Fiscal Analysis of New Mexico's Health Security Plan: Final Report

Prepared For:

New Mexico Legislative Finance Committee

Submitted By:

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KNG HEALTH CONSULTING LLC

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About KNG Health Consulting, LLC

KNG Health Consulting, LLC, is a health economics and policy consulting company assisting clients across all sectors of the health care industry. The company's work focuses on two main practice areas: Healthcare Reform and Payment Innovation (HRPI); and Evaluation and Health Economics (EHE). In the HRPI practice, KNG Health's experts work with our clients to estimate the effects of a wide range of health care reform and payment innovation policies, ranging from modeling innovative state and federal proposals to reduce health insurance premiums to facilitating learning systems for providers on alternative payment models. In the EHE practice, KNG Health's experts conduct studies on the efficiency, effectiveness, and value of medical interventions using big and small data, applying careful research designs, and translating findings into actionable results.

KNG Health is a small, woman- and minority-owned business located in the Washington, DC metropolitan area.

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Acronyms

Acronym	Meaning
ACA	Affordable Care Act
ACS	American Community Survey
AV	Actuarial Value
CMS	Centers for Medicare & Medicaid Services
CPI-M	Consumer Price Index for Medical Care
CPS	Current Population Survey
ED	Emergency Department
ERISA	Employee Retirement Income Security Act
ESI	Employer-Sponsored Insurance
FPL	Federal Poverty Level
HB	House Bill
HCCI	Health Care Cost Institute
HPSA	Health Professional Shortage Area
HSA	Health Security Act
HSD	Human Services Department
HSP	Health Security Plan
IHS	Indian Health Service
IMPLAN	Impact Analysis for Planning
KNG-HRM	KNG-Health Reform Model
LFC	Legislative Finance Committee
MA	Medicare Advantage
MEPS	Medical Expenditure Panel Survey
MEPS-IC	Medical Expenditure Panel Survey - Insurer/Employer Component
NM	New Mexico
OOP	Out-of-pocket
RX	Prescription Drugs
SB	Senate Bill

Glossary Terms

Term	Definition
Administrative Costs	The expenses an organization incurs that are not directly related to the business function, such as providing health care services (health care providers) or spending for health care benefits (health care insurers).
Affordable Care Act	Formally known as the Patient Protection and Affordable Care Act, the law overhauled regulations and expands health coverage for individuals.
Beneficiary	Person eligible for health care and benefits pursuant to the HSA.
Consumer Price Index for Medical Care	Index as published by the Bureau of Labor Statistics of the Federal Department of Labor.
Cost-Sharing	The portion of health care costs not covered by a patient's health insurance plan.
Disease Prevention Microsimulation Model	A microsimulation model that simulates probabilities of disease onset among populations of interests.
Employee Retirement Income Security Act	A federal law that sets minimum standards for voluntary established pension plans in private industry to provide protection for individuals in these plans.
Employer-Sponsored Insurance	A health plan or plans selected and purchased by the employer and offered to eligible employees.
Federal Medicaid Matching Rate	The share of Medicaid spending that the federal government pays based on a formula that relies on a states' personal income. The ACA specifies match rates for different populations in Medicaid and CHIP.
Federal Poverty Level	A measure of income used to determine financial eligibility for certain federal programs, subsidies, and benefits.
Federal Waivers	The federal government (Centers for Medicare & Medicaid Services) may provide states with a waiver that states can use to test new or existing ways to deliver and pay for health care services in Medicare, Medicaid, and the Children's Health Insurance Program.
Fully-Insured Group Health Plans	A health plan in which the claims are managed by the medical care provider and insurer and the risk falls on the insurance company.
Global Budget	A fixed amount of funding for a fixed period of time for a specified population (e.g., a hospital can spend up to a fixed amount on health care).
Gross Receipt Tax	A state tax on the total gross revenues of a business.
Health Care	Health care provider services and health facility services.
Health Care Commission	A commission to be established to conduct administrative and planning activities related to the Health Security Plan.
Health Care Provider	Any of the following persons that is not a health facility and that is a person or network of persons licensed or certified and authorized to provide health care in the state, an individual licensed or certified by a nationally recognized professional organization and designated as a health care provider by the Commission, or a person that is a group practice of licensed providers or a medical transportation service.

Term	Definition
Health Facility	A school-based clinic, an Indian health service facility, a tribal or tribal entity health care facility, a state-operated health care facility, a general hospital, a special hospital, an outpatient facility, a psychiatric hospital, a primary clinic pursuant to the Rural Primary Health Care Act, a laboratory, a freestanding birthing facility, a skilled nursing facility or a nursing facility or other type of facility licensed as a health facility by the Department of Health and identified in commission rules, provided that the health facility is authorized to receive state or federal reimbursement.
Health Insurance Marketplace	A service available in each state through which individuals, families, and small businesses may find information and purchase health insurance. Also referred to as exchanges.
Health Security Act	Legislative proposal considered by the New Mexico Legislature that would create the Health Security Plan.
Health Security Plan	The program that is created and administered by the Commission for provision of health care pursuant to the HSA.
IMPLAN Model	A platform that combines extensive databases to create a system that models the degree to which service inputs are provided from businesses in a region.
Implementation Date	The start date that we assume the HSP will be enacted for modeling purposes.
KNG-Health Reform Model	A microsimulation model used to estimate baseline coverage and health care spending as well as the impact of health reform efforts.
Medicaid	A federal and state means-tested program that provides persons with health insurance whose income and resources are insufficient to pay for medical costs. This program is funded by the state and federal government and managed by the states.
Medicaid Drug Rebate Program	A federal and state government program with participating drug manufacturers that offset costs of most outpatient prescription drugs dispensed to Medicaid patients.
Medicare	A national health insurance program administered by the federal government primarily providing health insurance for persons aged 65 years and older. This program is funded by a variety of sources including a payroll tax, premiums, and surtaxes.
Medicare Advantage	A health insurance plan that provides Medicare benefits through a private-sector health insurer.
Out-of-Pocket Costs	Expenses for medical care that are not reimbursed by insurance.
Payroll Tax	A tax employers withhold from an employee's salary and pays on behalf of their employees.
Premiums	The amount of money charged by the insurer to the policyholder for the coverage set forth in the insurance policy.

Term	Definition
Self-insured Group Health Plan	A health plan in which the employer assumes the financial risk for providing health care benefits to its employees. These employers pay for out-of-pocket claims as they are incurred instead of paying a fixed premium to an insurer carrier.
Shortfall	The amount in which the obligations or liabilities exceeds the amount of funding available.
Surtax	An additional tax on something already taxed.
Synthetic Firm	A collection of employed New Mexicans that are assumed to work at the same firm based on the following hierarchy of characteristics: offer status, firm size, and industry. Coverage offering and characteristics of offered health plans are all decided at the synthetic firm level.
Workers' Compensation	A form of insurance providing wage replacement and medical benefits to employees injured during their employment with the employer in exchange for mandatory relinquishment of the employee's right to sue his or her employer for negligence.

Key Changes to Report

This final report differs from the preliminary report in a number of key ways. First, we restructured the presentation of findings to present four different scenarios rather than focusing on a base scenario and then presenting a series of alternatives, as was done in the preliminary report. In addition, the scenarios are structured differently than the alternative scenarios included in the preliminary report. Specifically, we modeled two scenarios that varied in premiums and cost-sharing structures to correspond to a typical employer-sponsored insurance plan and the requirements of the Affordable Care Act (modified to cap premiums as a share of income for those above 400 percent of the federal poverty level). Within each of these two scenarios, we modeled two alternatives that varied in terms of the assumed growth in the Health Security Plan (HSP) provider reimbursement rates for a total of four scenarios. Second, we expanded the methods sections in the report and also provide a Technical Supplement, which can be found at https://www.knghealth.com/fiscal-analysis-of-the-new-mexico-health-security-act-plan/. Third, we implemented a number of technical revisions to the analysis based, in part, on public comments received on the preliminary report. The primary technical revisions are:

1. We assumed bulk purchasing would result in reductions in prescription drug costs to the state under the HSP in all scenarios;

2. For Medicaid, we added the administrative costs incurred by the New Mexico Human Services Department (HSD), in addition to the administrative cost incurred by the Medicaid Managed Care Organizations;

3. We scaled Medicaid spending to spending levels reported in CMS-64 for New Mexico, rather than to spending estimates in the Medicaid Managed Care reports provided by New Mexico Human Services Department (although we still use the utilization information from the HSD data);

4. We included spending for the New Mexico County Indigent Fund and New Mexico Medical Insurance Pool in our estimate of health care spending; and

5. We modified our assumptions from findings derived from the Oregon Health Insurance Experiment regarding changes in utilization among those who become newly-insured under the HSP to correct an issue in our original estimates.

We appreciate the public comments that were submitted in response to the draft analysis plan and preliminary report.

Executive Summary

In 2019, the Legislature of the State of New Mexico considered House Bill 295[1] and Senate Bill 279[2], which were introduced to propose the enactment of the Health Security Act (HSA). The HSA would create a state health insurance plan ("Health Security Plan"), with the goal of providing universal health insurance coverage and access to affordable, high-quality health coverage for all state residents. After a competitive bidding process, the New Mexico Legislative Finance Committee (LFC) engaged KNG Health Consulting, LLC, and its partners, IHS Markit and Reynis Analytics, to conduct a fiscal analysis of the plan. The objective of the analysis is to assess, over an initial 5-year period, the cost of the proposed Health Security Plan (HSP) and whether existing revenue and potential savings from the plan would be sufficient to cover its cost.

KNG Health Consulting and its partners' approach for conducting the fiscal analysis of the HSP consisted of five steps. First, we conducted a qualitative assessment of the 2019 HSA to understand key features of the legislation as well as identify policy assumptions needed to conduct the fiscal analysis. Second, we solicited public feedback on our analytic approach and policy assumptions. Third, we conducted a quantitative analysis of the HSP using a microsimulation model and assessed the impact of alternate reform options ("scenarios"). This involved simulating the effects of each scenario on insurance coverage and health spending. We then translated these results into a budgetary impact for the state. Fourth, we solicited public feedback on our preliminary report. Lastly, we revised the preliminary report based, in part, on feedback from the public and LFC staff.

Policy Assumptions and Scenarios. Any projections about the effects of the HSP are dependent on the choices and decisions the state will make, as well as how stakeholders in the health delivery system will respond. We simulated the effects of the HSP as proposed in the 2019 HSA legislation that was introduced but did not pass the Legislature. As introduced during the 2019 New Mexico legislative session, the HSA specifies several features of the HSP, including policies related to eligibility and enrollment, benefits and cost-sharing, and premiums. However, modeling the costs of HSP required that we develop policy assumptions not specified in the legislation, as well as expand on some of the proposed features in the HSA. We developed all policy assumptions based on our review of the HSA, public feedback, and guidance from LFC staff.

We applied a standard set of policy assumptions consistently across the scenarios ("standard policy assumptions"). The standard policy assumptions relate to HSP implementation date, treatment of Medicaid and Medicare beneficiaries, employer participation in the HSP, tax treatment of HSP contributions, and enrollment mechanisms (Table ES1). Within each of the scenarios, we also included policy assumptions that varied across scenarios ("varying policy assumptions"). We modeled these alternative scenarios to provide information to New Mexico policymakers and stakeholders on the effects of various policy choices on the costs of HSP.

[1] New Mexico House of Representatives. House Bill 295. 2019. https://www.nmlegis.gov/Entity/LFC/Documents/Health_Security_Act_Procurement_Library/Health%20Security%20Act%20legislation%20and%20memorial/The%20Health%20Security%20Act%20-%20HB%20295%20as%20introduced,%202019.pdf

[2] New Mexico Senate. Senate Bill 279. 2019.https://www.nmlegis.gov/Sessions/19%20Regular/bills/senate/SB0279.pdf

In establishing the scenarios (varying policy assumptions), we focused on varying plan generosity and provider/facility reimbursement levels. These key elements affect the cost of the plan; the more generous the plan (in terms of lower premiums or cost-sharing), the more expensive the plan, while reductions in provider/facility payments may be used to help fund coverage expansion. In some scenarios, the HSP may be funded through existing revenue, while in other cases there may be a funding shortfall. Therefore, we approximated the size of a general payroll tax likely needed to close any of the funding shortfalls for a specific HSP scenario.

Table ES1. Health Security Plan Standard Policy Assumptions

Policy Issue	Modeling Assumptions
Implementation Date	January 1, 2024
Benefits	Comprehensive benefits package comparable to what is currently available to state's public employees. No long-term care benefits.
Treatment of Medicaid & Medicare Beneficiaries	Medicaid beneficiaries would be folded into the HSP upon implementation of the plan; Medicare beneficiaries would remain outside of the HSP during the initial 5-year modeling period.
Employer HSP Participation	Employers offering a self-insured group health plan may participate in the HSP or offer their own plan. Employers that do not offer a self-insured group health plan are assumed to participate in HSP and their employees enroll in HSP.
Employer Contribution to HSP	Employers that do not offer a self-insured group health plan would pay to partially cover their employees' premium costs. Employer contributions are established as a percentage of payroll and set so that aggregate contributions across all participating firms are the same in baseline and HSP.
HSP Eligibility of Employees at Employers Offering a Self-insured Group Health Plan	Employees with access to employers' self-insured group health plans may enroll in the HSP but would only decide to do so if their employer's coverage was not affordable.
Tax Treatment of Employer and Individual Contributions toward Premiums	Employer and individual contributions to premiums would be tax-exempt.
Enrollment Mechanisms	Retroactive eligibility for those who would be eligible for the HSP. Voluntary enrollment for employers offering a self-insured group health plan and their employees.

We examined 4 primary scenarios for structuring the HSP (Table ES2). The first two scenarios (1 and 2) assumed premiums and cost-sharing similar to typical employer-sponsored insurance (ESI) coverage (ESI-Comparable Scenarios), while the remaining scenarios (3 and 4) assumed premiums and cost-sharing similar to requirements under the federal Affordable Care Act (ACA) (ACA-Comparable Scenarios). In the first year of all models, we established provider/facility payment rates such that total payments for a provider/facility category (e.g., hospital, physician, etc.) would be comparable to what the

provider/facility was paid prior to the implementation of the HSP. In some scenarios (1 and 3), we grew provider/facility payment rates by the Consumer Price Index for Medical Care (CPI-M), and in other scenarios (2 and 4), we grew provider/facility payment rates by CPI-M minus 1 percentage point.

Table ES2. Health Security Plan Policy Scenarios

	ESI-Comparable		ACA-Comparable	
Policy Issue	**Scenario 1**	**Scenario 2**	**Scenario 3**	**Scenario 4**
HSP Standard Policy Assumptions	See Table ES1			
Cost-sharing	Cost-sharing would be similar to the average employer plan (based on actuarial value). No cost-sharing on preventative services. No cost-sharing for Native Americans or Medicaid-eligible beneficiaries.		Cost-sharing would be similar to the Affordable Care Act (ACA). No cost-sharing on preventative services. No cost-sharing for Native Americans or Medicaid-eligible beneficiaries.	
Premiums	Individual responsibility for premiums would be modeled on the average employer plan. HSP beneficiaries who would be eligible for lower premiums on the ACA Marketplaces would pay less. HSP beneficiaries who are Medicaid-eligible would pay no premiums.		Premiums would be established so that households pay no more than a fixed percentage of their income on plan premiums (capped at the full premium). We note that the ACA Marketplace limits premium amounts for households up to 400% FPL. We modified the policy to limit premiums for those above the 400% FPL. HSP beneficiaries who are Medicaid-eligible would pay no premiums.	
Payment Rates to Providers and Facilities	Payment rates would be established such that total payments for the provider/facility category (e.g., hospital, physician, etc.) would be comparable to what the provider/facility was paid prior to the implementation of the HSP. Prices would be adjusted for medical inflation as determined by the Consumer Price Index for Medical Care (CPI-M).	Payment rates in the initial year of HSP would be the same as Scenario 1. In subsequent years, rates would be inflated by CPI-M minus 1 percentage point.	Same as Scenario 1.	Same as Scenario 2.

Methods. We used a microsimulation model to estimate the effects of HSP on health insurance coverage and spending from 2024 (assumed initial year of the HSP) through 2028. We developed a baseline projection for the New Mexican population for the period from 2024 through 2028, which reflected health care coverage and spending under current law. We then compared the baseline to projected outcomes under the HSP (e.g., we compared projected 2024 spending under current law to projected 2024 spending under HSP). To simulate the impact of the HSP on insurance coverage, health care utilization, and spending, we started with the KNG-Health Reform Model (KNG-HRM), a microsimulation model capable of estimating the impact of health reform efforts. We then modified the model to incorporate New Mexico-specific data on the state's population and health care utilization, and to reflect HSP policies. The model uses an iterative process to estimate coverage choices (for those individuals and employers not assumed to be automatically enrolled in HSP), health care service use, spending, and premiums, as coverage affects health care use and spending, which in turn impact premiums and coverage choice.

With the information on those enrolled in the HSP, we estimated health care utilization and spending based on characteristics of the HSP population (e.g., age, gender, race/ethnicity, and health status and conditions) and prices paid for services. We assumed utilization changes as an individual's coverage type changes from less generous to more generous coverage. In addition, we allowed reimbursement rates for health care services to vary by payer. We assumed that administrative costs under the HSP would be 9 percent in 2024 and would fall by 1 percentage point each year to 5 percent in 2028. The 5-percent administrative cost is consistent with the requirement in the HSA (HB 295 § 30(D)). We also assumed that pharmacy costs would be reduced by 3.5 percent due to bulk purchasing and that a global budget on facilities would yield 2 percent savings on spending for facility services.

We accounted for four primary revenue sources to pay for the HSP. These include:

1. Premium and out-of-pocket (OOP) spending by New Mexicans enrolled in the HSP;
2. Employer contributions;
3. Federal and state spending for Medicaid, enrollment on the Marketplace, and public workers; and
4. Lost private health insurance tax revenues.

HSP beneficiary spending on premiums and OOP spending to support the plan vary by scenario, with higher collections from beneficiaries under the ACA-comparable scenarios than under the ESI-comparable scenarios. We assumed that employer contributions are established so that employers participating in the HSP pay into the program, in aggregate, the same amount they would pay toward ESI in the baseline. As a result, employers who do not offer coverage in baseline will pay more under HSP, while those employers who offer a fully-insured group health plan in baseline will pay less. In addition, we assumed that estimated baseline federal and state spending for Medicaid, financial assistance for those obtaining coverage on the Marketplace, and funding for public employees would be available to fund the HSP. Finally, with private insurers largely replaced by the HSP, we accounted for lost premium tax revenues when assessing revenue sources to cover the costs of the HSP.

Health care spending changes from the HSP would result in direct and indirect effects on economic output, as the demand for, and provision of, health care services change. We calculated the in-state economic contribution of spending under the HSP using the IMPLAN model of the New Mexico economy, which explicitly models the degree to which service inputs are provided from businesses in the state.

Key Findings. Implementation of the HSP would have impacts on health insurance coverage, health care spending by households, employers, and budgetary impacts for the state. We summarize the effects on each of the modeled scenarios in Table ES3.

- Coverage. The HSP would enroll most of the state's population into a state health insurance program. Doing so could bring near-universal health insurance coverage to New Mexico.

- Spending. Improved access to comprehensive health insurance would drive higher use of services, particularly among those who otherwise would have been uninsured. While higher service use would drive increased spending, savings from reduced payer-side (state) administrative costs are projected to offset these increases. Over the long-term, we projected that the HSP would decrease total health spending in New Mexico if administrative costs are kept at levels proposed by the HSA.

- Effects on HSP Beneficiaries. By offering reduced premiums for certain New Mexicans, the HSP would decrease the financial burden of health expenses for some HSP beneficiaries, particularly for low-income households not currently enrolled in Medicaid. The effect of the HSP on HSP beneficiaries varied by scenario. Under the more generous HSP plan (ESI-comparable premiums and cost-sharing), we estimated that premiums and OOP spending would be the same or lower for all groups of HSP beneficiaries relative to the baseline. Under the ACA-comparable scenarios, employees who had received coverage through their employer would pay significantly more in premiums under the HSP.

  With better access to preventative and other health care services, hospitalizations and the use of other acute services may fall. In additional analyses, we assumed that newly-insured adults under the HSP get patient-centered care that may result in lower blood pressure and cholesterol, some weight loss and smoking cessation, and better glycemic control. We estimated that these health benefits, if they materialized, could offset other types of health care spending, such as for hospitalizations, by between $100 and $150 million over the initial 5 years of the HSP. We did not factor these potential savings into our budgetary impact analysis.

- Effects on Employers. The net impact on employers is dependent on how policymakers implement employer contribution requirements, including the level of contribution and which employers are exempt from contributions. Under our scenarios requiring employers participating in the HSP to contribute to the cost of the plan, we estimated that the HSP would increase employer contributions to the health care system for some. These cost increases would fall on businesses that were previously not offering health benefits and, to a lesser extent, businesses that continued offering self-insured group health plans to their employees. On the other hand, we estimated that employer contributions among firms that offer a fully-insured group health plan in baseline would fall.

- Budgetary Impact. In our ESI-comparable scenario with no provider/facility payment reduction, we projected that the HSP would be underfunded by approximately $5.8 billion over the first 5 years (Table ES3, Scenario 1). Reducing the growth in provider/facility payment rates from CPI-M to CPI-M minus 1 percentage point would reduce the shortfall by approximately a billion dollars to $4.7 billion (Scenario 2). The funding shortfall would be significantly reduced under an HSP with premium and cost-sharing structures similar to the ACA, due largely to higher premium contributions among those who received ESI in baseline (Scenario 3). Under the ACA-comparable scenario, the shortfall would be eliminated by slowing the growth of provider/facility reimbursements by 1 percentage point below CPI-M (Scenario 4). We approximated the potential size of an additional payroll tax (in addition to employer contributions) required to close the budget shortfall for each scenario in Table ES3. For Scenario 1, an additional payroll tax of, on average across the initial 5 years, 2.3 percent would be required to fund the budget shortfall, while an average payroll tax of 0.3 percent would be required to close the budget shortfall for Scenario 3.

Table ES3. Total Costs of HSP, Revenues, and Budgetary Impact by Scenario (in Millions of Dollars)

	ESI-Comparable		ACA-Comparable	
	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Description	No Pay Reduction	1% Pay Reduction	No Pay Reduction	1% Pay Reduction
HSP Benefits and Administration	51,985	51,089	48,082	47,106
Total Revenue	46,186	46,367	47,214	47,168
Premiums	5,364	5,408	8,929	8,877
Employer Contributions	8,922	9,044	6,702	6,706
Available Federal Funding	22,246	22,246	22,246	22,246
Available State Funding Plus Tax Impacts	9,654	9,668	9,337	9,339
Budget Shortfall	5,799	4,723	868	-62
Average % Employer Contribution	8.0%	8.0%	7.0%	7.0%
% Employees with ESI in Baseline Who Enroll in HSP (2024)	59.0%	59.0%	51.0%	51.0%

Source: KNG Health analysis of the Health Security Plan.

Notes: In the "1% Pay Reduction" scenarios, we grew provider and facility payment rates by CPI-M – 1 percentage point. Tax Impacts include changes in state income tax revenue and insurer premium tax revenue.

Key Considerations in Assessing the Feasibility of the Health Security Plan. Our model made several assumptions that drive the overall findings regarding the cost and revenues available to fund the HSP. These key drivers require careful consideration as they affect the interpretation of our study findings.

- Federal Waivers – Medicaid and Marketplace. We assumed that New Mexico would receive waivers for Medicaid and the Marketplace to fold these programs into the HSP. Whether the state could obtain such waivers is uncertain. The federal government would, at a minimum, require budget neutrality and likely savings to grant the waivers. We also assumed that Medicaid take-up and enrollment in a Marketplace plan would remain similar to current levels, except for population growth. In other words, we did not assume federal funds are available for those New Mexico residents who are Medicaid-eligible but not enrolled. Federal contributions to cover the cost of the HSP could be increased by increasing enrollment in Medicaid and Marketplace plans for those eligible for federal financial assistance prior to the implementation of the HSP. In addition, the HSP limits eligibility to those who have resided in the state for at least one year. Many of those who fail the residency requirement may be eligible for federal Marketplace subsidies. The HSP would likely effectively eliminate the ACA Marketplace in New Mexico, potentially leaving a small number of people unable to access Marketplace coverage or the HSP.

- Continuation of ACA and Federal Funding. Our results assumed that the ACA and associated federal funding will continue to be available to the state. Under the ACA, the federal Medicaid matching rate applied for newly eligible adults under Medicaid expansion is 90 percent for 2020 and beyond. In addition, the ACA provides federal financial assistance to those eligible on the Marketplace. Together, these federal assistance programs contribute an estimated $2.1 billion to New Mexico.[3] California v. Texas, a pending case before the Supreme Court, could potentially strike down the entire ACA as unconstitutional. If this did occur, the impact on HSP funding would depend on what, if any new program, replaced the ACA.

- Eligible-but-not-enrolled Populations. We found that the HSP would achieve universal coverage among eligible populations. However, in practice, not all eligible individuals and households would choose to enroll. We assumed the state could implement "automatic enrollment," where applicable premiums are collected through state income tax filings, and non-enrolled individuals are covered via retroactive eligibility. However, many uninsured New Mexican residents are already covered through retroactive Medicaid eligibility. Therefore, a significant portion of those we classified as "uninsured" in the baseline, may already meet our coverage definition. In this sense, we may be overstating the coverage gains from the HSP. As many of those who "gain coverage" may not perceive themselves as covered, our model assumed utilization increases would be slightly lower (based on our estimate of non-Medicaid and Marketplace enrollment – take-up – among those eligible for Medicaid or

[3] Blumberg, L.J. et al. (2019). *State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA*. Washington, DC: The Urban Institute. https://www.urban.org/research/publication/state-state-estimates-coverage-and-funding-consequences-full-repeal-aca

Marketplace financial assistance in New Mexico, 12%) than those estimated in the Oregon Health Insurance Experiment.[4]

- Administrative Savings from the HSP. In our model, a key driver of savings would be reduced state administrative costs. The 2019 HSA introduced legislation that would limit administrative costs of the HSP to no more than 5 percent of total spending starting in the sixth year. We assumed that administrative costs represent 9 percent of total HSP spending in 2024 and fall to 5 percent by 2028. Our assumed administrative cost levels represent significantly lower costs as a percentage of total spending than is currently achieved by the state Medicaid program or by the national Medicare program. Spending on administrative costs accounted for roughly 12.4 percent of total New Mexico Medicaid spending in 2017.[5] According to the National Health Expenditure Accounts from the Centers for Medicare & Medicaid Services, administrative costs accounted for approximately 7 percent of Medicare spending. In countries with multiple payers but tightly regulated insurance markets such as Germany, the Netherlands, and Switzerland, administrative costs account for approximately 4 to 5 percent of total spending.[6]

- Tax Treatment for Employer and Employee HSP Contributions. There are considerable tax benefits to employer-sponsored insurance because contributions by employers are not subject to federal taxes and employee contributions are made using pre-tax dollars, lowering employees' tax liability. We assumed that these tax benefits would also apply under the HSP. Whether such preferential tax benefits would be applied to the HSP is uncertain, although, in prior analyses of health reform in New Mexico, this assumption was viewed as reasonable.[7] The tax treatment of contributions by employers and employees is an important issue that the state would need to resolve.

- Employee Retirement Income Security Act (ERISA) Compliance Plan. In our analysis, we assumed that the state would be able to develop an ERISA-compliant approach whereby the state would collect funds through a payroll fee on employers whose employees obtain coverage through the HSP. ERISA's "preemption clause" limits the ability of the state to make laws governing employer-based insurance to the extent that they "relate to" employer-sponsored health plans. We sought information on the likelihood that our assumptions would be consistent with ERISA. While no definitive conclusions were drawn, a general view could be surmised that it may be possible to design approaches that are materially similar to those assumed. This view is consistent with the approach

[4] National Bureau of Economic Research. *The Oregon Health Insurance Experiment*. https://www.nber.org/oregon/1.home.html

[5] New Mexico Legislative Finance Committee. (2019). *Medicaid Spending on Program and Managed Care Administration*. New Mexico Legislative Finance Committee. https://www.nmlegis.gov/Entity/LFC/Documents/Health_Notes/Health%20Notes%20-%20Medicaid%20Administrative%20Costs,%20May%202019.pdf

[6] Washington State Institute for Public Policy. Single-Payer and Universal Coverage Health Systems: Final Report. May 2019. http://www.wsipp.wa.gov/ReportFile/1705/Wsipp_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report_Report.pdf

[7] Chollet, D., Liu, S., Gillia, B et al. Quantitative and Comparative Analysis of Reform Options for Extending Health Care Coverage in New Mexico. July 31, 2007. Final Report. Mathematica Policy Research, Inc.

followed by Mathematica Policy Research in its assessment of health care reform options for extending coverage in New Mexico.[7] Nevertheless, the development of ERISA-compliant approaches to implement the HSP and achieve its goals could face legal challenges, which were not addressed in our study.

If implemented, the Health Security Act would be the most ambitious state-based health reform ever carried out in the United States. Under the HSP, the state's uninsured rate would likely fall well below 1 percent and the majority of the population would receive coverage through a public insurance program. The plan would also improve health care affordability for low- and middle-income households who would otherwise receive coverage through the non-group market. However, under the ACA-comparable scenarios, beneficiary premiums would increase for middle- and higher-income households transitioning from employer-based to HSP coverage. Over the initial 5-year period, the overall economic impact of the HSP is expected to be relatively small. However, the role of private insurance would be diminished, and some segments of the private insurance market would likely disappear altogether. As a result, HSP could produce financial hardship to New Mexican households and businesses dependent on the private insurance industry. Usage of health care services would increase, but long-term total health care spending could fall if reductions in payer-side administrative costs are achieved to the level specified in the HSA proposed legislation. Most of the cost of the HSP could be financed by redirecting public funding from duplicative health programs, requiring contributions from employers not offering coverage, and requiring beneficiaries with the means to pay a portion of their own premium costs. Nonetheless, additional funding sources may be needed to fully cover the cost of the plan, depending on the specific design features of the plan.

I. Introduction

In 2019, the Legislature of the State of New Mexico considered House Bill 295 and Senate Bill 279, which were introduced to propose the enactment of the Health Security Act (HSA). The HSA would create a state health insurance plan ("Health Security Plan"), with the goal of providing universal health insurance coverage and access to affordable, high-quality health coverage for all state residents. The proposed legislation would have directed the Legislative Finance Committee (LFC) to obtain a fiscal analysis of the first five years of HSP. Although the bills did not pass the legislature, the passage of the 2019 House Appropriations and Finance Committee Substitute for HB 548 and the 2019 Senate Finance Committee Substitute for SB 536 made appropriations to the LFC for a fiscal analysis of the HSP.

The LFC engaged KNG Health Consulting, LLC, and its partners, IHS Markit and Reynis Analytics, to conduct the fiscal analysis. The objective of the analysis is to assess, over an initial 5-year period, the cost of the HSP proposal and whether existing revenue and potential savings from the HSP would be sufficient to cover its cost. Findings from this analysis will inform legislators as they decide whether and how to proceed with establishing the HSP. In this report, we present findings from our fiscal analysis of the HSP.

A. Overview of the Health Security Plan

As proposed in the 2019 bills, there are three stated purposes of the HSA: (1) ensure health care coverage to all New Mexicans, (2) control escalating health care costs, and (3) improve the health care of all New Mexicans (Health Security Act of 2019, HB 295, 54th Legislature § 2 (2019)).

Ensuring Coverage to all New Mexicans. Prior to the Affordable Care Act (ACA), New Mexico had one of the highest uninsured rates in the nation, at 19 percent uninsured in 2013 as compared to the national rate of uninsured at 15 percent.[8] New Mexico experienced a significant reduction in the percentage of uninsured individuals after implementing Medicaid expansion, with roughly the same percentage of its population uninsured (9%) as the national average in 2018.[9] Nevertheless, the uninsured rate remains high for some segments of the New Mexico population, including those who do not qualify for Medicaid (incomes above 138 percent of the Federal Poverty Level (FPL)) and Native Americans.[10]

The HSA would expand health insurance coverage to individuals residing in New Mexico, including those currently covered by non-group and employers' fully-insured group health plans. The HSA specifies a one-year residency requirement to be eligible for the HSP, although the requirement is waived for individuals who moved to New Mexico for employment (HB 295 § 21(A)). The following populations are excluded from enrolling in the HSP: federal retiree health plan beneficiaries, active duty and retired military personnel, and individuals covered by the federal active and retired military health programs (HB 295 § 21(B)). Employers that offer a fully-insured group health plan in baseline would obtain coverage for

[8] Kaiser Family Foundation. (2013). *Health Insurance Coverage of the Total Population* [Data set] Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/

[9] Kaiser Family Foundation. (2018). *Health Insurance Coverage of the Total Population* [Data set]. Kaiser Family Foundation. https://www.kff.org/other/state-indicator/total-population/

[10] Banthin, J. et al. (2019). *The Uninsured in New Mexico*. Washington, DC: The Urban Institute. https://www.urban.org/sites/default/files/publication/101427/the_uninsured_in_new_mexico_final_v3.pdf

their employees through the HSP and would contribute to the funding of the plan (HB 295 § 21(E)). The HSA specifies that the fiscal analysis may consider minimum and maximum employer contributions to finance the HSP while taking into consideration an employer's payroll and the firm's number of employees (HB 295 § 47(B)(4)).

