NEW MEXICO FIRST
People. Ideas. Progress.

ISSUE GUIDE

Strengthening New Mexico Healthcare: Access, Coverage, and Economics

A town hall convened by **New Mexico First**

- **When:** May 3-5, 2007
- **Location:** UNM Student Union Building, Albuquerque, NM

Report Authors

Michael Ellis, Ph.D.,
New Mexico State University

Carol Erwin,
Eastern New Mexico University

Arthur Kaufman, M.D.,
UNM Health Sciences Center

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Forward

New Mexico First

New Mexico First is a nonpartisan, nonprofit organization that engages citizens in public policy. Co-founded in 1986 by U.S. Senators Pete Domenici (R-NM) and Jeff Bingaman (D-NM), the organization brings people together for two- and three-day town hall meetings. These town halls use a unique consensus-building process that enables participants to learn about a topic in depth, develop concrete policy recommendations addressing that topic, and then work with fellow New Mexicans to help implement those recommendations with policymakers.

The Town Hall Process

New Mexico First town halls are not typical conferences with day after day of presentations. There will be a few guest speakers to help set the context, but the bulk of the town hall is comprised of small group discussions among citizens who care about the topic.

Using **New Mexico First**'s proven consensus-building process, the three-day town hall will ask participants to share their best ideas for improving the state's healthcare system. Because citizen discussion is at the heart of this process, we require participants to take an active part on all three days of the town hall.

On day one of the town hall, participants are divided into their small groups to discuss the issues and answer a common set of questions. On day two, participants begin refining and combining those answers. On day three, participants finalize their recommendations for policymakers and industry leaders.

This Report

A number of New Mexicans from throughout the state contributed to this report. The authors and reviewers were not paid; instead they donated their time as a demonstration of their support of the town hall process. The staff and board of **New Mexico First** thank all the people who lent their expertise to this document.

Note: There are few right or wrong answers, and healthcare problems are complex. As a result, no brief explanation of the situation – including this report – can hope to cover all the information and opinions available. The authors have provided their knowledge and advice, but ultimately the people of New Mexico must decide what all the players – state, employers, individuals, insurers, and providers – should do or not do.

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Authors and Editors

Primary authors:

- Michael Ellis, PhD, New Mexico State University, the primary author of Approach 3 on economics;
- Carol Erwin, Eastern New Mexico University, the primary author of Approach 2 on the uninsured;
- Arthur Kaufman, MD, UNM Health Sciences Center, the primary author of Approach 1 on health services access.

Contributing editors included Jo Carter and Heather Balas of **New Mexico First.** Patricia Viramontes Chandler, also with New Mexico First, compiled Appendix A.

Research and Review Committee

The following people donated their time in identifying key issues for this report and reviewing it.

Raul Burciaga, New Mexico Legislative Council Service
Jacey Blue Campbell, New Mexico First
John Cordova, Cordova Public Relations
Barbara Damron, PhD, RN
Gayle Dine'Chacon, MD, UNM Center for Native American Health
Jeff Dye, New Mexico Hospital Association
Michael Ellis, PhD, NMSU Department of Economics
Carol Erwin, ENMU
Ruby Ann Esquibel, New Mexico Human Services Department
Bill Garcia, New Mexico First Board Chair
Robert Grassberger, economist
Charles Ivy, St. Joseph Community Health Services
Dan Jaco, New Mexico Medical Review Association
Jack Jekowski, Innovative Technology Partnerships
Arthur Kaufman, MD, UNM Health Sciences Center
Barbara Kimbell, New Mexico EPSCoR
Krista Koppinger, New Mexico First
Patricio Larragoite, DDS, New Mexico Health Policy Commission
Daniel Lopez, PhD, New Mexico Tech
Wanda Martin, UNM
Michelle Melendez, St. Joseph Community Health Service
Susan McGuire, New Mexico First Board Member
John Montgomery, ENMU
Carl Moore, The Community Store
Todd Sandman, Presbyterian Health Services
Scott Wallace, ValueOptions
Bill Wiese, MD, Robert Wood Johnson Center for Health Policy
Larry Winn, Connections, Inc.

About this Guide

This issue guide is designed to help participants prepare for the **New Mexico First** town hall, *Strengthening New Mexico Healthcare: Access, Coverage, and Economics.* The event will be held May 3-5, 2007 in Albuquerque. The guide is organized around three main approaches to reforming the healthcare system, which will frame the town hall discussion. They are not mutually exclusive, and most readers will find their opinions reflected in more than one.

Introduction

Healthcare has come a long way in the last century. Americans live far longer now, stay healthy and independent later in life, and recover from injuries and diseases that would have been devastating in the past. But while medical science has advanced rapidly, Americans are growing increasingly dissatisfied with the healthcare system. Patients, doctors, nurses, employers, and community leaders all complain that the current system just doesn't meet people's needs right now, much less projected into the future.

The way most New Mexicans see it, healthcare is expensive, complicated and too hard to get. Even doctors and nurses who work in the industry find themselves frustrated by bureaucracy, changing requirements, and their inability to help everyone who needs it. Job openings for medical staff go unfilled for months or years, as there are simply not enough doctors, nurses, and technologists to care for the wide variety of needs throughout the state, especially in rural areas.

New Mexico is listed as 40th in one 2006 national ranking of health[1], dropping two places from its 2005 place. This poor ranking stems from having one of the highest rates of uninsured people (48th of 50), limited access to adequate prenatal care (50th of 50), and a high percentage of children in poverty (47th of 50).

Ethical Considerations

In addition to the issues about insurance premiums and economic forces, the town hall participants must not forget the ethical issues that surround the topic of healthcare reform. These questions are not easily answered, and they often involve tradeoffs where you have to give up something you want to get something else you want. As you read the rest of this background report and take part in the town hall, we ask you to keep the following ethical concerns in mind.

Is Healthcare A Basic Human Right?

Any discussion of this subject rests on assumptions about whether healthcare is a human right or a privilege. If healthcare is a right, then speakers assume that it should be provided to everyone, as basic education is, for the good of the community. If healthcare is a privilege, then getting healthcare may require you make the right choices, just as getting a job or buying a house does.

When Do We Stop Providing Care?

Even among those who consider basic healthcare a right, there is no consensus as to when that right ends and luxuries begin. Should cosmetic surgery be covered? Obesity treatments? What level of healthcare should be available to everyone?

In 1994, Oregon created a list of medical conditions and prioritized them by importance; the higher an item's priority, the more likely the state's Medicaid system was to pay for related healthcare expenses. In years when the budget was tight, the state simply would not pay for treatment for the conditions on the bottom of the list. In reality, this rationing was never fully implemented. One person involved with this experiment said, "When someone is staring you in the face, how do you say it costs too much?"[2]

How Long Should We Try To Delay Death?

One fourth of Medicare's expenditures are spent on the last year of patients' lives[3]. Blue Cross Blue Shield of New Mexico reports that

[1] *America's Health Rankings* by the United Health Foundation. Available at http://www.unitedhealthfoundation.org/ahr2006.

[2] "As Death Nears, Health Costs Soar," from the *Albuquerque Journal* on February 25, 2007.

[3] "Last Year of Life Study," Center for Medicare and Medicaid Services, available at www.cms.hhs.gov/ActuarialStudies/03_Last_Year_of_Life.asp

56% of all money they spend on a patient's healthcare is spent in the last six months of that person's life[4]. This is often a very emotional time for the patient and family, and hospitals may continue treatment even when it seems evident that the patient will not recover. These costs raise insurance premiums and taxes for everyone. Is this an appropriate use of resources? Who decides?

Where Do Responsibilities Lie?

An individual's health is affected by personal choices, as well as a number of other people, organizations, and policies. For good nutrition, not only do we need to try to eat healthily, but we need to have access to healthy foods in the grocery store, the workplace, and the community. To maintain an active lifestyle, we need to have places to exercise. Even just going for an evening walk can be made more difficult without sidewalks, good lighting, or safe streets.

Some employers are beginning to offer wellness programs on the job, encouraging their employees to adopt healthy lifestyles. What exactly these programs offer depends on the company, but they can include paid time off to exercise, healthy food, and classes to help smokers quit. These employers say that these efforts pay off with healthier workers, fewer sick days, and lower insurance rates.

How are the various players – individuals, employers, communities, and healthcare providers – responsible for healthy living? Is it purely up to the individual to manage their healthcare and lifestyle choices? Should employers take the initiative to help their workers lead healthier lives, or is that an unreasonable expectation? Do local restaurants and stores bear some responsibility to conveniently provide the building blocks for healthy living?

Who Pays?

No matter how healthcare is managed, someone will be paying for it, whether that person is the patient, the taxpayers, employers, or providers. The decisions you make about how healthcare in New Mexico will be managed will determine which sectors of our community pay the bills. Who is most able to bear that burden?

Approaches to Solving the Problem

No one doubts that healthcare is a problem. Policymakers are debating change in health policy at both the state and national levels, and the recent New Mexico legislative session was filled with healthcare issues. This is a complex situation, and there are no easy solutions. There are, however, three primary approaches that people take toward healthcare reform, and those approaches are reflected in this issue guide.

Three Approaches to Reforming NM Healthcare	
Approach 1: Improve Access to Quality Care	Some people see **access** to medical care as the first thing to fix. Those who support this approach say that our state simply doesn't have the people and facilities to take care of all our needs. They point to the shortage of medical professionals and the fact that many of our doctors and nurses are approaching retirement. Specialist services are located almost entirely in cities, meaning that rural residents regularly have to either travel for the care they need or simply hold off on recommended treatments. Native American communities also suffer from a shortage of doctors and facilities and culturally appropriate options.
Approach 2: Insure All New Mexicans	Others say that New Mexico's biggest problem is the lack of **insurance coverage** for so many people and that the first step is to make sure that every individual can afford to go to the doctor. For too many people, insurance is tied to a job and not guaranteed. Employers are increasingly saying that they can no longer afford to offer full insurance to their employees and their employees' families, so that even people with full-time jobs may be searching for ways to be covered. With 21% of all New Mexicans uninsured, there is a significant economic impact, promoted by the cost of uncompensated care and increased emergency room visits.
Approach 3: Change the Economic Structure of Healthcare	A third approach insists that the real problem with the healthcare system deals with underlying **economic** factors, such as how the system rewards hospitals, insurers, providers, employers, and individuals, and why all these groups make the decisions they do about healthcare. Supporters of economic reform insist that improving access and coverage will only treat the symptoms of the problem, and that without major changes to the system of incentives that motivates doctors, patients, hospitals, and communities, no real improvements to people's health and rising costs will be possible.

[4] "As Death Nears, Health Costs Soar," in the *Albuquerque Journal* on February 25, 2007.

Approach 1: Improve Access to Quality Care

New Mexico has a shortage of healthcare providers, and that shortage is projected to worsen as the population grows and ages. For some, healthcare just isn't a normal part of their way of life, even if it is available. As a result, many New Mexicans – particularly those in rural areas or on tribal lands – find it difficult to see and keep a good healthcare provider. Given the complexities of the modern healthcare system, even people in urban areas often struggle to develop a relationship with a regular doctor or specialists such as dentists and mental health providers.

This section of this report addresses New Mexicans' access to quality health services and providers.

Current Situation in New Mexico

Good access to health services comes down to being able to get care when it is needed. This includes where hospitals and practitioners are located, the ability to get an appointment, and the level of understanding about how to navigate the system.

Right now, over half of New Mexico's population lives in rural areas, while 65% of the state's physicians and dentists practice in the urban areas of Albuquerque, Los Alamos, or Santa Fe[5]. Thirty of the state's 33 counties are designated as medical, dental or behavioral Health Professions Shortage Areas by the federal government. The rural nature of the state creates additional challenges for emergency and trauma care, transportation, and follow-up services for residents outside the major cities. Further, many uninsured urban residents, who may lack transportation or face language, economic, or cultural barriers, have similar challenges in accessing care.

What influences access to care issues? First, let's look at the basic levels of a healthcare delivery system:

Public Health System: This government-funded system targets the population in general. As in most states, New Mexico's public health services are the responsibility of the various federal, state, and local governmental agencies.

Primary care is primarily provided by family physicians, pediatricians and internists. Physician assistants and nurse practitioners also provide primary care, and in some cases, these are the only providers in rural communities.

Specialized care is the most complex and procedurally intense area. It includes hospitalization, inpatient rehabilitation, and surgical interventions. Some services have a limited number of specialists and waiting times can be weeks or months.

New Mexico's Healthcare Challenges

Because of a range of challenges presented later in this report, primary care can be hard to access, causing more people to use emergency rooms for non-emergency problems. Also, people who should be living in an assisted care environment often have problems paying for this care; when they try to take care of themselves, sometimes a minor medical condition turns into a bigger problem, leading to higher costs.

Across New Mexico, many patients don't have just one medical condition; each person may have multiple conditions that need to be treated or managed. For example, pediatricians are seeing more children without dental care. Primary care physicians are seeing a larger number of patients with both mental health and substance use issues. Increasing rates of diabetes among Native Americans and Hispanics are resulting in dialysis, amputations, and vision loss. An already overloaded healthcare system is trying to deal with this complexity, but right now, the effort to address all of patients' health needs reduces the availability of healthcare across all levels.

