MALPRACTICE AWARDS
Summary: (Identical to SB333) Changes the title of the Medical Malpractice Act to the New Mexico Medical Professional Liability Act and imposes limits on the amounts that may be awarded in medical malpractice suits against medical providers, hospitals, hospital affiliates and other business entities.

History: 04/07/2011—**G Vetoes by the Governor.**

Bill: **HB295**

Sponsors: Bandy (R3)

Title: EMPLOYEES OF ASSOCIATION MEMBERS GET HEALTH INSURANCE

Summary: Provides that any group health insurance policy issued to an association pursuant to the Insurance Code shall also insure an individual who is employed by a member of the association, as long as that individual's job duties are substantially related to the purposes for which the association was organized.

History: 03/17/2011—H Passed 64-0.

03/17/2011—S Introduced and referred to Senate Corporations & Transportation.

DEAD

Bill: **HB305**

Sponsors: Powdrell-Culbert (R44)

Title: PENALTIES FOR ASSAULT AND BATTERY IN NURSING FACILITIES

Summary: Expands the definition of "health care facility" to include skilled nursing facilities, nursing facilities, and other long-term residential care facilities (current law specifically excludes such facilities) for the purpose of including workers at these facilities in the existing penalty schedules regarding assault and or battery on health care workers.

History: 02/02/2011—H Introduced and referred to House Business & Industry.

02/02/2011—H Also referred to House Judiciary.

DEAD

Bill: **HB323**

Sponsors: Herrell (R51); James (R24)

Title: INTERSTATE HEALTH CARE FREEDOM COMPACT

Summary: Cited as the Interstate Health Care Freedom Compact, the measure proposes a legal framework to oppose implementation of a federal health care plan that would require participation by residents of New Mexico. Authorizes the Governor to enter into a compact agreement with other states (two states would make a compact) to join together in making it a crime to interfere with a person's exercise of a state's health care freedom laws (defined as any state law that protects and guarantees a resident's freedom to pay or not to pay directly for lawful health care services and to participate or not to participate in health care plans and health care systems).

History: 02/02/2011—H Introduced and referred to House Health & Government Affairs

DEAD

Bill: **HB334**

Sponsors: Stewart (D21); Picraux (D25)

Title: HEALTH INSURANCE: PROHIBITED DISCRIMINATION

Summary: Provides that group and individual health care coverage issued the Health Care Purchasing Act, the Insurance Code and the Health Maintenance Organization Law shall not discriminate with respect to the participation or reimbursement of any health care provider who acts within his scope of practice.

History: 02/03/2011—H Introduced and referred to House Business & Industry.

DEAD

Bill: **HB372**

Sponsors: Lewis (R60); Brown (R55)

Title: EXTENDING IMMUNITY FROM LIABILITY TO PAID EMERGENCY RESPONDERS

Summary: Relates to civil liability; amends the Public Health Act to provide immunity to persons who, under current law, are liable for their acts, if being done for remuneration, at an emergency scene. Applies to emergency situations where a person comes to the aid of

another by providing care or assistance in good faith, usually at the scene of an emergency. Under existing law, the immunity from liability granted to a person from an act or omission (except acts of gross negligence) does not extend to persons who are being paid, or expect to be paid for their services, or to a person who was at the accident scene soliciting business. This bill does away with that exception and extends immunity to everyone, regardless of whether they are being paid or not, or whether they are attempting to solicit business.

History: 03/12/2011—H Reported without recommendation as amended by House Consumer & Public Affairs.

DEAD

Bill: **HB373**

Sponsors: King (D50); Picraux (D25); Varela (D48)

Title: HSD MEDICAID FISCAL IMPACT ANALYSIS

Summary: Proposes a new section to the Public Assistance Act requiring the Human Services Department secretary to submit a written fiscal impact analysis to the LFC and DFA at least 60 days prior to submitting proposed changes to the state Medicaid plan for federal approval, applying for federal approval of a waiver of plan requirements, or approval of amendments to an existing waiver.

History: 03/24/2011—H Enrolled and engrossed.
03/24/2011—H Signed by Officers of House.
03/24/2011—S Signed by Officers of Senate.

POCKET VETO BY GOVERNOR

Bill: **HB380**

Sponsors: James (R24); Brown (R55)

Title: PROHIBITS REPRODUCTIVE HEALTH SERVICES IN SCHOOLS

Summary: Prohibits all school health centers from offering reproductive health services, to include advice or health care related to contraception, abortion, sexually transmitted diseases, and reproductive processes and functions.

History: 02/07/2011—H Introduced and referred to House Consumer & Public Affairs.

DEAD

Bill: **HB432**

Sponsors: Cook (R56)

Title: INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE PILOT PROJECT

Summary: (Identical to SB450) By January 1, 2012, requires the Interagency Behavioral Health Purchasing Collaborative to implement a pilot project for a network of behavioral health providers to form a partnership with another entity for at least two years to provide behavioral health services and managed care as a regional behavioral health entity. The network providers must have at least 51 percent control of the partnership. The collaborative is required to design the project to meet criteria for licensure as a risk-bearing entity by the Insurance Division of the Public Regulation Commission.

History: 03/17/2011—**G Signed by the Governor (Ch. 5, Laws 2011, 3/17/11).**

Bill: **HB454**

Sponsors: Irwin (D32)

Title: RISK RETENTION GROUPS PROHIBITED FROM WRITING MALPRACTICE LIABILITY INSURANCE

Summary: Amends the Insurance Code's Risk Retention and Purchasing Group Act to include health care provider malpractice liability insurance among the types of insurance that a risk retention group is prohibited from writing. A risk retention group is defined as a host of entities whose primary activity consists of assuming and spreading the liability exposure of its group members and whose activities do not include the provision of other lines of insurance.

History: 02/10/2011—H Introduced and referred to House Business & Industry.
DEAD

Bill: **HB493**
Sponsors: Park (D26)
Title: PATIENT BILL OF RIGHTS
Summary: Cited as the "Katie Faith Martinez Patients' Bill of Rights Act," the bill lists rights that are guaranteed to all health care patients in New Mexico, requires health care facilities to provide patients with a copy of the list, and provides procedures for patients whose rights have been violated to complain to the New Mexico Medical Board. The rights of patients are:

History: 03/11/2011—H Referred to House Judiciary.
DEAD

Bill: **HB514**
Sponsors: Chavez, Eleanor (D13)
Title: ENCOURAGES REPORTING OF IMPROPER PATIENT CARE
Summary: The Conscientious Health Care Employee Protection Act encourages health care professionals to notify appropriate public bodies of any improper quality of patient care. Prohibits an employer of four or more health care professionals from retaliating against employees who report an employer practice that constitutes improper quality of care, cooperate with an investigating agency, or refuse to participate in the employer practice. "Improper quality of patient care" means a practice that violates any law, rule or best practice standard.

History: 03/12/2011—S Introduced and referred to Senate Judiciary.
DEAD

Bill: **HB540**
Sponsors: Picraux (D25)
Title: PUBLIC EMPLOYEE HEALTH INSURANCE PREMIUM INCENTIVES BASED ON WELLNESS
Summary: Requires the Risk Management Division of the General Services Department to establish a results-based wellness incentive program intended to be operational by July 1, 2012. The program would tie the cost of a public employee's premium for group benefits self-insurance plan health care coverage to the employee's and the employee's dependents' status, which must be based on health risk evaluations.

History: 02/16/2011—H Introduced and referred to House Labor & Human Resources.
DEAD

Bill: **HB552**
Sponsors: Taylor, T. (R1)
Title: MEDICAL MALPRACTICE LIABILITY LIMITS
Summary: Proposes the Hospital Liability Act to specify that the maximum amount for all noneconomic damages arising from a malpractice claim for personal injury or death against a hospital health care worker shall be \$500,000 (adjusted for changes in the CPI after July 2011); the maximum amount recoverable for punitive damages is set at \$2 million.