Some groups could voluntarily choose to participate in the HSP. Employers offering self-insured group health plans covered under the Employee Retirement Income Security Act (ERISA) could continue to offer coverage through their plan or choose to obtain HSP coverage for their employees (HB 295 § 40(B)). Employees at firms offering a self-insured group health plan could choose instead to obtain HSP coverage, although some public commenters indicated that the intent of the legislation is to leave the decision to join HSP to employers only. Additionally, tribal governments, as sovereign entities, would have the discretion to choose to participate in the HSP (HB 295 § 21(C)).[11]

Controlling Health care Costs. The HSP is intended to be a premium-supported plan with individuals and participating employers paying into the system (HB 295 § 30). A Health care Commission established to oversee the HSP would, along with appropriate state agencies, apply for federal waivers to repurpose federal spending for Medicaid, Medicare, and spending to provide financial assistance under the Marketplace (HB 295 § 11). Through the HSP, premiums and cost-sharing would be subsidized for certain groups. Native Americans would not be charged any cost-sharing and no HSP beneficiary would pay for preventative services (HB 295 § 33(A)). The HSA specifies that the fiscal analysis may consider beneficiary cost-sharing options to help finance HSP based on beneficiary income, federal premium tax credits, federal cost-sharing subsidies, and Medicare offsets (HB 295 § 47(B)(3)).

The HSP would employ several approaches to help control growth in health care spending. First, a Health care Commission would be established that would, among other responsibilities, adopt cost-effective methods of providing quality health care to HSP beneficiaries, establish capital budgets for health facilities and equipment, and develop claims and payment procedures for health care services (HB 295 § 11). Second, the Health care Commission would negotiate reimbursement rates with health care providers and facilities and subject health care facilities to global budgets (HB 295 § 31). In addition, annual rate increases under the HSP would be limited to no more than the growth in the medical component of the Consumer Price Index. Third, the Health care Commission would use bulk purchasing on prescription and non-prescription drugs, durable medical equipment, and supplies, as well as administer a formulary and/or preferred drug list to reduce costs further. Fourth, the HSA envisions administrative savings as a result of most New Mexicans receiving coverage through a single insurer plan and would limit administrative costs to no more than 5 percent of the HSP budget beginning in the sixth and subsequent years of operation (HB 295 § 30(D)).

Improve Health care of all New Mexicans. The HSA envisions improvements to the health care of all New Mexicans through several mechanisms. These include expanded coverage to the uninsured, insurance benefits that are at least as good as those offered by the state employee health plan, no-cost access to

[11] Consistent with the Health Security Act, we assumed that Native Americans are automatically enrolled in HSP with other included populations.

preventative services, and care coordination, where appropriate. New Mexico has a shortage of primary care providers, with 32 of New Mexico's 33 counties classified as full or partially federally designated Health Professional Shortage Areas (HPSAs) for primary medical care.[12] Almost 25 percent of the population lives in a rural area, with 40 percent living in an HPSA. Therefore, the HSA directs the Health Care Commission to ensure the provision of health care services in rural and underserved areas (HB 295 § 14). Finally, the HSA calls for the establishment, in conjunction with other state agencies, of a comprehensive system to collect and analyze health care data to improve the quality, efficiency, and effectiveness of health care services in the state (HB 295 § 11).

B. Study Approach Overview

Our approach for conducting the fiscal analysis of the HSP consisted of five steps. First, we conducted a qualitative assessment of the HSP to understand key features as well as identify policy assumptions needed to conduct the fiscal analysis. This assessment involved reviewing the proposal to identify features of the HSP and reviewing literature to identify coverage reform options for those elements not fully specified in the legislation. Second, we solicited public feedback on our analytic approach and HSP policy assumptions. We received comments at a public meeting at the University of New Mexico in Albuquerque held on December 4, 2019, and through a second public meeting in the New Mexico State Capitol in Santa Fe on March 3, 2020. Additionally, we accepted written comments on our analysis plan. We provide a summary of the public comments and our responses to these comments in Appendix B. Third, we conducted a quantitative analysis of the HSP using a microsimulation model and assessed the impact of alternate reform options ("scenarios"). This involved simulating the effects of each scenario on key health-related measures, including insurance coverage and health spending. We then translated these results into a fiscal impact for the state, including the downstream economic impacts on the state, and released a preliminary report on May 22, 2020. Fourth, we solicited and reviewed public feedback on our preliminary report. We provide a summary of the public comments to the preliminary report and our responses to these comments in Appendix C. Fifth, we revised the preliminary report based, in part, on feedback from the public and LFC staff.

C. Structure of the Report

This report is designed to assist policymakers in assessing the potential impact of the HSP. We simulated the costs of the HSP using a range of different policy options and assumptions. The report is organized as follows. We first present a description of the HSP features and model assumptions, including the policy assumptions we used to develop alternate proposals for the microsimulation model. Next, we describe our methods, including the analytic database and the KNG Health Reform Model. We then present our findings for the current coverage, expenditures, and financing in New Mexico, followed by the change in coverage and costs under the different reform models by scenario. We present the economic impacts and other potential effects separately. We close the report with a discussion section.

[12] New Mexico Legislative Finance Committee. (2015). *Health Notes: Uncompensated Care in New Mexico After the Affordable Care Act*. New Mexico Legislative Finance Committee.

II. Health Security Act: Plan Features and Policy Assumptions

In this section, we report the findings from our qualitative assessment of the HSP, provide a discussion of policy assumptions, and present the policy scenarios we modeled. To model the potential costs of the HSP, we required explicit assumptions related to design features that are not fully specified in the legislation. We developed these policy assumptions based on input from the LFC staff and public comments received on our analysis plan. Our policy assumptions reflect our efforts to find reasonable options that reflect the intent of the plan and that can generate findings that will inform the state's implementation decisions. However, our assumptions regarding HSP policies should not be interpreted as policy recommendations for the final structure of the HSP, were it to be implemented.

A. Features of the Health Security Plan

Any projections about the effects of the HSP are dependent on the choices and decisions the state will make, as well as how stakeholders in the health delivery system will respond. We simulated the effects of the HSP as proposed in the 2019 HSA bills that were introduced, but did not pass the Legislature. As introduced during the 2019 New Mexico legislative session, the HSA specifies several features of the HSP, including policies related to eligibility and enrollment, benefits and cost-sharing, and premiums. However, modeling the costs of HSP required that we develop policy assumptions not specified in the legislation, as well as expand on some of the proposed features in the HSA. We developed all policy assumptions based on our review of the HSA, public feedback, and guidance from LFC staff.

In Table 2.1, we present a summary of the key proposed features of the HSP. We also provide notes on the non-proposed features of the HSP (i.e., features that are not explicitly described in the HSA or that are not described in sufficient detail for modeling purposes). There are open questions surrounding benefits (minimum standards are established by the HSA) and premiums; the costs to employers; and plan financing. In the following section, we present our treatment of these HSP policy aspects used for our modeling approach.

Table 2.1. Summary of Key Proposed and Non-Proposed Features of the HSP

Category	Proposed Features	Non-Proposed Features*
Overall		
General Approach	A premium-based system to expand health insurance coverage to most New Mexicans, including those currently covered by non-group plans and employers' fully-insured group health plans. The HSP would be financed through premium and cost-sharing payments from beneficiaries, employer contributions, and repurposed public expenditures for health care.	

Eligibility – Individuals	• Inclusion Criteria
	  ○ Individuals and their dependents residing in New Mexico for 1+ years
	  ○ New residents who moved to New Mexico to take a job
	• Exclusion Criteria
	  ○ Federal retiree health plan beneficiaries
	  ○ Active duty and retired military personnel
	  ○ Individuals covered by the federal active and retired military health programs
		• The HSA legislation does not explicitly require Medicare or Medicaid beneficiaries to be enrolled in the plan but directs the Health Care Commission to seek federal waivers to include these populations in the HSP.
		• Tribal governments may elect to participate in the HSP.

Eligibility – Employers	• All employers may offer coverage through the HSP. • Employers may offer comprehensive health benefits outside of the HSP if they offer a self-insured group health plan.	• The HSA envisions that the HSP would receive payments (contributions) from employers whose employees obtain coverage through the HSP to offset the cost of coverage for their employees. • The HSA does not specify the exact mechanism by which employers would contribute to the HSP or how much employers should contribute.
Enrollment	• Enrollment into the HSP would be required for all eligible beneficiaries, including employees at firms that do not offer a self-insured group health plan. • Enrollment would be voluntary for employers offering self-insured group health plans and tribal governments.	• The legislation does not address retroactive coverage for eligible populations who do not apply for coverage before consuming services.
Benefits and Cost-Sharing		
Benefits	• The HSP must cover the benefits currently offered by the state employee health plan.	• The HSP does not limit benefits to those covered by the state employee health plan.
Cost-Sharing Amounts	• HSP beneficiaries receive preventative services with no cost-sharing requirement; Native Americans in HSP would pay no cost-sharing for any service.	• The legislation does not specify cost-sharing requirements for non-preventative services delivered to non-Native American beneficiaries.

Category	Proposed Features	Non-Proposed Features*
Premiums		
Premium Amounts	• A single per person premium amount may be applied. • The premium level may be established to fund both benefits spending for HSP beneficiaries and HSP administrative costs. The administrative portion of the premium amount would be capped at 5% of total spending in the sixth year of HSP.	• Unspecified in the legislation is the obligation of eligible populations who have not applied for coverage to pay premiums and, if so, how premiums would be collected. • Administrative costs as a percentage of spending for the first 5 years of the HSP are not specified.
Premium Subsidies	• No detail provided.	• The legislation does not specify how premium subsidies should vary by income nor if premium subsidies should vary by household size.
Health care Providers and Facilities		
Participation	• Health care providers with negotiated rates participate in the HSP and may not charge any additional amount to HSP beneficiaries. A health resource certificate must be obtained by a health facility or health care provider participating in the HSP before making a major capital expenditure.	
Payments	• Reimbursement rates would be negotiated with the Health Care Commission. Health facilities would be subject to global budgets. Annual HSP rate increases would be limited to growth in the medical component of the Consumer Price Index. Supplemental payments may be provided to ensure access in rural and underserved areas.	• The HSA does not specify rates but leaves this to be negotiated with the Health Care Commission. Additionally, it does not specify the extent additional payments would be made to underserved and rural communities.

Note: *Non-proposed Features: features that are not explicitly described in the HSA or that are not described in sufficient detail for modeling purposes.

B. Standard Policy Assumptions for the Health Security Plan

To model the costs of the HSP, we required specific assumptions regarding the policies governing the HSP and specific plan features. We applied a standard set of policy assumptions consistently across the scenarios ("standard policy assumptions"). The standard policy assumptions relate to HSP start date, treatment of Medicaid and Medicare beneficiaries, employer participation in the HSP, tax treatment of HSP contributions, and enrollment mechanism (Table 2.2). Within each of the scenarios, we also included policy assumptions that varied across scenarios ("varying policy assumptions"). We modeled these alternative scenarios to provide information to New Mexico policymakers and stakeholders on the effects of various policy choices on the costs of HSP. The scenarios are provided at the end of Section II.

Table 2.2. Health Security Plan Standard Policy Assumptions

Policy Issue	Modeling Assumptions
Implementation Date	January 1, 2024
Benefits	Comprehensive benefits package comparable to what is currently available to state's public employees. No long-term care benefits.
Treatment of Medicaid & Medicare Beneficiaries	Medicaid beneficiaries would be folded into the HSP upon implementation of the plan; Medicare beneficiaries would remain outside of the HSP during the initial 5-year modeling period.
Employer HSP Participation	Employers offering a self-insured group health plan may participate in the HSP or offer their own plan. Employers that do not offer a self-insured group health plan are assumed to participate in HSP and their employees enroll in HSP.
Employer Contribution to HSP	Employers that do not offer a self-insured group health plan would pay to partially cover their employees' premium costs. Employer contributions are established as a percentage of payroll and set so that aggregate contributions across all participating firms are the same in baseline and HSP.
HSP Eligibility of Employees at Employers Offering a Self-insured Group Health Plan	Employees with access to employers' self-insured group health plans may enroll in the HSP but would only decide to do so if their employer's coverage was not affordable.
Tax Treatment of Employer and Individual Contributions toward Premiums	Employer and individual contributions to premiums would be tax-exempt.
Enrollment Mechanisms	Retroactive eligibility for those who would be eligible for the HSP. Voluntary enrollment for employers offering a self-insured group health plan and their employees.

1. Treatment of Medicaid and Medicare Beneficiaries

The HSA directs the Health Care Commission to seek waivers for the inclusion of Medicaid and Medicare beneficiaries in the HSP. Including Medicaid beneficiaries within HSP has advantages and disadvantages. Unlike Medicare, Medicaid is already administered by the state. Therefore, combining Medicaid with the HSP would likely reduce administrative complexity for both the state government and the rest of the state's health care system. To obtain a Medicaid waiver, the state would need to verify that the HSP complies with regulatory requirements for Medicaid plans, including cost-sharing requirements, premium costs for beneficiaries, and minimum benefits. Requirements related to out-of-pocket costs could likely be achieved through premium subsidies and cost-sharing reductions. For the most part, benefits could probably also be aligned or addressed through the HSP design, except, perhaps, for long-term services and support. Because of administrative savings and other benefits of including Medicaid in the HSP, we simulated the effects of the HSP where Medicaid beneficiaries are enrolled in the HSP.

The treatment of Medicare beneficiaries is not specified by the HSA, although it specifically directs the Health Care Commission to apply for all waivers that would allow the HSP to receive federal payments for services provided to Medicare beneficiaries (HB 295 § 11(T)). Including Medicare beneficiaries within the HSP would be administratively complex. Medicare beneficiaries' selection into the HSP would need to be voluntary. Prior research from Mathematica Policy Research suggested that the HSP could potentially be offered as a Medicare Advantage (MA) plan, which would allow for voluntary participation in the HSP.[13] Doing so would require the state to verify that the HSP complied with regulatory requirements for MA plans. This could either limit the state's flexibility in designing the HSP or require the state to offer an alternative version of the HSP specific to Medicare beneficiaries. In addition, the Centers for Medicare & Medicaid Services (CMS) has an established process for setting premiums for MA plans based on a plan's bid and other information. Thus, even if New Mexico was able to create an MA HSP, premiums would likely need to be established separately from the main HSP for non-Medicare beneficiaries, enrollment would be voluntary, and funding would come from current Medicare funding sources. For purpose of simulating the effects of the HSP, we assumed that Medicare beneficiaries are not eligible to enroll in HSP during the initial five-year period, because, while it might be possible for the state to establish an HSP in MA, this plan would likely be separate from the main HSP from a revenue and cost perspective.

2. Employer Participation and Contributions to the HSP

The implementation of the HSP and enrollment of individuals currently covered under public and employer-sponsored insurance (ESI) is made more complicated by federal laws and regulations. The Employee Retirement Income Security Act (ERISA) governs employers' fully-insured and self-insured group health plans. Because ERISA preempts all state laws related to employer-sponsored benefits, it imposes a significant challenge to states attempting to bring employer coverage under a state health

[13] Chollet, D., et al. (2007). *Quantitative and Comparative Analysis of Reform Options for Extending Health care Coverage in New Mexico*. Washington, DC: Mathematica Policy Research. https://www.mathematica.org/our-publications-and-findings/publications/quantitative-and-comparative-analysis-of-reform-options-for-extending-health-care-coverage-in-new-mexico

plan.[14] However, states regulate insurers and can, therefore, exert more control over employers with fully-insured group health plans. Section 40 of the HSA relates to the voluntary purchase of other insurance. It states that the HSA does not affect coverage pursuant to ERISA unless the state is granted a congressional exemption or waiver. It further notes that health plans that are covered by ERISA may elect to participate in the HSP.

After consultation with the LFC, we assumed that the intent of the proposal is to enroll employers and their employees with fully-insured group health plans in the HSP. This view of the proposal was also articulated in public comments we received on the HSA. Thus, for purposes of our model, we assumed that the state will be able to take actions that are both compliant with ERISA but also result in the enrollment of employees at firms that do not offer a self-insured group health plan. Moreover, the plan would allow employers offering self-insured group health plans to participate in the HSP (this can be viewed as an "opt-in" provision).

Employers pay some health care costs of their employees by subsidizing premiums for workers and dependents enrolled in their health plans. In public comments to our analysis plan, we received comments that described the HSP as a cooperative or co-op, where only those participating in the plan pay into the plan. Employers participating in the HSP (by default and in consultation with the LFC, we assumed that an employer participates in the HSP if it does not offer coverage and, thus, its eligible employees are enrolled in the HSP) would contribute to the cost of their coverage by making payments to the HSP. For the purpose of our model, we assumed that the HSP could develop an ERISA-compliant approach to obtain payments from all employers whose employees are enrolled in the HSP and who do not offer a separate self-insured group health plan. At the same time, we assumed that employers that offer a self-insured group health plan would not be responsible for contributing funds to the HSP.

Consistent with the co-op nature of the HSP, we estimated participating employer contributions to the HSP as follows:

1. We estimated the amount of money contributed by employers towards premiums for fully-insured group health plans.
2. We calculated total premium contributions as a percentage of total payroll across all employers that offered a fully-insured group health plan in the baseline or that did not offer coverage in baseline.

The percentage calculated in step 2 above was established as the contribution required for employers who participate in the HSP. This approach essentially holds employers neutral in aggregate in terms of spending for employee health coverage. It is important to note that the fixed percentage was applied to employers that do and do not offer coverage. As a result, the contribution of employers that do not offer coverage in baseline would increase (because they made no contributions in baseline), while the contribution of employers that offer coverage in baseline would fall.

[14] Brown E. & McCuskey E. (2019, July 22). *Could States do Single-Payer Health Care?* Health Affairs Blog. https://www.healthaffairs.org/do/10.1377/hblog20190717.466249/full/

3. HSP Eligibility of Employees at Self-insured Employers

Currently, not all employees with access to health insurance from their employer take up coverage. Some may gain coverage through a spouse who has access to ESI through his or her firm. Others may be eligible for Medicaid at low or no cost and choose that coverage instead of the coverage offered through their employer. Some employees, even those who take up their employer's plan, may find it preferable to enroll in the HSP.

The HSA does not address the HSP eligibility of employees at an employer that offers a self-insured group health plan, whether an individual has coverage through the firm or some other source or whether an individual remains uninsured. In the public comments we received, it was stated that the intent of the HSP would allow employers with self-insured group health plans to choose to participate in the HSP but not to have employees at these firms eligible to enroll in HSP as individuals. One concern is that presence of the HSP could encourage employers to design self-insured group health plans that limit eligibility to select workers, which would shift costs from these employers onto the HSP.

Because the HSA does not provide a mechanism to limit enrollment into the HSP for those with access to a self-insured plan and based on input from LFC staff, we assumed that these individuals may enroll in the HSP. However, our decision rule for whether or not an employee chooses the HSP favors the ESI plan. Specifically, we assumed that those who obtain ESI from an employer that offers a self-insured plan would continue to take up that plan as long as it is affordable. We defined ESI coverage as being affordable if the premium is less than 9.5 percent of the household's modified adjusted gross income ("affordability standard"). This threshold is similar to how affordability is defined for the highest income bracket in the ACA Marketplaces.

4. Tax Treatment of Employer and Employee Contributions toward Premiums

One advantage of employer-based health insurance coverage is that contributions toward premiums by individuals and their employers are tax-exempt. We assumed that the HSP would be set up to allow both employer and individual contributions to premiums to be tax-exempt. This assumption effectively neutralizes the effects of the tax preference for ESI coverage on employers' decisions to continue to offer a self-insured group health plan or enroll employees in the HSP, since contributions to coverage are treated the same under each situation. This assumption is consistent with the assumption followed by Mathematica Policy Research in its assessment of health care reform options for extending coverage in New Mexico.[15]

5. Process for Enrollment of Eligible Populations and Treatment of Ineligible Populations

The creation of a public coverage program will not necessarily result in universal coverage. For example, according to a recent report by the Urban Institute, approximately 30 percent of uninsured New Mexico

[15] Chollet, D., Liu, S., Gillia, B et al. Quantitative and Comparative Analysis of Reform Options for Extending Health Care Coverage in New Mexico. July 31, 2007. Final Report. Mathematica Policy Research, Inc.

residents are already eligible for Medicaid and 23 percent are eligible for subsidies on the New Mexico Health Insurance Marketplace but are not enrolled.[16] These residents could obtain coverage at little or no cost but have elected not to enroll in the program. The 2019 HSA would not impose an insurance coverage mandate on individuals or employers. The state may attempt to automatically enroll all eligible persons. However, this requires an administrative mechanism to both verify eligibility (i.e., the one-year residency requirement) and to collect premiums when applicable. In our environmental scan of state universal coverage legislative proposals, we did not identify any proposals that described an automatic enrollment process. One approach for "automatic enrollment" in HSP would be for the state to adopt retroactive eligibility, in which providers and facilities can be paid for services by enrolling eligible patients after care has already been received. Retroactive eligibility is currently used in New Mexico's Medicaid program. The state would probably need to collect unpaid premiums through end-of-year tax returns. Non-enrolled individuals with de facto coverage through retroactive eligibility may be required to pay a premium amount when filing their taxes. Some individuals may perceive the premiums as taxes. Some may also postpone enrolling in the HSP until they need care.

We assumed that the state achieves universal coverage among eligible populations through retroactive eligibility. In addition, we assumed that individuals, who do not qualify for premium-free HSP enrollment, would be required to pay premiums (collected through tax filings, if necessary) regardless of whether or not they actively enrolled in the HSP. However, we did not assume that the uninsured who now gain coverage under the HSP (in part, from retroactive eligibility) would seek care to the same extent that someone who was previously insured. Having access to care may not change behavior for those who choose to be uninsured, because of financial, cultural, or other reasons. Therefore, we assumed that "take up" (the active enrollment in a plan for which an individual is eligible) of HSP among the uninsured would be similar to the take-up rate for Medicaid and Marketplace financial assistance. For those who are uninsured and do not take up HSP, we assumed their utilization would not change.

6. Benefits and Cost-Sharing

The legislation specifies that benefits must be at least as expansive as those offered to New Mexico state government workers. The legislation does not specify whether more expansive benefits should be offered. The legislation does allow for the possibility of the benefits package being expanded over time. We assumed that, during the five-year projection window, HSP benefits would be similar to those benefits currently offered to state workers. This supposition underlies our modeling of assumptions regarding beneficiary use and spending for health care services. An assessment of the state workers' plan revealed that its actuarial value (percent of average total health care spending that is covered by the plan) is similar to an average ESI plan. Thus, we assumed that the use of services under the HSP would be similar to the use of services under an ESI plan, with adjustments for a waiver of cost-sharing for certain services and groups.

[16] Banthin, J. et al. (2019). *The Uninsured in New Mexico*. Washington, DC: The Urban Institute. https://www.urban.org/sites/default/files/publication/101427/the_uninsured_in_new_mexico_final_v3.pdf

Section 18 of the legislation calls for the appointment of an advisory "long-term care committee" one year after the implementation date of the HSP to determine if and how long-term care benefits should be included in the plan. Medicaid covers long-term care (LTC) benefits and accounts for more than half of total LTC services (after excluding short-term stays in skilled nursing facilities and home health).[17] We assumed that LTC benefits will not be included in the HSP within the 5-year projection window. While we allowed for Medicaid beneficiaries to be included in the HSP, we assumed that LTC benefits would be provided to this population outside of the HSP.

We assumed that total premiums would need to cover benefit spending for HSP beneficiaries and administrative overhead, although we recognized that some of these premium costs would be paid by employers and re-purposed federal and state funds (e.g., Medicaid funding). We interpreted the HSA as requiring a complete community rating, where all individuals are assigned the same premium amount. However, as many plan beneficiaries may not be able to afford the full premium costs, we assumed that the HSP would have income-based premium subsidies.

The HSP legislation provides little detail on beneficiary cost-sharing requirements (e.g., coinsurance and copayments). Section 33 states that the Health care Commission "may establish a copayment schedule if a required copayment is determined to be an effective cost-control measure." The HSP could have cost-sharing levels comparable to typical Marketplace plans, typical employer plans, or have no cost-sharing at all. The state may consider subsidies for low-income beneficiaries, like the Marketplace cost-sharing reduction plans. However, charging Medicaid-eligible HSP beneficiaries any cost-sharing may be disallowed under the state's federal Medicaid waiver. Lower levels of cost-sharing would have a fiscal impact on the policy, both by reducing beneficiary contributions and by inducing additional demand for services. Higher levels of cost-sharing may be burdensome for beneficiaries and lead patients to delay or forego high-value medical services.

In our review of state and federal regulations, we observed significant variation in proposed premium and cost-sharing levels. Most proposals had little or no beneficiary costs at all. We modeled the fiscal impact of the HSP under two premium and cost-sharing policy scenarios as shown in Table 2.3: (1) ACA Marketplace (modified); and (2) Common Employer Plan. In both scenarios, households would pay no more than the full premium but may pay less depending on limits to what share of their income could be paid in premiums. We also considered cost-sharing levels similar to those in the Medicare for America Act of 2019.[18] However, those results were similar to the Common Employer Plan. We also considered modeling a scenario without any cost-sharing for any HSP beneficiary, but we viewed that model as unrealistic, given the costs of the HSP. Our model that used a Common Employer Plan (referred to as ESI-Comparable) represents a generous policy, while the ACA Marketplace scenario (referred to as ACA-Comparable) represents a less generous approach.

[17] Collelo, K.J... (2018). *In Focus: Who Pays for Long-Term Services and Support?* Washington, DC: Congressional Research Service. https://fas.org/sgp/crs/misc/IF10343.pdf

[18] Medicare for America Act of 2019, H.R. 2452, 116th Congress. (2019).

Table 2.3. Beneficiary Cost Assumptions across Scenarios

	Cost-Sharing (Actuarial Values (AV))	Premiums
ACA Marketplace (Modified)	<138% FPL: 100% AV 138% - 150% FPL: 94% AV 151% - 200% FPL: 87% AV >200% FPL: 70% AV	Premiums would be established so that households pay no more than a fixed percentage of their income on plan premiums. The percentage would range from 3.09% for households with incomes at 138% FPL to 9.78% for households with incomes above 400% FPL. We note that the ACA Marketplace limits premium amounts for households up to 400% FPL. We modified the policy to limit premiums for those above the 400% FPL. There would be no premium obligations for household with income below 138% FPL.
Common Employer Plan	<138% FPL: 100% AV >138% FPL: 83% AV	Premiums would be set so that households must pay no more than a fixed percentage of their income on plan premiums. This would range from 3.09% for households with incomes at 138% FPL to 9.78% for households with incomes above 400% FPL. The minimum subsidy would equal 75% of the full premium cost. Households with incomes below 138% FPL would have no premium obligations.

7. Establishment of Payment Rates

In the proposal, the Health care Commission would prepare a budget and negotiate with health care providers and facilities. A key assumption in proposals for single-payer systems is that provider/facility administrative costs will be reduced as a result of reductions in physician, nurse, and administrative staff time spent on billing and other insurance-related activities. As a result, payment rates may be reduced without inducing negative supply responses. Some view reductions in health care provider/facility administrative costs as a key source of savings under a single-payer system or similar health reform efforts. Based on feedback at the public meeting, however, we assumed (in some scenarios) that HSP payment rates to providers and facilities (also referred to as HSP prices) are established to be "budget neutral" in aggregate: that is, the total payment rates to providers would be set equal to total payment rates prior to the implementation of the HSP. Public commenters noted that, with reduced provider/facility administrative costs but neutral payment rates, New Mexico physicians and hospitals may be able to reallocate any savings to improving their practices and the delivery of care. We also examined the potential impact of reducing the growth in HSP prices on the cost of the HSP.

While the model assumed budget neutrality for HSP prices in aggregate by type of provider/facility in some scenarios or slower growth in HSP prices for others, we did not assume any particular distribution of these funds across provider types and areas. For example, there is significant concern regarding the availability of primary and specialty care, particularly in rural areas in New Mexico.[19] Under the HSP, the Health care Commission could increase HSP prices to rural areas, for example, to help address underserved areas. We implicitly assumed that changes in the demand for care as a result of the HSP

[19] New Mexico Legislative Finance Committee. (2015). *Health Notes: Uncompensated Care in New Mexico After the Affordable Care Act*. New Mexico Legislative Finance Committee.

would be met by adequate supply. In Appendix D, however, we assess whether there is currently an adequate supply of physicians and nurses in the state.

Global budgeting is an innovative concept that moves reimbursement for hospitals and other health care facilities away from fee-for-service to a prospectively set amount of revenue for each facility.[20] The idea is to create an incentive for hospitals and other health care facilities to reorganize how they deliver care. The legislation stipulates that health care facilities would be subject to global budgets under the HSP, although limited detail is offered on how global budgets would be established; nor is there detail on how non-health facility providers would be paid. [21] We assumed savings from global budgets in all our scenarios, as described in the methods section.

The HSA calls on the Health care Commission to seek savings on prescription drugs and other medical supplies and equipment by, in part, using bulk purchasing. In all our scenarios, we assumed savings from bulk purchasing of prescription drugs, as described in the methods section.

8. HSP Scenarios Modeled

In establishing the scenarios (varying policy assumptions), we focused on varying plan generosity and provider/facility reimbursement levels. These key elements affect the cost of the plan; the more generous the plan (in terms of lower premiums or cost-sharing), the more expensive the plan, while reductions in provider/facility payments may be used to help fund coverage expansion. In some cases, the HSP may be funded through existing revenue, while in other cases there may be a funding shortfall. Therefore, we estimated the size of a general payroll tax needed to close any of the funding shortfalls for a specific HSP scenario.

We examined 4 primary scenarios for structuring HSP (Table 2.4). The first two scenarios (1 and 2) assumed premiums and cost-sharing similar to typical ESI coverage, while the remaining scenarios (3 and 4) assume premiums and cost-sharing similar to requirements under the federal ACA. In the first year of all models, we established provider/facility payment rates such that total payments for a provider/facility category (e.g., hospital, physician, etc.) would be comparable to what the provider/facility was paid prior to the implementation of the HSP. In some scenarios (1 and 3), we grew provider/facility payment rates by the Consumer Price Index for Medical Care (CPI-M), and in other scenarios (2 and 4), we grew provider/facility payment rates by CPI-M minus 1 percentage point.

[20] Berenson, R.A., et al. (2016). *Global Budgets for Hospitals*. Washington, DC: The Urban Institute. https://www.urban.org/sites/default/files/05_global_budgets_for_hospitals.pdf

[21] We recognize that global budgets under the HSP may generate system-wide savings on health care spending through reductions in utilization of hospitalizations. These types of savings will be factored into the simulation model but do not represent policy assumptions for non-proposed features of the HSP.

Table 2.4. Health Security Plan Policy Scenarios

	ESI-Comparable		ACA-Comparable	
Policy Issue	**Scenario 1**	**Scenario 2**	**Scenario 3**	**Scenario 4**
HSP Standard Policy Assumptions	See Table ES1			
Cost-sharing	Cost-sharing would be similar to the average employer plan (based on actuarial value). No cost-sharing on preventative services. No cost-sharing for Native Americans or Medicaid-eligible beneficiaries.		Cost-sharing would be similar to the Affordable Care Act (ACA). No cost-sharing on preventative services. No cost-sharing for Native Americans or Medicaid-eligible beneficiaries.	
Premiums	Individual responsibility for premiums would be modeled on the average employer plan. HSP beneficiaries who would be eligible for lower premiums on the ACA Marketplaces would pay less. HSP beneficiaries who are Medicaid-eligible would pay no premiums.		High-income HSP beneficiaries (>400% Federal Poverty Level) would be responsible for paying full premiums. HSP beneficiaries who would be eligible for lower premiums on the ACA Marketplaces would pay less. HSP beneficiaries who are Medicaid-eligible would pay no premiums.	
Payment Rates to Providers/Facilities	Payment rates would be established such that total payments for the provider/facility category (e.g., hospital, physician, etc.) would be comparable to what the provider/facility was paid prior to the implementation of the HSP. Prices would be adjusted for medical inflation as determined by the Consumer Price Index for Medical Care (CPI-M).	Payment rates in the initial year of HSP would be the same as Scenarios 1 and 2. In subsequent years, rates would be inflated by CPI-M minus 1 percentage point.	Payment rates would be established such that total payments for the provider/facility category (e.g., hospital, physician, etc.) would be comparable to what the provider/facility was paid prior to the implementation of the HSP. Prices would be adjusted for medical inflation as determined by the CPI-M.	Payment rates in the initial year of HSP would be the same as Scenarios 1 and 2. In subsequent years, rates would be inflated by CPI-M minus 1 percentage point.

III. Approach to Fiscal Analysis of New Mexico's Health Security Plan

We conducted a fiscal analysis of the Health Security Plan to assess the plan's costs to the state and current revenue sources available to pay for the plan. The key questions addressed by the study are:

- What would New Mexico's HSP cost the state?
- Would current revenue sources be sufficient to cover the cost of the HSP?
- What would be the economic and fiscal impacts of adopting the HSP on New Mexico?

