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Quantitative and Comparative Analysis of Reform Options for Extending Health Care Coverage in New Mexico

Final Report

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EXECUTIVE SUMMARY

INTRODUCTION

The Health Coverage for New Mexicans Committee requested that Mathematica Policy Research, Inc. estimate the cost of the current health care system in New Mexico and the relative cost of three alternative strategies to ensure that all New Mexicans become and remain insured.

To develop estimates that would help the Committee compare reform models on the same basis, we needed to develop relatively precise specifications for key components of the models. Implicit in our specifications are a number of key decisions, including:

- A focus exclusively on the noninstitutionalized civilian population under age 65 who are not enrolled in Medicare.
- Premium schedules for coverage in each reform model.
- Specification of employer roles and contributions, including the Fair Share amount that employers would pay under the Health Coverage Plan.

In addition, each of the reform models envisions various strategies to ensure compliance with a state requirement that all New Mexicans be insured, as well as strategies to control health care costs and improve the quality of care. Because any of the models could devise "best practice" approaches to achieve these goals, our estimates and projections assume that they all do so with equal success.

LEGAL CONSIDERATIONS

Any reform model that would touch employer-sponsored coverage can have important consequences for individual and employer tax liability and also implications with respect to the Employee Retirement Income Security Act (ERISA), which preempts state regulation of employee benefit plans. Collaborating with Mathematica, the Institute of Public Law (IPL) at the University of New Mexico explored these issues in detail. Some of the principal conclusions of their analysis are:

- The breadth of ERISA's preemption clause, ERISA may pose a significant obstacle to the success of each of the proposed models.
- For the purpose of this analysis, it is reasonable to assume that worker contributions to coverage in the Health Security Plan and New Mexico Health Choices Alliance could be tax exempt. In addition, the vouchers and subsidies used to provide or supplement employee health coverage under Health Choices may be tax-free to employees if the model is considered to be a general welfare program. In addition, the SCI program might be deemed a general welfare program for the purpose of employer participation and qualify as individual coverage for the purpose of individual tax liability.

Based on these conclusions, we developed several critical assumptions that underlie all of the estimates in this report:

- Each of the reform models would be structured to successfully navigate ERISA. To that end, when the reform model mentions the ability of self-insured employers to "opt out" of a plan, we assume that self-insured employers could take a full credit against any assessments that would otherwise be mandatory, if the employer offered coverage—without regard to the specifics of the coverage that is offered. Similarly, we assume that fair share payment required under the Health Coverage Plan's is sufficiently small and nonspecific as to not infringe on employers' ERISA protections.
- The SCI program is deemed a general welfare program for the purpose of employer participation, and also (though operationally much less important) qualifies as individual coverage for the purpose of individual tax liability.
- The vouchers that would be provided to subsidize coverage under New Mexico Health Choices would not constitute taxable income.
- Individual contributions to coverage in the Health Security Act and New Mexico Health Choices could be made through Section 125 "premium only" accounts, so that such contributions would be tax exempt.

CURRENT COVERAGE

Coverage is not static—in every state, people move in and out of different coverage from various sources, and gain and lose coverage during the year. An estimated 432 thousand New Mexicans are predominantly uninsured, accounting for 26 percent of noninstitutionalized civilian population under age 65. Under the eligibility rules that were authorized in the 2006-2007 legislative session, more than half of uninsured New Mexicans would be eligible for Medicaid or SCHIP.

Employer-sponsored plans are the predominant source of coverage for an estimated 42 percent of the state's noninstitutionalized civilian population under age 65. More than one-third of these New Mexicans are enrolled in self-insured employer plans. Public health insurance programs—primarily including Medicaid and SCHIP, but also the SCI program—cover an additional 30 percent of the noninstitutionalized civilian population under age 65.

CURRENT HEALTH CARE EXPENDITURES

Expenditures for personal health care services in New Mexico for the noninstitutionalized population under age 65 are projected to exceed $6 billion in 2007. Privately insured expenditures account for 44 percent of total health care spending, while state and federal expenditures account for 37 percent. New Mexicans are projected to pay 18 percent of health care expenditures out-of-pocket.

Federal government finances nearly three-fourths of approximately $2.3 billion spent by federal and state government to finance health care in New Mexico. Medicaid accounts for approximately two-thirds of all federal funds for health care in the state—nearly $1.1 billion.

STAKEHOLDERS IN NEW MEXICO

Employers. While New Mexico is generally characterized as a "small-employer" state, approximately as many private-sector workers are employed in very large firms in New Mexico as are employed in small firms. Overall, more than a third of private sector workers are enrolled in a self-insured plan in 2004, with self-insured coverage ranging as high as 76 percent among all workers in the largest firm sizes.

Consumers. Nearly half of the noninstitutionalized civilian population under age 65 who have health insurance coverage at any time during the year—either public or private—are uninsured part of the year, and 11 percent are uninsured all year. Children age 18 or younger account for just 12 percent of all-year uninsured New Mexicans. However, about 70 percent of children in the state lose insurance coverage at some time during the year. In contrast, adults over 30, whether insured or uninsured, are likely to maintain the same insurance status for the entire year.

New Mexico's noninstitutionalized population under age 65 finances about 19 percent of expenditures for health care services out-of-pocket, equivalent in 2007 to an estimated $669 per person. New Mexicans who are uninsured all year spend much more out of pocket ($858), a measure of their significant financial burden for health care services.

Health care providers. Office-based providers represent the largest single category of health care expenditures among the noninstitutionalized civilian population under age 65—and, therefore, the category of providers potentially most affected by major reform. Office-based providers account for approximately 26 percent of their total health care spending by this population, followed by prescription drugs (20 percent), and hospital inpatient care (18 percent). However, private insurance is an especially important source of financing for outpatient hospital care (56 percent) inpatient hospital care (50 percent), and emergency room visits (43 percent), as well as for office-based medical services (48 percent).

CHANGE IN COVERAGE UNDER THE REFORM MODELS

To compare the estimation results across the reform models in a meaningful way, a number of assumptions about implementation and behavioral responses were applied consistently to each model. Key assumptions underlying the coverage estimates include the following.

- Every New Mexican becomes insured. Moreover, the reform models are immediately and fully implemented, with immediate savings gained if they are expected to occur at full implementation.
- Both the Medicaid and SCHIP programs continue, although they may be incorporated into new programs. In addition, every individual eligible for Medicaid

or SCHIP enrolls unless they already are enrolled in an employer plan that continues to be available to them.

- Self-insured employer decisions are driven by consideration of premiums, and individuals always choose coverage that entails the lowest cost to them.

- When the reform model folds Medicaid and SCHIP into a new program, waiting periods and other crowd-out provisions are suspended.

- Coverage decisions are made at the family level, and family coverage is preferred when it is available. New Mexicans not living with a spouse or children make coverage decisions as individuals.

- Young adults first seek coverage on their own, accepting coverage from their own employers if offered before taking coverage as their parents' dependent.

The essential impacts on coverage would be as follows:

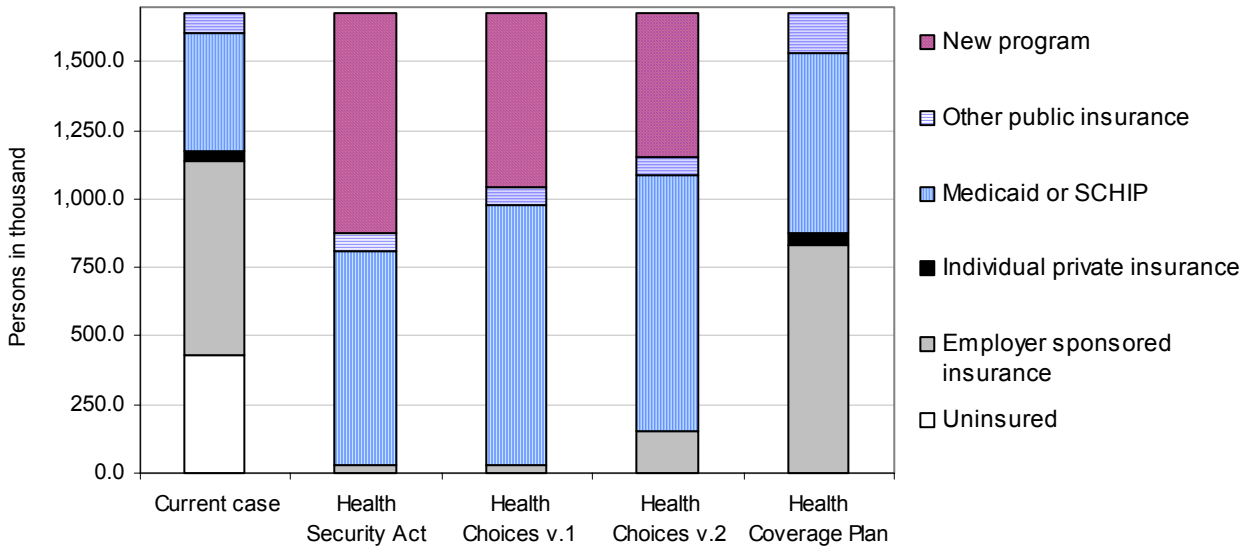
- Under the Health Security Act, nearly 1.6 million New Mexicans—94 percent of the noninstitutionalized civilian population under age 65—would enroll in the new Health Security Plan (Figure 1). Of this population, nearly half (46 percent of the noninstitutionalized civilian population under age 65) would be Medicaid or SCHIP enrollees. Responding only to lower premiums, most workers and dependents currently enrolled in self-insured plans would become enrolled in the Health Security Plan.

- New Mexico Health Choices would expand Medicaid and SCHIP the most, and rely most heavily on federal financing. Assuming that self-insured employers terminate their plans in New Mexico in response to a payroll tax with no exemptions, nearly 1.6 million New Mexicans would enroll in coverage through the Alliance in Version 1. Medicaid and SCHIP would account for nearly 60 percent of total enrollment in the Alliance Plan, and 57 percent of the total noninstitutionalized civilian population under age 65. Version 2 would enroll 529 thousand New Mexicans in coverage through the Alliance, with Medicaid and SCHIP accounting for 64 percent of Alliance enrollment and 56 percent of all noninstitutionalized civilian New Mexicans under age 65. Approximately 150 thousand New Mexicans would remain in employer-sponsored coverage in version 2, including 119 thousand in self-insured plans.

- The Health Coverage Plan would expand all current sources of coverage in New Mexico; it does not envision creation of a new plan. Approximately 122 thousand workers and dependents would newly enroll in employer-sponsored coverage increasing enrollment by 14 percent. Medicaid and SCHIP enrollment would expand (but only to the extent that uninsured New Mexicans are currently eligible but not enrolled) covering 39 percent of noninstitutionalized New Mexicans under 65. In addition, SCI would enroll 80 thousand now-uninsured adults under expanded eligibility for the program. Finally, nearly 11 thousand New Mexicans would enroll in individual coverage, including NMMIP.

FIGURE 1

DISTRIBUTION OF PREDOMINANT HEALTH INSURANCE COVERAGE
IN NEW MEXICO, CURRENT CASE AND SIMULATED REFORM MODELS



Source: Mathematica Policy Research, Inc.

CHANGE IN COST UNDER THE REFORM MODELS

The Health Security Act would generate the least new total cost for insuring all New Mexicans. The low estimated cost of the Health Security Act is due primarily to its low expected nonmedical cost. We estimate that expenditures under the Health Security Plan would be lower than expenditures in the current case (Figure 2). Because New Mexico Health Choices would layer new administrative costs over an essentially private system of insurance—and makes no provision for constraining private insurers' nonmedical costs—it would be more costly overall than either the Health Security Act or the Health Coverage Plan.

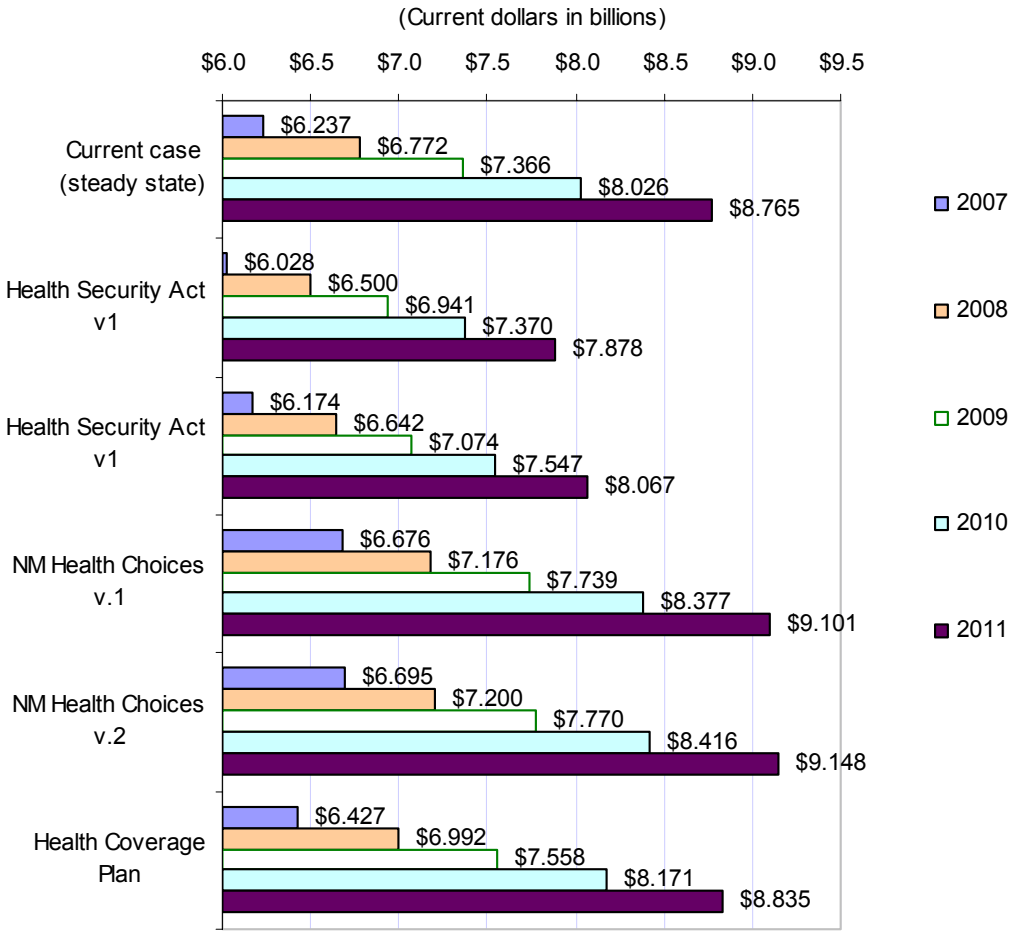
Any reform model that would reduce provider payments from current levels would, of course, be less costly than a reform model that maintained or increased provider payment levels. The Health Security Act assumes provider administrative savings associated with fewer payers in the system, and it anticipates negotiating provider payment rates down to capture those savings. However, the Health Security Plan probably would not ever be the only payer in New Mexico, and whether there is much provider administrative to be captured is uncertain. Nevertheless, even at current average payment levels (estimated as Health Security Act v.2), lower nonmedical costs would translate into lower per capita cost under the Health Security Act compared with either the current case or the other reform models.

Because each of the reform models entails different relative amounts of medical and nonmedical cost, and because these components of cost would grow at different rates in each of

the reform models, their total costs are likely to grow at different rates over time. We project the slowest cost growth for the Health Security Act (even assuming higher Medicaid and SCHIP payment increases than in the current case), followed by the Health Coverage Plan which we assume would update Medicaid and SCHIP reimbursement at historic rates. However, because all of the reform models would attempt to address medical cost growth, we presume that all would succeed at least modestly in doing so. By reducing medical cost growth just one percentage point below projected current-case rates, all of the reform models would either reduce total costs absolutely by 2011 or come within a few percentage points of the projected total cost of health care in the current case.

FIGURE 2

PROJECTED TOTAL EXPENDITURES IN THE CURRENT CASE AND REFORM MODELS 2007-2011



Source: Mathematica Policy Research, Inc.

FINANCING

Both the Health Security Plan and New Mexico Health Choices would put in place pure-community-rated systems of coverage—with no variation for personal characteristics or location. Neither reform model would require that self-insured employers, in particular, participate in the

new coverage programs that would be formed. To avoid potentially severe adverse selection from self-insured employer groups, it would be necessary to minimize premiums (so that lower cost groups would come into the new programs, as well as high-cost groups). However, these reform models then would rely heavily on payroll tax financing. We estimate that the payroll tax necessary to support these programs, assuming relatively low premium levels, could be as high as 8 percent of payroll (under New Mexico Health Choices v.1, which would rely solely on payroll tax financing) but probably not less than 4 percent of payroll (under the Health Security Plan v.1).

Under the Health Coverage Plan, the Fair Share Fund would accrue an estimated $93 million in 2007. This amount would be earmarked to cover services for New Mexicans who are temporarily uninsured (including homeless and transient persons) but are in need of health care services. However, the state would also incur additional cost related to significantly greater enrollment in Medicaid, SCHIP, and SCI; this additional liability—estimated at $34 million in 2007 (after federal match) has no currently identified source of funding.

ECONOMIC IMPACTS

The projected net economic impacts of the reforms are relatively small. Each of the reform models would produce a small net increase in jobs in the state, by as much as 1.6 percent of the wage and salary employment forecasted for 2007 (in New Mexico Health Choices v.2). Similarly, all would increase gross domestic product (GDP) and income in New Mexico. New Mexico Health Choices v.2 would have the greatest impact (generating an estimated $0.8 billion in GDP), related to the higher level of total health expenditures in this reform model and the inflow of federal dollars related to high growth in Medicaid and SCHIP enrollment. The sector impacts of the reform models are somewhat larger than the overall net impacts, but still relatively modest.

ISSUES FOR FURTHER CONSIDERATION

Our analysis raises a number of issues related to each of the reform models that the Committee may wish to consider carefully in crafting a proposal to cover all New Mexicans. Among these issues are the following:

- ***Affordability and Compliance.*** A requirement that all New Mexicans be insured forces the question of the affordability of coverage. Both the Health Security Act and New Mexico Health Choices would cap premiums (if any) at 6 percent of family income. However, the Health Coverage Plan has no such protection. We expect that the cost of private coverage in the Health Coverage Plan for New Mexicans who are ineligible for public coverage could be unaffordable for some New Mexicans; as many as 20 percent of New Mexicans might pay more than 6 percent of family income to obtain or keep private coverage.

- ***ERISA Preemption.*** Assuming that self-insured employers respond to estimated differences in premiums most workers and dependents who are now enrolled in self-insured coverage would move into the Health Security Plan and the Health Choices

Alliance, respectively. In New Mexico Health Choices v.2, self-insured employers would be subject to a payroll tax, regardless of whether they enrolled workers in coverage, and we assume that they would respond by terminating their health plans. However, the financial incentives that underlie these estimates could violate employers' ERISA protections, if they chose to challenge the reform models on ERISA grounds.

- ***Tax Status of Individual Payments for Coverage.*** To determine whether individual payments for health insurance coverage in the Health Security Plan or the New Mexico Health Choices Alliance would be tax exempt may require a U.S. Treasury letter ruling. Short of putting the issue before the Treasury, different experts have reached different conclusions in thinking about this issue. Currently, Massachusetts is the only state that is testing the proposition that a state-managed pooled market (the new Connector) would constitute a welfare plan and that employer-sponsored Section 125 premium-only accounts are a legitimate vehicle for tax-sheltering individual contributions via employer withholding. However, in Massachusetts, employers have generally agreed not to contest the state's reform on ERISA grounds, and therefore not to contest the characterization of the Connector as a welfare plan.

- ***Nonmedical Costs.*** Reform models that retain or increase nonmedical costs in the system would increase total cost to achieve coverage for all New Mexicans. Layering additional administrative cost over a larger system of private insurance—as New Mexico Health Choices would do—would magnify these costs, compared with reform models that would largely displace private insurance (the Health Security Act) or maintain current insurer roles (the Health Coverage Plan). Any reform model that retains or increases private insurance coverage could consider options for reducing levels and trends in private insurer nonmedical cost.

- ***Federal Medicaid/SCHIP Matching.*** Because each of the reform models would rely on significant expansion of Medicaid and SCHIP enrollment, the probability of obtaining federal match on a much-expanded program should be investigated carefully. By extending Medicaid coverage to all adults under 100 percent FPL, New Mexico Health Choices may have the greatest challenge in proving budget neutrality in order to obtain a waiver to cover non-disabled adults without children. Furthermore, by eliminating the SCI program, both the Health Security Act and New Mexico Health Choices would eliminate New Mexico's current vehicle for obtaining higher SCHIP match for this population. Both reform models might consider retaining the SCI program and providing additional coverage above SCI's $100,000 cap on covered benefits, as the Health Coverage Plan proposes.

Members of both the Committee and the general public have expressed concern that covered benefits in the reform models include preventive services and attention to health-promoting behaviors in order to improve health status and contain health system costs. However, there is reason to be cautious in prioritizing the allocation of health care resources toward preventive services as covered benefits in a health plan. While personal health care offers many opportunities for reduction of risk, prevention of disease, and early detection of treatable conditions, the effectiveness across the range of opportunities for clinical prevention varies widely. In some cases, public health strategies and community-based interventions may be the more effective directions for public investment.

I. INTRODUCTION

The Health Coverage for New Mexicans Committee has requested that Mathematica Policy Research, Inc. estimate the cost of the current health care system in New Mexico and the relative cost of the three alternative reform models intended to ensure that all New Mexicans become and remain insured. These reform models—the Health Security Act, two versions of New Mexico Health Choices, and the Health Coverage Plan—were described in relatively general terms in documents developed by the Committee and made available to the project.

- **The Health Security Act** would create a single statewide comprehensive health insurance plan similar to that provided to state employees. The Health Security Plan established under the Act would replace an array of the small-group and individual health insurance programs—the State Coverage Insurance Program (SCI), the Small Employer Insurance Program (SEIP), the Health Insurance Alliance (HIA), and the New Mexico Medical Insurance Pool (NMMIP). Individual premiums would be scaled to income. Employers would pay into the Health Security Plan as a percentage of payroll, but self-insured employers could elect whether to participate. The Health Security Plan's governing board would negotiate provider fees and facility budgets, and the state would seek federal waivers to integrate Medicaid beneficiaries and financing into the plan. The plan would exclude federal workers, and would hope to become a Medicare Advantage plan. However, with specific exceptions, HSA would cover all New Mexicans. Such exceptions would include federal employees and retirees, active or retired military personnel and their covered dependents, and individuals who may remain enrolled in employer-sponsored plans or other private coverage. The Health Security Plan would finance care for all residents who enroll, as well as for homeless and transient persons in New Mexico.

- **New Mexico Health Choices** would create a single, statewide risk pool to replace the individual and group health insurance markets, as well as SCI, SEIP, HIA, and NMMIP. Private insurers would continue to offer coverage within the Alliance, which would operate as a purchasing cooperative. All residents would be required to obtain coverage. In alternative versions of this reform model, all coverage in the Alliance would be on an individual basis and all employers would contribute in the form of a payroll tax (version 1); or employers could continue to offer coverage and would be exempted from the payroll tax for any worker enrolled directly in their health plan (version 2).[1] The state would provide vouchers to all residents to cover the cost of a limited benefit plan; employers and/or individuals could supplement these vouchers to purchase a more comprehensive plan. In both versions of New Mexico Health Choices, enhanced vouchers would be provided to residents below 400 percent of the federal poverty level (FPL) to purchase Alliance coverage with

[1] In effect, version 2 differs from version 1 only with respect to self-insured employer plans. All individual and fully insured plans would default to coverage in the Alliance, which replaces the individual and group insurance markets.

reduced cost sharing; in version 2, vouchers for families above 400 percent FPL would cap family premiums for low-option coverage as a percent of income. Coverage in the Alliance would be pure-community-rated, with no geographic adjustment. The Alliance would operate a mutual risk-adjustment program to support carriers under this rating system.

- **The New Mexico Health Coverage Plan** also would mandate individual coverage. The Health Coverage Plan would support the mandate by expanding access to existing sources of coverage. These would include multiple strategies: (1) all adults to 100 percent FPL would be eligible for Medicaid or SCHIP; (2) the State Coverage Insurance (SCI) program would cover adults to 300 percent FPL, with cost sharing scaled to income; (3) nonprofit organizations with fewer than 100 workers could buy into SCI or SEIP without a waiting period if they are vendors for the state; (4) premium assistance would be provided to pregnant women and to children under age 18; (5) a new state reinsurance program would remove the current annual limit on covered benefits in SCI; (6) parents could continue to cover their unmarried children as dependents under individual or group coverage to age 30; (7) funding for federally qualified health clinics (FQHCs) and primary care clinics would be increased; (8) incentives and subsidies would be developed to encourage the use of federal tax preferences for employer-sponsored coverage; and (9) a special low-cost insurance product would be developed for healthy adults (ages 19 to 30). In addition, employers would be required to pay into a Fair Share Fund for any worker whom they did not directly cover; the Fair Share Fund would pay claims for uninsured individuals and/or subsidize reinsurance in SCI and SEIP.

A. SPECIFICATIONS FOR DEVELOPING ESTIMATES

The Committee worked out each of the models with many details, but it was necessary to establish additional specific provisions, comparable across the models, to support modeling of coverage, cost, and financing. The Health Security Act and New Mexico Health Choices, in particular, left substantial detail to be developed by their respective governing bodies, once the models were implemented.

To develop sufficient specification for estimation, we undertook a process of describing each model in more detail, and through the Human Services Department, offered each specification for review by the models' primary authors. This process produced comments that were extremely helpful in clarifying the intent and details of each model. The final specifications for each model are included in this report as Appendix tables A1 though A3.

To develop estimates that would help the Committee compare the reform models on the same basis, we tailored the focus of each model and developed relatively precise specifications for key components of the models. The most significant decisions made to ensure comparability among the models included the following:

- **The covered population**. Our estimates focus exclusively on the nonelderly civilian population who are (1) noninstitutionalized and (b) ineligible for Medicare. The noninstitutionalized civilian population includes all New Mexicans except active

military personnel, inmates in penal institutions, and patients in long-term care facilities. While the Health Security Act, in particular, hopes to include both those in institutions and Medicare beneficiaries in the Health Security Plan, New Mexico Health Choices would explicitly exclude Medicare beneficiaries and persons over age 65. The Health Coverage Plan intends not to alter coverage for individuals who now are insured in public programs, so it would cover these persons in the same manner as the current case.

- **Subsidies to individuals.** The Health Security Act and New Mexico Health Choices, in particular, envision (respectively) income-related premiums and income-related vouchers for the purchase of coverage. To develop cost and financing estimates, it was necessary to develop relatively precise information about the subsidies implicit in these models. For both models, we developed a subsidy schedule similar to that currently in use by SCI, with persons under 100 percent FPL paying no premiums for coverage. For the Health Security Act, premiums are income-adjusted below 200 percent FPL and capped at 6 percent of income for families at 200 percent FPL or above. For Health Choices v.1, vouchers are scaled to income and calculated to fully finance high, medium, or low-option coverage, depending on the family's income. In v.2, families above 400 percent FPL would pay premiums, but their vouchers would cap family premiums at 6 percent of family income. For the Health Coverage Plan, the current SCI premium schedule was extended to 300 percent FPL; above 300 percent FPL, employers and employees each would pay $100 per month and self-employed individuals would pay $200 per month, but premiums would not otherwise be capped relative to income.

- **Payments by employers.** The Fair Share amount that employers would pay under the Health Coverage Plan was specified at $300 per employee per year. This amount would be payable per employee not directly enrolled in the employer's own health plan, whether or not the employee is offered coverage or is eligible for the employer plan.[2]

- **Incentive payments and tax credits for employers.** The Health Coverage Plan called for a system of incentives and subsidies to encourage the use of federal tax preferences for employer-sponsored coverage. Other states' efforts to do this have had no appreciable impact on employer offer. In light of the timeline for this study and the significant effort that would be necessary to specify the provisions of such a system and estimate its impacts, this provision was dropped from the analysis.

- **Special insurance products.** The Health Coverage Plan called for a special low-cost insurance product to be developed for healthy adults ages 19 to 30, and also expansion of eligibility for dependents benefits to age 30. In combination, these provisions could drive significant adverse selection in dependents coverage: under current law, insurers would have to issue dependents coverage regardless of the dependent's health status, but could deny applicants for the special product based on their health status. In light of concerns about adverse selection if there were no

[2] This amount was derived from the fair share payments levied in Massachusetts ($295 per employee per year) and Vermont ($350 per employee per year).

provision to limit insurers' underwriting for the special products, the introduction of special insurance products for healthy young adults was dropped from the specifications for the Health Coverage Plan.

Finally, each of the reform models envisions some mechanism for controlling health care costs and improving the quality of care. Under the Health Security Act and New Mexico Health Choices, a commission or governing board would negotiate provider payment rates and develop strategies to improve health care quality and healthy behaviors. The Health Coverage Plan would create a Cost, Access and Quality Council to identify and develop ways to contain cost, increase the quality of care, and implement wellness and prevention activities. We found no difference among the strategies devised in any of the reform models that is intrinsic to the model design. Instead, it seems reasonable that any of the reform models could devise a "best practice" approach to working with providers and covered New Mexicans to achieve the same goals. Therefore, our estimates and projections are not adjusted to reflect stated differences in governance among the models.

B. LEGAL CONSIDERATIONS

While each of the reform models would require that individuals become and remain insured, they envision somewhat different strategies to enforce the mandate. As with the reform models' cost and quality initiatives, the enforcement strategies that each envisions are not intrinsic to the model design: each could be implemented with the same "best practice" strategy for enforcement. However, various methods of enforcing an individual mandate raise legal considerations which warrant careful exploration before policy is made.

In addition, because the federal tax treatment of private insurance is integral to the current financing of coverage, any model that would touch private insurance—and employer-sponsored coverage, in particular—may have very important consequences for individual and employer tax liability. Obviously, they also could have implications with respect to the Employee Retirement Income Security Act (ERISA), which governs fully insured and self-insured employer plans.

Collaborating with Mathematica, the Institute of Public Law (IPL) at the University of New Mexico explored each of these issues in substantial detail. IPL's extensive analysis, included in full as Appendix B of this report, reached the following summary conclusions:

- ERISA may preempt any model that refers to employee benefit plans; acts immediately and exclusively upon an employee benefit plan; affects the benefits, structure, or administration of an employee benefit plan; interferes with an employer's ability to administer a multistate or national employee benefit plan; or produces such acute indirect economic effects that employee benefits plans would be modified or eliminated. Because of the breadth of ERISA's preemption clause, ERISA may pose a significant obstacle to the success of each of the proposed models.

- It is reasonable to assume that worker contributions to coverage in the Health Security Plan and New Mexico Health Choices could be tax exempt. In addition, the

vouchers and subsidies used to provide or supplement employee health coverage under Health Choices may be tax-free to employees if the model is considered to be a general welfare program. Finally, the SCI program might be deemed a general welfare program for the purpose of employer participation and qualify as individual coverage for the purpose of individual tax liability.

IPL's analysis also advises caution in implementing the individual mandate envisioned in each of the reform models, but does not challenge the essential legality of this approach. Specifically:

- Procedural and substantive due process requirements must be considered when establishing and enforcing the individual mandate through license denial, suspension, and revocation.
- Equal protection guarantees caution against using denial of public education as a means of enforcing the individual mandate as it relates to children.
- To avoid conflicts with the First Amendment, individuals with sincerely held religious objections to health insurance must be exempt from the individual mandate.

Based on these conclusions, we developed several assumptions that are fundamental to the Committee's consideration of the reform models and to calculating coverage and cost estimates. Specifically, we assume the following:

- Each of the reform models would be structured to successfully navigate ERISA. To that end, when the reform model mentions the ability of self-insured employers to "opt out" of a plan, we assume that self-insured employers could take a full credit against any assessments that would be otherwise mandatory, if the employer offered coverage—without regard to the specifics of the coverage that is offered. Similarly, we assume that fair share payment required under the Health Coverage Plan's is sufficiently small and nonspecific as to not infringe on employers' ERISA protections.
- The SCI program is deemed a general welfare program for the purpose of employer participation, and also (though operationally much less important) qualifies as individual coverage for the purpose of individual tax liability.
- The vouchers that would be provided to subsidize coverage under New Mexico Health Choices would not constitute taxable income.
- Individual contributions to coverage in the Health Security Act and New Mexico Health Choices could be made through Section 125 "premium only" accounts, so that such contributions would be tax exempt. This would not only maintain the tax status of contributions that are now tax exempt, but broaden the tax exemption both

to very small employers that may not now offer a Section 125 plan to tax shelter health insurance premiums and to other employed individuals.[3]

Finally, as described earlier, the Health Security Act, envisions including Medicare beneficiaries in the same plan that would finance health care for nearly all other New Mexicans. (Neither New Mexico Health Choices nor the Health Coverage plan calls for change in how care would be financed for Medicare beneficiaries.) To include Medicare beneficiaries, the Health Security Plan presumably would attempt to qualify as a Medicare Advantage Plan. In considering what cost and economic impacts this might have for New Mexico, if feasible, we considered both Medicare's current provisions for paying Medicare Advantage plans and the prospects for changes in payment in coming years. A summary of this information is included as Appendix C.

At present, Medicare Advantage plans are paid substantially more than the fee-for-service equivalent. Thus, if Medicare beneficiaries were included under current payment rules, Medicare beneficiaries might in effect constitute a "profit center" for the Health Security Plan. However, there is substantial uncertainty about how the payments to Medicare Advantage plans might change. The Medicare Payment Advisory Commission, or MedPAC, which advises the Congress on Medicare payment policy, is clear in its view that Medicare Advantage plans should no longer be paid more than fee-for-service. If Medicare reduces payment to Medicare Advantage plans to the level of fee-for-service, excluding Medicare beneficiaries from estimation of the Health Security Act is tantamount only to assuming that Medicare beneficiaries would not subsidize other enrollees in the Health Security Plan. For the Health Security Act as well as for the other models, to the extent that reform reduces provider payments and/or constrains provider charges for all New Mexicans, it is likely that Medicare payments would decline commensurately—whether paid directly to providers or to Medicare Advantage plans.

The following chapters describe our estimates of current-case health insurance coverage and expenditures in New Mexico as well as estimates of coverage under the reform models. Chapter II documents the methods used to produce estimates for this report—specifically, development of the microsimulation database and microsimulation logic for the current case and the reform models. In Chapter III, we report estimates of coverage and health care costs for New Mexicans in the current case; these current-case estimates are examined further from the perspective of various stakeholders—employers, consumers, and providers—in Chapter IV.

Estimates of the change in coverage and cost in each of the reform models are presented in Chapter V and compared with the current case. Estimates and potential concerns related to

[3] Massachusetts requires employers with at least 11 employees to establish a Section 125 plan "regardless of whether any underlying medical care coverage accessed through a Section 125 plan is maintained on an insured of self-insured basis, purchased on an individual or group basis, or provided through the Connector or through another distribution channel unrelated to the Connector" (http://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520March%252018%252C%25202007/Emergency%2520Section%2520125%2520Regulation.pdf). Section 125 premium-only plans allow employees to pay health insurance premiums with tax-free income. Employees save approximately 30 percent in personal income taxes and FICA contributions, and employers save an additional 7.65 percent in matching FICA contributions.

financing are presented in Chapter VI; specifically, we address potential concerns about the affordability of private coverage in the Health Coverage Plan (and therefore compliance) as well as the potential impact of undocumented persons on the financing of each of the reform models. In Chapter VII, we return to the perspective of stakeholders in New Mexico, examining the impacts of each of the reform models on employers, consumers, and providers. In addition, this chapter includes an overview of concerns about system capacity and access to care under reform, both prepared by Dr. William Wiese of the Institute of Public Health (IPL) at the University of New Mexico.

Chapter VIII includes the analysis of macroeconomic impacts prepared by the Bureau of Business and Economic Research (BBER) at the University of New Mexico. An additional analysis prepared by the state's Tax and Revenue Division (TRD) is summarized and TRD's full memorandum is included as an appendix to this report. Finally, Chapter IX includes a comparative summary of our results and discusses a number of considerations related to the implementation of the reform models in New Mexico, including the design of benefits in the reform models to promote population health.

II. METHODS

Estimates of enrollment and medical costs in the current case and in each reform model are based on microsimulation. Microsimulation differs from a macro, "top down" approach to developing estimates in that it involves detailed consideration of the circumstances of individuals and families in New Mexico. Modeling individual opportunities and decisions under major reform is essential for comparing each of the reform models on the same basis, to the extent that individuals in any of the reform models may choose where they would obtain coverage. Building estimates on a common basis ensures that the data and logic behind each of the estimates is comparable.

The microsimulation has two major components: (1) the microsimulation database and (2) the microsimulation logic. Each is described below.

A. THE MICROSIMULATION DATABASE

The microsimulation database was assembled in four steps. First, we developed a population data file, with a sufficient number of individuals and families in, or like those in, New Mexico to support detailed estimates. Second, for each individual in the data file we then developed estimates of expenditure by type of service and source of payment. Third, we developed estimates of the net cost of insurance. Following input from Committee members received in May 2007, these estimates were expanded to include not only conventional insurance costs but also the state agency cost of determining eligibility and the employer cost of administering a health insurance plan. Finally, we adjusted the database to reflect the expansion of eligibility for the State Coverage Insurance (SCI) program to adults without children below 100 percent of the federal poverty level (FPL) and the anticipated expansion of eligibility for Medicaid to parents below 100 percent FPL.

1. The Population Data File

Multiple years of the March Supplement of the Current Population Survey (CPS) form the basic input and output data file for the microsimulation analysis. The universe for the CPS is the civilian noninstitutional population of the United States and members of the Armed Forces in the United States living off post or with their families on post. The CPS includes persons living in group quarters such as rooming houses, staff quarters in hospitals, or halfway houses. However, all other members of the Armed Forces, citizens living abroad, and inmates or persons residing in penal institutions or long-term care facilities are not surveyed

To develop a microsimulation database of sufficient size, we merged the CPS sample in metropolitan statistical areas (MSAs) with population under 1 million in 2006 and rural areas from five states (Arizona, Colorado, Nevada, New Mexico, and Texas) over three years (2004, 2005, and 2006).[4] We then adjusted the Census-calculated probability (or "weight") for each

[4] The United States Office of Management and Budget (OMB) defines metropolitan statistical areas according to published standards that are applied to Census Bureau data. The general concept of a metropolitan statistical area

person who was not drawn from the New Mexico sample to equal the probability of persons in the New Mexico sample who were identical to them in key ways. The resulting data file included a much larger number of observations than the CPS sample in New Mexico, and who are identical to the 2004-2006 New Mexico sample in terms of their age, ethnicity, health status, family income and size, health insurance status, use of the Indian Health Service, and urban or rural location.[5]

The CPS identifies health insurance status as coverage at any time during the year from Medicare, Medicaid, employer-based coverage, or other private coverage. Persons without coverage from any of these sources (including those covered only by the Indian Health Service or other programs that provide direct services) were designated as uninsured.

All population surveys—including but not limited to the CPS—under-report Medicaid and SCHIP enrollment. Therefore, we adjusted reported Medicaid and SCHIP enrollment so that the number of New Mexicans with Medicaid or SCHIP coverage equaled New Mexico's administrative (unduplicated) count of enrollees by age and gender, and in urban and rural areas respectively. Individuals eligible for assignment to Medicaid or SCHIP (or to SCI, as described below) were those who met New Mexico's categorical requirements in combination with income requirements after application of earned income disregards. In general, earned income disregards subtract a significant share of earned income from the family's adjusted gross income before calculating family income as a percent of FPL. The application of earned income disregards (which in New Mexico vary by the presence and age of children in the family) has the effect of qualifying categorically eligible persons for public coverage at higher levels of total income while encouraging work effort.

Other individuals were assigned to SCI, the New Mexico Health Insurance Alliance (NMHIA), the New Mexico Medical Insurance Pool (NMMIP), and the Premium Assistance (PA) program on a probability basis. The resulting data file included families and individuals assigned to each program in numbers equal to the program's unduplicated counts of enrollees (by age, gender, and location if provided) in 2006. Self-employed and other individuals who were assigned to NMHIA and NMMIP included only those who reported good, fair, or poor health status—reflecting adverse selection into these programs commensurate with their cost experience.

In addition, every worker in the data file was identified as having an employer offer of coverage or not. To do this, we estimated a logistic regression model among all adult workers in the 2002 New Mexico Household Survey. The regression model considered the workers' socio-

(continued)
is that of a core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. Metropolitan statistical areas are relatively freestanding and typically surrounded by nonmetropolitan counties. Current metropolitan statistical area definitions were announced by OMB effective June 6, 2003 (See: http://www.census.gov/population/www/estimates/aboutmetro.html).

[5] Urban residents included those in metropolitan statistical areas (MSAs). In New Mexico, these include the Albuquerque MSA (including Bernalillo, Sandoval, Torrance, and Valencia County), Santa Fe MSA (i.e. Santa Fe County), Farmington MSA (i.e. San Juan County), and Las Cruces MSA (i.e. Dona Ana County). Rural residents included those in non-MSA counties.

demographics (age, gender, race, education, and marital status), health status, family characteristics (the presence of children, family size and level of family income), employment characteristics (industry, whether self-employed, and whether working full-time), and geographic location (in MSA or nonMSA).[6] We ran the model twice to estimate separate probabilities of having an offer for single coverage and having an offer for family coverage. The coefficient estimates were used to predict the probability of employer offer (of single and family coverage) for each adult worker in our population data file, who were not already enrolled with employer coverage. Because our microsimulation model assumes that none of the reform models would increase employer offer of coverage, only workers with a predicted offer would be eligible to enroll in the private group coverage under the proposed Health Coverage Plan.

Finally, private-sector workers with employer-sponsored coverage were assigned to self-insured group coverage versus insured group coverage. Private-sector workers with employer-sponsored coverage (as well as covered family members) were assigned randomly to self-insured coverage to equal to the proportion of private-sector workers in self-insured plans by firm size and industry group that was reported for New Mexico in the 2004 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC).

2. Medical Expenditure Estimates

Expenditure estimates for each record in the microsimulation database were obtained from the 2004 Medical Expenditure Panel Survey – Household Component (MEPS-HC). Two types of information were appended to each record in the population data file: (1) number of months enrolled in a specific source of coverage; and (2) the amount of expenditure by source of payment and type of service.[7] Sources of coverage included Medicaid/SCHIP, employer-based insurance, other private insurance, other federal programs, and other state programs. Types of services include inpatient and outpatient hospital care, emergency services, practitioner services, prescription drugs, home health care, vision and dental services, and other services and durable medical equipment.

For each individual, expenditure estimates were then adjusted in two ways. First, individual observations were re-weighted so that the total number of enrollment months in the data file equaled the number of enrollment months reported in 2006, by source of payment. This process identified a large number of low-income New Mexicans who were enrolled in Medicaid or SCHIP for just part of the year, consistent with the programs' administrative data on the average number of months per enrollee. (In SFY2006, the average reported duration of enrollment in these programs was 6.7 months.)

Second, expenditure levels (which in MEPS-HC reflect, in effect, the national average) were scaled to equal expenditure levels by source of payment in New Mexico, projected to 2007.

[6] Because a number of these variables (employee age, gender and industry) determine the premium quoted to the employer, in effect the regression model estimated a reduced form specification of employer demand, including price.

[7] Records were appended using "cold-deck" procedure, which statistically matched expenditures to person records controlling for age, health status, location, income, race, and insurance coverage.

Rates of increase to 2007 were calculated as the average annual rate of historical growth in expenditures per member per month by source of payment, typically from 2002 to 2006. Assumed rates of growth (as well as other key parameters) are documented in Table II.1.

TABLE II.1

AVERAGE ANNUAL MEDICAL COST GROWTH BY PAYER
(Per member per month)

Payer	Estimate	Source
FEHBP, self-insured employer plans and private group insurance	10.0%	Estimated as the average reported annual increase in state employee plan cost per member per month from FY2002 to FY2006.
Individual (nongroup) private insurance	23.3%	Estimated as 2/3 the estimated average reported annual medical cost growth for self-employed enrollees in NMHIA.
Medicaid and SCHIP	4.6%	NM Human Services Department. Estimated as the average reported annual increase in medical costs per member per month from FY2002 to FY2006.
NMHIA	22.6%	NM Health Insurance Alliance. Estimated as the average reported annual increase in medical costs per member per month from FY2002 to FY2006, including group and self-employed enrollees.
NMMIP	1.0%	NM Medical Insurance Pool. Estimated as the average reported annual increase in medical costs per member per month from FY2004 to FY2006.
SCI	22.6%	Estimated as the average annual increase in medical costs per member per month in NMHIA from FY2002 to FY2006.
State employee health plan	10.0%	Data provided by state employee plan carriers. Estimated as the average annual increase in state employee plan cost per member per month from FY2002 to FY2006.

3. Benefit Design

Benefit design has important implications for consumers' use of health services, both in the current case and in each of the reform models. To simulate the benefit design that individuals would experience in each of the reform models we developed a summary measure of benefit design for each of four major sources of coverage: (1) the state employee health plan; (2) private group insurance; (3) individual private insurance; and (4) Medicaid and SCHIP. For each source of coverage, we calculated average out-of-pocket spending as a percent of the total cost by type of service, among individuals with at least 10 months of coverage, while covered from that source.

These estimated "copayment" rates are implicit in the current case, and are used explicitly to measure benefit designs in the reform models and, therefore, the responses of individuals to a change in their source of coverage. For example, individuals who move from uninsured status (with a copayment rate of 100 percent for all services) to Medicaid or SCHIP would experience a

reduced copayment rate of 5.1 percent for physician services and 15.7 percent for prescription drugs in the reform model (Table II.2). Similarly, individuals who move from private group coverage in the current case to either the Health Security Plan or the New Mexico Health Choices Alliance "medium-option" standard benefit, both essentially patterned on the state employee health plan, would see an increase in their average copayment rate for hospital and physician services, but a somewhat lower copayment rate for prescription drugs.

TABLE II.2

MEASURES OF BENEFIT DESIGN: ESTIMATED AVERAGE COPAYMENT RATES BY SOURCE OF COVERAGE AND TYPE OF SERVICE IN THE CURRENT CASE

	State Employees	Private Group	Private Individual	Medicaid/SCHIP
	(Percent of total expenditures)			
Inpatient	2.5%	2.2%	9.1%	0.0%
Outpatient	7.2	5.0	15.6	0.5
Emergency room	10.9	8.6	11.4	1.3
Physician	21.4	16.1	40.5	5.1
Prescription drugs	34.8	35.3	59.6	15.7
Vision/dental	50.7	45.8	71.8	25.7
Other medical services and supplies	40.8	42.7	71.6	19.1
Home health	9.9	11.2	25.2	0.0

Source: Mathematica Policy Research, Inc.

4. Nonmedical Cost Estimates

The nonmedical cost of coverage includes an array of activities undertaken by state agencies, private and public employers, and private health insurance plans. These include administrative effort (such as determination of eligibility for coverage, and enrollment and disenrollment from coverage), claims processing and provider relations, and insurer surplus and profit.

Plan sponsors—both governments and employers—incur direct nonmedical costs to administer health insurance plans. Estimates of nonmedical costs in the current case, by plan sponsor, are documented in Table II.3. These estimates are calculated at the margin, in order to facilitate comparison of the current case and the reform models. That is, they are intended to approximate the additional cost that plan sponsors would incur as a percentage of medical cost, if enrollment increased. Conversely, a decline in enrollment would reduce administrative costs proportionate to the decline in medical expenditures.

In the case of means-tested public coverage, the marginal cost of administration is estimated as a per-person cost of eligibility determination; other agency costs—including the cost of contracting with private managed care organizations and other costs of oversight—are regarded as overhead that would not increase significantly with an expansion of enrollment such as the

reform models contemplate. In the case of employer coverage, NMHIA, and NMMIP, direct administrative cost is estimated in direct proportion to medical expenditures—the metric that private insurers and these programs currently use as context for the level of administrative cost.

State agencies with oversight of Medicaid, SCHIP, SCI, NMHIA, and NMMIP each provided estimates of the cost of program administration. For Medicaid and SCHIP, this amount was estimated as $125 per applicant in 2007. The employer cost of plan administration was estimated from analysis of the projected SFY2008 cost of the state employee health plan relative to projected medical expenditure.

TABLE II.3

MARGINAL COST OF PROGRAM ADMINISTRATION BY PLAN SPONSOR

Plan Sponsor	Estimate	Source
Employer cost of administering employee health insurance plans	1.0% of medical cost	NM General Services Department.[a] Estimated as FY08 projected permanent FTE staff costs per projected FY08 medical claims paid for state employees.
State cost of determining Medicaid/SCHIP/SCI eligibility	$125 per applicant	NM Human Services Department estimate.
NMHIA administration	3.9% of medical cost	NM Health Insurance Alliance. Estimated as the reported net administrative and overhead cost rate from January to June SFY2006 per paid claims.
NMMIP administration	5.6% of medical cost	NM Medical Insurance Pool, Administrative Summaries. Estimated as the reported FY2002-2006 unweighted average administrative cost per paid claims.

[a] See: http://www.generalservices.state.nm.us/pdf/ SDStratgcPlan2FY08.pdf, p. 21.

Finally, we estimated the total nonmedical cost of insurance separately for each source of coverage in New Mexico. These estimates are documented in Table II.4. Estimation of average total nonmedical costs—including both the cost of the plan sponsor and the cost of insurance coverage—was necessary in order to compare the net cost of reform models that might substantially or entirely eliminate some sources of coverage or greatly expand enrollment in some programs.

TABLE II.4

TOTAL NONMEDICAL COST AS A PERCENT OF TOTAL COST BY PAYER
(current case)

Payer	Estimate	Source
FEHBP	15.0%	NM Public Regulation Commission. Estimated as the average CY2004-CY2005 nonmedical cost rate reported for FEHBP coverage in NM, weighted by earned premiums.
Self-insured employer plans	15.7%	Estimated as the average 2004-2005 FEHBP nonmedical cost rate plus the employer cost of plan administration.
Group private insurance	18.8%	NM Public Regulation Commission. Estimated as the average CY2004-CY2005 nonmedical cost rate for group health insurance reported by NM group health companies (weighted by earned premiums) plus the employer cost of plan administration.
Individual (nongroup) private insurance	28.1%	NM Public Regulation Commission. Average CY2004-CY2005 nonmedical cost rate for nongroup health insurance reported by NM nongroup health companies, weighted by earned premiums.
Medicaid and SCHIP	16.3%	NM Human Services Department. Estimated as the average of (a) the allowed nonmedical cost of MCOs and (b) nonmedical cost for FFS reported by HSD, weighted by SFY2006 reported medical costs and converted to a percentage of total cost. Added to this amount is the HSD cost of eligibility determination ($125 per applicant).
NMHIA	20.4%	NM Health Insurance Alliance. Estimated as the sum of group private insurance nonmedical costs plus NMHIA administrative and overhead cost expressed as a percent of total cost.
NMMIP	5.3%	NM Medical Insurance Pool. Estimated as the reported FY2002-2006 unweighted average administrative cost per paid claims, converted to a percentage of total cost.
SCI	19.9%	NM Public Regulation Commission and NM Human Services Department. Estimated as the nonmedical cost of group insured plans plus the HSD cost of eligibility determination ($125 per enrollee).
State employee health plan	15.1%	NM Public Regulation Commission. Estimated as the average 2004-2005 nonmedical cost rate reported for FEHBP coverage in NM, weighted by earned premiums, plus employer cost of plan administration.

Estimates of the nonmedical cost of private insurance were obtained from the statements that health companies in New Mexico (and in all other states) file annually with the Public Regulation Commission. In cases where the reported data were inadequate to identify nonmedical costs (for example, for state employees in New Mexico) we made reasonable assumptions (in this case, assigning to state employees carriers' reported nonmedical cost rate for federal employees).

In public programs that contract with private insurance plans—including Medicaid, SCHIP, SCI, and NMHIA—the state cost of administration and the net cost of private insurance are

additive. Similarly, the employer cost of plan administration and the net cost of private insurance are additive. In general, higher nonmedical costs as a percentage of total cost are associated with relatively small levels of enrollment and/or a relatively high enrollment of very small groups and/or self-employed individuals. Conversely, relatively low nonmedical costs are associated with greater scale of operations and/or high levels of medical cost per enrollee.

5. Anticipated Expansion of Eligibility for Medicaid and SCI

The microsimulation database was assembled during the course of New Mexico's 2007 legislative session. During this session, Governor Richardson proposed an expansion of SCI eligibility to include all adults below 100 percent FPL. Approximately one year after implementation of expanded SCI eligibility, the Administration hopes to make parents below 100 percent FPL eligible for Medicaid—a transition that would improve benefits for which they qualify (SCI benefits are capped at $100,000 annually) but reduce the level of federal match.

We were asked to incorporate both changes in the "current case" for the purpose of modeling. To reflect these changes in the microsimulation database, all parents with income below 100 percent FPL (after the application of earned income disregards) were transitioned to Medicaid. Other income-eligible parents with uninsured months were randomly assigned until the number of enrolled parents equaled Human Services Department's (HSD) projected enrollment associated with this expansion of Medicaid eligibility.

To simulate new enrollment in SCI, income-eligible individuals who reported at least one uninsured month were assigned randomly to the program, until the number of enrolled individuals equaled New Mexico's projected net SCI enrollment associated with this expansion of eligibility. Individuals were then re-matched to MEPS-HC expenditure records to obtain estimates of average monthly expenditure while on Medicaid or SCI, respectively, and new expenditures were scaled to projected 2007 levels.

B. THE MICROSIMULATION MODEL

The microsimulation uses a logic model that assigns individuals by coverage month to various sources of available coverage. It assumes that all individuals in New Mexico, when subject to a requirement that they have coverage, comply with that requirement. The reasonableness of that assumption is then examined in terms of the personal cost to New Mexico families and individuals of complying.