[5] HPC's Quick Facts 2007, p. 28.

Community Profile

In rural communities like Portales, NM (population 12,000), people rely on a small network of local doctors, nurse practitioners, and physician assistants for most of their care. The 22-bed Roosevelt General Hospital is quite new (built in 2001) and employs 140 people. It provides general medical and surgical care for local residents, many of whom are elderly.

People with more complex medical needs are typically transferred to larger hospitals in Lubbock or Albuquerque. For example, if a local resident needed gallbladder surgery, she could have the procedure in Portales. However, if a resident had a major heart attack, he would probably be transferred.

Like many small communities, Portales works hard to retain physicians. It faces a chronic shortage in areas such as cardiology, urology, and orthopedics. To address its need to attract and retain good people, the community offers higher physician salaries than in larger cities. It also has to compensate physicians for being on call during weekends and holidays since there is not a large pool of physicians to share the load.

Unlike many other small hospitals, however, Portales is fortunate in that it does not face a serious shortage in nurses and physical therapists. This supply comes, in part, from two nearby college nursing programs. Further, the hospital is generally considered a good place to work, so it successfully retains its employees.

Portales is one of at least 32 small and mid-sized New Mexico communities with local hospitals.

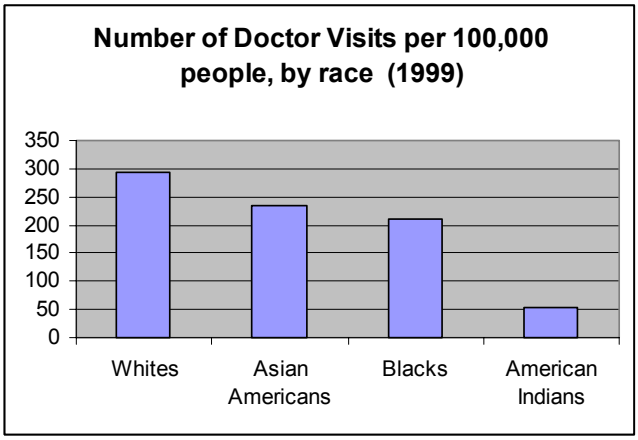
Special Populations

As New Mexicans continue to age, the system is having a hard time dealing with the increased demand for access to care for the elderly. Most older citizens are insured through Medicare, but this does not cover dental care unless such care is required as a result of a medical condition. Long-term care in an assisted living facility is not generally covered under Medicare. Nationally, 20% of adults who need long-term care can't get the care they need, often with serious consequences[6].

At the other end of the age spectrum, New Mexico averages 28,000 births per year, half of them to single mothers. New Mexico has the second lowest rate of women receiving prenatal services in the nation[7]. In 2004, 42% of mothers received late or inadequate prenatal care, with younger mothers receiving the lowest levels of prenatal care[8]. In 2004, 16% of New Mexico's public school enrollment (51,814 students) were disabled and in special education programs[9]. Pregnant teenagers and disabled children represent yet another challenge to assuring access to care.

Native Americans

Access is one of the greatest barriers to adequate healthcare for Native Americans. Only 28% of them receive private health insurance through an employer, and 55% rely on the federal Indian Health Service (IHS) for all their healthcare needs. According to the National Center for Health Statistics, Native Americans make fewer visits to physicians' offices and outpatient departments than any other racial or ethnic group[10]. On the other hand, they had more



[6] *Health Affairs*, Vol. 19, No. 3, p. 41.

[7] Kaiser Family Foundation, "State Health Facts Online," available at www.statehealthfacts.org

[8] New Mexico Department of Health, Bureau of Vital Records & Health Statistics. "New Mexico Selected Health Statistics Annual Report for 2004." (2006) Available at www.health.state.nm.us/pdf/2004annualreport.pdf.

[9] National Center for Education Statistics, Digest of Education Statistics, 2005, Table 52. Number and percentage of children served under the Individuals with Disabilities Education Act. Available at nces.ed.gov/programs/digest/d05/tables/dt05_052.asp.

[10] Data available at www.cdc.gov/nchs/nhcs.htm.

emergency room visits than Whites or Asian Americans. According to the 2000 Census, nearly 60% of Native Americans live in urban areas around the country and about 50,000 of these live in the Albuquerque metro area.

The IHS is the primary healthcare provider for most Native Americans. IHS spends roughly 60% less on its beneficiaries than is spent on the average American for healthcare, and while government programs such as Medicare and Medicaid keep pace with inflation by accruing interest, IHS funds do not[11]. Critics say that this fact keeps IHS underfunded, making healthcare for Native Americans even harder to obtain.

Barriers to Quality Care

Health Disparities

The term **health disparities** means that racial, ethnic, geographic or financial groups have different challenges when accessing the healthcare system, and some are healthier than others because of it. Some groups may have more or less access to good doctors, may be more likely to develop conditions (such as diabetes or high blood pressure), or may feel less comfortable seeing a medical provider[12]. Throughout the United States, health disparities are well documented in minority populations. When compared to Whites, minority groups have more long-term medical conditions, higher death rates and poorer overall health. Minorities also generally have higher rates of cardiovascular disease, HIV/AIDS, and infant mortality than Whites. A recent study by the State's Department of Health confirmed that these disparities are present here in New Mexico[13].

Disparities in Access to and Quality of Medical Care

Why do some people have less access to medical care than others? There are many possible causes, including:

- Inadequate or no insurance coverage,
- The high cost of health services,
- No regular healthcare provider,
- Shortages of healthcare providers,
- Legal barriers,
- Stigmas associated with visiting a doctor or receiving some treatments,
- Shortages of doctors, nurses and other medical professionals,
- Cultural and linguistic barriers that prevent effective communication and relevant care options,
- Hospital and provider hours that may not fit with a work or school schedule,
- Overbooked/overcrowded facilities,
- Distrust of doctors or the medical system,
- Poor understanding of the healthcare system,
- Lack of diversity in the healthcare workforce, and
- Geographic isolation.

Shortages of Healthcare Professionals

New Mexico has problems in the supply and distribution of health professionals, especially for primary care, nursing, behavioral health (mental health and substance abuse), specialty physicians, and dentists/dental hygienists. In 2000, the state had only 194 physicians for every 100,000 citizens, which puts us 5% below the national average[14]. About 33% of active physicians in the state are over age 55 and approaching retirement[15]. In some specialty areas, the situation is even worse – 46% of New Mexicans have no access to mental health care facilities, compared to 17% of the nationwide population[16]. Our shortage makes it harder for some New Mexicans to access care for needed services, and the problem is projected to grow. Because of shortages of other healthcare providers, nurses are often the first point of care for many people. The latest data predict a 43% shortage of full-time registered nurses (RN) in New Mexico by 2020[17]. That means half the jobs requiring an RN will go unfilled at that point. Nationally, nursing schools have not seen additional funding to support more faculty or students to keep up with the demand, though New Mexico nursing schools have managed to expand their capacity to produce new nurses[18].

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[11] "A Quiet Crisis," US Commission on Civil Rights, 2003.

[12] US Department of Health and Human Services (HHS), Healthy People 2010: National Health Promotion and Disease Prevention Objectives. (Washington DC: January 2000).

[13] New Mexico Department of Health, "Racial and Ethnic Health Disparities Report Card." (August 30, 2006) Available at www.health.state.nm.us/OPMH/ReportCard.pdf.

[14] New Mexico Department of Health, "2006 Comprehensive Strategic Health Plan," p. 5.

[15] New Mexico Health Policy Commission, "Physician Supply in New Mexico 2002."

[16] State Health Care Rankings, 2007. Morgan Quitno Press, p. 441.

[17] "Projected Supply, Demand, and Shortages of Registered Nurses: 2000-2020," Health Resources and Services Administration, 2002.

[18] "Status of Nursing in New Mexico," 2007, New Mexico Center for Nursing Excellence.

Each vacant primary care practice represents at least 1,500-1,800 patients who have to either drive to another community to see a doctor, skip the doctor visit entirely, or rely on an emergency room. For dentistry, the numbers may be as high as 1,800-2,100 patients for every missing dentist. Some data suggest when new primary care is brought into an area, previously undiagnosed illnesses are identified, thus increasing demand for specialty services as well.

When healthcare shortages are addressed, communities benefit in other ways. Improving access to healthcare improves economic and community development. For example, when a physician sets up practice in a rural community, about 23 new jobs are created directly and indirectly[19]. In addition, the presence of adequate healthcare is important to attract businesses and retirees to a community.

Getting Access to Prescription Drugs

For over a decade, prescription drugs have been the fastest-growing part of healthcare expenditures, rising in price more than twice as fast as the overall industry[20]. There are several reasons why these costs are increasing so quickly: more prescriptions are being written; pharmaceutical companies have started advertising to consumers; patients have shifted from older, cheaper drugs to newer, more expensive medications; and manufacturer costs have risen[21].

In a 2002 survey, 12% of New Mexicans reported that they had trouble reliably getting the medications they had been prescribed. Even among those who had full health insurance, 35% of them said that prescriptions were not fully covered by their health plan.

Medicare Part D, enacted in January 2006, has begun to cover prescription costs for most Medicare recipients. It is as yet unclear how this policy will affect access to prescription drugs long-term.

[19] "The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-migrating Health Services," January 2007, National Center for Rural health Works, available at www.ruralhealthworks.org.

[20] "A Study on the Impact of the Rising Cost of Prescription Drugs in New Mexico" by the New Mexico Health Policy Commission.

[21] "Prescription Drug Trends: A Chartbook Update,"Kaiser Family Foundation, 2001.

Strategies for Improving Access

Eliminating Health Disparities

The Commonwealth Fund, a national health research organization, recommended steps for eliminating racial and ethnic disparities[22]:

- Have healthcare providers gather consistent data by race and ethnicity.
- Conduct effective evaluation of the programs trying to reduce these disparities.
- Develop minimum standards for culturally and linguistically competent health services.
- Have more minorities working in healthcare.
- Establish/enhance government offices of minority health.
- Expand access to services for all ethnic and racial groups.
- Involve all health system representatives in minority health improvement efforts.

Building a Strong Public Health System

A strong public health system is responsible for assessing the health of the community, developing appropriate and effective health policies, and ensuring that the system of care delivers needed services and protection.

Public health has the responsibility to address service gaps in the insurance-based system. Our current public health safety net, however, has the resources and the authority to address only a fraction of the unmet need. In 2003, the New Mexico Department of Health assessed the state's overall system of public health and found strengths in its ability to assess health and manage outbreaks, but recommended improvements to planning, evaluation, and accountability, with better alignment of resources and priorities[23].

Using Technology

Health information technology may offer some relief. The newly-created New Mexico Telehealth Commission helps rural doctors discuss patients' health problems with long-distance specialists. This way, rural patients receive specialized care even when there is no specialist living in their area. While this approach is promising, it is still a small program.

[22] "State Policy Agenda to Eliminate Racial and Ethnic Health Disparities," from the Commonwealth Fund (June 2004).

[23] "Assessment of the Healthcare System in New Mexico," from the Institute for Public Health (October 2003). Available at hsc.unm.edu/som/iph/documents/assessmentreport.pdf.

Technology can also help to coordinate care between a wide variety of practitioners all working with one patient. "Smart cards" store all of a patient's medical records electronically on something the size of a driver's license. Doctors can then instantly access these records to understand the medical history and can add their own diagnoses and treatments. The use of patient "smart cards" or other electronically stored health records have the potential to dramatically improve the quality of medical care by preventing many medical errors; it can also drive down hospital operating costs by reducing the time and labor associated with paper medical records[24].

Building a Strong Primary Care System

Having a good relationship with a primary care provider, preferably over several years, is associated with better, more appropriate care, better health, and much lower health costs[25]. In New Mexico, however, every county except Los Alamos County is experiencing a shortage of primary care health professionals, with 17 rural counties facing a severe shortage[26]. For the past few decades, there has been an effort to build a system of community-based primary care centers for New Mexico's underserved population, but these 135 centers are meeting only half of the unmet demand for healthcare in New Mexico[27]. The most practical approach is to organize services around strengthened primary care. Additionally, more incentives (such as student loan repayment, sign-on bonuses, practice subsidies, and continuing education allowances) are needed to encourage primary care practice and to recruit and retain providers in underserved areas.

Nationally, the percentage of doctors, physician assistants, and nurse practitioners entering primary care and serving rural communities is declining, while the need for primary care is growing. Pay in specialty fields is much higher, and urban job opportunities pull providers away from rural communities. So, how to fix the problem? Options include:

- Recruiting students from rural and ethnic minority populations. These students have a significantly higher rate of practicing primary care and serving those populations after graduation.
- Increasing the number of medical students in general, creating a greater supply of medical professionals to cover the state. This will require improving the understanding of math and science in P-20 schools statewide.
- Developing training programs in underserved areas.
- Creating appealing healthcare jobs and environments in underserved areas.
- Providing a support structure and network for medical professionals in geographically isolated communities.
- Helping prospective medical students to pay for their education or to repay student loans they have incurred (often $100,000-$140,000 per student). Oftentimes, rural areas offer lower pay, which keeps rural practitioners in debt longer[28].