In this section, we present an overview of our approach, the development of the analytic database to conduct the study, and specific model assumptions. We have prepared a detailed Technical Supplement on the construction of the analytic database (in a separate document available at https://www.knghealth.com/fiscal-analysis-of-the-new-mexico-health-security-act-plan/).

A. Overview of Approach

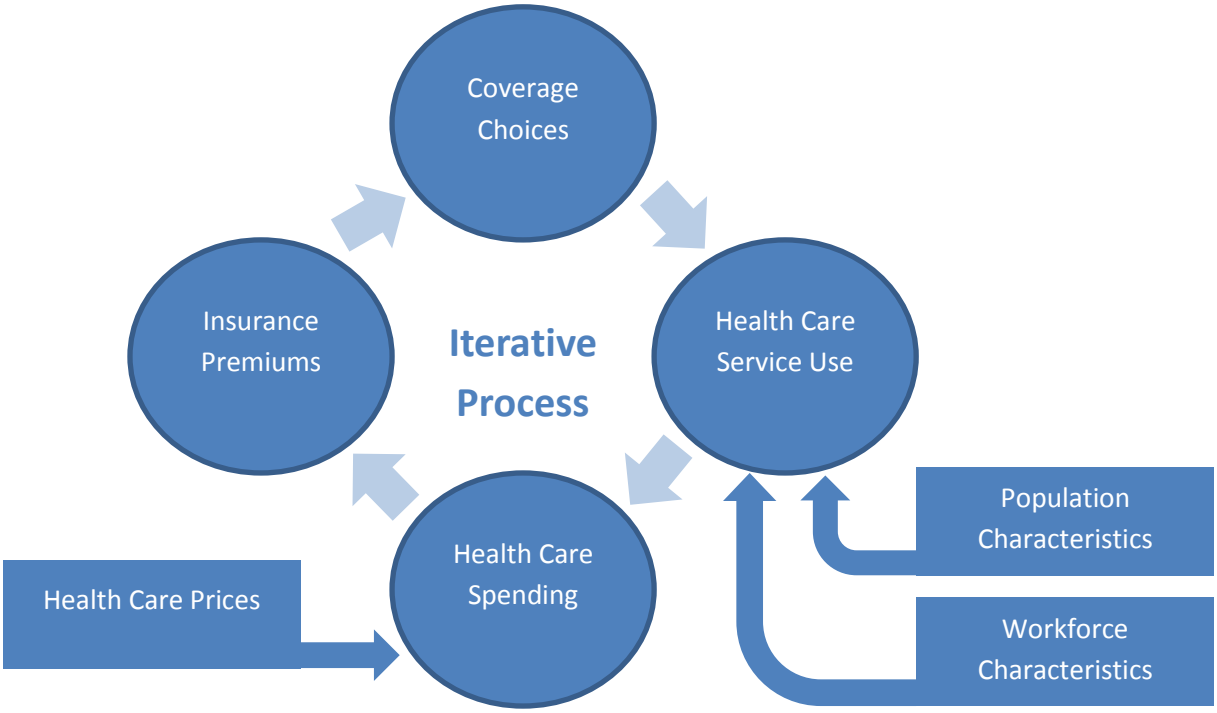
We used a microsimulation model to estimate the effects of the HSP on health insurance coverage and spending. Based on findings from the microsimulation model, we estimated the cost of HSP to New Mexico and compared these costs to existing sources of revenue, including payments from individuals and employers and repurposed federal and state payments for private (i.e., Health Insurance Marketplace Plans) and public insurance (i.e., Medicaid). Additionally, we estimated the economic impact of HSP and the implications for state tax revenue.

To simulate the impact of HSP on insurance coverage, health care utilization, and spending, we started with the KNG-Health Reform Model (KNG-HRM), a microsimulation model to estimate health insurance coverage and health care spending under various health reform efforts.[22,23] We then modified the model to incorporate New Mexico-specific data on the state's population and to reflect HSP policies. The model uses an iterative process to estimate coverage choices, health care service use, spending, and premiums as coverage affects health care use and spending, which in turn impacts premiums and coverage choice (Figure 3.1).

[22] KNG Health Consulting. (2019). KNG Health Reform Model. Rockville, MD. https://www.knghealth.com/kng-health-develops-health-reform-model/

[23] Saavoss, A. et al. (2019). The Impact of Medicare for America on the Employer Market: Technical Appendix. KNG Health Consulting. http://www.knghealth.com/kngwp/wp-content/uploads/2019/10/KNG-Health-The-Impact-of-Medicare-for-America-Technical-Appendix-10162019.pdf

Figure 3.1. Overview of the KNG Health Reform Model



The Costs of the HSP. Understanding the costs of the HSP requires estimates of the number of covered individuals and the cost of the health care services they receive plus administrative costs. The intent of the HSP is to cover all New Mexico residents, except for those with available coverage at a firm with a self-insured group health plan and individuals not eligible for the HSP (generally those with <12 months of New Mexico residency). We assumed automatic enrollment of eligible individuals based on a retrospective enrollment process. Thus, in our model, all individuals eligible for the HSP may immediately access covered services, although our model did not assume that they all access care immediately. Instead, our model recognized that some newly-insured individuals in New Mexico would fully access services, while others would not and would rather continue to behave as if they are uninsured even if they are eligible to receive services under the HSP at little or no cost.[24]

While enrollment is automatic for those eligible for the HSP, there is still uncertainty over the size of the population enrolled in the HSP because of the unknown response of employers and employees around the state. The introduction of the HSP could result in employers with self-insured group health plans dropping coverage and their employees participating in the HSP. It is also possible that employers who previously offered a fully-insured group health plan may switch to offering self-insured coverage. We modeled the decision of firms with a self-insured group health plan to continue to offer coverage (see below for further discussion on our modeling approach for firms). However, we assumed that firms

[24] As discussed below, we operationalized the assumption that not all newly-insured individuals will fully access services under the HSP by assuming smaller increases in the use of services among the uninsured who gained HSP coverage than suggested by the literature.

offering a fully-insured plan would not become self-insured under the plan. Instead, we assumed employees at these firms with fully-insured group health plans in baseline would obtain coverage through the HSP.

With information on those enrolled in HSP, we estimated health care utilization and spending based on characteristics of the HSP population (e.g., age, gender, race/ethnicity, and health status and conditions) and the prices charged for services. We assumed utilization changes as an individual's coverage type changes from less generous to more generous coverage. In addition, we allowed reimbursement rates for health care services to vary by payer. We estimated total spending for an individual as the sum of the number of health care services multiplied by the price per service.

Revenue Sources to Pay for the HSP. We accounted for four primary revenue sources to pay for the HSP. These include:

1. Premium and out-of-pocket (OOP) spending by New Mexicans enrolled in the HSP;
2. Employer contributions to the HSP;
3. Federal and state spending for Medicaid, enrollment on the Marketplace, and public workers; and
4. Lost private health insurance tax revenue.

HSP beneficiary spending on premiums and OOP spending to support the plan vary by scenario, with higher collections from beneficiaries under the ACA-comparable scenarios than under the ESI-comparable scenarios. We assumed that employer contributions are established so that employers participating in the HSP pay into the program, in aggregate, the same amount they would pay toward ESI in the baseline. As a result, employers who do not offer coverage in baseline will pay more under HSP, while those employers who offer coverage in baseline will pay less.[25] In addition, we assumed that estimated baseline federal and state spending for Medicaid, financial assistance for those obtaining coverage on the Marketplace, and funding for public employees would be available to fund the HSP. Finally, with private insurers largely replaced by the HSP, we accounted for lost premium tax revenue when assessing revenue sources to cover the cost of the HSP.

Economic Impact of the HSP. Health care spending changes from the HSP would result in additions to output and income as the demand for, and provision of, health care services increases, from more intense utilization of existing resources and the addition of capital investment in the state. We calculated the in-state economic contribution of spending under the HSP using the IMPLAN model of the New Mexico economy, which explicitly models the degree to which inputs of goods and services are provided by businesses in the state. The modeling using IMPLAN generated direct and indirect impacts of the new spending on related state sectors – for example, an increase in physician office visits generates an indirect demand for office space, and medical support staff. The full direct and indirect impacts on households

[25] This occurs because firms not offering coverage in baseline did not contribute toward worker premiums. Given our assumption, these firms would have to make contributions to HSP under the plan. The contributions from firms who did not offer coverage in baseline offset the contributions required among firms that offered coverage in baseline to keep aggregate contributions the same under baseline and under the HSP.

and businesses in each sector are reported as changes relative to the baseline from the date of plan implementation to 5 years beyond.

B. Analytic Database

To complete the study, we developed a comprehensive analytic database (also referred to as the analytic file) that includes information on New Mexican residents and employers (See Technical Supplement for further detail at https://www.knghealth.com/fiscal-analysis-of-the-new-mexico-health-security-act-plan/). We developed the analytic database to cover our assumed initial year of the HSP (2024) and the four subsequent years. The resident data include baseline estimates for demographic information, chronic conditions, utilization rates, and spending patterns. The employer data include baseline data on a set of synthetic firms offering coverage and characteristics of offered health plans. We grouped employed New Mexicans into a synthetic firm.

Our analytic file is based on the American Community Survey (ACS), which includes information for a large nationally representative sample of the U.S. population and is used to conduct analyses at the national, state, and local levels.[26] We combined 2016, 2017, and 2018 ACS data and limited it to individuals in New Mexico. We excluded those on Medicare, those residing in institutional group quarters (i.e., correctional institutions, mental institutions, and institutions for the elderly, handicapped, and poor), and those covered under a military health insurance program. Our final sample includes 41,783 observations representing individuals residing in New Mexico. We supplemented the ACS with New Mexico and national data sources to populate our analytic file with necessary fields (Table 3.1).

Table 3.1. Key Data Sources

Data Base	Description	Uses
American Community Survey (ACS)[27]	2016-2018 Representative Survey of New Mexicans.	Baseline demographic, disability, health insurance coverage, and income for analytic file.
CMS Monthly Medicaid Enrollment File[28]	State Medicaid enrollment.	Calibrate New Mexico Medicaid enrollment in the analytic file to administrative data.

[26] United States Census Bureau. American Community Survey. https://www.census.gov/programs-surveys/acs
[27] U.S. Census Bureau. (2019) American Community Survey [Data set]. https://www.census.gov/programs-surveys/acs
[28] Centers for Medicare & Medicaid Services. (2017). *CMS Monthly Medicaid Enrollment* [Data file]. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html

Data Base	Description	Uses
CMS Medical Loss Ratio Public Use File[29]	Health insurance companies spending on health care and administrative costs, such as salaries and marketing.	Calibrate non-group enrollment in New Mexico.
HCCI Annual Report[30]	2017 Employer-sponsored insurance utilization, price, and spending data.	Scaling of health care prices, utilization, and spending on ESI and non-group coverage and the uninsured.
Managed Care Expenditure Reports[31]	2018 Medicaid enrollment and health care utilization for each of New Mexico's Medicaid Managed Care Organization (MCO) plans from the New Mexico Human Services Department.	Medicaid spending and health care service utilization to match administrative data benchmarks.
Form CMS-64[32]	2018 state expenditures tracked through the automated Medicaid Budget and Expenditure System/State Children's Health Insurance Budget and Expenditure System	Scaling of Medicaid sending.
Medical Expenditure Panel Survey (MEPS)[33]	Large-scale surveys of households and individuals, their medical providers, and employers. MEPS tracks individual characteristics, health status, and health care utilization	Estimate health care utilization and spending for observations in an analytic database; Scaling health care spending for those on ESI to match New Mexico-specific employer-based premiums.
New Mexico Emergency Department (ED) Encounter Data[34]	2017 state ED database containing encounters for all ED visits in New Mexico.	Scaling estimated ED utilization in New Mexico to match administrative data.
New Mexico Hospital Inpatient Database[35]	2017 state inpatient database containing discharge records for all hospital discharges in New Mexico.	Scaling estimated inpatient hospital utilization in New Mexico to match administrative data.

[29] Centers for Medicare & Medicaid Services. (2019). *Medical Loss Ratio Data and System Resources* [Data set]. https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr
[30] Health Care Cost Institute. (2019). *2017 Health Care Cost and Utilization Report* [Data set]. https://bit.ly/3b2K89y.
[31] Provided by the Legislative Finance Committee to the KNG Health team
[32] https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-medicaid-chip/index.html
[33] Agency for Health care Research & Quality. (2019) *Medical Expenditure Panel Survey* [Data set]. https://www.meps.ahrq.gov/mepsweb/
[34] New Mexico Department of Health. (2017) *Emergency Department Data Annual Report* [Data set]. https://nmhealth.org/data/view/systems/2229/
[35] New Mexico Department of Health. (2017). *Hospital Inpatient Discharge Data Annual Report* [Data set]. https://nmhealth.org/data/view/systems/2216/

Calibrating Coverage in ACS. We compared New Mexico Medicaid enrollment and non-group enrollment in the ACS to enrollment reported in several administrative data sources.[36,37] In the ACS, Medicaid enrollment was lower than enrollment counts reported in the CMS monthly Medicaid enrollment reports. Conversely, non-group enrollment was higher than enrollment estimates from the Medical Loss Ratio Public Use Files. Similar discrepancies in the ACS have been observed by other researchers.[38] To match these administrative benchmarks, we reclassified some non-group beneficiaries to having Medicaid coverage in the baseline. When reclassifying respondents to Medicaid coverage, we prioritized those respondents who are Medicaid-eligible and preserved the ratio of adults to children in each program. We also reclassified a small number of Medicaid-eligible individuals with Medicare or military coverage into Medicaid.

New Mexico Population Projections. We projected the New Mexico population to the 5-year period from 2024 through 2028 using data from the U.S. Census Bureau. We obtained population projections by age, gender, race/ethnicity, and nativity status. We then updated the ACS weights for future years to reflect the changing composition of the New Mexican population.

Estimating Health Care Utilization and Spending. We assigned health care utilization rates and prices to each individual in our ACS sample. Since a comprehensive all-payer claims database does not exist for New Mexico, we developed utilization and spending estimates using a regression-based approach based on data from the MEPS [39] and scaled these data to match administrative and other data specific to New Mexico.

For non-elderly adults, we estimated health care utilization using data from the MEPS, a large household survey that tracks individual characteristics, health status, and health care utilization. We used the 2014-2016 MEPS to develop 5 regression models to predict health care utilization for the following categories:

- Hospitalizations;
- Outpatient hospital visits;
- Emergency room (ER) visits;
- Physician visits; and
- Prescription drug fills and refills.

Each model included the survey year and a series of covariates, including demographic, family structure, general health status, disability, healthy behaviors, and chronic conditions. We developed utilization estimates for children by age using data from the HCCI.

[36] Center for Medicare & Medicaid Services. (2018). *Medical Loss Ratio Public Use File* [Data set]. https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

[37] Kaiser Family Foundation. (2018) *Total Monthly Medicaid and CHIP Enrollment* [Data Set]. https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment

[38] Lynch, V. et al. (2011). *Improving the validity of the Medicaid/CHIP estimates on the American Community Survey: The role of logical coverage edits*. U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/working-papers/2011/demo/improving-the-validity-of-the-medicaid-chip-estimates-on-the-acs.pdf

[39] U.S. Agency for Health care Research and Quality. (X). Medical Expenditure Panel Survey.

We adjusted our estimates of health care service utilization by Native Americans. Our modeling approach suggests a relatively high utilization of services by Native Americans because they have high rates of disability and chronic conditions, relative to others with similar insurance coverage. However, our results on service utilization (which will translate to higher spending) run counter to federal spending on health services for Native Americans as well as anecdotal evidence. In 2017, for example, the Indian Health Service (IHS) spent $4,078 per user of IHS health care services, where U.S. national health care spending was more than 2.3 times higher.[40] While IHS per user spending is a low estimate of Native American health care spending because they receive care from non-IHS funded providers, observations from MEPS suggest it may be appropriate to further adjust spending for Native Americans (we do not control for Native American status in our MEPS regression models). Therefore, we used MEPS to estimate spending for Native Americans and others by broad age groups. We then calculated a ratio of average per person spending by age group between Native Americans and the overall average. We adjusted all utilization for Native Americans in our database by these ratios.

To develop estimates of spending, we multiplied our estimates of health care utilization by prices, using service-specific unit prices which vary by payer. Prices vary by age, gender, and location within the state. Initial prices are set for commercial and Medicaid beneficiaries using data from the HCCI and the New Mexico Human Services Department (HSD). Following findings from the literature, we assumed uninsured individuals pay, on average, Medicare prices for hospital care and commercial prices for physician services.[41,42] We inflated prices to 2024 using projections from the National Health Expenditures Accounts. For future periods (2025-2028), we inflated prices by the Consumer Price Index for Medical Care, as specified in the HSA.

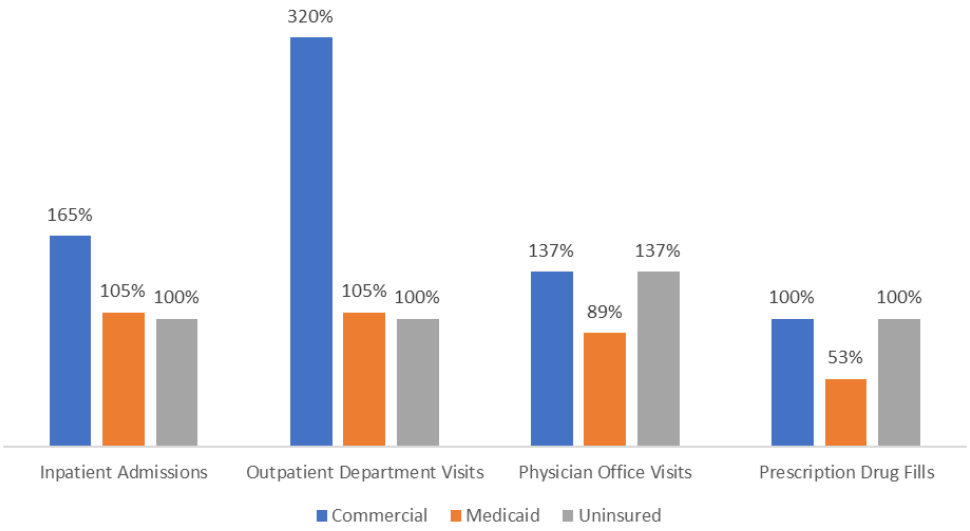
We assumed individuals would pay different prices if they changed insurance coverage. For each payer and service category, we developed assumptions for average payment levels (prices) relative to Medicare in New Mexico. For this exercise, we reviewed a variety of published resources from the Congressional Budget Office[43,44], the HCCI[45], the Kaiser Family Foundation[46], the RAND Corporation[47], and the Medicaid

[40] Indian Health Service. (2020) *IHS Profile.* Indian Health Service. https://www.ihs.gov/newsroom/factsheets/ihsprofile/
[41] Melnick, G.A. & Fonkych, K. (2008). Hospital Pricing And The Uninsured: Do The Uninsured Pay Higher Prices? *Health Affairs*: 27 (Suppl 1). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.w116
[42] Gruber, J. & Rodriguez, D. (2007). How much uncompensated care do doctors provide? *J Health Econ* 26:1151-1169. https://economics.mit.edu/files/6423
[43] Pelech, D. (2018*). Working Paper: An Analysis of Private-Sector Prices for Physicians' Services: Working Paper 2018-01*. Congressional Budget Office. https://www.cbo.gov/publication/53441
[44] Maeda, J.L. & Nelson, L. (2017). *An Analysis of Private-Sector Prices for Hospital Admissions: Working Paper 2017-02*. Congressional Budget Office. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf
[45] Johnson, B., et al. (2020). *Healthy Marketplace Index*. Health Care Cost Institute. https://www.healthcostinstitute.org/research/hmi.
[46] Kaiser Family Foundation. (2016). *Medicaid-to-Medicare Fee Index*. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/
[47] White, C. & Whaley, C. (2019). *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR3033.html

and CHIP Payment and Access Commission.[48] Figure 3.2 shows the price ratios that we used to adjust spending.

Our model assumed that health care provider supply would be adequate to meet any increases in demand for health care services under the HSP. We conducted an analysis, reported in Appendix D, to assess whether current provider supply is adequate to meet demand.

Figure 3.2. Average Prices Relative-to-Medicare by Payer and Service Category



Source: Analysis by KNG Health Consulting.

Scaling Health care Utilization, Prices, and Spending. We scaled health care utilization and spending to match aggregate administrative data from New Mexico, as appropriate. We scaled using the following step-wise approach:

1. Scaled per-capita spending rates obtained from the MEPS model to ESI levels using HCCI data;
2. Scaled hospital inpatient and ED per-capita utilization to New Mexico all-payer data;
3. Scaled spending for individuals on ESI to match New Mexico-specific premiums from MEPS; and
4. Scaled per capita Medicaid spending to Medicaid expenditures from the 2018 New Mexico CMS-64.

New Mexico Synthetic Firm File Development. The datasets used in the synthetic firm analysis are the ACS (2016-2018) and the Current Population Survey (CPS, 2016-2018). We grouped working ACS respondents into a synthetic firm. The ACS indicates whether the respondents are employed but does not include information on the size of the firm where they are employed. Because employer insurance varies significantly by firm size, we used the CPS data to impute firm size. Firms were classified into 5 firm size categories: (1) fewer than 10 workers; (2) 10 to 49 workers; (3) 50 to 100 workers; (4) 100 to 999

[48] Medicaid and CHIP Payment and Access Commission. (2017).*Medicaid Hospital Payment: A Comparison across States and to Medicare.* https://www.macpac.gov/publication/medicaid-hospital-payment-a-comparison-across-states-and-to-medicare/

workers; and (5) more than 1,000 workers. We calibrated the imputed ACS private sector firm size to match the distribution for New Mexico in the MEPS-Insurer/Employer Component (IC).

We assigned each ACS worker's initial health coverage offer status using various MEPS-IC tables (by firm size, industry, and income quartile) and made adjustments as necessary to ensure consistency between ESI offer and ESI enrollment. Next, we combined the ACS workers into synthetic firms based on the following hierarchy of characteristics: health coverage offer status, firm size, industry, region, and state. We populated each ASC synthetic firm until it had the same number of employees as the midpoint of the firm size category. We treated all federal government employees as working for the same firm. We treated other government employees residing in New Mexico as being employed by the same firm. We also assumed that all local, state, and federal government employees have access to ESI coverage and work in a firm with more than 1,000 employees.

C. Simulating Health Reform Proposals

We used our analytic file to estimate the effects of the HSP on enrollment, health care utilization, and spending. Even with the policy aspects of the HSP and our policy assumptions (see Section II of this report), we needed to develop model assumptions related to individual and firm behavior and the effects of changes in coverage on medical spending. In this section, we present our model assumptions for simulating the impact of the HSP.

1. Enrollment

We simulated individual enrollment decisions using a series of decision rules. These decision rules are summarized in Table 3.2. We assumed non-working people who have resided in New Mexico for less than one year would not enroll in the HSP because they would be ineligible. The following populations would be automatically enrolled in the HSP:

- Uninsured populations;
- Non-group health plan beneficiaries;
- Workers enrolled in a fully-insured group health plan offered by their employer; and
- Medicaid beneficiaries.

For individuals covered by their employer's self-insured group health plan, enrollment would be voluntary. We assumed a portion of this population would choose to enroll in the HSP based on the cost of coverage and their income (Table 3.2). However, those with employer coverage may favor staying with that employer coverage, if available, and only choose to enroll in the HSP if their employer coverage is unaffordable. We chose not to include Medicare beneficiaries in our model scenarios.

Table 3.2. Assumptions Guiding Individual Enrollment Decisions

Group	HSP Policy	Enrollment Assumptions
Residents living in New Mexico for less than one year	Ineligible for the HSP but could be eligible if moved to New Mexico to accept an employment offer.	Would not enroll in the HSP, unless working. If ineligible for the HSP, would maintain existing coverage unless that coverage becomes unavailable or unaffordable.
Medicare beneficiaries	Health care Commission would seek waivers to cover Medicare beneficiaries in the HSP.	Would not enroll in the HSP during initial 5 years. Would maintain existing Medicare coverage.
Workers Enrolled in Employer's Self-Insured Group Health Plan	May voluntarily enroll in the HSP.	If income is under 138% FPL, would enroll in the HSP. If income is above 138% FPL, an employee would drop ESI if the ESI premium would be unaffordable according to the ACA-based affordability standards. Otherwise, would maintain ESI.
Medicaid beneficiaries	Health care Commission would seek waiver to cover Medicaid beneficiaries in HSP.	Medicaid beneficiaries would be automatically enrolled in the HSP.
All other New Mexico residents	Automatically enrolled in the HSP, except for ineligible groups.	Would enroll in the HSP.

Implementing the HSP could lead employers with a self-insured group plan to stop offering insurance coverage if doing so would result in significant savings to the firm and its employees. We defined the savings from dropping coverage as the difference in costs between a scenario where the firm offers coverage and a scenario where the firm drops coverage (and participates in the HSP). If these savings exceed a minimum savings threshold (i.e., 5% of annual payroll[49]), we assumed the firm drops coverage and its employees enroll in the HSP. The cost components considered in our savings calculation are defined in Table 3.3. If a firm drops coverage, we assumed all employees move into the HSP.

[49] We established the threshold at 5% because, in prior KNG Health analyses, this threshold results in predicted employer health insurance offer patterns similar to those observed in the U.S. after implementation of the Affordable Care Act.

Table 3.3. Self-Insured Employer Decisions to Offer Coverage: Cost Components Considered

Cost Component	If the employer maintains coverage…	If the employer drops coverage…
Premiums for workers and dependents, net of subsidy	The sum of: • The employees' and employers' share of ESI premiums for those taking-up ESI coverage reduced by the enrolling household's marginal tax rate; and • HSP premiums for those opting out of ESI coverage reduced by the income-based HSP subsidy.	HSP premiums for all workers and dependents reduced by the income-based HSP subsidy.
Out-of-Pocket Costs	Out-of-pocket health costs of the workers and dependents either participating in the ESI plan or receiving coverage through the HSP.	Out-of-pocket health costs for workers and dependents receiving coverage through the HSP.
Other Costs	The internal Human Resources administrative burden of offering coverage.	None.

2. Health Care Spending Impacts under the HSP

The availability of HSP may influence health utilization and spending through several mechanisms:

1) Health care prices;
2) Administrative cost savings;
3) Coverage gains;
4) Cost-sharing changes;
5) Use of global budgets on health care providers; and
6) Bulk purchasing of prescription drugs.

Health Care Prices. For the HSP, we set initial prices so that average prices paid for program beneficiaries are similar to what would have been paid for those beneficiaries under current law. As most HSP beneficiaries previously had Medicaid or commercial coverage, this resulted in HSP prices approximately halfway between Medicaid and commercial rates. As proposed by the legislation, we inflated HSP prices using projected growth in the Consumer Price Index for Medical Care (or by CPI-M minus 1% point).

Administrative Costs and Savings. A key potential cost savings from the adoption of the HSP would be reduced administrative costs from both the payer and health care provider or facility perspective. We discuss our assumptions regarding payer-side administrative costs in the sections describing our development and assumptions regarding premiums (see below). With respect to provider-side administrative costs, research suggests that U.S. hospital administrative costs are higher than in other countries that either have single-payer systems or more tightly regulated multi-payer systems.[50] Hospital

[50] Himmelstein, D. U. et al. (2014). A comparison of hospital administrative costs in eight nations: US costs exceed all others by far. *Health Affairs*, 33(9), 1586-1594.

and other health care provider administrative costs arise due to time spent by physicians, nurses, and administrative staff on billing and insurance-related activities relative to the time delivering care.

We examined the portion of provider-specific costs that are linked to administrative activities and could potentially be reduced under the HSP.

- *Total health care-related administrative costs in hospitals*. Following the methodology in Himmelstein et al. (2020)[51] , we used the Medicare cost reports to classify hospital expenses as "administrative," "clinical," "mixed," and "other" expenses. The administrative load is calculated as Administrative costs/ (Administrative costs + Net Clinical Expenses). Administrative costs include administrative expenses plus a portion of expenses that are classified as "mixed." Examples of mixed expenses include interest expenses, employee benefits expenses, and maintenance expenses. The portion of mixed expenses included in administrative costs is based on the share of administrative expenses in the hospital's operating expenses. Net Clinical expenses are calculated using the "clinical" category of expenses and deducting expenses classified as "other." Examples of other expenses include intern and resident program costs, research costs, and nursing home costs.

  Using New Mexico hospitals' Medicare cost reports, we estimated that total administrative costs account for 24.5 percent of total hospital expenses (Himmelstein et al. (2020) reported a national administrative load of 26.6 percent).

- *Calculating the administrative load in physicians' offices*. We used data from the ACS 2014-2018 limited to employees in physician offices in New Mexico. Following Himmelstein et al. (2020), we categorized employees into 4 categories: "Nurses," "Clerks," "Managers," and "Physicians." We used data on average working hours and annual incomes to calculate the total costs in physician offices in New Mexico. To calculate administrative load, we used estimates from Morra et al. (2011)[52] for practice-wide time spent on administration-related activities per physician. These activities included time spent on formularies, claims/billing, credentialing, quality data, and prior authorizations. Using these estimates, we estimated administrative costs account for 27.6 percent of physician practice costs (Himmelstein et al. (2020) reported a national administrative load in physician offices of 21.8 percent).

In studies comparing provider administrative costs between countries with different payer systems, single-payer or tightly regulated multi-payer systems had lower administrative costs of up to 60 percent.[53] Although we do not directly incorporate potential provider-side administrative savings into our HSP modeling, these potential savings may be reflected in HSP prices paid to providers as negotiated between

[51] Himmelstein, D.U. et al. (2020) Health Care Administrative Costs in the United States and Canada, 2017. Annuals of Internal Medicine. https://hca-mn.org/wp-content/uploads/2020/01/Adm-Costs-2017.pdf.
[52] Morra, D. et al. (2011) *US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers*. Health Affairs: 30(8). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0893
[53] Gee, E., & Spiro, T. (2019). *Excess Administrative Costs Burden the U.S. Health Care System*. Center for American Progress. https://www.americanprogress.org/issues/health care/reports/2019/04/08/468302/excess-administrative-costs-burden-u-s-health-care-system/

the Health care Commission and New Mexico health care providers and facilities. Therefore, we modeled scenarios that assume slower growth in HSP prices than the maximum allowed under the HSA.

Utilization Changes due to Coverage Gains. As individuals gain coverage and gain better access to care, their utilization is likely to increase, although some utilization – particularly in the long-term, may be offset by reductions in other types of services. Using a randomized controlled trial approach, the Oregon Health Insurance Experiment studied the effect of expanding Medicaid on several key outcomes, including health care use and patient outcomes, during the first two years of the program.[54] To randomize beneficiaries, the state drew names by lottery for its Medicaid program for low-income and uninsured adults. An evaluation of the Oregon Health Insurance Experiment found that previously uninsured people gaining Medicaid coverage increased inpatient utilization by 30 percent, emergency department utilization by 68 percent, physician visits by 50 percent, and prescription drug usage by 15 percent.[55] As a randomized experiment, the Oregon Health Insurance Experiment offers the strongest evidence on the impact of gaining coverage on the utilization of services.

We used the results from the Oregon Health Insurance Experiment to make a one-time adjustment to the utilization for New Mexicans gaining coverage under the HSP. However, we adjusted the estimated effects to recognize that not all those currently eligible for no or low cost health care in the state are currently enrolled in available health insurance coverage. Thus, it is reasonable to assume that gaining coverage in the HSP through retroactive enrollment may not induce the previously uninsured to utilize services the way an insured individual would utilize services. We multiplied the effects from the Oregon Health Insurance Experiment by the estimated proportion of individuals eligible for Medicaid and subsidies on the Marketplace who take up coverage in New Mexico (approximately 88 percent). In other words, we reduced the change in utilization implied by the Oregon Health Insurance Experiment by 12 percent. Public commenters raised concern with our use of findings from the Oregon Health Insurance Experiment because of different demographic profiles in the states and for other reasons. Therefore, we assessed the sensitivity of our findings to the assumptions regarding the utilization of services by those previously uninsured prior to the implementation of the HSP.

Utilization Changes due to Cost-Sharing Reductions. Lower cost-sharing is likely to induce additional utilization. For example, the RAND Health Insurance Experiment found that a 10-percent decrease in cost-sharing was associated with a 2-percent increase in utilization.[56] We used this empirical relationship to adjust utilization for changes in coverage generosity.

Utilization Decrease due to Global Budgets. Global budgets de-link health facility revenue with volume, which may encourage efficiencies in the health care system. U.S. experience with global budgets is limited as is published research of its effects on spending. Researchers have found that global budgets in

[54] National Bureau of Economic Research. *The Oregon Health Insurance Experiment*. https://www.nber.org/oregon/1.home.html

[55] Finkelstein, A., et al. (2012). The Oregon Health Insurance Experiment: Evidence from the First Year. *The Quarterly Journal of Economics*, 127(3), 1057-1106. https://academic.oup.com/qje/article-abstract/127/3/1057/1923446

[56] Newhouse, J. P. (1993). *Free for all? Lessons from the RAND Health Insurance Experiment*. Harvard University Press. https://www.rand.org/pubs/commercial_books/CB199.html

Maryland resulted in spending declines of 4.0 percent for Medicare fee-for-service beneficiaries but no statistically significant change for those in commercial plans.[57] We assumed global budgeting would result in a 2-percent reduction in spending for health care facilities in New Mexico (the average between Maryland's experience for Medicare and commercially-insured populations).