1. Enrollment in Coverage

All of the simulations assume that employers will not newly sponsor coverage if they do not do so in the current case. Workers (and their dependents) may newly enroll in employer coverage if it remains available to them, but any new enrollment in employer-sponsored is due to workers who are offered coverage in the current case but do not enroll deciding in the reform model to accept coverage.

Following the logic that there is no new offer of employer sponsored coverage, the microsimulation first assigns individuals who are eligible for Medicaid or SCHIP to those

programs for the full year. For the Health Security Act and New Mexico Health Choices version 1, other adults and children (except American Indians and other Native Americans, as described below) were assigned full year coverage in the Health Security Plan and New Mexico Health Choices plan, respectively.

For New Mexico Health Choices version 2 and for the Health Coverage Plan, the microsimulation assumes that, when there is a choice of plan, individuals always enroll in the least expensive option open to them. Therefore, in New Mexico Health Choices version 2, self-insured employers buy coverage through the Alliance if the Alliance premium is less than they are paying per employee for coverage. Both self-insured and insured employers that currently offer coverage continue to do so. Employees that decline an offer of coverage from their employer either accept public coverage (if eligible) or enroll as individuals in the Alliance.

In the Health Coverage Plan, individuals accept Medicaid and SCHIP coverage if eligible, or they accept an employer offer of coverage if it is available to them and requires no contribution to coverage. Otherwise they accept employer offer with an employee contribution to coverage, buy individually into SCI (if eligible), or buy individual coverage. NMMIP remains the insurer of last resort: individuals who are denied individual coverage (and otherwise are neither eligible for public coverage nor offered employer coverage) buy coverage in NMMIP.

In each of the simulations, American Indians and other Native Americans are assumed to enroll as do other New Mexicans. Tribal participation in the programs—potentially with tribal contributions to coverage—is not assumed during the projection period.

2. Actuarial Cost Projections

Actuarial Research Corporation provided estimates of the change in health services use and expenditure that would occur as New Mexicans changed their health insurance status and sources of coverage under each of the reform models. A change in coverage that results in lower out-of-pocket costs induces enrollees to use more services, resulting in higher total spending. Conversely, when out-of-pocket costs increase, enrollees tend to use fewer services and thus have lower total spending.

To estimate the effect of changes in cost sharing on utilization, an induction factor ("alpha") is used. An induction factor is a measure of the change in total spending associated with a change in out-of-pocket costs. For example, if the induction factor is 0.5, this means that for every $1 decrease in out-of-pocket costs, covered charges will increase by $0.50. Conversely, every $1 increase in out-of-pocket costs results in a $0.50 decrease in total spending.

For some services (such as inpatient hospital care), the need for the service is important enough that people are less likely to change their spending patterns based on changes in out-of-pocket costs. However, in some circumstances, consumers may perceive other services (such as physician office visits or prescription drugs) as discretionary. Thus, the induction factors used in the microsimulation model vary by service, as documented in Table II.5.

TABLE II.5

INDUCTION FACTORS FOR ESTIMATION OF CHANGE IN UTILIZATION AND EXPENDITURE

Type of Service	Change in Covered Charges Associated with a $1 Decrease in Out-of-Pocket Costs (in dollars)
Hospital inpatient	0.30
Hospital outpatient	0.70
Emergency room	0.30
Physician	0.70
Prescription drugs	1.00
Vision/dental	0.70
Other services and supplies	0.70
Home health	0.70

Source: Based on induction factors used by E. Hustead, P. G. Hendee, et al., "Medical Savings Accounts: Cost Implications and Design Issues." Washington, DC: American Academy of Actuaries, 1995

For the New Mexico analysis, the effect of induction is modeled on the average spending of subgroups of the population, not on each individual. The subgroups were chosen to reflect similarities in total spending and cost-sharing situations in both the current case and the reform models. The data were divided into 30 categories based on the insurance status, poverty status (that is, income adjusted by family size), and location:

- Type of current-law insurance coverage (private, public, or uninsured)
- Income relative to FPL (<100%, 100-199%, 200-299%, 300-399%, 400%+)
- Urban or rural location (MSA or non-MSA)

Three expenditure matrices (with total expenditures in thirty population categories by eight service types) then were created: (a) the current case (reflecting current law); (2) the shift case (reflecting the reform regime before the induction adjustment), and (3) the response case (reflecting the reform regime including the effect of induction). To create the shift matrix, expenditures in the current case were adjusted to reflect the change in benefit design that individuals who changed sources of coverage would experience. As explained above, this was done by calculating current-case out-of-pocket expenditures relative to total expenditures by detailed source of coverage and type of service, and applying these ratios to the expenditures of persons by their source of coverage in the reform regime (Table II.2). Induction effects were then calculated separately for each cell in the shift matrix by calculating the change in total spending using the induction formula. The response matrix was calculated as current-case spending plus the induction effect.

The estimation assumed that several sources of expenditure in New Mexico would remain unchanged between the current case and the reform models. These included spending associated with enrollees in the Federal Employee Health Benefit Plan (FEHBP) or in TRICARE in the current case. Consequently, new total spending was distributed among all other sources of spending in the reform model using the shift matrix relationships. This process was repeated for each cell and each type of service for each of the reform models. The resulting estimates approximate total spending by service type and source of payment, accounting for consumer response to changes in benefit design, if any, that they experience in the reform models.

III. CURRENT COVERAGE AND EXPENDITURES IN NEW MEXICO

This chapter provides an overview of current sources of coverage in New Mexico, allocating individuals to the source of coverage that they held for the longest period during the year. We then consider how much New Mexicans now pay for health care, including payments to health care providers (medical expenditures) and the cost of administering public programs and private coverage (nonmedical expenditure).

A. CURRENT COVERAGE

Coverage is not static—in every state, people move in and out of different coverage from various sources, and also gain and lose coverage during the year. In New Mexico, we estimate that part-year coverage is especially common.

To simplify the analysis, we identified individuals by their predominant source of coverage based on simulated months of coverage during the year. We identified individuals as predominantly uninsured if they were uninsured six months or more during the year. All others were assigned to their predominant source of coverage, defined as the source of coverage that they reported for the greatest number of months during the year.[8]

In 2006, an estimated 42 percent of the state's noninstitutionalized non-elderly population—more than 700 thousand New Mexicans—were predominantly covered by employer-sponsored insurance (Figure III.1). Approximately 2 percent purchased individual private insurance directly from insurers or from the state's high-risk pool, the New Mexico Medical Insurance Pool (NMMIP). NMMIP enrolls approximately one thousand "high-risk" individuals who were denied private coverage or quoted a higher premium due to past or current health problems.

Public health insurance programs covered an estimated 30 percent of New Mexicans under age 65 in 2006. Together, Medicaid and SCHIP (excluding SCI) covered 432 thousand people—just over a quarter of the population.[9] Other state or federal public programs—respectively including the State Coverage Insurance (SCI) program and the federal TRICARE program—covered an estimated 4 percent of the population.[10, 11]

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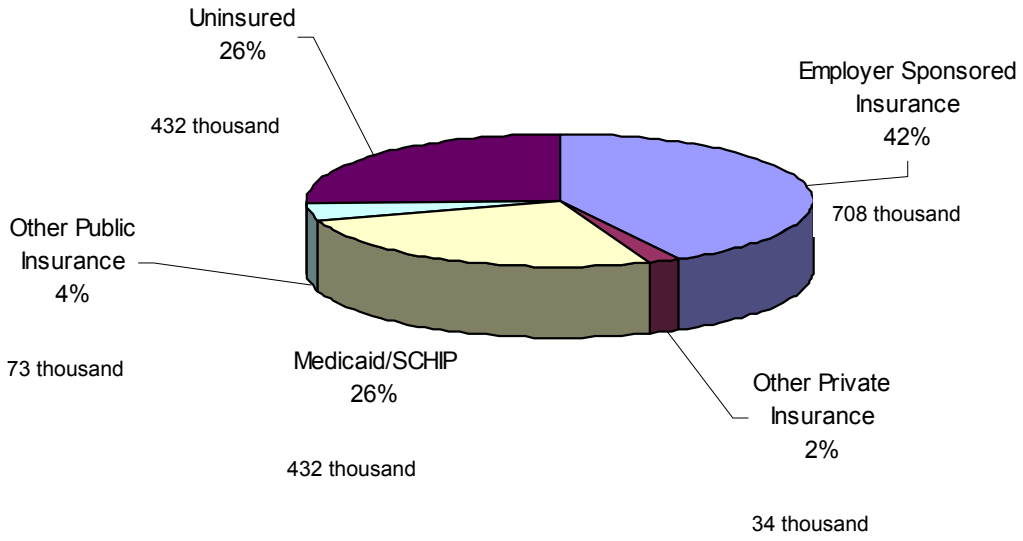
[8] This method of identifying uninsured New Mexicans (based on MEPS-reported months of coverage) differs from the definition used in the CPS. The CPS defines individuals as uninsured if they are uninsured all year, but the similarity between the MEPS and CPS estimates has led many researchers to regard CPS as reporting point-in-time estimates. CPS estimates of uninsured in New Mexico in 2006 (24 percent of the noninstitutionalized population under age 65) are slightly lower than our MEPS-based estimates (26 percent).

[9] In addition to these persons, Medicaid covers dually eligible Medicare beneficiaries in the community and income-qualified residents of nursing homes and facilities for mentally retarded residents. These beneficiaries were excluded from the analysis, in large part because their complex care needs and the federal rules that apply to these persons warrant separate consideration beyond the time and resources available to this project.

[10] While active military personnel were excluded from the analysis, a small number of military retirees and dependents reported benefits from TRICARE.

FIGURE III.1

ESTIMATED DISTRIBUTION OF NEW MEXICANS UNDER AGE 65
BY PREDOMINANT SOURCE OF HEALTH COVERAGE, 2006



Source: Mathematica Policy Research, Inc.

Notes: Data include only the noninstitutionalized population under age 65. Medicare beneficiaries and active military personnel are excluded. Individuals are identified as uninsured if they were uninsured at least 6 months during the year; all others are allocated to the source of coverage they reported for the greatest number of months.

Detailed estimates of New Mexicans by their predominant sources of health coverage are reported in Table III.1. Among New Mexicans predominantly covered by an employer-sponsored plan, 90 percent are private-sector employees and their dependents. The remaining 10 percent are state or federal employees and their dependents. Federal employees in New Mexico account for an estimated 2 percent of the noninstitutionalized civilian population under age 65, and just over 4 percent of New Mexicans with employer sponsored coverage. Covered by Federal Employee Health Benefits Program (FEHBP), these employees and their covered dependents would remain in FEHBP under each of the reform models.

An estimated 36 percent of insured New Mexicans with employer-sponsored coverage (approximately 255 thousand workers and dependents) are enrolled in self-insured plans. These plans are governed by the federal Employee Retirement Income Security Act (ERISA) and are exempt from state regulation or taxation.

(continued)

[11] Indian Health Service (IHS), the Veterans Administration (VA) and some other public programs that directly pay for personal health care services are not considered health insurance programs. New Mexicans with only IHS- or VA-covered spending are considered uninsured.

TABLE III.1

ESTIMATED NUMBER AND PERCENT OF INSURED AND UNINSURED NEW MEXICANS BY PREDOMINANT SOURCE OF COVERAGE IN 2006

Source of Coverage	Number of Persons (in thousands)	Percent	Percent within Major Source of Coverage
Total	1,679.1	100.0%	---
Employer sponsored insurance	707.9	42.2	100.0
Private employers	637.6	38.0	90.1
Self-insured plans	254.5	15.2	36.0
Insured plans	383.1	22.8	54.1
Firms with 1-24 employees	87.9	5.2	12.4
Firms with 25-99 employees	47.6	2.8	6.7
Firms with 100 or more employees	242.7	14.5	34.3
NMHIA	5.0	0.3	0.7
State and local government	39.0	2.3	5.5
Federal government	31.3	1.9	4.4
Individual private insurance	34.1	2.0	100.0
NMMIP	1.4	0.1	4.2
Other private insurance	32.6	1.9	95.8
Public Insurance	505.0	30.1	100.0
Medicaid/SCHIP	431.9	25.7	85.5
SCI/SEIP	8.2	0.5	1.6
TRICARE	64.8	3.9	12.8
Uninsured	432.1	25.7	100.0
Medicaid/SCHIP eligible	227.5	13.5	52.6
Not Medicaid/SCHIP eligible	204.6	12.2	47.4

Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded. Individuals are identified as uninsured if they were uninsured at least 6 months during the year; all others are allocated to the source of coverage they reported for the greatest number of months.

Private employers that offer insured health plans provide coverage to additional 383 thousand workers and dependents. Employers with fewer than 100 employees provide coverage to about a third of these workers and dependents—about 8 percent of New Mexicans under age 65.

New Mexico has launched a series of initiatives in the recent years to improve access to insurance coverage. Currently, nearly 5 thousand small-group employees or self-employed workers and dependents obtain coverage through the New Mexico Health Insurance Alliance (NMHIA). The State Coverage Insurance (SCI) program and the Small Employer Insurance Plan (SEIP) together enroll approximately 8 thousand New Mexicans. Enrollees in SCI have

coverage capped at $100,000 per year, pay low and subsidized premiums for coverage, and draw the same federal match as SCHIP enrollees.

Finally, 432 thousand New Mexicans are predominantly uninsured, accounting for 26 percent of population under age 65. In New Mexico, children through age 18 below 235 percent of the federal poverty level (FPL) with earned income disregards are eligible for Medicaid or SCHIP. In addition, as of 2007, both parents and adults without children to 100 percent FPL are eligible to enroll in SCI. New Mexico hopes to move SCI-eligible parents into Medicaid, and requested that we model the "current case" under the assumption that these parents would indeed be Medicaid-eligible. Base on these expanded eligibility rules, we estimate that slightly more than half of uninsured New Mexicans would be eligible to enroll in either Medicaid or SCHIP.

B. CURRENT HEALTH CARE EXPENDITURES

1. Total Expenditures

In 2004, New Mexico's Legislative Council Service (LCS) completed an extensive report on health care costs in New Mexico for the Legislative Health and Human Services Committee.[12] This report was a valuable tool in the preparation of the estimates that follow. Our estimates differ in that they exclude expenditures for New Mexicans age 65 or older, other Medicare beneficiaries under age 65, and active-duty military personnel. In addition, all expenditures are projected to 2007. Finally, private insurance expenditures include coverage for local government units that may have been included as public expenditures in the LCS report.

In 2007, expenditures for personal health care services in New Mexico for the noninstitutionalized civilian population under age 65 are projected to exceed $6 billion (Table III.2). Privately insured expenditures account for 44 percent of total personal health care spending; New Mexicans pay 18 percent of health care expenditures out of pocket (Figure III.2).

[12] Legislative Health and Human Services Committee, House Bill 955 Comprehensive Study on Health Care and Health Care Costs in New Mexico, December 2004 [http://legis.state.nm.us/lcs/lcsdocs/153454.pdf].

TABLE III.2

PROJECTED HEALTH CARE EXPENDITURES AND FUNDING
FOR NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER AGE 65, 2007
(2006 Dollars in millions)

Program	Total Expenditures	MSA Counties[a]	Non-MSA Counties
Total [b]	**$6,305.9**	**$3,960.5**	**$2,345.4**
Federal expenditures	**1,782.8**[c]	**1,086.0**	**696.9**
Federal employees	121.8	63.1	58.7
Medicaid	1,149.6	709.1	440.5
SCHIP	107.3	71.1	36.2
TRICARE	267.7	151.2	116.5
Veteran Affairs	32.6	28.4	4.2
Other federal programs	8.6	---	---
Indian Health Services	26.0	---	---
Other federal funding:			
Maternal and Child Health	3.8	---	---
Emergency medical services for children	0.7	---	---
Family planning services	3	---	---
Community health centers	51.6	---	---
Immunization grants	0.8	---	---
Breast & cervical cancer detection	3.3	---	---
Infant health initiative programs	0.3	---	---
Coal miners respiratory impairment treatment clinics and services	0.3	---	---
Diabetes control programs	0.6	---	---
Maternal and child health services block grant	4.8	---	---
State expenditures	**641.7**	**374.7**	**267.0**
State employees	136.0	59.0	77.0
Medicaid	448.6	276.7	171.9
SCHIP	12.7	5.1	7.6
SCHIP-SCI	13.4	12.2	1.2
Premium Assistance	2.9	2.4	0.5
Other state programs	28.1	19.3	8.8
Private insurance expenditures	**2,746.0**	**1754.0**	**992.0**
New Mexico Health Insurance Alliance	22.5	16.9	5.6
New Mexico Medical Insurance Pool (MIP)	25.5	15.0	10.5
SCI premiums	0.6	0.5	0.05
Privately insured	2,697.4	1,721.6	975.8
Out-of-pocket expenditure	**1,135.4**	**745.8**	**389.6**

Sources: Mathematica Policy Research estimates. Indian Health Services and other federal funding are estimated from: U.S. Census Bureau, Consolidated Federal Funds Report: Fiscal Year 2004 [http://www.census.gov/govs/ www/cffr.html]; and are allocated to MSA and non-MSA based on population size for total expenditures by location.

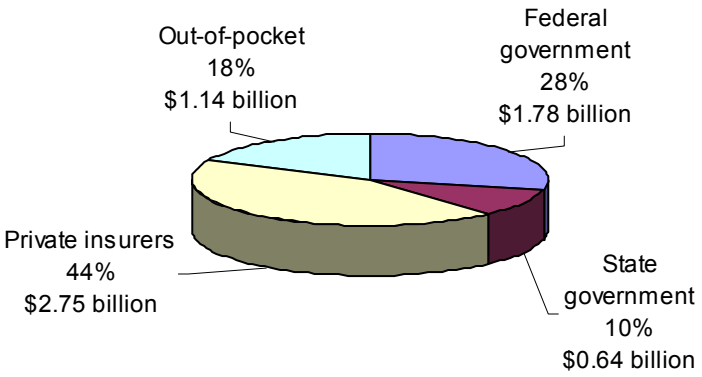
[a] MSA counties include Bernalillo, Sandoval, Torrance, and Valencia Counties (Albuquerque MSA), Santa Fe County (Santa Fe MSA), San Juan County (Farmington MSA), and Dona Ana County (Las Cruces MSA).

[b] Estimates exclude DHHS health programs targeted to specific conditions and/or populations.

[c] Future estimates may be different, because other federal funding is not included in our microsimulation model.

FIGURE III.2

PROJECTED TOTAL NEW MEXICO HEALTH EXPENDITURES
FOR NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER AGE 65, 2007



Source: Mathematica Policy Research, Inc.

Notes: Data reflect the noninstitutionalized population under age 65. Medicare beneficiaries and active military personnel are excluded.

Together, federal and state government finance approximately 38 percent of total health care expenditures for the noninstitutionalized civilian population under age 65 in New Mexico—in 2007, an estimated $2.4 billion. Federal government finances nearly three-fourths of this amount—an estimated $1.8 billion. However, most care is paid privately—either through private insurers or out-of-pocket. Private insurers pay nearly $2.3 billion for medical services in New Mexico for the noninstitutionalized civilian population under age 65, while consumers pay about $1.1 billion out of pocket to cover medical expenditures that are not covered by any public or private insurance.

In New Mexico, Medicaid is the single largest federal program that finances health care for the civilian noninstitutionalized population under age 65, followed by expenditures for military dependents enrolled in TRICARE. Medicaid accounts for approximately two-thirds of federal funds received by the state—estimated at nearly $1.2 billion in 2007. TRICARE spending and the Veteran Affairs health care expenditures for service-related medical conditions together are estimated at $300 million. By comparison, Indian Health Services expenditures in New Mexico are relatively small (just over $26 million), while federal block grant programs and funding for federally qualified community health centers account for $69 million of health care spending in New Mexico.

State expenditures to finance personal health care services are projected to reach $642 million in 2007. Nearly all of this expenditure is for Medicaid and SCHIP ($461 million) and for state employee health benefits ($136 million). In addition, the state operates a number of programs intended to help individuals who do not qualify for Medicaid or SCHIP—including SCI and premium assistance for children and pregnant women. These programs are projected to

spend $44 million in 2007—approximately 7 percent of all state expenditures for health care services.

For nearly all programs, expenditures are higher in MSAs (Albuquerque, Santa Fe, Farmington, and Las Cruces) due to the larger number of beneficiaries in these population centers. However, expenditures per member month in Medicaid and SCHIP are higher in non-MSA counties than in MSA counties—in part reflecting low patient volume and therefore providers' higher average costs. For both the state employee health plan and in SCHIP—where the numbers of enrollees are more equal between MSAs and non-MSAs—expenditures in non-MSA counties are about 30 percent higher than in MSA counties.

In addition to direct expenditures for health care services, the federal government provides funding via Medicare reimbursement rates for medical education to teaching hospitals. Indirect medical education (IME) payments are based on Medicare inpatient cases, and are intended to compensate teaching hospitals for the extra patient care costs they incur.[13] Additional Medicare payments for direct medical education (DME)—sometimes called graduate medical education, or GME—are based on the number of medical residents and help teaching hospitals to cover the direct costs of providing clinical education.

Finally, the federal government provides special funding for "disproportionate-share hospitals" (DSH), recognizing that Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to care without regard to patients' ability to pay. DSH payments to hospitals that serve a disproportionate number of low-income or uninsured patients are based on the hospital's number of Medicare (Part A) days as well as the number of Medicaid days, the hospital's size, and whether it is a sole community provider or rural referral hospital. In 2007, hospitals in New Mexico are projected to receive almost $55 million in federal medical education and DSH payments; most of this funding (78 percent) will be directed to disproportionate share hospitals (Table III.3).

TABLE III.3

ACTUAL AND PROJECTED MEDICARE REIMBURSEMENT FOR DIRECT AND INDIRECT MEDICAL EDUCATION AND DISPROPORTIONATE IN NEW MEXICO, 2003-2007
(Dollars in millions)

	2003	2005	2007
Total	$41.3	$72.3	$54.6
Direct Medical Education (DME)	$2.4	$3.8	$3.0
Indirect Medical Education (IME)	$7.0	$11.7	$9.0
Disproportionate Share Hospital (DSH)	$31.9	$56.7	$42.6

Source: Mathematica Policy Research, Inc. Estimates based on: Centers for Medicare and Medicaid Services, Medicare Advantage – Rates and Statistics: FFS Data 2005 [http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/05_FFS_Data.asp].

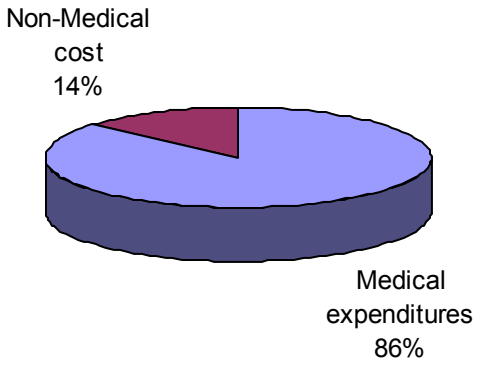
[13] IME payments are calculated by a formula in the Medicare statute that considers each hospital's medical resident-to-bed ratio. Hospitals receive IME payments as a percentage addition to their Medicare prospective payment per case.

2. Medical Expenditures

Of approximately $6.2 billion total health care expenditures associated with the noninstitutionalized civilian population under 65, approximately 86 percent (approximately $5.4 billion) is spent to pay providers for medical care (Figure III.3).

FIGURE III.3

PROJECTED MEDICAL EXPENDITURES VS. NON-MEDICAL COST
FOR NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER AGE 65, 2007



Source: Mathematica Policy Research, Inc.

Total medical expenditures by type of service are reported in Table III.4. In New Mexico, office-based providers constitute the largest single category medical expenditures for the noninstitutionalized civilian population under age 65. These providers account for an estimated 30 percent of total medical spending for this population, followed by prescription drugs (23 percent), and hospital inpatient care (21 percent).[14] Hospital inpatient and emergency room services account for about 12 percent of medical expenditure. Other services (including vision, dental, home health care, and other medical services and equipment) account for the remaining 14 percent.

[14] Inpatient hospital care includes both facility charges and expenses for physician services during a hospital stay.

TABLE III.4

ESTIMATED TOTAL MEDICAL EXPENDITURES FOR NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER 65 BY TYPE OF SERVICE AND LOCATION, 2007

	Total Medical Expenditures		MSA Counties		Non-MSA Counties	
	Total (in millions)	Percent of Total	Total (in millions)	Percent of Total	Total (in millions)	Percent of Total
All Medical Services	$ 5,394.6	100.0	$ 3,393.2	100.0	$ 2,001.4	100.0
Hospital inpatient	1151.1	21.3	703.6	20.7	447.6	22.4
Hospital outpatient	452.0	8.4	245.2	7.2	206.7	10.3
Emergency room	204.4	3.8	123.1	3.6	81.3	4.1
Office-based medical providers	1614.2	29.9	1048.6	30.9	565.6	28.3
Prescription	1232.5	22.8	758.3	22.3	474.2	23.7
Other medical services	740.4	13.7	514.5	15.2	225.9	11.3

Source: Mathematica Policy Research, Inc.

New Mexicans living in rural (non-MSA) areas spend a larger proportion of their medical dollars on hospital services (inpatient, outpatient, and emergency room) and prescription drugs, and a lower proportion on office-based providers and other service, than the population living in urban areas of the state.

3. Nonmedical Cost

All systems of health care financing entail significant nonmedical costs. For public programs, these costs include eligibility determination, negotiation and management of private health plan contracts, contract administrative services, provider relations, general administration and overhead. For privately insured or self-insured plans, nonmedical costs include claims processing, provider relations and contract management, marketing, general administration, surplus, and profit. Plan sponsors—including employers that offer health insurance benefits—also incur administrative cost associated with selecting, reviewing, and modifying coverage and enrolling and disenrolling employees from coverage when the enter, exit, or change coverage.

In all states, public systems that contract with private insurance plans incur the cost of program administration layered over the costs of private insurers. For example, in New Mexico (as in all other states), the Medicaid and SCHIP programs contract with private managed care organizations (MCOs) to provide and coordinate care for enrollees. The Human Services Department (HSD) conducts eligibility determination and enrollment and incurs some cost associated with MCO contracting. In addition, it allows MCOs a 15-percent margin over medical cost for their services. As a result, the total nonmedical cost of Medicaid and SCHIP are higher than 15 percent for beneficiaries enrolled in the MCOs.

Other programs (such as NMHIA and SCI) that contract with private insurers also have the same layering of nonmedical costs. In general, this additional nonmedical cost for public

programs is deemed cost effective; contracting private insurers are expected to ensure access to care, coordinate care effectively and efficiently, and monitor the quality of care that is provided.

In total, the nonmedical cost of state-based insurance programs and private insurance arrangements in New Mexico accounts for an estimated $842 million—more than 16 percent of total expenditures for health care among the civilian noninstitutionalized population under age 65 (Table III.5). Insured groups and individuals pay the highest rate of nonmedical cost—nearly 19 percent of total health care expenditures. As in other states, the highest nonmedical cost rates are associated with individual (nongroup) coverage—where on average 28 percent of premium is nonmedical cost—and small employer groups (estimates not shown separately). It is in part due to the high nonmedical cost of coverage that small employers are least likely to offer coverage and that individuals without an employer offer of coverage (unless eligible for public coverage) are most likely to be uninsured.

TABLE III.5

ESTIMATED TOTAL NONMEDICAL COST
FOR STATE AND PRIVATE THIRD-PARTY PAYERS IN NEW MEXICO, 2007

	Total, State and Private Payers	Medicaid, SCHIP, and SCI	Insured Groups and Individuals	Private Self-Insured Groups	Other Government Programs
Total nonmedical cost (in millions)	$842.1	$284.2	$403.5	$149.9	$4.5
Percent of total medical and nonmedical cost	16.5%	16.4%	18.5%	15.7%	7.2%

Source: Mathematica Policy Research, Inc.

Notes: Nonmedical expenditures include plan sponsors' marginal cost of administration plus private insurers' nonmedical costs. Medicaid, SCHIP and SCI estimates include amounts that are financed with federal matching funds. Insured groups include private, state, and federal public employees and dependents, including NMHIA, NMMIP, and TRICARE. Self-insured nonmedical cost estimates are based on the FEHBP nonmedical costs reported by health companies in New Mexico. Because out-of-pocket expenditures are excluded, percentage estimates do not equal those in Figure III.3.

In Chapter IV, we describe current health care coverage and expenditures in New Mexico from the perspective of key stakeholders—including employers, consumers, and health care providers. We then report (in Chapter V) the projected impacts of the reform models on total coverage and cost relative to the current-case estimates, and in Chapter VI turn again to the impacts on key stakeholders.

IV. STAKEHOLDERS IN THE CURRENT CASE

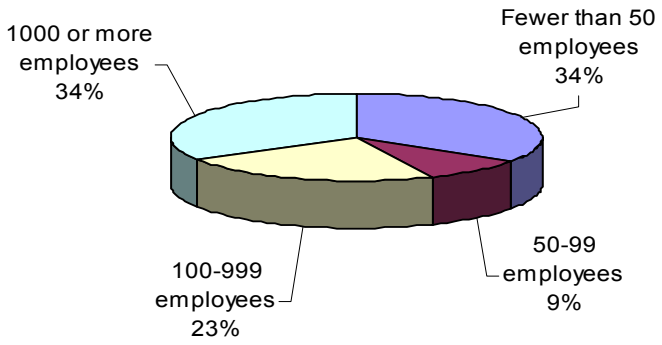
In this chapter, we describe current health care coverage and expenditures from the perspective of key stakeholders in New Mexico—employers, consumers, and providers. As described in Chapter II, our population-based estimates of coverage rely on a simulation using national data benchmarked extensively to New Mexico administrative data. This benchmarking process identified a significant number of New Mexicans with part-year coverage from various sources. A high rate of "churning"—movement across sources of coverage, and gain and loss of coverage—may disrupt access to care, compromise the quality of care, and contribute to higher nonmedical costs of coverage in New Mexico.

A. EMPLOYERS

While New Mexico is generally characterized as a "small-employer" state, about as many private-sector workers are employed in very large firms in New Mexico as are employed in small firms. In 2004, two-thirds of workers employed in the private sector worked either in small firms with 50 or fewer employees or in very large firms with 1,000 employees or more—divided about evenly between the two (Figure IV.1).[15]

FIGURE IV.1

DISTRIBUTION OF PRIVATE-SECTOR WORKERS IN NEW MEXICO
BY SIZE OF ESTABLISHMENT, 2004



Source: Medical Expenditure Panel Survey – Insurance Component (2004) [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2].

[15] Information about employers in New Mexico was obtained from the 2004 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), sponsored by the federal Agency for Research and Quality (AHRQ). MEPS-IC produces statistically significant estimates for New Mexico, and for many employment-size and industry subcategories of establishments in New Mexico.

Approximately 79 percent of private-sector workers in New Mexico are employed in firms that offer coverage (Table IV.1). About two-thirds of these workers are eligible for coverage, and when eligible most enroll. However, two aspects of this pattern are striking in New Mexico, as in other states. First, despite apparent high rates of offer, eligibility and enrollment are important determinates of ultimate coverage. In New Mexico, just half of private-sector workers ultimately enroll in employer-sponsored coverage, although more than three-quarters work in firms that offer coverage to at least some of their workers.

Second, the rate of employer offer in the smallest firms is strikingly low. In New Mexico, just 40 percent of workers in firms with fewer than 25 employees where coverage was offered to any workers; one-third were eligible for coverage; and just 26 percent were enrolled.

TABLE IV.1

PERCENT OF PRIVATE-SECTOR WORKERS OFFERED, ELIGIBLE, AND ENROLLED IN COVERAGE IN NEW MEXICO BY SIZE OF FIRM, 2004

		Number of Employees			
	Total	Less than 25	Less than 50	50 or More	1000 or More
Percent of employees in firms that offer coverage	78.5%	39.7%	48.8%	94.1%	99.7%
Percent of employees offered and eligible for coverage	67.7%	33.3%	39.2%	82.6%	86.3%
Percent of workers enrolled in coverage in firms that offer	52.0%	25.7%	27.9%	64.7%	67.8%

Source: Medical Expenditure Panel Survey – Insurance Component (2004) [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2].

Note: The percentage of employees offered and eligible for coverage is estimated from aggregated data by firm size.

On the whole, employers in New Mexico contribute slightly more as a percentage of premium to cover their workers than the national average—but this statistic is entirely related to the fact that small employers typically pay a larger share of premium than larger employers. In New Mexico, employers pay (on average) an estimated 83 percent of premium for single coverage in the smallest firms and 79 percent in the largest firms (Table IV.2).

The higher proportion of premium paid by small employers is, in general, related to how private insurance is rated; all else being equal, small firms are charged higher pemiums than larger firms—so that each addition employee who participates lowers the average premium for all. Controlling for firm size, employers in New Mexico paid a somewhat lower share of premium for single coverage than the national average, especially in both the smallest and largest firms.

TABLE IV.2

EMPLOYER CONTRIBUTIONS AS A PERCENT OF PREMIUM
IN NEW MEXICO AND THE U.S. BY SIZE OF FIRM, 2004

		Number of Employees			
	Total	Less than 25	Less than 50	50 or More	1000 or More
U.S. average					
Single coverage	81.9%	86.7%	85.5%	80.7%	80.2%
Family coverage	75.6%	77.3%	75.2%	75.1%	77.6%
New Mexico					
Single coverage	82.0%	83.4%	83.9%	81.4%	79.4%
Family coverage	79.9%	76.5%	74.8%	80.7%	73.9%

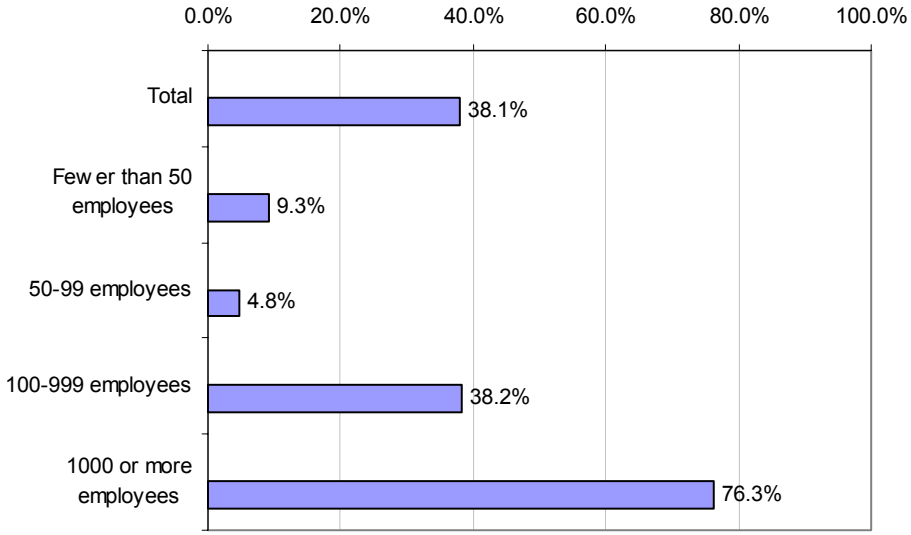
Source: Medical Expenditure Panel Survey – Insurance Component (2004) [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2].

Related to the significant level of private-sector employment in large firms in New Mexico, a large proportion of private-sector workers with employer-sponsored coverage are enrolled in self-insured plans. As noted in Chapter I, ERISA generally protects self-insured employer plans from state intervention.

In New Mexico, an estimated 38 percent of private-sector workers in 2004 were enrolled in a self-insured plan (Figure IV.2). Self-insured coverage is relatively rare in smaller firms: fewer than 10 percent of workers in firms with fewer than 100 workers were enrolled in self-insured plans. However, among workers employed in the largest firms (with more than 1,000 employees), 76 percent were enrolled in self-insured plans.

FIGURE IV.2

PERCENT OF PRIVATE-SECTOR WORKERS IN NEW MEXICO OFFERED AND ENROLLED IN SELF-INSURED COVERAGE BY SIZE OF ESTABLISHMENT, 2004



Source: Medical Expenditure Panel Survey – Insurance Component (2004) [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2].

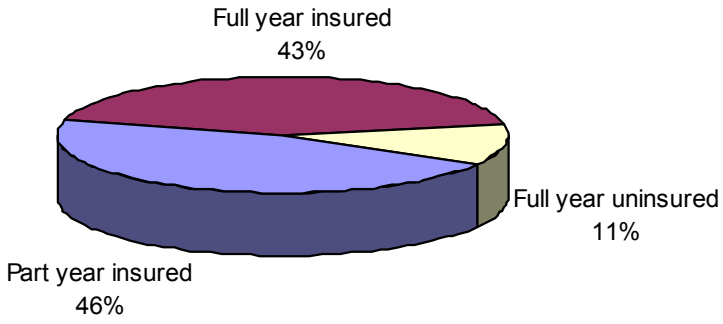
B. CONSUMERS

Nearly half (46 percent) of noninstitutionalized civilian New Mexicans under age 65 who have either public or private health insurance coverage at some time during the year—nearly 766 thousand individuals—are uninsured part of the year.[16] That is, these individuals gain or lose coverage at least once during the year, potentially representing gaps in access to care, but surely representing administrative costs associated with enrollment and disenrollment from coverage. A slightly smaller proportion—estimated at 43 percent of the population, or 728 thousand people—have health coverage all year. Approximately 11 percent (185 thousand people) are uninsured all year.

[16] As described in Chapter II, estimates of coverage and expenditures were derived from a process of matching national data on health care expenditures and months of coverage by source to an expanded, synthetic sample of New Mexico's noninstitutionalized population, taking into account an array of personal characteristics, insurance status, and location of residence. We then adjusted this information to state program data describing enrollment months, medical expenditures, and the characteristics and location of enrollees. This process produced probability estimates of full- and part-year coverage, as well as the expenditure estimates reported in Chapter III.

FIGURE IV.3

ESTIMATED PERCENT OF NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER AGE 65 WHO ARE INSURED ALL OR PART OF THE YEAR, 2006



Source: Mathematica Policy Research, Inc.

Note: Data include the noninstitutionalized population under age 65, and exclude Medicare beneficiaries and active military personnel.

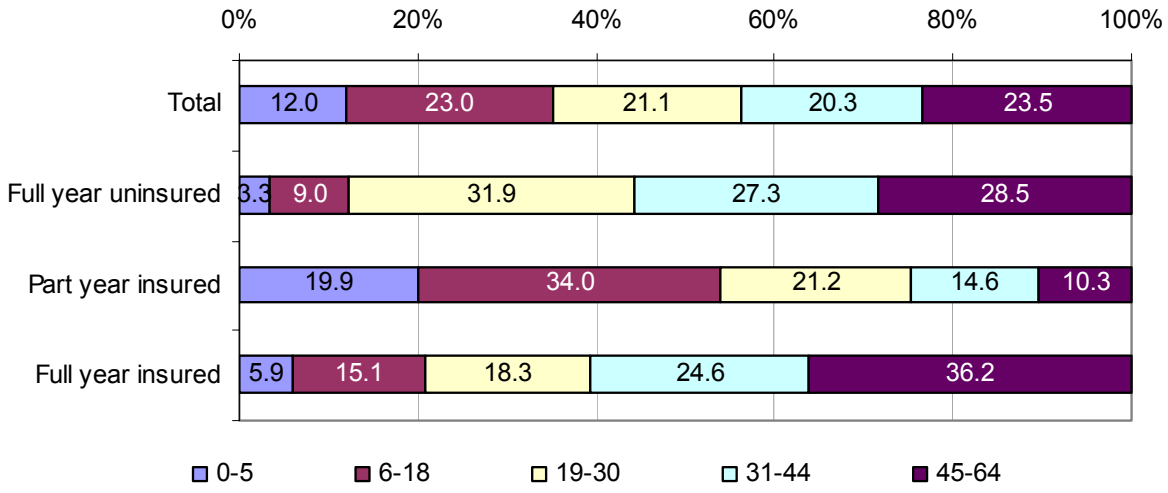
1. Characteristics of Uninsured New Mexicans

Most uninsured New Mexicans are adults, often under age 30. Often they are employed in small firms (with fewer than 25 employees), and have relatively low family income. However, we estimate that children in New Mexico are most at risk for part-year coverage—an apparent artifact of widespread access to public coverage but only part-year enrollment in these programs. These characteristics of the uninsured are described in more detail below.

Age. Most New Mexicans who are uninsured all year are adults (88 percent), most often under age 45 are (Figure IV.5). Adults aged 19 to 30 account for nearly one-third (32 percent) of the all-year uninsured New Mexicans—reflecting the high rate at which young adults in New Mexico currently are uninsured. Conversely, adults age 45 to 64 are most likely to be insured all year.

FIGURE IV.4

ESTIMATED DISTRIBUTION OF NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER AGE 65 BY AGE AND FULL- OR PART-YEAR COVERAGE, 2006



Source: Mathematica Policy Research, Inc.

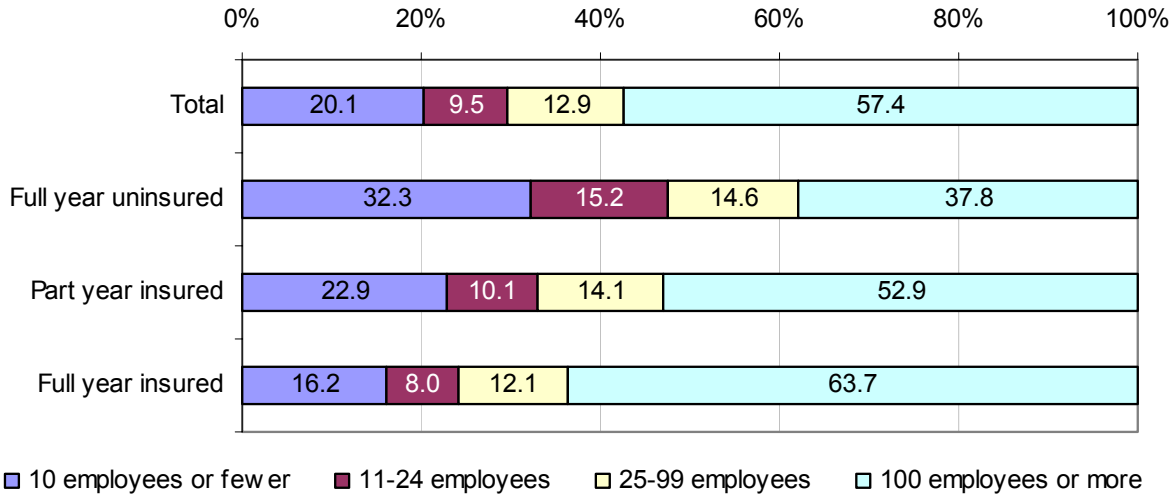
Note: Data include the noninstitutionalized population under age 65, and exclude Medicare beneficiaries and active military personnel.

While just 12 percent of all-year uninsured New Mexicans are children age 18 or younger, children account for more than half of the population that is part-year uninsured. An estimated 70 percent of children in New Mexico lose insurance coverage at some time during the year. Interruption of coverage is most common among children ages 6 to 18, who account for 34 percent of all part-year insured New Mexicans. In contrast, adults over 30, whether insured or uninsured, are likely to maintain the same insurance status for the entire year.

Firm size. Consistent with the earlier discussion of employer offer in small firms, workers in the smallest firms are at the greatest risk of being uninsured throughout the year (Figure IV.6). Workers in firms with 10 or fewer employees account for approximately 20 percent of all workers, but they account for 32 percent of workers who are uninsured all year. Workers in firms of 11-24 employees are as likely as those in the smallest firms to be uninsured all year, but because fewer workers are employed in firms of this size, they account for a smaller share (15 percent) of workers who are uninsured all year.

FIGURE IV.5

ESTIMATED DISTRIBUTION OF WORKERS IN NEW MEXICO
BY SIZE OF FIRM AND FULL- OR PART-YEAR INSURANCE STATUS, 2006



Source: Mathematica Policy Research, Inc.

Note: Data include the noninstitutionalized population under age 65, and exclude Medicare beneficiaries and active military personnel.

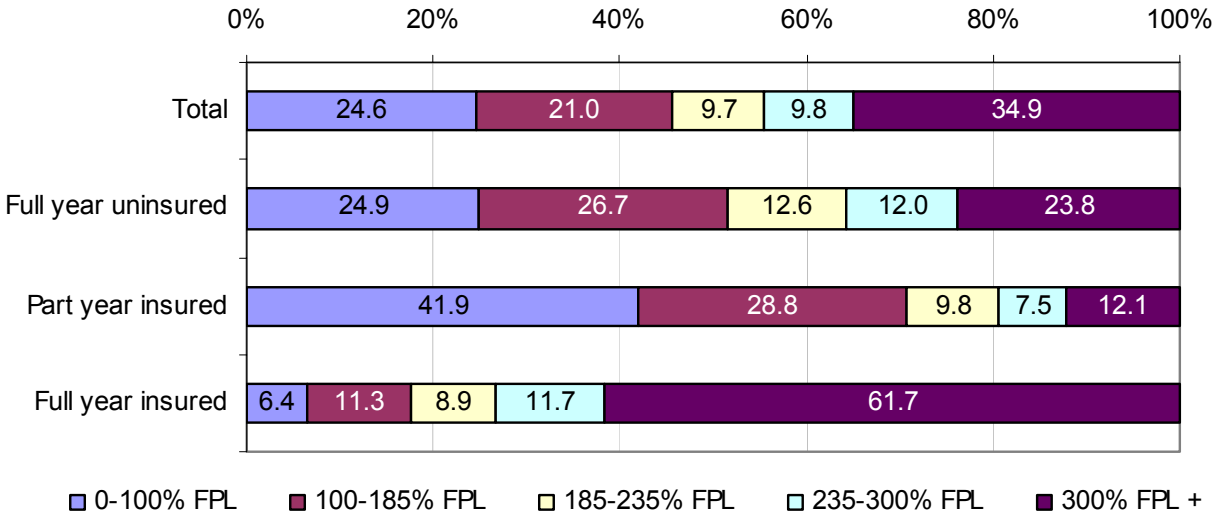
In contrast, workers in larger firms are more likely to have coverage throughout the year. Workers in firms with 100 employees or more account for about 57 percent of all workers, but nearly 64 percent of workers who are insured all year. Nevertheless, workers in large firms still account for more than half of workers in New Mexico who are insured part-year (53 percent) and more than one-third of workers who are uninsured all year (38 percent).

Family income. Slightly more than half of full-year uninsured New Mexicans under age 65 have family income below 185 percent FPL; at this level of income, all children qualify for Medicaid if they are residents (Figure IV.7). Moreover, 71 percent of the population that is insured just part of the year also report family income in this range.

New Mexicans with income below 100 percent FPL are rarely insured all year, but often have coverage part of the year—generally from public programs. This population accounts for nearly one-quarter of the noninstitutionalized population under age 65, but just six percent of those who are of full-year insured. Four in ten New Mexicans (42 percent) with part-year coverage have income below 100 percent FPL. In contrast, New Mexicans with family income above 300 percent FPL account for 62 percent of the population with full-year coverage.

FIGURE IV.6

ESTIMATED INCOME DISTRIBUTION OF NEW MEXICANS BY FULL- AND PART-YEAR INSURANCE STATUS, 2006



Source: Mathematica Policy Research, Inc.

Note: Data include the noninstitutionalized population under age 65, and exclude Medicare beneficiaries and active military personnel.

Other Characteristics. In addition to the differences by age and family income, New Mexicans who are uninsured all year differ by gender, race/ethnicity, health status, and whether they live in an urban or rural area of the state (Table IV.3). In general, these differences are not systematic—with the exception of health status. Among New Mexicans who are full-year uninsured, 41 percent report health status that good, fair, or poor (versus excellent or very good), compared with 35 percent who are part-year insured and just 30 percent of those who are insured all year.

In contrast, New Mexicans who are uninsured part-year (compared with those who are either insured or uninsured all year) are systematically more likely to be women and to live in rural areas of the state. They are also more likely to be nonworkers or dependents—many of them children. Compared with full-year insured New Mexicans, they generally report lower health status.

TABLE IV.3

INSURED AND UNINSURED POPULATION (IN THOUSAND) BY SELECTED DEMOGRAPHIC CHARACTERISTICS AT BASELINE

	Total Population		Full Year Uninsured		Part Year Insured		Full Year Insured	
	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent
Total	1,679.1	100%	185.3	100%	765.5	100%	728.2	100%
Gender								
Male	776.5	46.2	91.9	49.6	323.5	42.3	361.1	49.6
Female	902.6	53.8	93.4	50.4	442.1	57.7	367.1	50.4
Race/Ethnicity								
White	632.8	37.7	55.7	30.1	173.3	22.6	403.8	55.5
Hispanic	804.2	47.9	105.1	56.7	445.8	58.2	253.3	34.8
American Indian	173.5	10.3	16.9	9.1	116.3	15.2	40.3	5.5
Other	68.7	4.1	7.7	4.1	30.2	3.9	30.8	4.2
Employment Status								
Full-time	723.9	43.1	89.9	48.5	186.5	24.4	447.5	61.4
Part-time	113.3	6.7	16.8	9.1	47.5	6.2	49.0	6.7
Unemployed or non worker	841.9	50.1	78.6	42.4	531.6	69.4	231.8	31.8
Health Status								
Excellent or very good	1,113.6	66.3	109.7	59.2	495.8	64.8	508.2	69.8
Good, fair, or poor	565.5	33.7	75.7	40.8	269.7	35.2	220.1	30.2
Location								
MSA	1,050.0	62.5	121.4	65.5	443.6	57.9	485.0	66.6
Non-MSA	629.1	37.5	63.9	34.5	321.9	42.1	243.2	33.4

Source: Mathematica Policy Research, Inc.

Note: Data include the noninstitutionalized population under age 65, and exclude Medicare beneficiaries and active military personnel.

American Indians represent approximately ten percent of noninstitutionalized New Mexicans under 65. Consistent with Census definitions, those that reported only receiving services covered by the Indian Health Service were designated as uninsured. By this definition, less than a quarter of American Indians living in New Mexico have full-year health insurance. An estimated two-thirds are part-year insured, accounting for 15 percent of all part-year insured New Mexicans. Similar to the population as a whole, 10 percent are uninsured throughout the year. We estimate nearly 75 percent of predominantly uninsured American Indians would qualify for Medicaid or SCHIP under the state's recently expanded eligibility rules.

2. Out-of-Pocket Cost

The noninstitutionalized civilian population under age 65 finances about 19 percent of expenditures for health care services out-of-pocket—on average, an estimated $676 per person in 2007 (Table IV.4).

New Mexicans with full-year insurance generally spend more out-of-pocket for health care (an estimated $960) than those who are uninsured part or all of the year. Higher out-of-pocket spending among full-year insured individuals reflects both higher average income among this population and also more regular access to health care services. However, New Mexicans who are uninsured all year spend nearly as much out-of-pocket per capita ($858). Such high out-of-pocket spending among the uninsured, consistent with their much lower reported health status, is a measure of the uninsured population's significant financial burden for health care.

Out-of-pocket spending among people who have insurance only for part of the year is notably low. On average, New Mexicans who are part-year insured spend an estimated $362 out-of-pocket, about one-third the level of expenditure among the full-year insured population.

In general, New Mexicans who are older, female, white (non-Hispanic), in good-to-poor health status, and reside in urban areas spend more out-of-pocket than others under age 65, regardless of the insurance status, with two exceptions:

- Young adults ages 19 to 30 spend almost as much out-of-pocket as adults aged 31 to 44—and much more ($873 versus $618) when they are uninsured all year; and
- Rural New Mexicans spend more out-of-pocket when they are insured all year than urban residents—possibly reflecting differences in the comprehensiveness of individual coverage (which is more prevalent in rural areas) and group coverage.

Probably also reflecting benefit design, New Mexicans who are insured all year and work in firms with fewer than 10 employees have unusually high out-of-pocket cost. In addition, out-of-pocket cost spending among two other population groups is also worth noticing: on average, the American Indian population in New Mexico spend $488 out of pocket, about half the level among white, non-Hispanic population; in particular, American Indian who are uninsured all year spend only $177 on health care, significantly lower than any other race/ethnicity groups. Finally, part-time workers who are insured part of the year have the highest ($1,155) out-of-pocket cost—compared with workers who work full time or are insured or uninsured all year—representing a significant share in their limited income.

TABLE IV.4

AVERAGE ANNUAL PER CAPITA OUT-OF-POCKET COST (IN $)
FOR INSURED AND UNINSURED NEW MEXICANS, BY SELECTED
PERSONAL CHARACTERISTICS AT BASELINE, 2007

	Total Population	Full Year Uninsured	Part Year Insured	Full Year Insured
Total	$676	$858	$362	$960
Age				
0-5	191	337	100	493
6-18	231	402	123	464
19-30	687	873	561	756
31-44	667	618	522	772
45-64	1,358	1,277	1,022	1,475
Gender				
Male	674	835	323	948
Female	678	881	390	972
Race/Ethnicity				
White, non-Hispanic	1,028	1,522	553	1,164
Hispanic	454	636	292	664
American Indian	488	177	364	977
Other	513	583	298	706
Employment Status				
Full-time	915	942	584	1,047
Part-time	1,028	952	1,155	932
Unemployed/Non Worker	424	743	213	799
Firm Size (number of employees)				
10 or fewer	931	853	680	1,132
11-24	775	1,010	347	933
25-49	835	1,035	527	953
100 or more	977	958	823	1,040
Unemployed/Non Worker	424	743	213	799
Health Status				
Excellent or very good	518	610	226	782
Good, fair, or poor	988	1,218	611	1,371
Income				
0-100% FPL	484	946	352	935
100-185% FPL	396	811	247	546
185-235% FPL	523	523	259	827
235-300% FPL	725	958	384	892
300% FPL and above	1,009	947	740	1,071
Location				
MSA	710	899	399	948
Non-MSA	619	781	311	985

Source: MPR's NM Microsimulation database built from CPS AND MEPS-HC

Note: Medicare and TRICARE beneficiaries are not included.