History: 03/10/2011—H Reported Do Pass by House Business & Industry.
DEAD

Bill: **HB560**
Sponsors: Espinoza (R59)
Title: HEALTH CARE PURCHASES INCOME TAX CREDIT
Summary: Authorizes individuals to claim a refundable income tax credit against personal income tax in an amount equal to the premium for health care insurance purchased for the individual's spouse and dependents multiplied by a percentage, which varies by income

from 98 percent for persons with adjusted gross income of up to 133 percent of the federal poverty level to 90.5 percent for persons whose adjusted gross income is up to 399% of federal poverty level.

History: 02/17/2011—H Introduced and referred to House Consumer & Public Affairs.
DEAD

Bill: **HB580**
Sponsors: Maestas (D16)
Title: STANDARDS FOR PRESCRIBING SCHEDULED DRUGS FOR CHRONIC PAIN MANAGEMENT
Summary: Provides protocols and criteria for prescribing controlled substances to patients who seek care for pain management. Includes a web-based clearinghouse of patient information that prescribers must consult before prescribing certain controlled substances.
History: 02/17/2011—H Introduced and referred to House Business & Industry.
DEAD

Bill: **HB584**
Sponsors: McMillan (R37)
Title: HEALTH BENEFIT EXCHANGE ACT
Summary: (Similar to HB33, SB38, and SB370) Creates a nonprofit public corporation, the New Mexico Health Benefit Exchange, to certify and make qualified health plans available to qualified individuals and qualified employers by January 1, 2014. Directs the Exchange to report to the First Session of the 51st Legislature with recommendations for transition to the Exchange of all functions of the N.M. Medical Insurance Pool (Sec. 59A-54-1 through 59A-54-21) and the N.M. Health Insurance Alliance (Sec. 59A-56-1 through 59A-56-25). The Pool now offers health insurance to residents considered uninsurable; the Alliance offers health insurance to eligible small businesses and individuals.
History: 02/17/2011—H Introduced and referred to House Health & Government Affairs.
DEAD

Bill: **HB590**
Sponsors: Park (D26)
Title: MEDICAL MALPRACTICE RECOVERY
Summary: Under current law, the amount recoverable by all persons arising from any injury or death to a patient as a result of malpractice cannot exceed \$600,000. Beginning January 1, 2012, this limit would be raised to \$1.5 million per occurrence. Neither the current nor the proposed limit excludes additional liability for punitive damages and medical care and related benefits. Beginning July 1, 2013, and each year thereafter, the maximum recoverable amount is adjusted to the percentage change in the Consumer Price Index.
History: 02/17/2011—H Introduced and referred to House Business & Industry.
DEAD

Bill: **HJM9**
Sponsors: Stewart (D21)
Title: STATE HEALTH INSURANCE PROGRAM WAIVER DATE
Summary: Seeks to change the federally mandated date for filing a state health insurance program innovation waiver from January 1, 2017 to January 1, 2013. Under the Patient Protection and Affordable Care Act, states are required to set up health insurance exchanges by 2014 but are not eligible to apply for a waiver for state innovation until 2017. Copies of this memorial are to be delivered to members of the New Mexico congressional delegation and the governor.
History: 03/17/2011—S Reported Do Pass by Senate Public Affairs.
DEAD

Bill: **HJM12**
Sponsors: Picraux (D25)

Title: PUBLIC HEALTH OBJECTIVES AND NEEDS
Summary: Requests a collaborative review of public health objectives and needs by the Department of Health, the University of New Mexico schools of medicine, nursing, and health sciences, and New Mexico managed care organizations. Recommendations will align New Mexico with national goals found in "Healthy People-2020" and funding for implementation will be pursued through the federal Patient Protection and Affordable Care Act. Report will be made to the interim Legislative Health and Human Services Committee and the Legislative Finance Committee by October 1, 2011.
History: 03/17/2011—S Reported Do Pass by Senate Public Affairs.
DEAD

Bill: HJM14
Sponsors: Chavez, Eleanor (D13)
Title: NURSING EDUCATION
Summary: Requests the Higher Education Department to track funding for nursing education through the Nursing Program Enhancement Fund, the Higher Education Funding Formula and other funding for nursing education. The department must report its findings on the uses and distributions of the funds to the Legislature. It must report its progress toward developing a statewide plan for nursing education to the interim Health and Human Services Committee by November 2011.
History: 03/18/2011—S Reported Do Pass by Senate Education.
DEAD

Bill: HJM40
Sponsors: Madalena (D65); Jeff (D5)
Title: COLLABORATIVE HEALTH CARE REFORM FOR AMERICAN INDIANS
Summary: Calls upon Native American pueblos, tribes, and nations to collaborate in establishing a mechanism to engage in planning and to capitalize on opportunities to reform health care for American Indians in New Mexico.
History: 03/31/2011—S Signed by Officers of Senate.

Bill: HJM50
Sponsors: Stewart (D21); Miera (D11)
Title: MEDICAID SCHOOL-BASED SERVICES STUDY
Summary: Requests the interim Legislative Health and Human Services Committee to study and compare current New Mexico Medicaid school-based services program practices with those of other states and consider strategies that will maximize Medicaid reimbursements and eliminate procedural barriers.
History: 03/14/2011—S Reported Do Pass by Senate Education.
DEAD

Bill: HJR23
Sponsors: Chasey (D18); Egolf (D47)
Title: CA: SUPERINTENDENT OF INSURANCE IS AN ELECTED STATE OFFICE
Summary: Proposes to amend Articles 5 and 11 of the Constitution to provide that the Superintendent of Insurance is an elected state office (similar to the offices of State Auditor, Secretary of State, State Treasurer and Attorney General), elected for a four-year term and responsible for regulating insurance companies and others engaged in risk assumption.
History: 02/16/2011—H Introduced and referred to House Business & Industry.
DEAD

Bill: SB5
Sponsors: Cisneros (D6); Gonzales (D42)
Title: HEALTH SECURITY ACT

Summary: (For the Legislative Health and Human Services Committee) (Substantially similar to 2009 SB281 and HB339; 2008 SB3 and HB214; 2007 SB720 and HB1222) The Health Security Act provides health care coverage available to all New Mexicans through a combination of public and private financing. Participation is mandatory for holders of private insurance. Seeks to control escalating health care costs and improve health care for all New Mexicans. The act creates a Health Care Commission, charged with developing and adopting a five-year Health Security Plan designed to provide comprehensive health care benefits, including preventive health care and primary, secondary and tertiary health care for acute and chronic conditions. The plan may provide for certain preventive health care to be offered to all New Mexicans, regardless of a person's eligibility to participate as a beneficiary. An individual is eligible for coverage if physically present in the state for one year prior to the date of application for enrollment. Private insurance may not be provided to a beneficiary for health care that is covered by the plan; however, a beneficiary may purchase private, supplemental benefits and insurance for benefits not covered under the plan.

History: 03/08/2011—S Reported Do Pass by Senate Judiciary.
DEAD

Bill: **SB14**
Sponsors: Feldman (D13); Picraux (D25)
Title: HEALTH CARE WORK FORCE DATABASE
Summary: (For the Legislative Health and Human Services Committee) Subject to the availability of federal, state or private funding, the Secretary of Health is directed to create and maintain a health care work force database.

History: 04/08/2011—**G Signed by the Governor (Ch. 152, Laws 2011).**

Bill: **SB15**
Sponsors: Feldman (D13); Picraux (D25)
Title: GOVERNMENT REORGANIZATION: HEALTH POLICY AND FINANCE DEPARTMENT
Summary: Both a reorganization and substantive law measure that Creates the Health Policy and Finance Department, headed by a cabinet-level secretary and initially comprised of five major divisions: Administrative Services Division, Medical Assistance Division, Behavioral Health Services Division, Long-Term Services Division, and the Health Policy and Planning Division. The divisions will be headed by directors who are exempt from the Personnel Act as is a Director of Communications. The Legislature is given statutory authority to oversee all aspects of medical assistance and health-related programs.