Summary

This section of the report has focused on how to improve patients' access to health services. The section presented basic elements of the healthcare system, and it highlighted our state's chronic shortage of medical professionals. It described special challenges faced by the elderly, rural communities, and Native Americans. Lastly, it identified possible solutions for eliminating health disparities, strengthening public health, and using technology.

[24] KPMG Technology Insider, December 2006. Available at www.kpmginsiders.com/display_analysis.asp?cs_id=175458.

[25] Starfield, Barbara. "The Primary Care Solution: Put Doctors Where They Count," *The Boston Review* (November/December 2005).

[26] New Mexico Health Policy Commission, "2007 Quick Facts," (January 2007).

[27] New Mexico Department of Health. "The State of Health in New Mexico," (2005).

[28] "Medical Educational Costs and Student Debt," by the Association of American Medical Colleges, March 2005.

Approach 2: Insure All New Mexicans

One in five New Mexicans do not have health insurance. There appears to be growing consensus in the state that this problem must be solved. Policymakers are considering a number of ways to address this issue. It is interesting to note that, in the recent state legislative session, Democrats and Republicans both introduced universal healthcare bills. The question appears to be not *whether* to insure all New Mexicans, but *how*.

This section describes the insurance situation in the state and compares different healthcare reform models.

The Current Situation in New Mexico

Like most Americans, New Mexicans today are finding it harder to get consistent healthcare, and insurance coverage plays a large role in this struggle, both nationwide and on a state level. Our state has the second highest percentage rate of uninsured residents in the nation; 21% (approximately 401,000 people) do not have healthcare insurance[29]. In order to examine New Mexico's current situation, we will discuss the types of uninsured people, the role of business in providing healthcare insurance, current and future concerns for providing care for New Mexicans, and the state's responses to these needs and concerns.

Uninsured New Mexicans

Why Are People Uninsured?

When polled on why they don't have insurance, uninsured New Mexicans gave the following answers. (They were allowed to offer more than one reason, so the results do not sum to 100%.)

- 67% said "can't afford it,"
- 38% said "not eligible for health insurance"
- 28% said "changing their job status"
- 20% said "because they were healthy"
- 19% said "health insurance isn't important to my household"

Who Are the Uninsured in New Mexico? [30]	
Ethnicity[31]	• 55.9% are Hispanic • 28% are White • 13.5% are Native American • 2.6% are none of these ethnicities
Age[32]	• 24% are 18 and under • 76% are 19-64 • Most people aged 65 and up are covered by Medicare
Geography	Uninsured rates are highest in northwest and southern New Mexico and lowest in the Albuquerque metro area (though there are significant differences in Albuquerque, depending on income level).
Income	• 35% have an income below the federal poverty level • 30% have an income that is less than 185% of the federal poverty level • 18% have an income that is less than 235% of the federal poverty level
Employment	• 31% are part-time workers • 31% are seasonal workers • 17% are full-time workers • 21% are unemployed or other

[29] State of New Mexico. *Insure New Mexico!* Council. Insure New Mexico: A Window of Opportunity. Report to Governor Richardson on Jan. 21, 2005. <www.insurenewmexico.state.nm.us>.

[30] State of New Mexico. *Insure New Mexico!* Council. Insure New Mexico: A Window of Opportunity. Report to Governor Richardson on Jan. 21, 2005. <www.insurenewmexico.state.nm.us>.

[31] "Final Report 2004 Household Health Insurance Survey," New Mexico Human Services Dept.

[32] Kaiser Family Foundation, "State Health Facts Online," available at www.statehealthfacts.org.

Factors Influencing the Insurance Debate

One of the reasons insurance coverage is receiving so much national attention recently is because the middle class is also beginning to feel the financial pressure of maintaining coverage for their families[33]. These newly uninsured people say that employers are not offering premiums at a price they can afford anymore. There is a small portion of the uninsured that are not affected by price. Approximately 6% of those not insured are in the upper financial bracket, most of whom are younger and don't think they need insurance[34].

In addition to financial issues, there are other factors. Rural New Mexicans are less likely to have insurance than those who live in cities. The complexity of the insurance system scares away some people who have access to some level of benefits, so they may be insured but don't know how to take advantage of that coverage[35].

While many states face similar insurance challenges, New Mexico's situation is unique. A far larger share of New Mexicans are uninsured than in most other states[36], and our economy is growing but remains relatively fragile.

New Mexico's Response

To address the range of health insurance issues, Governor Bill Richardson created a five-point plan:

1. State vendors may be required to provide health insurance benefits to their New Mexico employees.
2. State employees who do not choose to enroll will be identified.
3. Medicaid coverage is expanded for low-income adults up to 100% of the federal poverty line.
4. The state coverage insurance (SCI) program will be expanded to cover more working adults.
5. The Health Coverage for New Mexicans Committee was created to identify and conduct a cost study of healthcare coverage models as viable solutions for our state.

The Health Coverage for New Mexicans Committee chose three coverage models designed to provide health coverage for all New Mexicans, including subsidies for those who find it difficult to pay. All of them include those people with high healthcare needs or pre-existing conditions. Each model attempts to optimize the use of federal funds in programs like Medicare and Medicaid and federal matching funds. Finally, each one also utilizes the commercial insurance market in varying degrees[37]. The three different models are currently under review, and a draft cost analysis comparing the three will be released by the Committee in mid-May.

Profile: One Uninsured Man

Recently a man passed through the doors of an Albuquerque health clinic. He had no health insurance or money, and he had an unreasonably large growth on his eye.

According to Dr. Sandra Penn, Medical Director of Albuquerque Health Care for Homeless, the condition had needed treatment for over nine months, during which time the growth had grown larger and larger. Because the man did not have insurance, he did not know how to find the help he needed.

By the time he saw a physician at the clinic, it was determined that he would probably lose his cornea and possibly his vision. And while he will now get some pro bono healthcare, if he had received this care a few months earlier, preventative care may have saved his sight. Further, the cost of his treatment would have been far smaller had his condition been diagnosed sooner.

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[33] "Health Care: Squeezing the Middle Class with More Costs and Less Coverage," Kaiser Commission on Medicaid and the Uninsured. Available at www.statehealthfacts.org.

[34] State of New Mexico. Dept. of Health. Health Policy Commission. 2006 Comprehensive Strategic Health Plan. Available at www.health.state.nm.us/pdf/NMCSHP.pdf.

[35] State of New Mexico. *Insure New Mexico!* Council. Insure New Mexico: A Window of Opportunity. Report to Governor Richardson on Jan. 21, 2005. <www.insurenewmexico.state.nm.us>; Del Mauro, Diana. "Health-care study finalists narrowed to three teams." Santa Fe New Mexican. Dec 1, 2006, C1.

[36] State of New Mexico. *Insure New Mexico!* Council. Insure New Mexico: A Window of Opportunity. Report to Governor Richardson on Jan. 21, 2005. <www.insurenewmexico.state.nm.us>.

[37] New Mexico Human Services Dept. "Governor's Richardson's 5-Point Plan

Three New Mexico Health Reform Models Being Studied by the Health Coverage for New Mexicans Committee

This table describes the three models, based on the information available in early April. Modifications to the models may be made by the committee.

	Health Security Act	New Mexico Health Choices	Health Coverage Plan
Snapshot	A plan that would be administered by a commission appointed by the Governor.	A market-based universal coverage plan with vouchers that would be provided to individuals.	A plan that would build on the current coverage system in the state, focusing on those not currently covered.
Description	The Health Security Act would create an appointed commission that would provide health coverage through a single plan. This would cover all New Mexicans, with the exception of undocumented immigrants, people who have not established residency, federal and military retirees, and military personnel. (Federal and military people already have insurance.) The coverage would be the same as is offered to state employees currently. Participants would be able to select their provider, hospital, pharmacist, or clinic from those who have contracts with the commission. The commission would determine fees that providers could charge and base patients' co-pays on their income. Employers and tribes could contribute toward insurance costs.	The Health Choices Plan is a market-based universal coverage model based on vouchers given to individuals. Its aim is to give people a range of private and government options to make insurance more affordable. New Mexicans not covered by programs such as Medicaid would be given a voucher (the amount varying according to income) to buy insurance through a few commercial pre-selected carriers. While insurance coverage would be mandatory, different cost-sharing options (low, medium, and high) would be offered. Undocumented immigrants and homeless or transient people would be covered through safety net programs. All employers would pay a payroll tax to help finance the vouchers.	The Health Coverage Plan builds upon the current public and private healthcare system. It would require all people living in New Mexico to buy or be provided with some type of coverage, whether commercial, employer-sponsored, or federal or state subsidized programs. The plan would offer incentives to employers and tax credits or tax incentives to consumers while also expanding on Medicaid and state insurance coverage for adults. Several different benefit options would be offered. Undocumented immigrants and people who have lived in NM less than six months would be covered through safety net programs. Employers would be required to pay part of the cost of healthcare for employees or pay into a uncompensated care fund.
Key points	• Patients would select their own healthcare providers; the providers would be paid by the commission. • Private health insurance companies in NM would only cover federal employees and those citizens who want supplemental insurance. • Tribes could choose to join the plan. • All New Mexicans would be automatically enrolled and pay a premium based on income.	• The plan would combine government support and private industry through government-subsidized vouchers. • Private health insurance companies would continue to exist, offering benefits similar to those now held by state employees.	• The plan would rely upon the current public and private health coverage systems. • It would expand the number of people who could be covered under Medicaid, maximizing federal funds. • The plan would represent the smallest amount of changes to the current system.
Issues To Consider	• Because everyone would be in the same pool, cost and risk would be spread across the state, thus lowering premium rates for all. • The plan would offer a single comprehensive benefit plan for all, regardless of health risk or location. • The plan would have a negative impact on the insurance industry statewide. • Some question whether the commission could be truly fair and independent.	• The plan would create one risk pool for most New Mexicans under 65, thus providing portability. • Each insurance carrier would offer three plans: limited, basic, and comprehensive. Individuals and employers would decide which coverage level to purchase. • The vouchers would only cover basic, not comprehensive, care. • Like the Health Security Act, this plan would create big changes to the current system, requiring lots of public education.	• While the other two plans "start from scratch," this plan builds upon what is already in existence. • It would allow children to stay on parents' insurance through age 30. • The plan may not address perceived problems with the current systems. • It would require parents to show proof of health insurance before admission to school or child care, and adults to show proof of insuance before obtaining driver's or professional licenses.

A Fourth Model?

The previous table describes the three healthcare models for which the Health Coverage for New Mexicans Committee has commissioned cost analyses. During the most recent legislative session, several additional healthcare bills were introduced, including one comprehensive plan that supporters say is on par with the three models being considered by the Committee. This model is based around the idea of a centralized insurance exchange, and received bipartisan support during the 2007 legislative session. If healthcare reform is taken up during the 2008 legislative session, many expect that this model will be considered alongside the other three.

Health Right New Mexico	
Snapshot	Creates a centralized exchange for health insurance, so that individuals can keep the same plan regardless of their employer.
Description	The Health Right Plan is a consumer-driven, market-based universal coverage model that would create a new statewide Health Insurance Exchange. This exchange would organize a centralized system where individuals and employers could buy and sell health insurance. This model would allow personal, portable health insurance which employees could keep during periods of unemployment, part-time employment, and self-employment.
Key points	• Private health insurance companies would continue to exist, offering plans through the centralized exchange. • Individuals and employers would quality for tax credits and deductions when purchasing health insurance through the exchange. • Use of technology would be expanded, including electronic medical record keeping and telehealth services to rural areas. • All New Mexico residents would be required to purchase health insurance.
Issues To Consider	• Competition, choice, and a single private risk pool would make health insurance more affordable and accessible. • Like the other models, this plan projects that uncompensated care (free care provided by hospitals and other healthcare providers) would decrease as a result of universal coverage. • The plan would place a two-year moratorium on Medicaid expansion. • The plan would require significant changes to the existing system, requiring individuals, employers, health plans, and healthcare providers to adapt.

Federal Level Healthcare Discussions

Republicans, Democrats, state officials, large corporations, providers, and even insurance companies are acknowledging the need to make changes to our system. This section will explore specific responses from the federal government, including the President, other government officials, state lawmakers across the country, and the business industry.

There is a groundswell of concern nationally regarding the economics of healthcare. In a recent New York Times/CBS poll, a majority of Americans think the federal government should guarantee health insurance to every American, with coverage for children leading the list[38]. And in contrast to earlier years, they seem willing (in polls at least) to pay higher taxes to get it accomplished.

President Bush has proposed tax deductions as a way to make healthcare more affordable for workers while also using the savings to help low-income workers obtain coverage. While this plan could expand coverage to many people not currently covered, some politicians believe tax credits would work better. Others say the plan would lead to funding problems for hospitals. Some critics believe the overall plan still falls short since it fails to address high-risk patients that insurance companies avoid[39]. Most presidential candidates are proposing different forms of universal coverage.