C. HEALTH CARE PROVIDERS

While private insurance finances an estimated 44 percent of payments to providers in New Mexico, it is a somewhat larger source of financing for providers of some types of services. Specifically, private insurance finances more than half (57 percent) of all outpatient hospital care for the noninstitutionalized civilian population, and approximately half of expenditures for inpatient hospital care (50 percent), office-based medical services (48 percent) and emergency room visits (43 percent) (Table IV.5).

Federal and state government—mostly but not entirely associated with Medicaid—finance most other expenditures that are not paid out-of-pocket. Together, federal and state government programs finance an estimated 38 percent of total expenditures for New Mexico's noninstitutionalized civilian population under age 65.

TABLE IV.5

ESTIMATED SOURCES OF PAYMENT FOR HEALTH CARE AMONG NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER 65 BY TYPE OF SERVICE, 2007
(Percent of total expenditures)

	Total	Hospital Inpatient	Hospital Outpatient	Emergency Room	Office-based Medical Providers	Prescription Drugs	Other Medical Services and Supplies	Non-medical Expense
Total expenditures	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Federal and state programs and employee plans	37.8	47.0	36.5	46.3	34.8	32.7	32	41.8
Medicaid, SCHIP, and SCI	*27.8*	*39.1*	*23.9*	*28.8*	*24.1*	*20.7*	*25.2*	*33.7*
Private Insurance	44.0	50.1	57.0	43.1	48.1	28.8	27.3	58.2
Out-of-Pocket	18.2	2.9	6.6	10.6	17.1	38.5	40.7	--

Source: Mathematica Policy Research, Inc.

Notes: Enrollee premiums paid for SCI coverage are included in private insurance payments. Supporting detail is provided in Appendix D.

The following chapter describes total coverage and expenditure changes under each of the reform models, and estimates of impacts on stakeholders in each of the reform models are reported in Chapter VI.

V. CHANGE IN COVERAGE AND COST UNDER REFORM MODELS

The discussion below presents estimates of coverage and cost under each of the reform models. These estimates reflect the specifications developed for each model as described in Chapter I and reported in Appendix tables A1 through A3. In addition, they reflect a series of assumptions about the behavior of employers and consumers in New Mexico, as well as about the product designs and methods of payment implicit in each of the reform models. These assumptions are described in detail in the respective sections on changes in coverage and cost under the reform models.

A. CHANGES IN COVERAGE

1. Major Assumptions

To compare the modeling results across the reform models in a meaningful way, we made some underlying assumptions about implementation and behavioral responses that are consistently applied to each model. Key assumptions that drive changes in the coverage estimates include the following.

- **Every New Mexican becomes insured.** Each reform model envisions requiring that every New Mexican become and remain insured. In addition, each envisions a somewhat different approach to enforcement—although (as described in Chapter I) we presume that a "best practice" enforcement strategy could be developed and applied with equal effect to each. Our estimates of coverage in each reform model assume that New Mexicans comply fully with the mandate. That is, it is assumed that every resident would obtain coverage from some available source.

- **Immediate full implementation.** Each reform model envisions the development of a governing body with different levels and types of authority and responsibility. In addition, some assume major changes in how providers are paid and how insurance markets would operate. All of these changes will entail time to implement, and some reform models may take longer to reach full effect than others. However, there is no real basis for modeling such differences among the reform models. Therefore, we assume immediate full implementation, with immediate savings gained if they are expected to occur at full implementation. Slower implementation or different rates of implementation among the reform models would affect both the distribution of coverage (discussed in "Considerations" below) and the absolute and relative costs of the models.

- **Maximum enrollment in Medicaid and SCHIP.** In order to retain the significant federal funding of Medicaid and SCHIP in New Mexico, we assume that both programs continue (although the funding for each would vary among the models). Moreover, we assume that every individual eligible for Medicaid or SCHIP would enroll in these programs unless they already are enrolled in an employer plan and

that plan continues to be available to them. All currently uninsured New Mexicans who are eligible for Medicaid or SCHIP are assumed to enroll in the program.

- **Self-insured employer decisions are driven by cost.** Under Health Security Act and New Mexico Health Choices, self-insured employers are confronted with a decision to maintain their ERISA-protected self-insured plans or to close them in favor of having their employees enroll in a new statewide program. We assume that employers make this decision purely on a cost basis, with some "drag" associated with their costs of making such a major change in compensation. Specifically, we assume that self-insured employers terminate their plan in favor of a newly available coverage option if the per-member cost of the self-insured plan is at least 20 percent more than the per-member cost of the new coverage option.

- **Individual choices among coverage options are driven by cost.** When individuals or their employers have more than one coverage option, we assume that they always choose the option that is of lowest cost to them. The Health Coverage Plan offers the most opportunities for individuals to make such choices. Under this model, we assume that uninsured workers who are eligible for both employer-sponsored coverage and individual enrollment in SCI choose employer coverage if it is less than the SCI individual premium (including the employer share of premium) by as little as $100 per person per year. This high level of sensitivity reflects the low family income of individuals eligible for the program. Similarly, when they are not eligible for public coverage but have an employer offer of coverage available to them, we assume that they accept the employer offer before enrolling in individual coverage. Only individuals who are denied individual private coverage based on health status enroll in NMMIP. In all of the reform models, when uninsured individuals have available to them enrollment in Medicaid or SCHIP, versus any private coverage, we assume that they enroll in Medicaid and SCHIP.

- **Crowd out.** Of the reform models, only New Mexico Health Choices envisions expanded eligibility for Medicaid beyond that assumed in the current case.[17] However, in each of the models, insured children who are currently eligible for Medicaid or SCHIP could enroll in these programs, "crowding out" other coverage. With respect to the Health Coverage Plan, we reasoned that categorically eligible, privately insured individuals could already have enrolled in Medicaid or SCHIP but did not; therefore, we assume that they do not drop private coverage to enroll in Medicaid or SCHIP after reform. In New Mexico Health Choices, individuals who are eligible for Medicaid or SCHIP receive a voucher to participate in the Alliance, in the same way as other New Mexicans affected by the reform. As with the Health Security Act, the designation of Medicaid- or SCHIP-enrolled under New Mexico Health Choices is retained solely for the calculation of federal matching.

[17] New Mexico Health Choices calls for Medicaid enrollment of all adults under 100 percent FPL; estimates of coverage under this model assume that the state can obtain waiver authority to expand eligibility to these persons. Both the Health Security Act and the Health Coverage Plan would retain Medicaid eligibility for parents below 100 percent FPL (as presumed in the current case), as well as children to higher levels of family income. The Health Coverage Plan would enroll (as at present) adults without children in SCI, with reinsurance to cover expenditures above the current limit.

- **Family coverage is preferred when available.** We assume that coverage decisions are made at the family level. Thus, insurance family units (spouse and children) are not separated, unless either (1) program eligibility rules do not allow the entire family to enroll or (2) certain members are already enrolled in coverage (for example, Medicaid or SCHIP) at lower cost. New Mexicans not living with a spouse or children make coverage decisions as individuals.

- **Young adults first seek coverage on their own.** The Health Coverage model envisions extending coverage to unmarried adults through age 30 as dependents. We assume that, if working, these young adults would take coverage from their own employers if it were offered, before taking coverage as a dependent on their parents' policy.

- **Native Americans enroll in coverage, as do all other New Mexicans.** For the purpose of estimating coverage and cost in the reform models, we assume that all New Mexicans have the same enrollment opportunities and obligations—including Native Americans who live either in urban areas or on reservations. Similarly, we assume that noncitizens may enroll in coverage on the same basis as others living in New Mexico.

2. Coverage Estimates Relative to the Current Case

Consistent with the assumption that every New Mexican becomes insured under each of the reform models, each of the simulations redistributes uninsured individuals into a coverage category. In addition, in some models, individuals who are now covered by self-insured employer plans may change their source of coverage, if their employer terminates the self-insured plan in favor of the new statewide plan.

Both the Health Security Act and New Mexico Health Choices would introduce a new statewide plan intended to cover most of the population. Under the Health Security Act, the private insurance market would disappear in favor of coverage in the Health Security Plan; in addition, employers would terminate self-insured plans if Health Security Plan coverage were significantly less costly. Under Health Choices v.1, the insured market would be folded into the Alliance plan (in effect, as a single statewide purchasing cooperative) and self-insured employers would cease coverage; under Health Choices v.2, self-insured employers would terminate coverage only if Alliance coverage is substantially less costly. The Health Coverage Plan would retain the current market, with growth in each segment. In all models, federal employees would remain in FEHBP. These results are summarized in Table V.1 and depicted in Figure V.1. Additional detail is offered in Appendix E.

TABLE V.1

ESTIMATED NUMBER AND PERCENT OF PERSONS IN THE CURRENT CASE AND SIMULATED REFORM MODELS BY SOURCE OF COVERAGE

	Current Case	Health Security Act	Health Choices v.1	Health Choices v.2	Health Coverage Plan
	Number of Persons (in thousands)				
Total	1,679.1	1,679.1	1,679.1	1,679.1	1,679.1
Uninsured	432.1	--	--	--	--
Employer sponsored insurance	707.9	31.9	31.3	150.4	829.8
Individual private insurance	34.1	-	-	-	45.5
Medicaid or SCHIP	431.9	778.1	948.6	934.6	659.4
Other public insurance	73.1	64.8	64.8	64.8	144.4
New program	--	804.3	634.3	529.2	--
Including Medicaid and SCHIP	--	1,582.4	1,582.9	1,463.9	--
	Percent of Persons				
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Uninsured	25.7%	--	--	--	--
Employer sponsored insurance	42.2%	1.9%	1.9%	9.0%	49.4%
Individual private insurance	2.0%	0.0%	0.0%	0.0%	2.7%
Medicaid or SCHIP	25.7%	46.3%	56.5%	55.7%	39.3%
Other public insurance	4.4%	3.9%	3.9%	3.9%	8.6%
New program	--	47.9%	37.8%	31.5%	--
Including Medicaid and SCHIP	--	94.2%	94.3%	87.2%	--
Medicaid/SCHIP as a percent of enrollment in the new program	--	49.2%	59.9%	63.8%	--

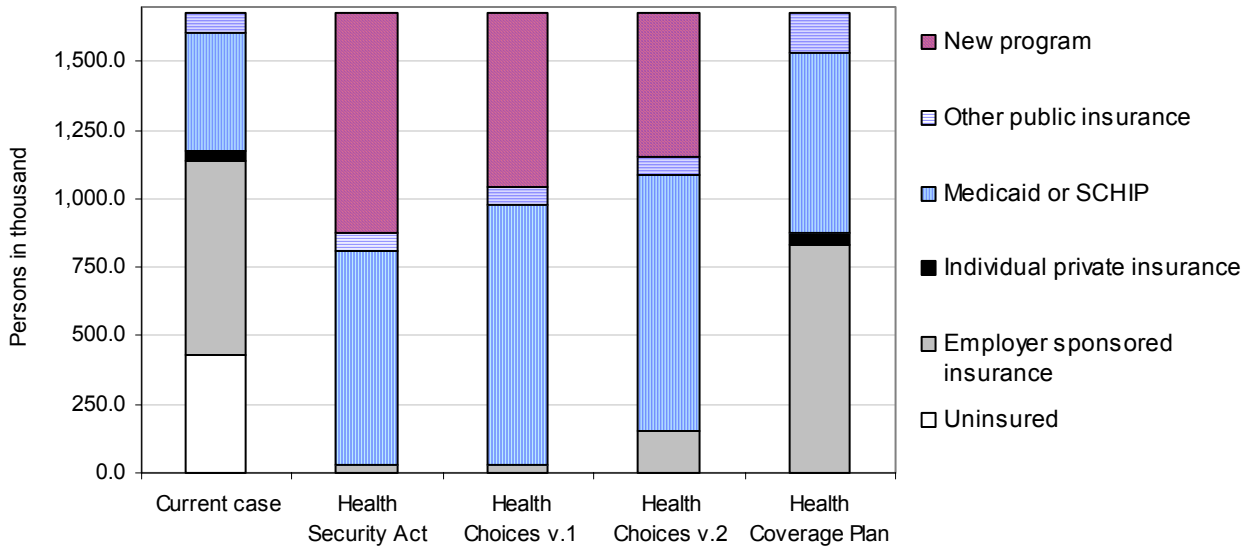
Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded.

In each of the reform models, enrollment in Medicaid and SCHIP would increase, even if eligibility for coverage would not. Additionally in each model, uninsured individuals who are eligible in the current case but not enrolled would become enrolled. Neither the Health Security Act nor the Health Coverage Plan would change eligibility rules for Medicaid or SCHIP. However, many more people enroll in Medicaid or SCHIP under the Health Security Act, because all currently insured New Mexicans enroll in these programs (when eligible) through the Health Security Plan, and self-insured employers terminate their health plans in favor of Health Security Plan coverage when it is less expensive.

FIGURE V.1

DISTRIBUTION OF PREDOMINANT HEALTH INSURANCE COVERAGE IN NEW MEXICO, CURRENT CASE AND SIMULATED REFORM MODELS



Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded. Employer-sponsored insurance includes NMHIA. Other private insurance includes NMMIP. Other public programs include SCI.

New Mexico Health Choices would enroll even more individuals in Medicaid, as childless adults under 100 percent FPL would become eligible. In general, these adults and all other eligible New Mexicans would enroll in Medicaid and SCHIP through the Alliance. Under Health Choices v.1, we assume that self-insured employers terminate coverage—since they would pay into the plan regardless of whether they sponsor a health plan. Under Health Choices v.2, self-insured employers do not pay into the Alliance if they offer coverage, and therefore make a cost-based decision whether to terminate their self-insured plan. As a result, more New Mexicans would enroll in the Alliance under version 1 than under version 2 of Health Choices. Specific coverage results for each reform model are summarized below.

The Health Security Act

Under the Health Security Act, nearly 1.6 million New Mexicans—94 percent of noninstitutionalized civilian New Mexicans under age 65—would enroll in the new Health Security Plan. Of this population, nearly half (778 thousand) would be Medicaid or SCHIP enrollees. With full enrollment in Medicaid and SCHIP, these programs would cover 46 percent of the population (not including institutionalized persons and persons also eligible for Medicare).

Most workers and dependents now enrolled in self-insured plans would become enrolled in the Health Security Plan. However, these estimates assume that self-insured employer plans do not systematically enroll workers who are significantly higher-paid than workers in insured

coverage, so that the payroll tax that they would pay under the Health Security Act is approximately equal to the average cost of Health Security Plan coverage. To the extent that self-insured employers have higher average payroll, our estimates of workers in self-insured employer plans that terminate coverage is high, and simulated enrollment in the Health Security Plan is commensurately high.

Our estimates of residual employer-sponsored insurance include mostly FEHBP-enrolled federal employees who remain in FEHBP coverage, as well as some workers and dependents in self-insured employer plans. Similarly, dependents currently enrolled in TRICARE (other public coverage) would retain that coverage.

New Mexico Health Choices v.1

New Mexico Health Choices v.1 would require all employers to contribute to financing the Alliance, regardless of whether they offer coverage to workers and their dependents. The simulation assumes that self-insured employers terminate their plans in New Mexico; workers and dependents that currently are enrolled in employer plans are automatically folded into the Alliance. As a result, nearly 1.6 million New Mexicans would become enrolled in the Alliance Plan, including all workers and dependents that in the current case had coverage from employer plans that were self-insured.

Medicaid and SCHIP enrollment peak under this reform model: the 949 thousand New Mexicans enrolled in Medicaid and SCHIP would account for nearly 60 percent of total enrollment in the Alliance Plan, and 57 percent of the total noninstitutionalized civilian population under age 65. Because self-insured employers are assumed to terminate their plans in New Mexico, individuals remaining in employer-sponsored coverage include only federal employees.

New Mexico Health Choices v.2

The incentives confronting self-insured employers differ between New Mexico Health Choices v.2 and v.1; in v.2, the incentives for self-insured employers are the same as under the Health Security Act. However, we estimate that the per-member cost of Alliance coverage would exceed the per-member cost of coverage in the Health Security Plan, largely on the basis of whether the Health Security Plan is successful in reducing provider payments to reflect their lower administrative costs in dealing with a single payer. To the extent that Alliance premiums are somewhat higher, fewer self-insured employers would terminate coverage.

Under New Mexico Health Choices v.2, we estimate that 119 thousand New Mexicans would retain private, self-insured employer coverage. In total (including both self-insured workers and federal employees), approximately 150 thousand New Mexicans would remain in employer-sponsored coverage—including approximately 14 thousand Medicaid or SCHIP-eligible workers and families now enrolled in employer coverage with no employee contribution.

The Alliance would enroll 529 thousand New Mexicans, of whom Medicaid and SCHIP would again account for a large proportion. Approximately 64 percent of Alliance enrollment

would be Medicaid- or SCHIP-enrolled. Similar to v.1, these individuals would account for approximately 56 percent of all the total noninstitutionalized civilian population under age 65.

The Health Coverage Plan

The Health Coverage Plan would expand all current sources of coverage in New Mexico; it does not envision creation of a new plan. It is the only reform model where employer-sponsored private coverage would expand. Approximately 122 thousand workers and dependents would newly enroll in employer-sponsored coverage, presuming the same rates of employer offer and contribution to coverage as in the current case: a 14-percent increase in total enrollment compared with the current case.

In addition, the Health Coverage Plan would expand SCI eligibility to include now-uninsured adults under 300 percent FPL. As a result, approximately 80 thousand individuals would enroll in SCI (in Table V.1, included in "other public coverage"), compared with just 8 thousand in the current case.

Under the Health Coverage Plan, Medicaid and SCHIP enrollment also would expand, but only to the extent that uninsured New Mexicans are eligible but not enrolled in the current case. Compared with the Health Security Act and New Mexico Health Choices, fewer individuals enroll in Medicaid or SCHIP (the latter excluding SCI-enrolled adults), only because those who are enrolled in employer-sponsored coverage with no employee contribution in the current case remain in that coverage. All uninsured workers (and their dependents) who are offered employer coverage with a contribution to coverage enroll instead in Medicaid or SCHIP, if they are eligible. Reflecting these decisions, Medicaid and SCHIP enrollment expands to 659 thousand under the Health Coverage Plan—accounting for approximately 39 percent of noninstitutionalized civilian New Mexicans under age 65.

Finally, individual coverage would grow slightly under the Health Coverage Plan. As is likely true also in the current case, only individuals not offered employer coverage (either as a worker or dependent) and not eligible for Medicaid, SCHIP, or SCI would turn to the individual market. An additional 9,932 New Mexicans would enroll in individual coverage, and an additional 1,526 New Mexicans are expected to enroll in NMMIP. All of these individuals have income above 300 percent FPL.

3. Changes in Coverage under the Reform Models

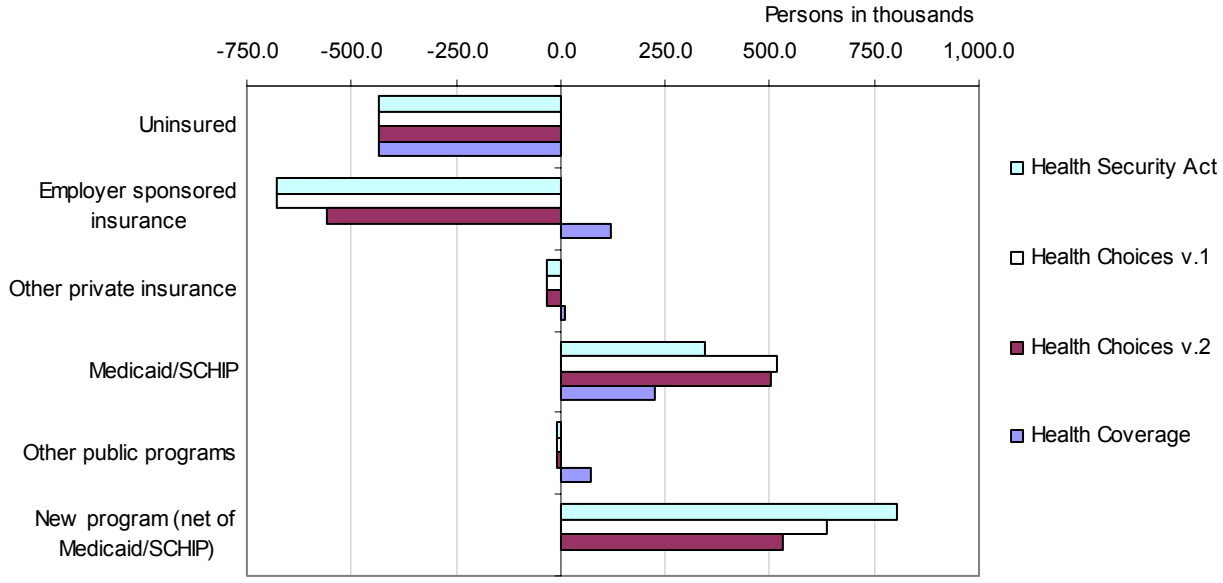
The results reported above with respect to changes in coverage are summarized in Figure V.2, and supporting estimates are provided in Appendix E. Because full compliance with the individual mandate is assumed, each of the reform models would cover all of the uninsured. However, the reform models differ substantially in the extent to which they would affect current sources of coverage.

The Health Security Act and New Mexico Health Choices v.1 would effectively or overtly eliminate employer-sponsored coverage, and fully eliminate individual private coverage, except for supplemental policies. Based on preliminary cost estimates for the Health Security Act, very few employers that now offer self-insured coverage to workers and dependents would continue

to do so, rather than pay into the Health Security Plan. While some employer-based coverage would remain under Health Choices v.2, only under the Health Coverage Plan would employer coverage expand modestly to include workers and dependents over 300 percent FPL who are offered coverage but are not enrolled. Similarly, only the Health Coverage Plan would increase slightly the number of New Mexicans enrolled in individual coverage, including NMMIP.

FIGURE V.2

SIMULATED NET CHANGE IN THE NUMBER OF NEW MEXICANS COVERED IN EACH REFORM MODEL BY FINAL SOURCE OF COVERAGE



Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded. Employer-sponsored insurance includes NMHIA. Other private insurance includes NMMIP. Other public programs include SCI.

All of the plans would increase coverage in Medicaid and SCHIP—either within a new program (the Health Security Plan or the Alliance) or in the programs as they are currently configured. Because the New Mexico Health Choices models would extend Medicaid eligibility to childless adults under 100 percent FPL, the estimated increase in Medicaid and SCHIP enrollment (excluding SCI) is much greater than under the other reform models.

Both the Health Security and New Mexico Health Choices are designed to enroll nearly all New Mexicans in a new statewide program (respectively the Health Security Plan and the Alliance), and we estimate that both would be largely successful in doing so. The principal difference between the coverage results of the Health Security Act and Health Choices v.1 is the proportion of New Mexicans in the new program who are Medicaid- or SCHIP-enrolled. The new program is somewhat smaller under Health Choices v.2 because some Medicaid- or SCHIP-eligible workers and/or their dependents remain in self-insured employer-sponsored coverage, as in the current case.

4. Sources of Coverage for Uninsured New Mexicans

Both the Health Security Act and New Mexico Health Choices would substantially alter the sources of coverage for New Mexicans who are now insured, as well as provide coverage for New Mexicans who are now uninsured. Because the focus of all of the reform models is to ensure that New Mexicans whom are now uninsured obtain coverage, it is useful to understand exactly how the uninsured population fares in each model.

The Health Security Act would cover all of the currently uninsured population in the Health Security Plan, and New Mexico Health Choices v.1 would cover all uninsured in the Alliance (Table V.2). In both cases, a substantial number of the uninsured would qualify for Medicaid or SCHIP, and would be enrolled in the new program on that basis.

TABLE V.2

SIMULATED SOURCES OF COVERAGE FOR CURRENTLY UNINSURED NEW MEXICANS IN EACH REFORM MODEL

	Health Security Act		Health Choices v.1		Health Choices v.2		Health Coverage Plan	
	Number (thousands)	Percent of uninsured	Number (thousands)	Percent of uninsured	Number (thousands)	Percent of uninsured	Number (thousands)	Percent of uninsured
Total uninsured in the current case	432.1	100.0%	432.1	100.0%	432.1	100.0%	432.1	100.0%
Employer-sponsored coverage	--	--	--	--	--	--	119.1	27.6
NMHIA	--	--	--	--	--	--	2.8	0.6
Individual insurance	--	--	--	--	--	--	9.9	2.3
NMMIP	--	--	--	--	--	--	1.5	0.4
Medicaid/SCHIP	227.5	52.6	327.9	75.9	327.9	75.9	227.5	52.6
SCI/SEIP	--	--	--	--	--	--	71.3	16.5
New program	204.6	47.4	104.3	24.1	104.3	24.1	--	--
New program including Medicaid/SCHIP-enrolled	432.1	100.0	432.1	100.0	432.1	100.0	--	--

Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded. The SCI program is reinsured, effectively eliminating the $100,000 limit on covered benefits.

In New Mexico Health Choices v.2, some workers who are offered self-insured employer-sponsored coverage but currently are uninsured could accept coverage in those plans. However, the Alliance would offer generous subsidies to most of New Mexicans who are now uninsured. As a result, all of uninsured workers and dependents that have an offer of self-insured coverage in the current case are assumed to accept coverage in the Alliance under New Mexico Health Choices v.2, as well as in v.1.

Only in the Health Coverage Plan do uninsured New Mexicans disperse among various sources of coverage. More than one-quarter of the uninsured enroll in employer-sponsored coverage—including some self-employed workers who enroll in NMHIA. These uninsured are in families with income above 300 percent FPL (and therefore are ineligible for Medicaid, SCHIP, or SCI). Most are currently offered employer-sponsored coverage but do not enroll.

Nearly 53 percent of the uninsured enroll in Medicaid or SCHIP under the Health Coverage Plan—very similar to the Health Security Act. Neither reform model would expand eligibility for Medicaid or SCHIP, so in both models all uninsured New Mexicans who enroll in these programs are currently eligible but not enrolled.

Finally, a small number of uninsured New Mexicans would enroll in individual coverage, including NMMIP. While all are in families with income above 300 percent FPL, this coverage is likely to be very costly for them.

B. CHANGES IN COST

1. Major Assumptions

To estimate the change in cost that would result from each of the reform models, several assumptions were made, as follows:

- **Alternative benefit designs.** All estimates rely essentially on four alternative benefit designs observed in the current case: (1) the state employee health plan; (2) private group insurance; (3) individual private insurance; and (4) Medicaid and SCHIP. Modeling the same benefit designs across the reform models produces medical cost estimates that vary only on the basis of the characteristics of individuals who enroll. They do not differ based on the plan designs available to enrollees. This assumption makes the cost results somewhat more transparent and permits more direct comparison with the other reform models.

- **Measurement of benefit design.** We assume that coverage in both the Health Security Plan and the New Mexico Health Choices Alliance would entail the same rate of out-of-pocket cost (relative to total cost) by type of service as in the state employee plan. This assumption does not mean that the cost estimates rely on the precise definitions of either covered services or cost sharing as in the state employee plan. However, the average proportion of expense paid out of pocket by state employees is implicit in the estimates.

- **"Low-option" coverage in New Mexico Health Choices**. New Mexico Health Choices envisions "low option" benefit design which would be available to all, although only New Mexicans with income above 400 percent FPL would have an incentive to purchase it. However, no guidance is offered in the reform model about the specific design intended for that plan. Because private group insurance, in practice, entails slightly less out-of-pocket expense than the state employee plan and individual private coverage entails greater out-of-pocket expense than may be desirable in a reform model, we had no obvious benchmark for specifying cost sharing in a low-option plan without further guidance. The medical cost estimates

for New Mexico Health Choices might be somewhat lower if individuals elected to enroll in a plan option that offered less coverage, and out-of-pocket costs would be higher. However, it is likely that selection bias—that is, healthier individuals selecting the standard plan that offers less coverage—would minimize differences in aggregate cost.

- **Reduction in payments to reflect lower provider administrative cost.** By reducing the number of payers in New Mexico's health care system, the Health Security Act, in particular, claims administrative cost savings and would attempt to capture them by reducing payments to providers. Various members of the Committee have challenged this claim and produced some evidence that, because multiple payers would remain in the system—at least during the projection period for this study, provider costs in fact would not be reduced. Others have expressed concern that reduction in provider payment rates would pose a hardship for providers in especially rural areas where many are marginally viable, but in fact currently interact with relatively few different payers. We addressed these concerns in several ways:

  - First, we assumed that there would be some saving in providers' administrative costs, but only in urban areas of the state where there are now the greatest number of payers for care.
  - Second, we assumed that the reduction in payments to providers in urban areas would be just half that estimated for providers in the Canadian health care system, reported in the research literature (Woolhandler et al. 2003). Accordingly, payments to urban hospitals (for inpatient, outpatient, and emergency room services) were reduced by 5.7 percent, payments to office-based providers (including vision and dental services) were reduced by 5.4 percent, and payments for home health services were reduced 9.6 percent.
  - Third, we developed an alternative scenario for the Health Security Act that reflects no reduction in provider payments. Thus, we refer in this section to Health Security Act v.1 (which reduces payment rates to urban providers) and Health Security Act v.2 (which retains current average levels of payment).

- **Nonmedical cost rates.** Each of the reform models would entail different levels of nonmedical cost. In large part, these costs would be associated with the costs of retaining private insurers and screening individuals for program eligibility, as well as general administration of programs under reform. In the current case, we include in nonmedical costs the cost of screening and enrolling Medicaid/SCHIP enrollees (estimated at $125 per screened applicant); other nonmedical costs are estimated as was described in Chapter II. In each of the reform models, we also include the cost of screening Medicaid/SCHIP/SCI enrollees, but assume full-year enrollment and estimate the cost on enrolled lives in the programs. With respect to the reform models we assume additional nonmedical costs as follow:

  - Under the Health Security Act, nonmedical costs are estimated at $300 per person enrolled in the Health Security Plan in 2007, equal to 2.5 times

Medicare's FFS administrative cost experience per enrollee, to account for activities not included in Medicare's administrative cost calculation (See Appendix A-1). Built up on a percentage of medical cost basis, this would equal 4.35 percent of estimated 2007 medical cost for administration of enrollment and claims (equal to Medicare administrative cost for FFS enrollees); 1.45 percent for operations and overhead (equal to one-half the NMHIA rate for these functions, allowing for economies of scale); and 2.9 percent for all other functions (equivalent to $100 per member per year). After allowing for health care management (described below), this would leave a net allowance of 0.45 percent of medical cost (equal to $15.51 per member per year) for public processes and negotiation of provider rates.

- In New Mexico Health Choices, nonmedical costs include an estimated $125 per person to administer an income-based voucher system; no additional cost is included for Medicaid or SCHIP eligibility determination. However, the Alliance incurs some unique costs: an additional 1.015 percent per paid claim for administration of the Alliance (allowing for economies of scale, equal to one-half the rate incurred by NMHIA excluding marketing and net of operating income which might also accrue to the Health Choices Alliance). In addition, insurers in the Alliance would finance a reinsurance program, to help manage guaranteed issue and pure community rating in the Alliance; this cost is estimated at 1 percent of medical cost. Finally, New Mexico Health Choices calls for elimination of the premium tax, and retains private insurers within the Alliance. When we subtract the 4 percent premium tax from group premiums in New Mexico, the average net nonmedical cost rate for private group coverage in New Mexico is 13.8 percent. The nonmedical cost rate for FEHBP (which is not subject to the premium tax) is 10.03 percent. For NM Health Choices, we assumed the lower nonmedical cost rate for contracting insurers (10.03 percent), to account not only for the elimination of the premium tax but also to reflect a more competitive environment in the Health Choices Alliance relative to the current market.

- Nonmedical costs for the Health Coverage Plan are equal to the average historical nonmedical rates by payer, as reported in Chapter II.

- **Medical management in the Health Security Act.** While the Health Security Act would want to eliminate some of the practices of private insurers—specifically, denial of claims—that now occur, we assume it nevertheless would develop management across the system that would be much like that in Medicaid MCOs. In the current case, Medicaid MCOs are paid 4.45 percent of medical cost (net of the premium tax and net of the administrative functions already captured in the first bullet above) to cover enrollment functions and claims. We assume that 2 percentage points of this amount are profit, and that the net amount – 2.45 percent – approximates the cost of medical management and management of provider contracting. However, if the Health Security Plan conducts no medical management, the reform model's medical cost are likely to be significantly higher than our estimates indicate.

- **Other federal sources of payment.** Finally, we assume that some federal sources of payment for care in the current case—specifically, Veterans Administration facilities and the IHS—would charge insured New Mexicans for care that they would have provided to uninsured patients without charge. As a result, the coverage models supplant these sources of federal funding and some care that the VA and IHS financed in the base case is refinanced through the various sources of coverage.

2. Total Costs of the Reform Models

Changes in coverage that result in lower out-of-pocket costs are expected to result in greater use of services and higher total expenditure for health care services in each of the reform models. All else being equal, this effect would dominate the effects of each of the reform models and total expenditures in each would rise. However, (in addition to the reduction in payment rates to urban providers in the Health Security Act v.1), two aspects of the estimates temper this result:

- In cases where employees and dependents with group coverage are moved into standard coverage patterned on the state employee health plan does slightly lower use of services occur, reflecting the slightly higher average cost sharing estimated for the state employee plan. Our medical cost estimates (reported in Section 3 below) reflect the net results of slightly greater average cost sharing for currently insured New Mexicans as they move into either the Health Security Plan or the Health Choices Alliance, as well as reduced cost sharing for individuals who enroll in Medicaid or SCHIP from either privately insured or uninsured status in the current case.

- Second, the estimated nonmedical costs of the reform models differ substantially. These differences in nonmedical costs also underlie the differences in estimated total cost among the models.

Results of cost changes are summarized in Table V.3, and the distribution among different payers is depicted in Figure V.3. In each of the reform models, both federal and state spending would increase, since more New Mexicans would enroll in Medicaid and SCHIP. The Health Security Act would largely displace private insurance (with only some self-insured employer plans remaining), so that private insurance spending largely disappears. New Mexico Health Choices would retain private insurers within the Health Choices Alliance; those expenditures, while privately insured, appear in Table V.3 as expenditures through the new program. Otherwise, private insurance expenditures in New Mexico Health Choices v.2 are associated only with remaining self-insured employer plans. In the Health Coverage Plan, conventional private insurance expenditures would increase, reflecting greater enrollment in both group and individual health insurance plans.

Because more New Mexicans would become insured, and because many would enroll in Medicaid or SCHIP with very low cost-sharing and comprehensive benefits, out-of-pocket spending is projected to decline in each of the reform models. Cost estimates for each of the reform models are described in greater detail below.

TABLE V.3

ESTIMATED AMOUNT AND PERCENT OF TOTAL MEDICAL AND NONMEDICAL EXPENDITURES IN THE CURRENT CASE AND REFORM MODELS BY SOURCE OF PAYMENT, 2007

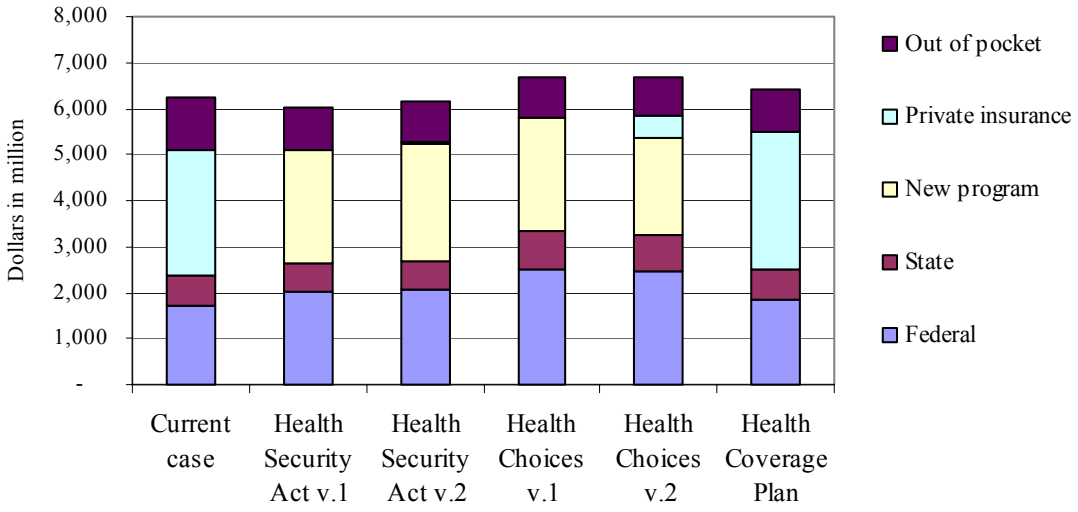
	Current Case	Health Security Act v.1	Health Security Act v.2	Health Choices v.1	Health Choices v.2	Health Coverage Plan
	Total expenditures (in billions)					
Total	$6.237	$6.028	$6.174	$6.676	$6.695	$6.427
Federal Medicaid/SCHIP	1.257	1.630	1.662	2.135	2.073	1.444
Other federal spending	0.457	0.390	0.390	0.390	0.390	0.390
State Medicaid/SCHIP	0.461	0.626	0.638	0.822	0.798	0.508
Other state spending	0.178	--	--	--	--	0.180
New program	--	2.455	2.557	2.472	2.109	--
Private insurance	2.749	0.015	0.015	--	0.498	2.958
Out of pocket	1.135	0.912	0.912	0.858	0.827	0.947
	Percent of expenditures					
Total	100%	100%	100%	100%	100%	100%
Federal Medicaid/SCHIP	20.2	27.0	26.9	32.0	31.0	22.5
Other federal spending	7.3	6.5	6.3	5.8	5.8	6.1
State Medicaid/SCHIP	7.4	10.4	10.3	12.3	11.9	7.9
Other state spending	2.8	--	--	--	--	2.8
New program	--	40.7	41.4	37.0	31.5	--
Private insurance	44.1	0.2	0.2	--	7.4	46.0
Out of pocket	18.2	15.1	14.8	12.9	12.4	14.7

Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded.

FIGURE V.3

ESTIMATED DISTRIBUTION OF TOTAL MEDICAL AND NONMEDICAL EXPENDITURES IN NEW MEXICO BY SOURCE OF PAYMENT, CURRENT CASE AND REFORM MODELS, 2007



Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded.

The Health Security Act

The Health Security Act v.1, which reduces payments to urban providers presuming reduced administrative costs, is estimated to reduce total health care spending in New Mexico relative to the current case. In this reform model, total health care expenditures for the noninstitutionalized civilian population under age 65 are projected to decline from $6.237 billion (in the current case) to $6.028 billion. If the Health Security Plan maintained current levels of provider reimbursements in New Mexico (version 2), the anticipated reduction in total expenditures would be less, but projected total expenditures still would be lower than the current case—totaling an estimated $6.174 billion.

Reflecting expanded enrollment, Medicaid expenditures would increase to an estimated $2.256 billion (in v.1), $626 million of which would be state spending and federal match would fund $1.630 billion. Under this scenario for the Health Security Act, Medicaid and SCHIP spending would account for an estimated 37 percent of all health expenditures for the noninstitutionalized civilian population under age 65. In addition, federal government would continue to pay $390 million for federal employee health benefit and TRICARE dependents.

The Health Security Plan would replace other sources of coverage, including group and individual private insurance, and also the state's array of sponsored insurance programs—SCI (and SEIP), NMHIA, and NMMIP. As a result, it would account for more than 40 percent of total health care spending for the state's noninstitutionalized civilian population under age 65—paying directly for $2.245 billion in health care and administrative services. Compared with an estimated $2.749 billion that private insurers now represent—covering half of New Mexicans in

group and individual policies—only self-insured employer coverage would remain, accounting for just $15 million of total health care expenditures and approximately 5 thousand enrolled lives. The Health Security Act also would reduce consumer out-of-pocket expenditures to $912 million out of pocket (15 percent of total cost), compared with $1,135 million (18 percent of total cost) in the current case.

New Mexico Health Choices v.1

Under New Mexico Health Choices v.1, Medicaid and SCHIP enrollment would peak—covering more than half of the noninstitutionalized civilian population under age 65. As a result, federal and state spending for Medicaid and SCHIP also would peak, reaching $2.956 billion. Of this amount, the state would finance an estimated $822 million, and federal matching would finance $2.135 billion. Medicaid and SCHIP would finance 44 percent of all health care spending in New Mexico for this population.

With the exception of federal workers and TRICARE dependents, all civilian workers and dependents who are currently enrolled in group coverage, as well as New Mexicans enrolled in private individual coverage and state programs such as NMHIA, SCI, and NMMIP would move under the Health Choices Alliance. The Alliance would finance an estimated $2.472 billion in total expenditures for heath care in 2007. Consumers' out of spending—at $858 million (13 percent of total cost)—would be less than in the current case, and (due to greater enrollment in Medicaid and SCHIP) less than under the Health Security Act.

New Mexico Health Choices v.2

Under Health Choices v.1 and v.2, self-insured employers confront somewhat different incentives. As a result, some are expected to remain in v.2, but all are projected to terminate their plans under v.1. This difference in employer behavior leads to somewhat different cost estimates between the two reform models. Under Health Choices v.2, an estimated 119 thousand New Mexicans would retain self-insured employer coverage, and these plans would finance an estimated $498 million in health care costs in 2007—7 percent of total expenditures for the noninstitutionalized civilian population under age 65. Retention of workers and dependents in self-insured group coverage would reduce the number of New Mexicans who enrolled in Medicaid/SCHIP relative to v.1. Nevertheless, enrollment would increase substantially; bringing combined federal and state expenditures in these programs $2.871 billion—approximately 43 percent of total expenditures for this population.

The Health Choice Alliance would account for $2,109 million in spending, $363 million (15 percent) less than under Health Choices v.1, but still representing nearly a third of total spending for this population. Consumers' out-of-pocket spending drop just below that estimated in v.1; the difference is due with the lower average level of out-of-pocket costs in private group coverage compared with the state employee health plan model assumed for non-Medicaid/SCHIP enrollees in the Alliance.

The Health Coverage Plan

The Health Coverage Plan would expand all current sources of coverage in New Mexico in lieu of creating a new plan. Consequently, it is the only reform model that directly increases private insurance expenditures compared with the current case. Under the Health Coverage Plan, private insurance spending would reach $2.958 billion, accounting for 46 percent of total expenditures for the noninstitutionalized civilian population under age 65.

The Health Coverage Plan also would expand Medicaid and SCHIP enrollment, but (by retaining private sources of coverage) less than either the Health Security Act or New Mexico Health Choices. Federal and state spending for Medicaid/SCHIP would increase from $1,718 million in the current case to $1,951 million in the Health Coverage Plan, representing just over 30 percent total health care expenditures for the noninstitutionalized civilian population under age 65. Expanded enrollment in SCI would account for an additional $3 million in state expenditure (with federal match for expenditures under the waiver included in federal SCHIP spending).

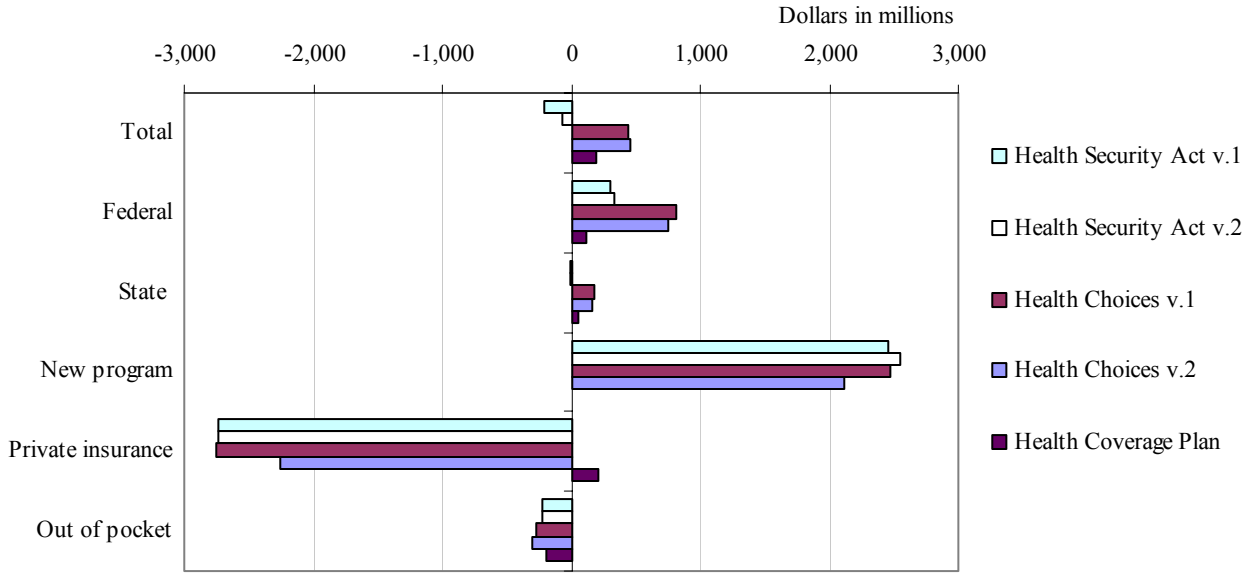
Because the Health Coverage Plan would retain most New Mexicans in their current sources of coverage, it would maintain higher levels of out-of-pocket expenditure than the other reform models. Still, the impact of covering all New Mexicans is apparent: consumers would bear $947 million out-of-pocket spending, equal to 15 percent of their total health care expenditure—and approximately 17 percent less than in the current case.

3. Changes in Cost and Payer under the Reform Models

The changes in cost reported above for each reform model are summarized in Figure V.4 by source of payment. With the exception of the Health Security Act, which would reduce total health care spending by an estimated $62 million (v.2) to $209 million (v.1), each of the reform models would result in higher health care expenditures. Health Choices v.2 would lead to the greatest increase of $458 million (7.3 percent more than the current case), followed by Health Choices v.1 (7.0 percent) and the Health Coverage Plan (3.0 percent). Such low levels of estimated additional cost reflect both the significant spending to finance care for New Mexico's uninsured population that occurs currently and the reform models' heavy reliance on Medicaid and SCHIP, which pay less for health services than private insurance plans.

FIGURE V.4

SIMULATED NET CHANGE IN 2007 TOTAL HEALTH CARE EXPENDITURES
UNDER EACH REFORM MODEL BY SOURCE OF PAYMENT



Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded.

However, the reform models differ substantially in the amount that they would affect major current sources of health care financing. Largely driven by the different size of Medicaid/SCHIP expansion under each reform model, federal spending would increase from $119 million under the Health Coverage Plan to $811 million under New Mexico Health Choices v.1. Expanded Medicaid/SCHIP would also increase state spending, but the additional cost is partly offset by reduced spending for other state-operated programs under the Health Security Act and Health Choices. Consequently, the increase in state expenditures is relatively small. Assuming immediate reduction in provider payment, the Health Security Act v.1 would reduce state expenditures by $13 million despite greater enrollment in Medicaid and SCHIP.

The new programs formed under the Health Security Act and New Mexico Health Choices would finance from $2,109 to $2,557 million (under New Mexico Health Choices v.2 and the Health Security Act v.2, respectively). Employer group coverage would greatly contract (under the Health Security Act and New Mexico Health Choices v.2) or be eliminated entirely (under New Mexico Health Choices v.1). However, the Health Coverage Plan would expand private coverage, especially in insured employer groups but also in individual coverage, driving an estimated $210 million increase in privately insured health care expenditures.

Because each of the reform models would insure all New Mexicans, each is projected to reduce consumers' out-of-pocket costs. In addition, in both the Health Security Act and New Mexico Health Choices, many move from private coverage with relatively high cost sharing to

Medicaid or SCHIP, with much lower cost sharing. Health Choices v.2 would achieve the greatest reduction in out-of-pocket expenditure due to both greater enrollment in Medicaid/SCHIP and retention of self-insured employer plans that have lower average cost sharing than standard coverage in the Health Choices Alliance.

4. Changes in Non-Medical Costs

Although sources of payment could shift significantly under the reform models, none of the reform models would drive much change in the distribution of expenditures across types of medical services. In each of the reform models, office-based medical providers would continue to be the largest expenditure category, followed by prescription drugs and hospital inpatient services.

A much greater change would occur in non-medical costs, which represent 13.5 percent of total spending in the current case (Table V.4). Under the Health Security Act, nonmedical costs would decline to about 10 percent of total health care expenditures for the noninstitutionalized civilian population under age 65, largely reflecting the movement of New Mexicans into a system much like Medicare fee-for-service, with some additional cost associated with determination of Medicaid and SCHIP eligibility. Nonmedical cost savings under the Health Security Act is estimated $227 million, approximately 27 percent less than in the current case. This savings would offset the increased cost of coverage ($165 million) with no reduction in provider payment levels (Figure V.5).

Under New Mexico Health Choices, the additional cost of administering an income-voucher system and also maintaining private insurance margins would increase non-medical costs by an estimated $230 million a year, added to increased medical costs under the reform. Under this reform model, nonmedical costs are projected to rise to approximately 16 percent of total expenditures for the noninstitutionalized civilian population under age 65.

Similarly, under the Health Coverage Plan nonmedical costs are projected to increase to 14 percent of total expenditures for this population. This increase is due to greater enrollment in private insurance coverage—particularly in small group and individual coverage, which entail the highest nonmedical cost rates.

TABLE V.4

ESTIMATED AMOUNT AND PERCENT OF 2007 TOTAL HEALTH CARE EXPENDITURES IN THE CURRENT CASE AND SIMULATED REFORM MODELS BY TYPE OF SERVICE

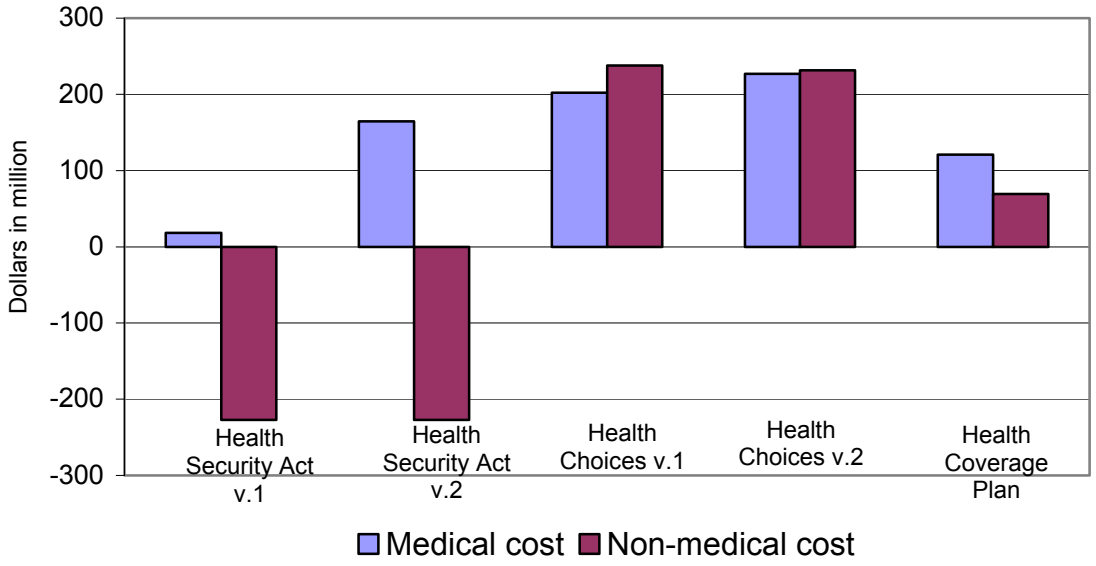
	Current Case	Health Security Act v.1	Health Security Act v.2	Health Choices v.1	Health Choices v.2	Health Coverage Plan
	Total Expenditures (in billions)					
Total	$6.237	$6.028	$6.174	$6.676	$6.695	$6.427
Hospital inpatient	1.151	1.106	1.151	1.152	1.152	1.137
Hospital outpatient	0.452	0.446	0.463	0.464	0.465	0.456
Emergency room	0.204	0.202	0.209	0.210	0.210	0.222
Office-based medical provider	1.614	1.572	1.628	1.641	1.653	1.628
Prescription	1.233	1.357	1.357	1.373	1.378	1.324
Other medical services	0.740	0.729	0.751	0.757	0.763	0.749
Non-medical cost	0.842	0.615	0.615	1.080	1.073	0.911
	Percent of Total Expenditures					
Total	100%	100%	100%	100%	100%	100%
Hospital inpatient	18.5	18.3	18.6	17.2	17.2	17.7
Hospital outpatient	7.2	7.4	7.5	6.9	6.9	7.1
Emergency room	3.3	3.3	3.4	3.1	3.1	3.4
Office-based medical provider	25.9	26.1	26.4	24.6	24.7	25.3
Prescription	19.8	22.5	22.0	20.6	20.6	20.6
Other medical services	11.9	12.1	12.2	11.3	11.4	11.6
Non-medical cost	13.5	10.2	10.0	16.2	16.0	14.2

Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded.

FIGURE V.5

ESTIMATED CHANGES IN MEDICAL AND NON-MEDICAL COST IN THE REFORM MODELS COMPARED WITH THE CURRENT CASE



Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded.

C. PROJECTED COST GROWTH

We projected the growth in total expenditures for the current case and each of the reform models. For each source of payment in the current case, we projected cost based on the historical growth in estimated cost per member per month, as described in Chapter II. Thus, our estimates assume that over the projection period, all insured New Mexicans remain in their current sources of coverage, and also that uninsured New Mexicans remain uninsured. Certainly, at the current rate of premium growth relative to personal income, it is likely that more New Mexicans would lose coverage over the projection period. However, further erosion of coverage would decrease total expenditures and distort comparison with the coverage models. Therefore, relative to a true projection of expenditures, it is likely that the differences between the reform models and the "steady state" current case would be less in the outlying years than we have estimated here. However, at present, loss of coverage and growing enrollment in Medicaid or SCHIP (which have maintained low rates of expenditure growth per member per month) would be the only reasons to expect lower expenditure growth.