Bulk Purchasing of Prescription Drugs. Cost containment strategies to procure prescription drugs to reduce consumer costs are coming to the forefront as a way to reduce state budgets. In the 2019 New Mexico legislative session, the state has identified cost containment as an important issue. The legislature passed SB 131, which establishes an Interagency Pharmaceuticals Purchasing Council to recommend cost containment strategies and opportunities on procuring prescription drugs and other benefits for constituent agencies, constituent agencies purchasing in the private sector, and for New Mexico residents in the private sector (SB 131 § 1).[58]

One such cost containment strategy is bulk drug purchasing. We reviewed publicly available information to identify the potential cost savings states have saved from participation in a drug purchasing program (Table 3.4). The literature on state savings from consolidating drug purchasing is sparse, as the information is either not publicly available, outdated, or estimates are not tied to data. For example, California enacted an executive order last year to consolidate drug purchasing for its Medicaid program that is estimated to save about 2 percent or $150 million a year, based on statements from leaders in the state. Vermont reported that it saved about 5 percent from participating in a bulk drug purchasing program in 2008.

Following our review, we chose to use an estimate from a New Mexico LFC fiscal impact report on SB 131. The report cited a finding that "…bulk purchasing of pharmaceuticals can save between 2 and 5 percent of spend. Using that metric, the state could potentially save between $14 million and $35 million annually with bulk purchasing alone."[59] We chose to use a 3.5 percent savings estimate on bulk purchasing of pharmaceuticals based on the midpoint of the finding presented in the LFC report.

[57] Haber, S, et al. (2018). *Evaluation of the Maryland All-Payer Model Third Annual Report*. Centers for Medicare & Medicaid Services. https://downloads.cms.gov/files/cmmi/md-all-payer-thirdannrpt.pdf

[58] New Mexico Senate. Senate Bill 131. 2019. https://legiscan.com/NM/text/SB131/id/1978639/ New_Mexico-2019-SB131-Enrolled.pdf.

[59] New Mexico Legislative Finance Committee. (2019). Fiscal Impact Report: SB 131 Interagency Pharmacies Purchasing Council. New Mexico Legislative Finance Committee. Available at https://nmlegis.gov/Sessions/19%20Regular/firs/SB0131.PDF

Table 3.4. Savings from Bulk Drug Purchasing Programs

State - Program	Drug Costs (Dollars)	Bulk Drug Purchasing Savings (Dollars)	Savings (Percentage)
California – Medicaid[60,61]	$8 billion[62]	$150 million[63]	1.88%
Vermont – SSDC & PDL[64]	$112.4 million	$5.3 million	4.7%
New York – Medicaid[5]	-	$82.5 million	-
Oregon & Washington – Northwest Prescription Drug Consortium[6]	-	$130 million	-
Minnesota Multistate Contracting Alliance for Pharmacy	-	-	2.8-4.4% lower prices compared to other group purchasing organizations[65]
New Mexico – State Agencies[66]	$703 million	$14-$35 million	2-5%

Notes: SSDC= Sovereign States Drug Consortium; PDL = Preferred Drug List

3. Premiums and Out-of-Pocket Costs

Premiums are driven by enrollment, health spending, benefit generosity, and administrative costs. We calculated premiums for HSP beneficiaries, non-group beneficiaries, Medicaid beneficiaries, and employer-based coverage beneficiaries. The calculation of premiums followed six steps. First, we calculated total benefit spending for the risk pool. Second, we partitioned benefit spending into out-of-pocket costs and plan liability based on the plan's cost-sharing parameters (i.e., the plan's actuarial value). Third, we inflated plan liability by an administrative loading factor. Fourth, we allocated premiums to individuals based on rating rules specific to each coverage type. Fifth, we updated enrollment decisions

[60] Governor Gavin Newsom signed an executive order for California's Department of Health Care Services to consolidate drug purchasing across all state-run programs by 2021. Review Executive Order N-01-19 at https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf.

[61] The California Legislative Analyst's Office estimated that consolidating drug pricing would likely save the state "hundreds of dollars annually." See Gabriel Petek, "Analysis of the Carve Out of Medi-Cal Pharmacy Services from Managed Care" (Sacramento, CA: California Legislative Analyst's Office, 2019), available at https://lao.ca.gov/Publications/Report/3997.

[62] Michael Blood, Associated Press, "Los Angeles County and state partner for lower drug prices," *The Press Democrat*, April 17, 2019, available at https://www.pressdemocrat.com/news/9509777-181/los-angeles-county-and-state.

[63] Samantha Young, "Can California Beat The Federal Government In Lowering Drug Prices?", Kaiser Health News, February 14, 2019, available at https://khn.org/news/can-california-beat-the-federal-government-in-lowering-drug-prices/.

[64] Vermont reported in FY2008 that the state saved 4.7% from SSDC and PDL, on top of the 27.1% from the standard federal Medicaid formula rebate, based on a $112.4 million pharmaceutical budget. National Conference of State Legislatures, "Health Cost Containment and Efficiencies: NCSL Briefs for State Legislators" (Denver: 2010), available at http://www.ncsl.org/portals/1/documents/health/NEGOTIATED-2010.pdf

[65] https://www.americanprogress.org/issues/healthcare/reports/2020/02/13/480415/state-policy-options-reduce-prescription-drug-spending/

[66] New Mexico Legislative Finance Committee, "Fiscal Impact Report: SB 131 Interagency Pharmacies Purchasing Council." (New Mexico: 2019), available at "https://nmlegis.gov/Sessions/19%20Regular/firs/SB0131.PDF

based on updated premiums. Sixth, we repeated this sequence of steps until enrollment decisions and premium levels stabilize.

Definitions for actuarial value and administrative loading factors. The actuarial value represents the average percent of beneficiary health care spending covered by the plan (i.e., the ratio of plan benefit spending to total health care spending among plan members). The administrative loading factor represents the percent of total premiums that go towards administrative costs, overhead, and profit (i.e., plan administrative costs divided by the sum of both plan benefit spending and administrative costs). Our assumptions for actuarial value and administrative load varied by payer. The administrative loading factor accounts for payer-side administrative costs, but not provider-side administrative costs. Provider-side administrative spending is classified as benefit spending for purposes of calculating premiums.

Actuarial value assumptions. We assumed actuarial value varied across different types of plans. For employer plans, we assumed an average actuarial value of 83 percent.[67] Among those with employer coverage, we varied actuarial value across plans based on firm size, firm wages, the ratio of full- and part-time workers, plan type (e.g., HMO, PPO, etc.), and region.[68] In New Mexico, Marketplace enrollment is divided roughly equally between Bronze plans (~60% actuarial value), Silver plans (~70% actuarial value), and Gold plans (~80% actuarial value).[69] For purposes of calculating premiums, we assumed an actuarial value of 70 percent for non-group beneficiaries. For purposes of calculating cost-sharing, we increased actuarial value for non-group plan members eligible for ACA Cost-Sharing Reduction subsidies. Though some Medicaid beneficiaries are required to pay copayments for certain services, these copayments are relatively low (e.g., $30 for hospital admission).[70] To simplify, we assumed Medicaid actuarial value was 100 percent (i.e., no Medicaid cost-sharing). For the HSP, actuarial value varied by scenario, as described in Table 2.3.

Administrative load assumptions for employer coverage. We varied administrative loading factors by coverage type. For employer plans, we assumed administrative loads ranged from 8 percent to 20 percent depending on firm size.[71] We further increased administrative loads for health insurance taxes, which varied between firms offering self-insured and fully-insured group health plans. Finally, we scaled

[67] Blumberg, L. J., Holahan, J., & Wengle, E. (2016). Are nongroup marketplace premiums really high? Not in comparison with employer insurance. Washington, DC: Urban Institute.
[68] Actuarial Research Corporation. Analysis of Actuarial Values and Plan Funding Using Plans from the National Compensation Survey. May 2017.
[69] Kaiser Family Foundation. Marketplace Plan Selections by Metal Level. Open Enrollment 2020. https://www.kff.org/health-reform/state-indicator/marketplace-plan-selections-by-metal-level-2.
[70] New Mexico Medicaid Program Cost Sharing Chart. New Mexico Human Services Department. 2018. https://bit.ly/2CPKCmU.
[71] Eibner, C., Girosi, F., Miller, A., Cordova, A., McGlynn, E. A., Pace, N. M., ... & Gresenz, C. R. (2011). Employer self-insurance decisions and the implications of the Patient Protection And Affordable Care Act as modified by the health care and education reconciliation Act of 2010 (ACA). Rand health quarterly, 1(2).

aggregate employer coverage administrative loads to 12 percent, which was the national average estimate for private health insurance in 2017, reported by the National Health Expenditure Accounts.[72]

Administrative load assumptions for other coverage types. For Medicaid, we assumed an administrative loading factor of 12 percent, based on a previously published LFC analysis of the state's Medicaid program.[73] This estimate included both administrative costs incurred by Medicaid managed care organizations and costs incurred by the HSD. In the non-group market, federal regulations establishing minimum medical loss ratios (MLRs) effectively cap administrative loading factors at 20 percent. In 2018, we estimated that approximately half of the non-group market received MLR rebates, indicating that minimum MLR requirements are often binding in the state.[74] We assumed a 20-percent administrative loading factor for the non-group market. For the uninsured, we assumed no payer-side administrative costs. As proposed by the HSA, no more than 5 percent of total spending should be on administrative costs by the sixth and subsequent years of the HSP. Since we are modeling the first five years of the plan, we assumed that HSP administrative loading factors would be 9, 8, 7, 6, and 5 percent in years one through five of its operation.

Risk pools and family rating. Risk pools and family ratings also varied by coverage type. For large-group employer plans, firms were pooled separately. Following ACA rating rules, all beneficiaries in small-group employer plans were pooled together. The state's non-group and Medicaid markets were each pooled separately. We assumed all HSP beneficiaries would be pooled together. We assumed large-group employer plans, Medicaid, and HSP practiced community rating. The non-group and small-group markets followed ACA rating rules, allowing premiums to vary by age and tobacco use.

D. Downstream Economic Impacts

The spending increases from the HSP may result in additions to output and income as the demand for, and provision of, health care services increases, from more intense utilization of existing resources and from the addition of capital investment in the state. (Note that not all the increases would represent in-state sales and directly contribute to increased economic output. Prescription drugs, which are imported from out-of-state, are a notable exception.) We calculated the in-state economic contribution of spending under the HSP using the IMPLAN model of the New Mexico economy. The IMPLAN model is an input-output model where the production of goods or services depends upon the purchase of a set of specific inputs, that is, labor and required materials. The inputs may be purchased within the state or imported from locations outside the state, but the overall impact on the state's economy will be greater the more reliance there is on local or, in this case, in-state sources of supply.

This IMPLAN analysis generates direct and indirect impacts of the new spending on related state sectors – for example, an increase in physician office visits generate an indirect demand for office space, medical

[72] Centers for Medicare & Medicaid Services. (2019). *National Health Expenditure Data* [Data set]. https://go.cms.gov/36tomIQ.
[73] Legislative Finance Committee. Health Notes: Medicaid Spending on Program and Managed Care Administration. May 2019. https://bit.ly/38h40oD.
[74] Kaiser Family Foundation. Total Medical Loss Ratio (MLR) Rebates in All Markets for Consumers and Families. September 2019. https://www.kff.org/health-reform/state-indicator/mlr-rebates-total.

support staff, etc. Moreover, the sales and income earned in these related sectors further generate demand for other goods and services in the state. So what starts in the health care industry as an increase in physician office visits will set in motion increases in employment and additional production of goods and services in other industries.

E. Budgetary Analysis

We developed a state budget model to estimate the fiscal impact of the HSP on the State of New Mexico. Our model had four key factors:

1) Total administrative and benefit spending for HSP beneficiaries;
2) The amount HSP beneficiaries would contribute to premiums;
3) Repurposed Federal and state spending; and
4) The net impact of key revenue sources, like the state income tax.

Total administrative benefit spending for HSP beneficiaries. Plan spending was calculated as total HSP member spending, multiplied by actuarial value, and inflated by the plan administrative loading factor. More detail on our actuarial value and administrative loading factor assumptions was provided in an earlier section (see "Premiums and Out-of-Pocket Costs").

The amount HSP beneficiaries would contribute to premiums. HSP beneficiary premiums varied by scenario. In all scenarios, we assumed that Medicaid-eligible beneficiaries pay no premiums; and Marketplace-eligible beneficiaries pay no more than they would have paid for a Marketplace Silver plan. In the ESI-comparable scenario, we assumed that even higher-income HSP beneficiaries pay no more than a typical subsidized ESI premium, estimated at $1,800 per beneficiary in 2024. In the ACA-comparable scenario, HSP beneficiary premiums scale with income. Households with incomes above 400 percent of the FPL (e.g., $104,800 for a household of 4 in 2020) would pay the lower of either (1) 9.56 percent of their household's income, or (2) the full HSP premium (i.e., the HSP premium without any reductions from the state). This amount is much higher than the comparable amount such a household would have paid for a subsidized employer plan.

Repurposed federal and state spending. The HSP would effectively replace several existing public health programs. We assumed that funding for those programs could be repurposed to support the HSP. We evaluated the potential to repurpose federal and state funding for: Medicaid, the New Mexico Marketplace, state workers, the Centennial Care Waiver, the Safety Net Care Pool, the County Indigent Fund, the County-Supported Medicaid Fund, the Disproportionate Share Hospitals Fund, Medicaid spending for emergency medical services for undocumented residents, and the New Mexico Medical Insurance Pool fund.

Medicaid Funding. We assumed the state could repurpose a portion of state and federal Medicaid funding to help finance the HSP. Repurposing federal funding would require a federal waiver. We based New Mexico's current level of state and federal Medicaid spending on expenditure totals reported in the

state's CMS-64 report.[75] The CMS-64 Expenditure report is a standard resource used for state-level Medicaid expenditures, and is regularly relied upon in analyses conducted by CMS, the Congressional Budget Office, and the Medicaid and CHIP Payment and Access Commission. For fiscal year 2018, New Mexico reported about $5.1 billion in Medicaid spending in its CMS-64 report.[76] This is notably less than the $5.6 billion in 2018 Medicaid spending reported in the LFC's Report to the Fifty-Fourth Legislature, Second Session.[77] The HSD offered several possible explanations to explain this discrepancy, including differences in reporting periods, treatment of drug rebates, and the exact set of included programs.

Our baseline Medicaid spending estimates are likely 10 percent lower than what they would have been had we used the LFC budget projection rather than the CMS-64 data. Using the budget projections would have increased the amount of available Medicaid funding that could be used to finance HSP. However, using the budget projections would also have increased our estimate for the cost of covering Medicaid beneficiaries under the HSP. These effects would mostly offset each other, leaving our estimates for funding shortfall less affected by this differential than one might otherwise have expected. We estimated that using the budget projections would have reduced the funding shortfall by between $100 and $150 million over the 5-year period.

The HSP would not substitute for all current Medicaid activities. Specifically, we assumed HSP would not cover LTSS services and would not cover Medicare beneficiaries (dual-eligible). After excluding spending for these groups, we estimated that about 71 percent of Medicaid spending, about $3.6 billion in 2018, could be repurposed to fund the HSP. We projected this would increase to about $5.0 billion by 2024, which reflects expected changes in prices, usage, and enrollment. This includes $3.93 billion in federal funding and $1.06 billion in state funding that could be repurposed to fund the HSP. Almost all of this funding would be consumed in providing HSP coverage to beneficiaries who otherwise would have been covered by Medicaid, although some of these funds could be used to cover other HSP costs because of the lower administrative costs in the HSP as compared to New Mexico Medicaid.

Federal Marketplace Funding. The federal government provided financial assistance for beneficiaries obtaining coverage through the federal Marketplaces. We assumed the state could repurpose federal Marketplace funding to help finance the HSP. Repurposing this funding would require a federal waiver. In 2019, the Federal government paid about $153 million in premium tax credits to New Mexican residents receiving coverage on the Marketplace.[78] We estimated that this would increase to $168 million by 2024. All of this repurposed funding would be consumed providing HSP coverage to beneficiaries who otherwise would have been covered by subsidized Marketplace plans, although some of these funds

[75] State Expenditure Reporting for Medicaid & CHIP. Centers for Medicare & Medicaid Services. 2018. https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-medicaid-chip/index.html.

[76] Total Medicaid Spending. Kaiser Family Foundation. FY 2018. https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/

[77] Legislating for Results: Supplemental Charts and Graphs. New Mexico Legislative Finance Committee. Page 95. January 2020. Available at nmlegis.gov/Entity/LFC/Documents/Session_Publications/Budget_Recommendations/2021RecommendVolIII.pdf

[78] Estimated Total Premium Tax Credits Received by Marketplace Enrollees. Kaiser Family foundation. 2019. Available at https://www.kff.org/health-reform/state-indicator/average-monthly-advance-premium-tax-credit-aptc.

could be used to cover other HSP costs because of the lower administrative costs in the HSP as compared to Marketplace plans.

State Worker Funding. We assumed that the HSP would cover state workers, and that existing subsidies for state worker health coverage could be repurposed to finance the HSP. We estimated that available funding from state worker premium subsidies would be about $880 million in 2024. Almost all of this repurposed funding would be consumed in providing HSP coverage to beneficiaries who otherwise would have been covered by state worker health plans, although some of these funds could be used to cover other HSP costs because of the lower administrative costs in the HSP as compared to state worker insurance coverage.

County Indigent Fund. The County Indigent Fund provides funding to support health care provided to indigent New Mexico residents. The LFC projected the County Indigent Fund to be about $60 million in 2015.[79] We projected that the fund would increase to about $83 million in 2024. We adjusted current law reimbursement levels for uninsured residents to account for the existence of the County Indigent Fund, and also assumed these dollars could be repurposed to fund the HSP.

New Mexico Medical Insurance Pool. The New Mexico Medical Insurance Pool (NMMIP) provides subsidized coverage to high-need patients. In 2018, assessments to fund the pool were about $71 million.[80] We adjusted current law reimbursement levels for non-group beneficiaries to account for the existence of the NMMIP, and also assumed these dollars could be repurposed to fund HSP.

Other Programs. Based on discussions with HSD, we believe that spending on other state health programs is captured within the Medicaid CMS-64 expenditure spending total. As such, funding for these programs is already accounted for in our estimates of available state and federal Medicaid funding; and it was unnecessary to make further adjustments for specific programs.

Summary. In total, we estimated that the state could repurpose $6.16 billion in public funding in 2024 to help fund the HSP. This includes $4.10 billion in federal funding and $2.06 billion in state funding. The federal funding primarily comes from the state Medicaid program ($3.93 billion), but also includes some Marketplace funding ($0.17 billion). The state funding primarily comes from the state Medicaid program ($1.06 billion), premium subsidies for state workers ($0.88 billion), the County Indigent Fund ($0.08 billion), and the NMMIP ($0.07 billion).

State Revenue Sources. We examined the effect of the HSA on revenue from state income taxes and taxes on private insurance companies. Premiums for employer coverage are deductible from state income taxes. These deductions could decline as people move from employer coverage onto HSP, which increases tax revenue. However, we assumed that both HSP beneficiary premiums and employer contributions to HSP would also be deductible from state income taxes. These tax deductions would be

[79] New Mexico Legislative Finance Committee. (2015). Health Notes: Uncompensated Care in New Mexico After the Affordable Care Act. New Mexico Legislative Finance Committee. https://www.nmlegis.gov/Entity/LFC/Documents/Health_Notes/Uncompensated%20Care%20in%20New%20Mexico%20After%20the%20Affordable%20Care%20Act.pdf

[80] Report of Independent Auditors and Financial Statements with Supplementary Information. Moss Adams. December 2018.

similar in magnitude to the existing employer deductions, leaving state income tax revenue largely unchanged.

The state imposes significant taxes on private health insurance companies. This includes a 3-percent health insurance premium tax that applies to fully-insured group health plans, Medicaid managed care organizations, and non-group insurance plans; a 1-percent premium surtax that applies to all health plans, including self-insured health plans; and an additional tax applying to all health plans to fund NMMIP. As HSP crowds out private health insurance plans within the state, much of this revenue would decline. The extent of these declines varied by scenario.

IV. Current Coverage and Expenditures in New Mexico

To understand changes in coverage and spending from the HSP, we generated baseline estimates of health care coverage and spending for the non-elderly civilian population of New Mexico. Baseline estimates reflect expected population changes, insurance coverage, and health care spending under current law (without the HSP, with ACA). We projected the baseline estimates beginning with the assumed start year for the HSP, 2024, through 2028. These baseline estimates form the foundation for our fiscal analysis and are compared to coverage and health care spending under the HSP. In this section, we describe baseline estimates for coverage and spending for New Mexicans for 2024, which can be used to help understand our findings reported in subsequent sections.

A. Coverage

The analytic database includes 41,783 observations representing, after application of sample weights to ensure our sample is representative of the New Mexico population, roughly 1.7 million New Mexicans under the age of 65 in baseline (Table 4.1). In 2024, most residents will have ESI (44.2%), followed by Medicaid (40.9%), which together will account for approximately 85 percent of the state's population. We estimated that in 2024, roughly 11 percent of New Mexicans will be uninsured. Of those with coverage through an employer, most individuals are employed at a firm offering a self-insured group health plan (73%), because most workers are employed at large firms that tend to provide self-insured group health plans. The majority of New Mexico's workforce with insurance coverage is employed at private sector companies, with another 35.9 percent employed by federal, state, or local governments (not shown).

Based on input from the LFC, we assumed (in our base model) that most individuals in New Mexico, including those on Medicaid, non-group insurance, and those with ESI through a fully-insured group health plan, would be enrolled in the HSP, as is the intent of the HSA. Employers offering a fully-insured group health plan in baseline would no longer offer coverage but, instead, would obtain coverage for their employees through the HSP (as per our policy assumptions in Tables 2.1 and 2.2). In our base model, these employers, as well as their employees, would pay into the HSP to cover premiums. Employers who offer a self-insured group health plan tend to be larger than firms that offer a fully-insured group health plan. Thus, most individuals covered under ESI may continue to maintain access to ESI, unless the introduction of the HSP induces a firm to drop offering coverage. In our model, firms offering self-insured group health plans may continue to offer their own plan or have their employees gain coverage through the HSP.

Table 4.1. Baseline Insurance Coverage for the Non-Elderly Civilian Population before Implementation of the HSP, 2024

	N (Thousands)	% of Total	% of Major Category
Total Population	1,700	100	
Employer-sponsored Insurance (ESI)	751	44.2	
Coverage through Self-insured Firm Plan	550	32.3	73.2
Coverage from Fully Insured Firm Plan	201	11.8	26.8
Employees with ESI by Firm Size			
Firms with Fewer than 10 Employees	36	2.1	4.7
Firms with 10-49 Employees	42	2.4	5.5
Firms with 50-99 Employees	23	1.3	3.0
Firms with 100-999 Employees	75	4.4	10.0
Firms with 1,000 or More Employees	576	33.9	76.7
Marketplace and Non-group Coverage	66	3.9	
Medicaid	696	40.9	
Uninsured	188	11.0	

Source: Analysis by KNG Health Consulting
Note: Numbers may not add due to rounding

In our baseline, insurance coverage status varies significantly across race and ethnicity (Table 4.2). White and Asian residents are most likely to have coverage through an employer whereas all other race and ethnicity categories are most likely to have Medicaid coverage. New Mexicans identifying as Native Americans are disproportionately likely to be uninsured, with nearly 22 percent without insurance coverage in 2024. While tribal governments may choose to participate in the HSP, our model assumed that Native Americans are enrolled in the HSP if eligible, unless employed at a firm that offers a self-insured group health plan.

Table 4.2. Race and Ethnicity Differences at Baseline for the Non-Elderly Civilian Population before Implementation of the HSP, 2024

		Percentage of Total Population			
	Total (Thousands)	ESI	Medicaid	Marketplace & Non-group	Uninsured
Total	1,700	44.2	40.9	3.9	11.0
Race					
White	1,230	47.6	38.4	4.4	9.6
Black	32	45.8	41.7	4.2	8.3
Native American	178	22.9	54.6	0.9	21.6
Asian	31	64.5	23.7	7.2	4.6
Other Race	158	38.4	45.4	2.1	14.0
Two Major Races	70	41.0	48.1	3.7	7.2
Ethnicity					
Hispanic	958	40.5	45.2	2.7	11.6

Source: Analysis by KNG Health Consulting

Note: Numbers may not add due to rounding

B. Spending

We projected baseline total health care spending in 2024 to be nearly $13 billion in New Mexico (Table 4.3) among those eligible for coverage under the HSP. Spending on hospital inpatient care is estimated to be $2.2 billion, about 17 percent. Visits that occur in hospital outpatient departments, EDs, or physician offices together account for over $3 billion. The state is estimated to spend $1.6 billion for prescription drugs at baseline plus $4.6 billion in other medical costs such as laboratory services and medical equipment. The proportion of direct medical care (excluding administration) spent on hospital-based care (inpatient plus outpatient) of 30 percent is comparable to national estimates of 32.7 percent in 2017.[81] Although the total number of beneficiaries in Medicaid and individuals with ESI is similar, nearly half of all spending ($6.4 billion) is concentrated in ESI. Medicaid is the next largest payer for health care at $5.1 billion.

[81]National Health Statistics Group. (2018). *Table 43. National health expenditures, average annual percent change, and percent distribution, by type of expenditure: United States, selected years 1960–2017*. Centers for Medicare & Medicaid Services. https://www.cdc.gov/nchs/data/hus/2018/043.pdf

Table 4.3. Baseline Spending by Service Type and Insurance Coverage (in million dollars), 2024

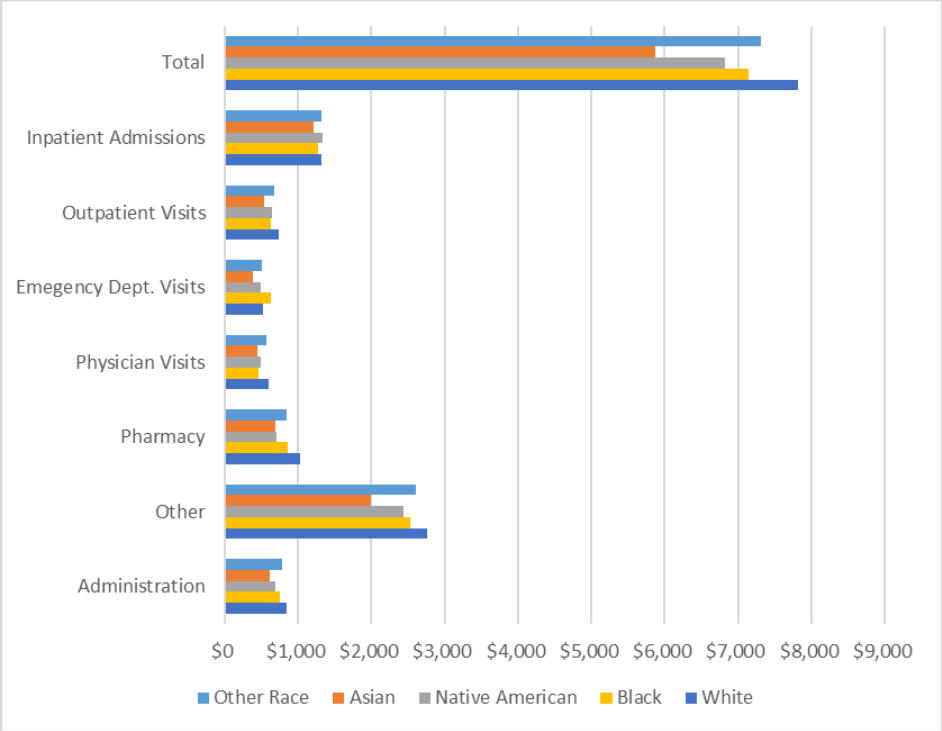
	Total		ESI		Medicaid		Marketplace & Non-group		Uninsured	
	$ Millions	%	$ Millions	%	$ Millions	%	$ Millions	%	$ Millions	%
Total Spending	12,919	100.0	6,419	100.0	5,090	100.0	680	100.0	730	100.0
Hospital Inpatient	2,238	17.3	1,005	15.7	914	18.0	106	15.6	213	29.2
Hospital Outpatient	1,219	9.4	625	9.7	492	9.7	68	10.0	34	4.7
Emergency Department	877	6.8	574	8.9	216	4.3	47	6.9	39	5.4
Physician Visits	988	7.6	390	6.1	501	9.8	36	5.3	61	8.3
Pharmacy	1,632	12.6	884	13.8	463	9.1	94	13.8	192	26.3
Other Outpatient	4,569	35.4	2,282	35.6	1,873	36.8	223	32.8	191	26.1
Administration	1,395	10.8	658	10.3	631	12.4	107	15.7	0	0.0

Source: Analysis by KNG Health Consulting

Note: Numbers may not add due to rounding

On a per-capita basis, we estimated baseline health care spending of $7,600 per New Mexican (excluding long-term care services), ranging from around $5,871 for Asians to $7,822 for Whites (Figure 4.1). We projected that per capita health care spending for Native Americans will be approximately $6,825 in 2024. Spending is influenced by insurance coverage (e.g., the uninsured are assumed to access health care less than those with insurance coverage; provider reimbursement rates or prices also vary by payer) as well as age, gender, disability, presence of chronic conditions.

Figure 4.1 Baseline Per Capita Spending Per Resident by Race, 2024



Source: Analysis by KNG Health Consulting

C. Baseline Disparities in Utilization and Spending By Race and Ethnicity

In our baseline estimate, individuals with ESI or Marketplace coverage make greater use, on average, of hospital outpatient and pharmacy services compared to Medicaid beneficiaries, who make greater use of hospital inpatient and ED services. The uninsured generally have lower rates of utilization than those with insurance, particularly for hospital outpatient and physician office visits.

Asian New Mexicans use less of all health care service categories than Whites across coverage categories except inpatient use among those with employer coverage (Table 4.4). Blacks use less of all types of services than Whites, especially physician visits and pharmacy services. The exception for black residents is ER visits, which are 42 percent higher in Marketplace plans and 31 percent higher for those with employer-sponsored coverage. We projected that the Native American population will use more ED services and fewer physician office visits and prescription drugs than Whites. For hospital inpatient admissions, Native Americans without insurance, with ESI, or in Marketplace plans were more likely to use inpatient than Whites, while Medicaid beneficiaries use inpatient less frequently than Whites. These patterns are generally similar for ethnicity, where we see less utilization across service categories and insurance coverage for Hispanic residents (Table 4.5).

Table 4.4. Baseline Spending Per Resident by Type of Service, Type of Insurance Coverage and Race (in dollars), 2024

	Spending per Resident (in dollars)							
Coverage Type	Inpatient Admissions	Outpatient Visits	ED Visits	Physician Visits	Pharmacy	Other	Admin.	Total
Total	1,317	717	516	581	960	2,688	821	7,600
Employer-sponsored Insurance	1,338	833	765	520	1,177	3,039	877	8,549
White	1,310	847	746	536	1,226	3,061	889	8,615
Black	1,319	780	978	407	1,096	3,057	804	8,441
Native American	1,628	970	1,030	452	1,019	3,526	994	9,618
Asian	1,399	586	467	436	754	2,130	612	6,384
Other race	1,318	798	789	474	1,151	2,962	819	8,311
Two races	1,514	621	838	484	796	2,712	793	7,758
Medicaid	1,314	707	311	720	665	2,693	906	7,317
White	1,346	713	303	752	707	2,740	928	7,489
Black	1,309	551	294	580	569	2,234	783	6,321
Native American	1,195	689	355	582	505	2,504	824	6,654
Asian	872	454	214	531	482	1,905	630	5,087
Other race	1,362	781	305	736	717	2,794	947	7,643
Two races	1,213	633	334	735	506	2,728	869	7,019
Marketplace, Other Non-group	1,608	1,029	716	545	1,426	3,387	1,619	10,331
White	1,665	1,074	719	566	1,506	3,498	1,679	10,707
Black	1,223	755	1,019	359	1,388	3,028	1,402	9,174
Native American	1,699	1,223	946	488	1,238	3,952	1,834	11,379
Asian	910	590	331	391	857	1,899	941	5,919
Other race	1,568	926	751	529	1,209	3,268	1,501	9,751
Two races	1,212	611	645	392	685	2,345	1,088	6,977
Uninsured	1,137	181	210	323	1,024	1,017	0	3,893
White	1,059	183	194	337	1,082	1,020	0	3,875
Black	885	132	209	236	753	815	0	3,031
Native American	1,371	194	270	294	906	1,071	0	4,105
Asian	820	110	101	273	616	696	0	2,616
Other race	1,181	164	201	317	1,030	973	0	3,867
Two races	1,205	171	195	309	797	947	0	3,625

Source: Analysis by KNG Health Consulting

Note: Numbers may not add due to rounding

Table 4.5. Baseline Spending Per Resident by Type of Service, Type of Insurance Coverage and Ethnicity (in dollars), 2024

	Spending per Resident (in dollars)							
Coverage Type	Inpatient Admissions	Outpatient Visits	ED Visits	Physician Visits	Pharmacy	Other	Admin.	Total
Total	1,317	717	516	581	960	2,688	821	7,600
Employer-sponsored Insurance	1,338	833	765	520	1,177	3,039	877	8,549
Not Hispanic	1,385	963	770	562	1,314	3,322	938	9,255
Hispanic	1,294	711	760	480	1,049	2,776	819	7,889
Medicaid	1,314	707	311	720	665	2,693	906	7,317
Not Hispanic	1,502	809	340	743	740	2,883	992	8,008
Hispanic	1,200	645	294	706	620	2,578	855	6,898
Marketplace, Other Non-group	1,608	1,029	716	545	1,426	3,387	1,619	10,331
Not Hispanic	1,733	1,158	702	586	1,561	3,638	1,737	11,114
Hispanic	1,415	828	739	481	1,218	2,998	1,436	9,116
Uninsured	1,137	181	210	323	1,024	1,017	0	3,893
Not Hispanic	1,179	208	228	335	1,075	1,101	0	4,126
Hispanic	1,108	163	198	315	988	960	0	3,732

Source: Analysis by KNG Health Consulting

Note: Numbers may not add due to rounding

V. Change in Coverage and Costs under Reform Models

A. Overview

Using a microsimulation modeling approach, we estimated coverage, service use, spending, and budgetary effects of different scenarios under the HSP. We also assessed different strategies for funding the legislation, while accounting for likely behavioral responses from households, employers, and insurance companies. We report additional details on the findings from the 4 scenarios in Appendix A.