History: 01/18/2011—S Introduced and referred to Senate Rules.
DEAD

Bill: **SB16**
Sponsors: Feldman (D13); Picraux (D25)
Title: PHARMACY BENEFITS MANAGER REGULATION ACT
Summary: (Similar to 2009 SB295) Under current law, pharmacy benefit managers (PBM) are not licensed or regulated by the state. Provides for such regulation to be administered by the Insurance Division of the Public Regulation Commission.

History: 03/18/2011—H Reported Do Pass by House Judiciary.
DEAD

Bill: **SB22**
Sponsors: Ortiz y Pino (D12)
Title: HEALTH CARE PROVIDER PROTECTION AND OMBUDSMAN ACTS
Summary: (For the Legislative Health and Human Services Committee) Creates the Health Care Provider Protection Act and the Managed Health Care Ombudsman Act. Both acts contemplate the provision of insured health care services under a Managed Health Care Plan on a capitated or prepaid flat-rate basis by a network of health care professionals and facilities to an individual or other legal entity. The Insurance Division of PRC would

create and operate a Managed Health Care Ombudsman Office to investigate patient and Provider complaints; to work with each Managed Health Care Plan's consumer assistance office to protect patient and Provider rights; to resolve disputes through informal and formal means; and to contract with independent organizations to operate an ombudsman program to advocate on behalf of individuals and Providers. The ombudsman program would be independent from any state agency or health care plan.

History: 03/03/2011—S Reported Do Not Pass but Do Pass as substituted by Senate Corporations & Transportation.

DEAD

Bill: **SB34**

Sponsors: Leavell (R41)

Title: LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Summary: (For the Economic and Rural Development Committee) (Identical to 2009 SB75 as amended by SCORC) This 73-page bill substantially amends the Life and Health Insurance Guaranty (LHIG) Law, Secs. 59A-42-1 through 59A-42-16, renaming it the LHIG Association Act. It adds definitions, expands the coverage as well as the limitations on claim payments under certain insurance policies, expands the powers and duties of the LHIG Association, amends the types of accounts and assessments covered by the association and prohibits certain kinds of advertising.

History: 03/18/2011—H Reported Do Pass as amended by House Judiciary.

DEAD

Bill: **SB38**

Sponsors: Feldman (D13)

Title: NEW MEXICO HEALTH INSURANCE EXCHANGE ACT

Summary: (For the Legislative Health and Human Services Committee) (Identical to HB33) Creates a nonprofit public corporation, the New Mexico Health Insurance Exchange, to offer qualified health plans to qualified individuals and small groups by January 1, 2014. "To the extent possible," operationally and under law, the Exchange is intended to assume the functions of the N.M. Health Insurance Pool (Sec. 59A-54-1 through 59A-54-21) and the N.M. Health Insurance Alliance (Sec. 59A-56-1 through 59A-56-25). The Pool now offers health insurance to residents considered uninsurable; the Alliance offers health insurance to eligible small businesses and individuals.

History: 04/08/2011—**G Vetoes by the Governor (SEM 53).**

Bill: **SB89**

Sponsors: Munoz (D4)

Title: PRIVATE HEALTH INSURANCE PURCHASING COOPERATIVE ACT

Summary: Authorizes the formation of a private health insurance purchasing cooperative to obtain health benefit plans for small or large employer groups by contracting with carriers pursuant to terms of the Small Group Rate and Renewability Act, Secs. 59A-23C-1 through 59A-23C-10. A nonprofit cooperative may be formed by any combination of two or more small or large employers. The type of group that may be covered by a health benefit plan issued through a cooperative is not limited.

History: 04/04/2011—**G Signed by the Governor (4/2/11 Signed) (Ch. 34, Laws 2011).**

Bill: **SB90**

Sponsors: Munoz (D4)

Title: HEALTH INSURANCE ALLIANCE ACCESS FOR LARGE EMPLOYERS

Summary: Amends the Health Insurance Alliance Act, Secs. 59A-56-1 through 59A-56-25, to increase access to voluntary health insurance coverage to large employer groups as well as small employers now covered.

History: 01/19/2011—S Introduced and referred to Senate Public Affairs.

DEAD

Bill: SB98
Sponsors: Keller (D17)
Title: HEALTH IMPACT REPORTING ACT AND INSURERS' FEE
Summary: (Identical to 2009 SB71) A new Health Impact Reporting Act requires the Department of Health to provide written impact reports on proposed legislation that affects community health. The Legislative Finance Committee would initiate the request to DOH and incorporate the health impact report into its reporting system.
History: 02/02/2011—S Reported Do Pass by Senate Public Affairs.
DEAD

Bill: SB133
Sponsors: Campos, P. (D8)
Title: UNM ACCELERATED ADMISSION TO DENTAL SCHOOL
Summary: Appropriates \$5,000 to UNM to study the feasibility of establishing a program to allow qualified students to advance directly from a bachelor of arts degree program to dental school. The results to the study will be presented to the interim Health and Human Services Committee and the Legislative Finance Committee by September 1, 2011.
History: 04/06/2011—**G Signed by the Governor (Signed 4/5/11) (Ch. 76, Laws 2011).**

Bill: SB161
Sponsors: Lopez (D11)
Title: PROFESSIONAL LICENSING BOARD REVIEW ACT
Summary: (Similar to 2009 SB874) Establishes a new process for changing the scope of practice for health care professionals, and for creating new licensed health care professions. Cited as the Professional Licensing Board Review Act, the bill authorizes a member of the licensing board, a licensee, or any other person seeking a change or expansion in the activities permitted by a health profession license to notify the appropriate licensing board and request a review. The licensing board must conduct a review, report to the Legislature, and make recommendations on any legislative action needed to implement the proposed change in the scope of practice.
History: 02/23/2011—S Referred to Senate Finance.
DEAD

Bill: SB162
Sponsors: Lopez (D11)
Title: NEW HEALTH CARE ADMINISTRATION AND FINANCE DEPARTMENT
Summary: (For the Government Restructuring Task Force) Creates a new cabinet-level Health Administration and Finance Department. Five divisions are specified: (1) Administrative Services, (2) Medical Assistance, (3) Behavioral Health Services, (4) Long-Term Services, and (5) Health Policy and Planning. Transfers medical assistance and behavioral health service programs currently under the jurisdiction of the Human Services Department to the new department on July 1, 2011. Transfers long-term service, brain-injury, elder care and quality assurance programs currently under the jurisdiction of the Aging and Long-Term Services Department on January 1, 2014. Transfers medically fragile and acquired immunodeficiency condition waiver programs currently in the Department of Health on January 1, 2014.
History: 01/20/2011—S Introduced and referred to Senate Rules.
DEAD

Bill: SB208
Sponsors: Feldman (D13)
Title: HEALTH INSURANCE PREMIUM RATE INCREASES
Summary: Amends and proposes sections of the NM Insurance Code to provide greater transparency and new standards in review of applications for health insurance premium

rate review determinations.

History: 04/08/2011—**G Signed by the Governor (Signed 4/7/211) (Ch. 144, Laws 2011).**

Bill: **SB227**

Sponsors: Wirth (D25)

Title: HEALTH CARE AND HMO PLAN INCENTIVES AND REIMBURSEMENT RATES

Summary: Amends the Health Care Purchasing Act and the Health Maintenance Organization Law to allow group health and HMO coverage plans to provide incentives for participants to use their health care services. Includes guidelines for calculating “usual and customary” reimbursement for health care services outside of preferred provider arrangements. When reimbursement is made to a nonpreferred provider, the group coverage or HMO plan shall determine the rate based upon the prevailing market cost of that particular service delivered in that geographic area, and calculate the prevailing market cost by obtaining data from an independent database and by using statistics developed using generally accepted professional standards for statistical analysis.