To project cost growth for the current case and each reform model, we distributed total expenditures into three categories by source of payment: medical costs, nonmedical fixed (per enrollee) costs, and nonmedical variable costs which grow in direct proportion to medical costs.

In the current case, we projected medical costs at historical average rates of growth by payer. In the reform models, we assumed that medical costs would grow one percentage point less each year than they would in the current case, reflecting efforts to constrain cost growth. Nonmedicals fixed costs include the cost of eligibility determination in income-tested public programs as well as plan sponsor administration; in the current case and reform models, they were projected to grow at approximately 3.7 percent per year—the average annual rate of growth in nonfarm wages in New Mexico from 1997 to 2002 (the most recent estimates available). Nonmedical variable costs include private insurer nonmedical costs, which historically have grown at the same rate as to medical costs.

The average annual cost growth rates resulting from these calculations are reported in Table V.5. In the current case, total expenditures are projected to grow at an average rate of 8.9 percent per year, peaking at 9.2 percent in 2011. Reflecting the separation of nonmedical cost growth from medical cost growth, total expenditures grow more slowly in the Health Security Act. Medical cost growth is assumed to be equal for all participants in the Health Security Plan—including Medicaid and SCHIP. Expenditures for these programs grow faster than they have historically and also faster than in the base case. Still, the lower base cost of the Health Security Act and the slower trajectory of nonmedical costs produces a lower average rate of expenditure growth over the projection period.

TABLE V.5

ESTIMATED ANNUAL RATES OF GROWTH IN TOTAL EXPENDITURES IN THE CURRENT CASE AND THE REFORM MODELS, 2007-2011

	Average 2007-2011	2007-2008	2008-2009	2009-2010	2010-2011
Current case (steady state)	8.9%	8.6%	8.8%	9.0%	9.2%
Health Security Act v.1	6.9%	7.8%	6.8%	6.2%	6.9%
Health Security Act v.2	6.9%	7.6%	6.5%	6.7%	6.9%
NM Health Choices v.1	8.1%	7.5%	7.8%	8.2%	8.6%
NM Health Choices v.2	8.1%	7.5%	7.9%	8.3%	8.7%
Health Coverage Plan	8.3%	8.8%	8.1%	8.1%	8.1%

Source: Mathematica Policy Research, Inc.

Under New Mexico Health Choices, total expenditures also grow more slowly than in the current case. However, the Alliance would retain private insurance, and the reform model makes no provision for constraining nonmedical cost growth (although it does reduce the level of these costs at the start of the projection period). The growth of private insurers' nonmedical costs at the medical cost growth rate forces higher average cost throughout the projection period—generally tracking that in the Health Coverage Plan. In addition we assume that medical costs for Medicaid/SCHIP enrollees would increase at the same average annual rate for all enrollees in the Alliance. Because New Mexico Health Choices would pool Medicaid/SCHIP enrollees with

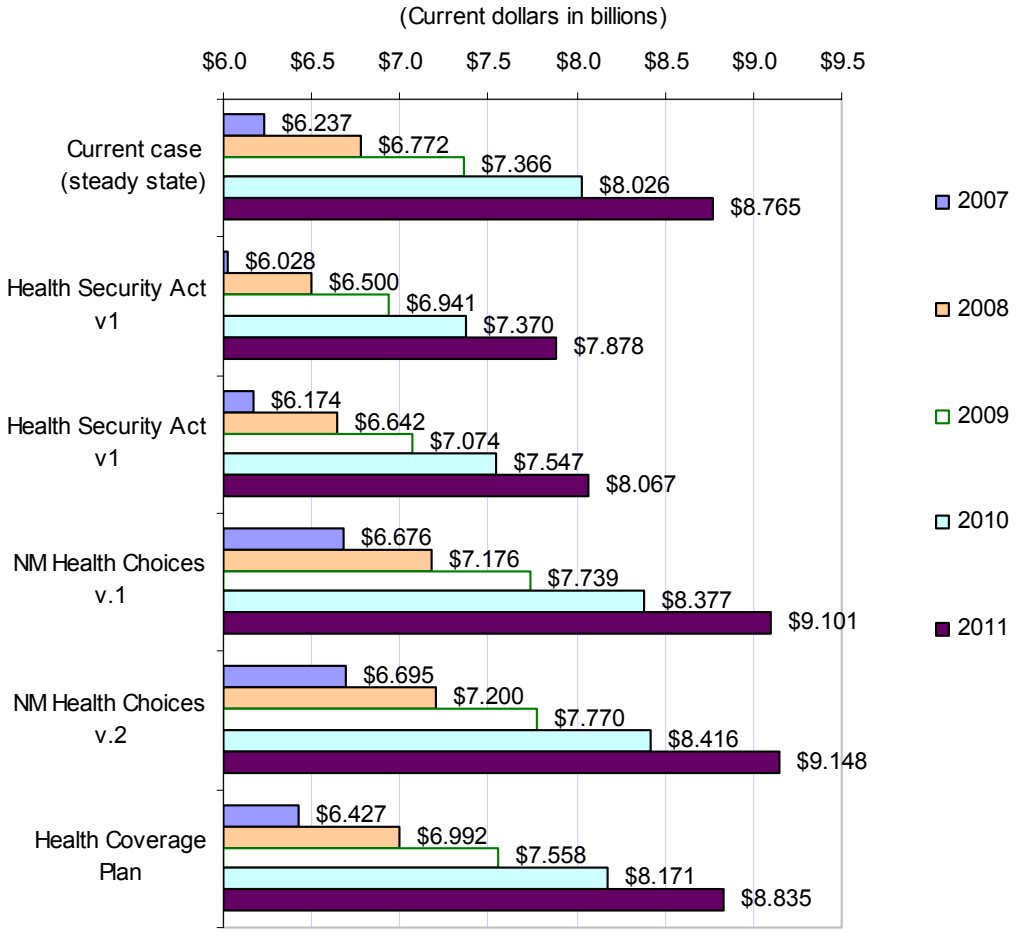
all other Alliance enrollees, medical cost growth for Medicaid/SCHIP enrollees is assumed to grow at the same average rate as for other enrollees—equal to medical cost growth in the Health Security Act, but faster than in the current case.

Finally, in the Health Coverage Plan, we assume that medical costs for New Mexicans in the Health Coverage Plan increase at historical levels minus one percentage point, but Medicaid and SCHIP reimbursements are projected to grow at historic levels—which have been much lower than medical cost growth for other payers in New Mexico. As a result, total expenditure growth measured across all payers slows over the course of five years.

The resulting levels of total expenditures are shown in Figure V.6. The lower estimated level of expenditures in 2007 and slower growth over the projection period produces much lower levels of total spending under the Health Security Act by 2011 ($7.9 to $8.1 billion), compared with either the current case ($8.8 billon) or any of the other reform models. For both New Mexico Health Choices and the Health Coverage Plan, estimated expenditures in 2007 are higher than the current case, and they are projected to remain higher in 2011.

FIGURE V.6

PROJECTED TOTAL EXPENDITURES IN THE CURRENT CASE AND REFORM MODELS 2007-2011



Source: Mathematica Policy Research, Inc.

These differences are reported in Table V.6. Because each of the reform models are assumed to produce slower rates of growth in both medical and nonmedical expenditures than the current case, all of the reform models are projected to accumulate savings over time. By 2011, the Health Security Act is projected to save as much as 10 percent in total expenditures compared to the current case. New Mexico Health Choices is projected to increase total expenditures approximately 4 percent relative to the current case. The Health Coverage Plan would essentially break even by 2011, with projected expenditures within one percentage point of projected expenditures for the current case.

TABLE V.6

PROJECTED DIFFERENCES IN TOTAL EXPENDITURES BETWEEN THE REFORM MODELS AND THE STEADY-STATE CURRENT CASE, 2007-2011

	2007	2008	2009	2010	2011
	Difference in Current Dollars (in millions)				
Health Security Act v.1	(209.1)	(272.0)	(425.4)	(656.5)	(886.9)
Health Security Act v.2	(62.5)	(129.8)	(292.2)	(479.1)	(698.5)
NM Health Choices v.1	439.7	404.4	373.4	351.0	335.6
NM Health Choices v.2	458.3	427.7	404.0	389.5	382.9
Health Coverage Plan	190.3	220.1	192.3	145.0	69.6
	Percent Difference from the Current Case				
Health Security Act v.1	-3.4%	-4.0%	-5.8%	-8.2%	-10.1%
Health Security Act v.2	-1.0%	-1.9%	-4.0%	-6.0%	-8.0%
NM Health Choices v.1	7.1%	6.0%	5.1%	4.4%	3.8%
NM Health Choices v.2	7.3%	6.3%	5.5%	4.9%	4.4%
Health Coverage Plan	3.1%	3.2%	2.6%	1.8%	0.8%

Source: Mathematica Policy Research, Inc.

VI. FINANCING

In this chapter, we review the financing of each of the reform models and offer estimates of funded and unfunded costs. The chapter concludes with an examination of family burden associated with payment of premiums. Because both the Health Security Act and New Mexico Health Choices would limit burden to 6 percent of family income, we focus specifically on the level of burden that the Health Coverage Plan may entail for families who enroll in private coverage in compliance with an individual mandate. Finally, we turn to the issue of undocumented persons and their potential impacts on financing of the reform models.

A. FINANCING PROVISIONS OF THE REFORM MODELS

Each of the reform models specifies a somewhat different system of financing:

- The Health Security Act would charge premiums for participation in the Health Security Plan scaled to income. Premiums would be a fixed amount per person below 200 percent FPL; at higher levels of family income relative to FPL, premiums would be capped at 6 percent of family income. Health Security Plan costs not funded by premiums would be covered by a statewide tax on payroll tiered by employer size to approximate the amount that employers now offering coverage pay as a percent of payroll. Only self-insured employers would be exempted for workers that they cover directly.

- NM Health Choices v.1 would be financed entirely by a tax on payroll. Like the payroll tax envisioned under the Health Security Act, for NM Health Choices it would tiered by firm size so as not to exceed the average current cost that employers pay for coverage when they sponsor a health insurance plan. This reform model makes no provision for exempting employers from the payroll tax, regardless of whether they offer and enroll workers in a self-insured health plan.

- NM Health Choices v.2 would rely on premiums, as well as a payroll tax to fund the net cost of coverage in the Alliance. Families below 400 percent FPL would pay no premiums for coverage, but those at higher levels of income would pay the full cost of coverage, not to exceed 6 percent of family income.

- The Health Coverage Plan would retain current sources of health care financing in New Mexico. However, it would expand eligibility for, and subsidies to, SCI for individuals up to 300 percent FPL. In addition, the Health Coverage Plan calls for a "fair share" payment from employers that do not directly enroll workers in coverage. For the purpose of estimating financing, we assumed that the fair share amount would equal $300 per year for each worker not directly enrolled in a health plan sponsored by his or her employer. We assume just one fair share payment per worker. This assumption recognizes that employers are likely to finance fair share payments by reducing workers' wages, especially those of the lowest-wage workers. By capping fair share payments for each worker at $300 per year, the lowest-wage workers—many who work multiple jobs and more than 40 hours per week—would not be disadvantaged. Nevertheless, this assumption may offer a high-end estimate of Fair Share revenue for a number of reasons, discussed further below.

In addition to these explicit sources of financing, both the Health Security Act and New Mexico Health Choices would exempt, respectively, the Health Security Plan and all Health Choices Alliance plans from the current state tax on premiums. These financing provisions, as well as assumptions about the federal funds that would be available to the reform models, are summarized in Table VI.1.

Finally, both the Health Security Act and New Mexico Health Choices would require that health insurance premiums be pure community rated with no geographic adjustment. This requirement poses an incentive problem for self-insured employers, especially. That is those with the lowest-cost (that is, healthiest and/or youngest) employees would pay more in premiums than they do now, and therefore would not move into the new programs. Considering the large number of workers in New Mexico now enrolled in self-insured coverage, this selection effect would pose a serious problem for these reform models: the highest-cost employees would move into the new programs, bringing with them an unknown level of taxable payroll.

To address this potentially serious problem of adverse selection, we developed the financing projections that minimize premium payments at the expense of increasing payroll tax financing for these models. This strategy is implicit in our enrollment projections, and it is the reason that our estimates indicate that so many workers and dependents now enrolled in self-insured employer plans enroll in the Health Security Plan and New Mexico Health Choices. For the Health Coverage Plan, which retains current sources of coverage and also current insurance rating, increased adverse selection is not an issue—although insurance rating that reflects health status, age, and location would affect affordability, as it does now.

TABLE VI.1

PROPOSED FINANCING OF THE REFORM MODELS

	Individuals	Employers	State	Federal
Health Security Act	Premiums scaled to income: • 0-100% FPL: $0 per member per month (pmpm) • 101-150% FPL: $17.50 pmpm • 151-200% FPL: $35 pmpm • 200%+ FPL: average plan cost capped at 6% of family income	Tax on payroll, not to exceed the current cost for employers that offer coverage, tiered by company size.	Health Security Plan exempted from premium tax. General Fund obligation for unfunded Health Security Plan expenditures.	Funding continues for: • Medicare • Medicaid/SCHIP • Federal employees and retirees and TRICARE • Other federal programs Estimates assume that DSH and UPL funds continue under waiver authority. VA and IHS charge for services provided to insured persons.
NM Health Choices v1	Health Choices Alliance premiums for standard coverage = $0. Voluntary premiums net of vouchers received for improved benefits. Estimates assume two plan designs and no purchase in excess of waiver amounts.	Tax on payroll, not to exceed the current cost for employers that offer coverage, tiered by company size.	Health Choices Alliance exempted from premium tax. General Fund obligation to finance income-based vouchers and unfunded NM Health Choices expenditures.	
NM Health Choices v2	Below 400% FPL, Health Choices Alliance premiums for standard coverage = $0 Above 400% FPL, family premiums are capped at 6% of family income.	Tax on payroll, approximating average cost of the high-cost-sharing plan (for comparison purposes, estimated as the state employee health plan design). Offering employers are exempted.		
Health Coverage Plan	Individual contributions for SCI, individual coverage, NMMIP Individual SCI premiums scaled to income, not to exceed full cost. If no employer contribution: • Medicaid/SCHIP adults and children: $0 • Other < 100% FPL: $0 pmpm • 101-150% FPL: $95 pmpm • 151-200% FPL: $110 pmpm • 201-250% FPL: $150 pmpm • 250-300% FPL: $200 pmpm • 301 FPL+: full cost Individual contributions are reduced by employer contributions (if any): • <250% FPL: $75 pmpm • 250% FPL+: $100 pmpm	Voluntary contributions to coverage. Employers pay a "fair share" contribution per employee not directly covered.	General Fund for premium assistance. General Fund or gross receipts tax for other unfunded expenditures.	

B. ESTIMATES OF STATE COST

The role of federal funding for Medicaid and SCHIP is important to understanding the financing of the reform models. Both the Health Security Act and NM Health Choices would enroll Medicaid and SCHIP enrollees in, respectively, the Health Security Plan and the standard Health Choices Alliance plans with low cost sharing. For the purpose of estimation, we assumed the current Medicaid/SCHIP benefit design would continue for individuals now enrolled in those programs as well as for new enrollees after implementation of the reform models. However, only the actual costs of Medicaid and SCHIP enrollees would qualify for federal matching—not the average cost of all enrollees in the new program.[18]

In both the Health Security Act and NM Health Choices, the average cost of non-Medicaid/SCHIP enrollees in the new program is higher—and sometimes significantly higher—than the average cost of enrollees in Medicaid and SCHIP. (In part, the lower average cost of Medicaid/SCHIP enrollees is due to the relatively high proportion of children in these programs.) (Table VI.2). Because both reform models would require that coverage be pure community rated without geographic adjustment, the average premium for coverage in the new program would be the same for all participants (except, of course, for those enrolled in Medicaid or SCHIP). We assume that, after federal match, all net costs are pooled, any premium payments are accounted for, and remaining costs are then financed with a tax on payroll. Because the amount of federal match in New Mexico is so high—and simulated enrollment in these programs so substantial—pooling enrollees in this manner reduces the premium (measured as the net per capita cost for non-Medicaid/SCHIP participants in the new program) by 36 percent (in the Health Security Act) to 48 percent (in NM Health Choices).

In summary, our financing estimates for both the Health Security Act and NM Health Choices assume that Medicaid and SCHIP enrollees in these reform models pay no premiums for coverage. All other enrollees pay the per capita average total cost of coverage after federal funding for Medicaid and SCHIP enrollees (for example, $1,947 per member per year for the Health Security Act v.1 and $2,081 per member per year for NM Health Choices v.1), not to exceed the reform models' income-related limits on premium payments.

[18] Presumably, this would require explicit accounting for or actuarial reconciliation of cost for Medicaid and SCHIP enrollees, separate from all other enrollees in the Health Security Plan or Health Choices Alliance.

TABLE VI.2

ESTIMATED COST FOR MEDICAID/SCHIP ENROLLEES
AND OTHER NEW PROGRAM ENROLLEES IN THE REFORM MODELS

	Total New Program Enrollees	Medicaid/ SCHIP Enrollees	Other New Program Enrollees	Total New Program Enrollees	Medicaid/ SCHIP Enrollees	Other New Program Enrollees
	Health Security Act v1			Health Security Act v2		
Per capita total cost	$2,977	$2,899	$3,052	$ 3,070	$2,956	$3,179
Per capita cost net of federal Medicaid/SCHIP funds	$1,947	$805	$3,052	$ 2,019	$821	$3,179
	NM Health Choices v1			NM Health Choices v2		
Per capita cost	$3,430	$ 3,117	$3,897	$3,835	$3,072	$5,794
Per capita cost net of federal Medicaid/SCHIP funds	$2,081	$867	$3,897	$2,239	$854	$5,794
	Health Coverage Plan					
Per capita cost	N/A	$2,701				
Per capita cost net of federal Medicaid/SCHIP funds	N/A	$748				

Source: Mathematica Policy Research, Inc.

[a] Per capita costs and federal SCHIP match in the Health Coverage Plan include SCI enrollees. Federal match is provided only for covered costs less than the current program cap on covered expenditures per year.

The components of financing for each of the reform models are summarized in Table VI.3. At least two aspects of these estimates are noteworthy. First, the amounts to be financed under either the Health Security Act or NM Health Choices are small relative to the potential capacity of the financing strategies proposed. While there are no data specific to New Mexico that allow precise calculation of current employer contributions to coverage as a percentage of payroll among employers that offer coverage, the premium amounts now paid by employers appear to be substantially more than the estimated per capita cost of the reform models net of federal financing.

Net of premiums and federal match for Medicaid and SCHIP enrollees, financing these reform models would entail levying a payroll tax estimated at 4.3 to 4.6 percent of payroll (for the Health Security Act) to 5.2 or 8.0 percent of payroll (respectively for NM Health Choices v2 and v1). However, for the Health Security Act and New Mexico Health Choices v2, these estimates are sensitive to self-insured employer behavior—despite our having developed financing in a manner that would minimize adverse selection. If self-insured employers continue coverage for highly compensated workers (that is, those for whom contributions to coverage would be less than the estimated payroll tax), the payroll base would be less than that assumed in our calculations. Within the time and resources available for this study, we are unable to estimate the potential magnitude of this effect.

TABLE VI.3

ESTIMATED FINANCING OF STATE PROGRAMS IN THE REFORM MODELS
(in billions)

	Health Security Act v1	Health Security Act v2	NM Health Choices v1	NM Health Choices v2	Health Coverage Plan
Total cost	$4.711	$4.857	$5.429	$4.980	$1.996
Federal funds [a]	$1.630	$1.662	$2.135	$2.073	$1.444
State funds					
State funds obligated in the reform model	$3.081	$3.196	$3.294	$2.907	$0.553
Current funds	$0.503	$0.503	$0.503	$0.503	$0.50
Medicaid	$0.475	$0.475	$0.475	$0.475	$0.475
Other programs	$28.0	$28.0	$28.0	$28.0	$28.0
Net new obligated state funds	$2.578	$2.693	$2.791	$2.404	$0.050
Other sources of funds					
New program and SCI premiums	$1.075	$1.096	N/A	$0.600	$0.016
Fair share payments	N/A	N/A	N/A	N/A	$0.094
State obligation net of premiums					
Total	$1.503	$1.597	$2.791	$1.805	$0.034
Percent of taxable payroll	4.3%	4.6%	8.0%	5.2%	N/A

Source: Mathematica Policy Research, Inc.

Note: State funds exclude state employee plan costs. State employees are included in New Program and SCI premiums, and state employee payroll is subject to a payroll tax if applicable to the reform model.

[a] Current-case reported expenditures covered by IHA and VA are excluded Estimates assume that the new program would not recoup these funds as coordination of benefits.

Second, because we assume that employers that do not now offer coverage to their workers will not begin to do so under any of the reform models, many workers would continue not to have access to coverage from their own employer under the Health Coverage Plan—although direct coverage would increase somewhat as workers newly accepted current offers of coverage. We also assume that workers who already have coverage from an employer plan as a dependent remain in that coverage—that is, the Fair Share payment is not sufficient incentive to induce them to enroll in their own employer's health plan when offered. Consequently, an estimated 42 percent of workers would not enroll directly in employer-sponsored coverage—either because they are currently covered as the dependent of another worker or because they do not have an offer of coverage from their own employer.

Thus, payment of $300 per year for each worker who is not directly enrolled in an employer-sponsored plan would produce a substantial fair share pool in New Mexico—estimated at more than $93 million in 2007. As this amount would be earmarked to pay for transitionally uninsured New Mexicans and/or homeless and transient persons, it would not be available to finance expanded enrollment in Medicaid, SCHIP, or SCI. The state's financial obligation for these

programs, net of federal matching and SCI premiums, is estimated at $34 million under the Health Coverage Plan.

C. FAMILY BURDEN AND COMPLIANCE

Both the Health Security Act and NM Health Choices v.1 explicitly limit premiums paid to 6 percent of family income for individuals who pay premiums at all. Our estimates assume that individuals whose premiums would exceed this ceiling would make application to the program for premium relief. As noted in Chapter III, this might impose additional administrative costs in the Health Security Act that are not included in our estimates, although those costs would appear to be relatively low.

In contrast to both the Health Security Act and NM Health Choices, the Health Coverage Plan does not attempt to limit premiums paid as a percent of family income other than for enrollees in Medicaid, SCHIP, or SCI—all programs that would draw federal matching funds. However, all New Mexicans would be required to have coverage, causing many to enroll in available private coverage when not eligible for Medicaid, SCHIP, or SCI. As a result, some may pay premiums substantially in excess of the 6-percent-of-income cap that the Health Security Act and NM Health Choices envision as a *de facto* measure of affordability.

In the Health Coverage Plan, this situation raises two related issues. First, compliance with the requirement that all New Mexicans have coverage might be seriously compromised. With respect to this concern, it is notable that Massachusetts—the only state that mandates individuals to obtain coverage if affordable—has deemed a significant proportion of residents exempt because of concerns about affordability. Second, the Health Coverage Plan does raise a significant amount of "fair share" funds intended to help individuals who are temporarily uninsured or otherwise exempted from compliance with the mandate. If everyone were insured, the projected amount of this fund ($93.5 million) would seem to be much greater than might be required for this purpose. However, given the likely burden of compliance for those not eligible for public coverage, the Health Coverage Plan's fair share fund might be called upon to finance care for many who cannot reasonably afford private coverage, despite the Plan's individual mandate.

To gauge the potential magnitude of the difficulty of compliance under the Health Coverage Plan, we estimated the average cost of individuals who would be insured by source of coverage. Because the Health Coverage Plan would not affect how private insurance in New Mexico is priced, these estimates are necessarily extremely rough—specifically, they assume that all individuals within a coverage category pay the same average premium for coverage—similar to the pure community rating rule without geographic adjustment called for in both the Health Security Act and NM Health Choices. Furthermore, it seems likely that employer contributions to coverage for those currently offered and eligible for coverage are unusually low. We assume (as a worst-case estimate) that the employer would contribute little or not at all to coverage for these workers. For both reasons, it is likely that our calculations overstate the number of persons who would pay in excess of 6 percent of family income for private coverage and, therefore, they should be considered upper-bound estimates.

Based on this very rough method of calculation, we estimate that as many as 20 percent of New Mexicans who would need to enroll in private coverage might pay more than 6 percent of family income to comply with the Health Coverage Plan's individual mandate (Table VI.4). (Coincidentally, this estimate is very similar to that recently developed for Massachusetts.[19]) Of these individuals, just over 20 percent (that is, approximately 4 percent of New Mexicans who would pay more than 6 percent of income in premiums) are uninsured currently for at least 6 months during the year.

TABLE VI.4

ESTIMATED PERCENTAGE OF NEW MEXICANS WHO MIGHT PAY MORE THAN 6 PERCENT OF FAMILY INCOME FOR PRIVATE INSURANCE UNDER THE HEALTH COVERAGE PLAN, BY SOURCE OF COVERAGE, CURRENT UNINSURED STATUS, AND FAMILY INCOME

	Number of Persons	Percent of Total	Percent of Population Paying more than 6% of Family Income within Source of Coverage	Percent Paying more than 6% of Family Income Who Are:	
				Currently Uninsured	with Income Below 300% FPL
Total	165.1	100.0%	20.5%	21.6%	68.1%
Self-insured employer	29.1	17.6%	11.4%	0.0%	71.0%
Other group (including NMHIA)	100.4	60.8%	19.9%	27.7%	81.0%
Individual (including NMMIP)	35.6	21.6%	78.2%	22.2%	29.4%

Source: Mathematica Policy Research, Inc.

Note: Estimates exclude state and federal employees. Even under the assumptions applied to private-sector employees (that is, no employer contribution to coverage), very few state or federal employees would pay more than 6 percent of income to cover themselves and dependents.

Two thirds of these New Mexicans (68 percent) are in families with income less than 300 percent FPL. For the purpose of simulating enrollment in public coverage, we assumed that these individuals would not move from their current private coverage into Medicaid, SCHIP or SCI. However, except for crowd-out provisions in these programs, it is likely that many could. At present their burden to support health insurance premium payments is significant, and they would appear to be at risk of becoming uninsured.

Most of New Mexicans who might pay more than 6 percent of family income for coverage would be in employer-sponsored group coverage, either self-insured or insured. This is certainly

[19] Alice Dembner, "Health plan may exempt 20% of the uninsured." *The Boston Globe* April 12, 2007 (http://www.boston.com/news/local/massachusetts/articles/2007/04/12/health_plan_may_exempt_20_of_the_uninsured/).

a high estimate, if employers would contribute to premium. However, at least 20 percent would be in nongroup coverage, including New Mexicans who are self-employed or whose only option would be to purchase individual group coverage.

Whether the fair share fund is adequate to care for the potentially significant number of people whom it would exclude from coverage is unclear. Again very roughly calculated, if half of the individuals who might pay more than 6 percent of family income became uninsured and presented for care, the estimated $93.5 million in the fair share fund could cover approximately $1,100 per person for their care.

D. POTENTIAL IMPACT OF UNDOCUMENTED PERSONS

It is our understanding that the intent of the Committee is that each of the reform models would include undocumented persons. These persons are a source of particular concern, to the extent that they would be unable to pay premiums for coverage when available, but also would not qualify for federal matching if included in Medicaid, SCHIP, or SCI.

It is unclear either how many undocumented persons reside in New Mexico or the extent to which our coverage, cost, and financing estimates capture them. By one estimate, 58 thousand undocumented persons live in New Mexico (Passel 2006, unpublished detail), while our estimates capture an estimated 156.6 thousand noncitizens—including 117 thousand who are currently uninsured all of part of the year.

While the financing for all of the models could certainly be affected by an undercount of undocumented persons, it seems unlikely that unexpected enrollment by undocumented persons would change the essential feasibility of financing for any of the reform models. However, all would need to anticipate some impact.

In Table VI.5, we report—again very roughly calculated—estimates of the potential, "worst case" impact on each of the reform models, under the assumption that all of the estimated undocumented persons in New Mexico enrolled in the Health Security Plan and New Mexico Health Choices Alliance, respectively, with no payment of premiums. For both reform models, the required payroll tax rate might rise as much as 0.5 to 0.7 percentage points. However, we emphasize that the assumptions underlying these estimates are severe, and that they represent the upper bound of what might actually occur.

TABLE VI.5

ESTIMATED MAXIMUM IMPACT OF UNDOCUMENTED PERSONS ON FINANCING FOR THE HEALTH SECURITY ACT AND NEW MEXICO HEALTH CHOICES

	Percent addition to new program	Current estimated payroll tax	Maximum estimated payroll tax to fund participation of undocumented persons
Health Security Act v1	7.2%	4.3%	4.8%
Health Security Act v2	7.2%	4.6%	5.1%
NM Health Choices v1	9.1%	8.0%	8.7%
NM Health Choices v2	15.9%	5.2%	6.2%

Source: Mathematica Policy Research, Inc.

Analogous calculations for the Health Coverage Plan necessarily must be done on a somewhat different basis. The Health Coverage Plan presumably would rely on the Fair Share Fund to finance care for undocumented persons who are uninsured. Again, roughly calculating a worst-case scenario, if undocumented residents are uninsured at the same rate as the noncitizens represented the Current Population Survey and half of these persons present for care during the year representing payments equal to the projected average medical cost of Medicaid beneficiaries, they might represent an additional $21 million in costs to be financed by the Fair Share Fund. By this estimate, they might draw down as much as 22 percent of the estimated amount of the Fair Share Fund in 2007, assuming that employers do not contribute on their behalf into the Fund.

VII. IMPACTS ON STAKEHOLDERS

The discussion below provides an analysis of the impacts of the reform models on the three stakeholder groups overviewed in Chapter III: employers, consumers, and providers. Each of the reform models entails substantial change for employers and consumers, especially. In the Health Security Plan and New Mexico Health Choices, many New Mexicans would move into a new program, and employers that now sponsor insured or self-insured coverage would be relieved of those costs in trade for payment of a payroll tax. For providers, the greatest change will be in the amount of care demanded, potentially straining capacity in some areas of the state in the short term, but presumably inducing greater supply of services over time.

A. EMPLOYERS

Employers in New Mexico, as in other states, currently sponsor most of the private health insurance that pays for New Mexicans' health care, and most of the population under age 65 participates in employer sponsored coverage—either directly (as the primary insured) or as a dependent. Available information about how employers in New Mexico offer and contribute to coverage suggests that the expense of sponsoring a health insurance plan is considerable. Premiums for single coverage averaged $3,401 per worker in 2004; on average, the smallest employers paid nearly 9 percent more, typically for plans with lower benefits and greater cost sharing (Table VII.1). Average premiums for family coverage approached or exceeded $10,000 per worker. These premiums have grown since 2004 at an estimated average rate of approximately 10 percent per year per member per month; at that rate of growth single premiums for private employer-sponsored coverage now exceed $4,500 for single coverage and $12,900 for family coverage. As reported in Chapter IV, private employers in New Mexico pay approximately 80 percent of this amount, while employees contribute the balance. Roughly calculated, employer contributions to coverage in New Mexico, when offered, may equal to 10 to 12 percent of wages and salaries among workers in New Mexico who are offered coverage and enroll.

TABLE VII.1

TOTAL SINGLE AND FAMILY PREMIUMS FOR PRIVATE EMPLOYER-SPONSORED COVERAGE IN NEW MEXICO BY SIZE OF FIRM, 2004

		Number of Employees			
	Total	Less than 25	Less than 50	50 or More	1000 or More
Single	$3,401	$3,704	$3,636	$3,329	$3,172
Family	$9,623	$10,006	$9,883	$9,587	$9,308

Source: Medical Expenditure Panel Survey – Insurance Component (2004) [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2].

Estimating detailed impacts on employers associated with each of the reform models was infeasible within the resources and timeline available for this study. However, a number of impacts are evident, and can be summarized qualitatively:

- The Health Security Act would replace nearly all of employer-sponsored coverage with an individualized system of publicly sponsored coverage. We assume that employers would provide (or be required to provide) tax-exempt accounts through which employees could pay premiums, as required, for Health Security Plan benefits. But employers would not need to contribute to these accounts. Instead, they would be required to pay a tax on payroll of 4 to 5 percent. Employers that now sponsor coverage may pay less than they do currently; obviously, employers that do not sponsor coverage—predominantly the smallest employers in the state—would pay more. Self-insured employers might largely or entirely avoid this tax, taking an exemption for each covered worker. It is likely that they would do so, especially for relatively highly compensated workers, for whom contributions to self-insured coverage represent a relatively low proportion of payroll.

- New Mexico Health Choices would fold all private insurance coverage into the Alliance, merging group and individual coverage throughout the state. The impacts of this strategy on employers in New Mexico would be much the same as those for the Health Security Act. However, related largely to greater nonmedical cost, the estimated tax on payroll needed to support New Mexico Health Choices v.2 would be greater—and therefore, the incentives for self-insured employers to maintain coverage for relatively highly compensated employees would be greater. In New Mexico Health Choices v.1, the required payroll tax would be greater due to the absence of premium financing, but all employers would be required to pay regardless of whether they offer or enroll workers in coverage.

- The Health Coverage Plan would cause the least change for employers. However, we estimate that approximately 122 thousand adults and children who currently are offered coverage from their employer would accept it to comply with the requirement that they be insured (Table VII.2). Most would be children—suggesting that such high family premiums in employer-sponsored coverage in the current case are indeed a critical obstacle to private coverage for children among workers whose family income is higher than would qualify them to enroll their children in SCHIP. Reflecting current patterns of offer and eligibility, urban employer would be most affected, and most workers who would enroll either themselves or their dependents would be full-time employees.

TABLE VII.2

ESTIMATED NUMBER AND SELECTED CHARACTERISTICS OF NEW MEXICANS WHO WOULD ENROLL IN EMPLOYER-SPONSORED COVERAGE UNDER THE HEALTH COVERAGE PLAN

	Number (in thousands)	Percent
Total	121.9	100.0
Adults	7.4	6.0
Children	114.5	94.0
Full-time workers	69.6	57.1
Part-time workers	14.7	12.1
Unemployed/non-worker	37.5	30.8
MSA	80.6	66.1
Non-MSA	41.3	33.9

Source: Mathematica Policy Research, Inc.

B. CONSUMERS

Each of the reform models would affect consumers in New Mexico in two major ways. First, for many, their predominant source of coverage would change. Second, with changes in coverage and benefit design, their out-of-pocket costs would change. Each of these impacts is discussed below.

1. Coverage

While every New Mexican would be covered as a result of the reform, the reform models would affect different subgroups of population differently. In order to illustrate how various people may be affected differently, a few examples are provided below. Supporting tables are provided in Appendix F.

- Among full-time workers with private group insurance as their predominant source of coverage in current case:

  - The Health Security Act would enroll 83 percent in the Health Security Plan, including 3 percent who would enroll in Medicaid or SCHIP. About 17 percent would remain in group coverage—primarily FEHBP or TRICARE, but also a very few in self-insured plans.

  - New Mexico Health Choices v.1 also would enroll approximately 83 percent in the Health Choices Alliance, including 11 percent who would enroll in Medicaid or SCHIP. Similar to the Health Security Plan, 17 percent would remain in group coverage—exclusively in FEHBP or TRICARE.

- New Mexico Health Choices v.2 would enroll a smaller proportion of these workers (61 percent) in the Health Choices Alliance. A larger proportion—39 percent—would remain in group coverage
- By assumption, all workers who are currently group-insured would remain so in the Health Coverage Plan.

- Among New Mexicans with family income above 300 percent FPL with individual private insurance as their predominant source of coverage in current case:
  - The Health Security Act would enroll all of them in the Health Security Plan, including 1 percent who would become enrolled in Medicaid or SCHIP.
  - New Mexico Health Choices v.1 and v.2 would also enroll all of these individuals in the Health Choices Alliance. Similar to the Health Security Act, 1 percent of these individuals would become enrolled in Medicaid or SCHIP.
  - By assumption, the Health Coverage Plan would retain all of these individuals in their current coverage.

- Among children enrolled predominantly in Medicaid or SCHIP in current case:
  - The Health Security Act would enroll all of them in the Health Security Plan. Without full-year eligibility for Medicaid or SCHIP, a small number (approximately 6 percent) whose current income would no longer qualify them would enroll in the standard Health Security Plan benefit with higher cost sharing than in Medicaid or SCHIP.
  - New Mexico Health Choices v.1 and v.2 also would enroll all of these New Mexicans in the Health Choices Alliance. Within the Alliance, virtually all would retain their enrollment in Medicaid and SCHIP.
  - The Health Coverage Plan also would retain enrollment of these children in Medicaid and SCHIP.

- Among uninsured New Mexicans living in rural areas:
  - The Health Security Act would enroll all of these individuals in the Health Security Plan. Two thirds (66 percent) would be enrolled in Medicaid or SCHIP.
  - New Mexico Health Choices v.1 and v.2 also would enroll all of these individuals in the Alliance. However, 83 percent—including adults without children under 100 percent FPL—would enroll Medicaid or SCHIP.

- The Health Coverage Plan would enroll 20 percent in private group insurance, 2 percent in non-group insurance, and 78 percent in Medicaid, SCHIP, or SCI (removing the current annual limit on SCI coverage).

2. Out-of-Pocket Costs

Per capita out of pocket cost. Under each of the reform models, we assume that uninsured individuals comply with the requirement that all New Mexicans become and remain insured. Thus, uninsured individuals gain coverage, but some who are now insured move into new coverage with a different benefit design. As a result, New Mexicans who are currently uninsured all or part of the year have reduced out-of-pocket cost for health care services, while some who are full-year insured may experience slightly higher out-of-pocket costs as their plan design changes.

Estimated changes in per capita total and out-of-pocket cost under each of the reform models are summarized in Table VII.3. Each of the reform models would increase total expenditures per capita and reduce out-of-pocket costs. Health Choices v.2 would generate the highest total expenditure, and therefore the highest total expenditure per capita ($3,987). It also would produce the lowest out-of-pocket cost ($493) related to high enrollment in Medicaid and SCHIP with very little cost sharing. The Health Coverage Plan, which would entail the least change in current sources of coverage, would entail the least change in per capita out-of-pocket expenditure.

TABLE VII.3

ESTIMATED PER CAPITA OUT-OF-POCKET (OUT-OF-POCKET) COST A PERCENT OF TOTAL EXPENDITURES IN THE CURRENT CASE AND THE REFORM MODELS, 2007

	Total Expenditures per Capita	Out-of-Pocket Cost per Capita	Out-of-Pocket Cost as a Percent of Total Expenditures
Current Case	$3,714	$676	18.2%
Health Security Act v.1	$3,590	$543	15.1%
Health Security Act v.2	$3,677	$543	14.8%
Health Choices v.1	$3,976	$511	12.9%
Health Choices v.2	$3,987	$493	12.4%
Health Coverage Plan	$3,828	$564	14.7%

Source: Mathematica Policy Research, Inc.

The reform models would have different impacts on out-of-pocket cost for individuals with different personal characteristics, with different current sources of coverage, and in urban and rural areas. Not surprisingly, New Mexicans who are currently uninsured would experience the largest reduction in out-of-pocket cost—spending 50 to 60 percent less out-of-pocket than in the current case. For New Mexicans with family income below poverty, average out-of-pocket costs also would decline markedly: by 37 percent under Health Coverage Plan to 53 percent under

New Mexico Health Choices, as adults below the poverty line gain Medicaid coverage. In general, rural residents also would experience larger reductions in out-of-pocket spending, reflecting the higher rates of currently uninsured New Mexicans in rural areas who would gain coverage as well as the larger proportion of rural residents who would enroll in Medicaid and SCHIP.

TABLE VII.4

ESTIMATED CHANGE IN PER CAPITA OUT-OF-POCKET COST UNDER THE REFORM MODELS BY SELECTED PERSONAL CHARACTERISTICS, 2007

		Health Security Act		Health Choices v.1		Health Choices v.2		Health Coverage Plan	
	Current Case	Change	Percent Change	Change	Percent Change	Change	Percent Change	Change	Percent Change
Total	**$676**	**-$133**	**-19.6%**	**-$165**	**-24.4%**	**-$183**	**-27.1%**	**-$112**	**-16.6%**
Predominant source of coverage in the current case									
Private/SCI	$956	-$70	-7.3%	-$114	-11.9%	-$154	-16.1%	-$23	-2.4%
Public	$347	-$93	-26.8%	-$93	-26.7%	-$93	-26.8%	-$85	-24.4%
Uninsured	$570	-$288	-50.5%	-$338	-59.3%	-$339	-59.5%	-$297	-52.2%
Family income									
Below 100% FPL	$484	-$200	-41.5%	-$254	-52.5%	-$254	-52.5%	-$178	-36.7%
100-199% FPL	$408	-$113	-27.7%	-$197	-48.1%	-$192	-47.1%	-$133	-32.6%
200-299% FPL	$639	-$118	-18.5%	-$119	-18.6%	-$135	-21.2%	-$89	-13.9%
300% FPL and above	$1,009	-$105	-10.4%	-$104	-10.3%	-$151	-15.0%	-$62	-6.2%
Location									
MSA	710	-$130	-18.4%	-$167	-23.5%	-$190	-26.7%	-$121	-17.0%
Non-MSA	619	-$137	-22.1%	-$162	-26.2%	-$173	-27.9%	-$98	-15.8%

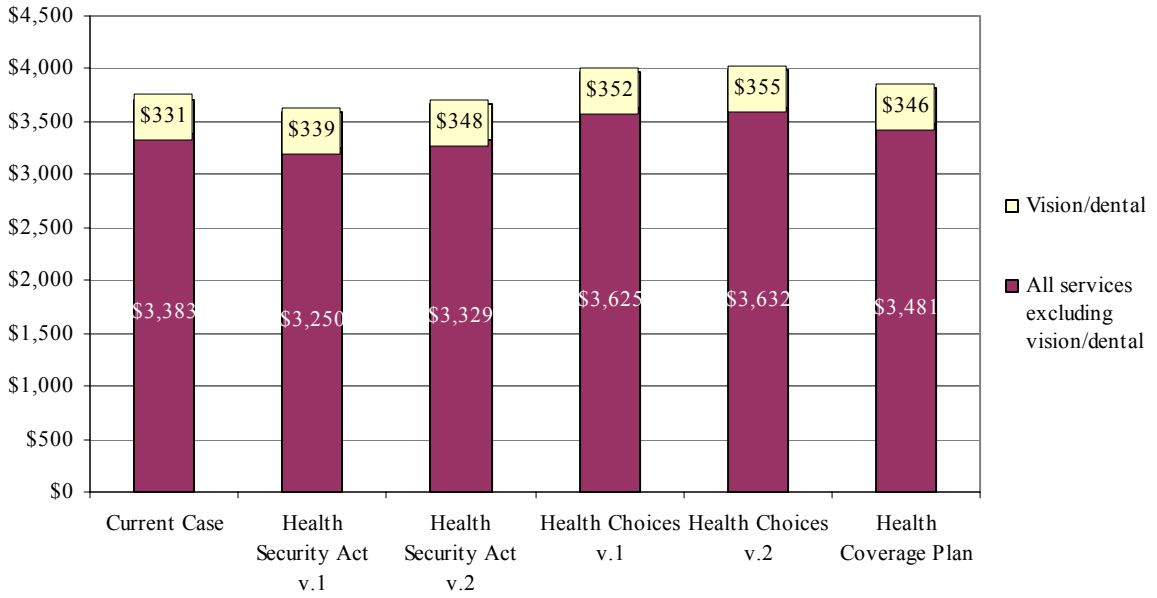
Source: Mathematica Policy Research, Inc.

Vision and dental coverage. The Health Security Act and New Mexico Health Choices potentially differ on whether the standard benefit design would include coverage for vision and dental services. The Committee requested that payments for these services be considered separately, so as to better understand the impacts of covering these services in a standard benefit

Estimated per capita total expenditures for vision and dental services separated from all other services that would be covered under each of the reform models are displayed in Figure VII.1. In the current case, vision and dental services cost $331 per capita. Presuming coverage in each of the reform models, this amount would increase by $9 (Health Security Act v.1) to $24 (Health Choices v.2).

FIGURE VII.1

ESTIMATED PER CAPITA TOTAL EXPENDITURES WITH AND WITHOUT VISION/ DENTAL SERVICES IN THE CURRENT CASE AND REFORM MODELS, 2007



Source: Mathematica Policy Research, Inc.

If vision and dental services were not covered in the reform models, some New Mexicans—predominantly those currently in group coverage—would lose insurance that now pays for these services. Because our estimates of expenditure in the reform models reflect the effect of insurance on the use of dental and vision services, they represent an upper-bound estimate of the magnitude of expenditure that would occur if individuals entirely lost vision and dental coverage.

In both the Health Security Plan and the Health Choices Alliance, the standard benefit is assumed to cover approximately half of total expenditures for dental and vision services—equal to the estimated proportion of coverage provided currently in the state employee health plan. Therefore, if these reform models entirely excluded coverage for these services, for consumers enrolled in the standard benefit, out-of-pocket expense would increase by as much as about $175 per capita—that is, by as much as 50 percent of total per capita expenditure. We assume that Medicaid and SCHIP beneficiaries would retain vision and dental coverage with relatively low cost sharing, regardless of the configuration of the standard benefit in either the Health Security Plan or the Health Choices Alliance.

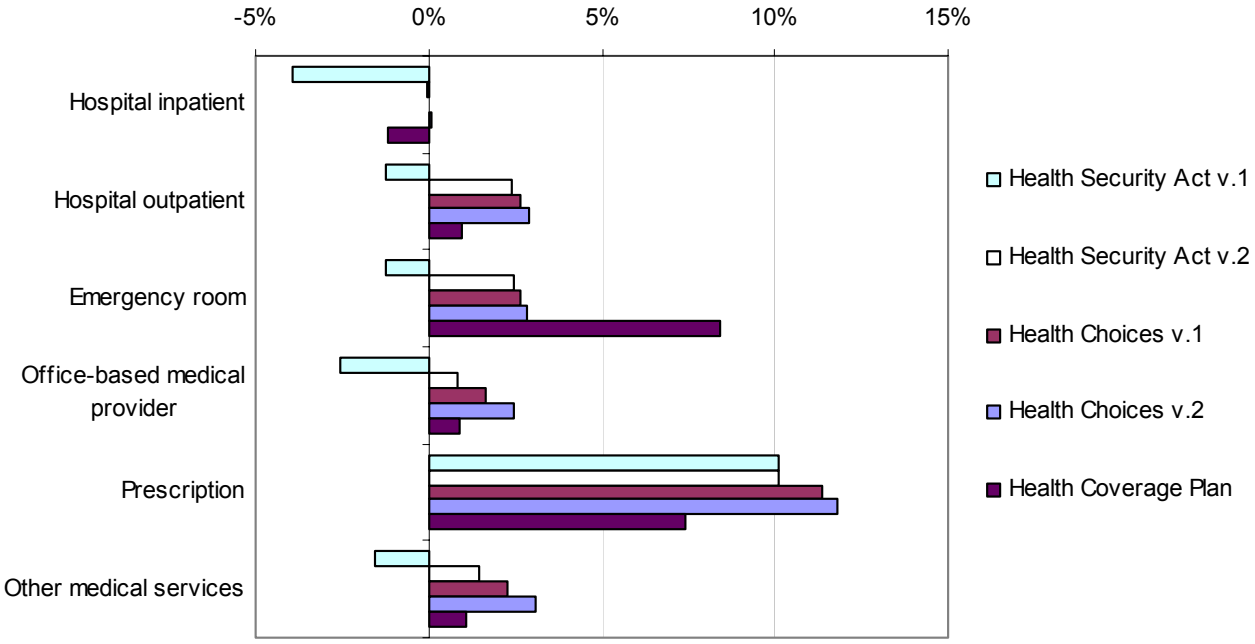
C. HEALTH CARE PROVIDERS

With health insurance coverage for all New Mexicans, health care providers would see a significant increase in the demand for services and payment for the services they provide. All of our estimates assume that providers retain any mark-up in payment rates that currently help them to finance uncompensated care. Only the Health Security Act envisions capturing reduced provider administrative burden associated with fewer payers—estimated here as version 1 of that

reform model—producing a decline in payments to providers. Only spending for prescription drugs—which occurs in the context of a national market—would increase under this version of the Health Security Act (Figure VII.2). Notably, spending for prescription drugs would increase in each of the reform models more than expenditures for other service types, reflecting (in the Health Security Plan and New Mexico Health Choices) slightly lower average cost sharing in the standard benefit than the average in current private group or individual coverage, and in each of the reform models greater enrollment in Medicaid and SCHIP.

FIGURE VII.2

PERCENT CHANGE IN ESTIMATED TOTAL EXPENDITURES BY TYPE OF SERVICES IN THE REFORM MODELS COMPARED WITH CURRENT CASE, 2007



Source: Mathematica Policy Research, Inc.

Because only individuals who are currently uninsured move in the Health Coverage Plan, the relatively high projected increase in expenditures for emergency room care reflects the current high use of emergency room services among the uninsured. This anomalous result points to the importance of changing patterns of care for the uninsured population when they gain coverage, both to improve quality and control cost. It also echoes some of the issues that have been raised about provider capacity to meet new demand after health care reform, as discussed below.

Transition issues for providers. At least two concerns have been raised in the Committee's consideration of the reform models that are fundamentally related to impacts on providers: (1) whether there is sufficient provider capacity to respond to the increased demand for health care services that the reform models would support; and (2) whether reform would critically disrupt the health care service systems on which underserved populations depend.

Dr. William Wiese on our project team conducted a series of semi-structured key-informant interviews with individuals in leadership positions in New Mexico and/or recognized as representing the views of New Mexico hospitals (including those in rural areas), primary care and community health centers, providers in underserved areas, and the Indian Health Service. These interviews identified a number of capacity and provider concerns related to major reform to insure all New Mexicans that parallel some of the concerns the Committee has raised. Underlying these concerns is a consensus that the clinical capacity now serving underserved populations is saturated at most locations, and there would be limited ability to absorb increased clinical load. Some predicted degradation of access to services for those already covered, particularly in where service capacity is saturated.

The concerns expressed by the key informants that Dr. Wiese interviewed can be summarized in two categories:

- Increasing the proportion of insured patients may improve revenues but at least in the short term, it would not necessarily translate into increased capacity to address clinical demand or need. At least three issues are germane to this concern:

  - A national shortage of physicians affects many specialty areas, but most notably in primary care and psychiatry.
  - Nurse practitioners and physician assistants are turning to specialty and hospital-based jobs, not to primary care.
  - Provider systems in well-supplied urban areas offer greater income, attractive options for relieving debt, and ability to address family concerns and life-style preferences to compete successfully for providers. In general, rural communities do not have the same resources to attract providers.

- Already experiencing financial stress, the health care systems and entities that now provide services to underserved populations believe that a significant proportion of clinic users—including undocumented aliens, transients, persons who have not signed up or are otherwise are not participating—will remain uncovered. As a result, these providers perceive potential threats from major reform, including:

  - A possible reduction in hospitals' net receipts as the budgeted financing proposed in a single-payer model replaces current financing mechanisms.
  - A possible loss of subsidies from 330 grants, Rural Primary Health Care Act awards, and other sources under mistaken assumptions that a universal insurance plan would fully cover provider costs.
  - The loss of newly insured patients to other systems of care. Giving patients choice is generally acknowledged as socially and ethically desirable. However, it may critically destabilize local systems of care (such as rural community health centers and the Indian Health Service clinics), undermining

their ability to serve populations that may not have options. Key informants articulating these concerns urged that IHS, tribal, and other Indian interests be represented in discussions and planning for health care financing reform.

- New demand by patients with complex conditions. Some newly covered New Mexicans will need attention for health care needs that they had deferred. There is concern that the formulas used to set funding levels might not anticipate this response.

The above stated concerns not withstanding, none of the key informants opposed the concept of expanding health care coverage. All believed that the expansion of financing should be done deliberately, to ensure that access to services would not be compromised. Some stated that systems reforms and financing reforms should be addressed concurrently.

VIII. IMPACTS ON THE NEW MEXICO ECONOMY

This analysis of the economic impacts of alternative models for achieving universal coverage in New Mexico builds on the work of Mathematica. It is important to note, at least from a legal standpoint, that the analysis presented represents a "best case" analysis for HSA and Health Choices. The analysis assumes that the models can each be designed in a way that will be acceptable under ERISA and that the State program established for each will be considered an employer plan for purposes of a tax deduction under Section 125.

The IMPLAN Pro-2 model, which is widely used for regional economic analysis, is used to estimate the economic impacts of the changes resulting from full implementation of each of the models for financing universal coverage. This is a comparative static analysis: the universal coverage model at full implementation versus base case in 2007 dollars.

A. METHODOLOGY

This economic impact analysis of alternative models for achieving universal health coverage for New Mexicans assumes that the Health Security Act and the Health Choices models can each be designed in a way that will be acceptable under ERISA and that the State program established for each will be considered an employer plan for purposes of a tax deduction under Section 125. From this legal perspective at least, the analysis of these two types of models represents a "best case" analysis.

The economic impact analysis takes as inputs the data contained both in the summary tables and the financing tables produced by Mathematica. Essentially, the summary tables from Mathematica on each of the health coverage models are compared with the Revised Baseline to generate estimates of changes in health care expenditures by category of expenditure (e.g., hospitals, ambulatory, home health care, prescription drugs) and in the net cost of insurance/program administration.[20]

Each of the models for universal coverage has an associated financing plan involving a combination of existing and new federal, state, and private dollars. New state programs are financed from a combination of sources, specifically an expansion in federal funding under Medicaid/SCHIP, the assessment of a schedule of household health care premium payments dependent on household income and household size (to determine income as a % of Federal Poverty Level), and/or a payroll tax on employers. A net increase in the flow of federal dollars supports a higher level of overall economic activity. New program dollars that rely on State or private funding, however, require careful analysis of the impacts of the specific funding plan on individual businesses and households. Any individual mandate or mandatory health insurance premium payments will affect positively or negatively what individual households have available

[20] Mathematica specified a 2007 base case for Health Expenditures and Financing, which they subsequently modified to take account of legislation designed to increase coverage by expending Medicaid/SCHIP and SCI. The economic impacts of the revisions to the Baseline are presented in Appendix G.1.

to spend on other goods and services. Changes in household disposable income, whether positive or negative, are expected to affect spending decisions, and the effects will vary depending upon the level of income. Movement to a system that mandates employers to provide health insurance or imposes a payroll tax to fund health care alters the wage and benefit package used to retain and attract workers and may, in addition, have tax consequences for either or both.