Key Findings

Implementation of the HSP would have impacts on health insurance coverage, health care spending by households, employers, and budgetary impacts for the state.

- Coverage. The HSP would enroll most of the state's population into a state health insurance program. Doing so could bring near-universal health insurance coverage to New Mexico.
- Spending. Improved access to comprehensive health insurance would drive higher use of services, particularly among those who otherwise would have been uninsured. While higher service use would drive increased spending, savings from reduced payer-side (state) administrative costs are projected to offset these increases. Over the long-term, we projected that the HSP would decrease total health spending in New Mexico if administrative costs are kept at levels proposed by the HSA.
- Effects on HSP Beneficiaries. By offering reduced premiums for certain New Mexicans, the HSP would decrease the financial burden of health expenses for some HSP beneficiaries, particularly for low-income households not currently enrolled in Medicaid. The effect of the HSP on HSP beneficiaries varies by scenario. Under the more generous HSP plan (ESI-comparable premiums and cost-sharing), we estimated that premiums and OOP spending would be the same or lower for all groups of HSP beneficiaries relative to the baseline. Under the ACA-comparable scenarios, employees who had received coverage through their employer would pay significantly more in premiums.
- Effects on Employers. The net impact on employers is dependent on how policymakers implement employer contribution requirements, including the level of contribution and which employers are exempt from contributions. Under our scenarios requiring employers participating in the HSP to contribute to the cost of the plan, we estimated that the HSP would increase employer contributions to the health care system. These cost increases would fall on businesses that were previously not offering health benefits and businesses that continued offering self-insured group health plans to their employees.
- Budgetary Impact. In our ESI-comparable scenario with provider/facility payment reduction or a general tax, we found that the HSP would be underfunded by approximately $5.8 billion over the first 5 years (Table 5.1, Scenario 1). Reducing the growth in provider/facility payment rates from CPI-M to CPI-M minus 1 percentage point would reduce the shortfall by approximately a billion dollars to $4.7 billion (Scenario 2). The funding shortfall would be significantly reduced under an HSP with premium

and cost-sharing structures similar to the ACA, due largely to higher premium contributions among those who received ESI in the baseline. Under the ACA-comparable plan, the shortfall would be eliminated through slowing the growth of provider/facility reimbursements by 1 percentage point below CPI-M.

B. Effects on Health Insurance Coverage

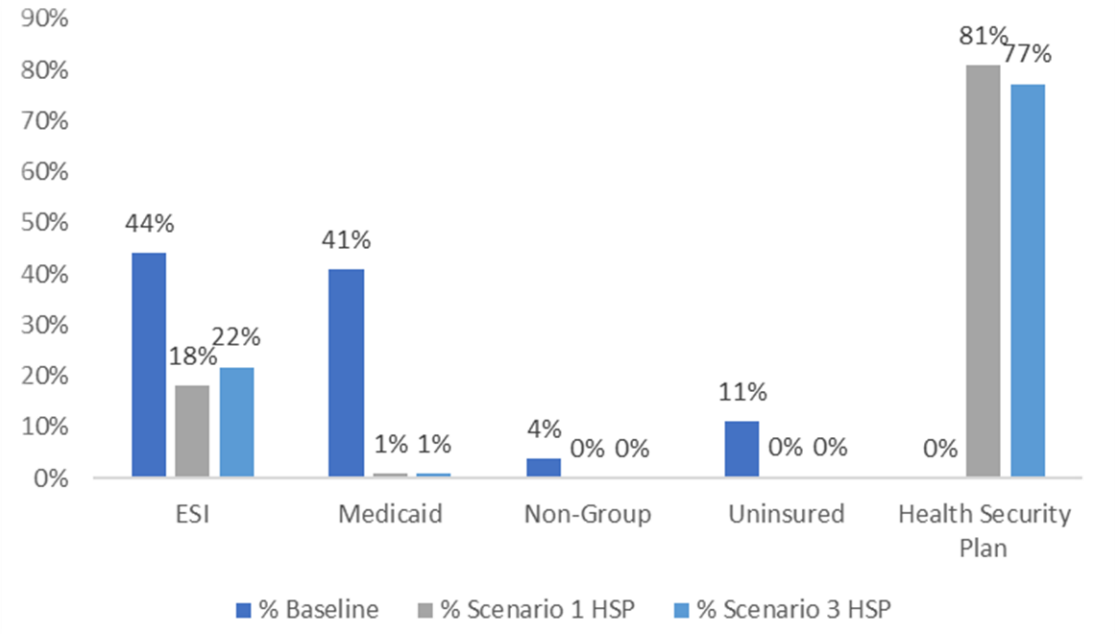
Because the effects of enrollment in HSP did not vary materially with different assumptions regarding updates to HSP prices, we focused on Scenario 1 (ESI-Comparable without HSP Price Reductions) and Scenario 3 (ACA-Comparable without HSP Price Reductions).

In 2024, we estimated that 1.4 million (81%) and 1.3 million (77%) people would enroll in the HSP in Scenario 1 and Scenario 3, respectively (Figure 5.1). Most HSP beneficiaries would have otherwise had Medicaid (Scenario 1: 50%, Scenario 2: 52%) or employer coverage (32%, 29%), while the rest would have been uninsured (13%, 14%) or had non-group coverage (5%, 5%). Many employers offering self-insured group health plans would choose to stop offering coverage and have their employees instead enroll in the HSP. About 44 and 33 percent of individuals enrolled in an employer's self-insured group health plan in the baseline would work at firms that stopped offering independent coverage in Scenarios 1 and 3, respectively. For some low-income households, coverage under the HSP would be available at little or no costs. Some of these individuals and households would enroll in the HSP even if they continued to have access to an employer's self-insured group health plan.

The HSP would create near-universal coverage in the state, resulting in the uninsured rate falling from 11.0 percent to 0.3 percent in both scenarios (Figure 5.1). Among those who do not enroll in the HSP, nearly all would be workers or dependents enrolled in an employer-based self-insured group health plan. There also would be a small number of remaining Medicaid beneficiaries and uninsured individuals. These individuals would be ineligible for the HSP due to the 1-year residency requirement.[82] A small percentage of remaining uninsured individuals previously had non-group coverage. The HSP would result in a significant contraction in the private non-group insurance market to the point that such plans may not have enough potential beneficiaries to be viable. This would leave a small number of individuals, who would have received non-group coverage in the baseline, with no source of coverage because of HSP ineligibility. The relative effects of the HSP on enrollment in different coverage categories were consistent across years.

[82] The HSA allows individuals to enroll in the HSP even if they resided in New Mexico for less than a year, provided they traveled to the state with an employment offer. For purposes of this analysis, we assumed households were exempt from the residency requirement if any household member is employed.

Figure 5.1. HSP Impact on Health Insurance Coverage in New Mexico in 2024: Percent of New Mexicans by Coverage Type in Baseline and Under HSP Scenarios



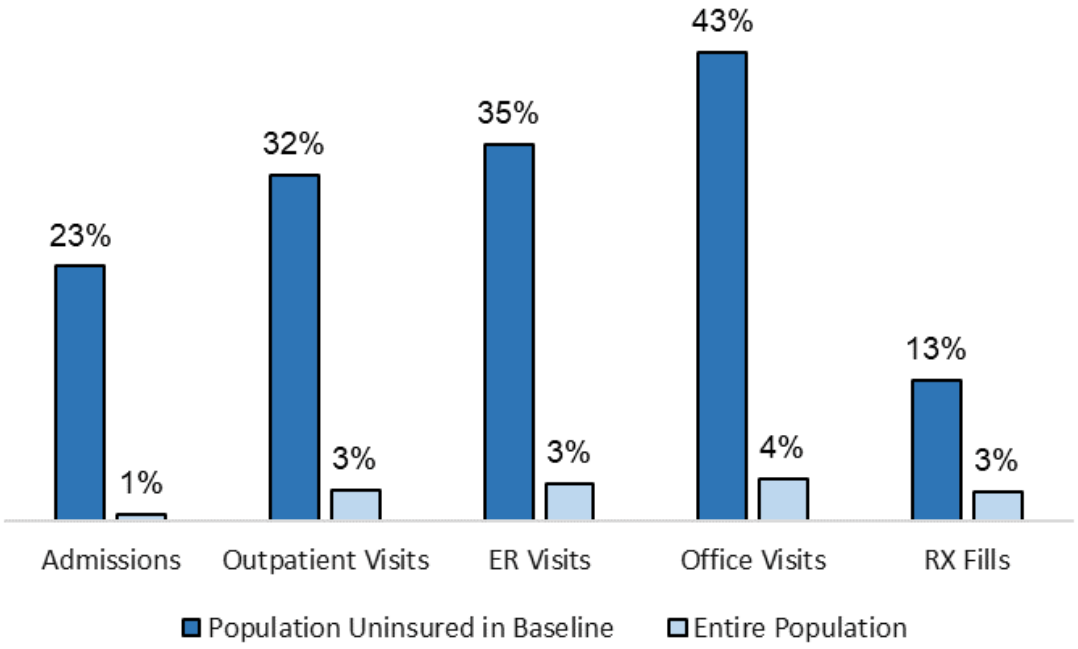
Source: Analysis by KNG Health Consulting
Note: Numbers may not add due to rounding.

C. Effects on Health Care Usage

We forecasted that the HSP would result in increased service use (Figure 5.2). These effects would be larger for those who are uninsured in the baseline. For the uninsured who would gain coverage under the HSP, we assumed large utilization increases in all service categories, including hospital admissions (+23%), outpatient visits (+32%), ED visits (+35%), physician office visits (+43%), and prescription drug (RX) fills (+13%). We also estimated utilization increases among those who would have otherwise had non-group coverage, as we assumed the HSP would have lower levels of cost-sharing than plans typically obtained in the individual market.

Those who otherwise would have had Medicaid or employer coverage would face similar cost-sharing under the HSP. Therefore, we projected little change in service use among these populations. As most of our simulation population (85% in 2024) would have either had employer or Medicaid coverage, the overall population impacts on health care service use are small, relative to corresponding effects assumed for the uninsured. The HSP would subject health care facilities to global budgets. This would encourage providers to improve efficiency and reduce volume. We assumed that this would decrease health facility admissions and outpatient visits, which partially offsets the increase in utilization from coverage improvements.

Figure 5.2. Impact of the HSP on Utilization of Health Care Services, 2024-2028



Source: Analysis by KNG Health Consulting

D. Effects on Health Care Prices

We established prices under the HSP so that average prices across payers for services would not change. This resulted in prices that are higher than those typically paid by Medicaid or the uninsured, but lower than those typically paid by private insurance. In 2024, we set HSP inpatient prices to be 25 percent above Medicare, outpatient prices to be 59 percent above Medicare, ER prices to be 82 percent above Medicare, physician prices to be 9 percent above Medicare, and RX prices to be 24 percent below Medicare in Scenarios 1 and 2. We established similar HSP prices for Scenarios 3 and 4 (24% above Medicare for inpatient hospital, 55% for outpatient, 76% for ER, 8% for physician, and 25% below Medicare for prescription drugs).

By simplifying the payer landscape, the HSP could reduce provider-side administrative costs. This could offer a rationalization for reducing provider reimbursement, which could help fund the plan. However, in Scenarios 1 and 3, we kept average payment levels the same as in baseline. We inflated HSP prices by either CPI-M (Scenarios 1 and 3) or CPI-M – 1 percent (Scenarios 2 and 4). Our base scenario also assumed that the HSP would be able to maintain access to discounts from the Medicaid Drug Rebate Program, which would require a federal waiver.

E. Effects on Health Care Spending

Overall spending effects. Over our five-year projection window, the HSP is projected to reduce health care spending in the state, although the extent of the reduction in spending depends on the scenario (Figure 5.3). In the baseline, we projected total state-wide health care spending (including administrative costs) to increase from $12.9 billion in 2024 to $15.0 billion in 2028, with total spending over the 5-year period of $68.9 billion. Aggregate 5-year savings relative to baseline range from approximately $1.6 billion (Scenarios 1 and 3) to $2.7 billion (Scenarios 2 and 4).

In general, health reforms could affect health care spending through three mechanisms:

1. **Health care prices.** The HSP has a neutral effect on average health care prices (see "Effects on Health Care Prices").

2. **Health care service use**. The HSP does induce a net increase in health care service use, which increases health care spending (see "Effects on Health Care Usage").

3. **Health care administrative spending.** The HSP reduces payer-side administration and administrative cost savings increase over time.

Figure 5.3. Total Health Care Spending for State in Baseline and by Scenario, 2024-2028

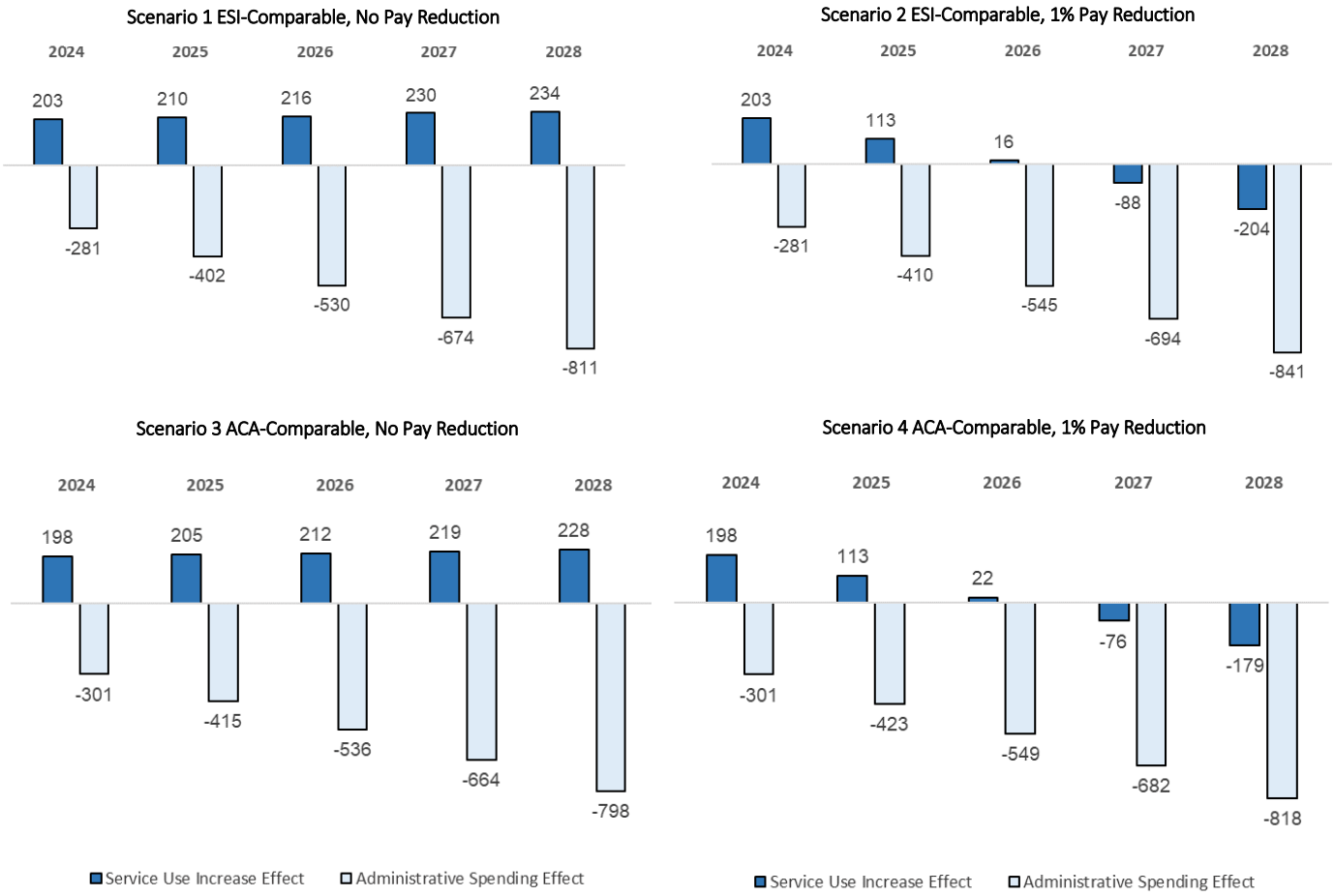
	2024	2025	2026	2027	2028
Baseline	$12,919	$13,416	$13,932	$14,484	$15,043
Scenario 1	$12,840	$13,224	$13,618	$14,039	$14,466
Scenario 2	$12,840	$13,119	$13,403	$13,702	$13,997
Scenario 3	$12,816	$13,206	$13,609	$14,039	$14,473
Scenario 4	$12,816	$13,106	$13,405	$13,726	$14,046

Source: Analysis by KNG Health Consulting.

Notes: Scenario 1: ESI-Comparable with No Pay Reduction; Scenario 2: ESI-Comparable with 1% Pay Reduction; Scenario 3: ACA-Comparable with No Pay Reduction; Scenario 4: ACA-Comparable with 1% Pay Reduction.

The net effect of the HSP on spending is determined by the relative magnitudes of the service-use increase and the administrative spending decrease (Figure 5.4). We found that in each year and scenario the administrative savings more than offset increases in health care spending. In Scenarios 2 and 4 with a 1-percent reduction in HSP price adjustments, we estimated that increased utilization of services would be offset by lower prices relative to the baseline so that spending on services falls relative to the baseline in 2027 and 2028.

Figure 5.4. Changes in Total Health Care Spending for Increased Service Use and Reduced Administrative Costs by Scenario, 2024-2028



Source: Analysis by KNG Health Consulting.

Effects on Employer Premiums. The share of health spending borne by employers would increase from 23 to 25 or 26 percent, across all scenarios. In "employer premiums," we included (1) subsidies paid by the employer to directly sponsor self-insured private health insurance coverage for workers and dependents; and (2) employer payroll contributions made into the HSP among firms not offering health insurance coverage. The HSP would decrease employer premiums in the first set of firms, as fewer firms would directly offer coverage to their workers. We set the employer payroll contribution toward the HSP so that they equaled the total contribution of employers to premiums in the baseline. We estimated that firms not offering coverage would need to contribute about 8 percent (or 7 percent for Scenarios 3 and 4) of payroll to replace foregone employer premiums.

The financial impact on different employers would vary depending on their coverage policies both under current law and under the HSP:

- Firms that neither provide coverage under current law nor under the HSP. These firms, which overwhelmingly tend to be small (<100 workers), do not subsidize employer-based health insurance coverage under current law. However, these firms would contribute to the health system under the HSP, as we estimated they would have to pay 7 to 8 percent of their payroll towards the HSP. Thus, these firms would pay more into the health care system under the HSP.
- Firms that provide coverage under current law but do not under the HSP. These firms do subsidize employer-based health insurance coverage under current law and would also contribute 7 to 8 percent of their payroll into HSP. These HSP contributions would be less than what these firms would have paid toward employee premiums in the baseline, as the burden of replacing forgone employer contributions is also being shared by firms that would not have offered coverage in the baseline. This set of firms, which includes firms of all sizes, would pay less into the health care system under the HSP.
- Firms that both provide separate coverage under current law and under the HSP. These firms subsidize employer-based health insurance coverage under both current law and the HSP. As these firms would still be directly supplying coverage to their workers, they would not contribute to the HSP. As other employers drop coverage, our model predicted that dual-income spouses will migrate to the employer-based plans that remain. Among those remaining firms, this will increase employee participation rates as well as the average number of enrolled dependents. Employer benefit spending among these firms, which tend to be larger (>100 workers), would thereby increase under the HSP.

These effects on employers did not account for changes in federal and state income tax deductions. As we assumed that both HSP premiums and employer-based coverage premiums would be tax-deductible, we would not expect significant changes in tax deductions. However, the ability to deduct increases in premium contributions from taxes would partially offset the increase in employer spending. After accounting for tax offsets, the increase in employer spending would be about 5 percent.

The consequences of changes in employers' costs are difficult to predict. For example, under our policy assumptions, employers who did not previously offer health benefits would now be required to contribute 7 to 8 percent of their payroll into the HSP, depending on the scenario. Some employers could cut wages or reduce their workforce. This could require the state to further increase the employer contribution rate. In estimating employer contribution, we did not account for these effects.

Effects on Household Premiums. We estimate household premiums falling from 13 percent of spending to 12 percent of total spending in Scenarios 1 and 2. Household premiums for those obtaining insurance through the non-group market in baseline would decrease disproportionately (-63%). Many of these households are ineligible for the ACA Marketplace premium subsidies and under current law would pay the full premium price. Even non-group beneficiaries eligible for non-group premium subsidies, but near

the income-eligibility cutoff, would pay much lower premiums under our HSP base scenario. This is because we established HSP premiums paid by beneficiaries based on a typical employer plan, which tends to be lower cost than a Marketplace plan for higher-earning households. To illustrate, in 2018, an individual earning $48,000 (i.e., just under 400% of the FPL) might pay about $4,500 per year with federal assistance for a Marketplace plan, but $1,500 per year for an employer-based plan.

In addition, premiums fall for some low-income HSP beneficiaries who otherwise would have participated in employer health plans. For example, we assumed that individuals earning less than 138 percent of the FPL would pay no premium under the HSP. Some of these individuals would have paid premiums for employer-based coverage under current law.

In Scenarios 3 and 4, household spending on premiums would increase by approximately 40 percent, increasing from 13 to 18 percent of total spending. This increase is driven by reduced subsidies provided to employees who go from ESI coverage to HSP under the ACA-comparable scenarios. Without additional financial support from employers, households moving from ESI to HSP under the ACA-comparable scenarios would pay significantly more for health coverage.

Effect on Other Sources of Spending. Spending from other sources includes household out-of-pocket spending, spending from other public programs including IHS and charity care. We found spending from other sources decreases under the HSP by approximately 50 percent from 14 percent of total spending to 7 percent in Scenarios 1 and 2 (or by approximately 40 percent in Scenarios 3 and 4 from 14 percent to 9 percent) of total spending. This change is mostly the result of coverage expansions under the HSP. In addition, we would expect spending from other sources to decrease for households not subject to cost-sharing under the HSP. This includes both households with incomes below 138 percent of the FPL and Native Americans.

Effect on Government Spending. We assumed that under the HSP, the state would be able to preserve federal funding currently being paid on behalf of Medicaid and Marketplace beneficiaries. However, nearly all this funding would be redirected to pay for the HSP. Both under current law and under the HSP, we projected 33 or 34 percent of health spending to be financed by the federal government. This amount does not include federal tax reduction for employer-based coverage nor the HSP. If we included these tax subsidies in this calculation, we would have reported an increase in the federal contribution to New Mexico's health spending.

We projected the state's share of health spending in New Mexico to increase from 17 to 23 (or 22) percent for Scenario 1 (or Scenario 2). Baseline state spending includes the state's share of Medicaid spending and premium contributions paid for public workers. Under the HSP, the state keeps these obligations, while also covering many more people in the state. State spending increases reflect the cost of providing insurance coverage to those uninsured in the baseline, improving subsidies for those enrolled in non-group coverage in the baseline, and reducing cost-sharing for low-income and Native American beneficiaries. This leads to a significant increase in the share of the health spending assumed by the state, which mirrors the decline in household premiums and spending from other sources. However,

under the ACA-comparable scenarios, the state's share of health spending falls as households pay a larger share of total spending.

Effect on Native American Health Care Spending. HSP would disproportionately affect Native American populations in several ways. First, Native Americans are more likely to be uninsured than other residents. As Native Americans would be eligible for HSP, they would represent a disproportionate share of those gaining coverage under the HSP. Second, Native Americans would be exempt from cost-sharing under the HSP. Third, we did not assume that HSP would replace IHS benefits. Native Americans could continue to use their IHS benefits in addition to HSP. However, as more Native American households are covered under HSP, spending on IHS facilities and providers may be lower.

F. Budgetary Impact under Alternative Scenarios and Sensitivity Analyses

The HSA would create an entitlement program for the state. In 2024, we estimate total state benefit spending and administrative costs for HSP beneficiaries would be $9.8 billion for Scenarios 1 and 2 or $9.1 billion for Scenarios 3 and 4 (For details on budgetary impact, see Appendix A, Tables A1.6, A2.6, A3.6, and A4.6). Over the 5-year period, total HSP spending would be between $47 and $52 billion dollars (Table 5.1). In addition, the state would lose approximately $1.5 billion in revenue from taxes paid by private insurance companies. The cost of HSP would be funded by premiums paid by HSP beneficiaries, employer contribution, federal funding, and state expenditures.

We estimated significant variation across scenarios in the ability of the state to fund the HSP with existing revenue. Over the initial 5-year period, we estimated that the HSP would be underfunded by $5.8 billion for Scenario 1 - ESI-Comparable with No Pay Reduction, while existing funding would be sufficient to cover the cost of the HSP in Scenario 4 – ACA-Comparable with 1% Pay Reduction. Employers would contribute 7 to 8 percent of payroll to HSP and, we estimated, 59 percent and 51 percent of employees would obtain coverage through the HSP under Scenario 1 (and 2) and Scenario 3 (and 4), respectively. For Scenarios 1, 2, and 3, we approximated the amount of a general payroll tax likely needed to close the funding shortfall. These general payroll taxes would need to average approximately 2.3 percent, 1.7 percent, 0.3 percent for Scenarios 1, 2, and 3, respectively, over the initial 5 years of the HSP.

We conducted sensitivity analyses on assumptions related to utilization under the HSP by those previously uninsured and the effects of slower growth in payments to providers and facilities. Specifically, we modeled the following 3 additional scenarios:

- **Sensitivity Analysis 1**: Utilization of those who are newly insured under the HSP (i.e., uninsured in baseline) increases by half the amount suggested by the Oregon Health Insurance Experiment.

- **Sensitivity Analysis 2:** Utilization of those who are newly insured under the HSP (i.e., uninsured in the baseline) does not change under the HSP.

- **Sensitivity Analysis 3:** Provider and facility payment rates under the HSP (HSP prices) grow by CPI-M minus 2 percentage points.

Table 5.1. Total Costs of HSP, Revenues, and Budgetary Impact by Scenario (in Millions of Dollars)

	ESI-Comparable		ACA-Comparable	
	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Description	No Pay Reduction	1% Pay Reduction	No Pay Reduction	1% Pay Reduction
HSP Benefits and Administration	51,985	51,089	48,082	47,106
Total Revenue	46,186	46,367	47,214	47,168
Premiums	5,364	5,408	8,929	8,877
Employer Contributions	8,922	9,044	6,702	6,706
Available Federal Funding	22,246	22,246	22,246	22,246
Available State Funding Plus Tax Impacts	9,654	9,668	9,337	9,339
Budget Shortfall	5,799	4,723	868	-62
Average % Employer Contribution	8.0%	8.0%	7.0%	7.0%
% Employees with ESI Baseline Who Enroll in HSP (2024)	59.0%	59.0%	51.0%	51.0%

Source: KNG Health analysis of the Health Security Plan

Notes: In the "1% Pay Reduction" scenarios, we grew provider and facility payment rates by CPI-M – 1 percentage point; Tax Impacts include changes in state income tax revenue and insurer premium tax revenue.

We received public comments raising concerns over our use of the Oregon Health Insurance Experiment findings to adjust the utilization of those who are uninsured in the baseline. Therefore, we tested the sensitivity of our findings on budget shortfall under alternative assumptions. We reran Scenario 1 but under an assumption that utilization for the uninsured would increase by half of that used in our Scenario 1 (Sensitivity Analysis 1) and that utilization would not change with the HSP for the previously uninsured (Sensitivity Analysis 2). We estimated budget shortfalls of $5.25 billion and $4.71 billion in Sensitivity Analysis 1 and 2, respectively. We also examined the sensitivity of the budget shortfall in Scenario 1 to alternative assumptions regarding the growth in provider and facility reimbursement rates (HSP prices). We found that for every 1-percentage-point reduction in the growth of HSP prices, the budget shortfall would fall by roughly $1.1 billion (Scenario 1 vs. Scenario 2, a budget shortfall of $5.8 billion and $4.7 billion as reported in Table 5.1.; Sensitivity Analysis 3, a budget shortfall of $3.6 billion).

VI. Economic Impacts and Other Potential Effects of the Health Security Plan

The HSP may have additional effects on New Mexico and New Mexicans beyond those directly estimated in our microsimulation model. For example, changes in health care spending as a result of the HSP could have macroeconomic effects on the state, which could impact employment, earnings, and state taxes. Some effects relate to the myriad forms of insurance that supplement spending on health care through medical insurance. Examples include health care spending associated with workers' compensation claims and automobile insurance policies. Moreover, the HSP would provide expanded access to health care, including preventative screening and services, which could improve the overall health of New Mexicans. In this section, we consider these potential downstream effects.

A. Economic Impact

Based on the effects of the HSP described in the previous section, we conducted an economic analysis of the plan. The HSP is expected to increase the size of the health care provider sector in New Mexico. Any health care spending increases from the HSP will result in additions to this sector's output through more intense utilization of existing resources, or from the addition of new providers and capital investment in the state. To conduct the economic analysis, we assumed that the HSP is self-financing since the state must maintain a balanced budget. As a result, changes in state spending are offset by changes in revenue from taxes, insurance premium payments, and reduced provider payments. Demand for all New Mexico businesses will increase only to the extent out-of-state purchases on other goods are reduced as state consumption is reallocated towards health care.

Economic Contribution. We used the IMPLAN model of the New Mexico economy, which models the degree to which goods and services inputs are provided from businesses in the state. The IMPLAN model is an input-output model where the production of goods or services depends upon the purchase of a set of specific inputs, that is, labor and required equipment and materials.[83] The IMPLAN model of New Mexico estimates the direct and indirect effects on jobs and incomes in the state, such as hospitals' purchase of more supplies, or physician offices' and medical clinics' contracts for more accounting, maintenance, and legal services.

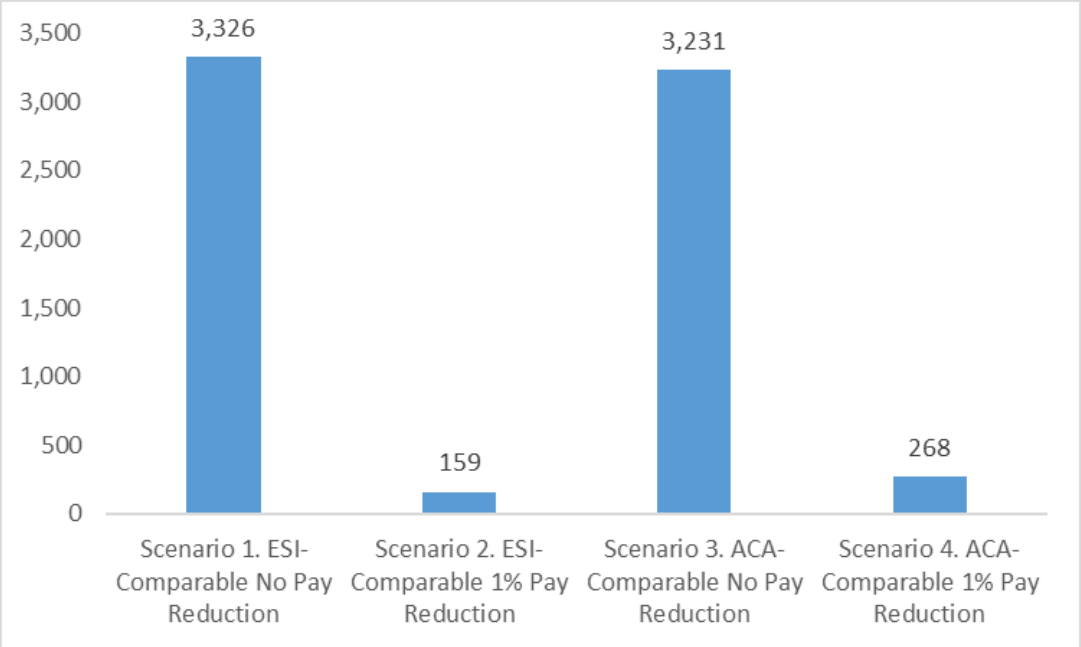
The in-state economic contribution of new spending under the HSP consists, first, of direct spending at new or existing health care providers and facilities in New Mexico. This expansion adds jobs and income, measured by its contribution to gross state product, (i.e., the value of goods and services produced in New Mexico). In addition, there is a positive indirect impact from that spending as suppliers of goods and services to health care providers and facilities themselves employ more workers and in turn purchase additional goods and services as inputs to their own business. For example, additional physician office visits may generate an indirect demand for office space and medical support staff. In presenting economic impacts, we focus exclusively on changes in spending for health care services. Each of the HSP scenarios will also reduce administrative costs. The direct effect of the reduced administrative spending

[83] The quantitative requirements are modeled by the detailed input-output production matrix estimated by the US Bureau of Economic Analysis. U.S. Bureau of Economic Analyses. (2019). *Regional Economic Accounts* [Data set]. https://www.bea.gov/data/gdp/gdp-state.

will adversely impact those firms and workers which provide them, at insurance companies for instance. In that sense they have a negative economic impact. But they also drive savings in total health care spending, which reduce required government and HSP beneficiary spending. In these cases, under the HSP, those savings are available to be spend on other goods and services, either directly, or through reduced taxes. We assume that those spending increases will exactly offset the negative direct effect of the reduced administrative spending.