Many states are also responding to the crisis. Recently, Republican Governor Mitt Romney and the Massachusetts state legislature, in a bipartisan effort, devised a plan to provide coverage for all its residents. Based upon this model, California Governor Arnold Schwarzenegger has also proposed a plan for universal coverage. Both plans are an attempt to augment the traditional means of providing insurance through employment. While these plans make insurance coverage mandatory, they propose to offer subsidies for those who need it through government and business. Arizona is currently introducing a bill very similar to New Mexico's proposed Health Security Act[40]. In addition, Maine, Connecticut, and New York also initiated significant healthcare reforms in recent years.

National and state levels of government are not the only institutions

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[38] March 2, 2007 poll.

[39] Hirsh, I.B. "High-risk pool. Ensures fair, universal healthcare." Sante Fe New Mexican Feb, 4, 2007. p. F3; Pickler, Nedra. "Universal health coverage urged." Albuquerque Journal Jan. 27, 2007. p. A6.

[40] Arizona House Bill 2757, First session 2007. Available at www.azleg.gov/formatdocument.asp?indoc=/legtext/48leg/lr/summary/s.2757health.doc.htm.

calling for change. Business groups, labor unions, and the insurance industry have, in some cases, joined forces to advocate proposals for universal coverage. On February 7, 2007, Wal-Mart and the Service Employees International Union announced a cooperative campaign to support universal healthcare coverage. Both groups supported the idea of sharing financial responsibilities between individuals, businesses, and the government[41].

Opponents

Opponents to universal coverage, whether through a state-funded program or cooperative initiatives with business and government programs, have various arguments. Some believe the current figures do not reflect the real situation. For example, some believe that many of the 45 million Americans not uninsured today are younger people that are just not bothering to get covered because they are counting on their good health. Others believe more people could afford healthcare if they were more responsible with their finances. Others are concerned about the government's increasing involvement in what used to be primarily private industry.

Those who are concerned with the government's involvement also believe it could decrease the quality and availability of care. This argument is based on both the value of competition to improve technology and standards as well as the principal of supply and demand. For example, if more people have ready access to care, will it overwhelm our existing shortage of physicians?

Some New Mexicans believe that helping everyone obtain coverage does not really solve many health problems because of the rural nature of the state. Their view is that community health centers and other strategies for improving access to health services – not necessarily access to more insurance – should be the top priority.

Businesses within our state are also concerned about how this situation will be handled. Ninety percent of small businesses say they do not want the state forcing them to provide healthcare for full-time employees[42].

Summary

This section has described Approach 2, which focuses on expanding health insurance in New Mexico. It profiled the uninsured and factors influencing insurance issues, both in New Mexico and nationally. It presented the three reform models currently being researched by the Health Coverage for All New Mexicans Committee, all of which would result in universal health coverage in New Mexico. It also described a fourth plan introduced during the last legislative session. Lastly, this section presented the concerns raised by people who oppose universal health insurance.

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[41] Kaiser Daily Health Report. "Wal-Mart, SEIU, to launch campaign seeking universal health coverage, shared responsibility." Feb. 7. 2007; Graham, Judith and Michael Martinez. "States become innovators behind healthcare and reform." Santa Few New Mexican. Jan. 21 2007. p. A5.

[42] National Federation of Independent Business poll, available at www.nfib.com/object/io_32136.html; Heacox, Don. "Health Security Act needs to get done." Deming Headlight. Dec. 18, 2006. p. 4; Rusher, William. "The other side of healthcare." Farmington Daily News. Jan. 14, 2007. p. D3.

Approach 3: Change the Economic Structure of Healthcare

Currently, everyone in the healthcare system – patients, employers, health plans, doctors, hospitals – wants to save themselves money, which means that healthcare decisions are made based on costs, not on quality of care. Some people believe that our current system rewards all the wrong things, but fixing it might involve making some substantial changes to the basics of how our healthcare system works.

This section presents basic economic theory and describes options for private sector changes that could be made to the healthcare system.

Prologue

This section presents an economic view of the healthcare system as a whole, which can imply a number of different specifics. For some, the issues are those of the basic economic forces of supply and demand at work in the system; others want to look at the concrete changes that different players in the system can make. This section will attempt to address both of those interests in turn, beginning with an overview of system-wide economics (pages 17-18), moving to a discussion of the history and trends in employer-based healthcare (pages 18-19), and ending with a number of potential reforms that could be implemented through the private sector (pages 20-21).

As individuals, healthy behavior is often easy to define; we should eat a reasonable amount of nutritious food and exercise moderately on a regular schedule. And yet many of us do not always make these choices. Individuals weigh the costs and benefits of even minor decisions – do I have donuts for breakfast today? – and many times end up making unhealthy choices (either because of convenience or cost). Making these kinds of unhealthy choices regularly can create problems that no amount of medical care can solve.

Many of these bad decisions are made as a result of an individual's unconscious economic thinking. In its simplest form, economics is the study of how supply and demand divide up scarce resources. When there's not enough of something to go around, how do we determine who gets it? As this report has already shown, healthcare is a scarce resource – we're already short on the doctors, nurses, and facilities we need, and our growing population continues to need more and more care every year. Each individual doctor's time is also a scarce resource – there are only so many hours in a day. And each of us as individuals make daily choices about how to spend our time and money in ways that affect our health.

So from an economic viewpoint, the question is how do we best use the resources we have? Even if we increase the supply of medical professionals and facilities, even if we provide coverage for all, that basic question of how to best divide up what we have remains relevant.

Economics is a topic that many people would rather not talk about, since the conversation can sometimes turn into vocabulary lists and graphs. But we intend to keep it on an understandable level, talking about why people make the choices they do.

A Glance at the Extremes

When looking at healthcare from an economic perspective, it seems there are two very visible extreme positions.

- The first is **a free market approach** – if you can pay for it, you can get it. This idea depends on individual choice and responsibility and has little government intervention.
- The opposite extreme is **socialized medicine**, where the state or federal government own all the means of providing healthcare and all healthcare professionals are government employees. As a citizen of the country, you receive healthcare as a birthright. The government sets the prices and takes care of all costs.

Neither of these extreme approaches is actually used anywhere in the world today. Britain and Canada come close to a socialized model, but even in those countries, many hospitals are privately owned and operated. Many people claim that the U.S. operates under a free market system today, but about 45% of healthcare in the U.S. is currently publicly funded, including Medicaid/Medicare, Indian Health Services, and military and veterans health, among others.

Neither of the two extremes is politically or economically possible for New Mexico. Our situation must lie somewhere in between and a wide variety of public and private programs could be a part of this system.

Problems with a Free Market Healthcare System

Some people suggest that the best economic structure for healthcare is that of the free market. This system sets prices and costs purely based on the relationship between individual healthcare preferences/needs and providers' ability to offer services. Under this system, people can have the health services that they can personally afford.

Free market economic structures are based on four basic assumptions (see table below), all of which must be true in order for a free market to work properly. Unfortunately, none of those four assumptions fits the healthcare system. Sometimes an assumption is broken by the way our system works right now and sometimes by qualities inherent in healthcare.

Free Market Assumptions	Healthcare Realities
There are no monopolies, and all companies have to compete with each other for customers.	Often times, there will be only one doctor or hospital that offers a particular service within the local area; if there are multiple providers for that service in the area, they may only have to compete to get insurers to sign up with them, not individual patients.
All companies and consumers have complete knowledge about what products and services are available and the quality of each company's services.	Healthcare issues are complicated and difficult for many consumers to understand. There is little information available about the relative quality of various doctors and hospitals.
New suppliers can easily enter the competition, and consumers can easily change who they buy from.	Becoming a doctor or nurse involves years of study and earning professional credentials. Most consumers can't pick their doctors; instead, their insurance company chooses which healthcare providers are available.
Personal and rational self-interest is what motivates all companies and consumers.	Many buying choices are made by a health plan or insurer, not the consumer who will actually receive the care. Often, healthcare decisions are made under emotional stress and pressure, rather than through rational consideration of the options.

Employer-Based Insurance

Fifty-nine percent of Americans are covered by employer-based health insurance[43], and that percentage is fairly close to New Mexico figures (51%). The original employer-based health insurance programs began during WWII, when the federal government prevented civilian employers from increasing wages. Instead, big employers such as General Motors, U.S. Steel, Alcoa and DuPont created health insurance and other non-wage benefits to attract workers. This program proved popular, and the number of people covered by employer-based insurance increased from 1.3 million people in 1940 to 32 million people in 1945[44].

These employer-based insurance programs had everyone pay the same price for insurance. This flat fee covered the costs of healthcare for fitter employees with extra money left over. This extra paid for healthcare for employees who needed more extensive medical care than their flat fee premium would cover. Workers across

[43] State of New Mexico. Insure New Mexico Council. Insure New Mexico: A Window of Opportunity. Report to Governor Richardson on Jan. 21, 2005. <www.insurenewmexico.state.nm.us>; "Government's role in healthcare needs thought." NM Business Weekly. Jan. 12-18, 2007. p. 17; www.census.gov/hhes/www/hlthins/historic/hihistt4.html.

[44] Health Insurance Institute report, 1970, p. 37-39. Available at www.rwjf.org/files/research/037-part1-chapter3.pdf.

the country in different companies were all part of one insurance company's pool, so expenses were shared across thousands of people.

Since WWII, the situation has changed because of two basic trends. First, the American economy has become more competitive, which means companies need to cut their costs or innovate. Second, healthcare has advanced to be able to treat more conditions, which makes it overall more expensive. These two factors, working together, have made many companies move away from that traditional insurance model. Currently, 81% of New Mexican employers say that current and future costs are the main reason why they can't offer health benefits[45].

Trends in Employer-Based Insurance

Companies deal with this problem in a number of different ways.

- Some offer cheaper rates to healthier, lower-risk individuals. While these lower rates are attractive to individual consumers, it means that no one is helping to pay costs for individuals who need extensive care, and their insurance rates have skyrocketed. Some employees pay less and some pay more, depending on how much healthcare they're likely to need.
- Some act as their own insurer, with no outside insurance company involved at all, and taking on the risk of just their own employees. While this often cuts company costs, it means that far fewer people have to pay their collective healthcare costs. One person's dramatically expensive healthcare can raise rates across the company.
- Some offer Health Savings Accounts as a way for employees to save money for the healthcare they think they will need in the future. Here, each individual has to pay for more of the healthcare they receive.
- Some only pay part of the premiums on their benefits packages, requiring the employee to pay part of the insurance costs. Only 37% of companies that offer insurance pay 100% of the premiums, while another 28% of them pay less than half[46].
- Some no longer extend their health insurance to the family members of their employees.
- Some simply don't offer health benefits. Frequently, this happens in companies that offer the lowest employee wages or only part-time work[47]. This means that many low-wage employees not only lack employer-provided benefits, but they also earn less money, making it much harder to pay for insurance on their own.

As a result of all these changes, individuals are paying for more and more of their own healthcare expenses. If the individual is unable to meet these increasing financial demands, he or she will either seek coverage through government programs or drop it altogether and become a part of the growing population of uninsured people. Studies indicate that if this trend continues, 56 million will have no insurance by 2013 (as opposed to 47 million today)[48].

Even among those employees with insurance, many may still go bankrupt, either because of an illness that requires expensive medical treatment, underestimating how much insurance is needed, or a combination of both[49].

Passing the Buck

These changes in insurance have come about because of the pressure to cut costs, but someone has to pay the bill. In order to be successful, everyone wants to shift their costs to someone else. Some employers try to shift the burden of costs to employees by creating Health Savings Accounts (HSAs) or by offering plans with high deductibles or co-insurance requirements. Workers try to shift it back to companies by demanding traditional workplace insurance. Medicare and Medicaid programs try to shift costs to privately insured patients by underpaying providers for services rendered.

In the current system, all consumers look for the arrangement that saves them the most money. But while everyone wants to pay as little as possible, everyone seems to agree that what they really want is quality healthcare.

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[45] "Uninsured Employer Survey," New Mexico Health Policy Commission, January 2005, p. 47.

[46] State of New Mexico. Insure New Mexico Council. Insure New Mexico: A Window of Opportunity. Report to Governor Richardson on Jan. 21, 2005. Available at www.insurenewmexico.state.nm.us.

[47] State of New Mexico. Insure New Mexico Council. Insure New Mexico: A Window of Opportunity. Report to Governor Richardson on Jan. 21, 2005. <www.insurenewmexico.state.nm.us>;

[48] "It's the Premiums, Stupid: Projections of the Uninsured through 2013," Health Affairs Health Tracking Trends, April 5, 2005; "Government's role in healthcare needs thought." NM Business Weekly. Jan. 12-18, 2007. p. 17; Broder, David S. "Healthcare reform momentum builds toward '08" Albuquerque Journal. Feb. 3, 2007. p. B2; Graham, Judith and Michael Martinez. "States become innovators behind healthcare and reform." Santa Few New Mexican. Jan. 21 2007. p. A5

[49] Hirsh, I.B. "High-risk pool. Ensures fair, universal healthcare." Sante Fe New Mexican Feb, 4, 2007. p. F3

Good Competition

Some critics of the healthcare system argue that it is overly focused on competition and saving money. But some New Mexico health plans are showing they are willing to spend money to improve patient care.