The IMPLAN Pro-2 model, which is widely used for regional economic analysis, is used to estimate the economic impacts – direct, indirect, induced, and total – respectively of the different models for financing universal coverage. (The IMPLAN model is discussed in Appendix G.2.) For the current purposes, the IMPLAN model is used to estimate economic impacts on employment, on labor income (compensation plus self-employment earnings), output and value added. Model results were aggregated by 2-digit NAICS industry, although more detail on the medical services industries may be found in the appendix. Mathematica presented results separately for the more urban areas, specifically the state's four Metropolitan Statistical Areas (MSAs), and for the non-metro, or more rural, rest-of-the-state. Where possible, our analysis separately examines the macro impacts for the metro and the non-metro areas of the state, with the detailed tables provided in the Appendices.

B. CHANGES IN EXPENDITURES

1. Changes in Health Care Related Expenditures

In each of the five models to be estimated, we first looked at the total changes in spending by health care category and on insurance/program administration compared to the Revised Baseline as developed by Mathematica. These changes are summarized in Table VIII.1. Note that total spending on medical services increases in each case except HSA 1, where total expenditures decline slightly in the MSAs, reflecting reduced provider back-office costs for processing and collecting for services delivered. The net cost of insurance (i.e. nonmedical costs) varies tremendously, with the two Health Security Act models (HSA 1 and 2) indicating substantial savings (over $200 million), while the New Mexico Health Choices reform models (H Choice 1 and 2) show substantial increases (over $200 million).

The health care categories were first consolidated into IMPLAN categories, and the economic impacts of the changes in health spending by category were then estimated using the IMPLAN Pro-2 model. Runs were done for metro and non-metro areas, assuming complete implementation in 2007. These estimates are presented in Section D (Economic Impacts).

TABLE VIII.1

MODEL CHANGES FROM REVISED BASELINE

All Figures in $1,000,000s	Revised Baseline	Changes from the Revised Baseline				
		HSA 1	HSA 2	H Choice 1	H Choice 2	H Cov
Metropolitan Statistical Areas (Allbuquerque, Farmington, Las Cruces & Santa Fe MSAs)						
Total medical services	**3,393**	**(18)**	**96**	**122**	**141**	**88**
Hospital inpatient	704	(37)	(2)	(2)	(2)	(4)
Hospital outpatient	245	(7)	4	5	6	4
ER	123	(5)	1	2	2	1
Office-based medical provider	1,049	(40)	2	11	20	5
Rx	758	80	80	91	95	73
Other	515	(8)	11	15	20	10
Net Cost of Insurance	**524**	**(189)**	**(189)**	**150**	**146**	**36**
Non-Metro Areas						
Total medical services	**2,001**	**37**	**69**	**80**	**86**	**33**
Hospital inpatient	448	(8)	2	2	2	(9)
Hospital outpatient	207	2	7	7	8	1
ER	81	2	4	4	4	16
Office-based medical provider	566	(1)	11	16	19	9
Rx	474	45	45	50	50	18
Other	226	(3)	(0)	2	3	(1)
Net Cost of Insurance	**318**	**(38)**	**(38)**	**87**	**85**	**34**
New Mexico						
TOTAL EXPENDITURES	**6,237**	**(209)**	**(62)**	**440**	**458**	**190**
Total medical services	5,395	18	165	202	227	121
Hospital inpatient	1,151	(45)	(0)	0	1	(14)
Hospital outpatient	452	(6)	11	12	13	4
ER	204	(3)	5	5	6	17
Office-based medical provider	1,614	(42)	14	27	39	14
Rx	1,233	125	125	140	145	91
Other	740	(11)	11	17	23	8
Net cost of insurance	**842**	**(227)**	**(227)**	**238**	**231**	**69**

UNM BBER from Summary Table provided by Mathematica

2. Changes in Nonmedical Costs

In addition to analyzing the economic impacts of changes in expenditures for health expenditures, it is necessary to analyze the impacts of changes in nonmedical expenditures on insurance or program administration. Table VIII.2 re-arranges Mathematica's output to provide estimates of these administrative/net insurance costs to the entities actually performing the administrative/insurance function for the program in question. Thus, for example, Mathematica estimates that 57% of these costs for the Medicaid program are currently State costs, with the remainder going to the private contractors who administer Salud.

TABLE VIII.2

ADMINISTRATIVE/NET INSURANCE COSTS ALLOCATED TO SECTOR PERFORMING SERVICE

All Figures in $1,000,000s	Revised Baseline	Universal Coverage Models				
		HSA 1	HSA 2	H Choice 1	H Choice 2	H Cov
Federal Government	**27**	**22**	**22**	**22**	**22**	**22**
Tricare, VA, Other non Medicaid	27	22	22	22	22	22
State Government	**159**	**572**	**572**	**264**	**244**	**115**
Medicaid/SCHIP/SCI	155	331	331	155	152	115
Other State	3	-	-	-	-	0
NEW PROGRAM	-	242	242	110	92	-
Private	**656**	**21**	**21**	**794**	**808**	**774**
Medicaid/SCHIP/SCI	129	-	-	421	408	195
NEW PROGRAM	-	-	-	355	303	-
Private Insurance	527	21	21	18	97	579
Total	**842**	**615**	**615**	**1,080**	**1,073**	**911**

UNM BBER calculations from data provided by Mathematica

Table VIII.3 presents the calculated changes in administrative/net insurance costs for each of the models from the Revised Baseline. The impacts of these changes were modeled using IMPLAN. The results are presented in Section D (Economic Impacts).

TABLE VIII.3

CHANGES IN ADMINISTRATIVE/NET INSURANCE COSTS FROM THE BASELINE

All Figures in $1,000,000s	Revised Baseline	Universal Coverage Models				
		HSA 1	HSA 2	H Choice 1	H Choice 2	H Cov
Federal Government	**27**	**(5)**	**(5)**	**(5)**	**(5)**	**(5)**
Tricare, VA, Other non Medicaid	27	**(5)**	**(5)**	**(5)**	**(5)**	**(5)**
		-	**-**	**-**	**-**	**-**
State Government	**159**	**414**	**414**	**106**	**85**	**(44)**
Medicaid/SCHIP/SCI	155	**175**	**175**	**(1)**	**(4)**	**(40)**
Other State	3	**(3)**	**(3)**	**(3)**	**(3)**	**(3)**
NEW PROGRAM	-	**242**	**242**	**110**	**92**	**-**
		-	**-**	**-**	**-**	**-**
Private	**656**	**(635)**	**(635)**	**138**	**152**	**118**
Medicaid/SCHIP/SCI	129	**(129)**	**(129)**	**292**	**280**	**67**
NEW PROGRAM	-	**-**	**-**	**355**	**303**	**-**
Private Insurance	527	**(507)**	**(507)**	**(509)**	**(431)**	**52**
Total	**842**	**(227)**	**(227)**	**238**	**231**	**69**

UNM BBER calculations from data provided by Mathematica

C. FINANCING

In addition to analyzing changes in the economy resulting from modeled changes in expenditures on medical services and on net insurance, BBER also analyzed the effects of the proposed financing arrangements for new and expanded programs. The underlying financing for each of the models and for the baseline is presented in Table VIII.4. All the models increase use of Medicaid/SCHIP, resulting in an inflow of federal dollars that funds additional health expenditures. Both the HSA and Health Choices create new State programs. These programs and the additional State Medicaid match are funded by imposing a payroll tax on employers and, in the cases of HSA and Health Choices 2, by assessing health care premiums on households. The only private insurance outside these new State programs is that provided by businesses that continue to self-insure.

TABLE VIII.4

UNDERLYING FINANCING FOR HEALTH REFORM MODELS

All Figures in $1,000,000s	Revised Baseline	Universal Coverage Models				
		HSA 1	HSA 2	H Choice 1	H Choice 2	H Cov
Total to Be Funded	**6,237**	**6,028**	**6,174**	**6,676**	**6,695**	**6,427**
Federal Government	**1,714**	**2,019**	**2,051**	**2,524**	**2,462**	**1,833**
Medicaid/Schip	1,257	1,630	1,662	2,135	2,073	1,444
Tricare, VA, Fed Emps, Other	457	390	390	390	390	390
State Government	**639**	**503**	**503**	**503**	**503**	**639**
Medicaid/SCHIP/SCI	475	475	475	475	475	553
State Employees	136	*	*	*	*	135
Other State	28	28	28	28	28	-
NEW PROGRAM		-	-	-	-	-
Private	**3,884**	**3,506**	**3,620**	**3,649**	**3,730**	**3,999**
Private Insurance	2,748	15	15	-	498	2,942
Employer Contributions	2,021	-	-	-	-	2,151
Employee Premiums	539	-	-	-	-	572
Individual Premiums	188	-	-	-	-	220
SCI Premiums	1	-	-	-	-	16
Individual Premiums	-	1,075	1,096	-	600	-
Employer Payroll Tax *	-	1,503	1,597	2,791	1,805	-
Fair Share Payments **	-	-	-	-	-	94
Out of Pocket	1,135	913	913	858	827	947

*For HSA and Health Choices, estimates for employer payroll tax include amounts that State will pay for employees, although this remains a liability of the State payable from the General Fund or the fund that pays an individual employee's compensation. The State contribution has been netted out of the employer contributions both for the Baseline and for Health Coverage and is shown under State contribution.

** Fair Share payments generate $93.7 million, which is more revenue than needed to cover addtional State program costs of $49.2 million. The total to be funded is therefore less than the sum of the federal, state, and private payments.

UNM BBER calculations from data provided by Mathematica

Imposition of a payroll tax in lieu of employer premiums is assumed to have no effect on total compensation, but it does affect pre-tax wages. Table VIII.5 provides estimates of employer premium payments by industry for the Revised Baseline and estimates by industry of the payroll tax or health care premiums to be paid under the different universal coverage models, excluding Health Coverage. Note that the industries include state and local governments.

If the payroll tax/premium is less, a negative entry appears in the column labeled Difference. Since compensation does not change, this negative translates to a positive pre-tax gain in wages and salaries. However, the gain is less than the amount of the savings in employer premiums, since the employer must pay approximately 7% in payroll taxes (FICA) on any additions to gross wages.[21] The economic impacts of these gains/losses are presented in the next section on Economic Impacts.

The Health Coverage model is not included in Table VIII.5. Employer contributions under that model consist of premiums, very similar to those in place today, although they generate $130 million in additional payments. Employers also pay a Fair Share payment of $300 for each employee not covered by employee health insurance. That contribution is made regardless of whether the employee is now covered by other insurance, e.g., Medicaid. Total Fair Share Payments are estimated to generate $93.6 million in new revenues to the state. The impacts of both these employer contributions are modeled under Economic Impacts.

[21] Social Security's *Old-Age, Survivors, and Disability Insurance* (OASDI) program and Medicare's *Hospital Insurance* (HI) program. The 2007 rate for OASDI is 6.2% up to the maximum earnings of $97,500; that for HI is 1.45%, without a limit on earnings. For self-employed, the respective percentages are 12.4% and 2.9%. Source: US Social Security Administration, Office of the Chief Actuary, Social Security Online (www.ssa.gov/OACT/ProgData/taxRates.html). Data extracted July 10, 2007.

Table VIII.5
Estimated Changes in Employer Contributions to Health Insurance

All figures in $1000s	Estimated Base Case [1]	Health Security Act 1 Calc %	Health Security Act 1 Payroll Tax	Health Security Act 1 Difference	Health Security Act 2 Calc %	Health Security Act 2 Payroll Tax	Health Security Act 2 Difference	Health Choices 1 Calc %	Health Choices 1 Payroll Tax	Health Choices 1 Difference	Health Choices 2 Calc %	Health Choices 2 Payroll Tax	Health Choices 2 Difference
INDUSTRIES/ Estimated total Premiums/Payroll Tax													
FARM [2]	25,464	4.3%	30,209	4,745	4.6%	32,095	6,631	8.0%	56,091	30,627	5.1%	36,269	10,805
NATURAL RESOURCES & MINING	131,658	4.3%	94,457	(37,200)	4.6%	100,353	(31,305)	8.0%	175,383	43,725	5.1%	113,404	(18,253)
CONSTRUCTION	169,361	4.3%	123,296	(46,065)	4.6%	130,991	(38,370)	8.0%	228,928	59,567	5.1%	148,028	(21,333)
MANUFACTURING	181,524	4.3%	91,966	(89,558)	4.6%	97,706	(83,818)	8.0%	170,757	(10,767)	5.1%	110,414	(71,110)
TRADE, TRANS, UTILITIES	368,555	4.3%											
WHOLESALE	92,900	4.3%	52,660	(40,240)	4.6%	55,947	(36,954)	8.0%	97,776	4,876	5.1%	63,223	(29,677)
RETAIL	192,548	4.3%	121,967	(70,581)	4.6%	129,580	(62,968)	8.0%	226,461	33,913	5.1%	146,432	(46,116)
TRANS & WAREHSG	55,494	4.3%	43,062	(12,432)	4.6%	45,749	(9,745)	8.0%	79,954	24,460	5.1%	51,699	(3,795)
UTILITIES	27,543	4.3%	11,328	(16,216)	4.6%	12,035	(15,509)	8.0%	21,032	(6,511)	5.1%	13,600	(13,944)
INFORMATION	56,298	4.3%	35,652	(20,646)	4.6%	37,877	(18,421)	8.0%	66,197	9,899	5.1%	42,804	(13,495)
FINANCIAL ACTIVITIES	108,181	4.3%	85,691	(22,490)	4.6%	91,039	(17,142)	8.0%	159,105	50,924	5.1%	102,879	(5,301)
PROFESSIONAL & BUSINESS	319,267	4.3%	272,754	(46,513)	4.6%	289,778	(29,489)	8.0%	506,432	187,166	5.1%	327,465	8,199
PROF & TECHL	236,601	4.3%	176,636	(59,965)	4.6%	187,660	(48,941)	8.0%	327,965	91,365	5.1%	212,066	(24,534)
ADMIN & WASTE SERV	63,895	4.3%	55,991	(7,904)	4.6%	59,485	(4,410)	8.0%	103,960	40,065	5.1%	67,222	3,327
EDUCATION & HEALTH SERVICES	271,847	4.3%											
EDUCATION	16,462	4.3%	14,008	(2,453)	4.6%	14,883	(1,579)	8.0%	26,010	9,548	5.1%	16,818	357
HEALTH CARE	253,143	4.3%	161,272	(91,870)	4.6%	171,338	(81,805)	8.0%	299,440	46,298	5.1%	193,622	(59,521)
LEIASURE & HOSPITALITY	72,049	4.3%	68,592	(3,457)	4.6%	72,873	825	8.0%	127,358	55,309	5.1%	82,351	10,302
ACOMMOD & FOOD SERV	62,899	4.3%	56,167	(6,731)	4.6%	59,673	(3,226)	8.0%	104,288	41,389	5.1%	67,434	4,535
OTHER SERVICES	55,345	4.3%	47,553	(7,792)	4.6%	50,521	(4,824)	8.0%	88,293	32,948	5.1%	57,091	1,747
GOVERNMENT	-		-	-		-	-		-	-		-	-
STATE & LOCAL	424,968	4.3%	248,796	(176,173)	4.6%	264,324	(160,645)	8.0%	461,948	36,979	5.1%	298,701	(126,267)
FEDERAL GOVERNMENT													
Total [3]	2,156,741		1,503,264	(678,941)		1,597,089	(585,116)		2,791,165	608,960		1,804,801	(377,404)

1 Base case premiums estimated from insurance and health insurance contributions per dollar of compensation by industry, as published in the US Bureau of Labor Statistics, US Compensation Survey, December 2006

2. Farm sector insurance rates assumed to be same as those for natural resources and mining.

3 Base case excludes those employed who are 65 +, as found in the US Census Bureau, 2005 American Community Survey for New Mexico

UNM BBER Estimates

In terms of modeling the economic impacts of changes in household expenditures on healthcare, it is necessary to estimate the net impacts of changes in individual premiums and out-of-pocket expenses on households by income category. If the changes are negative, households have more discretionary income they can spend on non-health related categories of expenditure and conversely, if the changes are positive, the burden of paying for health services is greater. Table VIII.6 provides estimates of changes between each model and the Revised Baseline by income category in estimated expenditures out-of-pocket and for health care premiums. Because the tax treatment is different, employee expenditures on health premiums are broken out separately.[22]

Note the substantial reductions in out-of-pocket expenditures as uninsured individuals become covered, regardless of model. Individual premiums also fall under each of the proposals. Under HSA and Health Choices 2, many workers not now covered by their employers will pay premiums that are assumed to receive favorable tax treatment under IRS Regulation 125.[23] Some of these individuals and/or their dependents may previously have purchased insurance on the individual market. Of course, the greatest savings for individuals and employees is achieved under Health Choices 1, which has only a payroll tax and no individual nor employee premiums.

[22] Under Section 125 of the IRS Code, employee contributions toward health insurance for themselves and their dependents are from pre-tax dollars, while individual contributions toward health insurance are after taxes. In this analysis, workers include individuals who are self-employed and who do not otherwise work for someone else. The economic impact analysis assumes that premium payments made by those counted as self-employed are out of pre-tax dollars even though not all those counted as self-employed may qualify for favorable tax treatment under IRS regulations. In this regard, the analysis may understate the impacts on spending. On the other hand, the analysis treats all out-of-pocket expenses as after tax even though many employees are able to participate in flexible spending plans that allow them to meet out-of-pocket expenses from pre-tax dollars. This latter assumption has the effect of overstating impacts on spending.

[23] As noted in the introduction, the New Mexico Taxation and Revenue Department has taken the position that premiums paid by workers under both HSA and Health Choices will be ineligible for favorable tax treatment. This TRD "worst case" is modeled in a subsequent section of the report.

TABLE VIII.6

ESTIMATED CHANGES IN OUT-OF-POCKET AND PREMIUM EXPENSES

Household Health Insurance and Out-of-Pocket Expenditures by Income Category

In $1,000,000's	Revised Baseline	Changes from the Revised Baseline				
		HSA 1	HSA 2	H Choice 1	H Choice 2	H Cov
Out of Pocket						
Less than 10,000	147	(69)	(69)	(82)	(82)	(62)
10,000 to 14,999	40	(11)	(11)	(20)	(20)	(10)
15,000 to 24,999	100	(25)	(25)	(41)	(41)	(27)
25,000 to 34,999	131	(30)	(30)	(42)	(42)	(29)
35,000 to 49,999	156	(22)	(22)	(27)	(34)	(19)
50,000 to 74,999	218	(25)	(25)	(26)	(34)	(21)
75,000 to 99,999	140	(20)	(20)	(20)	(26)	(11)
100,00 to 149,999	120	(9)	(9)	(9)	(15)	(7)
150,000 or more	83	(11)	(11)	(11)	(14)	(3)
Totals	**1,135**	**(223)**	**(223)**	**(277)**	**(308)**	**(188)**
Individual Premiums						
Less than 10,000	13	(13)	(13)	(13)	(13)	(0)
10,000 to 14,999	2	(1)	(1)	(2)	(2)	(0)
15,000 to 24,999	5	(1)	(1)	(5)	(5)	3
25,000 to 34,999	14	(8)	(8)	(14)	(14)	9
35,000 to 49,999	18	(10)	(10)	(18)	(17)	10
50,000 to 74,999	53	(44)	(44)	(53)	(47)	13
75,000 to 99,999	27	(22)	(22)	(27)	(22)	4
100,00 to 149,999	31	(26)	(26)	(31)	(25)	8
150,000 or more	25	(21)	(21)	(25)	(21)	0
Totals	**188**	**(147)**	**(146)**	**(188)**	**(167)**	**47**
Employee Premiums						
Less than 10,000	20	(20)	(20)	(20)	(20)	1
10,000 to 14,999	6	(3)	(3)	(6)	(6)	2
15,000 to 24,999	53	(24)	(24)	(53)	(53)	3
25,000 to 34,999	64	15	16	(64)	(64)	4
35,000 to 49,999	85	67	70	(85)	(61)	8
50,000 to 74,999	128	140	144	(128)	0	6
75,000 to 99,999	76	117	121	(76)	67	3
100,00 to 149,999	67	122	127	(67)	103	4
150,000 or more	41	80	84	(41)	73	2
Totals	**539**	**494**	**514**	**(539)**	**39**	**32**

UNM BBER Calculations based on Mathematica results

D. ECONOMIC IMPACTS

Table VIII.7 provides summary estimates of the net impacts – on employment, earnings, output and value added - of changes in health spending for each of the models. Details on the direct, indirect, induced and total impacts by 2-digit NAICS industry and for the Metropolitan Statistical Areas (MSAs) versus the non-metro areas of the state are provided in **Appendix Table G.3.1**. The labor income figures in Table VIII.7 are compensation plus proprietor's income. The magnitude of the health impacts displayed in Table VIII.7 are broadly in line with the baseline changes calculated in Table VIII.1. However, the composition of total health expenditures varies from one universal coverage model to another as well as the overall amount of spending, and this has an effect on the economic impacts. Basically, the underlying multipliers for some industries are much larger than for others. To give an example, much of the spending on prescription drugs will be for goods produced outside New Mexico, so the multipliers will be small. By contrast, a large portion of spending at a local doctor's office will be on labor, providing income, much of which may be spent within the state, so the multipliers are higher. **Appendix G.4 (Table G.4.1)** gives details on the impacts of changes in health care expenditure on different sub-industries within the health services industry.

TABLE VIII.7

ESTIMATED ECONOMIC IMPACTS OF CHANGES IN HEALTH CARE EXPENDITURES

Income and Output in $1,000s	**Direct**	**Indirect**	**Induced**	**Total**
Health Security Act 1				
Employment	941	2	(108)	835
Labor Income	2,822	50	(3,591)	(719)
Output	24,376	1,536	(10,861)	15,051
Health Security Act 2				
Employment	2,203	355	533	3,091
Labor Income	73,433	12,079	15,698	101,209
Output	154,024	36,147	50,096	240,267
Health Choices 1				
Employment	2,624	439	685	3,747
Labor Income	91,047	14,906	20,206	126,159
Output	187,078	44,270	64,398	295,746
Health Choices 2				
Employment	2,899	496	799	4,194
Labor Income	104,502	16,895	23,658	145,055
Output	210,930	49,872	75,308	336,110
Health Coverage				
Employment	1,755	283	422	2,459
Labor Income	60,101	9,711	12,699	82,511
Output	124,767	28,884	40,194	193,845

UNM BBER estimates using IMPLAN Model

The results presented assume full implementation. Implicitly, the results also assume that an increase in demand for medical goods and services will be met by increased hiring of medical professionals and others. Critically, this assumes that New Mexico clinics, hospitals and other providers can pay sufficient salaries to attract and keep qualified doctors, nurses and other health professionals and that the revenue stream will be sufficient to encourage doctors, dentists and others to go into private practice.

Table VIII.8 presents the summary IMPLAN results on employment, labor income and output of the changes in the health insurance industry resulting from implementation of each of the models. No geographic breakdown is given. Data from the US Bureau of Labor Statistics indicate that the direct health and medical insurance carriers (NAICS 524114) are

TABLE VIII.8

ESTIMATED ECONOMIC IMPACTS OF CHANGES TO THE INSURANCE INDUSTRY

Income and Output in $1,000s	**Direct**	**Indirect**	**Induced**	**Total**
Health Security Act 1				
Employment	(2,010)	(2,243)	(1,551)	(5,804)
Labor Income	(102,212)	(92,284)	(46,272)	(240,768)
Output	(635,466)	(265,023)	(150,273)	(1,050,762)
Health Security Act 2				
Employment	(2,010)	(2,243)	(1,551)	(5,804)
Labor Income	(102,212)	(92,284)	(46,272)	(240,768)
Output	(635,466)	(265,023)	(150,273)	(1,050,762)
Health Choices 1				
Employment	435	486	336	1,257
Labor Income	22,133	19,983	10,020	52,137
Output	137,606	57,389	32,541	227,536
Health Choices 2				
Employment	480	536	370	1,386
Labor Income	24,416	22,045	11,053	57,515
Output	151,800	63,309	35,897	251,006
Health Coverage				
Employment	374	418	289	1,081
Labor Income	19,033	17,184	8,616	44,834
Output	118,331	49,350	27,983	195,664

UNM BBER estimates using IMPLAN Model

heavily concentrated in Bernalillo County, with 99% of total payroll wages.[24] Other insurance activities, like brokers, are undoubtedly more disbursed, but in 2005, Bernalillo County accounted 80% of all insurance industry employment and 83% of wages.

The most dramatic changes would occur with the establishment of the new State program under the Health Security Act. Under HSA, the only people in the study population whose health care needs will continue to be covered under private insurance plans are federal government employees and those employees whose employers opt to self-insure. However, in addition to these populations there is the population age 65 and over now covered by private insurance programs that target Medicare recipients.[25] Effectively, HSA would eliminate about 72.4% of the current market for health insurance in New Mexico, including the three firms which currently contract with the State to administer the Salud program for Medicaid.[26] Insurers currently underwrite about $2.2 billion in health insurance in New Mexico, but they must make payments to providers from what is collected. Mathematica estimates the reduction in net insurance costs under HSA at $635 million. (See Table VIII.3 above.) It is important to note that neither the functions performed by the health insurance industry for the study population nor the jobs and income would totally disappear. The new State program would have to assume responsibility for processing and making payments to medical providers for health services rendered. As indicated in Table VIII.3 above, the net additional costs of this program administration to the state are estimated by Mathematica to be $413.6 million, which is roughly two-thirds the change in net insurance.

Health Choices creates a voucher system that gives New Mexico residents vouchers to buy health insurance from the private sector. The total amount of health insurance underwritten within the state expands, as does the net to the insurance companies over and above plan payouts for health care services, prescriptions drugs, etc. The insurance industry also expands under Health Coverage, but the model involves incremental changes to the current system as opposed to a complete overhaul.

Appendix G.5 (Tables G.5.1 and G.5.2) presents information on the detailed occupations impacted by a contraction or expansion in the health insurance industry. Table G.5.2 indicates other industries where those in the top health insurance industry occupations could look for alternative employment. Presumably many of those insurance professionals impacted will also find employment opportunities with the new State program under the Health Security Act.

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[24] CareerOneStop, America's Career InfoNet: Industry Profile, 52411 – Direct Health and Medical Insurance Carriers and 5241 – Insurance Carriers. Site sponsored by the US Department of Labor (http://www.acinet.org/acinet/industry/Ind_Search_Report)

[25] It should noted that those over 65 could be rolled into the State program if the State program becomes a Medicare Advantage insurer.

[26] Estimate based on data on insured populations provided to Mathematica by the Insurance Division of the Public Regulation Commission.

Table VIII.9 presents the results for changes in the federal government administration of health care programs (e.g., TRICARE, Veterans Administration, Indian Health Service). The changes are relatively small and uniform across the different models.

TABLE VIII.9

ESTIMATED ECONOMIC IMPACTS OF CHANGES IN
FEDERAL GOVERNMENT ADMINISTRATION

Income and Output in $1,000s	**Direct**	**Indirect**	**Induced**	**Total**
Health Security Act 1				
Employment	-	-	-	-
Labor Income	(5,230)	-	(1,263)	(6,493)
Output	(5,454)	-	(4,107)	(9,561)
Health Security Act 2				
Employment	-	-	-	-
Labor Income	(5,230)	-	(1,263)	(6,493)
Output	(5,454)	-	(4,107)	(9,561)
Health Choices 1				
Employment	-	-	-	-
Labor Income	(5,230)	-	(1,263)	(6,493)
Output	(5,454)	-	(4,107)	(9,561)
Health Choices 2				
Employment	-	-	-	-
Labor Income	(5,230)	-	(1,263)	(6,493)
Output	(5,454)	-	(4,107)	(9,561)
Health Coverage				
Employment	-	-	-	-
Labor Income	(5,230)	-	(1,263)	(6,493)
Output	(5,454)	-	(4,107)	(9,561)

UNM BBER estimates using IMPLAN Model

By contrast, there are huge differences in the roles of the State of New Mexico across the different universal coverage models. The estimated economic impacts of changes in State administrative costs associated with the universal coverage models are presented in Table VIII.10. HSA largely eliminates the health insurance industry, replacing it with a new state program under which residents can obtain needed medical services under a uniform benefit plan from the provider of their choice, with the new plan handling all payments for medical services rendered. Health Choices preserves a health insurance industry but changes the rules to require community rating and gives New Mexicans vouchers toward the purchase the health plan of their choice. Everything is brought under a new State plan, but the role of the new state program is very different from that envisioned by HSA. Not surprisingly, the state costs for administration are considerably less. Health Coverage expands slightly the roles of state government in health care.

TABLE VIII.10

ESTIMATED ECONOMIC IMPACTS OF CHANGES IN STATE GOVERNMENT ADMINISTRATION

Income and Output in $1,000s	Direct	Indirect	Induced	Total
Health Security Act 1				
Employment	2,500	1,300	700	4,500
Labor Income	134,746	58,212	47,131	240,089
Output	413,609	146,260	152,468	712,337
Health Security Act 2				
Employment	2,500	1,300	700	4,500
Labor Income	134,746	58,212	47,131	240,089
Output	413,609	146,260	152,468	712,337
Health Choices 1				
Employment	600	100	-	700
Labor Income	34,383	14,841	12,014	61,238
Output	105,540	37,309	38,893	181,742
Health Choices 2				
Employment	500	100	-	600
Labor Income	27,681	11,950	9,671	49,302
Output	84,966	30,036	31,316	146,318
Health Coverage				
Employment	(300)	(100)	-	(400)
Labor Income	(14,208)	(6,133)	(4,960)	(25,301)
Output	(43,613)	(15,414)	(16,065)	(75,092)

UNM BBER estimates using IMPLAN Model

Tables VIII.7 through 10 presented the program changes under each model that will need to be financed. Table VIII.4 summarized the financing plan for each model, identifying who would pay program costs. Table VIII.11 is calculated from Table VIII.4. It summarizes the changes from the baseline in terms of the total dollars needed to provide services and who effectively underwrites the costs. As noted each of the plans relies on an expansion of federal government funding for Medicaid/SCHIP. Any additional funding needed over and above that which comes from the federal government must come from households and businesses**.** The economic impacts vary considerably, depending upon where the additional burden falls or where the relief is felt.

TABLE VIII.11

CHANGES IN WHO PAYS

All Figures in $1,000,000s	Base Case	Universal Coverage Models				
		HSA 1	HSA 2	H Choice 1	H Choice 2	H Cov
Total to Be Funded	**6,237**	**(209)**	**(62)**	**440**	**458**	**190**
Federal Government	**1,714**	**305**	**337**	**810**	**748**	**119**
Medicaid/Schip	1,257	373	405	878	816	187
Tricare, VA, Fed Emps, Oth	457	(67)	(67)	(67)	(67)	(67)
State Government	**639**	**(136)**	**(136)**	**(136)**	**(136)**	**0**
Medicaid/SCHIP/SCI	475	-	-	-	-	29
State Employees	136	(136)	(136)	(136)	(136)	(0)
Other State	28	-	-	-	-	(28)
NEW PROGRAM						
Private	**3,884**	**(379)**	**(264)**	**(235)**	**(154)**	**115**
Private Insurance	2,748	(2,733)	(2,733)	(2,748)	(2,250)	194
Employer Contributions	2,021	(2,006)	(2,006)	(2,021)	(2,021)	130
Employee Premiums	539	(539)	(539)	(539)	(539)	32
Individual Premiums	188	(188)	(188)	(188)	(188)	32
SCI Premiums	1	(1)	(1)	(1)	(1)	16
Individual Premiums	-	1,075	1,096	-	600	-
Employer Payroll Tax *	-	1,503	1,597	2,791	1,805	-
Fair Share Payments **	-	-	-	-	-	94
Out of Pocket	1,135	(223)	(223)	(277)	(308)	(188)

*For HSA and Health Choices, estimates for employer payroll tax include amounts that State will pay for employees, although this remains a liability of the State payable from the General Fund or the fund that pays an individual employee's compensation. The State contribution has been netted out of the employer contributions both for the Baseline and for Health Coverage and is shown under State contribution.

** Fair Share payments generate $93.7 million, which is more revenue than needed to cover addtional State program costs of $49.2 million. The total to be funded is therefore less than the sum of the federal, state, and private payments.

UNM BBER calculations from data provided by Mathematica

Table VIII.12 summarizes the economic impacts of changes from the Baseline in the new targets for employer contributions (payroll tax in the case of HSA and Health Choices) developed by Mathematic. BBER's estimates of the changes by industry were presented in Table VIII.5 above. Employer savings on employee health insurance are assumed to result in higher pre-tax wages (and, conversely, in lower pre-tax wages when the employer contribution is increased). Average wages vary considerably by industry and this fact was used to allocate the changes in pre-tax wages across income categories to estimate changes in spending out of estimated changes in disposable income.

As would be expected from the calculations presented in Table VIII.5, the net impacts are positive for each of the models except Health Choices 1, which relies totally on the federal government and the employer payroll tax to fund the new State program, and Health Coverage, which expands employer coverage and mandates a fair share payment of $300 for each employee who is left without employer health insurance. The positive impacts are larger for HSA 1 than HSA 2 because overall health-related expenditures are less due to savings on

administrative costs. As modeled here, both HSA 1 and HSA 2 rely more heavily on individual premiums than on the payroll tax.

TABLE VIII.12

ESTIMATED ECONOMIC IMPACTS OF CHANGES IN EMPLOYER CONTRIBUTIONS FOR EMPLOYEE HEALTH INSURANCE

Income and Output in $1,000s	Direct	Indirect	Induced	Total
Health Security Act 1				
Employment	2,998	817	926	4,742
Labor Income	86,403	28,312	27,693	142,407
Output	287,916	92,335	89,570	469,821
Health Security Act 2				
Employment	2,555	697	789	4,041
Labor Income	73,616	24,127	23,595	121,338
Output	245,414	78,677	76,318	400,410
Health Choices 1				
Employment	(3,019)	(824)	(935)	(4,779)
Labor Income	(87,287)	(28,537)	(27,960)	(143,784)
Output	(289,400)	(93,184)	(90,436)	(473,020)
Health Choices 2				
Employment	1,638	446	506	2,590
Labor Income	47,141	15,461	15,112	77,714
Output	157,414	50,399	48,880	256,693
Health Coverage				
Employment	(1,073)	(291)	(331)	(1,696)
Labor Income	(30,969)	(10,052)	(9,901)	(50,922)
Output	(101,703)	(32,797)	(32,025)	(166,525)

UNM BBER estimates using IMPLAN Model

Table VIII.13 summarizes the economic impacts of changes in the premiums paid by workers for themselves and their dependents, assuming favorable tax treatment of worker premiums. Particularly in New Mexico, many workers either are not offered health insurance by their employers or they decline to take-up the offer, for example, because the package offered is too expensive. Under HSA, workers currently without insurance and their dependents will now be covered and the premiums they pay may qualify to be paid out of pre-tax dollars. The negative impacts are largest for HSA. This is both because HSA relies more heavily on premiums and because more workers and their dependents will be covered.

Health Choices 1 has no premiums to be paid by households, so the positive impacts are largest under this plan. It should be noted, however, that there are tax consequences to eliminating employee premiums, since currently these premiums are pre-tax, effectively with both the federal and the state government picking up part of the tab in lost revenues. Workers come out ahead, but their gain is less than the full amount of the premiums currently paid.

TABLE VIII.13

ESTIMATED ECONOMIC IMPACTS OF CHANGES IN HOUSEHOLD SPENDING
FOR INSURANCE PREMIUMS FOR WORKERS AND THEIR DEPENDENTS

Income and Output in $1,000s	Direct	Indirect	Induced	Total
Health Security Act 1				
Employment	(2,397)	(640)	(718)	(3,755)
Labor Income	(66,881)	(22,010)	(21,458)	(110,349)
Output	(225,619)	(71,099)	(69,406)	(366,124)
Health Security Act 2				
Employment	(2,494)	(666)	(747)	(3,907)
Labor Income	(69,611)	(22,906)	(22,333)	(114,850)
Output	(234,778)	(73,997)	(72,236)	(381,011)
Health Choices 1				
Employment	2,738	740	840	4,317
Labor Income	78,426	25,540	25,095	129,062
Output	259,216	83,157	81,170	423,544
Health Choices 2				
Employment	(67)	(8)	(0)	(75)
Labor Income	150	(162)	(3)	(14)
Output	(4,049)	134	(9)	(3,924)
Health Coverage				
Employment	(166)	(45)	(51)	(263)
Labor Income	(4,795)	(1,559)	(1,534)	(7,888)
Output	(15,788)	(5,085)	(4,961)	(25,834)

UNM BBER estimates using IMPLAN Model

Both Health Choices 2 and Health Coverage expand coverage for workers and their dependents and increase the total amounts paid in employee premiums, reducing the amount that the associated households have to spend on other goods and services. The economic impacts in both cases are slightly negative.

Table VIII.14 presents the economic impacts that result from changes in the individual premium payments and out-of-pocket expenditures estimated by Mathematica for each of the universal coverage models. As indicated in Table VIII.6, the movement to universal coverage in each model succeeds in reducing out-of-pocket expenses, which are currently very high for those without insurance (Chapter IV). Spending on individual health premiums, however, also declines in each of the models, except Health Coverage, which mandates indivdual coverage. With the exception of Health Coverage, the economic impacts are positive and relatively large. The positive effects are greatest for the two Health Choices models.

Note that while there are net increases in health expenditures and net reductions in discretionary income for HSA, there are major differences in the impacts of the models across income groups. Basically, lower income households realize substantial reductions in health-related expenditures – both premiums and out-of-pocket and have more income to spend on other goods and services. Households in the $35,000 to $50,000 are the first group to experience net increases in health care costs. (Refer to Table VIII.6 above.)

TABLE VIII.14

ESTIMATED ECONOMIC IMPACTS OF CHANGES IN HOUSEHOLD SPENDING
FOR INDIVIDUAL PREMIUMS AND FOR OUT-OF-POCKET HEALTH EXPENDITURES

Income and Output in $1,000s	Direct	Indirect	Induced	Total
Health Security Act 1				
Employment	2,429	661	752	3,842
Labor Income	70,317	22,810	22,475	115,602
Output	231,152	74,394	72,694	378,240
Health Security Act 2				
Employment	2,425	660	751	3,836
Labor Income	70,199	22,771	22,437	115,406
Output	230,754	74,268	72,571	377,593
Health Choices 1				
Employment	3,059	833	949	4,840
Labor Income	88,731	28,745	28,352	145,827
Output	290,870	93,839	91,702	476,411
Health Choices 2				
Employment	3,116	848	966	4,931
Labor Income	90,398	29,291	28,886	148,576
Output	296,418	95,619	93,430	485,467
Health Coverage				
Employment	909	251	289	1,449
Labor Income	27,083	8,685	8,630	44,398
Output	87,229	28,531	27,914	143,674

UNM BBER estimates using IMPLAN Model

Similarly, Health Choices 2, which subsidizes the premium payments of lower income households, provides substantial savings for lower income households, with the burden falling on those at the higher end of the income distribution. In fact, the first income group to have net higher health related expenditures are those with incomes over $50,000.

Table VIII.15 sums the total impacts for each category of impact to produce a total estimated economic impact statewide for full implementation of each of the universal coverage models over the 2007 Revised Baseline. Figures are in 2007 dollars and assume no growth in population nor economic activity other than those resulting from full plan implementation.

As would be expected, the greatest net economic impacts are for the two Health Choices models. Each of these models assumes a waiver for Medicaid that brings substantial additional federal dollars into the state that supports a large expansion both in medical services and in insurance. None of the other models have such a large injection of federal dollars. The more modest results for the two HSA also reflect the assumed realization of substantial savings in administrative/net insurance costs. This is particularly true in HSA1, where realized savings in back-office expenses associated with processing and collecting from multiple insurers hold down overall health care costs.

TABLE VIII.15

ESTIMATED TOTAL ECONOMIC IMPACTS STATEWIDE OF FULL IMPLEMENTATION OF UNIVERSAL COVERAGE MODELS

Income and Output in $1,000s	Health Expend	Insurance	Federal Admin	State Admin	Employer Contribution	Employee Premiums	Individual Premiums Out of Pocket	Total Impacts
Health Security Act 1								
Employment	835	(5,804)	-	4,500	4,742	(3,755)	3,842	4,361
Labor Income	(719)	(240,768)	(1,263)	240,089	142,407	(110,349)	115,602	144,999
Output	15,051	(1,050,762)	(4,107)	712,337	469,821	(366,124)	378,240	154,457
Health Security Act 2								
Employment	3,091	(5,804)	-	4,500	4,041	(3,907)	3,836	5,757
Labor Income	101,209	(240,768)	(1,263)	240,089	121,338	(114,850)	115,406	221,161
Output	240,267	(1,050,762)	(4,107)	712,337	400,410	(381,011)	377,593	294,726
Health Choices 1								
Employment	3,747	1,257	-	700	(4,779)	4,317	4,840	10,082
Labor Income	126,159	52,137	(1,263)	61,238	(143,784)	129,062	145,827	369,376
Output	474,916	227,536	(4,107)	181,742	(473,020)	423,544	476,411	1,307,021
Health Choices 2								
Employment	4,194	1,386	-	600	2,590	(75)	4,931	13,626
Labor Income	145,055	57,515	(1,263)	49,302	77,714	(14)	148,576	476,885
Output	336,110	251,006	(4,107)	146,318	256,693	(3,924)	485,467	1,467,564
Health Coverage								
Employment	2,459	1,081	-	(400)	(1,696)	(263)	1,449	2,630
Labor Income	82,511	44,834	(1,263)	(25,301)	(50,922)	(7,888)	44,398	86,369
Output	193,845	195,664	(4,107)	(75,092)	(166,525)	(25,834)	143,674	261,625

UNM BBER estimates using IMPLAN Model

The net employment impacts reported in Table VIII.15 include both wage and salary workers and self-employment. Table VIII.16 presents data by NAICS industry on the estimated net gains in total wage and salary employment statewide and offers a comparison with the forecasted Revised Baseline for 2007. Note the net impacts on overall employment are in each case positive but relatively small. In terms of individual industries, the largest impacts are on insurance, which is included in financial activities (negative 9 percent in the case of HSA and 4 to 5 percent positive under Health Choices). Retail trade gets a boost, reflecting increases in discretionary income but also increased purchases of prescription drugs. Appendix G.4 provides much more detail on the associated medical industry impacts of the direct changes in expenditures on medical services under the different models. Public Administration employment increases under HSA by 1.5%.

TABLE VIII.16

ESTIMATED NET IMPACTS ON TOTAL WAGE AND SALARY EMPLOYMENT BY INDUSTRY

New Mexico Employment for Study Population, 2007

Change in Employment	Revised Baseline	HSA 1	HSA 2	Health Choices 1	Health Choices 2	Health Coverage
Agric, Forestry, Fishing, Hunting	12,800	27	26	42	73	2
Mining	20,212	22	21	34	58	2
Construction	61,888	17	20	52	78	9
Manufacturing	38,502	38	51	108	170	13
Wholesale Trade	24,257	209	209	179	306	12
Retail Trade	98,491	2,136	2,107	2,686	3,403	1,242
Transport, Whsg, Utilities	24,723	78	98	223	334	40
Information	17,061	0	5	124	181	34
Financial Activities	34,987	-3,221	-3,186	1,401	1,872	781
Professional & Business	113,291	1,133	1,258	751	1,056	53
Educational Services	11,245	43	41	159	199	0
Health Care & Social Assistance	97,643	302	1,538	2,031	2,800	629
Arts, Entertainment, & Recreation	8,870	86	84	212	317	17
Accommodation & Food Services	80,933	680	681	742	1,216	41
Other Services	38,692	267	260	631	907	32
Public Administration 1	167,520	2,544	2,545	705	658	-278
Total	851,115	4,361	5,757	10,082	13,626	2,630
Agric, Forestry, Fishing, Hunting	12,800	0.2%	0.2%	0.3%	0.6%	0.0%
Mining	20,212	0.1%	0.1%	0.2%	0.3%	0.0%
Construction	61,888	0.0%	0.0%	0.1%	0.1%	0.0%
Manufacturing	38,502	0.1%	0.1%	0.3%	0.4%	0.0%
Wholesale Trade	24,257	0.9%	0.9%	0.7%	1.3%	0.0%
Retail Trade	98,491	2.2%	2.1%	2.7%	3.5%	1.3%
Transport, Whsg, Utilities	24,723	0.3%	0.4%	0.9%	1.3%	0.2%
Information	17,061	0.0%	0.0%	0.7%	1.1%	0.2%
Financial Activities	34,987	-9.2%	-9.1%	4.0%	5.4%	2.2%
Professional & Business	113,291	1.0%	1.1%	0.7%	0.9%	0.0%
Educational Services	11,245	0.4%	0.4%	1.4%	1.8%	0.0%
Health Care & Social Assistance	97,643	0.3%	1.6%	2.1%	2.9%	0.6%
Arts, Entertainment, & Recreation	8,870	1.0%	0.9%	2.4%	3.6%	0.2%
Accommodation & Food Services	80,933	0.8%	0.8%	0.9%	1.5%	0.1%
Other Services	38,692	0.7%	0.7%	1.6%	2.3%	0.1%
Public Administration 1	167,520	1.5%	1.5%	0.4%	0.4%	-0.2%
Total	851,115	0.5%	0.7%	1.2%	1.6%	0.3%

UNM BBER estimates using IMPLAN Model. Baseline estimated from US Bureau of Economic Analysis data.

Table VIII.17 presents the estimates of the impacts on wages and salaries by NAICS industry. It is important to note that these increases do not include those higher wages assumed to result from reduced employer contributions for health care. The gains (losses) in wages for each industry in each of the universal coverage models are estimated assuming wage and salary workers maintain their share of total employment by industry. The estimated impacts as a percent of baseline wages and salaries for the study population are given in the final row of the table. Once again, the impacts are relatively small—1 percent or less—when compared to total estimated wages and salaries for 2007 (excludes federal government).

TABLE VIII.17

ESTIMATED IMPACTS ON WAGES AND SALARIES

			Additional Wages & Salaries ($000s)				
	New Mexico	**Average Wage**	**HSA 1**	**HSA 2**	**Health Choices 1**	**Health Choices 2**	**Health Coverage**
11	Agric, Forestry, Fishing, Hunting	27,246	298	281	462	790	19
21	Mining	61,589	1,100	1,022	1,668	2,853	123
23	Construction	36,379	479	573	1,468	2,180	261
31-33	Manufacturing	45,344	1,489	2,017	4,255	6,703	518
42	Wholesale Trade	45,582	7,693	7,690	6,606	11,263	446
44-45	Retail Trade	24,683	43,392	42,797	54,576	69,140	25,230
	Transport, Whsg, Utilities	45,257	2,969	3,671	8,253	12,386	1,470
51	Information	40,438	(14)	161	4,253	6,225	1,169
	Financial Activities	40,559	(101,278)	(100,804)	34,800	44,570	21,728
	Professional & Business	50,555	43,477	48,279	28,539	39,942	1,916
61	Educational Services	26,687	795	759	2,930	3,667	8
62	Health Care & Social Assistance	34,752	8,804	44,848	59,241	81,665	18,345
71	Arts, Entertainment, & Recreation	19,186	644	633	1,601	2,387	125
72	Accommodation & Food Services	14,647	9,326	9,347	10,179	16,682	565
81	Other Services	23,302	4,399	4,279	10,375	14,915	529
92	Public Administration	34,627	88,102	88,119	24,422	22,773	(9,619)
			111,675	153,673	253,629	338,141	62,834
	Percent of Baseline ($1,000s)	29,837,000	0.4%	0.5%	0.9%	1.1%	0.2%

UNM BBER Estimates

Table VIII.18 reports the net economic impacts on total value added for each of the universal coverage models. The latest release on Gross Domestic Product for New Mexico indicates that in 2006, state GDP was $62.5 billion. Health Choices 2 has the largest economic impact and would be expected to raise New Mexico GDP by about 1.3 percent. Health Choices 1 would be about 1.0%, with HSA 2 following at about 0.6%, HSA 1 at 0.5% and Health Coverage at 0.2%.

TABLE VIII.18

ESTIMATED IMPACTS ON TOTAL VALUE ADDED

	Health Expend	Insurance	Federal Admin	State Admin	Employer Contrib	Household Premiums Out of Pocket	TOTAL	% of NM GDP *
				Change in Value Added ($1,000s)				
HSA 1	7,062	(383,641)	(7,796)	401,944	269,225	5,450	292,244	0.5%
HSA 2	142,538	(383,641)	(7,796)	401,944	229,479	(3,487)	379,038	0.6%
H Choices 1	177,005	83,075	(7,796)	102,540	(270,656)	514,843	599,011	1.0%
H Choices 2	202,642	91,644	(7,796)	82,547	147,186	273,870	790,093	1.3%
H Coverage	116,061	71,438	(7,796)	(42,355)	(95,189)	66,961	109,120	0.2%

* Based on US Bureau of Economic Analysis 2006 estimate of $62.5 billion.

UNM BBER estimates using IMPLAN model

E. ECONOMIC IMPACTS IN URBAN AND RURAL AREAS

As Table VIII.19 below illustrates, the four MSAs (Albuquerque, Santa Fe, Las Cruces, and Farmington) account for 62.5 percent of the Study population under 65 but have a somewhat larger role in terms of economic activity.[27] The MSAs are comprised of a diverse group of counties that includes Dona Ana and Torrance Counties, which all have lower median family and household income than the state as a whole and higher rates of poverty, but they also include Santa Fe, Bernalillo and Sandoval Counties, which out-perform all other counties in the state on income measures except Los Alamos.[28] Taken together, these counties account for about 70 percent of personal income versus 62.5 percent of the study population.[29]

[27] Consistent with the study, the table excludes federal government employment and income, both civilian and military.

[28] Census 2000 Summary File 3 (SF 3, GCT-P14. Income and Poverty in 1999, New Mexico Counties as downloaded from American Factfinder on the Census Home Page July 10, 2007.

[29] US Bureau of Economic Analysis, SA05N Personal income by major source and earnings by industry -- New Mexico and New Mexico Metropolitan Statistical Areas, 2005.

TABLE VIII.19

METROPOLITAN AREAS AS A PERCENT OF STATE ECONOMIC ACTIVITY

Total Study Population	**62.5%**
Total Study Employment	**68.3%**
Wage and Salalry Employment	**69.8%**
Individual Proprietors	**62.5%**
Total Study Personal Income	**70.0%**
Compensation	**71.8%**
Wage and Salary Disbursements	**72.5%**
Proprietor Income	**66.9%**

UNM BBER calculations from US Bureau of Economic Analysis Data for 2005 (May 2007 release). Study population breakdown is from Mathematica and reflects the non-institutionlized population under 65.

Tables VIII.20 and 21 allocate the statewide economic impacts of the alternative models respectively between the MSAs and the rest-of-the-state. As noted, about 62.5 percent of the study population lives within one of the four metropolitan areas. However, the estimated economic impacts on this population vary widely from one model to another. Thus, only about 45 percent of the employment and labor income impacts from HSA 1 have been allocated to the MSAs, while over 70% of the impacts in the case Health Coverage accrue to these urban areas.

What drives the differences requires some explanation. First, with respect to medical and related expenditures, HSA1 has a much more positive impact on the rural areas. This largely reflects the assumption that providers in rural areas will have minimal if any savings in back-office costs. However, under both versions of the HSA, increased utilization in rural areas results in slightly higher economic benefits. In Health Choices 1 and 2 the benefits are roughly proportionate to population. In Health Coverage, the MSAs capture more than 70% of the economic impacts.

A decreased role for private health insurance primarily impacts the metro areas, since that is where the industry is concentrated, and conversely with programs that increase the role of private insurance. On the other hand, increasing the State's role in administering a new health care program may be expected to benefit the area(s) where this administrative function will be concentrated. BBER's allocation assumes this administration will be concentrated in the metro areas (specifically Santa Fe), but other decisions could be made. Under the Health Security Act, the State assumes many of the functions formerly provided by private insurance—but it does so with significant savings in administrative/net insurance costs, so the net economic impacts on the metro areas are negative.

As has been noted above, both HSA and Health Choices result in a redistribution of spending power. Both achieve substantial reductions in out-of-pocket expenses, as those

without insurance, many of whom are low income, are covered and all are covered by plans that on average have smaller co-payments. Furthermore, premiums for lower income households are on average lower than today, heavily subsidized or non-existent, while higher income households, except in Health Choices 1 where there are no premiums, are likely to face higher premiums on average.

Statewide programs which redistribute income and provide services to lower income households and families are likely to disproportionately benefit rural areas. According to income distribution tables provided by Mathematica, while the study area population within the metro areas accounts for 62.5% of the total, this population accounts for 71% of those with annual incomes of at least $75 thousand but less than $100 thousand; 75% of those with income of $100 thousand but less than $150 thousand, and 81% of those with incomes of $150 thousand or more. The modeled impacts of changes in household premium payments reflect this distribution.

Both versions of HSA, as modeled here, place greater reliance on individual premiums than do the other models. While premium payments are lower than Baseline for households up to $25,000, higher income households pay substantially more – up to 6% of income. As more workers and their dependents are covered, the differences in worker premium payments from the baseline result in large negative economic impacts statewide. However, over 70% of this additional burden falls on the metro economies, although they account for only 62.5% of the population. The economic gains resulting from savings on out-of-pocket expenses and individual premiums, slightly favor the metro areas, which account for 64 percent of the state total.