History: 02/17/2011—S Reported Do Pass as amended by Senate Public Affairs.
DEAD

Bill: **SB260**

Sponsors: Cravens (R21)

Title: DENTAL INSURANCE REIMBURSEMENT FOR SERVICES NOT COVERED

Summary: 04/07/2011—**G Signed by the Governor (Ch. 128, Laws 2011).**

Bill: **SB283**

Sponsors: Jennings (D32)

Title: NOTICE BY PROVIDER OF BREAST RECONSTRUCTIVE SURGERY OPTION

Summary: In advance of obtaining consent for surgery, requires a health care provider who provides mastectomy or lumpectomy or lymph node dissection surgery of the breast, to provide written information to the patient about the option of reconstructive surgery. Establishes informational criteria that includes patient access, availability of health insurance, and advantages and disadvantages of surgery options.

History: 04/08/2011—**G Signed by the Governor (Signed 4/7/11) (Ch. 145, Laws 2011).**

Bill: **SB295**

Sponsors: Ulibarri (D30); Kernan (R42)

Title: HEALTH CARE PROVIDER DEPENDENCY TASK FORCE

Summary: Requires the Health Department to establish a Health Care Provider Drug and Alcohol Dependency Task Force to study challenges faced by substance dependent providers and the resulting costs to patients, colleagues and the health care system.

History: 04/06/2011—**G Signed by the Governor (Ch. 90, Laws 2011).**

Bill: **SB323**

Sponsors: Kernan (R42); Feldman (D13)

Title: HEALTH CARE PROVIDERS MUST DISPLAY CREDENTIALS

Summary: Requires health care providers to wear name tags clearly specifying the type of license or certification they hold during all patient encounters. Further requires health care providers to display in their offices their education diploma or certification clearly specifying the type of license or certification held. Employees of health care providers who assist in patient encounters must wear name tags listing name and position.

History: 03/18/2011—H Reported Do Pass as amended by House Judiciary.
DEAD

Bill: **SB333**

Sponsors: Jennings (D32); Ingle (R27)

Title: LIMITS ON MEDICAL MALPRACTICE AWARDS
Summary: (Identical to HB267) Changes the title of the Medical Malpractice Act to the New Mexico Medical Professional Liability Act and imposes limits on the amounts that may be awarded in medical malpractice suits against medical providers, hospitals, hospital affiliates and other business entities.
History: 04/07/2011—**G Vetoes by the Governor.**

Bill: **SB336**
Sponsors: Morales (D28)
Title: MEDICAL IMAGING LICENSURE EXEMPTIONS
Summary: The bill seeks to exempt certain health care professionals from the licensure requirements of the Environmental Improvement Board pursuant to the Medical Imaging and Radiation Therapy Health and Safety Act.
History: 03/16/2011—H Failed to pass 31-37.
DEAD

Bill: **SB339**
Sponsors: Ortiz y Pino (D12)
Title: HEALTH INSURERS CANNOT DISCRIMINATE AGAINST PROVIDERS
Summary: Provides that group health coverage offered pursuant to the Health Care Purchasing Act shall not discriminate with respect to participation or reimbursement against any health care provider who is acting within the scope of their professional license. Creates new sections containing exactly the same prohibition against provider discrimination in articles of the Insurance Code governing individual health insurance contracts, group and blanket health insurance contracts, health maintenance organizations and nonprofit health care plans.
History: 02/01/2011—S Introduced and referred to Senate Public Affairs.
DEAD

Bill: **SB370**
Sponsors: Munoz (D4)
Title: SIMPLIFIED HEALTH INSURANCE EXCHANGE ACT
Summary: (Related to HB33 and SB38) This bill is similar to but less detailed than HB33 and SB38, identical bills introduced for the Legislative Health and Human Services Committee. Creates a nonprofit public corporation, the New Mexico Health Insurance Exchange, to provide qualified individuals and small employers with increased access to health insurance. Directs the Exchange to report to the First Session of the 51st (2013) Legislature with recommendations for transition to the Exchange of all functions of the N.M. Medical Insurance Pool (Sec. 59A-54-1 through 59A-54-21) and the N.M. Health Insurance Alliance (Sec. 59A-56-1 through 59A-56-25). The Pool now offers health insurance to residents considered uninsurable; the Alliance offers health insurance to eligible small businesses and individuals.
History: 02/21/2011—S Substituted in Senate Corporations & Transportation by SB38 and SB370 (Combined) See SB38 for succeeding entries.

Bill: **SB380**
Sponsors: Harden (R7)
Title: PERA: SPECIAL HOSPITAL DISTRICTS; SERVICE CREDIT PURCHASES
Summary: (Similar to 2010 SB225) Expands the definition of "public employer" in the Public Employees Retirement Act to include special hospital districts, thereby making their employees eligible for membership in PERA. Also incorporates the Senate Finance Committee amendment to 2010 SB 225 and changes the method of calculating the purchase of service credit under PERA.
History: 03/07/2011—S Reported Do Pass by Senate Finance.
DEAD

Bill: SB383
Sponsors: Fischmann (D37)
Title: MEDICAL HARM DISCLOSURE ACT
Summary: The Medical Harm Disclosure Act requires a health facility to report a medical harm event to the Department of Health within five days, or within 24 hours if the event is an urgent threat to personnel or visitors. Defines "health facility" as a public hospital, profit or nonprofit private hospital, outpatient facility, nursing home or intermediate care facility licensed by the department. Creates a surcharge on licensees and a fund to be used by the department in carrying out its duties under the act to collect reports and inform the public.
History: 02/03/2011—S Also referred to Senate Finance.
DEAD

Bill: SB386
Sponsors: Lopez (D11)
Title: LFC HEALTH BENEFITS PLAN DESIGNS AND ANALYSIS
Summary: (Identical to HB257, except that the House version was introduced on behalf of the Legislative Finance Committee) Requires the LFC, in collaboration with the Governor's Office, the Human Services Department, the Department of Health, the PRC's Insurance Division, the LCS and other experts, to perform a fiscal impact analysis of certain health care finance and administration plan designs. Appropriates \$100,000 from the General Fund to the Legislative Finance Committee to meet the federal requirement for cost sharing.
History: 03/07/2011—S Reported Do Pass as amended by Senate Public Affairs.
DEAD

Bill: SB390
Sponsors: Sanchez, M. (D29)
Title: PERSONAL INJURY AND MEDICAL MALPRACTICE STATUTE OF LIMITATIONS GONE
Summary: Relates to civil actions by doing away with the statute of limitations for personal injury and medical malpractice legal actions. Repeals Sec. 41-5-13 of the Medical Malpractice Act, which has the effect of doing away with the three-year limit during which an action must be brought against a health care provider after the date that the act of malpractice occurred. By amendment to Sec. 37-1-8, reduces the time period within which an action against sureties on fiduciary bonds may be brought on a personal injury or medical malpractice action from three to two years.
History: 03/08/2011—S Reported Do Pass by Senate Public Affairs.
DEAD

Bill: SB467
Sponsors: Martinez, Richard (D5)
Title: DENTAL PROFESSIONAL LIABILITY ACT
Summary: Cited as the Dental Professional Liability act, the bill's purpose is to require malpractice claims against dental health providers to be filed for review with the New Mexico Dental-Legal Review Committee before a tort claim may be filed with the court. Claims must be filed within three years after the date the act of malpractice occurred, except in the case of a minor under the age of six who has until the minor's 9th birthday to file. An attorney shall submit a case for consideration by a panel (appointed by the review committee) of licensed dentists or attorneys prior to filing a complaint in any district court by addressing an application, in writing, signed by the patient or the patient's attorney, to the Director (who is also an attorney appointed by the chief justice of the Supreme Court) of the Dental-Legal Review Committee.
History: 03/17/2011—S Passed Vote 33-0.
03/17/2011—H Introduced and referred to House Judiciary.
DEAD