One large New Mexico health plan is spending over $12 million this year in financial bonuses for physicians and nurse practitioners who provide quality care. In this instance, the plan set quality targets in the treatment of diabetes, asthma, childhood immunization rates, and patient satisfaction. Doctors and nurses who meet these quality targets – and thus improve patient service – could earn bonuses to reward their good behavior.

The premise of the program is that quality pays for itself. The health plan believes that incentives like these improve healthcare delivery and thus patients' health, and, in the long run, costs.

Private Sector Changes[50]

Some people and companies have tried to change the healthcare system, to create a situation that works better. Briefly, here are some strategies that have been implemented across the country.

Changes by Hospitals and Medical Providers

- Some hospitals have moved to using quality-based measures to judge their success. This practice often involves seeing an individual as a lifelong patient, not as a set of separate visits to various doctors.
- Instead of working as separate departments within the same hospital, some facilities are starting to organize as teams to treat specific medical conditions. The success of these teams are based on patient overall outcomes over the long-term.
- Focusing on quality of patient outcomes can make some facilities specialize more, so that they become better at one thing rather than trying to do many things.
- Measures of success and failure are made public, so that consumers can judge the quality of healthcare available to them. Patients can also receive a single bill for the range of services they receive from the team, rather than a bill for each separate service. This makes it easier for patients to compare the costs they pay to the benefits they received.

Changes by Insurers

- Some insurers are starting to reward excellence in providers, paying more to providers who provide higher quality care and innovate to prevent future healthcare needs.
- Some are working to help individuals better understand the available healthcare resources, serving as a counselor rather than a decision-maker.
- Some are working to provide better information to physicians, so that these doctors can make better and more informed referrals.
- Some have moved away from short-term insurance contracts to develop long-term relationships with their clients. These longer-term relationships mean that preventative care and risk management become worthwhile, rather than merely short-term costs.

Changes by Employers

- Some employers have begun to choose their company's health plan based on demonstrated excellence, rather than cheapest costs. They believe that healthier employees do a better job. Some of the newer health plans offer access to high-quality providers and work to develop "whole person" approaches to an individual's healthcare.
- Many employers are supporting and motivating their employees to make good health choices and manage their own health. This may mean incentives to go to the gym, to quit smoking, or to seek out good information.
- Health benefits can be seen as a major company success measure, rather than a middle-management concern.
- Some employers are collaborating to advocate for reform of the insurance system, trying to fix the system to provide value to all their employees.

[50] Porter, Michael E., and Teisbert, Elizabeth Olmsted. Redefining Health Care: Creating Value-Based Competition on Results. Harvard Business School Press, 2006.

Changes by Individuals

- Some individuals are starting to manage their own health more closely, accepting personal responsibility for their own health outcomes.
- Consumers are beginning to demand relevant information and to seek advice to interpret the information they get, allowing them to make better decisions about their health.
- Some consumers are beginning to make choices about what doctor to see based on the quality of care, rather than just cost and convenience.
- Some consumers are developing a long-term relationship with their insurer, choosing that insurance partner based on the value that will be provided, rather than just going with what the current employer offers.

These changes are merely things that some organizations and individuals have tried as they try to make the healthcare system work for them and for all parties concerned.

Summary

This section of the report has described Approach 3, a focus on changing the economic structures of the healthcare system. It provided a basic overview of whether free market theory applies to healthcare. It presented trends in employer-based health care, including impacts on employees. Lastly, this section describes potential private sector reforms that could be implemented by hospitals, insurers, employers, and individuals.

Appendix: Community Feedback on Healthcare

In an effort to ensure that the concerns of people in New Mexico's smaller and mid-sized communities were reflected during the statewide healthcare town hall, **New Mexico First** issued invitations across the state to organize "Community Coffees." These simple meetings enabled people to get together in an informal setting and talk about their perspectives of the state's healthcare system. Two towns, Silver City and Roswell, chose to participate.

New Mexico First board member Linda Kay Jones, with the support of fellow board member Sam Redford, hosted the Silver City coffee on the campus of Western New Mexico University on February 9, 2007. **New Mexico First** board member Jim Manatt, along with Executive Committee member Jack Swickard, held a coffee in Roswell on February 24, 2007.

Both gatherings included physicians, community leaders, local insurance representatives, and healthcare consumers. They addressed three key questions, with answers summarized below.

Question 1: What healthcare problems exist in NM?

- It is difficult to attract physicians to small towns. Physicians are being driven to medical groups out of rural areas.
- Medical insurance is not economically feasible for many people.
- Affordability of medical care is an issue.
- Many small community physicians are overbooked, which in turn increases the costs patients end up paying when they go to the emergency room for a routine injury or illness.
- Costs are shifted from lower income patients with no insurance to higher income people who have medical insurance.
- Many people seem to be sicker today, as compared to the past, and their treatment takes more time.
- Patients have a lack of knowledge about broad diversity of coverage/benefits available.
- When asked whether there were any cultural barriers causing a hindrance in obtaining quality care, participants cited the need for proper translation. One physician stated that it is difficult when some family members don't speak English well. Often, the participant said, someone in the family will tell the doctor what they want him to hear, and not necessarily what the patient wants. Another participant noted that doctors who take care of Spanish-dependant populations need to speak Spanish.

Question 2: What is good about healthcare in NM?

- Medical advances are phenomenal, but research and development costs money.
- Participants believed that medical care in their communities is good and that the quality of physicians is very high.
- Service centers, urgent care centers, specialist offices, mid-level providers are providing better services, faster and cheaper than big hospitals.
- The quality of life in New Mexico is a plus in retaining highly qualified physicians who might easily, otherwise, leave for higher-paying positions.

Question 3: What changes have you seen in healthcare in your community in your lifetime?

- Elderly people are getting better care.
- Medically, there are a lot of things done tremendously better.
- People do preventative maintenance to a great extent, however, obesity is on the rise. In the past, there was less obesity, and now, a rising number of obese patients will have a shorter life span than their parents.
- In some places, the local nonprofit hospitals have been sold to large for-profit health conglomerate. When profits are earned here, they are exported out of state.
- Recruiting has changed its focus. Many highly qualified, well-trained physicians now come from other countries.

- Nursing programs in both Roswell and Silver City were commended for their good work. Eastern New Mexico University at Roswell and Western New Mexico University in Silver City have successful nursing programs that are supplying nurses in both cities.

- Participants in Silver City said that they have to travel long distances for some medical care because their small community will never have all the services they need. Because of this reality, transportation can be a problem, whether it be the actual physical movement of a patient, or the fact that it is sometimes difficult to secure a bed for a patient at the other end.

Attendees

The Roswell Community Coffee was attended by:

- Fred French, M.D., partner, Roswell Regional Hospital and Rio Pecos Medical Group;
- Jim Manatt, New Mexico First board member;
- Dean Schear, CEO, Strategic Health Care Associates;
- Jack Swickard, New Mexico First Executive Committee member; and
- Renee Swickard, Swickard Agency health insurance provider.

The Silver City Community Coffee attendees included:

- Linda Kay Jones, Western New Mexico University and New Mexico First board member;
- Sam Redford, New Mexico First board member;
- Sean Ormand, President, First New Mexico Bank in Silver City;
- Robert Rydeski, Rydeski and Company Insurance;
- Dr. John Bell, Silver Internal Medicine Inc;
- Don White, Berean New Baptist Church;
- Lanny Olson, Holiday Inn Express;
- Mike Harris, Administrator, Southwest Bone and Joint Institute;
- Jean Remillard, M.D., M.B.A., CMO and Chief Quality Officer, Gila Regional Medical Center;
- Dr. Don Johnson; and
- Judy Ward, Western New Mexico University.

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FINAL TOWN HALL REPORT

Strengthening New Mexico Healthcare: Access, Coverage, and Economics

A town hall convened by **New Mexico First**

- **Conducted On:** May 3-5, 2007
- **Location:** UNM Student Union Building, Albuquerque, NM

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New Mexico First
320 Gold Avenue SW Suite 300
Albuquerque, New Mexico 87102
Phone: 505-241-4813 (Albuquerque)
888-663-0001 (Statewide)
Fax: 505-241-4819
Email: townhall@nmfirst.org
Website: www.nmfirst.org

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Executive Summary

Strengthening New Mexico Healthcare: Access, Coverage, and Economics was convened by **New Mexico First** on May 3-5, 2007 in Albuquerque. This town hall brought together healthcare stakeholders from all parts of the state.

In order to choose a topic for this town hall, **New Mexico First** polled the public through a series of surveys during the spring and summer of 2006. These survey results, combined with feedback from members, elected officials, and community leaders, identified healthcare as a universal concern. Further surveys gathered specific concerns that citizens had about healthcare, and these clustered into three basic areas: access to quality care, coverage for all, and economics that work. These clusters provided the structure for both the issue guide and the town hall

New Mexico First focuses on attaining balance between various stakeholder groups so that all necessary viewpoints are present in the discussion. To this end, full scholarships were offered to students as well as community members who indicated they needed financial support. Business representatives were also actively recruited. Registrants could choose between acting as a participant (attending the full town hall and actively taking part in discussions) or simply observing.

Almost 250 people took part in the three-day event, with 135 active participants. These participants developed recommendations about what should be done to strengthen New Mexicans' healthcare system.

More specifically, the participants made recommendations, covering all three aspects of the town hall discussion. These recommendations called for public and private sector leaders to make a number of improvements to the state's healthcare delivery system.

Access to Quality Care

Town hall participants developed the following recommendations on quality of care issues:

- Provide sustainable, permanent funding for incentives to recruit and retain healthcare professionals.
- Develop and fund a system of community health workers.
- Provide diversity and cultural competency training to everyone in the healthcare industry.
- Increase the capacity of our educational system to produce healthcare workers.
- Support home and community-based healthcare services across the lifespan.
- Give incentives to provide higher quality healthcare using high-tech, state of the art statewide.

Coverage for All

- Provide for universal coverage of healthcare, with an emphasis on individual choice and education.
- Create a public health infrastructure that monitors and assesses the state's healthcare situation.
- Make the healthcare system cost-efficient, including linkages with the national system.
- Link enrollment into healthcare programs with occasions when citizens use other public agencies.
- Encourage Congress to fully fund Native American healthcare.
- Develop point-of-service enrollment into coverage programs based on a statewide risk pool.

Economics that Work

- Create across-the-board incentives for measurable wellness, prevention, and healthy lifestyles outcomes.
- Fund and facilitate systemic coordination of the healthcare industry, including both technology and human resources.
- Provide and fund incentives to a comprehensive, coordinated, secure, electronic information system, where healthcare data will be analyzed to help policymakers and individuals make good decisions.
- Reduce the barriers and bureaucratic inefficiencies in the public and private healthcare systems.
- Establish a healthcare trust fund to provide dependable system financing.

These recommendations, presented in more depth later in the full report, will be taken up by an implementation team, composed of town hall participants and led by Bill Johnson, former CEO of UNM Hospital and former cabinet secretary for the state's Department of Health. This group will spend the next 12-18 months advancing the recommendations with policymakers, community leaders, and the public.

About New Mexico First

New Mexico First is a nonpartisan nonprofit organization that engages citizens in public policy. Co-founded in 1986 by U.S. Senators Pete Domenici and Jeff Bingaman, **New Mexico First** brings people together for two- and three-day town hall meetings. These town halls use a unique consensus-building process that enables participants to learn about a topic in depth, develop concrete policy recommendations addressing that topic, and then work with other New Mexicans to help implement those recommendations with state leaders. **New Mexico First** is entirely funded through donations, membership fees, town hall registrations, and contracts.

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Strengthening New Mexico Healthcare: Access, Coverage, and Economics

Introduction

In May 2007, **New Mexico First** convened its 35th statewide town hall. The topic was strengthening New Mexico healthcare. This was perhaps *the* most well attended town hall in **New Mexico First's** history, with participant registration reaching the maximum well before the deadline. It was made clear that many New Mexicans feel an urgent need to improve, clarify, and modify the healthcare system currently available throughout the state. Town hall speakers included Lieutenant Governor Diane Denish, as well as Michelle Lujan Grisham and Pam Hyde, the two current Cabinet Secretaries with oversight into healthcare issues. Participants heard keynote addresses from national-level experts Dr. Bob Crittenden from the Herndon Alliance and Edmund F. Haislmaier from the Heritage Foundation. Local business and healthcare experts also spoke.

Participants traveled from throughout the state to attend. **New Mexico First** ensured statewide representation by convening focus groups in two rural communities and by offering scholarships. These activities generated interest in the town hall while providing specific focus to the unique needs of rural areas[1]. Town hall participants included business leaders, education administrators, teachers, professors, community members, and college students. Scholarships covered registration, food, and lodging fees for those with financial need.