Health Choices 1 eliminates individual premiums altogether. Just under 65% of the economic benefits flow to the MSA's. Health Choices 2 subsidizes premium payments for low income households, with those households with more than $100 thousand in income paying much more than under the current system. Individual premiums are much lower on average than under HSA, but the economic impacts on metro areas are negative, while those on rural areas are positive. As is true under HSA, the economic impacts of savings on out of pocket expenses and individual premiums are roughly proportionate to population in the MSAs and non-metro areas.

Health Coverage makes minimal changes in the current private insurance system. Increase participation by workers results in an increase in premium payments that has a small negative economic impact statewide. Urban and rural areas share this burden roughly proportionate to their populations. The expansion of Medicaid, Schip, and SCI combined with a coverage mandate does result in a reasonable reduction in out-of-pocket with small increases in individual premiums above $15,000 in income. The overall economic gains slightly favor the rural areas.

TABLE VIII.20

ECONOMIC IMPACTS ON METROPOLITAN AREAS

Income and Output in $1,000s	Health Expend	Insurance	Federal Admin	State Admin	Employr Contrib	Worker Premium	Individual Premium & Out of Pocket	Total Impacts	Percent of NM
Basis for Allocating	Modelled	95%	62.5%	90%	Earnings	Modelled	Modelled		
Health Security Act 1									
Employment	147	(5,514)	-	4,050	3,448	(2,649)	2,473	1,955	44.8%
Labor Income	(21,107)	(228,729)	(789)	216,080	103,541	(77,805)	74,205	65,395	45.1%
Output	(31,770)	(998,224)	(2,567)	641,103	341,597	(258,040)	243,065	(64,836)	-42.0%
Health Security Act 2									
Employment	1,905	(5,514)	-	4,050	2,846	(2,756)	2,468	2,999	52.1%
Labor Income	59,992	(228,729)	(789)	216,080	85,458	(80,963)	74,070	125,117	56.6%
Output	147,702	(998,224)	(2,567)	641,103	282,006	(268,487)	242,619	44,153	15.0%
Health Choices 1									
Employment	2,384	1,194	-	630	(3,438)	2,797	3,084	6,650	66.0%
Labor Income	78,549	49,530	(789)	55,114	(103,442)	83,444	92,687	255,093	69.1%
Output	189,167	216,159	(2,567)	163,568	(340,304)	274,075	303,146	803,243	61.5%
Health Choices 2									
Employment	2,740	1,317	-	540	1,814	(357)	3,138	9,192	67.5%
Labor Income	93,710	54,639	(789)	44,372	54,421	(9,167)	94,325	331,511	69.5%
Output	221,857	238,456	(2,567)	131,686	179,756	(32,593)	308,543	1,045,138	71.2%
Health Coverages									
Employment	1,772	1,027	-	(360)	(1,198)	(167)	860	1,935	73.5%
Labor Income	56,667	42,592	(789)	(22,771)	(35,964)	(5,000)	26,338	61,074	70.7%
Output	136,876	185,881	(2,567)	(67,583)	(117,607)	(16,389)	85,274	203,885	77.9%

UNM BBER estimates using IMPLAN Model

TABLE VIII.21

ECONOMIC IMPACTS ON RURAL AREAS

Income and Output in $1,000s	Health Expend	Insurance	Federal Admin	State Admin	Employr Contrib	Worker Premium	Individual Premium & Out of Pocket	Total Impacts	Percent of NM
	Modelled	5%	37.5%	10%	Earnings	Modelled	Modelled		
Health Security Act 1									
Employment	687	(290)	-	450	1,294	(1,106)	1,369	2,405	55.2%
Labor Income	20,388	(12,038)	(474)	24,009	38,866	(32,544)	41,398	79,604	54.9%
Output	46,821	(52,538)	(1,540)	71,234	128,225	(108,084)	135,176	219,293	142.0%
Health Security Act 2									
Employment	1,186	(290)	-	450	1,195	(1,151)	1,367	2,757	47.9%
Labor Income	41,217	(12,038)	(474)	24,009	35,880	(33,887)	41,337	96,044	43.4%
Output	92,565	(52,538)	(1,540)	71,234	118,403	(112,525)	134,974	250,573	85.0%
Health Choices 1									
Employment	1,364	63	-	70	(1,341)	1,521	1,756	3,432	34.0%
Labor Income	47,610	2,607	(474)	6,124	(40,342)	45,618	53,140	114,283	30.9%
Output	285,749	11,377	(1,540)	18,174	(132,716)	149,469	173,265	503,778	38.5%
Health Choices 2									
Employment	1,453	69	-	60	776	282	1,793	4,434	32.5%
Labor Income	51,345	2,876	(474)	4,930	23,293	9,153	54,251	145,374	30.5%
Output	114,253	12,550	(1,540)	14,632	76,937	28,669	176,924	422,426	28.8%
Health Coverages									
Employment	688	54	-	(40)	(498)	(96)	588	696	26.5%
Labor Income	25,844	2,242	(474)	(2,530)	(14,959)	(2,888)	18,060	25,295	29.3%
Output	56,969	9,783	(1,540)	(7,509)	(48,918)	(9,446)	58,400	57,740	22.1%

UNM BBER estimates using IMPLAN Model

F. RESULTS IF EMPLOYEE PREMIUMS ARE NOT GRANTED FAVORABLE TAX TREATMENT

In this final section, we consider the possibility that neither the state program for implementing the Health Security Act nor that for Health Choices 2 will qualify as an employer plan under Section 125 of the Internal Revenue Code. All premium payments, including those for workers and their dependents, will paid out of after-taxable income. Effectively, workers and their families lose the tax deductions under which both the federal government and the state helped pay their health premiums. Table VIII.22 presents a summary comparison between the "best case" developed above and the case where employee premiums become taxable under both federal and state law. The NM Taxation and Revenue Department (TRD) has taken the position that neither HSA nor Health Choices will qualify under Section 125. Thus the reference to the TRD Base Case in the table.

The overall net economic impact of the loss in employee premium tax deductibility is a reduction in employment of roughly 1,300 jobs, or 0.15% of total non-federal government employment in 2007. In terms of State GDP, the impact is about 0.12%.

TABLE VIII.22

ECONOMIC IMPACTS ON ELIMINATING FAVORABLE TAX TREATMENT
OF EMPLOYEE PREMIUMS

Labor Income in $1,000s	"BEST CASE" Household Premium & OOP	"BEST CASE" Total Impacts	TRD BASE CASE Household Premium & OOP	TRD BASE CASE Total Impacts
Health Security Act 1				
Employment	**88**	**4,361**	**(1,224)**	**3,049**
Labor Income	**5,253**	**144,999**	**(33,742)**	**106,005**
Value Added	**5,450**	**311,116**	**(68,205)**	**237,462**
Health Security Act 2				
Employment	**(72)**	**5,757**	**(1,383)**	**4,445**
Labor Income	**556**	**221,161**	**(38,439)**	**182,167**
Value Added	**(3,487)**	**393,440**	**(77,141)**	**319,785**
Health Choices 1				
Employment	**9,157**	**10,082**	**7,846**	**8,771**
Labor Income	**274,890**	**369,376**	**235,895**	**330,381**
Value Added	**514,843**	**613,394**	**441,189**	**539,739**
Health Choices 2				
Employment	**4,856**	**13,626**	**3,545**	**12,314**
Labor Income	**148,562**	**476,885**	**109,567**	**437,890**
Value Added	**273,870**	**804,460**	**200,215**	**730,806**
Health Coverage				
Employment	**1,186**	**2,630**	**1,186**	**2,630**
Labor Income	**36,510**	**86,369**	**36,510**	**86,369**
Value Added	**66,961**	**123,821**	**66,961**	**123,821**

UNM BBER estimates using IMPLAN Model

IX. COMPARATIVE SUMMARY AND ADDITIONAL CONSIDERATIONS

A. SUMMARY OF ESTIMATES

To facilitate comparison of the reform models, an "at a glance" summary of the essential estimates differentiating the reform models is provided in Table IX. Briefly, our estimates indicate the following results of the reform models:

- All of the reform models would expand Medicaid and SCHIP enrollment. New Mexico Health Choices would result in the largest increase, more than doubling the current size of these programs; the SCI program would be eliminated. The Health Coverage Plan would increase in combined Medicaid, SCHIP, and SCI enrollment; the number of New Mexicans enrolled in these programs would increase an estimated 53 percent.

- By displacing current insurance arrangements that have relatively high nonmedical cost, the Health Security Act would generate the least new total cost for insuring all New Mexicans. Because New Mexico Health Choices would layer new administrative costs over an essentially private system of insurance, and because it makes no provision for constraining private insurers' nonmedical costs, it would be more costly overall than either the Health Security Act or the Health Coverage Plan.

- Any reform model that would reduce provider payments from current levels would, of course, be less costly than a reform model that maintained or increased provider payment levels. The Health Security Act assumes provider administrative savings associated with fewer payers in the system, and it anticipates negotiating provider payment rates down to capture those savings. However, the Health Security Plan probably would not ever be the only payer in New Mexico, and whether there is much provider administrative to be captured is uncertain. Nevertheless, even at current average payment levels (estimated as Health Security Act v.2), lower nonmedical costs would translate into lower per capita cost under the Health Security Act compared with either the current case or the other reform models.

- Because each of the reform models entails different relative amounts of medical and nonmedical cost, and because these components of cost would grow at different rates in each of the reform models, their total costs are likely to grow at different rates over time. We project the slowest cost growth for the Health Security Act (even assuming higher Medicaid and SCHIP payment increases than in the current case), followed by the Health Coverage Plan which we assume would update Medicaid and SCHIP reimbursement at historic rates. However, because all of the reform models would attempt to address medical cost growth, we presume that all would succeed at least modestly in doing so. By reducing medical cost growth just one percentage point below projected current-case rates, all of the reform models would either reduce total costs absolutely by 2011, or come within a few percentage points of the projected total cost of health care in the current case.

TABLE IX.1

COMPARISON OF SELECTED ESTIMATION RESULTS FOR THE CURRENT CASE AND THE REFORM MODELS

	Current case	Health Security Act v.1	Health Security Act v.2	Health Choices v.1	Health Choices v.2	Health Coverage Plan
Estimated coverage						
Total population covered (in millions)	1.25[a]	1.68	1.68	1.68	1.68	1.68
New program enrollment (including Medicaid and SCHIP)	--	94.2%	94.2%	94.3%	87.2%	--
Percent enrolled in Medicaid/SCHIP [a]	34.6%	46.3%	46.3%	56.5%	55.7%	39.3%
Percent enrolled in group and individual private insurance [b]	65.4%	5.8%	5.8%	5.8%	12.9%	60.7%
Change in enrollment in:						
Medicaid and SCHIP enrollment	--	80.2%	80.2%	119.6%	116.4%	52.7%
Group and individual insurance	--	-88.1%	-88.1%	-88.2%	-73.6%	25.1%
Estimated cost (2007)						
Total health care cost (in billions)	$6.237	$6.028	$6.174	$6.676	$6.695	$6.427
Per-capita total cost	$3,714	$3,590	$3,677	$3,976	$3,987	$3,828
Per-capita out-of-pocket cost	$676	$543	$543	$511	$493	$564
Projected cost (2011) [c]						
Total health care cost (in billions)	$8.765	$7.878	$8.067	$9.101	$9.148	$8.835
Total cost as a percent of current costs	--	-10.1%	-8.0%	3.8%	4.4%	0.8%
Financing (2007)						
Net new obligated state funds after premiums (in billions)	--	$1.503	$1.597	$2.791	$1.805	$0.034
Estimated as a percent of taxable payroll	--	4.3%	4.6%	8.0%	5.2%	--
Estimated federal funds (in billions)	--	$1.630	$1.662	$2.135	$2.073	$1.444
Estimated fair share payments (in billions)	--	--	--	--	--	$0.093
Economic impacts (2007)						
Number of additional jobs	--	2,493	3,961	10,495	4,998	1,698
Net increase in labor income (in millions)	--	$93.27	$176.58	$379.78	$217.73	$63.22
GDP growth (in millions)	--	$20.17	$166.11	$1,181.13	$631.62	$251.24

Source: Mathematica Policy Research.

Note: Estimates reflect coverage and costs for the noninstititutionalized civilian population under age 65. Active military personnel and Medicare beneficiaries are excluded.

[a] These persons include SCI enrollees in the Health Coverage Plan.

[b] In the current case, the estimate includes adults and children who covered for at least 6 months during the year. Includes private employer coverage, federal and state employee coverage, TRICARE; other state insurance programs (NMMIP, NMHIA, and SEIP), and non-group private insurance.

[c] Current case projections assume current rates and sources of coverage among New Mexicans continue.

- Both the Health Security Plan and New Mexico Health Choices would put in place pure-community-rated systems of coverage—with no variation for personal characteristics or location. Neither reform model would require that self-insured employers, in particular, participate in the new coverage programs that would be formed. To avoid potentially severe adverse selection from self-insured employer groups, it would be necessary to minimize premiums (so that lower cost groups would come into the new programs, as well as high-cost groups). However, these reform models then would rely heavily on payroll tax financing. We estimate that the payroll tax necessary to support these programs, assuming relatively low premium levels, could be as high as 8 percent of payroll (under New Mexico Health Choices v.1, which would rely solely on payroll tax financing) but probably not less than 4 percent of payroll (under the Health Security Plan v.1).

- Under the Health Coverage Plan, the Fair Share Fund would accrue an estimated $93 million in 2007. This amount would be earmarked to cover services for New Mexicans who are temporarily uninsured (including homeless and transient persons) but are in need of health care services. However, the state would also incur additional cost related to significantly greater enrollment in Medicaid, SCHIP, and SCI; this additional liability—estimated at $34 million in 2007 (after federal match) has no currently identified source of funding.

- The projected net economic impacts of the reforms are relatively small. Each of the reform models would produce a small net increase in jobs in the state, by as much as 0.5 percent of the wage and salary employment forecasted for 2007 (in New Mexico Health Choices v.1). Similarly, all would increase gross domestic product (GDP) and income in New Mexico. Again, New Mexico Health Choices v.1 would have the greatest impact (generating an estimated $1.2 billion in GDP), related to the higher level of total health expenditures in this reform model and the inflow of federal dollars related to high growth in Medicaid and SCHIP enrollment.

B. ISSUES FOR FURTHER CONSIDERATION

The estimates summarized above raise a number of important issues that warrant further consideration as New Mexico moves toward major health care reform. These are discussed briefly below:

- ***Affordability and Compliance.*** A requirement that all New Mexicans be insured forces the question of the affordability of coverage. Both the Health Security Act and New Mexico Health Choices would cap premiums (if any) at 6 percent of family income. However, the Health Coverage Plan has no such protection. We expect that the cost of private coverage in the Health Coverage Plan for New Mexicans who are ineligible for public coverage could be unaffordable for some New Mexicans; as many as 20 percent of New Mexicans might pay more than 6 percent of family income to obtain or keep private coverage.

- ***ERISA Preemption.*** Assuming that self-insured employers respond to estimated differences in premiums, most workers and dependents who are now enrolled in self-insured coverage would move into the Health Security Plan and the Health Choices

Alliance, respectively. In New Mexico Health Choices v.2, self-insured employers would be subject to a payroll tax, regardless of whether they enrolled workers in coverage, and we assume that they would respond by terminating their health plans. However, the financial incentives that underlie these estimates could violate employers' ERISA protections, if they chose to challenge the reform models on ERISA grounds.

- ***Tax Status of Individual Payments for Coverage.*** To determine whether individual payments for health insurance coverage in the Health Security Plan or the New Mexico Health Choices Alliance would be tax exempt may require a U.S. Treasury letter ruling. Short of putting the issue before the Treasury, different experts have reached different conclusions in thinking about this issue. Currently, Massachusetts is the only state that is testing the proposition that a state-managed pooled market (the new Connector) would constitute a welfare plan and that employer-sponsored Section 125 premium-only accounts are a legitimate vehicle for tax-sheltering individual contributions via employer withholding. However, in Massachusetts, employers have generally agreed not to contest the state's reform on ERISA grounds, and therefore not to contest the characterization of the Connector as a welfare plan.

- ***Nonmedical Costs.*** Reform models that retain or increase nonmedical costs in the system would increase total cost to achieve coverage for all New Mexicans. Layering additional administrative cost over a larger system of private insurance—as New Mexico Health Choices would do—would magnify these costs, compared with reform models that would largely displace private insurance (the Health Security Act) or maintain current insurer roles (the Health Coverage Plan). Any reform model that retains or increases private insurance coverage could consider options for reducing levels and trends in private insurer nonmedical cost.

- ***Federal Medicaid/SCHIP Matching.*** Because each of the reform models would rely on significant expansion of Medicaid and SCHIP enrollment, the probability of obtaining federal match on a much-expanded program should be investigated carefully. By extending Medicaid coverage to all adults under 100 percent FPL, New Mexico Health Choices may have the greatest challenge in proving budget neutrality in order to obtain a waiver to cover non-disabled adults without children. Furthermore, by eliminating the SCI program, both the Health Security Act and New Mexico Health Choices would eliminate New Mexico's current vehicle for obtaining higher SCHIP match for this population. Both reform models might consider retaining the SCI program and providing additional coverage above SCI's $100,000 cap on covered benefits, as the Health Coverage Plan proposes.

C. POTENTIAL IMPACTS ON HEALTH STATUS AND PUBLIC HEALTH

Finally, members of both the Committee and the general public have expressed interest and concern that covered benefits in the reform models include preventive services and attention to health-promoting behaviors in order to improve health status and contain health system costs. Many preventive services are considered core clinical services, and each of the reform models could (and probably would) define coverage for clinical services to include basic preventive care

if not also additional preventive services (such as weight management) linked to clinical outcomes.

Several considerations might help to guide the Committee in considering how and whether specific preventive services might be included in a core benefit design. Specifically:

- Outside of rehabilitation services, there is little, if any research on outcomes—such as improving health behaviors or health status, and reducing cost—in situations where health insurance finances access to comprehensive prevention. And while evaluations of comprehensive health promotion and wellness programs in the workplace have sometimes included positive outcomes, examples of workplace health promotion may not be applicable to clinical prevention. That is, the benefits and cost savings apparently achievable in the workplace may not translate to a clinical health care program serving patients or even a general population.[30]
- The effectiveness of clinical preventive services varies. Some preventive services—such as immunization programs, well-child care, and family planning—are simple and safe, and they generate clear cost savings. Others—such as screenings for cervical, breast, and colorectal cancers—are more costly, but constitute effective prevention and can have life-saving outcomes. But research has neither proved nor disproved the effectiveness of still other preventive and health promotion activities (such as: some dietary supplements). With respect to other types of preventive services, medical practice generally has deemed the cost excessive in light of the risk (for example, screening for ovarian cancer) or the risks and benefits simply remain unclear (for example, PSA screening for prostate cancer).
- Not all behavioral interventions in a clinical setting are known to be effective. For example:
    - While physical inactivity is unequivocally associated with increased occurrence of numerous medical and mental conditions (IOM 2007), the U.S. Preventive Services Task Force (USPSTF) has concluded that available evidence is insufficient to recommend for or against using clinical care sites to conduct counseling to improve physical activity.[31]

[30] Evaluations of comprehensive health promotion and wellness programs in the workplace have yielded mixed results, but have included positive outcomes. The Johnson and Johnson's Health and Wellness Program demonstrated reductions in medical care expenditures making available an on-site fitness center, financial incentives (Ozminkowski et al. 2002). These benefits occurred only in the third and fourth years of the program, suggesting that sustained participation may have a positive cumulative effect.

[31] The U.S. Preventive Services Task Force (USPSTF) is widely recognized as an independent authority that reviews the effectiveness of preventive services conducted in the clinical setting. It bases its recommendations for clinicians on rigorous reviews of controlled studies that are designed to evaluate the benefits achieved (AHRQ 2006), and has reviewed the effectiveness with which clinical interventions for most well-documented health risk behaviors—for example, tobacco use, inactivity, and diet associated with cardiovascular risk.

- In contrast, based on research evidence, the USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and other diet-related chronic diseases. But existing studies are insufficient in number and consistency to document the effectiveness of routine behavioral counseling to promote a healthy diet in unselected patients.
- The USPSTF also finds evidence to support strongly its recommendation that clinicians in primary care settings screen all adults for tobacco use and provide tobacco cessation intervention for those who use tobacco products.

These recommendations notwithstanding, payment for clinical prevention has been inconsistent, requiring that preventive services be linked to the management of diagnosable (usually co-morbid) conditions. Thus, smoking cessation might be covered as a component of managing chronic lung disease, but only in a limited manner or not at all as part of well-person care.

Finally, clinical care is just one context for preventive approaches. Strategies to reduce the incidence of disease or impairment (that is, primary prevention) should be applied across the populations at risk, and persons at risk are not necessarily found in clinical contexts. As a result, community-based strategies may be more effective—including outreach (such as the use of promatoras), broad health promotion (such as health education and physical activity in the schools), and a focus on underlying causes (such as tobacco advertising). For example, while counseling in a clinic is apparently not particularly effective in promoting increased physical activity, the independent Task Force on Community Preventive Services Strategies (TFCPS 2004) has identified a number of community based strategies that have been shown to be effective.[32]

In summary, there is reason to be cautious in prioritizing the allocation of health care resources toward preventive services as covered benefits in a health plan. While personal health care offers many opportunities for reduction of risk, prevention of disease, and early detection of treatable conditions, the effectiveness across the range of opportunities for clinical prevention varies widely. When offered to appropriate age/sex groups at risk, some preventive services predictably reduce risk and achieve a health benefit. Of these, some also save cost, and some are already commonly covered by health insurance. Other preventive services may benefit only occasional individuals, without demonstrable benefit of effectiveness when generally applied. In some cases, public health strategies and community-based interventions may be the more effective directions for public investment.

[32] The Task Force on Community Preventive Services Strategies (TFCPS) is systematically reviewing efforts based in community or population settings (as opposed to clinical settings) and has adopted a rigorous methodology that parallels that of the USPSTF. The TFCPS disseminates its evidence-based recommendations via *The Community Guide* (http://www.thecommunityguide.org/pa/pa.pdf).

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APPENDIX A

SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES

APPENDIX TABLE A-1

HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES

Note: Shaded cells indicate assumptions that are effectively the same for all models. Estimates for all models will reflect only the noninstitutionalized population under age 65 and not currently receiving Medicare.

Features	Mathematica Specification	Rationale/Comments	Current Case
Eligible for Health Security Plan[1]	Noninstitutionalized persons under age 65 and not currently covered by Medicare. Exclusion of the Medicare population in each model is equivalent to assuming that the Medicare population would not cross-subsidize the non-Medicare population under age 65. That is, if the Health Security Plan becomes a Medicare Advantage carrier, it will not necessarily affect the cost of enrollees in either Medicare or the Health Security Plan.	Institutionalized individuals (including jailed and prison populations and nursing home/ICF/MR populations) are not included in any population database available to this study. Coverage of the institutionalized population will not be estimated, but will be addressed as a consideration. Medicare payments will not be estimated for any model within time and budget available for the project, so that the models can be compared for the same populations at risk of being uninsured. See "excluded or nonparticipating" below.	Medicaid and other federal, state, and private funds cover institutionalized populations.
	IHS-eligible Native Americans enroll on same basis as other residents.	Specification is consistent with NM focus group findings indicating Native American preferences. Native Americans potentially could enroll as tribal groups; estimates will assume only individual enrollment Health Security Plan will contract with IHS providers, similar to current Medicaid program.	IHS-eligible Native Americans may be insured or uninsured and/or use IHS and other facilities.
	Homeless and transient persons.	Because homeless and transient persons are not included in any population database suitable for this study, costs will be estimated outside the model.	Largely uninsured.
	Self-insured employers will terminate coverage if the Health Security Plan cost per member per year is at least 20 percent less.	Specification assumes that self-insured employers will move to less costly available coverage. However, those with few employees located in New Mexico may be unlikely to terminate their offer of coverage. This is the same assumption as Health Choices v2. Employers that enroll employees in the Health Security Plan might contribute to employees' premiums or unpaid medical expenses through a Section 125 account or a Medical Reimbursement Account. This would change only the distribution of expenditures among payers, not the amount of expenditures or sources of coverage.	Self-insured employers are protected by ERISA. They are exempt from state taxation of their health benefits and also from state regulation of benefit design. ERISA precludes states from mandating that employers offer coverage or regulate the terms of offer.

[1] Replaces HIA, NMMIP, SEIP, and SCI. Elimination of programs may entail loss of federal funds for SCI (which operates under a waiver) and NMMIP (which receives federal grant funds to support program operation).

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Excluded or nonparticipating	All federal employees and retirees and military employees with federal/military retiree health benefits.	As specified in H.B. 1222 and SB 720 (2007). The Health Security Act assumes that Health Security Plan ultimately would become an FEHBP plan if agreements are reached that protect their rights and portability. However, FEHBP is a competitive model, and the Health Security Plan would compete with other FEHBP plans made available to federal employees. Exclusion of federal employees and retirees from the analysis is equivalent to assuming that FEHBP would not cross-subsidize coverage for other state residents.	Nearly all federal employees have health coverage from FEHBP, as do federal retirees by definition. Also, nearly all military employees have federal/military retiree health benefits.
	Institutionalized persons	Institutionalized individuals (including jailed and prison populations and nursing home/ICF/MR populations) are not included in any population database available to this study. Coverage of the institutionalized population will not be estimated, but will be addressed as a consideration.	Medicaid and other federal, state, and private funds cover institutionalized populations.
	Medicare enrollees	Medicare payments will not be estimated for any model within time and budget available for the project, so that the models can be compared for the same populations at risk of being uninsured. Exclusion of the Medicare population is equivalent to assuming that the Medicare population would not cross-subsidize the non-Medicare population under age 65. Although the Health Security Act model intends that Medicare enrollees would be included on an equal basis as other individuals utilizing federal funds, this would entail a change in federal law (see “eligible individuals” above).	Medicare covers eligible elderly and disabled, but does not cover all services (e.g., mental health, dental, vision) equally.
	Undocumented immigrants	Residency requirement applies: undocumented persons cannot be legal residents. Uncompensated care for undocumented immigrants will continue. Because the federal government will not pay emergency or MTALA funds if another source pays, including undocumented persons for emergency care could result in loss of federal funds. Hospitals continue to receive federal funds for emergency care (through the state) and MTALA care (directly).	Largely uninsured. Federal allotment of funds to hospital care for undocumented persons.

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Medicaid eligibility	Same as current case.	Estimates will assume that CMS will match only Medicaid/SCHIP enrollee costs.	Children ≤ 18 to 185% FPL with income disregards.[2] Parents to 100% FPL with income disregards. Pregnant women to 185% FPL.
SCHIP eligibility	SCI (with SCHIP match) will be terminated. Otherwise, same as current case.	Estimates will assume that CMS will match only Medicaid/SCHIP enrollee costs. This is the same specification as for the Health Choices. The specification does not differentiate between eligibility for children and foster children. Foster children from age 19-21 will not be included in the estimates.	Children ≤ 18 185-235% FPL with income disregards. Foster children to age 18, from 185-235% FPL, as well as f oster children from 19-21. Adults without children <100% FPL with income disregards, enrolled in SCI.
Participation and collection of premiums	Individual participation is automatic.	Estimates will assume full compliance. Actual compliance with premium payment will likely be less than 100 percent and will affect financing. At any point in time there will be new residents and others who are not enrolled and of whom the Health Security Plan is unaware. These individuals will be identified in the most efficient manner as proposed in any of the three models and enrolled in the Health Security Plan.	Offer and take-up of coverage is voluntary. When premiums are required, coverage is contingent on payment. Current rates of private and public coverage and current trends are assumed.
Role of private insurers with respect to plan-covered services	Used as financial intermediaries only.	The Health Security Act indicates that insurers may provide supplemental coverage to beneficiaries (see "supplemental coverage" in this document) and will be able to continue to offer insurance to those who are not beneficiaries. For the purpose of contracting with the Health Security Plan, HMOs may continue as group practices, but not as risk-bearing entities.	Insurers both bear risk and act as financial intermediaries for self -insured private plans and public programs.

[2] HSD is in the process of implementing Medicaid and SCHIP income disregards for children age 7 to 19, equal to those in place for children age 0 to 6. This change is reflected in the current case.

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Rating	No variation in rates by health status, age, gender, location, or other factors.	The Health Security Act specifies that rates will be based on income (see "Subsidy schedule" in this document) and are to be determined with public input. More specific assumptions are necessary to assign premiums to individuals for the purpose of producing cost and funding estimates.	Individuals: No restrictions in general market. Rate bands and community rating for self-employed in HIA. Small groups: rated on health (± 20% per class) and on age, gender, industry, and geography within 250% rate bands. No rating on group size. Renewal: trend plus 10% for claims, health, and duration.
Base premiums	Average medical cost plus nonmedical cost, calculated separately for Medicaid/SCHIP and other enrollees. Average medical cost will be adjusted to reflect cost efficiencies in the model. Nonmedical cost will be estimated as 2.5 times Medicare's FFS administrative cost experience per enrollee (estimated at $150 pmpy in 2007)[3] to reflect higher cost for functions that are not included in Medicare's administrative cost rate, but that the Health Security Act commission will be responsible for—including management of enrollment and disenrollment, data reporting and rate setting, holding public hearings, provider relations, and customer service. Ongoing operation of an income-scaled subsidy system estimated as state cost per applicant to administer means testing for Medicaid and SCHIP (in 2007, $125 per year, updated by 15 percent).	The Health Security Act assumes that the legislature and commission (with public input) will determine many decisions about premiums and sources of revenue. More specific assumptions are necessary to produce cost and funding estimates. Specification achieves income-scaled premiums via a subsidy schedule (see "Subsidy schedule" below). Estimates will assume that CMS will match only costs specific to Medicaid/SCHIP enrollees. Therefore, Medicaid/SCHIP enrollees will not be blended with the population for calculation of premiums. Nonmedical cost rate reflects functions that private carriers and state programs now perform, but that will become the direct responsibility of the Health Security Plan.	Medical cost plus nonmedical costs (including marketing, administration, surplus, and profit). Base premium varies by product. Current case will reflect market-wide average administrative cost rates relative to premiums for group and individual coverage, respectively.

[3] A study conducted for the Kaiser Family Foundation estimated that the administrative cost of the Medicare program for fee-for service beneficiaries was $133 per beneficiary in 2002–about half that per FEHBP enrollee (http://www.kff.org/medicare/upload/The-Federal-Employees-Health-Benefits-Program-Program-Design-Recent-Performance-and-Implications-for-Medicare-Reform-Report.pdf). Updated by the CPI, this amount would be 13% higher in 2007 (that is, $150 per enrollee).

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Subsidy schedule	0-100% FPL: zero premium. 101-200% FPL: premiums ≤$35/mo, scaled to income 200% FPL: premium is capped at 6% of family income[4]	Income-related premiums will be modeled as subsidies against the individual rate (in the Health Security Act, this is equal to the base premium). The Health Security Act assumes a governmental process to set premiums for individuals > 100% FPL. SCI premium subsidies were used to anchor assumptions for subsidies for these participants. These amounts could vary in any of the models and would affect both source of payments and amounts paid by individuals and employers. By comparison: • NM Health Choices assumes the SCI subsidy schedule, extended to 400%FPL with no cap on premiums relative to income. • Health Coverage Plan assumes SCI subsidy schedule extended to 300%FPL with no cap on premiums relative to income.	Medicaid/SCHIP children and adults pay no premiums. In SCI: • 0-100% FPL: full subsidy • 100-200% FPL: premiums ≤$35/mo, scaled to income. • Copayments capped at 5% of family income. Premium Assistance: • For children in families with countable family incomes above 235% FPL and that include children to age twelve: 50% of premium for approved comprehensive plans. • For pregnant women with countable family incomes above 235% FPL, and for only pregnancy-related services, premium is $150 in months 1-5, $300 in months 6-9 Under federal and NM tax law: • Voluntary employer contributions are tax-exempt. • Employee contributions paid through a Section 125 plan are tax-exempt. • Self-employed individuals may deduct 100% of payments for health insurance from taxable income. • Other taxpayers who do not itemize may deduct insurance payments that, together with other unreimbursed medical expenses, exceed 7.5% of adjusted gross income.[5]

[4] The Massachusetts Connector (as proposed) will cap premiums at 2% of gross income at 100-150% FPL, graduated to 5-6% of gross income at 250-300% FPL. The California proposal would cap individual premiums at 6% of gross family income for families 200-250% FPL, with no subsidy for families above 250% FPL.

[5] This provision is not widely used. See: Congressional Research Service (CRS) 2004, *Tax Benefits for Health Insurance: Current Legislation* [http://www.senate.gov/~hutchison/IB98037.pdf].

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Employer contributions	Employer contributions are required. Self-insured employers exempted for covered workers. Level of employer contribution is calculated as a percent of payroll, not to exceed average levels paid by employers that currently offer coverage.	The Health Security Act indicates that employer contributions will be capped, but does not specify level. Employer contributions to coverage will affect the financing of the Health Security Plan, but not the level of cost or sources of coverage. Model calls for the level of employer contribution to equal current average levels paid by employers that offer coverage in the general market, but paid by all employers as a percent of payroll.	For SCI, employer premiums are capped at $75 pmpm. For all other health plans, employer contributions vary by firm size:[6] • For single coverage: 78.8% in firms <50 and 81.4% in larger firms. • For family coverage: 74.8% in firms <50 and 80.7% in larger firms.
Covered benefits and cost sharing	Enrollees other than Medicaid/SCHIP receive state-employee covered services. No co-pays for preventive care; copays may apply for other services. Coverage will include dental and vision benefits. Estimates will assume that long-term care is not covered.	Specified in the Health Security Act. The Health Security Act assumes that Medicaid/SCHIP beneficiaries do not lose service coverage. Enrollees in Medicaid/SCHIP receive greater services than others in the Health Security plan, if Medicaid covers services the Health Security plan does not cover. Potential cost impacts of variation between Medicaid/SCHIP and in Health Security Plan coverage of services (such as preventive care, chiropractic care, substance abuse services, and other services) will be addressed as a consideration due to time and budget constraints for this study. For the purpose of modeling, some assumption about cost sharing in the Health Security Plan is necessary. Estimates will assume cost sharing that is less than the current state employee plan. This is the same assumption as for low-cost sharing in Health Choices. Estimates will assume that CMS will match only Medicaid/SCHIP enrollee costs. Vision and dental are optional in the state employee plan. The per capita and total cost of vision and dental benefits will be reported separately to assist in understanding the cost of the plan without these benefits.	Covered services and cost sharing vary by source of coverage. Medicaid and other federal, state, and private funds cover institutionalized long-term care. Medicaid covers vision and dental for children, but not for non-disabled adults

[6] 2004 MEPS-IC estimate [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp? component =2&subcomponent=2].

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Supplemental benefits	Insurer offer of supplemental benefits is optional.	The potential market for and cost of supplemental benefits will be addressed as a consideration. Cost will not be estimated due to time and funding constraints.	State employee plan includes dental and vision options.
Payment of providers	Medical trend rate is estimated as the Medicare medical cost trend per member per month, adjusted for coverage of prescription drugs (7.7%).[7] Administrative savings for providers are reflected in provider payment levels reduced by approximately 3.5% per year, to a maximum of approximately 11%.[8]	The Health Security Act assumes that the Commission will negotiate rates after public input. Medical trend assumption is the same as for Health Security Act and Health Coverage Plan The specifications for Health Coverage and Health Choices differ from the Health Security Act model in that only the Health Security Act assumes provider administrative cost savings. If provider rates are not reduced to reflect lower costs of provider administrative savings, overall costs will be more.	Payment levels vary by health plan.
Out of state providers	Paid the same as current case relative to in-state providers.	The Health Security Act assumes that out-of-state providers receive the same negotiated payment rates as in-state providers, unless alternative agreements are made.	Payment levels vary by health plan.

[7] The average annual growth in Medicare spending per capita from 1996 to 2003 (est.) was 4.2%. Estimated from FEHBP expenditure components, the trend would have been at least 3.5 percentage points higher (based on 2002-2003 change), had FEHBP-level drug coverage been included (Source: Mark Merlis. The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform. May 2003 [http://www.kff.org/medicare/upload/The-Federal-Employees-Health-Benefits-Program-Program-Design-Recent-Performance-and-Implications-for-Medicare-Reform-Report.pdf].

[8] Estimates will adjust for the difference in the provider administrative cost rate (per total cost) by type of services to equal administrative cost rates in the Canadian health care system, as calculated in: S. Woolhandler et al. (August 21, 2003). Costs of Health Care Administration in the United States and Canada. New England Journal of Medicine 349 (8): 768-775.]

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Misc. other sources of saving	Reduction in workers compensation and auto insurance.	No cost estimate is anticipated. Will be addressed as a consideration.	Workers compensation and auto insurance include medical coverage that is sole payer for persons who are uninsured and otherwise may be subrogated to private medical coverage.
	All uncompensated care is assumed to be associated with the non-Medicare population for the purpose of estimating costs.	NM Hospital Association estimates that 50% of uncompensated care is bad debt and 50% is charity care.[9] Recognizing the potential for inaccurate reporting of bad debt versus charity care, the same assumption will be used in developing estimates for all models so that any inaccuracy will affect estimates equally. County indigent funds will continue to the extent that they are used to match Medicaid/SCHIP; any excess funds will be directed to the Health Security Plan.	Uncompensated care is paid by counties and medical providers and/or shifted into charges to privately insured patients.
Quality improvement	All proposals include attention to quality improvement and wellness.	The specification assumes that all models will follow best practices related to quality improvement and wellness. No cost estimate is anticipated, but impacts will be addressed as a consideration. For example, because most New Mexicans will be covered under the Health Security Plan, data collection to assess quality of care may be easier than in a system of multiple private insurance plans. With respect to prevention and wellness, greater provision of preventive care may in the short run increase cost by identifying people who need care. Actuarial experience with wellness programs attributes little impact of wellness efforts on health care costs, but some state Medicaid programs have adopted innovations that are expected to save cost and potentially could be expanded to other insured populations.	Large plans may have quality improvement processes, but there is not currently a statewide health care quality improvement process.

[9] The American Hospital Association defined bad debt as services for which hospitals anticipated but did not receive payment, and charity care as services for which hospitals neither received, nor expected to receive, payment because they had determined the patient's inability to pay. In practice, hospitals have difficulty in distinguishing bad debt from charity care. Negotiated discounts with payers (including Medicare and Medicaid) are not regarded as uncompensated care [http://www.aha.org/aha/content/2005/pdf/ 0511UncompensatedCareFactSheet.pdf].

TABLE A-1. HEALTH SECURITY ACT: SPECIFICATIONS FOR COVERAGE, COST AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Sources of revenue	Primary sources include: • Employer contributions, tax exempt under federal law. • Individual contributions, generally taxable unless paid through an employer • State general fund • Federal Medicaid and SCHIP matching Premium tax will not apply to Health Security premiums. Federal DSH payments are discontinued.	Employers with fully insured health plans are assumed to participate, although collection of employer payments may be problematic. The proportion of employers that may not pay voluntarily and the amount of revenue they represent will be addressed as a consideration. Contributions from participating employers are assumed to be tax- exempt, although employers must volunteer to participate in this way. Participating employers will be assumed to set up federal tax-qualified plans to assist employees in contributing to coverage on a pre-tax basis. Individual contributions to coverage not made through an employer will be taxed at federal rates applicable to individual purchase. Federal revenues from Medicare, Tricare, FEHBP will remain in the system (but are not estimated for this plan, as these populations are excluded from Alliance Plans). IHS and VA funds remain. The DSH limit for each hospital is equal to its loss on services provided to Medicaid and uninsured patients. Because all New Mexicans would be insured and Medicaid/SCHIP would pay providers at commercial rates, DSH payments are discontinued, resulting in loss of federal funds to hospitals.	Primary sources include: • Employee contributions and individual premiums net of tax subsidy • Employer contributions • Federal Medicaid and SCHIP matching • Other federal funds (including DSH, MTALA, and administrative funds for NMMIP) • State and local funds

APPENDIX TABLE A-2

NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES

Note: Shaded cells indicate assumptions that are effectively the same for all models. Estimates for all models will reflect only the noninstitutionalized population under age 65 and not currently receiving Medicare. Unless otherwise noted, the specifications are the same for Version 1 and Version 2.

Features	Mathematica Specification	Rationale/Comments	Current Case
Eligible for Alliance Plan[1]	Noninstitutionalized persons under age 65 and not currently covered by Medicare. Exclusion of the Medicare population in each model is equivalent to assuming that the Medicare population would not cross-subsidize the non-Medicare population under age 65.	Institutionalized individuals (including jailed and prison populations and nursing home/ICF/MR populations) are not included in any population database available to this study. Coverage of the institutionalized population will not be estimated, but will be addressed as a consideration. Medicare payments will not be estimated for any model within time and budget available for the project, so that the models can be compared for the same populations at risk of being uninsured. See "excluded or nonparticipating" below.	Medicaid and other federal, state, and private funds cover institutionalized populations.
	IHS-eligible Native Americans enroll on same basis as other residents.	Specification is consistent with NM focus group findings indicating Native American preferences. Native Americans potentially could enroll as tribal groups; estimates will assume only individual enrollment Alliance plan will contract with IHS providers, similar to current Medicaid program	IHS-eligible Native Americans may be insured or uninsured and/or use IHS and other facilities.
	Health Choices V1: Employees now in self-insured plans will participate. Self-insured employers will terminate offer of coverage. Health Choices V2: Self-insured employers will terminate coverage if the Health Alliance cost per member per year at least 20 percent less.	Health Choices V1 specifies that all employers would pay a payroll tax, irrespective of coverage that may be provided. Specification reflects employer response to payroll taxation that would, in effect, double contributions to health coverage. Same specification as for Health Security Act. Health Choices V2 would allow all employers to take an exemption from the payroll tax for employees that they insure. Specification assumes that self-insured employers will move to less costly available coverage. However, those with few employees located in New Mexico may be unlikely to terminate their offer of coverage. This is the same assumption as Health Security Act. Employers could contribute to employees' premiums or unpaid medical expenses through a Section 125 account or a Medical Reimbursement Account. This would change only the distribution of expenditures among payers, not the amount of expenditures or sources of coverage.	Self-insured employers are protected by ERISA. They are exempt from state taxation of their health benefits and also from state regulation of benefit design. ERISA precludes states from mandating that employers offer coverage or regulate the terms of offer.

[1] Replaces HIA, NMMIP, SEIP, and SCI. Elimination of programs may entail loss of federal funds for SCI (which operates under a waiver) and NMMIP (which receives federal grant funds to support program operation).

TABLE A-2: NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Excluded or nonparticipating	All federal employees and retirees and military employees with federal/military retiree health benefits.	Specified in the model.	Nearly all federal employees have health coverage from FEHBP, as do federal retirees by definition. Also, nearly all military employees have federal/military retiree health benefits.
	Institutionalized persons	Institutionalized individuals (including jailed and prison populations and nursing home/ICF/MR populations) are not included in any population database available to this study. Coverage of the institutionalized population will not be estimated, but will be addressed as a consideration.	Medicaid and other federal, state, and private funds cover institutionalized populations.
	Medicare enrollees	Specified in the model. Medicare payments will not be estimated for any model within time and budget available for the project, so that the models can be compared for the same populations at risk of being uninsured. Exclusion of the Medicare population is equivalent to assuming that the Medicare population would not cross-subsidize the non-Medicare population under age 65.	Medicare covers eligible elderly and disabled, but does not cover all services (e.g., mental health, dental, vision) equally.
	Undocumented immigrants	Residency requirement applies: undocumented persons cannot be legal residents. Uncompensated care for undocumented immigrants will continue. Because the federal government will not pay emergency or MTALA funds if another source pays, including undocumented persons for emergency care could result in loss of federal funds. Hospitals continue to receive federal funds for emergency care (through the state) and MTALA care (directly).	Largely uninsured. Federal allotment of funds to hospital care for undocumented persons.

TABLE A-2: NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
	Homeless/transient persons included in or excluded from programs, as in current case.	Because homeless and transient persons are not included in any population database suitable for this study, costs will be estimated outside the model. Same specification as for the Health Coverage Plan. Health Security Act would cover these persons.	Largely uninsured. Federal allotment of funds toward hospital care for undocumented persons.
Medicaid eligibility	Children ≤ 18 and parents to 100% FPL with income disregards, as in current case. Adults without children to 100% FPL with income disregards.	Medicaid expansion for adults without children < 100% FPL. Medicaid/SCHIP will fund vouchers for basic benefit with low-cost-sharing. Federal match will apply only to voucher amount. For purpose of federal match, voucher amount will be calculated separately for Medicaid/SCHIP enrollees versus all other enrollees. Specification assumes that State will obtain Medicaid waiver as may be necessary to administer Medicaid as a voucher program.	Children ≤ 18 to 185% FPL with income disregards.[2] Parents to 100% FPL with income disregards. Pregnant women to 185% FPL.
SCHIP eligibility	SCI (with SCHIP match) will be terminated. Adults without children to 100% FPL (in the current case, eligible for SCI with SCHIP match) become Medicaid eligible. Otherwise, same as current case.	Estimates will assume that CMS will match only Medicaid/SCHIP enrollee costs This is the same specification as for the Health Security Act. The specification does not differentiate between eligibility for children and foster children. Foster children from age 19-21 will not be included in the estimates.	Children ≤ 18 185-235% FPL with income disregards. Foster children to age 18, from 185-235% FPL, as well as foster children from 19-21. Adults without children <100% FPL with income disregards, enrolled in SCI.
Participation and collection of premiums	Individual participation is mandated.	Estimates will assume full compliance. Actual compliance with premium payment will likely be less than 100 percent and will affect financing. At any point in time there will be new residents and others who are not enrolled and of whom the Alliance Plan is unaware. These individuals will be identified in the most efficient manner as proposed in any of the three models and enrolled in the Alliance Plan.	Offer and take-up of coverage is voluntary. When premiums are required, coverage is contingent on payment. Current rates of private and public coverage and current trends are assumed.
Role of private insurers with respect to plan-covered services	Used as risk-bearing entities. Insurers compete in merged group and individual market. Use of brokers or agents is prohibited in the Alliance Plan. Marketing expenses and other nonmedical costs are capped (see "Base premiums" in this document).		Insurers both bear risk and act as financial intermediaries for self-insured private plans and public programs.

[2] HSD is in the process of implementing Medicaid and SCHIP income disregards for children age 7 to 19, equal to those in place for children age 0 to 6. This change is reflected in the current case.

TABLE A-2: NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Rating	Premiums may vary by product and by carrier. No variation in rates by health status, age, gender, location, or other factors.	Health Choices indicates that risk adjustment will address regional differences in medical cost. This will add a cross-subsidization role to the risk adjustment program, in addition to such a program's usual role as a device to stabilize carriers' experience in the market.	Individuals: No restrictions in general market. Rate bands and community rating for self-employed in HIA. Small groups: rated on health (± 20% per class) and on age, gender, industry, and geography within 250% rate bands. No rating on group size. Renewal: trend plus 10% for claims, health, and duration.
Base premiums	Average medical cost plus nonmedical costs, calculated separately for Medicaid/SCHIP and other enrollees. Non-medical cost rate is limited to the current rate among HIA carriers, *minus* broker commissions paid by HIA plans and premium tax (both prohibited). Will be estimated at lower FEHBP nonmedical cost rate to reflect competition in Alliance. Assumed 0.5 percent additional cost relative to medical cost to administer the risk adjustment program. Ongoing operation of an income-scaled voucher system estimated as state cost per applicant to administer means testing for Medicaid and SCHIP (in 2007, $125 per year, updated by 15 percent).	The Health Choices model identifies general rules and structures affecting the Alliance Plan. Specific assumptions are necessary for the purpose of producing cost estimates. Multiple plans will retain cost for verification of specific plan enrollment and cost sharing (but not coordination of benefits in an individualized system). FEHBP carriers do not pay broker commissions for the program and are exempt from state taxes on FEHBP premiums.	Medical cost plus nonmedical costs (including marketing, administration, surplus, and profit). Base premium varies by product. Current case will reflect market-wide average administrative cost rates relative to premiums for group and individual coverage, respectively.

TABLE A-2: NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Subsidy schedule	Medicaid/SCHIP (for both children and adults): $0/mo. **Version 1:** Individuals not eligible for Medicaid/SCHIP receive income-adjusted vouchers: • 0-249% FPL: 100% of premium for the low cost-sharing plan • 250-399% FPL: 100% of premium for the medium cost-sharing plan • 400% FPL and above: 100% of premium for the high cost-sharing plan **Version 2:** Family premiums are capped at 6% of gross income for families above 400% FPL for high cost-sharing plan.[3] In addition, individuals not eligible for Medicaid/SCHIP receive subsidy as follows: • 0-249% FPL: 100% of premium for the low cost-sharing plan • 250-399% FPL: 100% of premium for the medium cost-sharing plan • 400% FPL and above: family premiums may not exceed 6% percent of family income.	Income-related premiums will be modeled as subsidies against the individual rate. In v1, all subsidies are paid in the form of vouchers. In v2, subsidies may be paid directly to carriers to upgrade employee coverage. Voucher/premium assistance to Medicaid/SCHIP eligibles covers the full cost of the premium. Vouchers and subsidized upgrades of coverage are assumed to be exempt from federal taxation, although some tax-exempt method of distribution (e.g., distribution through employers) will need to be devised.	Medicaid/SCHIP children and adults pay no premiums. In SCI: • 0-100% FPL: full subsidy • 100-200% FPL: premiums ≤$35/mo, scaled to income. • Copayments capped at 5% of family income. Premium Assistance: • For children in families with countable family incomes above 235% FPL and that include children to age twelve: 50% of premium for approved comprehensive plans. • For pregnant women with countable family incomes above 235% FPL, and for only pregnancy-related services, premium is $150 in months 1-5, $300 in months 6-9 Under federal and NM tax law: • Voluntary employer contributions are tax-exempt. • Employee contributions paid through a Section 125 plan are tax-exempt. • Self-employed individuals may deduct 100% of payments for health insurance from taxable income. • Other taxpayers who do not itemize may deduct insurance payments that, together with other unreimbursed medical expenses, exceed 7.5% of adjusted gross income.[4]

[3] Proposed single adult premium (with employer offer) ranges from 2.4% of gross income (at 200-250%FPL) to 2.8% of gross income (at 351-400% FPL). Both MA Connector and proposed CA subsidies would cap premiums at 6% of gross income for individuals eligible for subsidy.

[4] This provision is not widely used. See: Congressional Research Service (CRS) 2004, *Tax Benefits for Health Insurance: Current Legislation* [http://www.senate.gov/~hutchison/IB98037.pdf].

TABLE A-2: NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Employer contributions	**Version 1:** No employer contribution to coverage. • Level of employer contribution is calculated as a percent of payroll, not to exceed average levels paid by employers that currently offer coverage. **Version 2:** Employers may contribute to coverage. • Employers pay tax for workers not offered or who do not take up employer-sponsored coverage directly. Self-insured employers are exempted for covered workers. • Tax is equal to the average voucher amount for the high-cost-sharing plan.	Specification assumes that employer tax does not qualify as a contribution to coverage under current federal tax rules. Effect on employers' taxable income, if any, will be estimated. Model specifies that tax may be proportional to hours worked, and may be proportional to payroll, approximating current employer costs tiered by company size.[5]	For SCI, employer premiums are capped at $75 pmpm. For all other health plans, employer contributions vary by firm size:[6] • For single coverage: 78.8% in firms <50 and 81.4% in larger firms. • For family coverage: 74.8% in firms <50 and 80.7% in larger firms.
Covered benefits and cost sharing	Medicaid/SCHIP: • Medicaid/SCHIP will fund vouchers for basic benefit with low-cost-sharing.	Health Choices specifies vision and dental are not covered. The per capita and total cost of vision and dental benefits will be reported separately to assist in understanding the cost of the plan without these benefits. Federal match will apply only to voucher amount. For purpose of federal match, voucher amount will be calculated separately for Medicaid/SCHIP enrollees versus all other enrollees.	Medicaid covers vision and dental for children, but not for non-disabled adults. Medicaid and other federal, state, and private funds cover institutionalized long-term care.
	Other insured residents: • State employee-like benefit design only, as defined by minimum guidelines. 3 plan designs defined by differences in cost sharing (low, medium and high).[7] • Adults and children not eligible for Medicaid/SCHIP can enroll in any of 3 plan designs. • Estimates will assume that long-term care is not covered.	The low cost sharing plan is fully subsidized below 250% FPL. Adults below 100%FPL must enroll in Medicaid. Proposal states no coverage for vision or dental. The per capita and total cost of vision and dental benefits will be reported separately to assist in understanding the cost of the compared with Health Security Plan, which would include these benefits.	Covered services and cost sharing vary by source of coverage.
Supplemental benefits	Insurers may offer a more "comprehensive" plan, and HMOs may offer out-of-network riders.	No cost estimate anticipated. Will be addressed as a consideration. Some individuals (e.g., state employees) will forfeit dental/vision coverage to which employers now contribute.	State employee plan includes supplemental dental and vision options.

[5] In 2004, the estimated average private-sector employer contribution in NM was 82% for single coverage (78.8% in firms <50; 81.4% in larger firms) and 79.9% for family coverage (74.8% in firms <50; 80.7% in larger firms) [http://www.meps.ahrq.gov/ mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2].

[6] 2004 MEPS-IC estimate [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp? component =2& subcomponent=2].

