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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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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 health¹, 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' lives³. Blue Cross Blue Shield of New Mexico reports that

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

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

56% of all money they spend on a patient's healthcare is spent in the last six months of that person's life⁴. 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 Fe⁵. 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

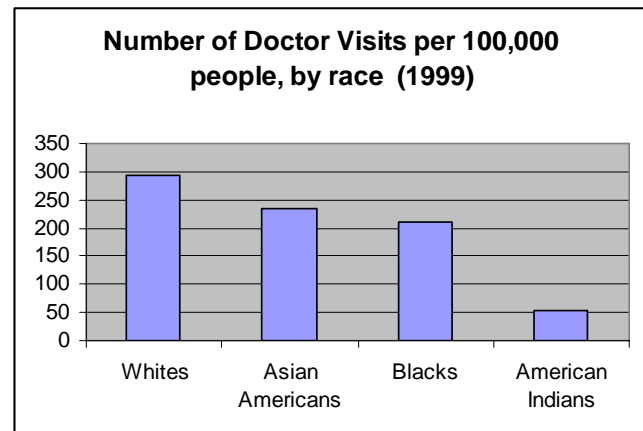
As New Mexicans continue to age, the system is having a hard time dealing with the increased demand for access to care for the elderly. Most older citizens are insured through Medicare, but this does not cover dental care unless such care is required as a result of a medical condition. Long-term care 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 consequences⁶.

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 nation⁷. In 2004, 42% of mothers received late or inadequate prenatal care, with younger mothers receiving the lowest levels of prenatal care⁸. In 2004, 16% of New Mexico's public school enrollment (51,814 students) were disabled and in special education programs⁹. 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 group¹⁰. 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 not¹¹. 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 provider¹². 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 Mexico¹³.

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 average¹⁴. About 33% of active physicians in the state are over age 55 and approaching retirement¹⁵. 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 population¹⁶. 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 2020¹⁷. 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 nurses¹⁸.

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.

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.

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 indirectly¹⁹. 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 industry²⁰. 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 risen²¹.

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 disparities²²:

- 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 priorities²³.

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 records²⁴.

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 costs²⁵. 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 shortage²⁶. 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 Mexico²⁷. 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 longer²⁸.

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 insurance²⁹. 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"

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.insurenwemexico.state.nm.us>.

Who Are the Uninsured in New Mexico? ³⁰	
Ethnicity ³¹	<ul style="list-style-type: none"> • 55.9% are Hispanic • 28% are White • 13.5% are Native American • 2.6% are none of these ethnicities
Age ³²	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 31% are part-time workers • 31% are seasonal workers • 17% are full-time workers • 21% are unemployed or other

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.insurenwemexico.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 families³³. 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 insurance³⁴.

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 coverage³⁵.

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 states³⁶, 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.

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.insurenwemexico.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.insurenwemexico.state.nm.us>.

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 degrees³⁷. 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.

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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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 insurance 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	<ul style="list-style-type: none"> • Private health insurance companies would continue to exist, offering plans through the centralized exchange. • Individuals and employers would qualify 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	<ul style="list-style-type: none"> • 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 list³⁸. 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 avoid³⁹. 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 Act⁴⁰. 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

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.2757/health.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 government⁴¹.

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 employees⁴².

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.

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 Fe 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; Risher, 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 insurance⁴³, 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 1945⁴⁴.

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.insurenwemexico.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/hihist4.html.

⁴⁴ Health Insurance Institute report, 1970, p. 37-39. Available at www.rwjf.org/files/research/037-part11-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 benefits⁴⁵.

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 half⁴⁶.
- Some no longer extend their health insurance to the family members of their employees.

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.insurenwemexico.state.nm.us.

- Some simply don't offer health benefits. Frequently, this happens in companies that offer the lowest employee wages or only part-time work⁴⁷. 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 both⁴⁹.

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.

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.insurenwemexico.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 Fe 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.

- 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.

Private Sector Changes⁵⁰

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.

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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