Background

When the town hall opened, the challenge given participants was as clear as it was difficult: achieve consensus on actionable recommendations that identify what needs to be done and who might do it. Speakers illustrated health disparities among minority and rural groups, systemic inefficiencies, and the concerns of a wide variety of stakeholders, including employers, the uninsured, medical professionals, tribal leaders, government officials, and healthcare administrators.

1 These dialogues were conducted in the format of "community coffees" convened in Silver City and Roswell. Please refer to the New Mexico First Town Hall 35 Issue Guide for a synopsis of these community-based dialogues.

Common Themes

After extensive discussions, town hall participants came to consensus on their recommendations as one large group. Participants developed their initial ideas in small groups. The ideas were combined and refined until the full group agreed to all the recommendations. Common themes began to emerge immediately including:

- Incentives to recruit and retain more health care professionals
- Affordable, portable, and individualized healthcare
- Personal responsibility by individuals through wellness and prevention activities
- Increased use of technology (electronic medical records, telehealth, health outcome tracking, and simpler health program enrollment)
- Improved community health services (including cultural competency training, home health care, and trauma services)
- Improved and portable coverage for Native Americans
- Cost efficiency throughout the healthcare system

The recommendations that were developed were based on a consensus agreement of what a good New Mexico healthcare system would look like. Participants agreed that such a system would be cost-effective, coordinated, and efficient, with sustainable funding. No one would be prevented from getting needed care for financial reasons.

This optimal system would include many more healthcare professionals, enough that healthcare becomes convenient for every individual. These healthcare workers would be culturally diverse and sensitive to the cultural diversity present throughout our state. Individuals would take personal responsibility for their health and their healthcare. They would be able to make informed healthcare choices. Urban, rural, tribal, and underserved populations would all see improved healthcare outcomes.

While the participants achieved consensus on the idea that healthcare costs should never be a barrier to care, they never achieved true agreement on *who* precisely should be covered by this financial umbrella[2]. Some favored coverage for "all people living in New Mexico," which would include undocumented workers. Others favored coverage for "all New Mexicans."

2 For a detailed explanation of this situation, please see footnote #4 on page 8.

Town Hall Recommendations

Access to Quality Care

Recommendation 1	In order to recruit and retain a larger number of healthcare professionals, lawmakers and the private sector should provide sustainable, permanent funding for incentives, especially for those providing services to rural and underserved areas. These incentives could include things such as: • Increased student loan forgiveness and repayment, • Tax abatements, • Reimbursements for uncompensated services.[3]
Recommendation 2	So that *all people living in New Mexico* are aware of and have the opportunity to access and receive needed health services, the Legislature, in partnership with private and public healthcare service organizations, should develop and fund a system of local community health workers. These community health workers would advocate for families and individuals by: • Helping them identify their needs, • Providing knowledge of resources, health education, and information, and • Assisting with navigation of the healthcare system. *Alternate language preferred by many Town Hall attendees: So that all New Mexicans are aware of….*[4]
Recommendation 3	So that adequate and appropriate access to quality healthcare is assured for individuals from diverse backgrounds, the public/private sector should: • Provide diversity and cultural competency training to healthcare professionals and all ancillary healthcare workers, • Recruit healthcare professionals from diverse backgrounds, and • Provide alternative accommodations to reduce cultural, linguistic, physical and cognitive barriers.
Recommendation 4	So that adequate and appropriate access to health professionals for all is assured, lawmakers should revamp and reprioritize policies and fund programs that increase the capacity of New Mexico's educational system to produce healthcare workers, including but not limited to: • Stipends, • Daycare, • Scholarships, • Prerequisite training, and • Incentives to recruit and compensate quality faculty.[5]
Recommendation 5	So that cost-effectiveness can be increased, lawmakers and the private and public sectors should support home and community-based services such as Hospice, Promotoras[6], and home healthcare across the life span with a focus on quality of life.
Recommendation 6	So that urban, rural, tribal and underserved populations and areas are better served with improved outcomes, the private and public sectors should be given incentives to move towards more Level 1 or Level 2 trauma services, state of the art technology, telehealth, transportation, traditional and non-traditional health providers, services and expertise in these areas.

3 Recommendation was edited for clarity. Original language approved during the town hall: So that a greater number of health care professionals can be recruited and retained, lawmakers and the private sector should provide sustainable, permanent funding for incentives including but not limited to increased student loan forgiveness and repayment, tax abatements, reimbursement for uncompensated services, and especially for providing services to rural and underserved areas.

4 During the town hall, some participants urged that all recommendations containing the phrase "all New Mexicans" be changed to read "all people living in New Mexico." This language change was agreed to during the final session, but following the event, several participants reported that the process had been unclear at that point and that the "all people living in New Mexico" language did not actually reflect the consensus of the group. Because of the number of participants that reported this concern, New Mexico First – in keeping with its commitment to nonpartisanship and fairness – conducted a follow-up email survey. Of the 135 participants, 51 answered the survey. About half (53%) said they favored the "all people living in New Mexico" language, 45% favored did not, and 2% said they did not know.

5 Recommendation was edited for clarity. Original: So that adequate and appropriate access to health professionals for all is assured, lawmakers should revamp and reprioritize policies and fund programs that increase New Mexico healthcare educational capacities, including but not limited to stipends, daycare, scholarships, prerequisite training, and incentives to recruit and compensate quality faculty.

6 Promotoras are community health workers in many Hispanic communities, often serving as a liaison between the official medical establishment and the local community.

Coverage[7] For All

Recommendation 7	So that *all people living in New Mexico* have access to affordable and portable healthcare that meets individual needs, lawmakers should create and fund a system that includes, but is not limited to: • Individual choice of healthcare coverage, • Individual ownership not tied to employment, so that payment dollars follow individual, • No denials, penalties, or premium increases due to pre-existing conditions, • Medical, behavioral, vision, and dental, and • Education of consumers by the public and private sectors.[8] *Alternate language preferred by many town hall attendees: So that all New Mexicans have access to….*[9]
Recommendation 8	So that New Mexico can strengthen the local public/community based health system, an adequate public health infrastructure should be funded to provide surveillance, monitoring, assessment and policy development. State and local governments will collaborate to expand resources and funding for community based solutions, such as community health councils, community health centers, school-based health support services and centers and local DOH Public Health offices. Individuals should have access to information/data specific to their own community and be directly involved in developing healthcare policy and planning for their community.
Recommendation 9	So that *all people living in New Mexico* have access to affordable and quality healthcare, lawmakers should enact a healthcare model that is cost-efficient. Our federal delegation should participate positively in the development of a national healthcare reform strategy to ensure that *all people living in New Mexico* have access to health coverage, including access to needed drugs. *Alternate language preferred by many town hall attendees: So that all New Mexicans have access to….*[9]
Recommendation 10	So that as many *people living in New Mexico* as possible enroll for the programs in which they are eligible, the private sector, in conjunction with governmental agencies and other public institutions, should implement processes to enroll individuals (or groups) by allowing for enrollment when accessing other services, and standardizing forms, systems, and communication. *Alternate language preferred by many town hall attendees: So that as many New Mexicans as possible enroll….*[9]
Recommendation 11	So that all Native Americans in New Mexico have access to healthcare, tribal leaders and the New Mexico Congressional Delegation should approach Congress, and Congress should fully fund healthcare services at 100 % levels for all Native Americans, regardless of where they reside, to ensure compliance with congressional mandates as committed to in historical treaties and subsequent agreements.
Recommendation 12	So that *all people living in New Mexico* can have access to competitive coverage for healthcare costs, the legislature should establish a mechanism for point-of-service automatic enrollment into a coverage program, including Indian Health, based on a statewide risk pool. *Alternate language preferred by many town hall attendees: So that all New Mexicans can have access….*[9]

7 Throughout this document, the term "coverage" is used to mean any form of insurance, public or private, that pays for individual medical expenses. It is not meant to denote only traditional private insurance systems.

8 Recommendation was edited for clarity. Original language approved during the town hall: So that all people living in New Mexico have access to affordable and portable healthcare that meets essential individual needs, lawmakers will create and fund a system that includes, but is not limited to:

- Individual choice of healthcare financing mechanisms
- individual ownership (payment dollars follow individual)
- no denials or penalties due to pre-existing condition exclusion and premiums not tied to medical history
- medical, behavioral, vision, and dental
- education of consumers by the public and private sectors
- is not tied to employment.

9 During the town hall, some participants urged that all recommendations containing the phrase "all New Mexicans" be changed to read "all people living in New Mexico." This language change was agreed to during the final session, but following the event, several participants reported that the process had been unclear at that point and that the "all people living in New Mexico" language did not actually reflect the consensus of the group. Because of the number of participants that reported this concern, New Mexico First – in keeping with its commitment to nonpartisanship and fairness – conducted a follow-up email survey. Of the 135 participants, 51 answered the survey. About half (53%) said they favored the "all people living in New Mexico" language, 45% said they did not, and 2% said they did not know.

Economics That Work

Recommendation 13	So that *all people living in New Mexico* take personal responsibility for their health, thus reducing healthcare costs, all sectors will use incentives tied to measurable wellness, prevention, and healthy lifestyle outcomes. This can be accomplished by: • Lawmakers providing financial incentives to employers for wellness programs and education, • Insurers providing financial and other incentives for healthcare professionals to provide preventive health solutions and education, • Insurers and employers providing encouragement and incentives for personal responsibility and accountability for healthy behavior and obtaining recommended preventive health screening. *Alternate language preferred by many town hall attendees: So that all New Mexicans take personal responsibility….*[10]
Recommendation 14	So that *every person living in New Mexican* has access to coordinated healthcare and in order to decrease duplication of services and medical errors, lawmakers shall fund and facilitate an interoperable architecture[11] for a secure healthcare information system which would provide and help facilitate transfer of enrollment, payment and medical records. *Alternate language preferred by many town hall attendees: So that every New Mexican has access to coordinated…*[10]
Recommendation 15	So that the medical care system in New Mexico encourages electronically transferred medical information, such as telehealth and secure e-mails. Public and private sectors will work together to fund and provide incentives to that end to providers and consumers of healthcare in the state of New Mexico.
Recommendation 16	So that the healthcare system becomes cost-effective and allows consumers to make informed choices, the public and private sectors should work together to fund and provide incentives for an interoperable, secure electronic information system. De-identified data[12] on patients, providers and treatment outcomes will be available to provide information on outcomes to patients, providers, payers and policymakers.
Recommendation 17	So that public and private health insurance will be more cost-effective, thereby lowering the cost of healthcare for all *people living in New Mexico*, law makers should develop a public and private collaborative to examine and identify all barriers and bureaucratic inefficiencies that can be significantly reduced in the public and private healthcare system. Lawmakers shall require all insurance providers to standardize definitions for, and make transparent cost, eligibility process, coverage, premiums and claims procedures and an implementation plan. *Alternate language preferred by many town hall attendees: ...healthcare for all New Mexicans, lawmakers…*[10]
Recommendation 18	So that there will be a sustainable healthcare funding, lawmakers should establish a healthcare trust fund to maximize delivery of care and positive health outcomes.

10 During the Town Hall, some participants urged that all recommendations containing the phrase "all New Mexicans" be changed to read "all people living in New Mexico." This language change was agreed to during the final session, but following the event, several participants reported that the process had been unclear at that point and that the "all people living in New Mexico" language did not actually reflect the consensus of the group. Because of the number of participants that reported this concern, New Mexico First – in keeping with its commitment to nonpartisanship and fairness – conducted a follow-up email survey. Of the 135 participants, 51 answered the survey. About half (53%) said they favored the "all people living in New Mexico" language, 45% said they did not, and 2% said they did not know.

11 Here, the term "interoperable architecture" refers to a highly-coordinated information technology network, where various parts of the system are able to communicate, share information, and work together seamlessly.

12 "De-identified data" means patient data that cannot be traced back to a specific patient.

Implementation of the Town Hall Recommendations

This **New Mexico First** town hall was not a destination, but rather was a launching point for statewide change. In order to ensure that these recommendations will be acted upon, **New Mexico First** identified an Implementation Team chair with leadership experience and influence. Bill Johnson, former CEO of UNM Hospital and former cabinet secretary for New Mexico's Department of Health, is heading up the implementation team, which is already 53 members strong.

The implementation team is composed of participants who wanted to be involved in taking action on the recommendations that were so thoughtfully prepared during the three-day process.

Updates on the progress of the Implementation Team will be provided to the town hall participants.