Bill: SB477
Sponsors: Sapien (D9)
Title: NEW STANDARDS FOR INSURANCE ADJUSTERS
Summary: The bill amends many sections of the Insurance Code related to insurance adjusters, and adds new sections regarding "public adjusters." Modifies the definition of "adjuster" in the Insurance Code to mean an individual who investigates, negotiates or settles insurance claims for clients as well as for insurers or insureds. Adds a definition for "public adjuster" meaning those who solicit clients and assist in settling first-party claims arising under the client's own real or personal property coverage, or third-party claims the client has against other insurers but excludes personal injury claims. The exclusion does not, however, apply to independent or insurance company staff adjusters. Clarifies that all who act as or represent themselves as adjusters must be licensed.
History: 03/18/2011—S Passed Vote 28-0.
03/18/2011—H Introduced and referred to House Business & Industry.
DEAD

Bill: SB497
Sponsors: Ortiz y Pino (D12)
Title: MANAGED HEALTH CARE OMBUDSMAN ACT
Summary: (Related to SB22) The Managed Health Care Ombudsman Act is proposed in this bill as a stand-alone act; the same ombudsman act is proposed in SB22 in conjunction with a new Health Care Provider Protection Act. The ombudsman act creates a procedure to investigate and resolve patient and provider complaints made pursuant to the Patient Protection Act, and to work with managed health care plans to ensure that each plan is protecting patient and provider rights. Defines "managed health care plan" as an insurer or provider network that offers financial incentives for a covered person to use providers which it employs or has under contract, and includes networks offering Medicaid services.
History: 03/04/2011—S Reported Do Pass by Senate Public Affairs.
DEAD

Bill: SB499
Sponsors: Papen (D38); Leavell (R41)
Title: REVIEWING CHANGES IN HEALTH INSURANCE RISKS AND RATES
Summary: (Related to SB208) Proposes new sections of the Insurance Code to provide new standards for review by the Superintendent of Insurance of health insurer filings for a change in rates or classification of risks. Provides that changes cannot be effective before filing and approval. Requires the superintendent to review a filing within 60 days, and approve it if it is actuarially sound, reasonable, not excessive or inadequate and not discriminatory. Requires the superintendent to issue written findings on the merits of the filing. Authorizes the superintendent to adopt rules on filing for rate or risk classification changes.
History: 03/07/2011—S Substituted in Senate Judiciary by SB208 (Combined).
03/07/2011—S Note: See SB208 for succeeding entries.

Bill: SB541
Sponsors: Ingle (R27); Jennings (D32)
Title: HOSPITAL PROVIDER FEES ACT
Summary: The Hospital Provider Fees Act recognizes that hospitals within the state incur significant fees by providing health care to those eligible for Medicaid in return for payments less than the cost of care, and to low-income and uninsured populations without receiving any compensation. The intent of the bill is to provide an additional payer source to hospitals, reduce the need to shift the cost of uncompensated care to other payers, and expand access to affordable health care.
History: 02/16/2011—S Introduced and referred to Senate Public Affairs.

Bill: SB562
Sponsors: Griego (D39)
Title: ASSISTANCE FOR THE SOLE COMMUNITY PROVIDER FUND
Summary: Proposes a temporary provision to require that during FY2012 the following amounts are appropriated to the Sole Community Provider Fund, notwithstanding a contrary disposition directed by Sec. 27-10-3:
History: 02/17/2011—S Introduced and referred to Senate Public Affairs.
DEAD

Bill: SB564
Sponsors: Lopez (D11)
Title: HEALTH CARE PROFESSIONAL WORKFORCE COMMISSION
Summary: Changes the name, duties and powers of the New Mexico Health Policy Commission to the New Mexico Health Care Professional Workforce Commission. The new workforce commission will shift its focus to enhancing the health care professional workforce. It will be administratively attached to the Department of Finance and Administration.
History: 03/14/2011—S Reported Do Pass by Senate Rules.
DEAD

Bill: SB569
Sponsors: Griego (D14)
Title: MEDICAL TREATMENT WITH OPIATES
Summary: Requires the Board of Pharmacy to establish and maintain a program to monitor the prescribing and dispensing of opiates by practitioners. The program is intended to provide information to practitioners, dispensers and patients to help avoid the illegal use of controlled substances. It requires establishing an accessible report of patient utilization of Schedule II or Schedule III controlled substances and sets out the procedures for providing and receiving such information.
History: 03/07/2011—S Reported Do Pass by Senate Public Affairs.
DEAD

Bill: SB595
Sponsors: Ingle (R27)
Title: EMERGENCY MEDICAL SERVICES PROTECTION FUND
Summary: SFC substitute for SB595 is a substitute for a dummy bill. Creates the nonreverting Emergency Medical Services Protection Fund in the state treasury, to consist of proceeds from the Emergency Medical Services Protection Fund that are derived from a \$5 fee imposed in magistrate and metropolitan courts as well as any gifts, grants, fees, bequests, or money otherwise accruing to the fund as well as earnings from investment of the fund. The fee would be collected in both courts upon conviction from persons convicted of operating a motor vehicle in violation of the Motor Vehicle Code, convicted of a crime constituting a misdemeanor or a petty misdemeanor or convicted of violating any ordinance punishable by a term of imprisonment. Money in the fund shall be appropriated by the Legislature annually to the Department of Health to be used in the amounts and for the purposes set forth below:
History: 03/18/2011—H Reported Do Pass as amended by House Taxation & Revenue.
DEAD

Bill: SB608
Sponsors: Feldman (D13)
Title: INSURANCE: COVERAGE, DEPENDENTS, RESCISSIONS, LIMITS
Summary: SPAC substitute for SB608 replaces a dummy bill. Relates to the Insurance Code, the Health Maintenance Organization (HMO) law and the Nonprofit Health Care Plan law to prohibit lifetime or annual limits; prohibits rescissions of coverage; provides for

misrepresentation; provides for rescission or breach of Nonprofit Health Care Plan subscriber contracts in cases of intentionally misleading misrepresentation; provides for coverage for preventive items and service for office visits in conjunction with preventive items and services; mandates coverage for individuals under the age of 26 who seek coverage under their parents' coverage; prohibits preexisting condition exclusions for individuals under 19; provides for special enrollment for individuals whose coverage ended by reasons of cessation of dependent status; provides for applicability of Health Insurance Mandate changes to "grandfathered" health plan coverage beginning before March 23, 2010 and continuing in effect; amends the Medical Care Savings Account Act to provide for dependent coverage until age 26; establishes health coverage requirements for emergency services; requires that covered children have access to pediatric care; requires that female covered individuals have access to obstetrical and gynecological care; and proposes new sections to the code to define "child" and "dependent."

History: 03/02/2011—S Referred to Senate Judiciary.
DEAD

Bill: **SJM1**
Sponsors: Feldman (D13)
Title: CONTINUE HEALTH CARE REFORM WORKING GROUP
Summary: (Similar to 2010 SJM1) Requests the continuation of the Health Care Reform Working Group to make recommendations regarding the implementation of the Patient Protection and Affordable Care Act.
History: 04/03/2011—S Enrolled and engrossed (Mar. 30 signature date).
04/03/2011—S Signed by Officers of Senate (Mar. 30 signature date).
04/03/2011—H Signed by Officers of House (Mar. 31 signature date).

Legislative Council Service decided in June not to fund this working group.