We estimate through IMPLAN that this new demand will, through 2028, in Scenario 1, generate an annual average of 3,326 additional jobs and about $805 million additional income (across the 5 years) for New Mexico residents (Figure 6.1, Table 6.1) (The model acknowledges and accounts for the fact that some supplies are purchased from out-of-state.) In Scenario 2, where provider and facility reimbursement rates are assumed to grow at a slower rate than in Scenario 1, the impact will be small, with an average increase of 159 jobs per year and total of $38 million in income across the 5 years. The results for the other scenarios (3 and 4) are similar to their corresponding scenario based on the ESI-comparable models.

Figure 6.1. Average Annual Impact on Jobs of the HSP, 2024-2028



Source: IHS Markit analysis of the Health Security Plan

Notes: In the "1% Pay Reduction" scenarios, we grew provider and facility payment rates by CPI-M – 1 percentage point.

Table 6.1. Direct and Indirect Economic Impact of the HSP (in $ Millions), 2024-2028

	Total Spending Under the HSP	Baseline Spending	Difference	Direct + Indirect Impacts	
				Spending	Wages
Scenario 1 ESI-Comparable No Pay Reduction					
Admissions	12,234	12,078	156	210	111
Out-Patient	6,567	6,570	-3	-5	-3
ER Visits	4,893	4,765	128	172	91
Office Visits	5,530	5,345	184	259	137
Rx Fills	8,777	8,788	-12	-15	-8
Other	25,348	24,709	639	897	476
Total	**63,348**	**62,255**	**1,093**	**1,517**	**805**
Scenario 2 ESI-Comparable 1% Pay Reduction					
Admissions	12,026	12,078	-52	-69	-37
Out-Patient	6,458	6,570	-112	-157	-83
ER Visits	4,816	4,765	52	69	37
Office Visits	5,434	5,345	88	124	66
Rx Fills	8,633	8,788	-155	-201	-107
Other	24,927	24,709	218	306	162
Total	**62,295**	**62,255**	**40**	**72**	**38**
Scenario 3 ACA-Comparable No Pay Reduction					
Admissions	12,231	12,078	153	206	109
Out-Patient	6,563	6,570	-7	-10	-5
ER Visits	4,891	4,765	126	169	90
Office Visits	5,528	5,345	182	256	136
Rx Fills	8,786	8,788	-2	-3	-1
Other	25,319	24,709	610	856	454
Total	**63,318**	**62,255**	**1,063**	**1,474**	**782**
Scenario 4 ACA-Comparable 1% Pay Reduction					
Admissions	12,034	12,078	-43	-58	-31
Out-Patient	6,462	6,570	-108	-152	-80
ER Visits	4,821	4,765	56	76	40
Office Visits	5,437	5,345	91	128	68
Rx Fills	8,655	8,788	-134	-173	-92
Other	24,924	24,709	215	302	160
Total	**62,333**	**62,255**	**78**	**122**	**65**

Source: IHS Markit analysis of the Health Security Plan.

Notes: In the "1% Pay Reduction" scenarios, we grew provider and facility payment rates by CPI-M – 1 percentage point. Totals may not add up due to rounding.

In principle, these effects can also generate "induced" spending of the additional incomes earned by newly employed workers, which would further expand the state economy. But the requirement of budget balance for governments and households requires that, in order to finance HSP spending, there must be corresponding reductions in other state spending or tax increases. If the former, the economic impact of those spending reductions would generate the same reduction in induced spending. Similarly, in the latter case, tax increases would have offsetting negative spending impacts. These direct spending flows enable and encourage employment and income responses from suppliers of the health care providers.

The HSP would replace some of the complex structure of employer-provided health insurance plans as the current balance of insurance cost-sharing shifts between employers and employees. This shift will have implications for the labor market and wage setting. We assumed that labor market adjustments over time, functioning efficiently, will result in wage impacts that, in general, maintain the net-of-insurance costs of both employees and employers. That is, to the extent that employers are relieved of premium costs they will similarly compensate workers at higher wage levels. Of course, there will be a range of outcomes across individual firms and workers of different types, but on average these will offset.

The New Mexico Economy and Tax Impacts. The full economic impacts must consider the competition for resources, especially labor, across the state and the country. The IHS Markit econometric model of the New Mexico economy consists of a series of simultaneous equations, with demand and spending in each sector of the economy a function of household (consumer) income and spending, business (investment or purchases of inputs), and government spending. That spending in turn creates the demand for labor in each sector, which, together with demographics and local labor supply, generates employment and wage and salary income.

Any net changes in business costs or household disposable income have further impacts on economic demand and activity across all sectors, which are captured in our model equations. The economic impact of these changes can be further analyzed through their influence on three sets of economic actors: government, business, and households.

A balanced annual state budget requires any increased spending to be balanced by increased tax revenues. We have calculated the required tax rate increases under various finance plans in order to analyze their impact on business and/or household taxpayers. These rates and tax cost changes have further implications for consumer spending and business activity, as these impacts are estimated by our economic model. Of course, as the HSP decreases business and household health insurance premiums, it may hold them harmless on the net.

Health sector expansion will generate additional state tax revenues based on increased revenue and incomes in the sector. We considered the implications for the tax revenue of the HSP.

- Individual Income Tax. To the extent that payrolls expand with expanded health care under the HSP, the additional income tax collected on wages and salaries is a positive fiscal impact of the program. New Mexico has a progressive income tax with a top marginal rate of 4.9%. As that rate applies for annual incomes above an annual rate of $24,000 (for a household, $16,000 for an individual), most new income will be taxed at that rate. The increased income in the health care sector, plus the

indirectly generated new income in other sectors is estimated to boost tax receipts over 2024 to 2028 by $67 million in Scenario 1, $20 million in Scenario 2, $65 million in Scenario 3, and $20 million in Scenario 4.

Gross Receipts Tax (GRT). Businesses in New Mexico are subject to a 5.135% tax on receipts from sales of goods and services. Some health care providers are exempt from the tax, so the HSP boosts GRT primarily through its effect on indirect spending. The resulting revenues over 2024 to 2028 total $20 million in Scenario 1, $6 million in Scenario 2, $8 million in Scenario 3, and $6 million in Scenario 4.

B. Other Factors

Workers' Compensation. The KNG Health Reform Model uses estimates of economy-wide spending on medical care from all sources. This includes public and private insurance as well as medical care and administrative costs associated with third-party payers, including those paid through workers' compensation and automobile insurance. Employer costs for workers' compensation will decrease to the extent that the medical portion of workers' compensation costs transfers from the workers' compensation ledger to the state budget under the HSP. To the extent that workers' compensation insurance is paid through employer and employee contributions, employees may likewise see a net increase in their paychecks.

Although those costs are factored into the microsimulation model, we did not estimate the magnitude of the reduction in payments by employers, workers, or drivers. The HSA calls for the superintendent of insurance to quantify these savings (HB 295 § 46(A)).

Automobile insurance. Automobile insurance has four basic expense categories:

1. Liability, which includes property and bodily injuries for which the policyholder is legally responsible.
2. Medical payments, which covers medical care for the insured and any passengers.
3. Uninsured motorists, which covers the medical costs associated with injuries due to an uninsured motorist.
4. Physical damage, which covers physical damage to the policyholder's car.

In principle, the HSP could eliminate uninsured motorist coverage because the uninsured motorist will have a primary source of medical care payment, a medical plan most commonly through the HSP. The expanded medical coverage may likewise reduce the cost of medical payments coverage for injuries to the policyholder and passengers, and possibly for any medical liabilities. The cost of automobile insurance is likely to decline, but these categories may not zero out to the extent that some New Mexico residents will remain medically uninsured.

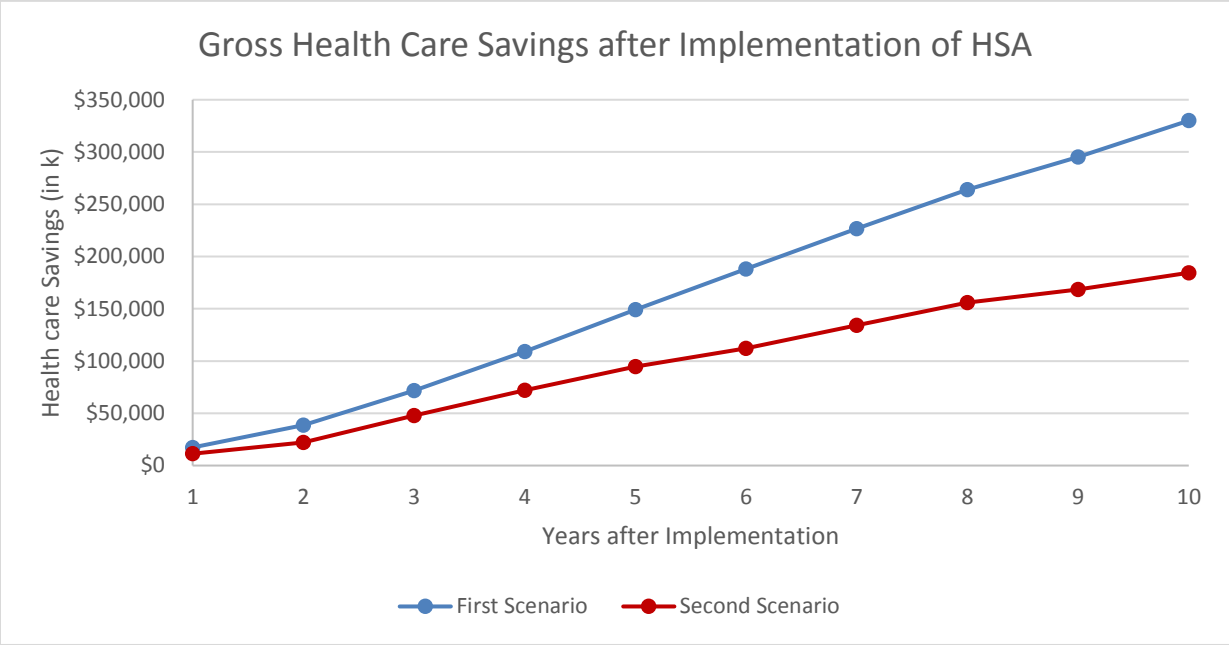
Potential Long Term Health Benefits. Health care expenditure savings may be realized over time as those newly insured by the HSP access preventative care, lowering the costs associated with preventable and manageable diseases. The analytic horizon of the budget impact analysis is only 5 years, while much of

the savings from improved access likely will be realized on a longer time horizon. IHS Markit used its Disease Prevention Microsimulation Model[84] to estimate the long-term effects of expanded coverage and access to preventative services under the HSP. The simulation was run over 10 years for each person in the New Mexico population, once assuming status quo treatments/interventions for the uninsured and again simulating patient-centered, preventative care for the newly insured. The two sets of results were compared to estimate the gains and losses from universal coverage. We assumed that newly insured adults under the HSP get patient-centered care resulting in lower blood pressure and cholesterol, some weight loss, smoking cessation, and better glycemic control (first scenario). An alternate scenario (second scenario) assumed that the patient-centered care resulted only in lower blood pressure and cholesterol, as well as better glycemic control (i.e., factors that could be controlled with medicine and did not require behavioral change).

We examined expected health care savings, household income increase, disability payment savings, and life years saved, by year after implementation of HSA and scenario. After the implementation of the HSA, outcomes increased over the first ten years under the first and second scenarios. The gross savings from such care (noting that the cost to provide this preventative care is included in the simulation output) are estimated to be $149 million over the first five years under the first scenario and $94 million under the second scenario (Figure 6.2). Health care savings over the first 10 years under the first scenario equate to $330 million and $184 million under the second scenario. Better health may be associated with increased productivity for the newly-insured, which could translate into higher income (estimate at over $2.7 billion over 10 years in the first scenario and almost $1.4 billion in the second scenario). More life years are expected to be saved under the first scenario compared to the second scenario. Five years after the implementation of the HSA, the life years saved are 7,931 and 5,820 under the first and second scenarios, respectively (not shown). The life years saved over 10 years under the first and second scenarios increase to 76,657 and 51,755 years, respectively. While the HSP may increase costs to the state, economic and life-year savings from the improved health of newly insured adults could offset some of these costs.

[84] Chen, F. et al. (2019). Ten-year Medicare budget impact of increased coverage for anti-obesity intervention. *Journal of Medical Economic*s 22(10):1096-1104. doi: 10.1080/13696998.2019.1652185.
Su, W. et al. (2018) Where can obesity management policy make the largest impact? Evaluating sub-populations through a microsimulation approach. *Journal of Medical Economics* 21(9):936-943. doi: 10.1080/13696998.2018.1496922.
Su, W. et al. (2016). Return on Investment for Digital behavioral Counseling in Patients with Prediabetes and Cardiovascular Disease. *Preventing Chronic Disease* 13:E13. doi: 10.5888/pcd13.150357.
Semilla, A.P. et al. (2015). Reductions in Mortality among Medicare Beneficiaries Following the Implementation of Medicare Part D. *American Journal of Managed Care* 21(9 Suppl):s165-71.
Dall, T.M., et al. (2015). Value of Lifestyle Intervention to Prevent Diabetes and Sequelae. *American Journal of Preventive Medicine* 48(3):271-80. doi: 10.1016/j.amepre.2014.10.003.

Figure 6.2. Potential Health Care Savings after Implementation of HSP from Patient-Centered Care*



Source: Analysis by IHS Markit.

Notes: *First Scenario: We assumed that newly insured adults under the HSP get patient-centered care resulting in lower blood pressure and cholesterol, some weight loss, smoking cessation, and better glycemic control. Second Scenario: We assumed that the patient-centered care resulted only in lower blood pressure and cholesterol, as well as better glycemic control (i.e., factors that could be controlled with medicine and did not require behavioral change).

VII. Discussion

If implemented, the Health Security Act would be the most ambitious state-based health reform ever carried out in the United States. Under the HSP, the state's uninsured rate would likely fall well below 1 percent and the vast majority of the population would receive coverage through a public insurance program. The role of private insurance would be diminished, and some segments of the private insurance market would likely disappear. The HSP would affect access to health care, health care spending, household disposable income, compensation, employment, and public finances. The direction and magnitude of these effects depend on the structure and scope of the HSP and behavioral responses from households, employers, health care facilities, providers, insurance companies, and the state government – all of which are uncertain. As these policies have never been tested in New Mexico or anywhere else in the United States, all predictions of potential effects are inherently speculative.

A. Summary of Key Findings

In this study, we examined the cost of the HSP under different scenarios and whether existing revenues would be sufficient to cover the cost of the plan. The extent to which current revenues are sufficient to cover the cost of the HSP depends on the structure of the plan. In our ESI-comparable scenario with no provider/facility payment reduction, we projected that the HSP would be underfunded by approximately $5.8 billion over the first 5 years. Reducing the growth in provider/facility payment rates from CPI-M to CPI-M minus 1 percentage point would reduce the shortfall by approximately a billion dollars to $4.7 billion (Scenario 2). The funding shortfall would be significantly reduced under an HSP with premium and cost-sharing structures similar to the ACA, due largely to higher premium contributions among those who received ESI in baseline (Scenario 3). Under the ACA-comparable scenario, the shortfall would be eliminated by slowing the growth of provider/facility reimbursements by 1 percentage point below CPI-M (Scenario 4).

In general, we found relatively small economic impacts from the HSP. While overall economic impacts are small, the private insurance industry and its employees would see significant negative impacts as private insurance in the state would be greatly reduced. The HSP would limit the role of private insurers as insurance coverage and associated administrative activities for the HSP are done by the state. As a result, many workers in this industry would likely lose their jobs. While resources currently being devoted towards insurance administration could be redirected towards other productive economic activities, including additional public administrative duties necessary for the operation of HSP, the HSP could produce financial hardship to New Mexican households and businesses associated with the private insurance industry. Across the state, we estimate positive, relatively small economic gains due to higher spending on health care services. Moreover, If administrative costs are compliant with the 5-percent cap established by the HSA, we estimated that total health care spending would be lower with the HSP than under the baseline. With lower health care spending, employers and individuals could spend more on other goods and services that may yield increases in New Mexicans' welfare.

B. Further Considerations and Study Limitations

Our model made several assumptions that drive the overall findings regarding the cost and revenues available to fund the HSP. These key drivers require careful consideration as they affect the feasibility of the HSP.

- **Federal Waivers – Medicaid and Marketplace.** We assumed that New Mexico would receive waivers for Medicaid and the Marketplace to fold these programs into the HSP. Whether the state could obtain such waivers is uncertain. The federal government would, at a minimum, require budget neutrality and likely savings to grant the waivers. We also assumed that Medicaid take-up and enrollment in a Marketplace plan would remain similar to current levels, except for population growth. In other words, we did not assume federal funds are available for those New Mexico residents who are Medicaid-eligible but not enrolled. Federal contributions to cover the cost of the HSP could be increased by increasing enrollment in Medicaid and on Marketplace plans for those eligible for federal financial assistance prior to the implementation of the HSP. In addition, the HSP limits eligibility to those who have resided in the state for at least one year. Many of those who fail the residency requirement may be eligible for federal Marketplace subsidies. The HSP would likely effectively eliminate the ACA Marketplaces, potentially leaving a small number of people unable to access Marketplace coverage or the HSP.

- **Continuation of ACA and Federal Funding.** Our results assumed that the ACA and associated federal funding will continue to be available to the state. Under the ACA, the federal Medicaid matching rate applied for newly eligible adults under Medicaid expansion is 90 percent for 2020 and beyond. In addition, the ACA provides federal financial assistance to those eligible on the Marketplace. Together, these federal assistance programs contribute an estimated $2.1 billion to New Mexico.[85] California v. Texas, a pending case before the Supreme Court, could potentially strike down the entire ACA as unconstitutional. If this did occur, the impact on HSP funding would depend on what, if any new program, replacing the ACA.

- **Eligible-but-not-enrolled Populations.** In the status quo, many of those who are currently uninsured are Medicaid-eligible. If those individuals enrolled in Medicaid under current law, the federal government would pay most of the cost. However, as these individuals are not enrolled in Medicaid currently, the state does not currently receive federal funding on their behalf. We assumed the state would not receive additional federal funding if these individuals were enrolled in the HSP. Similarly, we did not assume the state would receive additional federal funding from enrolling individuals eligible for Marketplace subsidies into the HSP. This suggests that the state could reduce the federal shortfall associated with HSP if they improved Medicaid and Marketplace participation rates prior to implementing the reform.

[85] Blumberg, L.J. et al. (2019). *State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA*. Washington, DC: The Urban Institute. https://www.urban.org/research/publication/state-state-estimates-coverage-and-funding-consequences-full-repeal-aca

We found that the HSP would achieve universal coverage among eligible populations. However, in practice, not all eligible individuals and households would choose to enroll. We assumed the state could implement "automatic enrollment," where applicable premiums are collected through state income tax filings, and non-enrolled individuals are covered via retroactive eligibility. However, many uninsured New Mexican residents are already covered through retroactive Medicaid eligibility. Therefore, a significant portion of those we classify as "uninsured" in the baseline, may already meet our coverage definition. In this sense, we may be overstating the coverage gains from the HSP.

- Administrative Savings from the HSP. In our model, a key driver of savings would be reduced state administrative costs. The 2019 HSA introduced legislation that would limit administrative costs of the HSP to no more than 5 percent of total spending starting in the sixth year. We assumed that administrative costs represent 9 percent of total HSP spending in 2024 and fall to 5 percent by 2028. Our assumed administrative cost levels represent significantly lower costs as a percentage of total spending than is currently achieved by the state Medicaid program or by the national Medicare program. Spending on administrative costs accounted for roughly 12.4 percent of total New Mexico Medicaid spending in 2017.[86] According to the National Health Expenditure Accounts from CMS, administrative costs accounted for approximately 7 percent of Medicare spending. In countries with multiple payers but tightly regulated insurance markets, such as Germany, the Netherlands, and Switzerland, administrative costs account for approximately 4 to 5 percent of total spending.[87]

- Tax Treatment for Employer and Employee HSP Contributions. There are considerable tax benefits to ESI because contributions by employers are not subject to federal taxes and employee contributions are made using pre-tax dollars, lowering employees' tax liability. We assumed that these tax benefits would also apply under the HSP. Whether such preferential tax benefits would be applied to the HSP is uncertain, although, in prior analyses of health reform in New Mexico, this assumption was viewed as reasonable.[88] The tax treatment of contributions by employers and employees is an important issue that the state would need to resolve.

- Employee Retirement Income Security Act (ERISA) Compliance Plan. In our analysis, we assumed that the state would be able to develop an ERISA-compliant approach whereby the state would collect funds through a payroll fee on employers whose employees obtain coverage through the HSP. We also considered an alternative scenario where the HSP is funded, in part, through a payroll tax on all employers. ERISA's "preemption clause" limits the ability of the state to make laws governing ESI to the extent that they "relate to" employer-sponsored health plans. We sought information on the

[86] New Mexico Legislative Finance Committee. (2019). *Medicaid Spending on Program and Managed Care Administration*. New Mexico Legislative Finance Committee. https://www.nmlegis.gov/Entity/LFC/Documents/Health_Notes/Health%20Notes%20-%20Medicaid%20Administrative%20Costs,%20May%202019.pdf

[87] Washington State Institute for Public Policy. Single-Payer and Universal Coverage Health Systems: Final Report. May 2019. http://www.wsipp.wa.gov/ReportFile/1705/Wsipp_Single-Payer-and-Universal-Coverage-Health-Systems-Final-Report_Report.pdf

[88] Chollet, D., Liu, S., Gillia, B et al. Quantitative and Comparative Analysis of Reform Options for Extending Health care Coverage in New Mexico. July 31, 2007. Final Report. Mathematica Policy Research, Inc.

likelihood that our assumptions would be consistent with ERISA. While no definitive conclusions were drawn, a general view could be surmised that it may be possible to design approaches that are materially similar to those assumed. This view is consistent with the approach followed by Mathematica Policy Research in its assessment of health care reform options for extending coverage in New Mexico.[88] Nevertheless, the development of ERISA-compliant approaches to implement the HSP and achieve its goals could face legal challenges, which were not addressed in our study.

C. Conclusion

Our analysis found that the HSP would create near-universal health insurance coverage in New Mexico. The plan would also improve health care affordability for low- and middle-income households that would otherwise receive coverage through the non-group market. Usage of health care services would increase, but total health care spending would fall due to reductions in payer-side administrative costs. Most of the cost of the HSP could be financed by redirecting public funding from duplicative health programs, requiring contributions from employers not offering coverage, and requiring beneficiaries with means to pay a portion of their own premium costs. Still, additional funding sources may be needed to fully cover the cost of the program, depending on the structure of the plan.

VIII. Appendices

A. Detailed Results Tables for Scenarios

Table A1.1. Coverage Impact of Health Security Plan by Year (in Thousands) (Scenario 1: ESI-Comparable, No Pay Reduction)

Year	Coverage	Baseline	Post	# Impact	% Impact
2024	ESI	751	307	-444	-59%
	Medicaid	696	13	-682	-98%
	Non-Group	66	0	-66	-100%
	Uninsured	188	4	-183	-98%
	HSP	0	1,375	1,375	
2025	ESI	748	306	-443	-59%
	Medicaid	694	13	-681	-98%
	Non-Group	65	0	-65	-100%
	Uninsured	187	4	-182	-98%
	HSP	0	1,371	1,371	
2026	ESI	745	304	-441	-59%
	Medicaid	694	13	-680	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	186	4	-181	-98%
	HSP	0	1,367	1,367	
2027	ESI	742	279	-463	-62%
	Medicaid	693	13	-679	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	185	4	-180	-98%
	HSP	0	1,386	1,386	
2028	ESI	740	300	-439	-59%
	Medicaid	691	13	-678	-98%
	Non-Group	63	0	-63	-100%
	Uninsured	184	4	-179	-98%
	HSP	0	1,360	1,360	

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan

Table A1.2. Total Volume of Services by Category, Coverage and Year (Scenario 1: ESI-Comparable, No Pay Reduction)

		Baseline (thousands)					Post (thousands)				
Year	Coverage	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	18	49	105	1,105	2,880
	Medicaid	69	54	391	3,160	5,590	1	1	8	66	109
	Non-Group	4	14	20	248	813	0	0	0	0	0
	Uninsured	9	21	53	420	1,542	0	1	1	10	36
	HSP	0	0	0	0	0	109	169	636	5,608	12,545
2025	ESI	46	126	265	2,741	7,285	19	49	106	1,119	2,908
	Medicaid	70	55	398	3,206	5,667	1	1	8	68	112
	Non-Group	4	14	20	248	811	0	0	0	0	0
	Uninsured	9	21	54	424	1,557	0	1	1	10	36
	HSP	0	0	0	0	0	110	171	646	5,679	12,672
2026	ESI	46	127	269	2,771	7,341	19	50	108	1,130	2,931
	Medicaid	71	56	405	3,254	5,746	1	1	8	69	114
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	429	1,571	0	0	1	10	35
	HSP	0	0	0	0	0	112	172	656	5,752	12,799
2027	ESI	47	128	272	2,798	7,390	17	46	101	1,052	2,716
	Medicaid	72	57	411	3,299	5,821	1	1	8	70	116
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	433	1,585	0	0	1	10	35
	HSP	0	0	0	0	0	115	178	674	5,911	13,159
2028	ESI	47	129	276	2,827	7,444	19	50	110	1,147	2,951
	Medicaid	73	58	418	3,344	5,892	1	1	8	71	117
	Non-Group	4	14	20	250	809	0	0	0	0	0
	Uninsured	9	22	56	437	1,597	0	0	1	10	34
	HSP	0	0	0	0	0	114	176	676	5,893	13,057

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Volume of services change, in part, because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A1.3. Total Volume of Services by Category, Baseline Coverage and Year (Scenario 1: ESI-Comparable, No Pay Reduction)

Year	Baseline Coverage	Baseline (thousands)					Post (thousands)				
		Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	45	124	265	2,751	7,325
	Medicaid	69	54	391	3,160	5,590	68	53	391	3,160	5,590
	Non-Group	4	14	20	248	813	4	15	22	278	913
	Uninsured	9	21	53	420	1,542	11	27	72	601	1,743
2025	ESI	46	126	265	2,741	7,285	46	125	269	2,784	7,390
	Medicaid	70	55	398	3,206	5,667	69	54	398	3,206	5,667
	Non-Group	4	14	20	248	811	4	15	22	279	911
	Uninsured	9	21	54	424	1,557	11	28	73	608	1,760
2026	ESI	46	127	269	2,771	7,341	46	126	273	2,814	7,447
	Medicaid	71	56	405	3,254	5,746	70	55	405	3,254	5,746
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	429	1,571	11	28	74	614	1,776
2027	ESI	47	128	272	2,798	7,390	47	127	276	2,843	7,503
	Medicaid	72	57	411	3,299	5,821	71	56	411	3,299	5,821
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	433	1,585	11	28	74	620	1,791
2028	ESI	47	129	276	2,827	7,444	47	128	280	2,871	7,553
	Medicaid	73	58	418	3,344	5,892	72	56	418	3,344	5,892
	Non-Group	4	14	20	250	809	4	15	23	281	909
	Uninsured	9	22	56	437	1,597	12	28	75	626	1,805

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Volume of services change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A1.4. Total Spending by Service Category, Coverage and Year (Scenario 1: ESI-Comparable, No Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Coverage	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total
2024	ESI	1,005	625	574	390	884	2,282	658	6,419	396	244	227	159	355	900	220	2,501
	Medicaid	914	492	216	501	463	1,873	631	5,090	16	10	4	10	9	40	13	102
	Non-Group	106	68	47	36	94	223	107	680	0	0	0	0	0	0	0	0
	Uninsured	213	34	39	61	192	191	0	730	3	1	1	1	4	4	0	15
	HSP	0	0	0	0	0	0	0	0	1,852	963	669	851	1,262	3,743	882	10,223
2025	ESI	1,043	648	598	405	916	2,369	683	6,663	412	253	236	165	369	935	229	2,599
	Medicaid	950	512	226	522	481	1,952	656	5,299	16	11	5	11	9	42	13	106
	Non-Group	108	69	49	37	96	229	109	697	0	0	0	0	0	0	0	0
	Uninsured	221	35	41	63	199	198	0	757	3	1	1	2	4	5	0	15
	HSP	0	0	0	0	0	0	0	0	1,921	999	697	885	1,309	3,888	805	10,503
2026	ESI	1,082	671	622	420	949	2,458	709	6,911	427	262	246	171	382	970	237	2,695
	Medicaid	988	532	236	543	500	2,034	684	5,518	17	11	5	11	9	43	14	111
	Non-Group	111	71	50	38	99	235	112	718	0	0	0	0	0	0	0	0
	Uninsured	229	36	43	65	206	205	0	785	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	1,994	1,036	725	920	1,357	4,041	724	10,797
2027	ESI	1,122	696	648	437	984	2,552	736	7,174	405	251	236	164	365	931	226	2,578
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	17	12	5	12	10	45	14	116
	Non-Group	114	73	52	39	102	243	116	739	0	0	0	0	0	0	0	0
	Uninsured	238	38	44	68	214	213	0	815	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	2,112	1,098	775	971	1,439	4,284	650	11,329
2028	ESI	1,164	721	675	453	1,019	2,648	764	7,445	457	280	265	184	407	1,039	252	2,883
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	18	12	5	12	10	47	15	120
	Non-Group	118	75	54	40	105	250	119	761	0	0	0	0	0	0	0	0
	Uninsured	246	39	46	70	222	221	0	844	4	1	1	2	5	5	0	16
	HSP	0	0	0	0	0	0	0	0	2,156	1,119	788	996	1,463	4,376	548	11,446

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Total spending may change because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A1.5. Total Spending by Service Category, Baseline Coverage and Year (Scenario 1: ESI-Comparable, No Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Baseline Coverage	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total
2024	Employer	1,005	625	574	390	884	2,282	658	6,419	850	430	427	346	764	1,725	415	4,957
	Medicaid	914	492	216	501	463	1,873	631	5,090	1,001	681	349	574	620	2,481	568	6,274
	Non-Group	106	68	47	36	94	223	107	680	87	36	30	32	80	145	34	443
	Uninsured	213	34	39	61	192	191	0	730	330	71	96	69	166	336	98	1,166
2025	Employer	1,043	648	598	405	916	2,369	683	6,663	883	446	445	359	792	1,790	406	5,121
	Medicaid	950	512	226	522	481	1,952	656	5,299	1,040	707	363	598	645	2,583	521	6,457
	Non-Group	108	69	49	37	96	229	109	697	89	37	31	33	82	148	30	450
	Uninsured	221	35	41	63	199	198	0	757	342	73	100	72	172	348	89	1,196
2026	Employer	1,082	671	622	420	949	2,458	709	6,911	915	461	462	373	819	1,856	396	5,283
	Medicaid	988	532	236	543	500	2,034	684	5,518	1,081	735	379	623	670	2,690	471	6,649
	Non-Group	111	71	50	38	99	235	112	718	91	38	32	34	84	153	27	459
	Uninsured	229	36	43	65	206	205	0	785	354	76	103	75	178	361	80	1,227
2027	Employer	1,122	696	648	437	984	2,552	736	7,174	943	470	476	385	844	1,904	374	5,397
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	1,133	772	400	651	701	2,824	421	6,902
	Non-Group	114	73	52	39	102	243	116	739	94	40	33	35	87	158	24	471
	Uninsured	238	38	44	68	214	213	0	815	368	80	109	78	186	378	71	1,268
2028	Employer	1,164	721	675	453	1,019	2,648	764	7,445	984	495	500	402	879	1,997	372	5,630
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	1,173	796	413	676	725	2,921	362	7,066
	Non-Group	118	75	54	40	105	250	119	761	97	40	34	36	89	162	20	478
	Uninsured	246	39	46	70	222	221	0	844	380	82	112	80	191	388	60	1,293

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Spending may change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A1.6. HSP Spending and Sources of Revenue by Year ($ in Millions) (Scenario 1: ESI-Comparable, No Pay Reduction)

Year	Health Security Plan Benefits and Admin.	Premiums Paid by Beneficiaries	Employer Contribution	Available Federal Funding	Available State Funding	Net State Income Taxes	Net Health Insurance Taxes	Budget Impact (Positive Values = Unfunded)
2024	9,796	951	1,627	4,096	2,062	9	-290	1,341
2025	10,062	1,004	1,689	4,262	2,143	8	-302	1,256
2026	10,340	1,060	1,752	4,439	2,230	8	-314	1,165
2027	10,832	1,166	1,956	4,629	2,337	12	-329	1,061
2028	10,955	1,183	1,897	4,820	2,415	4	-340	976
Overall	**51,985**	**5,364**	**8,922**	**22,246**	**11,188**	**41**	**-1,575**	**5,799**

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: Health Security Plan Benefits and Administration reflects spending for HSP only and will not match prior tables, which report total health care spending in New Mexico.