Appendix A: Town Hall Sponsors

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Appendix B: Town Hall Committees and Speakers

Town Hall 35 Research and Review Committee

Dr. Daniel H. Lopez, Chair

Raul Burciaga
John Cordova
Barbara Damron, PhD, RN
Gayle Dine'Chacon, MD
Jeff Dye
Michael Ellis, PhD
Carol Erwin
Ruby Ann Esquibel
Bill Garcia
Robert Grassberger
Charles Ivy
Dan Jaco
Jack Jekowski
Arthur Kaufman, MD
Barbara Kimbell
Patricio Larragoite, DDS
Wanda Martin
Michelle Melendez
Susan McGuire
John Montgomery
Carl Moore
Todd Sandman
Scott Wallace
Bill Wiese, MD
Larry Winn
Heather Balas, staff
Jacey Blue Campbell, staff
Jo Carter, staff
Krista Koppinger, staff

Town Hall 35 Leadership Team

Dr. Carl Moore, Chair
Tony Trujillo, Plenary Chair
Michelle Henrie, Master Recorder
Jami Grindatto, Assistant Master Recorder

Diane Albert
Julie Bain
J.D. Bullington
Jacey Blue Campbell
Lynne Canning
Jo Carter
Patricia Chandler
Philip Crump
Ellie Dendahl
Doug Frost
Diane Grover
Kathy Komoll
Kathleen Oweegon
Charlotte Pollard
Shannon Sandoval
Jeff Weinrach

Town Hall 35 Speakers & Presenters

Diane Denish, Lieutenant Governor of New Mexico
Pamela Hyde, Secretary, Human Services Department
Michelle Lujan Grisham, Secretary, Department of Health
Edmund H. Haislmaier, Senior Research Fellow, Heritage Foundation
Dr. Bob Crittenden, Executive Director, Herndon Alliance
Don Chalmers, President, Don Chalmers Ford
Charlotte Roybal, Executive Director, Health Action New Mexico
Dr. David Scrase, Executive VP and COO, Presbyterian Healthcare Services
Dr. Michael Trujillo, Executive Director for Program Development/Community Outreach, TGen

Town Hall 35 Implementation Team

Bill Johnson, Chair

Beverly Allen-Ananins
Celia Ameline
Debbie Armstrong
Catherine Baca
Regina Begay Roanhorse
Roxane Bly
Erin Bouquin
Jim Campbell
Yoshiko Chino
Alex Chisholm
James D'Agostino
Dr. J.R. Damron
Bill Doggett
Jaqueline Duhigg
Lori Flint
Susan Fox
John Franchini
Melinna Giannini
Maggie Gunter
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Jeannie Hardie
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Ann Riley
Chuck Ring
Leonie Rosenstiel
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Terry Schleder
Patty Smith
Chris Snyder
Eva Stevens
Joan Sullivan
Jack Swickard
Renee Swickard
Gayle Thompson-Prinkey
Ron Trevino
Doris Vician
Karen Wells
Judy Williams
Katy Yanda

Appendix C: Town Hall Registrants

Town Hall Participants

Richard Abeita
Isleta Pueblo
Isleta

Beverly Allen-Ananins
Grant County Health Council
Silver City

Mary Altenberg
State of NM/Dept of Health
Santa Fe

Celia Ameline
New Mexico Health Choices
Albuquerque

Debbie Armstrong
Aging and Long-Term Services Department
Santa Fe

Catherine Baca
Bueno Foods
Albuquerque

Donna Bader
Albuquerque Public Schools
Albuquerque

Ingrid Baker
Technology Ventures Corporation
Albuquerque

Roselyn Begay
Navajo Nation Division of Health
Window Rock

Regina Begay-Roanhorse
Navajo Local Collaborative
Canoncito

Barry Bitzer
City of Albuquerque
Albuquerque

Morrie Blumberg
Bernalillo County Metropolitan Court
Albuquerque

Roxane Bly
Native Healthcare Council of NM
Albuquerque

Erin Bouquin
Los Alamos National Laboratory
Los Alamos

Patricia Boyle
NM Council for Nursing Excellence
Albuquerque

Gina Bryant
NMSU School of Social Work
Albuquerque

Jim Campbell
Wellness Improvement Experts
Albuquerque

Melissa Candelaria
NM Indian Affairs Department
Santa Fe

Natalie Carter
Albuquerque Hispano Chamber
Albuquerque

Susan Casias
Resident
Albuquerque

Ervin Chavez
San Juan County
Aztec

Yoshiko Chino
Community Outreach Program for the Deaf
Albuquerque

Alex Chisholm
Chisholm Construction
Albuquerque

Larry Clevenger
Sandia National Laboratories
Albuquerque

Joe Cordova
Native Health Care Council-NM
Albuquerque

Phil Cordova
Pfizer
Albuquerque

Peter Cubra
Attorney
Albuquerque

James D'Agostino
Roosevelt General Hospital
Portales

David Dalton
Solterra Health
Albuquerque

J. R. Damron
Santa Fe Radiology, P.C.
Santa Fe

Barbara Damron
UNM Cancer Center
Santa Fe

John Diedrick
Blue Cross and Blue Shield
Albuquerque

William Doggett
SunBear Chiropractic
Albuquerque

Jacqueline Duhigg
AstraZeneca
Albuquerque

Shelby Fletcher
Pfizer
Albuquerque

Lori Flint
Flint & Associates, Inc.
Albuquerque

Susan Fox
College of Nursing/UNM
Albuquerque

John Franchini
New Mexico Mutual
Albuquerque

Kathy Ganz
New Mexico Primary Care Association
Albuquerque

Robert Garcia
Presbyterian Healthcare Services
Albuquerque

Melinna Giannini
ABC Coding Solutions
Albuquerque

Bret Goebel
Bret Goebel Consulting
Albuquerque

Teresa Gomez
NM Indian Affairs Department
Santa Fe

Maggie Gunter
Lovelace Clinic Foundation
Albuquerque

Paul Gutierrez
NMSU/Coop. Extension Service
Las Cruces

Jan Gutierrez-Abugharbie
Native Am. Health Care Coalition
Albuquerque

Jeanne Hamrick
NMSS Rio Grande Division
Albuquerque

Jeannie Hardie
Northern NM Human Resources Assoc.
Santa Fe

Jerry Harrison
New Mexico Health Resources
Albuquerque

John Heaton
State Legislator
Carlsbad

Sharon Huerta
Molina Healthcare of New Mexico
Albuquerque

Herb Hughes
Private Citizen
Albuquerque

Katherine Hughes-Fraitekh
NM HNCC
Albuquerque

Dan Jaco
NM Medical Review Association
Albuquerque

Jordon Johnson
Health Care for All
Albuquerque

Jeri Jones
UnitedHealthcare
Centennial

Sharon King
Roosevelt County Chamber
Portales

Kay Knutson
Presbyterian Health Plan
Albuquerque

Allison Kozeliski
New Mexico Board of Nursing
Albuquerque

Chris Krahling
New Mexico Mutual
Albuquerque

Nandini Kuehn
Health Services Consulting
Corrales

Anthony Lenhart
Presbyterian Healthcare Services
Albuquerque

Maria Lopez
SC Prevention Programs
Bernalillo

Laura Manire
HANM
Albuquerque

Barbara Marcus
New Mexico Mutual
Albuquerque

Dick Mason
League of Women Voters
Rio Rancho

Barbara McAneny
NM Oncology/Hematology
Albuquerque

Diana McEnnerney
UNM Institute for Public Health
Albuquerque

Marsha McMurray-Avila
NM Public Health Association
Albuquerque

Jamie Michael
Dona Ana County
Las Cruces

Stephen Moffat
Health Action New Mexico
Albuquerque

Mark Moores
New Mexico Dental Association
Albuquerque

Richard Moran
NM CPR
Albuquerque

Alma Olivas
Community Coalition for Healthcare Access
Albuquerque

Gary Oppedahl
FootPrints Home Care
Albuquerque

Robin Otten
NAWBO
Albuquerque

Mark Padilla
Molina Healthcare of New Mexico
Albuquerque

James Parker IV
Aging/Long Term Services Dept.
Santa Fe

Gabe Parra
Presbyterian Healthcare Services
Albuqueruqe

Lynn Pedraza
Albuquerque Public Schools
Albuquerque

Elizabeth Pelz
Aon
Albuquerque

Lydia Pendley
Health Care for All Campaign
Santa Fe

Sandra Penn
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Wayne Powell
UNM Institute for Public Health
Albuquerque