[7] **Low cost sharing** is equal to the intermediate SCI cost sharing design: $0 deductible, $5 per physician visit, $25 per hospital inpatient day, and $3 per prescription. **Medium cost sharing** is the minimum HSA deductible ($1,050 for single coverage and $2,100 for family coverage in 2006, updated to 2007) with no cost sharing above the deductible. **High cost sharing** is the $1,100/$2,200 deductible (updated to 2007) with out-of-pocket expenses capped at $5,250 (individual) and $10,500 (family), both updated to 2007. In all plans, preventive services (including prenatal and well-child care, child and adult immunizations, and annual physicals, mammograms, and pap smears) are covered on a first-dollar basis.

TABLE A-2: NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Payment of providers	Payment levels may vary by carrier. For the purpose of estimation, it is assumed that current state employee plan payment rates approximate commercial rates.	Alliance selects carriers on cost and quality criteria. Medical trend assumption is the same as for Health Security Act and Health Coverage Plan The specifications for Health Coverage and Health Choices differ from the Health Security Act model in that only the Health Security Act assumes provider administrative cost savings. .	Payment levels vary by health plan.
Out of state providers	Paid the same as current case relative to in-state providers.	Model is silent.	Payment levels vary by health plan.
Misc. other sources of saving	Reduction in workers compensation and auto insurance.	No cost estimate is anticipated. Will be addressed as a consideration.	Workers compensation and auto insurance include medical coverage that is sole payer for persons who are uninsured and otherwise may be subrogated to private medical coverage.
	All uncompensated care is assumed to be associated with the non-Medicare population for the purpose of estimating costs.	NM Hospital Association estimates that 50% of uncompensated care is bad debt and 50% is charity care.[8] Recognizing the potential for inaccurate reporting of bad debt versus charity care, the same assumption will be used in developing estimates for all models so that any inaccuracy will affect estimates equally. County indigent funds will continue to the extent that they are used to match Medicaid/SCHIP; any excess funds will be directed to the Health Security Plan.	Uncompensated care is paid by counties and medical providers and/or shifted into charges to privately insured patients.
Quality improvement	All proposals include attention to quality improvement and wellness.	The specification assumes that all models will follow best practices related to quality improvement and wellness. No cost estimate is anticipated, but impacts will be addressed as a consideration. With respect to prevention and wellness, greater provision of preventive care may in the short run increase cost by identifying people who need care. Actuarial experience with wellness programs attributes little impact of wellness efforts on health care costs, but some state Medicaid programs have adopted innovations that are expected to save cost and potentially could be expanded to other insured populations.	Large plans may have quality improvement processes, but there is not currently a statewide health care quality improvement process.

[8] The American Hospital Association defined bad debt as services for which hospitals anticipated but did not receive payment, and charity care as services for which hospitals neither received, nor expected to receive, payment because they had determined the patient's inability to pay. In practice, hospitals have difficulty in distinguishing bad debt from charity care. Negotiated discounts with payers (including Medicare and Medicaid) are not regarded as uncompensated care [http://www.aha.org/aha/content/2005/pdf/0511UncompensatedCareFactSheet.pdf].

TABLE A-2: NEW MEXICO HEALTH CHOICES: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Sources of revenue	Primary sources include: • Individual premiums, taxable under federal law. • Employer and/or employee contributions, tax exempt under federal law. Under v1, all employers would pay; under v2, employers that provide coverage are exempted per covered worker. • State general fund, or proportional tax on households' gross income. • Federal Medicaid and SCHIP matching Premium tax will not apply to Alliance premiums. Federal DSH payments may be reduced.	Specification assumes that individual contributions are fully exempt from state taxation. This presumes a change in current state law. Individual contributions to coverage not made through an employer will be taxed at federal rates applicable to individual purchase. Federal revenues from Medicare, Tricare, FEHBP will remain in the system (but are not estimated for this plan, as these populations are excluded from Alliance Plans). IHS and VA funds remain. The DSH limit for each hospital is equal to its loss on services provided to Medicaid and uninsured patients. Homeless and transient persons would remain uninsured. However, because nearly all New Mexicans would be insured and Medicaid/SCHIP would pay providers at commercial rates, DSH payments may be reduced, resulting in loss of federal funds to hospitals.	Primary sources include: • Employee contributions and individual premiums net of tax subsidy • Employer contributions • Federal Medicaid and SCHIP matching • Other federal funds (including DSH, MTALA, and administrative funds for NMMIP) • State and local funds

APPENDIX TABLE A-3

NEW MEXICO HEALTH COVERAGE PLAN:
SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES

Note: Shaded cells indicate assumptions that are effectively the same for all models. Estimates for all models will reflect only the noninstitutionalized population under age 65 and not currently receiving Medicare.

Features	Mathematica Specification	Rationale/Comments	Current Case
Eligible	Noninstitutionalized persons under age 65 and not currently covered by Medicare. Exclusion of the Medicare population in each model is equivalent to assuming that the Medicare population would not cross-subsidize the non-Medicare population under age 65.	Institutionalized individuals (including jailed and prison populations and nursing home/ICF/MR populations) are not included in any population database available to this study. Coverage of the institutionalized population will not be estimated, but will be addressed as a consideration. Medicare payments will not be estimated for any model within time and budget available for the project, so that the models can be compared for the same populations at risk of being uninsured.	Medicaid and other federal, state, and private funds cover institutionalized populations.
	IHS-eligible Native Americans gain coverage in the same ways as other residents.	Specification is consistent with NM focus group findings indicating Native American preferences.	IHS-eligible Native Americans may be insured or uninsured and/or use IHS and other facilities.
	Expanded SCI eligibility: • All adults to 300% FPL, uninsured 6 months, and ineligible for Medicaid or other public or employer-sponsored health insurance.	Specification assumes that the rate of employment in nonprofit firms with fewer than 50 workers is such that these firms account for 80 percent of nonprofit employment in NM. As of July 1st, nonprofit firms can enter SCI without a waiting period. Enrollment of small nonprofit firms without a waiting period will be addressed as a consideration. This provision will not be modeled.	SCI eligibility for adults (small employer, self-employed or HIPAA individual) to 200% FPL and childless adults to 100% FPL who have been uninsured one year, and are ineligible for Medicaid or other public or employer-sponsored health insurance.
	Dependents' coverage to age 30 in private insurance plans, regardless of residence.	Specified in model. For purpose of estimation, dependents will be defined as children to age 30 living with parents. There is no feasible way to identify other adults to age 30 with parents who are New Mexico residents.	Dependents' coverage to age 25 in private insurance plans, regardless of residence.
	Self-insured employers continue without change.		Self-insured employers are protected by ERISA. They are exempt from state taxation of their health benefits and also from state regulation of benefit design. ERISA precludes states from mandating that employers offer coverage or regulate the terms of offer.

TABLE A-3. NEW MEXICO HEALTH COVERAGE PLAN: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Excluded or nonparticipating	All federal employees and retirees and military employees with federal/military retiree health benefits	Specified in the model.	Nearly all federal employees have health coverage from FEHBP, as do federal retirees by definition. Also, nearly all military employees have federal/military retiree health benefits.
	Institutionalized persons	Institutionalized individuals (including jailed and prison populations and nursing home/ICF/MR populations) are not included in any population database available to this study. Coverage of the institutionalized population will not be estimated, but will be addressed as a consideration.	Medicaid and other federal, state, and private funds cover institutionalized populations.
	Medicare enrollees	Medicare payments will not be estimated for any model within time and budget available for the project, so that the models can be compared for the same populations at risk of being uninsured. Exclusion of the Medicare population is equivalent to assuming that the Medicare population would not cross-subsidize the non-Medicare population under age 65.	Medicare covers eligible elderly and disabled, but does not cover all services (e.g., mental health, dental, vision) equally.
	Undocumented immigrants	Residency requirement applies: undocumented persons cannot be legal residents. Uncompensated care for undocumented immigrants will continue, but may be paid from the "Fair Share" fund if not paid by Medicaid or MTALA for emergency care. Hospitals continue to receive federal funds for emergency care (through the state) and MTALA care (directly).	Largely uninsured. Federal allotment of funds to hospital care for undocumented persons.
	Homeless/transient persons included in or excluded from programs as in the current case.	Because homeless and transient persons are not included in any population database suitable for this study, costs will be estimated outside the model. Same specification as for the Health Choices. Health Security Act would cover these persons. Most of these persons could be covered by the expansion of Medicaid and SCI.	Largely uninsured.
Medicaid eligibility	Same as current case.		Children $\leq$ 18 to 185% FPL with income disregards.[1] Parents to 100% FPL with income disregards. Pregnant women to 185% FPL.

[1] HSD is in the process of implementing Medicaid and SCHIP income disregards for children age 7 to 19, equal to those in place for children age 0 to 6. This change is reflected in the current case.

TABLE A-3. NEW MEXICO HEALTH COVERAGE PLAN: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
SCHIP eligibility	Same as current case.	The specification does not differentiate between eligibility for children and foster children. Foster children from age 19-21 will not be included in the estimates.	Children ≤ 18 185-235% FPL with income disregards. Foster children to age 18, from 185-235% FPL, as well as foster children from 19-21. Adults without children <100% FPL with income disregards, enrolled in SCI.
Participation and collection of premiums	Individual coverage is mandated.	Estimates will assume full compliance. Actual compliance with premium payment will likely be less than 100 percent and will affect financing. At any point in time there will be new residents and others who are not enrolled and of whom the state is unaware. These individuals will be identified in the most efficient manner as proposed in any of the three models and enrolled in a plan for which they are eligible. Any uncompensated care for these persons will be paid from the Fair Share Fund.	Offer and take-up of coverage is voluntary. When premiums are required, coverage is contingent on payment. Current rates of private and public coverage and current trends are assumed.
Role of private insurers	No change from current case.		Insurers both bear risk and act as financial intermediaries for self-insured private plans and public programs.
Rating	No change from current case.		Individuals: No restrictions in general market. Rate bands and community rating for self-employed in HIA. Small groups: rated on health (± 20% per class) and on age, gender, industry, and geography within 250% rate bands. No rating on group size. Renewal: trend plus 10% for claims, health, and duration.
Premiums	Current employer and program premiums	No change from current.	Medical cost plus nonmedical costs (including marketing, administration, surplus, and profit). Base premium varies by product. Current case will reflect market-wide average administrative cost rates relative to premiums for group and individual coverage, respectively..

TABLE A-3. NEW MEXICO HEALTH COVERAGE PLAN: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Subsidy schedule	Medicaid/SCHIP children and adult premiums: zero premiums. Workers < 200% FPL with employer offer receive extended SCI subsidy. After $75 employer contribution, net premiums are: • 0-100% FPL: $0/mo • 101-150% FPL: $20 • 151-200% FPL: $35 • 200% FPL-250%: $75 • 250-300% FPL: • employer pays $100/ employee pays $100. Self-employed and other individual enrollees at or below 250% FPL pay $75/mo plus above schedule, not to exceed full cost. Self-employed and other individual enrollees 251-300% FPL pay $100/mo plus above schedule, not to exceed full cost. Family premium is not capped relative to income.	Proposal silent on premiums (if any) for Medicaid/SCHIP expansion populations; estimates will assume no premiums for these populations. Proposal refers to tax credit, but offers no details. If refundable, individual tax credits will be subject to federal income tax. If not refundable, low-income families with no tax liability will not benefit. Specification assumes no individual tax credit.	Medicaid/SCHIP children and adults pay no premiums. In SCI: • 0-100% FPL: full subsidy • 100-200% FPL: premiums ≤$35/mo, scaled to income. • Copayments capped at 5% of family income. Premium Assistance: • For children in families with countable family incomes above 235% FPL and that include children to age twelve: 50% of premium for approved comprehensive plans. • For pregnant women with countable family incomes above 235% FPL, and for only pregnancy-related services, premium is $150 in months 1-5, $300 in months 6-9 Under federal and NM tax law: • Voluntary employer contributions are tax-exempt. • Employee contributions paid through a Section 125 plan are tax-exempt. • Self-employed individuals may deduct 100% of payments for health insurance from taxable income. • Other taxpayers who do not itemize may deduct insurance payments that, together with other unreimbursed medical expenses, exceed 7.5% of adjusted gross income.[2]

[2] This provision is not widely used. See: Congressional Research Service (CRS) 2004, *Tax Benefits for Health Insurance: Current Legislation* [http://www.senate.gov/~hutchison/IB98037.pdf].

TABLE A-3. NEW MEXICO HEALTH COVERAGE PLAN: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Employer contribution	Current contributions to coverage. Employers eligible for SCI pay $75 per worker per month. "Fair share" payment for uninsured workers set at $300 per employee per year, applicable for all employees who are not enrolled in the employer's health plan (including offered but not enrolled).[3] Amount is prorated for part-time employees. Self-insured employers participate like other employers—i.e., are subject to fair-share payments.	Tax credit incentive to offer coverage indicated in proposal; no detail about type or level. Standard tax credits have been found to be ineffective in states that have offered them.[4] Consequently, development of a tax credit is unlikely to change the amount or cost of coverage, but could change the distribution of burden among payers.	For SCI, employer premiums are capped at $75 pmpm. For all other health plans, employer contribution varies by firm size: [5] • For single coverage: 78.8% in firms <50 and 81.4% in larger firms. • For family coverage: 74.8% in firms <50 and 80.7% in larger firms. Self-insured employers are protected by ERISA and are exempt from state taxation or regulation of benefit design.
Covered benefits and cost sharing	Reinsurance plan covers SCI expenditures above annual limit with no federal match on reinsurance amounts. Other benefit designs same as current case.	Implied in proposal. Special product for adults aged 19-30 is not estimated, due concerns about adverse selection in other private insurance plans.	Medicaid covers vision and dental for children, but not for non-disabled adults. Medicaid and other federal, state, and private funds cover institutionalized long-term care. For other public program and private insurance enrollees, covered services and cost sharing vary by source of coverage.
Supplemental benefits	No change from current.	Not relevant to reform model.	State employee plan includes supplemental dental and vision options.

[3] In Massachusetts, the fair share payment is assessed only on employers with more than ten employees if the employer does not "provide or make a reasonable contribution to health insurance for their employees [http://www.mass.gov/legis/sections.pdf]. The amount may not exceed $295 per employee per year and is prorated for part-time employees. In VT, the fair share payment is $350 per employee per year.

[4] Kansas has a refundable employer tax credit to encourage employers that have not offered coverage to begin doing so. Established in 1999 at $35 per eligible enrolled employee, Kansas doubled the credit to a maximum of $70 per eligible enrolled employee effective CY2004; the value of the tax credit declines each year and is eliminated after five years. Take-up of the tax credit has been very low, potentially due to the low level of the credit. However, available research suggests that even doubling the size of the credit may not significantly increase coverage among small-firm workers. Maine has a small employer tax credit designed to subsidize the provision of dependent coverage; no more than 13 firms have applied for the credit in any tax year, possibly due to low publicity and some complexity in the rules qualifying an employer for the credit. Other states (e.g., Oregon) also have implemented employer tax credits with similarly low take up and allowed them to sunset.

[5] 2004 MEPS-IC estimate [http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp? component =2&subcomponent=2].

TABLE A-3. NEW MEXICO HEALTH COVERAGE PLAN: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Payment of providers	Medical trend rate is estimated as the Medicare cost trend per member per month (7.7%).[6]	Specification assumes that the Cost, Access, and Quality Council will mitigate medical cost trends. Medical trend assumption is the same as for Health Security Act and Health Choices. The specifications for Health Coverage and Health Choices differ from the in Health Security Act model in that only the Health Security Act assumes provider administrative cost savings.	Payment levels vary by health plan.
Out of state providers	Paid the same as current case relative to in-state providers.	Proposal is silent.	Payment levels vary by health plan.
Misc. other sources of saving	Reduction in workers compensation and auto insurance.	No cost estimate is anticipated. Will be addressed as a consideration.	Workers compensation and auto insurance include medical coverage that is sole payer for persons who are uninsured and otherwise may be subrogated to private medical coverage.
	All uncompensated care is assumed to be associated with the non-Medicare population for the purpose of estimating costs.	NM Hospital Association estimates that 50% of uncompensated care is bad debt and 50% is charity care.[7] Recognizing the potential for inaccurate reporting of bad debt versus charity care, the same assumption will be used in developing estimates for all models so that any inaccuracy will affect estimates equally. County indigent funds collection and utilization will be the same as the current case.	Uncompensated care is paid by counties and medical providers and/or shifted into charges to privately insured patients.

[6] The average annual growth in Medicare spending per capita from 1996 to 2003 (est.) was 4.2%. Estimated from FEHBP expenditure components, the trend would have been at least 3.5%age points higher (based on 2002-2003 change), had FEHBP-level drug coverage been included (Source: www.opm.gov/pressrel/2002/fehb/2003_FEHB_Premiums.asp, cited in http://www.kff.org/medicare/upload/The-Federal-Employees-Health-Benefits-Program-Program-Design-Recent-Performance-and-Implications-for-Medicare-Reform-Report.pdf).

[7] The American Hospital Association defined bad debt as services for which hospitals anticipated but did not receive payment, and charity care as services for which hospitals neither received, nor expected to receive, payment because they had determined the patient's inability to pay. In practice, hospitals have difficulty in distinguishing bad debt from charity care. Negotiated discounts with payers (including Medicare and Medicaid) are not regarded as uncompensated care [http://www.aha.org/aha/content/2005/pdf/0511UncompensatedCareFactSheet.pdf].

TABLE A-3. NEW MEXICO HEALTH COVERAGE PLAN: SPECIFICATIONS FOR COVERAGE, COST, AND FUNDING ESTIMATES *(continued)*

Features	Mathematica Specification	Rationale/Comments	Current Case
Quality improvement	All proposals include attention to quality improvement and wellness.	The specification assumes that all models will follow best practices related to quality improvement and wellness. No cost estimate is anticipated, but impacts will be addressed as a consideration. With respect to prevention and wellness, greater provision of preventive care may in the short run increase cost by identifying people who need care. Actuarial experience with wellness programs attributes little impact of wellness efforts on health care costs, but some state Medicaid programs have adopted innovations that are expected to save cost and potentially could be expanded to other insured populations.	Large plans may have quality improvement processes, but there is not currently a statewide health care quality improvement process.
Sources of revenue	Primary sources include: • Individual premiums net of subsidy, largely taxable under federal law • Employer contributions to premiums, tax exempt under federal law • Employer fair share contributions • State general fund • Federal Medicaid and SCHIP matching.	No change in state tax code is presumed. Individual, employee, and employer contributions are tax qualified, as in current federal and state law. Employer fair share contributions are assumed not to qualify as contributions to coverage under federal and state tax rules, but may qualify as a cost of doing business. The DSH limit for each hospital is equal to its loss on services provided to Medicaid and uninsured patients (including homeless and transient). IHS and VA funds remain.	Primary sources include: • Employee contributions and individual premiums • Employer contributions • Federal Medicaid and SCHIP matching • Other federal funds (including DSH, MTALA, and administrative funds for NMMIP) • State and local funds

APPENDIX B

OVERVIEW OF POTENTIAL LEGAL ISSUES

OVERVIEW OF POTENTIAL LEGAL ISSUES

This memorandum identifies the legal questions raised by the Health Security Act, NM Health Coverage, and NM Health Choices and provides the legal arguments for and against any particular approach. More specifically, this memorandum reviews the constitutional issues raised by the individual mandate, potential problems arising under the Employee Retirement Income Security Act (ERISA), and the tax consequences of each model.

For a variety of reasons, this memorandum does not make predictions about the outcomes of these legal issues. To begin with, the models are described in fairly broad outline and with no proposed statutory language. Second, a number of the most significant legal issues, particularly those concerned with ERISA and federal tax law, are at this point unresolved legal questions. The exact approaches being evaluated have not been adopted in many, if any, other jurisdictions, and to the extent that similar models have been tried, the issues raised by those models have not yet worked their way through the court system.

I. ENFORCEMENT OF THE INDIVIDUAL MANDATE

All models propose mandatory participation in health coverage. Except for Medicaid/ SCHIP eligible individuals, it is unclear how the individual mandate would work and how it would be enforced. For example, the models indicate that all children, students, and licensed professionals "are enrolled." This raises many questions: Would these individuals be enrolled in a health care plan automatically when they enroll in school or when they apply for a professional license? If they would not be enrolled automatically, would they be denied licensure or public education if they do not have insurance at the time of application? If the language in the proposal ("Licensed professionals are enrolled") means that licensed professionals could have their licenses denied, suspended, or revoked for failure to obtain health coverage, then both substantive and procedural due process requirements would have to be satisfied before any of these actions could be taken because "a professional license is a recognized property right under the New Mexico Constitution." *Mills v. New Mexico Bd. of Psychologist Exam'rs*, 1997-NMSC-28, ¶ 14, 123 N.M. 421, 941 P.2d 502.

Substantive due process concerns the state's authority to impose a particular requirement on professional licensure at all. "As part of their exercise of police power," states may "impose reasonable regulations on professions which affect public health, morals, and safety. . . . [But,] substantive due process requires that regulations promulgated according to the grant of police powers, which place a protected property interest at risk, bear a reasonable and valid relationship to public morals, health, or safety." *Id.* (internal quotations and citations omitted). When courts review whether a regulation involving a protected property interest satisfies substantive due process, they apply a "rational basis" review of the regulation. *Marrujo v. New Mexico State Hwy. Transp. Dep't*, 118 N.M. 753, 757, 887 P.2d 747, 751 (1994). When applying this standard, courts defer to the legislature's determination of the "public good" and require anyone opposing the legislation or regulation to demonstrate that the "challenged legislation is clearly

arbitrary and unreasonable, not just that it is possibly so. The court will uphold the statute if any state of facts can be discerned that will reasonably sustain the challenged classification." *Id.* at 758, 887 P.2d at 752.

Under this deferential standard, the law suggested by the models, which would require professional licensees to have health insurance or be subject to license denial, suspension, or revocation, would probably bear a "reasonable and valid relationship" to public health so as to satisfy the substantive due process requirements of the Constitution because it would be enacted to increase health coverage across the state and decrease the costs incurred by the state in providing emergency and other health care to the uninsured.[1]

Assuming that the state may constitutionally impose a health coverage requirement on a professional license, the state must still satisfy procedural due process requirements before denying, suspending, or revoking a professional license. Procedural due process requires notice and an opportunity to be heard by a fair and impartial tribunal prior to depriving an individual of a protected property interest. *See Reid v. New Mexico Bd. of Exam'rs in Optometry*, 92 N.M. 414, 416, 589 P.2d 198, 200 (1979). The State could assure procedural due process in either of two ways: the new statute requiring health coverage of all licensees could require licensing boards to follow the Uniform Licensing Act provisions for denial, suspension and revocation. §§ 61-1-1 through 61-1-31 NMSA 1978. Or, the new statute could include specific procedural provisions for denial, suspension, and revocation, as the Parental Responsibility Act does in Sections 40-5A-4 (application for license), 40-5A-5 (renewal of license), and 40-5A-6 (suspension or revocation of license).

Exclusion from public education was proposed in an earlier version of the models as a method of enforcing the individual mandate, but it is not expressly included in the current models. This approach would have posed serious equal protection problems. The State should be concerned that disparate access to public education based on insurance coverage would be considered a violation of the constitution under *Plyler v. Doe*, 457 U.S. 202 (1982). In this case, the Supreme Court required a state to prove that disparate treatment in the provision of public education furthers a substantial state goal. In *Plyler,* the Supreme Court held that denying public education to undocumented children did not further a substantial state goal because lack of education "imposes a lifetime hardship on a discrete class of children not accountable for their disabling status." Consequently, the Court held that treating undocumented children differently than other children violated the Equal Protection Clause of the Constitution. The Court's analysis applies equally to the denial of education to uninsured children because these children are also unable to control whether they have insurance. Thus, children's uninsured status is unlikely to establish a sufficient, rational basis for denying them the same educational benefits that the state affords insured children.

The models also indicate that "other adults must be enrolled [in a qualifying health insurance plan] to apply for [a] driver's license." As above, this proposal raises numerous

[1] The law would likely survive substantive due process review even though it has little, if anything, to do with the licensee's or applicant's fitness to engage in a profession. Such a law would be similar to the Parental Responsibility Act, a New Mexico statute that allows the state to deny, suspend, or revoke a professional license when the licensee or applicant is delinquent in his or child support payments. §§40-5A-1 through -13 NMSA 1978.

questions: Who are "other adults"? Are they adults other than students and licensed professionals? What proof of health insurance would be required at initial licensure and at license renewal? Currently, the Motor Vehicle Division simply requires a driver to present his or her existing license for renewal. Should the MVD also require proof of current health insurance at renewal? At a minimum, requiring proof of health insurance in order to be eligible for an initial driver's license will require amendments to Section 66-5-9 of the Motor Vehicle Code and 18.19.5.12 NMAC. Changes to renewal requirements would require additional changes to the Motor Vehicle Code and rules.

Would an individual with a driver's license be subject to license suspension or revocation if the person's insurance lapses during the period of licensure (which is up to eight years in New Mexico)? If a person with a license that is suspended or revoked for some reason other than DWI is found guilty of driving during the period of suspension or revocation, the person is subject to significant penalties: "imprisonment for not less than four days or more than three hundred sixty-four days or participation for an equivalent period of time in a certified alternative sentencing program," and a fine of not more than one thousand dollars ($1,000). § 66-5-39(A) NMSA 1978. In addition, the motor vehicle that the individual was driving at the time of arrest may be immobilized for up to 30 days. § 66-5-39(B) NMSA 1978. Would these penalties reasonably deter drivers from letting their health coverage lapse?

Finally, none of the models indicates whether the coverage requirement for individuals could be waived under any circumstances. In order to avoid First Amendment challenges based on religious freedom, it would be advisable to include a provision waiving the coverage requirement for those who object to health insurance on religious grounds. For example, in Massachusetts, individuals are exempt from the health coverage requirement if they file a sworn affidavit with their income tax return stating that they did not have creditable coverage during the tax year and that their refusal to obtain and maintain coverage during the year was based on sincerely held religious beliefs. The Massachusetts law further clarified that anyone claiming a religious waiver who obtains medical care during the year is liable for the full cost of that care and is subject to penalties. 2006 Mass. Acts Ch. 58.

II. BUDGET NEUTRALITY, MEDICAID WAIVERS AND STATE PLAN AMENDMENTS

The models for NM Health Choices and NM Health Coverage propose increasing Medicaid coverage through Medicaid waivers, which are time consuming procedures that require budget neutrality. It is unclear how the State will achieve this budget neutrality. As an alternative to the waiver process, the State should consider using an amendment to the state Medicaid plan, which avoids the budget neutrality requirement, and which is permissible under the Deficit Reduction Act of 2005 (DRA) for certain types of Medicaid changes. P.L. 109-171 (Feb. 8, 2006). For example, states can extend SCHIP coverage to low-income pregnant women and unborn children for prenatal care through an SCHIP state plan amendment rather than a waiver. Additionally, using a state plan amendment states may now:

- establish benefit limits for current eligibility categories within limits established by the DRA;
- set premiums and cost sharing amounts within DRA limits;

- allow providers to deny care based on cost sharing; and,
- vary benefits and/or cost sharing across groups or locales. § 6044 of the DRA.

III. THE EMPLOYEE RETIREMENT INCOME SECURITY ACT: ERISA PREEMPTION

ERISA raises a number of federal preemption questions for the proposed models, ranging from preemption of the model itself to preemption of other state remedies. ERISA preempts state laws that "relate to" private sector employee benefit plans. 29 U.S.C. § 1144. An employee benefit plan subject to ERISA is any plan established or maintained by an employer for the purpose of providing medical insurance (among other things) to its employees. 29 U.S.C. §§ 1002(1) and 1003. ERISA excepts governmental plans and church plans from its definition of an employee benefit plan. 29 U.S.C. § 1002.

Until 1995, the United States Supreme Court consistently interpreted this ERISA preemption provision broadly, rendering very few state statutes capable of surviving an ERISA challenge. Since the Court's 1995 decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, the Court has begun to place some limits on ERISA preemption, upholding state laws that might have been preempted under the Court's earlier analysis. Despite this apparent change of interpretation, the Court simultaneously claims to adhere to its earlier opinions. The Court's new direction in interpreting ERISA's preemption provision makes it difficult to predict whether any or all of the proposed models can withstand ERISA preemption challenges.

Predicting whether any of the models will be preempted is further complicated by the inclusion of new methods of financing health care, particularly pay-or-play taxes and fair-share payments. These pay-or-play taxes and fair share payments have been tested in only one court case in the country, *Retail Industry Leaders Assoc.(RILA) v. Fielder*, No. 06-1840 (4th Cir. Jan. 17, 2007). Because Maryland has not sought review by the Supreme Court, the Fourth Circuit opinion in *RILA* stands as the only final determination in the country on whether pay-or-play taxes and fair share payments are preempted by ERISA. Although the Tenth Circuit, which includes New Mexico, is not bound by this decision, it deserves careful review in this memorandum because the Tenth Circuit would certainly consider *RILA's* analysis in any cases that come before it.

A. ERISA Preemption Generally

Congress intended ERISA to "provide a uniform regulatory regime over employee benefit plans." *Aetna Health Inc. v. Davila*, 542 US. 200, 208 (2004). ERISA's preemption provision is intentionally expansive: it aims to allow employers to develop employee benefit plans that apply uniformly in all states without state-by-state variation. *Ingersoll-Rand Co. v. McClendon*, 498 US. 133, 142 (1990). Consequently, ERISA preempts state laws that "relate to" private sector employee benefit plans. A state law relates to an employee benefit plan if it refers to such a plan or if it has a connection with a plan. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983). A state law refers to a plan if it acts "immediately and exclusively upon" a plan or if "the existence

of a plan is essential to the law's operation." *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325 (1997).

A state law has a connection with an employee benefit plan if it affects the plan's benefits, structure, or administration, for example by regulating an employer's contributions to a plan or by requiring an employer to provide insurance generally or certain particular benefits. *Travelers*, 514 U.S. at 648. However, a state law that "creates only indirect economic incentives that affect but do not bind the choices of employers or their ERISA plans is generally not preempted." *RILA*, at 19 (citing *Travelers*, 514 U.S. at 658).

Importantly, however, if a state law that ERISA would otherwise preempt because it relates to an employee benefit plan falls within an area of traditional state regulation, the Supreme Court "assumes the States' historic police powers are not superseded unless that was Congress' clear and manifest purpose." *Travelers*, 514 U.S. 645 (citing *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Applying these cases and principles in the *RILA* case, the Fourth Circuit Court of Appeals recently considered whether ERISA preempted Maryland's Fair Share Health Care Fund Act (the Fair Share Act). The Fair Share Act required every large for-profit employer to contribute to the State an amount equal to the difference between what it spends on its health benefit costs (including the costs of an employee benefits plan) and 8% of its payroll.

Maryland argued that ERISA did not preempt the Fair Share Act for two reasons. First, it claimed the Fair Share Act was not a statute affecting employers' provision of health care benefits; rather, the State claimed it was a revenue statute of general application involving a payroll tax, against which employers would receive a credit for their actual health care spending. Second, Maryland argued that the Act did not relate to employee benefit plans because employers could fulfill the Act's requirements by increasing their spending on employee health care without impacting their plans at all. (For example, Maryland argued that employers could choose to create on-site medical clinics, contribute more money to employee health savings accounts, or pay the state.)

A two-judge majority of the Fourth Circuit Court rejected both arguments, concluding first that the Act was not a revenue statute of general application. According to the Court, although the tax ostensibly applied to a small category of large employers, in reality it applied to only one large employer, Wal-Mart. As such, the Court held that the true purpose of the Act was not to raise revenue through taxation, but to regulate large employers by requiring them to provide health care benefits to their employees—a clear violation of ERISA. *RILA* at 17-18, 21 (explaining that "ERISA preempt[s] state laws that directly regulate employers' contributions to" their plans).

The Court further explained that "a state law that directly regulates the structuring or administration of an ERISA plan is not saved by inclusion of a means for opting out of its requirements." *Id.* at 18 (citing *Egelhoff v. Egelhoff*, 532 U.S. 141, 150-51 (2001)). In Maryland, the Fair Share Act required employers to pay an amount equal to eight percent of their payroll to the State or to spend at least the same amount on health care, whether through an employee benefit plan or other health benefit. The State argued that by allowing employers to choose between paying the tax, increasing their contributions to their employee benefit plan, and

providing other health care benefits, the Act did not relate to or have a connection with the employee benefit plans. The Court disagreed, determining that "even if a state law provides a route by which ERISA plans can avoid the state law's requirements, taking that route might still be too disruptive of uniform plan administration to avoid preemption." *RILA* at 19, 23. Indeed, in this case, the Court concluded that the Fair Share Act would force employers to structure their health care record keeping and spending to comply with the Act, an effect that would disrupt employers' uniform administration of employee benefits plans nationally. *Id.* at 21.

In sum, the Fourth Circuit held that ERISA preempted Maryland's Act because "the only rational choice employers have under the Fair Share Act is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold. The Act thus falls squarely under [the] prohibition of state mandates on how employers structure their ERISA plans." *Id.* at 20 (citing *Shaw*, 463 U.S. at 97).

The remainder of this section will evaluate each of the proposed models in light of these ERISA preemption considerations.

B. ERISA Preemption and the Proposed Models

1. The Health Security Act (HSA)

The HSA creates the Health Security Plan (HSP), a statewide health insurance plan in which all individuals would enroll. All employers would be required to pay a payroll tax to the state to support the HSP. The tax would be calculated as a percentage of the employer's payroll, but self-insured employers would be exempted from payment for their covered employees. Under this model, employers who maintain conventional health insurance for their employees (by contracting for health insurance) would make a payment to cover the payroll tax and might also make a voluntary payment to cover all or some of the cost of the employer's chosen private insurance. Self-insured employers would pay the costs of self-insurance and would also pay the tax for any employees who declined coverage under the employer's plan.

The HSA may face significant ERISA challenges, which will be discussed below. However, compared with Maryland's Fair Share Act, the HSA has two advantages that may protect it from ERISA preemption. First, unlike Maryland's preempted Fair Share Act, which determined the amount of an employer's fair share payment by directly comparing an employer's health care expenditures, (primarily, but not exclusively, its expenditures on its employee benefits plan), to a statutory minimum percentage of payroll, the HSA does not refer to a plan directly and does not depend on an employee benefit plan to determine the amount of the payroll tax. Because the HSA does not refer to an employee benefit plan, ERISA may not preempt it.

Second, for reasons described below, the HSA's payroll tax can reasonably be seen as a revenue raising measure of general application. This is significant because ERISA will not supersede state laws within areas of traditional state authority, such as taxation, unless it was Congress' clear and manifest intent to do so. *Travelers*, 514 U.S. 645 (concluding that states have traditional authority over health and welfare); *Hattem v. Schwarzenegger*, 449 F.3d 423 (2d Cir. 2006) (holding that taxation is an area of traditional state authority). If the HSA is seen as raising revenue to improve the health of New Mexicans, it is arguable that ERISA would not preempt this reform model because nothing in ERISA itself indicates that Congress intended to

supersede traditional state authority to tax businesses or regulate health and welfare beyond its express reporting, disclosure, and fiduciary responsibility requirements.

The payroll tax conceived by the HSA is likely to be considered a tax for two reasons. First, unlike the tax imposed by the Fair Share Act, which applied to only one large employer in the entire state once all of the Act's exemptions were applied, the HSA payroll tax applies to all employers, including self-insured employers who have uncovered workers. As such, it is a statute of general applicability designed to raise revenue and not a feigned attempt to mandate employer-sponsored health coverage.

Perhaps more significant for ERISA preemption than the reach of the payroll tax is that the HSA's payroll tax is not coupled with provisions that encourage employers to provide health coverage or enhanced benefits in order to avoid the tax. In the *RILA* case, the Fourth Circuit concluded that the Fair Share Act did not create a tax of general applicability because the Act's core provisions aimed "at requiring covered employers to provide medical benefits to employees." *RILA* at 21. In the court's view, the core provisions of the Act, which determined the amount of the "tax" by calculating the difference between eight percent of payroll and the employer's actual health costs, forced employers to provide or enhance their health coverage. Such state efforts to mandate, enhance, or structure employee benefit plans are preempted by ERISA. *See, e.g., Travelers*, 514 U.S. at 658; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739; *Shaw*, 463 U.S. at 97; *RILA* at 17-18, 21 (explaining that "ERISA preempt[s] state laws that directly regulate employers' contributions to" their plans).

On the other hand, it may be argued that the HSA has an impermissible connection with a plan because the payroll tax, without any credit for coverage provided to employees (other than self-insured coverage), would encourage employers to eliminate their employee benefit plans entirely due to the increased cost of paying both the tax and a health plan's premiums. The State could rely on *Travelers* to argue that ERISA does not preempt the HSA because the payroll tax would simply create an indirect economic effect on the costs of providing health coverage, which does not constitute an impermissible connection with an employee benefit plan. In *Travelers* the Court upheld a state statute imposing higher hospital surcharges on private insurers than on Blue Cross and Blue Shield providers because the indirect economic influence (increased cost of private insurance) on employee benefit plans did not bind employers to only one insurer. In that case, however, the indirect economic effect of the statute was unlikely to eliminate employee benefits plans, as it may here if the tax imposed by the HSA is too burdensome. If the payroll tax is not sufficiently low, it "might produce such acute, albeit indirect, economic effects as to force an [employee benefit] plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers," in which case, ERISA might preempt the law. *Travelers*, 514 U.S. at 668. Here, if the payroll tax is too burdensome, the HSA may force all employers to abandon private insurance because its cost would be too great when coupled with the additional cost of the payroll tax. This effect is likely to cause preemption problems.

Although an exemption from the tax for covered employees might overcome the problem of creating acute, indirect economic effects, the HSA might not survive an ERISA challenge, at least under the reasoning applied by the Fourth Circuit in *RILA*, even if it provided an exemption or credit to employers (whether for their contributions to an employee benefit plan or for the number of employees covered by the employer's plan). *RILA* held that ERISA preempted

Maryland's Fair Share Act even though it credited employers for their actual health care expenditures.

At least two problems are presented by either an exemption or credit. First, a credit based on the amount an employer spends on an employee benefits plan would likely impermissibly refer to the plan because the existence of the plan would be essential to the operation of the credit. *Dillingham Constr.*, 519 U.S. at 325. In other words, the state could not offer the credit without considering the amount each employer spends on its employee benefits plan, which was one of the problems that caused the Fourth Circuit to declare Maryland's Fair Share Act preempted by ERISA.

Second, an exemption from the payroll tax for employees covered by an employee benefit plan also faces ERISA preemption problems. Offering an exemption for covered employees would encourage employers to offer more attractive plans, either with more comprehensive benefits or with lowered employee cost sharing, so that they could avail themselves of the tax exemption. In essence, the availability of either the exemption or credit would turn on how attractive an employer's plan would be. State statutes that influence the benefits, structure, or administration of an employee benefit plan are preempted by ERISA. *Travelers*, 514 U.S. at 648.

2. New Mexico Health Choices (Version 1)

Version 1 of this model proposes to create a single, statewide risk pool that would replace the individual and group health insurance markets. Under this model, individuals would enroll in a plan offered by the Health Choices Alliance, which would be funded in part by a payroll tax imposed on all employers. The tax would be calculated as a percentage of payroll.

This model shares some of the advantages described above for withstanding an ERISA challenge: it would impose a tax on all employers, so might be outside the purview of ERISA because it falls within an area of traditional state regulation. And, the tax imposed would be calculated without any reference to amounts spent on an employee benefit plan because the effect of this model may be to completely replace employer based health coverage with individual coverage. If that is the case, it is difficult to imagine how Version 1 could survive an ERISA preemption challenge because it will relate to employee benefits plans. As noted above, an act relates to an employee benefit plan if it refers to a plan by acting "immediately and exclusively upon" it. *Shaw*, 463 U.S. at 97; *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 325 (1997). If Health Choices Version 1 eliminates employee benefit plans completely (by having employers pay a payroll tax to the state, which would then provide vouchers to individuals to purchase health coverage from the Alliance), it will be difficult to conclude that the model does not act immediately and exclusively upon those plans. The effect of this model is not simply to restrict an employer's choice of insurers, a problem the Court identified in *Travelers*, but to eliminate their choice of insurers completely. ERISA is likely to preempt this model if employers would no longer be able to use health benefits as a way of attracting or retaining employees, yet would remain responsible for at least part of the cost of health coverage (in the form of a payroll tax).

ERISA might not preempt Version 1 if the payroll tax is sufficiently low that employers would supplement their employee's health vouchers through the purchase of more

comprehensive coverage. Because employers might retain a limited role in providing health coverage to their employees through this supplementation, it may be argued that Version 1 does not completely eliminate employer based coverage. This supplemental coverage may, however, cause ERISA problems because of the difficulties it presents for the administration of a plan.

When deciding whether ERISA preempts a state act, courts evaluate whether the state act affects the ability of multistate employers to administer their employee benefit plans uniformly nationwide. *RILA* at 19. ERISA's preemption provision serves to "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government and to reduce the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *RILA* at 16 (internal quotations and citations omitted). Although Health Choices Version 1 would not require specific coverage, the individualized nature of health coverage in the state could impact large employers that purchase health insurance on a national or multistate basis for all of their employees. The problem could arise if a large employer wanted to ensure that its New Mexico employees receive the same benefits—or at least the same level of benefits—as its employees in other states. Under Version 1, the employer might not include its New Mexico employees in the national health plan it provides to all other employees and might have to pay increased costs for enhanced vouchers for its New Mexico employees just to bring their coverage to the same level as its other employees. Moreover, such an effort would require the employer to set aside a fund—separate from its expenditures on a national health care plan—to purchase equivalent coverage here. Such an effect, requiring employers to allocate and track their health care spending by state, would violate ERISA's objective of promoting the national administration of employee benefit plans.

3. New Mexico Health Choices (Version 2) and New Mexico Health Coverage

Although there are differences between Version 2 of New Mexico Health Choices and New Mexico Health Coverage, the differences are of little consequence for ERISA purposes, and so the two models will be considered together in this section of the memorandum.

Like Version 1, Version 2 proposes to create a single, statewide risk pool that would replace the individual and group health insurance markets. Under this version of Health Choices, employers could purchase fully insured health plans through the Alliance, could maintain self-insured plans, or could allow their employees to purchase plans from the Alliance using state vouchers. The Alliance would be funded in part by a payroll tax. Employers would pay this tax for workers who are not offered coverage or who do not take up employer-sponsored coverage. The tax would be equal to the average voucher amount for the high-cost sharing Alliance plan.

Similarly, New Mexico Health Coverage proposes to impose a fair share payment on all employers for all uninsured employees (whether they are uninsured because the employer does not offer a health plan or because the employee chooses not to enroll in an offered plan). The fair share payment would be a flat amount per year per full-time employee, but would be prorated for part-time employees.

If the Supreme Court follows its pre-*Travelers* cases for determining when a state statute refers to an employee benefit plan, then both models may be found to impermissibly refer to employee benefit plans. Under both models, an employer would retain a choice between providing a fully insured or self-insured employee benefit plan or paying the tax or fair share

payment. Because an employer's obligation to pay the State would turn on the existence or not of a plan, it can be argued that both models would impermissibly refer to an employee benefit plan and be preempted by ERISA. *Cf. Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (finding a state cause of action preempted by ERISA because the cause of action made specific reference to and was premised on the existence of a pension plan). *See also District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) (holding that a law "relates to" a plan for purposes of ERISA preemption if it refers to such a plan).

However, if the Court applies its newer approach to ERISA preemption, as is likely, then a state law refers to an employee benefits plan only if it acts "immediately and exclusively upon" such a plan or if "the existence of a plan is essential to the law's operation." *Dillingham*, 519 U.S. at 325. Since both models would allow employers to operate with or without an employee benefit plan, and since calculation of the tax or payment would not require consideration of amounts paid or benefits offered under a plan, neither model can be said to require a plan for its operation, nor to act immediately and exclusively upon a plan.

Even if these models do not refer to an employee benefit plan, they may have an impermissible connection to a plan. A state law has a connection with an employee benefit plan when it affects the plan's benefits, structure, or administration. *Travelers*, 514 U.S. at 648. Unlike Maryland's Fair Share Act, nothing in either of these models sets a minimum contribution to an employee benefit plan (or to spending on health care benefits not included in a plan). Moreover, nothing in either plan would mandate employer-based insurance or require an employer to provide specific health benefits. Under these circumstances, an employer could choose to maintain a plan and to make payments to the State for any uninsured employees, or it could choose to discontinue its plan and pay the State for all of its employees. Thus, both plans would retain an employer's flexibility in providing coverage or not.

The additional cost an employer might incur by having to pay the state for uncovered workers while continuing to provide a plan under either of these models could be seen as either an "irresistible incentive" to modify an employee benefit plan or an "indirect economic influence" on the cost of coverage, depending on the cost of the tax or fair share payment. If set too high, the additional cost could be seen as an "irresistible incentive" to modify or eliminate an employee benefit plan, which would violate ERISA. *RILA* at 21. Conversely, if the tax or payment imposed by these models were low enough, it is arguable that the models would create an indirect economic influence on an employer and its plan, which ERISA would not preempt. As Patricia Butler explains:

> An assessment might best be designed at a level that avoids putting very many employers in the position to argue they have no choice but to alter their existing ERISA plans. One way to do so would be setting the assessment at a level so that relatively few currently offering employers would have to increase their spending (i.e., modify their ERISA plans) to avoid liability for the fee. On the other hand, firms spending little or nothing on employee care might decide to pay the assessment. Such employer choices would be based on broader business considerations including the costs of various coverage options available in the market, the practical complexity of administering a health plan . . . , as well as whether their workers would be likely to benefit from any premium subsidies or

other advantages to the public program. (The Court in *Travelers* noted that the need to weigh such considerations in making business decisions does not by itself implicate preemption.)"

ERISA Update: Federal Court of Appeals Agrees ERISA Preempts Maryland's "Fair Share Act" at 4 (State Coverage Initiatives, National Academy for State Health Policy, Feb. 2007).

Without knowing the amount of the tax or payment, it is impossible to evaluate whether Health Choices Version 2 or New Mexico Health Coverage would be considered an "irresistible incentive" (which ERISA would preempt) or an "indirect economic influence" (which would not implicate ERISA preemption).

C. Preemption of Related Laws: The New Mexico Patient Protection Act and Limitation of Remedies

Section 502 of ERISA preempts state tort, contract, and statutory claims and imposes federal court jurisdiction over certain claims arising under an employee benefit plan. The New Mexico Patient Protection Act, §§59A-57-1 through 59A-57-11 NMSA 1978, defines the rights of patients enrolled in a managed health care plan in New Mexico, including a Medicaid program, and establishes private remedies to enforce patient and provider insurance rights. These remedies are in addition to other remedies extant under state statutes and common law. If any of the proposed models are preempted by §514 of ERISA (because they "relate to" an employer-sponsored benefit plan), it is likely that §502 of ERISA would preempt the remedies afforded by the Patient Protection Act for anyone enrolled in an insurance plan pursuant to that model. Under these circumstances, the patient would be limited to bringing the claims afforded by ERISA and might be limited to bringing those claims in federal court.

D. ERISA Conclusions

Despite recent changes in the Supreme Court's ERISA jurisprudence, ERISA's preemption provision remains broad. Any state initiative enacted to expand health coverage that touches employee benefits or employers is likely to come under close scrutiny by the courts. To determine whether ERISA preempts any of the proposed models, courts will consider whether the model:

1. refers to an employee benefit plan;
2. acts immediately and exclusively upon an employee benefit plan;
3. affects the benefits, structure, or administration of an employee benefit plan; or
4. interferes with an employer's ability to administer a multistate or national employee benefit plan.

ERISA will not preempt a model that creates indirect economic incentives that affect, but do not bind, an employer's choice of coverage. But, ERISA will preempt a model that creates

irresistible incentives to modify an existing employee benefit plan. Given the breadth of ERISA's preemption provision, and the Court's wide-reaching considerations in ERISA preemption cases, ERISA may pose a significant obstacle to the success of each of the proposed models.

IV. TAX CONSEQUENCES OF THE PROPOSED MODELS

This section examines the federal and state tax consequences of each proposed health coverage model for employers and employees. Because the tax consequences of these new methods of financing health care (including fair share payments and pay-or-play taxes) have not been tested before the Internal Revenue Service (IRS) or the courts, the conclusions reached in this section are necessarily tentative.

A. The Health Security Act

The HSA requires all New Mexico employers to pay a payroll tax to support the HSP, a statewide health plan covering both public and private sector employees. The amount of an employer's payment to the HSP would be determined as a percentage of the employer's payroll, but self-insured employers will pay the tax on their uncovered employees only. Although all employers must contribute to the HSP, they may also maintain private health coverage for their employees.

In large part, the HSA maintains the *status quo ante* regarding the tax treatment of health benefits:

- The amount the employer contributes to health coverage, would continue to be excluded from federal and state payroll taxes, thereby allowing the employer and the employee to benefit from greater compensation while minimizing the tax burden on both the employer or the employee (as compared with an equivalent compensation in cash only).
- The employer's contribution to health coverage would continue to be excluded from an employee's taxable income. 26 U.S.C. § 106(a).
- Employers would remain able to establish cafeteria plans, which allow employees to exclude the amount of their contributions to a Section 125 plan from their gross income. 26 U.S.C. §125(a).

While maintaining the *status quo ante* regarding the tax treatment of health benefits for employees, the HSA does, however, create a new payroll tax for employers, which will increase the employer's overall tax liability.

B. New Mexico Health Coverage

New Mexico Health Coverage proposes to impose a fair share payment on all employers for those employees who are not enrolled in the employer's health plan (whether that is because the employer does not offer a health plan or because the employee chooses not to enroll in an offered plan). The fair share payment would be a flat amount per year per uncovered full-time employee, but would be prorated for part-time employees. The employer's fair share payment would be a contribution to a state fund and would not be considered a tax or a contribution to employees' health coverage.

Additionally, employees who earn less than 300% of the federal poverty level would receive premium assistance for State Coverage Insurance (SCI).

Finally, the proposal refers to two tax credits, one for individuals (presumably for the cost of premiums, co-payments, and any uncovered health care paid for by the individual) and one for employers who provide health coverage, but the proposal does not describe these credits with any detail and does not indicate whether the credits would be refundable. We assume that these tax credits are state tax credits only, since the federal government has not enacted such a tax credit and we cannot safely assume that one would be enacted. Without more details about the proposed tax credit, it is difficult to understand precisely how a state tax credit would affect an individual's federal taxes. One consequence is clear, however: If the state tax credit is refundable, then the amount of the refund would be included in the employee's gross income for federal tax purposes, potentially raising a low-income worker's gross income beyond the minimum taxable threshold and increasing the individuals' federal tax liability. 26 U.S.C. § 61(a). However, if the state tax credit were not refundable, it would not benefit low-income families that are not liable for state taxes anyway.

1. Tax Consequences of the Fair Share Payment for Employers

The tax consequences of New Mexico Health Coverage for employers are unclear. On the one hand, employers that provide health coverage for their employees would experience no change in their tax liability because of the fair share payment. These employers could continue to deduct the amount of health coverage from their taxable income and could avoid paying payroll taxes on compensation provided in the form of health benefits (as opposed to wages and salaries).[2]

Employers that do not offer health coverage, or that have employees who decline coverage from the employer's health plan, would face a negative fiscal impact—though not necessarily increased taxation—because they would be forced to make a payment to the state that would be considered neither a tax nor a contribution to coverage. As such, the fair share payment would certainly be an increased expense. Whether the fair share payment would be considered a tax

[2] For this model to be beneficial for employers, rather than simply neutral, the state could create a refundable state tax credit for employers that provide health insurance to their employees. The amount of the refundable credit would be included in the employer's income for federal tax purposes (thereby increasing the employer's federal tax liability), but the deduction for the cost of health coverage probably would exceed the increase in gross income.

deductible business expense for purposes of Section 162(a) is an open question: Neither the federal government nor any state has considered whether such a payment is an ordinary and necessary business expense. However, the IRS has historically been quite flexible in allowing a wide variety of expenses to be deducted under Section 162(a), so it is quite likely that a state statutory requirement, such as the fair share payment, would be allowed as an ordinary and necessary business expense. Certainly, New Mexico could expressly allow the fair share payment to qualify as a deductible business expense under the state tax code.

2. Tax Consequences for Employees

Employees with employment based coverage would continue to enjoy exclusion from their taxable income of any contributions their employers make to their health coverage, any contributions they make to a Section 125 plan, and any payments they make toward their premiums or co-payments.

For workers who earn less than 300% of the federal poverty level, New Mexico Health Coverage would establish premiums at reduced rates based on the worker's income. Whether the amount of the premium subsidy would be taxable to the employee turns on whether it is includable in the employee's gross income.

Although the Internal Revenue Code defines "gross income" to mean all income, regardless of its source, 26 U.S.C. §61(a), the IRS "has consistently held that payments made under legislatively provided social benefit programs for promotion of the general welfare are not includable in the gross income of the individual being benefited." *Chief Counsel Advice* 199948040 (Dec. 3, 1999) (concluding that subsidies paid by the government to assist low income families with rent payments are in the nature of general welfare and are not includable in the taxpayer's gross income). If the premium assistance program established by New Mexico Health Coverage were determined to be a general welfare program, the premium assistance received by individual employees would not be taxable as gross income.

The general welfare exclusion from gross income "applies only to governmental payments out of a welfare fund based upon the recipient's identified need (which need not necessarily be financial), and not where made as compensation for services." *Private Letter Ruling* 200336030 (Sept. 5, 2003) (concluding that payments made by a tribe under a tribal housing program that was created by tribal legislative enactment were made to promote general welfare and were therefore excluded from the gross income of recipients). The first two prongs of this test require that the payments be made by a government, pursuant to a legislatively enacted program, and be based on an identified need of the intended recipients. A wide variety of government programs have met these requirements. *See, e.g., Private Letter Ruling* 9351017 (Sept. 24, 1993) (day care subsidies for low-income families); Rev. Rul. 98-19, 1998-15 I.R.B. 5 (relocation payments made to flood victims); Rev. Rul. 74-205, 1974-1 C.B. 20 (HUD replacement housing payments to aid displaced individuals and families); Rev. Rul. 74-74, 1974-1C.B. 18 (awards to crime victims); Rev. Rul. 57-102, 1957-1 C.B. 26 (payments to the blind).