Table A2.1. Coverage Impact of Health Security Plan by Year (in Thousands) (Scenario 2: ESI-Comparable, 1% Pay Reduction)

Year	Coverage	Baseline	Post	# Impact	% Impact
2024	ESI	751	307	-444	-59%
	Medicaid	696	13	-682	-98%
	Non-Group	66	0	-66	-100%
	Uninsured	188	4	-183	-98%
	HSP	0	1,375	1,375	
2025	ESI	748	306	-443	-59%
	Medicaid	694	13	-681	-98%
	Non-Group	65	0	-65	-100%
	Uninsured	187	4	-182	-98%
	HSP	0	1,371	1,371	
2026	ESI	745	304	-441	-59%
	Medicaid	694	13	-680	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	186	4	-181	-98%
	HSP	0	1,367	1,367	
2027	ESI	742	279	-463	-62%
	Medicaid	693	13	-679	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	185	4	-180	-98%
	HSP	0	1,386	1,386	
2028	ESI	740	279	-461	-62%
	Medicaid	691	13	-678	-98%
	Non-Group	63	0	-63	-100%
	Uninsured	184	4	-179	-98%
	HSP	0	1,381	1,381	

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan.

Table A2.2. Total Volume of Services by Category, Coverage and Year (Scenario 2: ESI-Comparable, 1% Pay Reduction)

		Baseline (thousands)					Post (thousands)				
Year	Coverage	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	18	49	105	1,105	2,880
	Medicaid	69	54	391	3,160	5,590	1	1	8	66	109
	Non-Group	4	14	20	248	813	0	0	0	0	0
	Uninsured	9	21	53	420	1,542	0	1	1	10	36
	HSP	0	0	0	0	0	109	169	636	5,608	12,545
2025	ESI	46	126	265	2,741	7,285	19	49	106	1,119	2,908
	Medicaid	70	55	398	3,206	5,667	1	1	8	68	112
	Non-Group	4	14	20	248	811	0	0	0	0	0
	Uninsured	9	21	54	424	1,557	0	1	1	10	36
	HSP	0	0	0	0	0	110	171	646	5,679	12,672
2026	ESI	46	127	269	2,771	7,341	19	50	108	1,130	2,931
	Medicaid	71	56	405	3,254	5,746	1	1	8	69	114
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	429	1,571	0	0	1	10	35
	HSP	0	0	0	0	0	112	172	656	5,752	12,799
2027	ESI	47	128	272	2,798	7,390	17	46	101	1,051	2,716
	Medicaid	72	57	411	3,299	5,821	1	1	8	70	116
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	433	1,585	0	0	1	10	35
	HSP	0	0	0	0	0	115	178	674	5,911	13,160
2028	ESI	47	129	276	2,827	7,444	18	47	102	1,072	2,729
	Medicaid	73	58	418	3,344	5,892	1	1	8	71	117
	Non-Group	4	14	20	250	809	0	0	0	0	0
	Uninsured	9	22	56	437	1,597	0	0	1	10	34
	HSP	0	0	0	0	0	116	180	684	5,971	13,284

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Volume of services change, in part, because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A2.3. Total Volume of Services by Category, Baseline Coverage and Year (Scenario 2: ESI-Comparable, 1% Pay Reduction)

		Baseline (thousands)					Post (thousands)				
Year	Coverage	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	45	124	265	2,751	7,325
	Medicaid	69	54	391	3,160	5,590	68	53	391	3,160	5,590
	Non-Group	4	14	20	248	813	4	15	22	278	913
	Uninsured	9	21	53	420	1,542	11	27	72	601	1,743
2025	ESI	46	126	265	2,741	7,285	46	125	269	2,784	7,390
	Medicaid	70	55	398	3,206	5,667	69	54	398	3,206	5,667
	Non-Group	4	14	20	248	811	4	15	22	279	911
	Uninsured	9	21	54	424	1,557	11	28	73	608	1,760
2026	ESI	46	127	269	2,771	7,341	46	126	273	2,814	7,447
	Medicaid	71	56	405	3,254	5,746	70	55	405	3,254	5,746
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	429	1,571	11	28	74	614	1,776
2027	ESI	47	128	272	2,798	7,390	47	127	276	2,843	7,503
	Medicaid	72	57	411	3,299	5,821	71	56	411	3,299	5,821
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	433	1,585	11	28	74	620	1,791
2028	ESI	47	129	276	2,827	7,444	47	128	280	2,873	7,558
	Medicaid	73	58	418	3,344	5,892	72	56	418	3,344	5,892
	Non-Group	4	14	20	250	809	4	15	23	281	909
	Uninsured	9	22	56	437	1,597	12	28	75	626	1,805

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Volume of services change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A2.4. Total Spending by Service Category, Coverage and Year (Scenario 2: ESI-Comparable, 1% Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Coverage	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total
2024	ESI	1,005	625	574	390	884	2,282	658	6,419	396	244	227	159	355	900	220	2,501
	Medicaid	914	492	216	501	463	1,873	631	5,090	16	10	4	10	9	40	13	102
	Non-Group	106	68	47	36	94	223	107	680	0	0	0	0	0	0	0	0
	Uninsured	213	34	39	61	192	191	0	730	3	1	1	1	4	4	0	15
	HSP	0	0	0	0	0	0	0	0	1,852	963	669	851	1,262	3,743	882	10,223
2025	ESI	1,043	648	598	405	916	2,369	683	6,663	412	253	236	165	369	935	229	2,599
	Medicaid	950	512	226	522	481	1,952	656	5,299	16	11	5	11	9	42	13	106
	Non-Group	108	69	49	37	96	229	109	697	0	0	0	0	0	0	0	0
	Uninsured	221	35	41	63	199	198	0	757	3	1	1	2	4	5	0	15
	HSP	0	0	0	0	0	0	0	0	1,902	989	690	876	1,295	3,849	797	10,398
2026	ESI	1,082	671	622	420	949	2,458	709	6,911	427	262	246	171	382	970	237	2,695
	Medicaid	988	532	236	543	500	2,034	684	5,518	17	11	5	11	9	43	14	111
	Non-Group	111	71	50	38	99	235	112	718	0	0	0	0	0	0	0	0
	Uninsured	229	36	43	65	206	205	0	785	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	1,954	1,016	711	901	1,330	3,961	709	10,582
2027	ESI	1,122	696	648	437	984	2,552	736	7,174	405	251	236	164	365	930	226	2,578
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	17	12	5	12	10	45	14	116
	Non-Group	114	73	52	39	102	243	116	739	0	0	0	0	0	0	0	0
	Uninsured	238	38	44	68	214	213	0	815	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	2,049	1,065	752	942	1,396	4,157	631	10,993
2028	ESI	1,164	721	675	453	1,019	2,648	764	7,445	427	260	246	171	376	966	234	2,680
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	18	12	5	12	10	47	15	120
	Non-Group	118	75	54	40	105	250	119	761	0	0	0	0	0	0	0	0
	Uninsured	246	39	46	70	222	221	0	844	4	1	1	2	5	5	0	16
	HSP	0	0	0	0	0	0	0	0	2,099	1,094	775	968	1,434	4,275	534	11,180

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Total spending may change because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A2.5. Total Spending by Service Category, Baseline Coverage and Year (Scenario 2: ESI-Comparable, 1% Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Coverage	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total
2024	Employer	1,005	625	574	390	884	2,282	658	6,419	850	430	427	346	764	1,725	415	4,957
	Medicaid	914	492	216	501	463	1,873	631	5,090	1,001	681	349	574	620	2,481	568	6,274
	Non-Group	106	68	47	36	94	223	107	680	87	36	30	32	80	145	34	443
	Uninsured	213	34	39	61	192	191	0	730	330	71	96	69	166	336	98	1,166
2025	Employer	1,043	648	598	405	916	2,369	683	6,663	878	444	443	357	787	1,782	404	5,095
	Medicaid	950	512	226	522	481	1,952	656	5,299	1,030	700	360	592	638	2,557	516	6,393
	Non-Group	108	69	49	37	96	229	109	697	88	37	30	32	81	147	30	446
	Uninsured	221	35	41	63	199	198	0	757	338	73	99	71	170	345	88	1,184
2026	Employer	1,082	671	622	420	949	2,458	709	6,911	905	457	458	369	811	1,839	393	5,232
	Medicaid	988	532	236	543	500	2,034	684	5,518	1,060	721	372	610	657	2,637	462	6,519
	Non-Group	111	71	50	38	99	235	112	718	90	37	31	33	83	150	26	450
	Uninsured	229	36	43	65	206	205	0	785	347	75	101	73	175	354	78	1,202
2027	Employer	1,122	696	648	437	984	2,552	736	7,174	927	464	469	379	830	1,875	370	5,313
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	1,099	750	389	632	680	2,742	409	6,701
	Non-Group	114	73	52	39	102	243	116	739	92	38	32	34	85	154	23	457
	Uninsured	238	38	44	68	214	213	0	815	358	77	105	75	180	366	69	1,231
2028	Employer	1,164	721	675	453	1,019	2,648	764	7,445	957	477	485	391	854	1,934	356	5,454
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	1,131	772	401	651	700	2,826	350	6,832
	Non-Group	118	75	54	40	105	250	119	761	93	39	33	35	86	157	19	462
	Uninsured	246	39	46	70	222	221	0	844	366	79	108	77	185	376	58	1,250

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Spending may change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A2.6. HSP Spending and Sources of Revenue by Year ($ in Millions) (Scenario 2: ESI-Comparable, 1% Pay Reduction)

Year	Health Security Plan Benefits and Admin.	Premiums Paid by Beneficiaries	Employer Contributions	Available Federal Funding	Available State Funding	Net State Income Taxes	Net Health Insurance Taxes	Unfunded
2024	9,796	951	1,627	4,096	2,062	9	-290	1,341
2025	9,961	1,004	1,689	4,262	2,143	8	-302	1,155
2026	10,135	1,060	1,752	4,439	2,230	8	-314	959
2027	10,511	1,166	1,956	4,629	2,337	12	-329	740
2028	10,688	1,227	2,020	4,820	2,428	8	-342	528
Overall	**51,089**	**5,408**	**9,044**	**22,246**	**11,200**	**45**	**-1,577**	**4,723**

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: Health Security Plan Benefits and Administration reflects spending for HSP only and will not match prior tables, which report total health care spending in New Mexico.

Table A3.1. Coverage Impact of Health Security Plan by Year (in Thousands) (Scenario 3: ACA-Comparable, No Pay Reduction)

Year	Coverage	Baseline	Post	# Impact	% Impact
2024	ESI	751	370	-381	-51%
	Medicaid	696	13	-682	-98%
	Non-Group	66	0	-66	-100%
	Uninsured	188	4	-183	-98%
	HSP	0	1,313	1,313	
2025	ESI	748	368	-380	-51%
	Medicaid	694	13	-681	-98%
	Non-Group	65	0	-65	-100%
	Uninsured	187	4	-182	-98%
	HSP	0	1,308	1,308	
2026	ESI	745	367	-378	-51%
	Medicaid	694	13	-680	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	186	4	-181	-98%
	HSP	0	1,304	1,304	
2027	ESI	742	365	-377	-51%
	Medicaid	693	13	-679	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	185	4	-180	-98%
	HSP	0	1,301	1,301	
2028	ESI	740	364	-376	-51%
	Medicaid	691	13	-678	-98%
	Non-Group	63	0	-63	-100%
	Uninsured	184	4	-179	-98%
	HSP	0	1,296	1,296	

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan

Table A3.2. Total Volume of Services by Category, Coverage and Year (Scenario 3: ACA-Comparable, No Pay Reduction)

		Baseline (thousands)					Post (thousands)				
Year	Coverage	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	22	59	126	1,337	3,485
	Medicaid	69	54	391	3,160	5,590	1	1	8	66	109
	Non-Group	4	14	20	248	813	0	0	0	0	0
	Uninsured	9	21	53	420	1,542	0	1	1	10	36
	HSP	0	0	0	0	0	105	158	614	5,373	11,930
2025	ESI	46	126	265	2,741	7,285	22	60	129	1,354	3,520
	Medicaid	70	55	398	3,206	5,667	1	1	8	67	112
	Non-Group	4	14	20	248	811	0	0	0	0	0
	Uninsured	9	21	54	424	1,557	0	1	1	10	36
	HSP	0	0	0	0	0	106	160	624	5,441	12,049
2026	ESI	46	127	269	2,771	7,341	23	60	130	1,369	3,547
	Medicaid	71	56	405	3,254	5,746	1	1	8	68	113
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	429	1,571	0	0	1	10	35
	HSP	0	0	0	0	0	108	162	634	5,510	12,173
2027	ESI	47	128	272	2,798	7,390	23	61	132	1,381	3,572
	Medicaid	72	57	411	3,299	5,821	1	1	8	69	115
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	433	1,585	0	0	1	10	35
	HSP	0	0	0	0	0	109	163	643	5,576	12,288
2028	ESI	47	129	276	2,827	7,444	23	61	134	1,396	3,601
	Medicaid	73	58	418	3,344	5,892	1	1	8	70	116
	Non-Group	4	14	20	250	809	0	0	0	0	0
	Uninsured	9	22	56	437	1,597	0	0	1	10	34
	HSP	0	0	0	0	0	111	165	652	5,641	12,396

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Volume of services change, in part, because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A3.3. Total Volume of Services by Category, Baseline Coverage and Year (Scenario 3: ACA-Comparable, No Pay Reduction)

		Baseline (thousands)					Post (thousands)				
Year	Coverage	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	45	124	264	2,747	7,314
	Medicaid	69	54	391	3,160	5,590	68	53	391	3,160	5,590
	Non-Group	4	14	20	248	813	4	15	22	278	913
	Uninsured	9	21	53	420	1,542	11	27	72	601	1,743
2025	ESI	46	126	265	2,741	7,285	46	125	268	2,780	7,379
	Medicaid	70	55	398	3,206	5,667	69	54	398	3,206	5,667
	Non-Group	4	14	20	248	811	4	15	22	279	911
	Uninsured	9	21	54	424	1,557	11	28	73	608	1,760
2026	ESI	46	127	269	2,771	7,341	46	126	272	2,810	7,436
	Medicaid	71	56	405	3,254	5,746	70	55	405	3,254	5,746
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	429	1,571	11	28	74	614	1,776
2027	ESI	47	128	272	2,798	7,390	47	127	276	2,837	7,486
	Medicaid	72	57	411	3,299	5,821	71	56	411	3,299	5,821
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	433	1,585	11	28	74	620	1,791
2028	ESI	47	129	276	2,827	7,444	47	128	280	2,867	7,541
	Medicaid	73	58	418	3,344	5,892	72	56	418	3,344	5,892
	Non-Group	4	14	20	250	809	4	15	23	281	909
	Uninsured	9	22	56	437	1,597	12	28	75	626	1,805

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Volume of services change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A3.4. Total Spending by Service Category, Coverage and Year (Scenario 3: ACA-Comparable, No Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Coverage	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total
2024	ESI	1,005	625	574	390	884	2,282	658	6,419	474	294	273	192	429	1,087	263	3,012
	Medicaid	914	492	216	501	463	1,873	631	5,090	16	10	4	10	9	40	13	101
	Non-Group	106	68	47	36	94	223	107	680	0	0	0	0	0	0	0	0
	Uninsured	213	34	39	61	192	191	0	730	3	1	1	1	4	4	0	15
	HSP	0	0	0	0	0	0	0	0	1,774	913	623	818	1,191	3,551	818	9,687
2025	ESI	1,043	648	598	405	916	2,369	683	6,663	493	305	285	200	445	1,130	274	3,131
	Medicaid	950	512	226	522	481	1,952	656	5,299	16	11	5	11	9	41	13	106
	Non-Group	108	69	49	37	96	229	109	697	0	0	0	0	0	0	0	0
	Uninsured	221	35	41	63	199	198	0	757	3	1	1	2	4	5	0	15
	HSP	0	0	0	0	0	0	0	0	1,840	946	648	850	1,234	3,689	747	9,954
2026	ESI	1,082	671	622	420	949	2,458	709	6,911	512	316	296	207	461	1,172	283	3,247
	Medicaid	988	532	236	543	500	2,034	684	5,518	17	11	5	11	9	43	14	110
	Non-Group	111	71	50	38	99	235	112	718	0	0	0	0	0	0	0	0
	Uninsured	229	36	43	65	206	205	0	785	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	1,909	982	675	884	1,280	3,834	672	10,235
2027	ESI	1,122	696	648	437	984	2,552	736	7,174	529	327	308	215	478	1,216	293	3,367
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	17	12	5	12	10	45	14	115
	Non-Group	114	73	52	39	102	243	116	739	0	0	0	0	0	0	0	0
	Uninsured	238	38	44	68	214	213	0	815	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	1,987	1,020	703	920	1,328	3,990	593	10,541
2028	ESI	1,164	721	675	453	1,019	2,648	764	7,445	549	340	321	223	496	1,263	304	3,496
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	18	12	5	12	10	47	15	120
	Non-Group	118	75	54	40	105	250	119	761	0	0	0	0	0	0	0	0
	Uninsured	246	39	46	70	222	221	0	844	4	1	1	2	5	5	0	16
	HSP	0	0	0	0	0	0	0	0	2,063	1,059	731	956	1,377	4,147	508	10,841

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Total spending may change because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A3.5. Total Spending by Service Category, Baseline Coverage and Year (Scenario 3: ACA-Comparable, No Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Coverage	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total
2024	Employer	1,005	625	574	390	884	2,282	658	6,419	865	451	442	351	776	1,783	413	5,081
	Medicaid	914	492	216	501	463	1,873	631	5,090	990	663	338	570	613	2,429	558	6,160
	Non-Group	106	68	47	36	94	223	107	680	86	35	29	32	79	141	29	432
	Uninsured	213	34	39	61	192	191	0	730	326	69	93	69	164	328	94	1,143
2025	Employer	1,043	648	598	405	916	2,369	683	6,663	897	467	460	365	805	1,851	410	5,255
	Medicaid	950	512	226	522	481	1,952	656	5,299	1,029	688	352	593	637	2,529	512	6,340
	Non-Group	108	69	49	37	96	229	109	697	88	36	30	33	81	145	27	439
	Uninsured	221	35	41	63	199	198	0	757	338	72	96	71	170	340	85	1,173
2026	Employer	1,082	671	622	420	949	2,458	709	6,911	931	484	478	379	833	1,919	406	5,430
	Medicaid	988	532	236	543	500	2,034	684	5,518	1,070	715	367	618	662	2,633	463	6,528
	Non-Group	111	71	50	38	99	235	112	718	91	37	31	33	83	149	24	448
	Uninsured	229	36	43	65	206	205	0	785	350	74	100	74	176	352	76	1,203
2027	Employer	1,122	696	648	437	984	2,552	736	7,174	965	501	498	393	863	1,991	401	5,612
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	1,116	745	384	644	689	2,745	411	6,733
	Non-Group	114	73	52	39	102	243	116	739	93	38	32	35	86	154	21	457
	Uninsured	238	38	44	68	214	213	0	815	363	77	104	77	183	366	67	1,236
2028	Employer	1,164	721	675	453	1,019	2,648	764	7,445	1,001	519	518	408	894	2,067	397	5,804
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	1,161	774	400	670	716	2,858	355	6,934
	Non-Group	118	75	54	40	105	250	119	761	96	39	33	36	88	158	18	467
	Uninsured	246	39	46	70	222	221	0	844	376	79	108	80	189	379	57	1,268

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Spending may change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A3.6. HSP Spending and Sources of Revenue by Year ($ in Millions) (Scenario 3: ACA-Comparable, No Pay Reduction)

Year	Health Security Plan Benefits and Admin.	Premiums Paid by Beneficiaries	Employer Contributions	Available Federal Funding	Available State Funding	Net State Income Taxes	Net Health Insurance Taxes	Unfunded
2024	9,094	1,722	1,241	4,096	2,031	-26	-284	313
2025	9,341	1,752	1,288	4,262	2,111	-25	-296	249
2026	9,601	1,784	1,339	4,439	2,195	-25	-307	177
2027	9,884	1,819	1,390	4,629	2,287	-25	-320	103
2028	10,161	1,852	1,444	4,820	2,377	-24	-333	26
Overall	**48,082**	**8,929**	**6,702**	**22,246**	**11,002**	**-125**	**-1,540**	**868**

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: Health Security Plan Benefits and Administration reflects spending for HSP only and will not match prior tables, which report total health care spending in New Mexico.

Table A4.1. Coverage Impact of Health Security Plan by Year (in thousand) (Scenario 4: ACA-Comparable, 1% Pay Reduction)

Year	Coverage	Baseline	Post	# Impact	% Impact
2024	ESI	751	370	-381	-51%
	Medicaid	696	13	-682	-98%
	Non-Group	66	0	-66	-100%
	Uninsured	188	4	-183	-98%
	HSP	0	1,313	1,313	
2025	ESI	748	368	-380	-51%
	Medicaid	694	13	-681	-98%
	Non-Group	65	0	-65	-100%
	Uninsured	187	4	-182	-98%
	HSP	0	1,308	1,308	
2026	ESI	745	367	-379	-51%
	Medicaid	694	13	-680	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	186	4	-181	-98%
	HSP	0	1,305	1,305	
2027	ESI	742	365	-377	-51%
	Medicaid	693	13	-679	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	185	4	-180	-98%
	HSP	0	1,301	1,301	
2028	ESI	740	364	-376	-51%
	Medicaid	691	13	-678	-98%
	Non-Group	63	0	-63	-100%
	Uninsured	184	4	-179	-98%
	HSP	0	1,296	1,296	

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan

Table A4.2. Total Volume of Services by Category, Coverage and Year (Scenario 4: ACA-Comparable, 1% Pay Reduction)

		Baseline (thousands)					Post (thousands)				
Year	Coverage	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	22	59	126	1,337	3,485
	Medicaid	69	54	391	3,160	5,590	1	1	8	66	109
	Non-Group	4	14	20	248	813	0	0	0	0	0
	Uninsured	9	21	53	420	1,542	0	1	1	10	36
	HSP	0	0	0	0	0	105	158	614	5,373	11,930
2025	ESI	46	126	265	2,741	7,285	22	60	128	1,353	3,517
	Medicaid	70	55	398	3,206	5,667	1	1	8	67	112
	Non-Group	4	14	20	248	811	0	0	0	0	0
	Uninsured	9	21	54	424	1,557	0	1	1	10	36
	HSP	0	0	0	0	0	106	160	624	5,441	12,052
2026	ESI	46	127	269	2,771	7,341	23	60	130	1,368	3,546
	Medicaid	71	56	405	3,254	5,746	1	1	8	68	113
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	429	1,571	0	0	1	10	35
	HSP	0	0	0	0	0	108	162	634	5,511	12,174
2027	ESI	47	128	272	2,798	7,390	23	61	132	1,381	3,572
	Medicaid	72	57	411	3,299	5,821	1	1	8	69	115
	Non-Group	4	14	20	249	811	0	0	0	0	0
	Uninsured	9	21	55	433	1,585	0	0	1	10	35
	HSP	0	0	0	0	0	109	163	643	5,576	12,288
2028	ESI	47	129	276	2,827	7,444	23	61	134	1,396	3,601
	Medicaid	73	58	418	3,344	5,892	1	1	8	70	116
	Non-Group	4	14	20	250	809	0	0	0	0	0
	Uninsured	9	22	56	437	1,597	0	0	1	10	34
	HSP	0	0	0	0	0	111	165	652	5,641	12,396

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Volume of services change, in part, because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A4.3. Total Volume of Services by Category, Baseline Coverage and Year (Scenario 4: ACA-Comparable, 1% Pay Reduction)

		Baseline (thousands)					Post (thousands)				
Year	Coverage	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills	Admissions	Outpatient Visits	ER Visits	Office Visits	RX Fills
2024	ESI	45	125	261	2,709	7,221	45	124	264	2,747	7,314
	Medicaid	69	54	391	3,160	5,590	68	53	391	3,160	5,590
	Non-Group	4	14	20	248	813	4	15	22	278	913
	Uninsured	9	21	53	420	1,542	11	27	72	601	1,743
2025	ESI	46	126	265	2,741	7,285	46	125	268	2,780	7,379
	Medicaid	70	55	398	3,206	5,667	69	54	398	3,206	5,667
	Non-Group	4	14	20	248	811	4	15	22	279	911
	Uninsured	9	21	54	424	1,557	11	28	73	608	1,760
2026	ESI	46	127	269	2,771	7,341	46	126	272	2,810	7,436
	Medicaid	71	56	405	3,254	5,746	70	55	405	3,254	5,746
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	429	1,571	11	28	74	614	1,776
2027	ESI	47	128	272	2,798	7,390	47	127	276	2,837	7,486
	Medicaid	72	57	411	3,299	5,821	71	56	411	3,299	5,821
	Non-Group	4	14	20	249	811	4	15	22	280	911
	Uninsured	9	21	55	433	1,585	11	28	74	620	1,791
2028	ESI	47	129	276	2,827	7,444	47	128	280	2,867	7,541
	Medicaid	73	58	418	3,344	5,892	72	56	418	3,344	5,892
	Non-Group	4	14	20	250	809	4	15	23	281	909
	Uninsured	9	22	56	437	1,597	12	28	75	626	1,805

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Volume of services change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A4.4. Total Spending by Service Category, Coverage and Year (Scenario 4: ACA-Comparable, 1% Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Coverage	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total	IP	OP Visits	ER Visits	Office Visits	RX Fills	Other	Admin	Total
2024	ESI	1,005	625	574	390	884	2,282	658	6,419	474	294	273	192	429	1,087	263	3,012
	Medicaid	914	492	216	501	463	1,873	631	5,090	16	10	4	10	9	40	13	101
	Non-Group	106	68	47	36	94	223	107	680	0	0	0	0	0	0	0	0
	Uninsured	213	34	39	61	192	191	0	730	3	1	1	1	4	4	0	15
	HSP	0	0	0	0	0	0	0	0	1,774	913	623	818	1,191	3,551	818	9,687
2025	ESI	1,043	648	598	405	916	2,369	683	6,663	493	305	285	199	445	1,129	273	3,128
	Medicaid	950	512	226	522	481	1,952	656	5,299	16	11	5	11	9	41	13	106
	Non-Group	108	69	49	37	96	229	109	697	0	0	0	0	0	0	0	0
	Uninsured	221	35	41	63	199	198	0	757	3	1	1	2	4	5	0	15
	HSP	0	0	0	0	0	0	0	0	1,822	937	642	841	1,222	3,653	740	9,857
2026	ESI	1,082	671	622	420	949	2,458	709	6,911	511	316	296	207	461	1,171	283	3,245
	Medicaid	988	532	236	543	500	2,034	684	5,518	17	11	5	11	9	43	14	110
	Non-Group	111	71	50	38	99	235	112	718	0	0	0	0	0	0	0	0
	Uninsured	229	36	43	65	206	205	0	785	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	1,872	962	661	866	1,254	3,759	659	10,033
2027	ESI	1,122	696	648	437	984	2,552	736	7,174	529	327	308	215	478	1,216	293	3,367
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	17	12	5	12	10	45	14	115
	Non-Group	114	73	52	39	102	243	116	739	0	0	0	0	0	0	0	0
	Uninsured	238	38	44	68	214	213	0	815	3	1	1	2	4	5	0	16
	HSP	0	0	0	0	0	0	0	0	1,928	990	682	892	1,289	3,872	575	10,228
2028	ESI	1,164	721	675	453	1,019	2,648	764	7,445	549	340	321	223	496	1,263	304	3,496
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	18	12	5	12	10	47	15	120
	Non-Group	118	75	54	40	105	250	119	761	0	0	0	0	0	0	0	0
	Uninsured	246	39	46	70	222	221	0	844	4	1	1	2	5	5	0	16
	HSP	0	0	0	0	0	0	0	0	1,981	1,017	703	918	1,323	3,983	488	10,414

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; HSP = Health Security Plan; Post = Post Policy (HSP) Period. Total spending may change because the number of individuals covered in each coverage group changes between the baseline and post policy period.

Table A4.5. Total Spending by Service Category, Baseline Coverage and Year (Scenario 4: ACA-Comparable, 1% Pay Reduction)

		Baseline ($ millions)								Post ($ millions)							
Year	Coverage	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total
2024	Employer	1,005	625	574	390	884	2,282	658	6,419	865	451	442	351	776	1,783	413	5,081
	Medicaid	914	492	216	501	463	1,873	631	5,090	990	663	338	570	613	2,429	558	6,160
	Non-Group	106	68	47	36	94	223	107	680	86	35	29	32	79	141	29	432
	Uninsured	213	34	39	61	192	191	0	730	326	69	93	69	164	328	94	1,143
2025	Employer	1,043	648	598	405	916	2,369	683	6,663	893	465	458	363	801	1,843	409	5,233
	Medicaid	950	512	226	522	481	1,952	656	5,299	1,019	681	349	587	630	2,504	507	6,278
	Non-Group	108	69	49	37	96	229	109	697	87	36	29	32	80	144	26	435
	Uninsured	221	35	41	63	199	198	0	757	335	71	96	71	168	337	84	1,161
2026	Employer	1,082	671	622	420	949	2,458	709	6,911	922	480	475	375	826	1,904	404	5,385
	Medicaid	988	532	236	543	500	2,034	684	5,518	1,049	701	360	605	649	2,582	454	6,401
	Non-Group	111	71	50	38	99	235	112	718	89	36	30	33	82	146	23	439
	Uninsured	229	36	43	65	206	205	0	785	343	73	98	73	173	346	75	1,179
2027	Employer	1,122	696	648	437	984	2,552	736	7,174	952	496	492	388	852	1,968	398	5,546
	Medicaid	1,031	555	246	567	521	2,122	713	5,756	1,083	723	372	625	669	2,665	399	6,536
	Non-Group	114	73	52	39	102	243	116	739	90	37	31	34	83	149	20	444
	Uninsured	238	38	44	68	214	213	0	815	352	74	101	75	177	355	65	1,200
2028	Employer	1,164	721	675	453	1,019	2,648	764	7,445	983	512	510	401	879	2,035	393	5,713
	Medicaid	1,073	578	257	590	542	2,211	742	5,993	1,116	744	384	644	688	2,747	342	6,665
	Non-Group	118	75	54	40	105	250	119	761	92	38	31	34	85	152	17	448
	Uninsured	246	39	46	70	222	221	0	844	361	76	104	77	182	364	55	1,219

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: ESI = Employer-Sponsored Insurance; Post = Post Policy (HSP) Period. Spending may change, in part, because the type of coverage may change from Baseline Coverage between the baseline and post policy period.

Table A4.6. HSP Spending and Sources of Revenue by Year ($ in Million) (Scenario 4: ACA-Comparable, 1% Pay Reduction)

Year	Health Security Plan Benefits and Admin.	Premiums Paid by Beneficiaries	Employer Contributions	Available Federal Funding	Available State Funding	Net State Income Taxes	Net Health Insurance Taxes	Unfunded
2024	9,094	1,722	1,241	4,096	2,031	-26	-284	313
2025	9,250	1,748	1,291	4,262	2,111	-25	-296	158
2026	9,411	1,774	1,339	4,439	2,195	-25	-307	-4
2027	9,591	1,803	1,390	4,629	2,287	-24	-320	-175
2028	9,761	1,831	1,444	4,820	2,377	-24	-333	-354
Overall	**47,106**	**8,877**	**6,706**	**22,246**	**11,002**	**-123**	**-1,540**	**-62**

Source: KNG Health analysis of the New Mexico Health Security Plan.

Notes: Health Security Plan Benefits and Administration reflects spending for HSP only and will not match prior tables, which report total health care spending in New Mexico.

B. Summary of Comments at March 3, 2020 Public Meeting

We held a public meeting at The University of New Mexico in Albuquerque on December 4, 2019, and a second public meeting in the New Mexico State Capitol in Santa Fe on March 3, 2020. Prior to the second public meeting, we published the analysis plan on our website and accepted written comments on our analysis plan from the end of February through early March. Through the feedback process, commenters raised some issues of concern regarding the fiscal analysis. We provide a summary of the important public comments and our responses to these comments below. The commenters suggested modifications to the fiscal analysis. The suggestions of some commenters were sometimes in conflict with the legal interpretation of the proposal or were impeded by unavailable or inadequate data. In our fiscal analysis, we sought to achieve a balance among the broad range of perspectives that were expressed.