Bill: **SJM17**
Sponsors: Griego (D39)
Title: INSURANCE FOR AMBULANCE SERVICE
Summary: Asks the Superintendent of Insurance to evaluate the possibility of requiring insurance coverage to pay for ambulance services. The Superintendent will evaluate:
History: 03/17/2011—S Passed Vote 33-0.
DEAD

Bill: **SJR5**
Sponsors: Ortiz y Pino (D12)
Title: CA: COMPREHENSIVE QUALITY HEALTH CARE SYSTEM
Summary: Proposes to amend Article 2 of the Constitution by adding a new section to read: "Health care is a fundamental right that is an essential safeguard of human life and dignity, and the state shall ensure that every resident is able to realize this right by establishing a comprehensive system of quality health care that is accessible to each resident on an equitable basis regardless of ability to pay."
History: 03/05/2011—S Reported Do Pass by Senate Judiciary.
DEAD

Legislative Health & Human Services Committee Report for 2011

2011 Legislation Endorsed by the Legislative Health and Human Services Committee							
	202#	Topic or Short Title	Description	PPACA-Related	Government Restructuring-Related	Appropriation	Sponsor
1	182459.4 ENDORSED	Health Care Workforce Data Collection, Analysis and Policy Act	<ul style="list-style-type: none"> • DOH directed to create a database to collect health care professional workforce data regarding demographics, specialties and professions; • Data collected at time of licensure or re-licensure; and • DOH directed to convene a work group of health care workforce specialists to make recommendations regarding education, recruitment and retention of health care providers 	Yes	No	No; directs DOH to seek a grant through PPACA	Sen. Dede Feldman
2	182632.2 ENDORSED	Health Care Provider Protection Act (including the Managed Health Care Ombudsman Act)	<p>Protections for health care providers working with managed care plans, including:</p> <ul style="list-style-type: none"> • timely reimbursement, • limits on payment recoupments, • required training, • uniform and timely credentialing processes, and • creation of a managed health care ombudsman office 	No	No	No	Sen. Gerald Ortiz y Pino

Legislative Health & Human Services Committee Report for 2011

2011 Legislation Endorsed by the Legislative Health and Human Services Committee							
	202#	Topic or Short Title	Description	PPACA-Related	Government Restructuring-Related	Appropriation	Sponsor
3	182663.2 ENDORSED	Managed Care and Medicaid Medical Home Requirements	Requires managed care organizations that contract with Medicaid, SCHIP and the SCI program to include specifications for funding and tracking implementation of medical home models of care	No	No	No	Rep. Danice Picraux
4	182696.3SA ENDORSED	Disability Fund Fees	Amends the Motor Vehicle Code to provide for a disability fund fee in addition to other motor vehicle registration fees to assist in funding disability-related activities	No	No	No	Sen. Phil A. Griego

Legislative Health & Human Services Committee Report for 2011

2011 Legislation Endorsed by the Legislative Health and Human Services Committee							
	202#	Topic or Short Title	Description	PPACA-Related	Government Restructuring-Related	Appropriation	Sponsor
5	182910.3 ENDORSED	Health Security Act	<ul style="list-style-type: none"> • Development of a state health coverage plan; • LFC cost study; implementation contingent on legislative approval of implementation and financing plans after LFC study; • Initial 5-year implementation plan; • Administered by a commission that is a government instrumentality; • Commission to seek federal waivers such as those for state innovation in PPACA; • Care planning, cost containment; • Delivery regions and regional councils; and • \$500,000 to LFC for cost study; directs LFC to seek partnerships and grants to offset costs of study 	Yes	Yes	Yes; for LFC financing options study	Sen. Carlos R. Cisneros
6	183033.6 ENDORSED	New Mexico Health Insurance Exchange Act	<ul style="list-style-type: none"> • Establishes a state exchange; • Quasi-governmental entity; • Meets the requirements of PPACA; • Robust exchange: rates and sells plans; and • Rulemaking with superintendent 	Yes	No	No	Rep. Danice Picraux

Legislative Health & Human Services Committee Report for 2011

2011 Legislation Endorsed by the Legislative Health and Human Services Committee						
202#	Topic or Short Title	Description	PPACA-Related	Government Restructuring-Related	Appropriation	Sponsor
7	183089.1 ENDORSED Memorial: Waivers of Innovation	Urges the congressional delegation to actively seek to amend the PPACA to remove the 2017 date for states to request a waiver of innovation	Yes	No	No	Sen. Carlos R. Cisneros
8	183222.2 ENDORSED Accountable Care Organization Task Force	Directs HSD secretary to establish an accountable care organization task force in Medicaid, SCHIP and the SCI program	No	No	No	Rep. Danice Picraux
9	183271.2 ENDORSED Health Insurance Premium Rate Review	Amends New Mexico Insurance Code to provide greater transparency in review of applications for health insurance premium rate increases; and provides for hearings related to such requests	Yes	No	No	Sen. Dede Feldman

Affordable Care Act in Your State: New Mexico

PPACA Funding in New Mexico

Since enactment of the Affordable Care Act on March 23, 2010, the Department of Health and Human Services has awarded \$62.3 million in new grant funding available in New Mexico, and helped many residents and employers take more control of their health care – from new patient protections to new coverage options.

19,941 [Medicare Part D “Donut Hole” Rebate Checks](#): In New Mexico, 19,941 Medicare beneficiaries have received a one time, tax free \$250 rebate to help pay for prescriptions in the ‘donut hole’ coverage gap. In 2011, beneficiaries will receive a 50 percent discount for covered brand-name prescriptions in the donut hole.

322 Uninsured New Mexico Residents Enrolled in the [Pre-Existing Condition Insurance Plan](#): This plan provides a health coverage option for consumers who have been uninsured for at least six months, have a pre-existing condition or have been denied health coverage because of their health condition, and are a U.S. citizen or are residing here legally. In New Mexico, the Pre-Existing Condition Insurance Plan is operated by the State government.

More than \$226,000 to Support a [Consumer Assistance Program](#): On September 30, 2010, HHS awarded new Consumer Assistance Program grants to help strengthen and enhance ongoing efforts in the States and local communities to protect consumers from some of the worst insurance industry practices. The Public Regulation Commission, Division of Insurance, Managed Health Care Bureau in New Mexico will receive more than \$226,000 to:

- Support the development of outreach materials and program information.
- Fund travel expenses for an ombudsman and staff.
- Provide volunteer and staff training.
- Develop IT systems.
- Provide interpreter services contract, a hotline system, and general supplies and equipment.
- Create an ombudsman position that will collaborate with certified community advocates and volunteers throughout the state to develop formal arrangements to:
- Deliver consumer services and information.
- Facilitate rulemaking and rule changes needed for the adoption of the Uniform Health Carrier External Review Model Act.
- Assist the Superintendent of Insurance with the selection of an independent review organization to be used for adverse appeals.

\$1 million to [Crack Down on Unreasonable Insurance Premium Increases](#): New Mexico will use the \$1 million in grant funding made available to:

- **Pursue Additional Legislative Authority:** New Mexico will introduce legislation to

allow improved transparency and require the division to post health insurance premium filings on its website as well as to set forth the authority to release information to the public, which insurers will be required to provide.

- **Improve the Review Process:** Currently all rate requests are subject to a review and approval process that includes a tiered approach with a more in-depth review (including trends analysis of historical medical loss ratio, evaluation of medical cost index and comparison of claims and financial Statement data) for proposed increases greater than 5 percent. The Department of Insurance will implement actuarial review of unreasonable rates and strengthen the rate review process by developing procedures that incorporate and implement federal regulations and State laws. Within the Insurance Division, the Department also intends to develop a Consumer and Business Services Bureau responsible for approving rates for the individual, small group and portability health insurance markets.
- **Increase Transparency and Accessibility:** The State provides access to health insurance premium filings upon request. The Department of Insurance will seek legislation to make rate filings public information and require the Division to post health insurance premium filings on its website once they are deemed complete.
- **Develop and Upgrade Technology:** New Mexico will improve efficiency and streamline data sharing.

\$1 million to Plan for a [Health Insurance Exchange](#): These grants will give States the resources they need to conduct the research and planning needed to build a better health insurance marketplace and determine how their Exchanges will be operated and governed. New Mexico will use these funds to:

- Fund a financial modeling tool and report, which will identify the population of affected individuals and employers and project the effect of an Exchange) on the marketplace, populations of affected individuals, State expenditures and changes in spending by payer.
 - Determine the changed distribution of health insurance coverage by payer and the change in health insurance coverage under all of the federal health care reform measures.
 - Study and begin to implement the details of implementing the Exchanges).
 - Provide follow-up research and analyses, as suggested by the direction and inquiries made by the Legislature and the incoming Governor.
- Consider a regional Exchange for group purchasing or collective IT vendor.