Cathy Raish
Heel Inc.
Albuquerque

Shelley Redford
Redford Associates
Silver City

Ron Reid
State of NM/Dept. of Health
Santa Fe

Barbara Rhees
Youth/Family Centered Services
Albuquerque

Ann Riley
Sandia National Laboratories
Albuquerque

Charles Ring
First Choice Family Health Care
Edgewood

Mary Romero Hart
Sandia National Laboratories
Albuquerque

Leonie Rosenstiel
ATEAM
Albuquerque

Charlotte Roybal
Health Action New Mexico
Albuquerque

Les Rubin
Hidalgo Medical Services
Lordsburg

Sydney Ryan
New Mexico Tech
Socorro

Rene Salgado
Doña Ana County
Las Cruces

Todd Sandman
Presbyterian Healthcare Services
Albuquerque

Sylvia Sapien
La Clinica de Familia
Anthony

Dean Schear
New Mexico QuickCare
Las Vegas

Terry Schleder
Community Coalition for Healthcare Access
Albuquerque

Doyle Smith
Aging/Long Term Services Dept.
Santa Fe

Patty Smith
Independent
Albuquerque

Chris Snyder
NMSU MSW Graduate Student
Albuquerque

Eva Stevens
Roosevelt General Hospital
Portales

Joan Sullivan
Heel Inc.
Albuquerque

Kristine Suozzi
State of NM/Dept of Health
Santa Fe

Jack Swickard
The Triton Group Inc.
Roswell

Renee Swickard
Swickard Agency, Inc.
Roswell

Ronald Tafoya
Intel Corporation/Digital Health Group
Rio Rancho

Gayle Thompson Prinkey
Network-Spiritual Progressives
Albuquerque

Janice Torrez
Blue Cross/Blue Shield-NM
Albuquerque

Ron Trevino
NaviNet Claims
Santa Fe

Susie Trujillo
Gila Regional Medical Center
Silver City

Doris Vician
Retired RN
Albuquerque

Lou Volk
New Mexico Mutual
Albuquerque

Liz Watrin
Blue Cross and Blue Shield
Albuquerque

Karen Wells
Aging/Long Term Services Dept
Santa Fe

Judith Williams
Williams, Stern & Associates
Santa Fe

Katy Yanda
Health Action New Mexico
Santa Fe

Lucien Young
Pecos Valley Medical Center
Pecos

Town Hall Observers

Gayle Adams
Lovelace Health Plan
Albuquerque

Roma Adipat
UnitedHealthcare
Centennial

Dyan Alexander
AstraZeneca
Arvada

Gene Baca
Bueno Foods
Albuquerque

Dana Beaulieu
Intel
Rio Rancho

Barbara Brazil
Former NM First President
Albuquerque

Brenda Broussard
Broussard Consulting
Albuquerque

Michelle Campbell
Presbyterian Health Services
Albuquerque

Chris Cervini
Lovelace Health System
Albuquerque

Jennifer Chavez
UNM HSC
Albuquerque

Denise Cholewka
Heart Hospital of New Mexico
Albuquerque

Sarah Cobb
Office of Representative Tom Udall
Rio Rancho

Carol Cochran
REDW The Rogoff Firm
Albuquerque

Doug Culling
Lovelace Medical Group
Albuquerque

Catherine Direen
NM Voices for Children
Albuquerque

Amy Dixon
Desert States Physical Therapy
Albuquerque

Tobie Dorsey
UNM Foundation
Albuquerque

Judith Espinosa
Office of the Lt. Governor
Santa Fe

Ruby Ann Esquibel
Insure New Mexico!
Santa Fe

Dede Feldman
New Mexico State Senate
Albuquerque

Paul Gessing
Rio Grande Foundation
Albuquerque

Debbie Gonzales
Pfizer
Albuquerque

Clay Holderman
Lovelace Medical Center
Albuquerque

Brian Ibsen
UNM Foundation
Albuquerque

Carolyn Ingram
Human Services Department
Santa Fe

Charles Ivy
St. Joseph Community Health
Albuquerque

Bill Johnson
Johnson and Associates
Albuquerqe

Mathias Kaesebier
Heel Inc.
Albuquerque

Elizabeth Kibler
PNM Resources
Albuquerque

Nancy Kirkpatrick
State of NM/Dept. of Health
Albuquerque

Ted Kostranchuk
Dekker Perich Sabatini
Albuquerque

Jennie Lusk
Legislative Council Service
Santa Fe

Rebecca Lynch
New Mexico Business Weekly
Albuquerque

Harry Magnes
Lovelace Medical Group
Albuquerque

Claire Manatt
Focus Energy
Albuquerque

Bob McGuire
Retired
Cedar Crest

Susan McGuire
Retired/US Senate
Cedar Crest

Mary Mckenzie
Resident
Albuquerque

Michelle Melendez
St. Joseph Community Health
Albuquerque

Dana Millen
Health Security for NM Campaign
Santa Fe

Danny Milo
U.S. Senator Jeff Bingaman
Albuquerque

Sheri Milone
Lovelace Women's Hospital
Albuquerque

Fred Mondragon
City of Albuquerque
Albuquerque

Lillian Montoya-Rael
LANL- Community Programs Office
Los Alamos

Laura Patterson
PNM Resources
Albuquerque

Richard Pope
Covenant Health System
Lubbock

Sharon Prudhomme
Lovelace Women's Hospital
Albuquerque

Dianne Rivera
Con Alma Health Foundation
Santa Fe

Anslem Roanhorse
Navajo Nation Division of Health
Window Rock

Kathleen Romero
Insurance Company
Albuquerque

Dolores Roybal
Con Alma Health Foundation
Santa Fe

Margaret Schultz
WICHE
Boulder

Amanda Searcy
Sandia Labs Federal Credit Union
Albuquerque

Linda Sechovec
NM Health Care Association
Albuquerque

David Selvage
State of NM/Dept of Health
Santa Fe

Jim Silva
Heart Hospital of New Mexico
Albuquerque

Lynn Slade
Modrall Sperling Law Firm
Albuquerque

William Sparks
UNM HSC
Albuquerque

Anne Sperling
Daniels Insurance, Inc.
Santa Fe

Douglas Steelman
Pfizer
Rio Rancho

Leah Steimel
UNM HSC
Albuquerque

Ron Stern
Lovelace Health System
Albuquerque

Marcia Stevenson
UNM Continuing Education
Albuquerque

Jacqueline Stiff
United Healthcare
Greenwood Village

Phyllis Sullivan
Heel Inc.
Albuquerque

Dave Tappan
Pfizer
Rio Rancho

Elizabeth Waltman
United Blood Services
Albuquerque

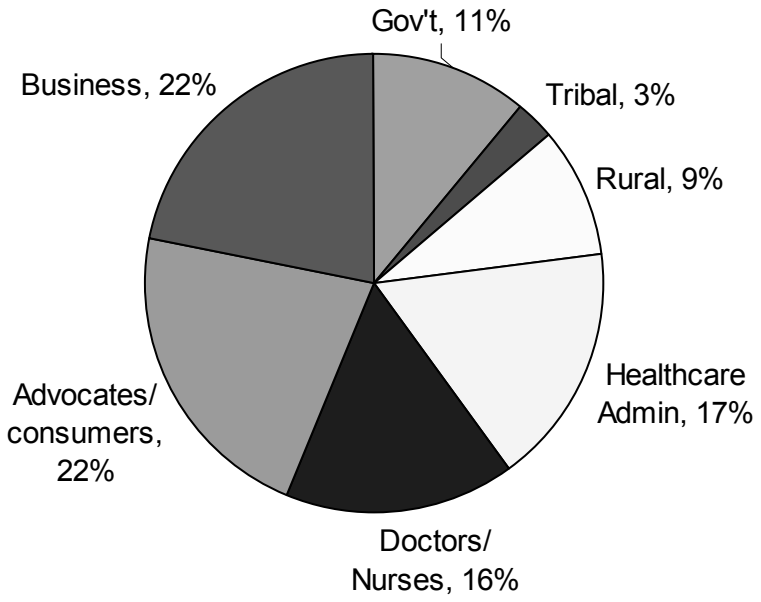
Ann Wehr
Molina Healthcare of New Mexico
Albuquerque

Michelle Welby
Office of Governor Bill Richardson
Albuquerque

Susan Wilson
Lovelace Health System
Albuquerque

Demographic Distribution of Participants

The 122 town hall participants and 70 observers were drawn from 22 communities around New Mexico including Albuquerque, Santa Fe, Silver City, Portales, Las Cruces and Window Rock. Similarly, these same 122 town hall participants were drawn from 7 different interest areas. The chart below demonstrates their distribution across these areas.



Appendix D: Community Conversation Participants

The following people participated in New Mexico First's Community Conversations program, a series of small town focus groups. The program ensured that the priorities of rural communities were reflected in the background report for the town hall.

Roswell

Dr. Fred French
Partner, Roswell Regional Hospital

Jim Manatt
President, Providence Technologies

Dean Schear
CEO, Strategic Health Care Associates

Jack Swickard
President, The Triton Group

Renee Swickard
Owner, The Swickard Agency

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Silver City

Dr. John Bell
Physician, Silver Internal Medicine

Linda Kay Jones
Special Asst to the President, WNMU

Mike Harris
Administrator, SW Bone/Joint Institute

Dr. Don Johnson
Physician, WNMU

Lanny Olson
Owner, Holiday Inn Express

Sean Ormand
President, First NM Bank in Silver City

Sam Redford
Owner, Redford Associates

Dr.Jean Remillard
CQO, Gila Regional Medical Center

Robert Rydeski
Owner, Rydeski & Co. Insurance

Judy Ward
Business Consultant, WNMU

Don White
Pastor, Berean New Baptist Church

Appendix E: New Mexico First Leadership

Executive Committee

William "Bill" Garcia
Chair
Santa Fe

Heather Balas
President
Corrales

Noel Behne
Endowment Chair
Albuquerque

Carol Cochran
Treasurer
Albuquerque

John Cordova
Public Relations Chair
Albuquerque

Luci Davis
At Large Member
Farmington

Jami Grindatto
At Large Member
Rio Rancho

Jim Hinton
Vice Chair District I
Albuquerque

Robert A. Jung III
Secretary
Los Ranchos de Albuquerque

Dr. Daniel Lopez
Research Chair
Socorro

Jim Manatt
Vice Chair District II
Roswell

Sherman McCorkle
At Large Member
Albuquerque

Susan McGuire
Implementation Chair
Cedar Crest

Lillian Montoya-Rael
Chair-Elect
Los Alamos

Dr. Carl Moore
Leadership Chair
Santa Fe

Bob Rosebrough
Vice Chair, District III
Gallup

Lynn Slade
Immediate Past Chair
Albuquerque

Jack Swickard
At Large Member
Roswell

Board Members

Phelps Anderson
Roswell

Brenda Brooks
Hobbs

Garrey Carruthers
Las Cruces

Curt "C.J." Chavez
Albuquerque

Michael DeWitte
Albuquerque

Ed Ely
Las Cruces

Jed Fanning
Albuquerque

Jack Fortner
Farmington

Javier Gonzales
Santa Fe

Linda Kay Jones
Silver City

Sharon King
Portales

Joseph M. Maestas
Espanola

Michael Martin
Lordsburg

Tom Mills
Santa Fe

Stuart Paisano
Albuquerque

Malcolm Petree
Albuquerque

Alice Quintanilla
Los Alamos

Lynn H. Slade
Albuquerque

Bill Real
Albuquerque

Shelley "Sam" Redford
Silver City

Jennifer Thomas
Albuquerque

Sayuri Yamada
Santa Fe

Mary Yates
Artesia

Board Emeritus

Robert Armstrong
Roswell

Jon Barela
Rio Rancho

Kathleen Bond
Iathe, Colorado

Mary Jean Christensen
Gallup

Dale Dekker
Albuquerque

Diane Denish
Santa Fe

John Dowling
Gallup

Richard Fairbanks
Albuquerque

Dr. Everett Frost
Portales

William "Bing" Grady
Albuquerque

Bill Knauf
Albuquerque

Carol Robertson Lopez
Santa Fe

Maureen Luna
Albuquerque

Tom Mills
Santa Fe

Arlene Roth
Fort Meyers, Florida

David Steinborn
Las Cruces

Thomas Tinnin
Albuquerque

A.P. Trujillo
Silver City

J. Ronald Vigil
Santa Fe

John Wagner
Albuquerque

Founders

The Honorable Jeff Bingaman
United States Senator

The Honorable Pete V. Domenici
United States Senator

Ex-Officio Board Members

The Honorable Bill Richardson
Governor of New Mexico

The Honorable Heather Wilson
US Congresswoman-District I

The Honorable Steve Pearce
US Congressman-District II

The Honorable Tom Udall
US Congressman-District III

Dr. James A. Fries
President, NMHU

Dr. John E. Counts
President, WNMU

Dr. Steven Gamble
President ENMU

Mr. David Harris
Acting President, UNM

Dr. Daniel H. Lopez
President, NMIMT

Dr. Michael Martin
President, NMSU

New Mexico First Staff

Heather Balas
President & Executive Director

Jacey Blue Campbell
Program Coordinator

Jo Carter
Research Analyst

Patricia Chandler
Program Director

Krista Koppinger
Administrative Director

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NEW MEXICO FIRST

People. Ideas. Progress. 20 Years.

New Mexico First
320 Gold SW, Suite 300
Albuquerque, NM 87102
505-241-4813
www.nmfirst.org
townhall@nmfirst.org

NEW MEXICO FIRST
People. Ideas. Progress.

Healthcare Legislative Outcomes

Town Hall 35

[Updated November 4, 2009]

New Mexico First convened its 35th statewide town hall in May 2007. The event, *Strengthening New Mexico Healthcare: Access, Coverage, and Economics* brought together stakeholders in the healthcare and business communities from all regions of New Mexico. Over 200 people took part in the event, with 122 active participants who remained for all three days of deliberations. After the town hall, an Implementation Team was established to advance the citizens' recommendations. In the months that followed, the team researched the recommendations, prioritized them, and developed the following priorities for the 2008 Legislative Session. The Implementation Team faced a contentious topic head on and the results below represent the first phase of their efforts. The Implementation Team will continue their work this summer, if Governor Richardson calls a Special Session. *(The full report, containing all 18 final recommendations, is available at www.nmfirst.org.)*

Implementation Team Chair Bill Johnson, along with other memebers of the team and New Mexico First staff, conducted several meetings and briefings with lawmakers and other leaders. These efforts lead to the activities below. Two bills championed by the Implementation Team became law.

Legislative Priority	Bill Description	Original Town Hall Recommendation (Summarized)	Outcomes
Recruit and retain healthcare professionals **SB 127** Waive Licensure Fees for Medical Doctors (Sponsored by Sen. Komadina) **SB 14** Health Professional Recruitment and Retention (Sponsored by Sen. Feldman)	SB 127 expands varying loan and loan repayment programs and reduces many of the other financial barriers that might impede students considering careers in medicine. SB 14 would have provided expanded appropriations for health professional recruitment, retention and educational opportunities.	**Rec 1:** Recruit and retain healthcare more professionals by providing permanent funding for incentives, especially for those serving rural and underserved areas.	**SB 127** was passed and signed into law by Governor Richardson. Funding included: • $480,000 for loan repayments; $250,000 for medical student loans for service; $1 million for the dental residencie;$7 million for dental residency center construction **SB 14 did not pass.** It passed the Senate Public Affairs Committee but was tabled in the Senate Finance Committee.
Support workplace wellness programs **SB 129** Healthy New Mexico Task Force (Sponsored by Sen. Feldman)	SB 129 establishes a Healthy New Mexico Task Force, mobilizing the state against chronic diseases through coordinated plans for prevention, case management, and primary care.	**Rec 13:** Use incentives tied to measurable wellness, prevention, and healthy lifestyle outcomes.	**SB 129** was passed and signed into law by Governor Richardson.

Legislative Priority	Bill Description	Original Town Hall Recommendation (Summarized)	Outcomes
HB 148/SB 148 Employee Wellness Program Tax Credit (Sponsored by Rep. Picroux, Rep.Taylor, and Sen. Komadina)	HB148/SB148 called for expansion of workplace wellness expansion benefits providing employers with tax credit for the costs of implementing workplace wellness programs		**HB 148/SB 148 did not pass.** Though extensive efforts were made by New Mexico First volunteers to move these bills forward, both were tabled in the Senate Finance Committee.
Improve Health Information Technology (HIT) projects **HB 37** Electronic Medical Records Act (Sponsored by Rep. Wirth)	HB 37 called for the development of an improved HIT plan, restructuring of the current Telehealth Commission, provision of new resources that would assist providers in both the areas of technology and funding, and the creation of a single provider registry.	**Rec 14-17:** Improve the use of technology and data in healthcare provision, coverage, and billing.	**HB 37 did not pass.** It passed the House Health and Government Affairs Committee and Senate Public Affairs Committee. A substitute version of the bill passed the House and Senate Judiciary Committees but did pass the full Senate.
Support workplace wellness programs. *(Advancing recommendation 13 from the healthcare town hall)*	The healthcare town hall called for incentives to encourage employer-based wellness efforts, prompting its implementation team to draft and support: • **HJM 24**, which established a collaborative study by the Departments of Health and Economic Development to determine the cost and impact of chronic disease on the New Mexico work force, and potential impacts of business-based wellness programs. • Members of the healthcare town hall Implementation Team served on a committee that wrote the study that was presented to the interim Health and Human Services Committee. The study is posted on the Department of Health's website at: http://www.nmhealth.org/DPP/HJM%2024%20Report%20Oct%2009%20FINAL.pdf.	**Rec 13:** Use incentives tied to measurable wellness, prevention, and healthy lifestyle outcomes.	• **HJM 24 PASSED.** It was introduced by Representative Danice Picraux.

****The New Mexico First town hall participants called for a healthcare system that would enable New Mexicans to have affordable and portable healthcare. The legislature had four competing coverage bills under consideration during the 2008 session, each advancing some priorities raised at the town hall. In order to remain true to the town hall, New Mexico First opted not to endorse one coverage bill over another. Instead the original coverage recommendations were shared with all legislators and the governor's office.**

Contacts:
Bill Johnson, Implementation Team Chair, (505) 821-5696, wjohnson119@comcast.net
Heather Balas, President, New Mexico First, (505) 241-4815, heatherb@nmfirst.org