Issue	Public Comments	Response
Provider Supply Constraints	• Concerns were raised that we proposed to limit the volume of health care services under the Health Security Plan to what we estimate the current workforce can meet. Some expressed the view that provider supply/capacity will increase under the HSP because providers will move to the state because of the appeal of a single-payer like system and/or providers will organize and deliver care in a more efficient way, increasing capacity. • Other commenters raised concerns that provider supply would fall under the HSP because of lower reimbursement.	In response to provider comments, we are not incorporating provider supply constraints into our core analysis. Instead, we discussed our assessment of the impact of the HSP on health care workforce supply in the discussion section.

Issue	Public Comments	Response
Administrative Costs and Savings	• Questions were raised regarding our ability to capture current administrative costs (provider side) for New Mexico (NM) providers. Some noted the willingness of the physician association in the state to collect provider administrative costs. Others noted that it is not clear from the analysis plan how we will estimate administrative costs for providers in the baseline. • Some commenters questioned whether any administrative savings would be realized by either the state or providers. Specifically, some commenters pointed out that: (1) there will still be multiple payers in the state (e.g., the HSP, Medicare, plans for those not eligible for the HSP, TPA for self-insured firms, etc.); (2) Administrative costs for private plans in the state are already very low relative to plans in other states; and (3) there have been historical examples of challenges in coordinating administrative functions in the state intended to yield savings to the health care system in the state. • One commenter asked how we would be accounting for the HSP start-up costs. • One commenter noted that health insurers in the state pay for care coordination, provider credentialing, prior authorization review, pharmacy formulary administration, and IT. They noted that these functions and associated costs will be borne by the state under the HSP. • Although the HSP limits administrative costs to the state to no more than 5% of the total cost, one commenter suggested that it would not be reasonable to think that administrative costs would be this low.	The methods section of the paper describes our approach to estimating provider-side administrative costs. However, in our base model, we did not use this information to determine provider payments. We assumed that the HSP administrative costs would fall over time to account for early start-up costs and the HSA's cap on administrative costs at 5 percent by the sixth year of the program. In the discussion section, we put the 5 percent administrative cost in perspective relative to other programs.
Providers and Payments	• Some commenters noted that many providers in the state are struggling financially. They took issue with our proposed assumption that provider reimbursement rates would be reduced for the state to capture administrative savings to providers and help fund the HSP. • Moreover, some commenters noted that the analysis plan did not specify how baseline payments to providers would be estimated. • Some commenters suggested that we should model higher payments for providers, particularly those in rural areas, as is permitted under the HSP. • Some suggested that we not model reduced payments to providers due to administrative savings, while one suggested that we model a shared savings approach. • Some commenters clarified that rates would be negotiated under the HSP between providers and the citizens' commission overseeing the program. One commenter noted that payment mix varies across providers and that this impacts baseline financial status and should be considered when establishing rates under the HSP. • One commenter raised concerns that providers would be allowed to do balance billing and the impact of such actions on the HSP. • One commenter noted that under the HSP there are no provider networks. As a result, those covered under the HSP would have wider access to physicians.	In response to provider comments, we did not assume that health care payments/prices would be reduced by provider administrative savings in the base model. We note that the legislation prohibits balance billing and assumes that HSP beneficiaries would not be subject to balance billing. In our methods section, we described how we established provider payment rates and scaled spending to external administrative data. We conducted sensitivity analyses to estimate the effect of global budgeting and other assumptions on our study findings.

Issue	Public Comments	Response
	• Some commenters indicated that the HSP would apply global budgets to all facilities and not just hospitals. • One commenter suggested that a global budget would result in rationing of care in the state. • One commenter said savings from global budgets would be less than in Maryland because NM has capitated payments, which already incentivizes providers to reduce utilization of services. • One commenter raised concerns on our using 2018 payment rates to establish initial reimbursement values for providers as rates have changed since then; in addition, they asked whether we would use Medicare or Medicaid or something else to establish these initial rates. • One commenter suggested that we rely on CMS data to establish baseline spending in NM or alternative use spending in the state health plan as a proxy.	
Economic Impact	• One commenter noted that we should account for lost premium taxes and lost wages for insurers. • Another commented that the ability to finance the HSP will depend on the economy; asked how will it be impacted by a recession? • One commenter asked whether the economic impact would account for the loss of health insurance jobs as well as spending (grants??) by insurers to non-profits. • One commenter suggested that we needed to include the costs associated with the citizens' commission for the HSP. • One commenter noted that the law requires administrative functions to be done in NM. Currently, insurers in the state provide some functions out of state. The commenter suggested that this change would have an economic impact that should be accounted for.	Our economic impact analysis accounted for reduced private insurance jobs and taxes on premiums. We used IHS Markit's estimates of economic performance for 2024 and beyond.
Revenue Sources – Employer	• Some commenters took issue with our proposed assumption that gaps in funding for the HSA would be modeled as being funded by a payroll tax. Specific concerns included: (1) a payroll tax would be imposed on all employers where the intent of the HSP is to only have employers who are participating in the HSP to contribute to its funding; (2) a payroll tax to close the gap in funding for the HSP would violate ERISA laws. • One commenter disagreed with our assumption that employer contributions would be based on payroll as the HSP indicates that payroll and the number of employees should both be considered when estimating employer contribution. • One commenter noted that the legislation says the fiscal analysis should establish minimum and maximum (caps) on employer and individual contributions.	In response to comments, we did not assume that a general payroll tax would be imposed on all businesses in New Mexico to fund the HSP. Instead, only those employers that participate in the plan and whose employees participate in the HSP were assumed to pay into the system in our base model. We modeled employers as paying a percentage of their payroll to support the HSP and individual contributions are capped as a percentage of their income.

Issue	Public Comments	Response
Premiums	• One commenter asked whether we would differentiate premiums for individuals and household (by size) as is done for the state employees' health plan. • One commenter noted that the premiums based on income for beneficiaries must assume minimum and maximum levels (caps). • One commenter took issue with our approach to calculate premiums, saying that we should calculate public dollars that would be used to offset the cost of the plan and, presumably, use this information in calculating premiums. • One commenter noted that for unionized workers, collective bargaining agreements would dictate what employers contribute to premiums. • One commenter noted that under the HSP, some employees who were previously getting subsidized coverage through their employer will be made worse off under the HSP because their employer will no longer subsidize their premiums.	We estimated premiums on a per person basis. We capped the percentage of a person's income that can be paid for premiums. We considered a number of cost-sharing and premium scenarios, including a scenario that would leave workers, on average, no worse off than in a situation where they received coverage through their employer and where the employer covered a share of their premiums.
Eligibility/Coverage	• Commenters raised questions regarding the treatment of non-citizens in the model, including: (1) whether non-citizens would be eligible for the HSP; (2) how new residents to NM would obtain coverage. The commenters noted that some undocumented immigrants obtain coverage through their employer. In addition, commenters raised concerns on the ability of new employees in the state to obtain coverage, if their employer does not offer coverage under the HSP. • Some commenters were skeptical that the HSP would achieve 100% enrollment, given that many who are eligible for Medicaid or subsidies for a Marketplace plan do not enroll. • Some commenters raised questions as to whether HSP beneficiaries would be able to receive covered services outside of the state. • One commenter noted that individuals who move to the state for employment can be covered by the plan and that their employer will pay a prorated amount. The residency requirement is waived for non-NM residents who work in NM.	We assumed that individuals residing in New Mexico for at least a year or those who moved to the state to take a job would be eligible for the HSP. We assumed retroactive enrollment for individuals eligible for the HSP. However, we recognize that previously uninsured individuals may not access services the same way as an individual that actively seeks insurance or was insured prior to the HSA.
Health care Utilization and Spending	• One commenter raised concern that reductions in the utilization of health care services and other efficiencies may reduce federal funding for the program (e.g., reduce Medicaid funding through the match). The commenter also noted that the legislation intended to prevent that from happening. • One commenter noted the complexity of estimating the effects of gaining coverage or changes in out-of-pocket costs on the utilization of health care services. The commenter suggested that we use the experience under Medicaid expansion in NM to help estimate the potential effects of HSA on the use of health care services. • One commenter noted that the plan envisions savings from bulk purchasing of prescription drugs, but that the analysis plan does not discuss this potential effect.	We assumed that federal funding would remain unchanged under the HSP. We describe our approach for estimating out-of-pocket expenses in our methods. In one of our sensitivity analyses, we assumed that bulk purchasing of drugs would yield additional savings to the state under HSP.

Issue	Public Comments	Response
Operational Challenges	• One commenter noted that ~ 40% of New Mexicans don't submit a tax return. Thus, the commenter questioned the notion that premiums would be collected from those who did not actively enroll. Another commenter suggested that NM has a high rate of tax filers due to low-income rebates.	We assume that the state would develop and implement a retrospective enrollment approach that would also be able to collect any outstanding premiums from HSP beneficiaries.
Benefits	• One commenter raised a question as to whether care provided outside of NM would be covered. • Another commenter noted that the state health plan provides for 2 free dental visits per year but otherwise does not cover dental or vision. In addition, benefits not covered under the HSP could be purchased through a supplemental insurance plan. • One commenter noted that the HSA indicates that preventative services could be provided to everyone in NM, including those not covered by the plan.	We did not assume that individuals not covered by the HSP or some other insurance would receive no-cost preventative services under the HSP. We note that Section 11(L) of the HSA identifies negotiating and contracting with out-of-state providers as one of the responsibilities of the commission overseeing the HSP.
Employer Choice	• One commenter asked that the self-insured and fully-insured employers be modeled and reported separately. • Some commenters stated that the decision to join the HSP is the decision of employers with ERISA plans and not employees at these firms. • One commenter raised the issue of employees at ERISA firms who do not have coverage – either because they refuse the firm insurance options or because they are not eligible for some reason. The commenter indicated that state policymakers will need to figure out how to address these situations and suggested these individuals could be excluded from the analysis. • One commenter noted that many in the state are covered by union health insurance plans and that these unions would decide whether to obtain coverage for their members through the HSP. • One commenter asked how an NM employer would obtain coverage for employees who were working out-of-state as group plans need to be written in the state in which the company is domiciled. The same commenter also asked about out-of-state employers who have employees that work in NM. • One commenter noted that ERISA plans can be created for a subset of workers and that some employers would do this to limit to high-income workers. • One commenter noted that all employers except those covered under ERISA will automatically be enrolled in the HSP – including the employers and employees.	Based on feedback from the LFC staff, we modeled all firms offering self-insured group health plans as participating in the HSP. In other words, we assumed they would drop any independent coverage they were offering and their employees would enroll in the HSP. We modeled the decision of employers with self-insured group health plans to continue to offer a separate plan or, instead have their employees enroll in HSP. As described in our methods, we allowed employees at firms offering a self-insured group health plan to enroll in HSP. The Health Security Act is silent on whether this is allowed, although we received public comments that this was not the intent. Nevertheless, we focused on the plan as described in the Health Security Act and sought guidance from LFC staff when policy assumptions were needed.

Issue	Public Comments	Response
	Moreover, the commenter stated that both beneficiaries and non-ERISA employers would contribute to the plan. • One commenter asked if the model would take into account those who are self-employed.	The model does account for self-employed individuals.
Automobile and Workers' Compensation Insurance	• Some commenters noted that the HSP would lower automobile and workers' compensation insurance costs and asked how we would incorporate them into the analysis.	We discuss the issue of automobile and workers' compensation insurance in the report.
Implementation Date	• Some commenters raised concerns with our modeling assumption that the HSP would be implemented starting with 2021. Instead, they suggested an implementation data of 2024 for modeling purposes.	We assumed the HSP implementation date is 2024.
Revenue Source – Payroll Tax	• One commenter asked what level of payroll tax would be assumed and whom it would apply to (e.g., all firms even those offering coverage).	We estimated the employer contribution based on baseline employer contributions under current law. Based on comments, we assume only employers that participate in the plan contribute to it.
Geographic Variability	• Some commenters noted significant variation across the state in how individuals access care, use health care services, demographic characteristics of the populations, and provider availability and financial status. They raised concerns as to how we would account for this variability.	We conducted the analysis at the state level. However, our underlying data for the model is at the individual and household level. To the extent population characteristics differ by state region, our analysis would capture this variation.
Data Sources	• One commenter suggested that we use claims experience data from Interagency Benefits Advisory Committee to help assist in estimating the costs associated with the HSA. • One commenter suggested that we contact the NM Taxation and Revenue Department for information on residency and income. This same commenter suggested that we rely on the LFC for revenue scenarios. • One commenter cautioned our use of physician and nurse state licensure survey data because it may include out-of-state providers.	We describe the development of the analytic database and sources in the paper. We attempted to use as much data specific to New Mexico as possible.

Issue	Public Comments	Response
Affordable Care Act	• Some commenters raised concerns with our implicit assumption that ACA revenue sources will remain (i.e., Medicaid expansion federal support, Marketplace premium subsidies). One commenter requested that we model scenarios assuming that such federal funding support disappears in the future.	We note in the discussion that we assumed continued availability of funding under the ACA and the impact if this funding were curtailed.
HSP Participation by Tribal Governments	• Some commenters noted that each tribal government could choose to participate in the HSP and asked how we would incorporate this decision into the model. • One commenter noted that individual Native Americans could choose to join the HSP and that approximately 10% of New Mexico's population is Native American.	We assumed that Native Americans would be enrolled in the HSP. We made no assumptions about the tribal governments.
Medicare	• One commenter indicated that a Medicare waiver could be possible and that we should model a scenario that assumed Medicare beneficiaries could enroll in the HSP. Some commenters agreed with our proposal to not include Medicare as a waiver would be complicated and may not be achievable within the first 5 years. • Some commenters noted that some elderly do not have Medicare Part B (and some, albeit fewer, do not have Part A). They noted that the HSA intended for these individuals to receive certain coverage through the HSP.	We did not include Medicare in our analysis.
Other	• Some commenters were unclear on some of the terminology used in the analysis plan. In particular, our definition of certain terms seems to conflict with how they are defined in the HSA. • Some commenters noted that the legislation would require a certificate of need (CON) requirements. One commenter suggested we should incorporate savings from the CON requirement, while another said CON is an outdated approach to health care. • One commenter asked whether the HSP would absorb the NM Insurance Pool. • One commenter asked whether we were incorporating the cost of IT for an integrated data system as well as the impact of potential delays with the development and implementation of the IT system. • Another commenter stated that there could be potential savings from such a system (integrated IT) as well as standard claim form and eligibility "smart" card, and asked how we would incorporate those potential savings.	We appreciated all the comments we received from stakeholders. Although we could not address all comments, we did our best to incorporate many as well as discuss the implications of others that we did not explicitly incorporate.

Issue	Public Comments	Response
	• One commenter noted that there could be spillover benefits of the HSP onto other payers like Medicare (from, for example, global budgets). • One commenter noted that, in prior versions of the HSA, the legislation specified that all premiums and employer contributions would be deposited into a dedicated Health Security Plan Fund and that this dedicated fund will earn interest, creating added dollars that can be used to help fund the plan. The commenter noted that this will be included in future versions of the bill.	

C. Summary of Comments to Preliminary Report

On March 3, 2020, we posted a preliminary report onto our website and invited public comments. We provide a summary of the important public comments and our responses to these comments below. The commenters suggested modifications to the fiscal analysis. The suggestions of some commenters were sometimes in conflict with the legal interpretation of the proposal or were impeded by unavailable or inadequate data. In our fiscal analysis, we sought to achieve a balance among the broad range of perspectives that were expressed.

Issue	Public Comments	Response
Administrative Costs and Savings	• One commenter noted that the baseline analysis does not assume cost reductions for providers due to lower administrative costs. • One commenter believes that the administrative savings are overestimated. • One commenter noted that the 5% administrative cap is too low. They requested that the analysis include a 7% administrative expense. • One commenter believes that reliance on the Medicare administrative cost model ignores the administrative activities that are required by the NM proposal but not present in the Medicare program.	We are now modeling four scenarios. In two of the scenarios, we reduced the growth in provider and facility reimbursement rates. We assumed that the HSP administrative costs would fall over time to account for early start-up costs and the HSA's cap on administrative costs at 5 percent by the sixth year of the program. This is in accordance with what is written in the Health Security Act of 2019. In the discussion section, we put the 5 percent administrative cost in perspective relative to other programs.
Providers and Payments	• One commenter noted that setting provider payment rates to be budget neutral is conservative. They suggest that 2024 be budget neutral and then phase-in estimated pricing reductions over the remainder of the five year period. • One commenter requested that we include in our model the possibility of providers leaving the state. • One commenter noted that many physicians are salaried under the physician groups they work for and that the groups should not be allowed to dictate fee-for-service going into a reformed health system.	For our modeled scenarios, we initially assumed that payment rates would be established such that aggregate payments for the provider category (e.g., hospital, physician, etc.) would be comparable to what they were paid prior to the implementation of the HSP. Prices were adjusted for medical inflation as determined by the Consumer Price Index for Medical Care (CPI-M) Prices. In two scenarios, we grew HSP prices by CPI-M minus 1 percentage point. In our appendix, we have a discussion assessing the adequacy of health care provider supply to meet the increased demand for health care services. In our methods section, we described how we established provider payment rates and scaled spending to external administrative data.

Issue	Public Comments	Response
Economic Impact	• A few commenters requested that we include the number of jobs that would be lost throughout the insurance industry and the fiscal impact.	We reported the net impact on jobs in New Mexico. We note in the report that the HSP would replace a significant share of the private insurance sector in New Mexico. As a result, jobs related to administrative activities of payer(s) would shift from the private sector to the state.
Eligibility/Coverage	• One commenter requested that we break out and figure the per capita spending for people who do not want coverage. • One comment requested that we consider the impact of extending HSP to all New Mexico residents, regardless of duration of residence or consider the loss of federal marketplace contribution. The commenter states that the analysis does not address people who move to NM and are unemployed, but unable to access the HSP until a year of residency is completed. • Some commenters asked if the analysis includes the comprehensive set of services offered to state employees.	We modeled four scenarios and additional sensitivity analyses. Unfortunately, we were not able to model all scenarios that have been requested. Our model assumed that services covered under the HSP are comprehensive, cover the essential health benefits required under the Affordable Care Act, and comparable to those offered to state employees. These benefit assumptions are reflected in estimates of health care spending for the HSP beneficiaries.
Health care Utilization and Spending	• One commenter noted that bad debt and collections should be identified and calculated as revenue gained. • One commenter suggested that savings associated with billing should be included in the analysis. • One commenter noted that if the MD global budget model is used, the analysis should include its pricing strategy that allows them to monitor inappropriate utilization. • One commenter believes the report fails to account for increased utilization rates among those 65+ and does not account for the higher rates of NM with multiple chronic conditions. • One commenter believes that assumptions do not acknowledge the work insurers have performed with regards to care management and fail to account for the cost of contracting as required in the HSA.	We appreciated all the comments we received from stakeholders. Although we could not address all comments, we did our best to incorporate many as well as discuss implications of others that we did not explicitly incorporate. We understand that some commented regarding a discrepancy in the paper on HSP spending. The commenters confused reported total health care spending (HSP plus other coverage) and spending for HSP beneficiaries only. We have attempted to make sure the labels on tables are clearer and all tables are referenced in the text. We assumed that savings associated with billing would fall under administrative costs. We modeled the HSP as not covering those individuals covered under Medicare, including dual-eligible. As a result, those 65 years and older are excluded from our analysis.

Issue	Public Comments	Response
	• One commenter believes that there is a discrepancy in the report in regard to the costs of the HSP. • One commenter believes that there should be several HSP cost possibilities presented in the report, not one based on varying assumptions. • One commenter states the report does not include any discussion of potential savings that might accrue from the certificate of need program. • One commenter requested that the impact of an IT system on health care costs and provider satisfaction should be included in the analysis. • One commenter requested that the cost analysis include reasonable assumptions about provider overhead and pharmaceutical drug cost savings. • One commenter noted that there are costs that are not in the analysis, but the state will face including startup costs associated with scaling up a brand new insurance plan, telehealth expansion, and transition safety nets for the unemployed to HSP. • One commenter believes that the report overstates savings without considering the efficiencies of private insurers and managed care plans versus traditional government-run plans. • One commenter states that the assumption that utilization will decrease due to global budget ignores the significant number of services already performed in fully-capitated arrangements which promote appropriate utilization, resulting in the model likely overstating savings. • One commenter believes that some innovations mentioned in the report, such as using a population-based or value-based approach, would create better health outcomes which would reduce costs significantly. They believe that this should be included in the analysis. • One commenter noted that the results from the Oregon experiment should not be the goal of the NM HSP. They believe the fiscal analysis should provide best practice managed care targets that will quantify fiscal gains with health gains.	We used the BRFSS to account for multiple chronic conditions of those residents in New Mexico. We described our approach for estimating costs expenses in our methods. In our preliminary report, we did assess several HSP cost possibilities in the report. In our final report, we reorganized and wrote new sections to clearly explain our methods and our results. In our final report, we include a discussion on bulk drug purchasing.

Issue	Public Comments	Response
Indigent Care Expenses	• One commenter noted that there is no reference to the issue of indigent care expenses being covered by taxes levied and spent by counties nor the Hospital Safety Net program. • One commenter believes that the report makes a false cost assumption about adding Native Americans to HSP. Under the Affordable Care Act, Native Americans can be added to Medicaid with 100% federal funding.	In response to commenters' concerns, we explicitly incorporated indigent care programs and provide more details about indigent care expenses in the final report. We assumed that federal funds to support the HSP would be based on current federal support levels.
Automobile and Workers' Compensation Insurance	• One commenter noted that the report mentions that there may be savings in automobile insurance premiums and in workers compensation insurance premiums for workers and for employers, but do not factor those savings into its estimation of costs and benefits for the state.	Correct. While we discuss potential impacts of the HSP on automobile insurance, we did not assume savings in our analysis. To the extent there are automobile insurance savings, consumers and employers in the state may realize economic benefits.
Revenue – Employer Contributions	• One commenter stated that the report is unclear whether employer contributions for employers who do not currently offer insurance or who do not offer employer-sponsored insurance would be required to participate in the HSP or whether the contributions would be voluntary. They requested that the final report should clarify whether the analysis is based on a voluntary contribution model or one based on payroll fees or taxes. • One commenter requested more information as to how the 8% of employer's contributions were derived and which employers were required to make contributions.	In response to commenter's concerns, we re-organized sections of our report regarding the discussion of employer contributions for employers. We also included more information on our methods and findings in the report. To be clear, we assumed that employers that do not offer a self-insured group health plan to their employees would participate in and contribute to the HSP.
Medicaid	• One commenter noted that three categories of Medicaid beneficiaries (those in waiver programs, LTSS, or having dual coverage) are assumed to remain within a separate future Medicaid program and not covered by the HSP.	We excluded LTSS and dual-eligible from our estimate of Medicaid spending that would be covered by the HSP.
Affordable Care Act	• Some commenters raised concerns with our implicit assumption that ACA revenue sources will remain (i.e., Medicaid expansion federal support, Marketplace premium subsidies). One commenter requested that we model scenarios assuming federal funding support disappears in the future.	We note in the discussion that we assumed continued availability of funding under the ACA and the impact if this funding were curtailed.

Issue	Public Comments	Response
Premiums	• One commenter requested that we analyze premiums and cost-sharing from the perspective of residents and their ability to pay, factoring in household incomes and other expenses. • One commenter requested that we model premium contributions with a cap at 400% FPL. • One commenter suggested we model a progressive wealth tax to assess revenue generated through a tax on higher-income households' non-wage income.	We considered two premium and cost-sharing scenarios. One scenario modeled individual responsibility for premiums based on the average employer plan. Beneficiaries who are eligible for lower premiums on the ACA Marketplaces would pay less, and beneficiaries who are Medicaid-eligible would pay no premiums. The second scenario determined premium subsidies similarly to subsidies on the ACA Marketplace. Unlike the ACA, however, higher-income households would be eligible for subsidies if HSP premiums exceeded 9.56% of their income. Beneficiaries eligible for Medicaid would pay no premiums.
Revenue Source - Payroll Tax	• One commenter requested that we model a statewide payroll tax for all employers. • One commenter requested that we model a universal, progressive payroll tax in which small businesses pay lower rates than large ones and in which businesses that have larger pay gaps between the highest-paid employee and the median employee are taxed at higher rates than businesses with more equitable salary and wage structures.	We appreciate all the suggestions we received. Unfortunately, we were not able to model all the scenarios suggested by commenters.
Health Outcomes	• One commenter requested that we include an assessment of improved health outcomes and how near-universal coverage could be expected to translate into better public health, and by extension, better educational, occupational, employment, and other outcomes.	We described the potential long-term effects of improved beneficiary outcomes in our report.
Revenue Sources – Federal and State	• A few commenters stated that they believe the anticipated federal revenues that would be available to the HSP were too low. • One commenter provided a list of presumed sources of funding from the state that could fund HSP. • One commenter asked for more detail and documentation on the numbers for federal and state revenues for Medicaid and other health services.	We appreciated the comments on revenue sources and have revised our approach. We described the development of the analytic database and sources in the paper. We attempted to use as much data specific to New Mexico as possible. We included additional detail and documentation of our revenue sources in the final report.

Issue	Public Comments	Response
	• One commenter noted that the savings from consolidating four IBAC programs into the HSP are not mentioned.	
Data Sources	• One commenter states that licensure data does not provide an accurate figure of registered physicians that work in the state. • One commenter does not believe the report has analyzed or taken into consideration the use of claims experience of state employees and education employees to project costs for the rest of the covered population.	We described the development of the analytic database and sources in the paper and technical documentation. We attempted to use as much data specific to New Mexico as possible. We did not use the state employees' claims experience as a proxy for health care utilization under the HSP. While different approaches have advantages and disadvantages, we were concerned regarding demographic and health differences between state employees and other state residents.
Other	• Some commenters requested much greater documentation of the report's figures and a more complete and organized discussion of the sensitivity analyses. One commenter specifically requested further explanation and breakdown of how the report came to its results including information about utilization, data sources, plan administrative assumptions, and provider administrative costs. • One commenter requested that we compare what the HSA will cost versus continuing the current system in New Mexico will cost. • One commenter believes that HSA should not be referred to as a state administered program as the program will be administered by a commission. • One commenter believes that the report understates the positive effects of the HSP.	We have added documentation and additional discussion of the sensitivity in the final report and associated technical documentation. Our analysis compares costs under the HSP versus the baseline, which is a projection of what costs will be under the current system. We agreed with the commenter and removed any references to a "state-administered program." Instead, we refer to the program as a state program. We have restructured the presentation of the HSP scenarios to provide a balanced view of the HSP's effects.

D. Workforce Adequacy

The increase in the number of New Mexicans with insurance coverage subsequent to implementation of the HSA would be expected to increase patient demand for health care services. This raises the question of whether New Mexico has sufficient capacity to meet patient demand for services. If health care demand were to increase significantly under the HSA such that current capacity could not meet all the demand predicted by the simulation model, this could affect the accuracy of the economic impact estimates. Thus, we conducted an evaluation of the adequacy of the supply of physicians and nurses in New Mexico to meet the increase in demand for their services expected under the HSA.

Estimates of the supply of physicians and nurses in New Mexico came from 2018 licensure data.[89] Demand projections for physicians (by specialty and setting) and registered nurses (by setting, as well as specialty for advanced practice registered nurses) were generated using IHS Markit's Health care Demand Microsimulation Model. This workforce model has been validated through modeling efforts for the federal government, state governments, professional associations, and hospitals and health systems. Modeling methods and findings have been published in academic journals and major reports.

Starting with a representative sample of the population in each county in New Mexico, the demand for health care services was simulated based on demographics, health risk factors, disease prevalence, medical insurance type, household income, and observed health care use patterns. Provider demand was estimated first under a status quo scenario, which modeled demand based on New Mexicans' current coverage market. Demand was also modeled under a universal coverage scenario[90], which applies health care demand levels observed for insured people (by demographic groups) to the whole population. Projected demand for health care services by type are used to estimate demand for physicians and nurses under the current system and under the HSP using national staffing patterns. Supply of physicians and nurses was compared to projected demand to assess adequacy of supply in 2018; then, factors related to projected changes in the future were analyzed to draw conclusions into the future.

While the adequacy of supply of physicians varies by specialty in New Mexico as around the country, our models suggest that overall in New Mexico supply is sufficient to meet 93% of projected demand based on national practice patterns, with the primary care specialties and general surgeon adequacy sufficient to provide a national average level of care. In contextualizing and interpreting this information, it is important to note that national practice patterns are not necessarily efficient or optimal and are not necessarily representative of treatment patterns in New Mexico, which may be optimized to treat all of the demand in the state. Additionally, in New Mexico, for some specialty areas, there appears to be greater use of physician assistants (PAs) and advanced practice registered nurses (APRNs) than the national average supplementing the physician workforce.

[89] Data were provided by Dr. Richard Larson at The University of New Mexico.

[90] While not all New Mexicans may have insurance coverage under the HSA, the goal of the legislation is to cover as many people as possible. Our analysis here is conservative, in that it assesses provider adequacy for the upper bound of all New Mexicans having insurance coverage.

Determining the extent of any current provider shortage in NM is beyond the scope of this project. However, given current practice patterns and the proportion of current demand that is met, the extra demand from insuring all New Mexicans is estimated to increase physician demand by about 1.8%. This is because most of the newly insured are young[91] and relatively healthy, the demographics that typically use fewer health care services; additionally, even when uninsured these individuals used some health care services or would have gained coverage under Medicaid under certain circumstances such as severe illness or pregnancy. Given this relatively small increase in physician demand, it is reasonable to assume that new demand for physicians predicted under HSA by the simulation model generally can be accommodated.

Analysis of the registered nurse (RN) data produced similar results – based on national practice patterns, approximately 88% of demand can be accommodated with current supply under both the status quo and universal coverage scenarios. Again, while determining the extent of any nursing shortage in New Mexico is beyond the scope of this analysis, it is reasonable to assume that the new demand for RNs reflected in the simulation model predictions under the HSP generally can be accommodated.

While New Mexico's overall shortfall of physicians and nurses is modest relative to the national average, across communities within the state there can be substantial variation in supply adequacy. Furthermore, the time horizon for assessing the potential health and economic impacts of HSP is 2024-2028. A recent report by the Association of American Medical Colleges, using IHS Markit's microsimulation models, suggests that the demand for physicians is rising faster than supply at the national level. By 2024 a projected gap of 55,600 to 87,200 physicians is estimated nationwide, rising to 62,200 to 126,400 gap by 2029. The gap is particularly large for non-primary care physicians (surgeons and medical subspecialists) for which there is less ability to use APRNs and PAs to offset physician shortfalls. Hence, while the physician workforce can accommodate the estimated 1.8% increase in provider demand from HSA, in future years there might be increased barriers to receiving care for all New Mexicans due to provider shortfalls expected nationally.

In New Mexico overall, the growth in demand for physicians from 2018 to 2024 under the status quo scenario is 10.9%, while the increase from 2018 to 2029 is 20.1%. This projected growth in demand for physicians is based primarily on population growth and aging as well as the increase in prevalence of chronic health conditions associated with changing demographics. The estimated 1.8% growth in demand for physicians associated with the HSP, therefore, is a relatively small proportion of overall projected growth in demand for New Mexico.

In contrast, at the national level the supply of registered nurses, APRNs, and PAs is growing rapidly—with APRN and PA growth helping to compensate for slower growth in physician supply. Our projections indicate that absent HSP the demand for RNs in New Mexico will reach 22,047 by 2024 and 24,251 by 2029 based on the state's projected demographics and health risk factors. Under the HSA, the demand projections are 22,135 and 24,342. The small increase in demand for RNs due to the HSA (equivalent to

[91] Only 4.6% of the New Mexico population are 45 years or older and not currently insured.

about 90 full time equivalent) is due to (a) the population newly covered by the HSP being relatively young and healthy so gaining insurance coverage will have minimal impact on hospital admissions or hospital length of stay, and (b) newly insured populations will have improved access to ambulatory services which helps address health issues to reduce the need for hospitalization. A 2017 Health Resources and Services Administration report estimated that RN supply in New Mexico is growing at a rate that exceeds growth in demand, so the state should have a sufficient supply of nurses to meet demand for services in 2024-2029.

These analyses are extrapolations from the baseline situation; however, it is unclear how the economic fallout from the coronavirus disease 2019 precipitated recession as well as the recent collapse of oil prices will affect the state's population demographics and demand for health care. Additionally, changes in care models incentivized in the details of the HSA could affect supply adequacy (positively or negatively) as well.

While it is a rigorous evaluation of the question of workforce adequacy, this analysis has limitations. First, it is limited to physicians and nurses. Although these clinicians deliver much of health care received, the many other types of providers who deliver crucial health care were not analyzed. Additionally, the current analysis does not account for an initial burst of demand that might occur among the newly insured resulting from foregone care while uninsured. Rather, the model predicts adequacy when the newly-insureds' health care patterns settle into those of the otherwise similarly situated currently insured. Finally, some people, especially near borders, may cross into other states for care and some out-of-state residents may seek care in New Mexico. The health workforce models assume that all demand generated by New Mexicans is met by providers in New Mexico.