6 Employers Enrolled in [Early Retiree Reinsurance Program](#): The Early Retiree Reinsurance Program (ERRP) provides much-needed financial relief to businesses, schools and other educational institutions, unions, State and local governments, and non-profits, in order to help retirees and their families continue to have quality, affordable health coverage. Find a list of organizations accepted into this program in your state [here](#).

\$4.73 million in Therapeutic Discovery Project Program Tax Credits and Grants: This program was created by the Affordable Care Act to support groundbreaking biomedical research to produce new therapies, address unmet medical needs, reduce the long-term growth of health care costs and advance the goal of curing cancer within the next 30 years. In New Mexico, this program will support 25 projects that show significant potential to produce new and cost-saving therapies, support good jobs, and increase U.S. competitiveness. This program is operated by the U.S. Department of Treasury, and a full list of small businesses participating in this program is available.

⇒ **\$1.2 Million in Grants from the Prevention and Public Health Fund:** The Affordable Care Act creates a new Prevention and Public Health Fund to prevent illness and promote health, so that all Americans can lead longer, more productive lives. This year, the Fund supported programs across New Mexico, including:

- \$60,340 for community and clinical prevention activities, which will help New Mexico and its partners prevent and manage costly conditions.
 - \$782,443 to support public health infrastructure. These grants strengthen State and local capacity to meet 21st century public health challenges.
 - \$354,239 invested in primary care training, to expand and support New Mexico's primary care workforce.
-
- **Other Grants Made Available in New Mexico:**
 - **\$430,000** for Maternal, Infant and Early Childhood Home Visiting Programs
 - **\$500,000** for Aging and Disability Resource Centers
 - **\$300,000** for Medicare improvements for patients and providers
 - **\$26.4 million** to support capital development in health centers
 - **\$1.3 million** for the Pregnancy Assistance Fund Program
 - **\$1.5 million** to implement the National Background Check Program for long term care workers
 - **\$23.7 million** for Money Follows the Person demonstration project

Republican Governor's Letter to HHS Secretary (February 7, 2011)

While continuing to fight for a total overhaul of the Patient Protection and Affordable Care Act (PPACA), 21 Republican governors sent a letter today to U.S. Health and Human Services Secretary Kathleen Sebelius asking her to make six critical adjustments to the rules concerning state-run healthcare exchanges or risk having the federal government assume full responsibility.

A section of the states: "We wish states had been given more opportunity to provide input when the PPACA was being drafted. We believe in its current form the law will force our health care system down a path sure to lead to higher costs and the disruption or discontinuation of millions of Americans' insurance plans."

Among the requested changes are granting states authority to choose benefits that meet the needs of their citizens, waiving provisions that discriminate against consumer-driven health plans, such as health savings accounts, and commissioning an independent assessment of how many people will be "offloaded" into the exchanges by employers.

"Dear Secretary Sebelius;

Many of us believe the Patient Protection and Affordable Care Act (PPACA) should be repealed by Congress if the courts do not strike it down first. But, with no assurance of either outcome, we face the decision of whether to participate in the bill by operating state exchanges, or to let the federal government take on that task, if the bill remains in effect in 2014.

In addition to its constitutional infringements, we believe the system proposed by the PPACA is seriously flawed, favors dependency over personal responsibility, and will ultimately destroy the private insurance market. Because of this, we do not wish to be the federal government's agents in this policy in its present form.

We wish states had been given more opportunity to provide input when the PPACA was being drafted. We believe in its current form the law will force our health care system down a path sure to lead to higher costs and the disruption or discontinuation of millions of Americans' insurance plans. Though we still have grave concerns with other provisions of the PPACA, we suggest the following improvements:

- Provide states with complete flexibility on operating the exchange, most importantly the freedom to decide which licensed insurers are permitted to offer their products
- Waive the bill's costly mandates and grant states the authority to choose benefit rules that meet the specific needs of their citizens.
- Waive the provisions that discriminate against consumer-driven health plans, such as health savings accounts (HSA's)

- Provide blanket discretion to individual states if they chose to move non-disabled Medicaid beneficiaries into the exchanges for their insurance coverage without the need of further HHS approval.
- Deliver a comprehensive plan for verifying incomes and subsidy amounts for exchange participants that is not an unfunded mandate but rather fully funded by the federal government and is certified as workable by an independent auditor.
- Commission a new and objective assessment of how many people will end up in the exchanges and on Medicaid in every state as a result of the legislation (including those “offloaded” by employers), and at what potential cost to state governments. The study must be conducted by a neutral third-party research organization agreed to by the states represented in this letter.

We hope the Administration will accommodate our states’ individual circumstances and needs, as we believe the PPACA in its current form threatens to destroy our budgets and perpetuate and magnify the most costly aspects of our health care system. While we hope for your endorsement, if you do not agree, we will move forward with our own efforts regardless and HHS should begin making plans to run exchanges under its own auspices.

Sincerely,

Governor Robert J. Bentley Governor Nathan Deal
Governor C.L. “Butch” Otter Governor Mitch Daniels
Governor Terry E. Branstad Governor Scott Walker
Governor Sam Brownback Governor Gary R. Herbert
Governor Bobby Jindal Governor Rick Perry
Governor Paul R. LePage Governor Bill Haslam
Governor Haley Barbour Governor Nikki Haley
Governor David Heineman Governor Tom Corbett
Governor Brian Sandoval Governor Mary Fallin
Governor Susana Martinez Governor John R. Kasich
Governor Dennis Daugarrd”

SUMMARY AND ANALYSIS OF PPACA EFFORTS

LEGISLATIVE

During the 2011 Legislative Session 1,591 bills, memorials and constitutional amendments were introduced. Out of those introduced bills, over 100 in some way addressed health care issues and health reform concerns.

Health Insurance Exchange

Most significant to health insurance reform and the PPACA legislation were the bills specifically calling for the creation of a New Mexico Health Insurance Exchange. Several exchange bills were introduced: HB34 (Representative Picraux); HB 584 (Representative McMillan); SB 38 (Senator Feldman); and SB 370 (Senator Muñoz). SB 38 combined with SB370 eventually passed both the Senate and the House largely along party lines (Democrats supporting/Republicans opposing), only to be vetoed by the Governor. SB 38/370 would have enabled the creation of a statewide exchange and the development of a plan for how such an entity would work. The Governor's veto leaves the state without the ability to apply for additional PPACA funding to work on exchange planning and implementation. PPACA mandates that an exchange be in place within a state by January 1, 2013.

Cooperatives

Another significant bill also passed and signed by the Governor was SB 89 (Senator Muñoz) enabling the creation of health insurance purchasing cooperatives among employers. A nonprofit organization could be formed by both large and small employers including associations to offer various health insurance plans to their employees. The cooperatives would be regulated by the Department of Insurance. Several of the Chambers of Commerce in the state are already working to develop this private coop/exchange model. A successful business coop/exchange could morph into a PPACA exchange with legislative and executive action.

Medical/Health Homes

HB 34, (Representative Picraux) to require the managed care organizations to support the creation of medical homes was pocket vetoed by the governor. The use of medical homes or health homes as referred to in PPACA are significant in the implementation of federal health reform plans.

Dental Providers

A number of bills attempted to address the shortage of dental providers. As indicated in this report, many areas of the state have insufficient dental services available, especially for low-income children and families. HB 187 (Representative Ed Sandoval), which was signed by the

Governor, expands the scope of practice of dental hygienists and other dental auxiliary providers. Though another bill creating a new category of dental provider failed, HB 187 may help provide greater access to dental services in areas of the state where dental hygienists provide care.

Nursing Education Funding

HB 103 (Representative E. Chavez) would have required the Higher Education Department (HED) to work with college and university schools of nursing to streamline the curriculum for nursing education. Another piece of legislation by Representative Chavez, HJM 14 asked HED to study the funding formula and other funds for the schools of nursing. Both bills failed, but if passed and signed would have assisted in addressing systemic issues which slow public higher education from adequately funding nursing education. As indicated in this report, New Mexico along with the nation faces an ongoing nursing shortage. Further exacerbating these funding issues, the legislature cut funding in half to most schools of nursing and reduced the HED Nursing Enhancement fund by \$2.5 million from \$3.2 last fiscal year.

Workforce

SB 14 (Senator Feldman), which was signed by the Governor, requires all health care licensing boards to collect workforce data on their licensees. If funding to the Department of Health becomes available, cumulative data from the boards would be collected and analyzed to determine current and future workforce needs.

Health Policy Commission and Finance Department

SB 15 (Senator Feldman), HB 94 (Representative Picraux), and SB 162 (Senator Lopez) all addressed the creation of a cabinet-level Health Policy and Finance Department through combining several health departments and creating a planning division within them. All three bills failed, ending efforts in 2011 to coordinate and plan health care delivery and policy.

Other Health Insurance Reform

SB 5 (Senator Cisneros) provided that the Health Security Act if passed and signed would have created a health coverage system through a combination of public and private financing. The system would create one entity to be responsible for funding and delivering all health care "insurance."

Insurance Rate Review

SB 208 (Senator Feldman) combined with SB 499 (Senator Papen) amended sections of the New Mexico Insurance Code to provide greater transparency and new standards for review of applications for health insurance premium rate increases. The combined bill was passed and signed by the Governor.

Medicaid

HB 372 (Representative King) proposed a new section of the Public Assistance Act requiring the Human Services Department to submit a written fiscal impact analysis to LFC and DFA at least 60 days prior to submitting any proposed changes to the State Medicaid plan for federal approval. The bill passed both chambers, but was pocket vetoed by the Governor.

General Health Care Reform

Senator Feldman introduced SJM 1, which would have continued the 2010 health care reform working group. As indicated in this report, the working group agreed upon numerous recommendations concerning health insurance reform and health insurance exchanges. Many of those recommendations were contained in failed legislation. Although the joint memorial passed both chambers, the Legislative Council Service did not fund its continuation, citing financial concerns.

Health Care Provider Protection and Ombudsman Act

SB 22 (Senator Ortiz y Pino) if passed would have created a managed care ombudsman to investigate patient and provider complaints and to aid in resolving disputes.

Insurance

SB 608 (Senator Feldman) attempted to place PPACA insurance provisions into the State of New Mexico insurance law. The bill was introduced late and did not pass.

EXECUTIVE

Governor Martinez exercised her veto pen on the legislation related to the creation of a state health insurance exchange, SB 38/370. In her veto message she indicated “general support for the creation of a framework to establish a state insurance exchange. However, this legislation is premature because federal law does not require the state to demonstrate its readiness to run an exchange before January 2013...” She further stated that challenges to components of the law are in federal court now so the state should wait to implement any state exchange legislation. This veto, coupled with her signature on a Republican governors’ letter to Secretary of Health and Human Services Sebelius requesting reconsideration of PPACA and a number of recommendations giving states more flexibility, strongly indicates her overall lack of support for action on a PPACA defined exchange.

The Governor’s administration has mentioned the possibility of an executive order to create a minimal exchange structure; however, no timeframe has been indicated. Several state governors are utilizing executive orders to begin work on their exchanges. Staff in the administration have suggested to members of the business community that a small business exchange somewhat along the lines of that in Utah would be viewed favorably. The

administration was very enthusiastic about Senator Muñoz's cooperative bill enabling associations to create business exchange-like entities.

GRANTS

Since enactment of the PPACA on March 23, 2010, the Department of Health and Human Services has awarded \$62.3 million in new grant funding available in New Mexico and has helped many residents and employers take more control of their health care – from new patient protections to new coverage options:

\$1 million to Plan for a Health Insurance Exchange. New Mexico will use these funds to:

- Fund a financial modeling tool and report.
- Determine the changed distribution of health insurance coverage by payer.
- Study and begin to implement the details of implementing the Exchange(s).
- Provide follow-up research and analyses.
- Consider a regional Exchange for group purchasing or collective IT vendor.

\$1 million to Crack Down on Unreasonable Insurance Premium Increases. New Mexico will use the \$1 million in grant funding made available to:

- Pursue Additional Legislative Authority.
- Improve the Review Process.
- Increase Transparency and Accessibility.
- Develop and Upgrade Technology.

19,941 Medicare Part D “Donut Hole” Rebate Checks.

322 Uninsured New Mexico Residents Enrolled in the Pre-Existing Condition Insurance Plan.

More than \$226,000 to Support a Consumer Assistance Program.

6 Employers Enrolled in Early Retiree Reinsurance Program.

\$4.73 million in Therapeutic Discovery Project Program Tax Credits and Grants (biomedical research).

\$1.2 Million in Grants from the Prevention and Public Health Fund.

Other Grants Made Available in New Mexico:

- \$430,000 for Maternal, Infant and Early Childhood Home Visiting Programs.
- \$500,000 for Aging and Disability Resource Centers.

- \$300,000 for Medicare improvements for patients and providers.
- \$26.4 million to support capital development in health centers.
- \$1.3 million for the Pregnancy Assistance Fund Program.
- \$1.5 million to implement the National Background Check Program for long term care workers.
- \$23.7 million for Money Follows the Person demonstration project.

Governor Bill Richardson’s administration set up the Office of Health Care Reform Leadership Team, comprised of executive agency decisionmakers. The Leadership Team completed a Transition Plan in December 2010. One of its recommendations under Leadership, Resources, and Support included: Use the Office of Health Care Reform as a central entity for housing and reporting data on all PPACA grants to ensure accuracy of grant tracking and federal reporting for all state agencies.

Leadership Team member New Mexico Department of Health was tasked with the compilation of available PPACA grants, application dates, eligible applicants, grant amounts, whether the grant was submitted, and amounts awarded. <http://www.hsd.state.nm.us/pdf/hcr/HCRSpreadsheet6-30-11.pdf> The system is only as good or as accurate as the voluntary reporting from entities around the state. The report indicates that the majority of funds available to the state have not been applied for or the information is unknown whether entities applied. There is no current mechanism for the collection of data from all eligible institutions in the state.

A top priority for the newly created Office of Health Care Reform under Governor Martinez should be to gather information about available funds that could come into New Mexico. The newly created office could coordinate the dissemination of information, the availability and purposes of funds, and the collection of entities applying for the funds. Coordination, communication, and collaboration in these grant application efforts could spell success for New Mexico.

OTHER

Due to the poverty level in the state, concerted PPACA implementation efforts should be addressed to our vulnerable populations – children, families, and adults in need.

In the near term, legislative action on a PPACA health insurance exchange may be futile. The current governor has not expressed immediate interest in PPACA implementation. If the executive branch is uninterested in a state-controlled PPACA exchange, the governor will not place it on the “call” in the 2012 legislative session, curtailing the legislature’s ability to even discuss the issue.

Possible actions without legislation:

- Businesses could join together through their chamber of commerce to create a small business exchange or business co ops.

- Colleges and universities can continue to pursue funding for workforce enhancement and participate in statewide workforce task forces.
- Licensing boards can collect new and detailed workforce data.
- Educational institutions could take on the role of health policy research for the state.
- Nonprofit groups could address a meaningful role in outreach to individuals to access health care.
- Nonprofits can take leadership roles in accessing PPACA funds.
- Local foundations could partner with national foundations to fund local PPACA efforts – research, outreach, dissemination of information.

Foundations have a role in bringing together leaders of various communities – Native American, African American, Children, Women, Seniors, Hispanics, Nonprofits, Health care, Education, Business – to create networks. A network could provide guidance and strategic planning, design, and implementation advice to help implement health care reform in New Mexico.