Additionally, to be excluded from gross income by the general welfare doctrine, the payment or subsidy must not be compensation for services provided. *Bannon v. Commissioner*, 99 TC 59 (Jul. 20, 1992) (explaining that payments under a government program received by a parent for providing care to her disabled adult child were included in the parent's gross income

because the payments were not welfare assistance payments, but were compensation to the parent as the disabled person's service provider).

Finally, the person claiming the subsidy is not gross income must be the intended beneficiary of the government welfare program. In *Bannon*, the Tax Court considered whether the person claiming the exclusion (the parent who provided services to the disabled adult) was the intended beneficiary of the general welfare program and concluded that the intended beneficiary of the government subsidy was the disabled adult, not the service provider. For this reason alone, the amount of the subsidy was includable in the parent's gross income. *See also Graff v. Commissioner*, 74 TC 743, 753-754 (Jul. 21, 1980) (holding that only the persons intended to be the "ultimate beneficiaries" of the subsidy can be said to have received a welfare benefit excludable from taxation).

Given these authorities applying the general welfare doctrine, the premium subsidy may not adversely affect the tax liability of low income workers. New Mexico Health Coverage could be considered a general welfare program because it would be established by state statute, the subsidy would be paid by a governmental fund, and the recipients of the subsidy would be established by financial need.

It is possible, however, that the IRS would contest whether the fund would be a "government fund" because of employer contributions to the fund. The IRS could argue that the employer's contribution to the fund is compensation for services and that the government fund simply masks what is actually remuneration. In the event that the employer's contribution renders the fund something other than a government fund, it may be possible to argue that SCI is a Section 106 employer-provided health plan, which is excluded from the worker's gross income.[3]

C. New Mexico Health Choices

Version 1 of this model proposes to impose a tax on all employers. Under this model, the state would pay a health coverage subsidy in the form of a voucher to individuals, but the model

[3] While there are no private letter rulings, Tax Court opinions, or court cases addressing this question to provide any guidance, one could apply the reasoning of *Private Letter Ruling* 9242012 (Jul. 20, 1992) to New Mexico Health Coverage. This ruling examined whether the amounts paid by a trust fund established to defray the cost of government retirees' health insurance premiums were taxable to the retirees as gross income. In this case, the subsidy was not part of a general welfare program because the trust was not established by statute and payments from the trust were not based on the retiree's need, but were based on the retiree's years of government service. In essence, in creating the trust, the state was not acting as a governmental entity, but as any employer. Nevertheless, the IRS determined that the subsidy was excludable from gross income when the state paid the subsidy directly to retiree's insurer for health coverage, not because the subsidy was part of a general welfare program, but because the subsidy qualified as employer-provided coverage under 26 U.S.C. § 106. However, when the state paid the subsidy directly to the retiree, the amount of the subsidy was includable in the retiree's gross income because nothing in the plan required proof of health insurance coverage. Under these circumstances, the subsidy did not qualify as employer-provided health coverage under Section 106. *Cf. State Medicaid Director Letter* #06-008 (Mar. 31, 2006) (concluding that state payment of premiums for benchmark or benchmark-equivalent health coverage provided through a private employer "shall be treated as payments for medical assistance," which are excluded from the employee's gross income).

does not specify how the vouchers would be distributed—to the worker, to the employer, or to the insurance carrier directly.

Version 2 would allow employers to maintain fully insured or self-insured plans, but would require employers to pay a tax on all uncovered employees (including employees not offered coverage and employees who are offered, but who decline coverage). The state subsidy may take the form of vouchers or subsidized upgrades to existing employee coverage. As with Version 1, Version 2 of the model does not specify whether the vouchers would be distributed to individuals directly, to employers on behalf of individuals (when there is no private coverage), or to an insurance carrier.

1. Federal Tax Consequences of the Health Choices Tax for Employers

Businesses can deduct certain enumerated state taxes from their gross income for federal tax purposes, including, for example, state real property and income taxes. 26 U.S.C. § 164(a). While the proposed Health Choices tax would not fall within any of these enumerated state taxes, it may still be deductible if it is incurred as an ordinary and necessary business expense. 26 U.S.C. § 162(a).[4] It is possible that the Health Choices tax could be construed to be an occupation tax, which is a type of excise tax charged for the privilege of conducting a business in the state or locality. However, even if the Health Choices tax were not considered an occupation tax (either because it is not required in order to conduct business or because it is not charged at a flat rate), it could still reasonably be seen as an ordinary and necessary business expense. Indeed, the IRS has recently issued a Technical Advice Memorandum concluding that an insurance company's contributions to a state insurance pool were deductible from its gross income when state law required insurance companies to secure certain coverage either through contributions to the state pool or by offering the coverage themselves. *IRS Technical Advice Memorandum* 200517030 (Jan. 31, 2005).

2. Tax Consequences of Vouchers and Subsidized Upgrades for Employees

Both Versions of Health Choices would offer vouchers for health care to employees. Version 1 may also include subsidized upgrades to an employee's existing coverage through an employer. The tax consequences for employees of vouchers and subsidized upgrades would be the same under both versions of this model, so they are considered together in the discussion that follows.

As with the premium assistance offered under New Mexico Health Coverage, the amount of any health care voucher or subsidized upgrade to coverage would be taxable to the employee if that amount were includable in the employee's gross income. As there appears to be no mechanism to deliver a health coverage subsidy or voucher to employees without negative tax consequences, the only way that the value of a Health Choices voucher or subsidy may be excluded from an employee's income is if it fell within the general welfare doctrine described above. The general welfare exclusion from gross income "applies only to governmental

[4] For example, an employer can deduct flat-rate occupation taxes from its gross income as business expenses.

payments out of a welfare fund based upon the recipient's identified need (which need not necessarily be financial), and not where made as compensation for services." *Private Letter Ruling* 200336030 (Sept. 5, 2003). Because Health Choices would be created statutorily and be paid out of a state general welfare fund, and because its purpose would be to meet the recipient's need for health coverage, it might qualify as a general welfare program and the payments might be excluded from the recipient's gross income. Additionally, since the voucher or subsidy would not be contingent upon contribution by an employer, the voucher should not be seen as compensation for services rendered to an employer.

Finally, as noted earlier, the Health Choices models do not specify the method or form of distributing health coverage vouchers. Federal law is relatively clear that whether income is includable does not turn on the form of the income; income would be included whether it is cash, a voucher, another type of subsidy, and "whether the amount is paid directly to a recipient or indirectly to a third party on behalf of the recipient." *Chief Counsel Advice* 199948040 (Dec. 3, 1999). To ensure that the Health Choices voucher or subsidy is not taxable because of the general welfare doctrine, any voucher or subsidy paid directly to an individual (instead of to a third party, such as an insurance carrier), must either require proof that it is actually being used for health coverage purposes by the recipient or must be in a form that cannot be converted to cash and used for another purpose.[5]

V. CONCLUSIONS

Given the uncertainty in the Supreme Court's ERISA jurisprudence and the novelty of the proposed methods of increasing health coverage and financing health care, it is unwise to draw firm conclusions about the proposed models. However, at this early stage of development of each of the models, the following tentative conclusions seem reasonable:

A. Procedural and substantive due process requirements must be considered when establishing and enforcing the individual mandate through license denial, suspension, and revocation;

B. Equal protection guarantees caution against using denial of public education as a means of enforcing the individual mandate as it relates to children;

C. To avoid conflicts with the First Amendment, individuals with sincerely held religious objections to medical must be exempt from the individual mandate;

D. ERISA may preempt any model that binds employers' choice of coverage, produces such acute indirect economic effects that employee benefits plans would be

[5] *Cf. Private Letter Ruling* 9242012 (Jul. 20, 1992) (concluding that a subsidy was excludable from gross income when the state paid the subsidy directly to the retiree's insurer for health coverage, but not when the state paid the subsidy directly to the retiree without requiring proof of health insurance coverage); *Private Letter Ruling* 9351017 (Sept. 24, 1993) (day care subsidies for low-income families are excluded from recipient's income whether paid directly to the day care provider or whether a certificate is issued to the parent because the certificate can be used only for day care).

eliminated, or interferes with the employer's administration of a multistate or national employee benefit plan;

E. The Health Security Act is unlikely to change the tax liability of employees, but will increase an employer's tax liability;

F. New Mexico Health Coverage's fair share payment would create an increased expense for employers with uninsured workers, though not necessarily increased tax liability. This increased expense might be considered a tax-deductible business expense at the federal level and could be enumerated in state statutes as a business expense deduction;

G. Under New Mexico Health Coverage, low-income workers whose employers contribute to SCI could enjoy a tax-exempt premium subsidy if the SCI is determined to be a general welfare program;

H. The Health Choices tax imposed on all employers may be deductible as an ordinary and necessary business expense; and

I. The vouchers and subsidies used to provide or supplement employee health coverage under Health Choices may be tax-free to employees if the model is considered to be a general welfare program.

APPENDIX C

MEDICARE FEE-FOR-SERVICE REIMBURSEMENT AND MEDICARE ADVANTAGE PLANS

APPENDIX C

MEDICARE FEE-FOR-SERVICE REIMBURSEMENT AND MEDICARE ADVANTAGE PLANS

Medicare has two components—the fee for service (FFS) program and the Medicare Advantage (MA) program, as described in the following sections. While various reform initiatives may anticipate that the proposed reform program might qualify as a Medicare Advantage plan, in particular, there is no basis for anticipating that Medicare will maintain the current relatively high levels of payments to Medicare Advantage plans, or that Medicare reimbursement would cover the costs of enrollees other than Medicare beneficiaries.

Medicare FFS Outpatient and Inpatient Hospital Prospective Payment Systems

Medicare has two reimbursement systems to pay hospitals for inpatient and outpatient care, respectively: the inpatient prospective payment system (IPPS) and the outpatient prospective payment system (OPPS). Both systems rely on a nationally standardized base rate that is adjusted for geographic differences in wages and the complexity of services provided, and both make supplemental payments to account for unusual hospital-specific characteristics.

IPPS uses two nationally standardized per-admission payments, respectively for hospitals in urban areas with a population greater than one million, and for all other hospitals. The standardized amount reflects local labor costs (62 or 70 percent of the standard payment) and non-labor costs; this wage-adjusted standard payment is further adjusted for the patient's complexity illness, based on 579 diagnosis related groups (DRGs).[1] Hospitals may receive additional payments per admission if they treat a high percentage of low-income Medicare beneficiaries (known as disproportionate share, or DSH payments), if they are a designated teaching hospital (known as indirect medical education (IME) adjustments), or if they are a qualifying rural hospital. Under IPPS, hospitals receive just one total amount per admission, although particularly costly admissions may qualify for additional outlier payments.

Medicare's OPPS also begins with a nationally standardized base payment; 60 percent of the base payment is adjusted for local wages. OPPS classifies each outpatient procedure into one of over 800 ambulatory payment classification groups (APC), which group procedures with clinical and cost similarities. Like each DRG, each APC has a relative weight that reflects the median costs of treating Medicare beneficiaries within that APC; the wage-adjusted standard payment is multiplied by the APC weight to calculate total reimbursement. Under the OPPS, hospitals may receive outlier payments for particularly costly patients, but they do not receive supplemental DSH or IME adjustments. Additionally, hospitals may be paid for more than one APC per patient encounter.

[1] Each DRG has a relative weight that reflects the median resources costs of treating Medicare beneficiaries within that DRG. Until fiscal year 2007, DRGs reflected the relative *charges*, not the relative costs, associated with Medicare beneficiaries within each DRG.

Medicare Fee-for Service Physician Payment

Since 1992, Medicare has used a fee schedule to calculate physician payments. The fee schedule bases payment for individual services on measures of the relative resources used to provide them. The schedule is updated using a Sustainable Growth Rate (SGR) factor. The SRG is intended to control spending on physicians' services by setting an overall target amount of spending (measured on both an annual and a cumulative basis) for physicians' services as well as payments that Medicare makes for items—such as laboratory tests, imaging services, and physician-administered drugs—that are furnished in connection with physicians' services.

Payment rates are adjusted annually—upward if actual spending is below the target, downward if actual spending is above the target. From 1997 through 2005, per-beneficiary spending on services paid for under the physician fee schedule grew by about 6.5 percent per year, about half as fast as per beneficiary spending in the rest of Medicare, excluding Medicare Advantage (Marron 2006).[2]

Since 2002, spending measured by the SGR method has consistently been above the targets established by the formula. As a result, under current law, the SGR mechanism will reduce payment rates for physicians' services 25 percent to 35 percent over the next several years if physicians continue to provide services at the current rate. Because of the impending reductions in payment rates required under current law, Medicare spending on services provided by physicians is projected to grow relatively slowly for the next several years—at a projected average annual growth rate of less than 2 percent, in contrast to 7.7 average annual growth from 1997 through 2005.

Medicare Advantage

Medicare Advantage (MA) uses a system of plan "bidding" as the means of determining plan payments and beneficiary premiums. The bids are against benchmarks, which often are legislatively set. Setting benchmarks well above the cost of traditional Medicare signals that the program welcomes plans that are more costly than traditional Medicare. Except in the case of regional PPO plans, benchmarks are set at the county level. The benchmarks vary significantly from county to county, and the difference between a given county's benchmark and FFS expenditure levels in the county can vary significantly.

Because MA's current program payment rates reflect previous statutory changes that provided for minimum payment levels in certain counties, program payments for MA plan enrollees currently are well above 100 percent of FFS expenditure levels. On average, MA program payments are at 112 percent of Medicare FFS levels (MedPAC 2007). Based on where plans tend to operate, the payments vary among plan types, ranging from 110 percent of FFS for

[2] Aside from growth in Part B enrollment, which has averaged about 1 percent annually since 1997, increases in spending subject to the fee schedule can be attributed mainly to increases in the fees themselves and in the volume and intensity of services being provided by physicians. Although some of the increase has resulted from the addition of covered services, most of the increase not associated with increased payment rates (about 2 percentage points) is attributable to growth in the volume and intensity of services, which has averaged about 4.5 percent per year over the period.

HMOs, for example, to 119 percent of FFS for private fee-for-service (PFFS) plans. As of 2007, Medicare payments at the individual beneficiary level are fully risk adjusted for health status.[3]

Some Medicare Advantage plans provide "rebates" or extra benefits at no additional charge to the enrollee. These are expressed as a percent of Medicare FFS expenditures for the geographic areas from which plans draw their enrollment. These rebate amounts are determined based on the plan bid and its relation to the area benchmark, which is the maximum program payment to an MA plan in a given county or geographic area. If a plan is able to provide the Medicare Part A and Part B benefit package for less than the benchmark level, enrollees receive extra benefits valued at 75 percent of the difference between the benchmark and the plan bid for the Medicare package (with 25 percent of the difference retained by the Medicare Trust Funds).[4]

While HMOs can provide the Medicare benefit at 97 percent of Medicare FFS costs, not all plans achieve the same level of efficiency: on average, PFFS plans are paid 9 percent more than the Medicare program to provide the traditional Medicare FFS benefit package.[5] If benchmarks are reduced to 100 percent of FFS, HMO plans still could provide extra benefits to enrollees in the MA program, but no PFFS plans would be able to provide extra benefits.

To pay MA plans appropriately, the Medicare Payment Advisory Commission (MedPAC) has recommended that benchmarks—the basis of plan payments in MA—should be set at 100 percent of Medicare FFS expenditures (MedPac 2007).[6] In this case, the Medicare program would pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. In addition, MedPAC recommends that the same clinical quality measures that MA plans report also be reported for FFS Medicare, allowing Medicare

[3] Plans receive an additional hold-harmless provision payment during a phase-out period over the next few years, as Medicare moves towards payments solely at the risk-adjusted level. That is, plans are paid a portion of the difference between risk-adjusted payments and the payment that would have been made without the health status risk adjustment. Although the net result of phasing out the hold-harmless provision would have been an overall reduction in average plan payments, MedPAC is concerned that current enrollment patterns—with PFFS enrollment growing more rapidly than enrollment in other plans and drawing enrollment from counties with very high benchmarks in relation to FFS —will tend to widen the difference between Medicare FFS expenditure levels and MA payment rates. This enrollment trend would counteract the phase-out of the "hold-harmless" provision, which would otherwise narrow the difference between FFS and MA payment levels. It is unclear how or whether New Mexico would be the beneficiary of this anomaly, or that the Congress will not act to reset the program on its intended path—toward budget neutrality relative to FFS.

[4] Plans may also provide extra benefits that enrollees pay for through an additional premium to the plan.

[5] Although PFFS plans provide enrollees with rebates valued at about 10 percent of Medicare FFS expenditures, program payments on behalf of PFFS enrollees are 19 percent above FFS expenditure levels—so only about half of the excess amount is used to finance extra benefits for enrollees. In HMOs, some of the extra benefits are financed by rebate dollars that are generated because these plans provide the Medicare benefit package more efficiently than the Medicare FFS program in the counties where HMOs have their enrollees.

[6] Because of the impact on beneficiaries enrolled in plans with extra benefits, MedPAC notes that the Congress may wish to employ a transition approach in implementing the Commission's recommendation on payment rates. Among the possible transition strategies that MedPAC identifies are: (a) freeze all county rates at their current levels until each county's rate is at the FFS level; (b) differentially reduce MA rates, with counties in which payments are highest in relation to Medicare FFS facing a larger reduction to more rapidly arrive at FFS rates in each county; or (c) reduce rates in all counties at the same percentage each year until arriving at FFS rates in each county.

beneficiaries to compare FFS Medicare with private plans in terms of their performance on quality measures. Finally, MedPAC has recommended elimination of the benefit stabilization fund, which provided an advantage to the regional preferred provider organizations introduced in the Medicare Modernization Act.

In general, the MedPAC strongly favors a level playing field for all plan types, with no plan type having an advantage over another plan type unless special circumstances dictate otherwise. Thus, MedPAC is exploring whether there are unwarranted advantages currently in place for special needs plans, PFFS plans, and medical savings account (MSA) plans in the MA program—and has questioned why MSA plans are not required to have 25 percent of the difference between the MSA plan bid and the benchmark retained in the Trust Funds, as is the case for other plan types.

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APPENDIX D

ESTIMATED TOTAL HEALTH EXPENDITURES FOR NONINSTITUTIONALIZED CIVIIAN NEW MEXICANS UNDER 65 IN MSA AND NON-MSA COUNTIES 2007

APPENDIX TABLE D.1

ESTIMATED TOTAL HEALTH EXPENDITURES FOR NONINSTITUTIONALIZED CIVIIAN NEW MEXICANS UNDER 65
BY SOURCE OF FUNDING AND TYPE OF SERVICES, 2007
(in millions)

	Total	Hospital Inpatient	Hospital Outpatient	Emergency Room	Office-Based Medical Providers	Prescription	Other Medical Services	Non-Medical Costs
Total	$6,236.7	$1,151.1	$452.0	$204.4	$1,614.2	$1,232.5	$740.5	$842.1
Federal expenditures								
Medicaid	1149.7	306.9	75.8	37.4	260.7	173.2	107.9	187.6
SCHIP	107.3	19.0	2.1	5.6	21.7	11.2	29.0	18.7
Federal employees	121.8	20.2	12.0	5.0	33.0	22.4	10.9	18.3
TRICARE	267.7	31.2	26.8	17.2	64.1	96.4	10.4	21.7
VA	32.7	11.1	1.4	3.4	8.6	4.4	1.0	2.3
Other federal programs	34.5	0.9	4.2	3.1	21.7	0.4	1.3	2.8
State government								
Medicaid	448.7	119.8	29.6	14.6	101.7	67.6	42.1	73.2
SCHIP-SCI	13.4	3.6	0.4	1.1	3.4	1.7	0.6	2.7
Other SCHIP	12.8	1.1	0.1	0.2	1.9	1.0	6.5	1.9
State employees	136.0	22.3	11.4	4.8	41.1	24.2	11.5	20.6
Premium assistance	2.8	0.1	0.2	0.1	0.8	0.3	0.8	0.5
Other state programs	28.0	5.4	0.5	2.1	3.6	0.1	14.7	1.7
Private								
SCI premiums	0.5	0.1	0.0	0.0	0.1	0.1	0.0	0.1
NMHIA	22.4	2.4	4.5	0.6	6.5	2.1	1.7	4.7
NMMIP	25.6	4.2	2.9	1.1	9.1	6.1	0.8	1.4
Privately insured	2697.4	569.8	250.2	86.4	760.3	347.3	199.7	483.6
Out of pocket	1135.4	32.9	29.7	21.7	275.8	474.2	301.2	0.0

Source: Mathematica Policy Research, Inc.

APPENDIX TABLE D.2

ESTIMATED TOTAL HEALTH EXPENDITURES FOR NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER 65 IN MSA COUNTIES BY SOURCE OF FUNDING AND TYPE OF SERVICES, 2007
(in millions)

	Total	Hospital Inpatient	Hospital Outpatient	Emergency Room	Office-Based Medical Providers	Prescription	Other Medical Services	Non-Medical Costs
Total	$3,917.2	$703.6	$245.2	$123.1	$1,048.6	$758.3	$514.5	$524.0
Federal expenditures								
Medicaid	709.1	198.6	28.3	19.0	165.8	104.8	77.0	115.7
SCHIP	71.1	15.2	1.9	4.5	18.9	8.1	9.5	13.1
Federal employees	63.1	7.5	6.9	2.3	17.8	13.3	5.8	9.5
TRICARE	151.2	30.3	22.5	6.1	42.7	33.9	3.4	12.3
VA	28.4	11.1	1.2	3.4	7.0	2.4	0.9	2.3
Other federal programs	19.8	0.9	3.8	0.4	12.6	0.1	0.4	1.6
State government								
Medicaid	276.7	77.5	11.1	7.4	64.7	40.9	30.0	45.2
SCHIP-SCI	12.2	3.4	0.4	1.0	3.1	1.4	0.6	2.4
Other SCHIP	5.1	0.3	0.1	0.1	1.5	0.6	1.7	0.8
State employees	59.0	7.8	5.2	1.8	19.3	9.3	6.7	8.9
Premium assistance	2.4	0.1	0.1	0.1	0.7	0.2	0.7	0.4
Other state programs	19.3	0.0	0.5	1.5	1.4	0.1	14.6	1.2
Private								
SCI premiums	0.5	0.1	0.0	0.0	0.1	0.1	0.0	0.1
NMHIA	16.9	2.0	3.8	0.5	4.8	1.3	1.0	3.5
NMMIP	15.0	4.1	1.4	0.6	5.3	2.3	0.5	0.8
Privately insured	1721.6	323.8	140.3	59.7	502.3	235.2	154.1	306.2
Out of pocket	745.8	20.9	17.8	14.7	180.5	304.3	207.7	0.0

Source: Mathematica Policy Research, Inc.

Notes: Data include estimated expenditures in Albuquerque MSA (including Bernalillo, Sandoval, Torrance, and Valencia County), Santa Fe MSA (i.e. Santa Fe County), Farmington MSA (i.e. San Juan County), and Las Cruces MSA (i.e. Dona Ana County).

APPENDIX TABLE D.3

ESTIMATED TOTAL HEALTH EXPENDITURES FOR NONINSTITUTIONALIZED CIVILIAN NEW MEXICANS UNDER 65 IN NON-MSA COUNTIES BY SOURCE OF FUNDING AND TYPE OF SERVICES, 2007
(in millions)

	Total	Hospital Inpatient	Hospital Outpatient	Emergency Room	Office-Based Medical Providers	Prescription	Vision/ Dental	Non-Medical Costs
Total	$2,319.5	$447.6	$206.7	$81.3	$565.6	$474.2	$225.9	$318.1
Federal expenditures								
Medicaid	440.5	108.4	47.5	18.4	94.9	68.4	31.1	71.9
SCHIP	36.2	3.8	0.2	1.1	2.8	3.1	19.6	5.6
Federal employees	58.7	12.7	5.1	2.7	15.2	9.1	5.0	8.8
TRICARE	116.5	0.9	4.3	11.1	21.4	62.4	7.0	9.5
VA	4.2	0.0	0.2	0.0	1.6	1.9	0.1	0.0
Other federal programs	14.8	0.1	0.5	2.7	9.1	0.3	0.9	1.2
State government								
Medicaid	171.9	42.3	18.5	7.2	37.0	26.7	12.1	28.1
SCHIP-SCI	1.2	0.2	0.0	0.2	0.2	0.3	0.0	0.2
Other SCHIP	7.6	0.8	0.0	0.1	0.5	0.4	4.8	1.1
State employees	77.0	14.5	6.3	3.0	21.8	15.0	4.8	11.6
Premium assistance	0.5	0.0	0.1	0.0	0.1	0.0	0.1	0.1
Other state programs	8.8	5.4	0.0	0.5	2.2	0.0	0.1	0.5
Private								
SCI premiums	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NMHIA	5.6	0.4	0.7	0.1	1.6	0.8	0.7	1.2
NMMIP	10.5	0.1	1.5	0.4	3.8	3.8	0.4	0.6
Privately insured	975.8	246.0	109.9	26.7	258.0	112.1	45.6	177.4
Out of pocket	389.6	12.0	11.9	7.0	95.3	169.8	93.6	0.0

Source: Mathematica Policy Research, Inc.

APPENDIX E

ESTIMATED NUMBER AND PERCENT OF NEW MEXICANS BY SOURCE OF COVERAGE IN THE REFORM MODELS AND CHANGE FROM THE CURRENT CASE, 2007

APPENDIX TABLE E.1

ESTIMATED NUMBER AND PERCENT OF NEW MEXICANS BY SOURCE OF COVERAGE: CURRENT CASE AND REFORM MODELS, 2007

	Current Case		Health Security Act		Health Choices v.1		Health Choices v.2		Health Coverage Plan	
	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent	Number (000s)	Percent
Total	1,679.1	100%	1,679.1	100%	1,679.1	100%	1,679.1	100%	1,679.1	100%
Uninsured	432.1	25.7	--	--	--	--	--	--	--	--
Employer sponsored coverage	707.9	42.2	31.9	1.9	31.3	1.9	150.4	9.0	829.8	49.4
Self-insured private employers	254.5	15.2	0.5	0.0	--	--	119.1	7.1	254.5	15.2
Insured private employers	378.1	22.5	--	--	--	--	--	--	497.2	29.6
NMHIA	5.0	0.3	--	--	--	--	--	--	7.8	0.5
State/local government	39.0	2.3	--	--	--	--	--	--	39.0	2.3
Federal government	31.3	1.9	31.3	1.9	31.3	1.9	31.3	1.9	31.3	1.9
Individual coverage	34.1	2.0	--	--	--	--	--	--	45.5	2.7
NMMIP	1.4	0.1	--	--	--	--	--	--	3.0	0.2
Other individual coverage	32.6	1.9	--	--	--	--	--	--	42.6	2.5
Public Insurance	505.0	30.1	842.9	50.2	1,013.5	60.4	999.4	59.5	803.8	47.9
Medicaid/SCHIP	431.9	25.7	778.1	46.3	948.6	56.5	934.6	55.7	659.4	39.3
SCI	8.2	0.5	--	--	--	--	--	--	79.5	4.7
TRICARE	64.8	3.9	64.8	3.9	64.8	3.9	64.8	3.9	64.8	3.9
New Program										
Health Security Plan	--	--	804.3	47.9	--	--	--	--	--	--
Health Choices Alliance	--	--	--	--	634.3	37.8	529.2	31.5	--	--

Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded.

APPENDIX TABLE E.2

ESTIMATED CHANGES IN COVERAGE: CURRENT CASE AND REFORM MODELS, 2007
(Persons in thousands)

	Predominant Source of Coverage in Current Case								
	Self-Insured Private Employer	Other Private Employer	Federal Government	State/Local Government	Non-group Insurance	Medicaid/ SCHIP	SCI/ SEIP	TRICARE	Uninsured
Health Security Act									
Self-insured private employer	0.5								
Other Private employer									
Federal government			31.3						
State/local government									
Non-group insurance									
Medicaid / SCHIP	5.4	110.2			3.0	431.9	0.1		227.5
SCI									
TRICARE								64.8	
Health Security Plan	248.6	272.9		39.0	31.0		8.1		204.6
Health Choices v.1									
Self-insured private employer									
Other Private employer									
Federal government			31.3						
State/local government									
Non-group insurance									
Medicaid / SCHIP	32.4	141.5			7.5	431.9	7.4		327.9
SCI									
TRICARE								64.8	
Health Choices Alliance	222.1	241.6		39.0	26.5		0.9		104.3
Health Choices v.2									
Self-insured private employer	119.1								
Other Private employer									
Federal government			31.3						
State/local government									
Non-group insurance									
Medicaid / SCHIP	18.4	141.5			7.5	431.9	7.4		327.9
SCI									
TRICARE								64.8	
Health Choices Alliance	117.1	241.6		39.0	26.5		0.9		104.3
Health Coverage Plan									
Self-insured private employer	254.5								
Other Private employer		383.1							121.9
Federal government			31.3						
State/local government				39.0					
Non-group insurance					34.1				11.5
Medicaid / SCHIP						431.9			227.5
SCI							8.2		71.3
TRICARE								64.8	

Source: Mathematica Policy Research, Inc.

Notes: Data include the noninstitutionalized civilian population under age 65. Medicare beneficiaries and active military personnel are excluded. If not otherwise specified, nongroup insurance includes NMMIP; insured private employer coverage includes NMHIA.

APPENDIX F

SOURCES OF COVERAGE FOR NEW MEXICANS IN THE REFORM MODELS BY SELECTED CHARACTERISTICS AND CURRENT SOURCES OF COVERAGE

TABLE F.1

ESTIMATED PERCENT OF POPULATION WITH PREDOMINANT GROUP INSURANCE IN THE CURRENT CASE BY TYPE OF COVERAGE IN REFORM MODELS

		Health Security Act			Health Choices v.1			Health Choices v.2			Health Coverage Plan		
	Total Population	Group	Medicaid/ SCHIP	Health Security Plan	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Private Non-Group	Medicaid/ SCHIP/ SCI/SEIP
Adults	158,585	8.9%	54.2%	36.9%	8.8%	54.2%	37.0%	16.1%	52.6%	31.4%	100.0%	0.0%	0.0%
Children	614,178	19.8	4.8	75.4	19.7	14.3	66.0	37.2	12.5	50.3	100.0	0.0	0.0
Below 300% FPL	309,367	19.2	33.4	47.3	19.1	52.3	28.6	30.2	47.9	21.9	100.0	0.0	0.0
Above 300% FPL	463,396	16.4	2.6	81.0	16.4	2.6	81.0	34.7	2.5	62.8	100.0	0.0	0.0
Full-time workers	425,804	17.1	2.8	80.1	17.1	11.3	71.6	38.3	9.3	52.3	100.0	0.0	0.0
Part-time workers	64,671	15.1	14.9	70.0	14.9	25.4	59.7	33.4	21.9	44.6	100.0	0.0	0.0
Unemployed/non-worker	282,288	18.7	33.3	48.0	18.7	38.7	42.6	24.6	37.5	37.9	100.0	0.0	0.0
MSA	508,113	14.3	11.1	74.6	14.3	18.8	67.0	32.2	17.1	50.8	100.0	0.0	0.0
Non-MSA	264,650	23.7	22.4	53.9	23.7	29.7	46.7	34.3	27.7	38.0	100.0	0.0	0.0

Source: Mathematica Policy Research, Inc.

Notes: Adults include non-institutionalized civilians age 19 through 64. Group insurance includes coverage from private employer, federal or state government, and TRICARE.

TABLE F.2

ESTIMATED PERCENT OF POPULATION WITH PREDOMINANT NON-GROUP PRIVATE INSURANCE IN CURRENT CASE BY TYPE OF COVERAGE IN REFORM MODELS

		Health Security Act			Health Choices v.1			Health Choices v.2			Health Coverage Plan		
	Total Population	Group	Medicaid/ SCHIP	Health Security Plan	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Private Non-Group	Medicaid/ SCHIP/ SCI
Adults	5,852	0.0%	50.7%	49.3%	0.0%	50.7%	49.3%	0.0%	50.7%	49.3%	0.0%	100.0%	0.0%
Children	28,217	0.0	0.2	99.8	0.0	16.2	83.8	0.0	16.2	83.8	0.0	100.0	0.0
Below 300% FPL	10,557	0.0	25.5	74.5	0.0	68.3	31.7	0.0	68.3	31.7	0.0	100.0	0.0
Above 300% FPL	23,513	0.0	1.4	98.6	0.0	1.4	98.6	0.0	1.4	98.6	0.0	100.0	0.0
Full-time workers	13,948	0.0	0.6	99.4	0.0	9.1	90.9	0.0	9.1	90.9	0.0	100.0	0.0
Part-time workers	5,641	0.0	0.8	99.2	0.0	5.1	94.9	0.0	5.1	94.9	0.0	100.0	0.0
Unemployed/non-worker	14,481	0.0	20.0	80.0	0.0	41.4	58.6	0.0	41.4	58.6	0.0	100.0	0.0
MSA	20,438	0.0	6.5	93.5	0.0	20.9	79.1	0.0	20.9	79.1	0.0	100.0	0.0
Non-MSA	13,631	0.0	12.5	87.5	0.0	24.0	76.0	0.0	24.0	76.0	0.0	100.0	0.0

Source: Mathematica Policy Research, Inc.

Note: Adults include non-institutionalized civilians age 19 through 64. Non-group private insurance includes NMMIP and other non-group coverage.

TABLE F.3

ESTIMATED PERCENT OF POPULATION WITH PREDOMINANT MEDICAID, SCHIP, OR SCI COVERAGE IN CURRENT CASE BY TYPE OF COVERAGE IN REFORM MODELS

		Health Security Act			Health Choices v.1			Health Choices v.2			Health Coverage Plan		
	Total Population	Group	Medicaid/ SCHIP	Health Security Plan	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Private Non-Group	Medicaid/ SCHIP/ SCI
Adults	292,344	0.0%	100.0%	0.0%	0.0	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Children	147,797	0.0	94.5	5.5	0.0	99.4	0.6	0.0	99.4	0.6	0.0	0.0	100.0
Below 300% FPL	418,213	0.0	98.2	1.8	0.0	99.9	0.1	0.0	99.9	0.1	0.0	0.0	100.0
Above 300% FPL	21,928	0.0	98.2	1.8	0.0	98.2	1.8	0.0	98.2	1.8	0.0	0.0	100.0
Full-time workers	44,333	0.0	95.6	4.4	0.0	99.2	0.8	0.0	99.2	0.8	0.0	0.0	100.0
Part-time workers	23,918	0.0	95.4	4.6	0.0	99.7	0.3	0.0	99.7	0.3	0.0	0.0	100.0
Unemployed/non-worker	371,890	0.0	98.6	1.4	0.0	99.9	0.1	0.0	99.9	0.1	0.0	0.0	100.0
MSA	297,326	0.0	97.9	2.1	0.0	99.7	0.3	0.0	99.7	0.3	0.0	0.0	100.0
Non-MSA	142,815	0.0	98.7	1.3	0.0	99.9	0.1	0.0	99.9	0.1	0.0	0.0	100.0

Source: Mathematica Policy Research, Inc.

Note: Adults include non-institutionalized civilians age 19 through 64.

TABLE F.4

ESTIMATED PERCENT OF POPULATION PREDOMINANTLY UNINSURED IN CURRENT CASE
BY TYPE OF COVERAGE IN REFORM MODELS

		Health Security Act			Health Choices v.1			Health Choices v.2			Health Coverage Plan		
	Total Population	Group	Medicaid/ SCHIP	Health Security Plan	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Medicaid/ SCHIP	Health Choices Alliance	Group	Private Non-Group	Medicaid/ SCHIP/ SCI/SEIP
Adults	131,476	0.0%	92.8%	7.2%	0.0%	92.8%	7.2%	0.0%	92.8%	7.2%	5.6%	1.6%	92.8%
Children	300,663	0.0	35.1	64.9	0.0	68.5	31.5	0.0	68.5	31.5	38.1	3.1	58.8
Below 300% FPL	355,464	0.0	60.6	39.4	0.0	88.9	11.1	0.0	88.9	11.1	19.4	0.0	80.6
Above 300% FPL	76,674	0.0	15.6	84.4	0.0	15.6	84.4	0.0	15.6	84.4	69.2	14.9	15.9
Full-time workers	130,141	0.0	30.2	69.8	0.0	57.5	42.5	0.0	57.5	42.5	53.5	1.9	44.6
Part-time workers	38,283	0.0	39.5	60.5	0.0	70.4	29.6	0.0	70.4	29.6	38.5	3.2	58.4
Unemployed/non-worker	263,715	0.0	65.6	34.4	0.0	85.7	14.3	0.0	85.7	14.3	14.2	2.9	82.8
MSA	224,137	0.0	40.5	59.5	0.0	69.6	30.4	0.0	69.6	30.4	36.0	3.2	60.9
Non-MSA	208,001	0.0	65.7	34.3	0.0	82.6	17.4	0.0	82.6	17.4	19.9	2.1	78.1

Source: Mathematica Policy Research, Inc.

Note: Adults include non-institutionalized civilians age 19 through 64.

APPENDIX G

DETAIL FOR ECONOMIC IMPACT ESTIMATES

APPENDIX G.1

ECONOMIC IMPACTS OF LEGISLATION TO INCREASE HEALTH CARE COVERAGE BY EXPANDING MEDICAID/SCHIP/SCI

The Revised Baseline reflects proposed changes from the 2007 legislative session. State Coverage Insurance (SCI) eligibility was to be expanded to include all adults below 100 percent Federal Poverty Level (FPL). The Administration also hopes to expand Medicaid eligibility to parents below 100 percent FPL after implementation of SCI eligibility expansion. Mathematica incorporates these assumed changes and estimates medical and insurance expenditures for 2007. Anticipated new liabilities lead Federal funds to comprise the majority of greater medical spending while private medical spending decreases. Federal spending increases by about $72 million while private spending decreases by about $8 million. The main effect of increased eligibility is increased spending on Hospitals and Office-based medical providers, accounting for about $57 and $27 million respectively. The increased spending is concentrated highly in the Metro Areas. **Table G.1.1** displays the changes in medical spending by source and type in thousands of dollars.

TABLE G.1.1

REVISED BASELINE - MEDICAL SPENDING CHANGES BY SOURCE AND TYPE IN $000s

	Rural Areas			Metropolitan Statisical Areas			
	Federal	State	Private	Federal	State	Private	Total
Health and personal care stores	1,859	542	(4,423)	5,980	1,670	(4,821)	807
Home health care services	230	90	0	139	54	(9)	504
Office-based medical provider	4,161	1,545	(1,821)	19,292	5,757	(2,125)	26,809
Other ambulatory health care services	18	7	2	374	101	124	625
Hospitals	9,064	3,359	(984)	30,778	9,523	5,738	57,477
Total	15,332	5,542	(7,226)	56,563	17,105	(1,094)	

The resulting economic impacts show expansion in the Health Care and Social Assistance sector, for both geographies, but much greater growth in the Metro Areas[1]. The Rural Area decrease in Retail Trade is the result of less private spending in Health and personal care stores. **Table G.1.2** summarizes employment, labor income and output impacts from the Revised Baseline.

Labor income[2] is converted to additional Wage and Salary for the state in **Table G.1.3**.

[1] Health and personal care stores are classified under Retail Trade while the remaining categories fall under Health Care and Social Assistance.

[2] Implan constructs labor income as employee compensation plus proprietors' income.

TABLE G.1.2

REVISED BASELINE - MEDICAL SERVICES IMPACTS

Rural Areas

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	0	1
21	Mining	0	0	0	1
22	Utilities	0	0	0	0
23	Construction	0	1	0	1
31-33	Manufacturing	0	1	0	1
42	Wholesale Trade	0	1	1	2
44-45	Retail Trade	-20	1	10	-9
48-49	Transportation & Warehousing	0	2	1	4
51	Information	0	0	1	1
52	Finance and Insurance	0	1	2	3
53	Real Estate & Rental Leasing	0	2	1	3
54	Professional, Scientific, & Technical	0	2	1	3
55	Mgt of Companies & Enterprises	0	0	0	0
56	Admin & Support & Waste Mgt & Remed	0	6	1	8
61	Educational Services	0	0	1	1
62	Health Care & Social Assistance	145	0	11	156
71	Arts, Entertainment, & Recreation	0	0	2	2
72	Accommodation & Food Services	0	4	8	12
81	Other Services	0	2	6	8
92	Public Administration	0	1	1	1
	Total	125	25	47	197

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	1	2	2
21	Mining	0	1	1	2
22	Utilities	0	1	2	3
23	Construction	0	3	2	5
31-33	Manufacturing	0	10	5	15
42	Wholesale Trade	0	6	10	15
44-45	Retail Trade	39	8	54	101
48-49	Transportation & Warehousing	0	12	8	20
51	Information	0	5	5	9
52	Finance and Insurance	0	9	13	22
53	Real Estate & Rental Leasing	0	30	18	48
54	Professional, Scientific, & Technical	0	22	12	33
55	Mgt of Companies & Enterprises	0	4	2	6
56	Admin & Support & Waste Mgt & Remed	0	52	15	67
61	Educational Services	0	2	10	12
62	Health Care & Social Assistance	583	2	64	648
71	Arts, Entertainment, & Recreation	0	3	12	15
72	Accommodation & Food Services	0	17	42	59
81	Other Services	0	7	33	40
92	Public Administration	0	2	4	6
	Total	622	194	312	1,128

TABLE G.1.2 *(continued)*

REVISED BASELINE - MEDICAL SERVICES IMPACTS, p. 2

Rural Areas

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	5,513	17,730	23,243
21	Mining	0	21,331	22,458	43,789
22	Utilities	0	12,385	22,313	34,698
23	Construction	0	18,112	10,524	28,636
31-33	Manufacturing	0	66,939	22,544	89,483
42	Wholesale Trade	0	30,526	44,861	75,387
44-45	Retail Trade	-472,044	26,123	225,843	-220,078
48-49	Transportation & Warehousing	0	106,291	53,078	159,369
51	Information	0	17,400	24,877	42,277
52	Finance and Insurance	0	56,752	62,486	119,238
53	Real Estate & Rental Leasing	0	46,863	26,482	73,345
54	Professional, Scientific, & Technical	0	89,113	38,024	127,137
55	Mgt of Companies & Enterprises	0	12,067	5,921	17,988
56	Admin & Support & Waste Mgt & Remed	0	172,935	37,415	210,350
61	Educational Services	0	1,569	16,817	18,386
62	Health Care & Social Assistance	6,958,717	10,200	359,816	7,328,733
71	Arts, Entertainment, & Recreation	0	1,721	24,996	26,717
72	Accommodation & Food Services	0	52,832	109,931	162,763
81	Other Services	0	34,585	95,804	130,389
92	Public Administration	-3,745	31,467	43,907	71,629
	Total	6,482,928	814,724	1,265,827	8,563,479

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	21,317	63,192	84,509
21	Mining	0	57,226	87,137	144,363
22	Utilities	0	111,051	165,779	276,830
23	Construction	0	122,347	86,610	208,957
31-33	Manufacturing	0	636,954	270,025	906,979
42	Wholesale Trade	0	278,834	472,985	751,819
44-45	Retail Trade	1,021,560	204,225	1,504,182	2,729,967
48-49	Transportation & Warehousing	0	569,208	344,874	914,082
51	Information	0	209,670	215,344	425,014
52	Finance and Insurance	0	544,115	690,981	1,235,096
53	Real Estate & Rental Leasing	0	599,420	361,996	961,416
54	Professional, Scientific, & Technical	0	1,065,002	534,255	1,599,257
55	Mgt of Companies & Enterprises	0	272,154	109,094	381,248
56	Admin & Support & Waste Mgt & Remed	0	1,238,329	356,232	1,594,561
61	Educational Services	0	33,142	217,733	250,875
62	Health Care & Social Assistance	33,390,380	82,517	2,460,766	35,933,663
71	Arts, Entertainment, & Recreation	0	29,541	164,360	193,901
72	Accommodation & Food Services	0	279,078	691,854	970,932
81	Other Services	0	208,960	688,632	897,592
92	Public Administration	9,843	104,114	181,844	295,801
	Total	34,421,783	6,667,204	9,667,875	50,756,862

TABLE G.1.2 *(continued)*

REVISED BASELINE - MEDICAL SERVICES IMPACTS, p. 3

Rural Areas

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	19,857	58,625	78,482
21	Mining	0	90,311	103,853	194,164
22	Utilities	0	64,000	117,369	181,369
23	Construction	0	47,515	28,176	75,691
31-33	Manufacturing	0	306,197	256,078	562,275
42	Wholesale Trade	0	81,204	119,337	200,541
44-45	Retail Trade	-1,116,579	70,092	574,380	-472,107
48-49	Transportation & Warehousing	0	188,315	136,778	325,093
51	Information	0	91,450	130,162	221,612
52	Finance and Insurance	0	138,097	222,651	360,748
53	Real Estate & Rental Leasing	0	254,250	126,853	381,103
54	Professional, Scientific, & Technical	0	201,176	87,751	288,927
55	Mgt of Companies & Enterprises	0	32,796	16,094	48,890
56	Admin & Support & Waste Mgt & Remed	0	326,598	82,374	408,972
61	Educational Services	0	3,662	31,772	35,434
62	Health Care & Social Assistance	14,017,069	31,624	712,494	14,761,187
71	Arts, Entertainment, & Recreation	0	6,453	66,538	72,991
72	Accommodation & Food Services	0	174,779	366,092	540,871
81	Other Services	0	92,276	249,039	341,315
92	Public Administration	-4,494	101,451	763,766	860,723
	Total	12,895,996	2,322,103	4,250,182	19,468,281

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	59,669	180,379	240,048
21	Mining	0	267,952	409,737	677,689
22	Utilities	0	555,346	830,183	1,385,529
23	Construction	0	297,224	211,822	509,046
31-33	Manufacturing	0	3,327,178	1,861,816	5,188,994
42	Wholesale Trade	0	742,001	1,258,656	2,000,657
44-45	Retail Trade	2,359,654	550,220	3,797,918	6,707,792
48-49	Transportation & Warehousing	0	997,859	834,449	1,832,308
51	Information	0	942,387	1,049,438	1,991,825
52	Finance and Insurance	0	1,261,376	2,225,880	3,487,256
53	Real Estate & Rental Leasing	0	3,358,932	1,922,204	5,281,136
54	Professional, Scientific, & Technical	0	2,299,125	1,167,470	3,466,595
55	Mgt of Companies & Enterprises	0	659,167	264,229	923,396
56	Admin & Support & Waste Mgt & Remed	0	2,312,769	746,342	3,059,111
61	Educational Services	0	73,833	430,519	504,352
62	Health Care & Social Assistance	63,468,987	228,089	4,656,468	68,353,544
71	Arts, Entertainment, & Recreation	0	76,709	407,154	483,863
72	Accommodation & Food Services	0	850,705	2,126,392	2,977,097
81	Other Services	0	530,842	1,595,935	2,126,777
92	Public Administration	8,963	294,016	4,211,909	4,514,888
	Total	65,837,604	19,685,399	30,188,900	115,711,903

TABLE G.1.3

ADDITIONAL WAGE AND SALARY DISBURSEMENTS

	New Mexico	Average Wage	Revised Baseline
11	Agric, Forestry, Fishing, Hunting	27,246	31
21	Mining	61,589	104
22	Utilities		-
23	Construction	36,379	168
31-33	Manufacturing	45,344	607
42	Wholesale Trade	45,582	641
44-45	Retail Trade	24,683	1,869
	Transport, Whsg, Utilities	45,257	996
48-49	Transportation & Warehousing	34,575	654
51	Information	40,438	354
	Financial Activities	40,559	1,318
52	Finance and Insurance		-
53	Real Estate & Rental Leasing		-
	Professional & Business	50,555	4,449
54	Professional, Scientific, & Technical		-
55	Mgt of Companies & Enterprises		-
56	Admin & Support & Waste Mgt & Remed		-
61	Educational Services	26,687	234
62	Health Care & Social Assistance	34,752	23,440
71	Arts, Entertainment, & Recreation	19,186	127
72	Accommodation & Food Services	14,647	980
81	Other Services	23,302	791
92	Public Administration1[1]	34,627	256
			36,366

1. General government. To estimate impacts, assumed similar labor and material input use as Admin & Support services.

UNM BBER Estimates

APPENDIX G.2

ECONOMIC IMPACT ANALYSIS USING IMPLAN

Any change in direct local expenditure associated with a program will have "ripple" effects throughout the economy. In other words, each dollar of additional direct expenditure generates more than one dollar in economic activity. Expenditures could be the hiring of employees or the purchases of goods and services. Employees and vendors then spend their money in the community generating additional local economic impacts. How this additional expenditure is financed, however, is critical. If the increase in spending comes from the federal government or is otherwise financed by a flow of dollars into the state (e.g., a national firm investing in new plant in New Mexico), then one can include the full effects of the new spending. However, where an increase in spending in one area is financed by taxing or imposing fees on local households or businesses, the negative impacts of their spending decisions must also be taken into account.

Each industry in an economy makes a certain amount of goods or services that are either used by other industries, purchased by institutions (households, government, etc), or exported outside of the region of analysis. Additionally, each industry uses as inputs goods and services from other industries as well as purchasing inputs from households (labor services) and imports from outside the region. These transactions within the region and without are assembled mathematically to determine the multiplier effect, i.e., the total impacts in terms of employment, income or output as an expansion or contraction of activity ripples through the economy. The expenditures by one industry on the goods and services produced by other industries create *indirect* effects as those transactions stimulate changes in output, employment and income. The payments to institutions (e.g., households) create *induced* effects as those institutions spend those payments in the region, stimulating expansion by the businesses from which goods and services are purchased and resulting in increased employment, income and output.

Direct *These are the direct expenditures on equipment, material inputs, services, and labor. Some of the direct expenditures "leak" out of the economy when they are used to import goods and services.*

Indirect *The indirect impact is the additional economic activity generated by the local vendors. The impact is created when the local vendors receive payment for goods and services and then spend that money. Some of this second round of spending in turn will leak out of the economy.*

Induced *The induced impact is the increase in household expenditures that arise from the wages and salaries paid directly and indirectly. Portions of the increased spending are leaked outside the area through imports, taxes and savings.*

Using an *input-output* (I-O) model, appropriate multipliers for the indirect and induced effects can be developed that will show how the production of a particular industry affects the rest of the regional economy. An I-O model measures the interactions among hundreds of industries using the BEA "Make" and "Use" tables.[3] For this study, the classification of expenditures by detailed industry, the in-state share of expenditures and the estimation of economic impacts on output, labor income and employment were determined using IMPLAN Pro 2.0.[4] IMPLAN is a regional economic modeling and impact analysis application that works with proprietary input-output databases that capture the multipliers for the state and for the counties. IMPLAN calculates how much of any given expenditure stays in the state and traces the economic impact on New Mexico industries. IMPLAN is widely used in performing economic impact analyses. BBER has validated IMPLAN results for New Mexico in other studies, where both IMPLAN and BBER's FOR-UNM economic forecasting model have been used to estimate economic impacts.

Impacts are denoted in the tables in this study as "employment," which includes both full and part-time jobs, and "income," which is actually employee compensation, including benefits, and proprietor's income.[5]

Regional Purchase Coefficients (RPC)

"The Regional Purchase Coefficient represents the proportion of local demand purchased from local suppliers."[6] RPC's are a critical component of this analysis. IMPLAN calculates the RPC for each industry based on a set of econometric models. These calculations determine the extent to which a particular commodity can be purchased locally.

Economic Impact

The analysis of alternative models for providing universal coverage separately examines the changes from baseline in spending on health services, on insurance services and on

[3] The Bureau of Economic Analysis produces these tables as part of their Regional Economic Information Service (REIS) and updates them every five years.

[4] Minnesota IMPLAN Group, Inc., IMPLAN System (data and software), 1725 Tower Drive West, Suite 140, Stillwater, MN 55082 www.IMPLAN.com

[5] In the tables in this study, "Direct Output" refers to direct expenditures on goods, services, and payroll.

[6] Minnesota IMPLAN Group, Inc. IMPLAN Professional Version 2.0: Analysis Guide, Feb 2004.

government administration. It then asks the question of how these changes in overall expenditures are financed and separately analyzes these impacts. To the extent that the flow of additional funding from the federal governments covers additional costs there is less need to raise monies from households and businesses, but any redistribution of financial burden may also be expected to have economic impacts that should properly be analyzed.

APPENDIX G.3

ECONOMIC IMPACTS OF CHANGES IN HEALTH EXPENDITURES UNDER ALTERNATIVE MODELS

TABLE G.3.1

HEALTH SECURITY ACT 1 - MEDICAL SERVICES IMPACTS

Rural Areas

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	0	0
21	Mining	0	0	0	1
22	Utilities	0	1	0	1
23	Construction	0	1	0	2
31-33	Manufacturing	0	1	0	1
42	Wholesale Trade	0	0	2	2
44-45	Retail Trade	435	5	11	451
48-49	Transportation & Warehousing	0	5	2	7
51	Information	0	6	1	7
52	Finance and Insurance	0	2	2	4
53	Real Estate & Rental Leasing	0	3	1	5
54	Professional, Scientific, & Technical	0	5	1	6
55	Mgt of Companies & Enterprises	0	3	0	3
56	Admin & Support & Waste Mgt & Remed	0	-1	2	1
61	Educational Services	0	0	1	1
62	Health Care & Social Assistance	148	2	13	162
71	Arts, Entertainment, & Recreation	0	1	2	3
72	Accommodation & Food Services	0	5	10	15
81	Other Services	0	3	8	10
92	Public Administration	6	1	1	8
	Total	588	43	56	687

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	-1	-1
21	Mining	0	0	-1	0
22	Utilities	0	1	-1	0
23	Construction	0	1	-1	0
31-33	Manufacturing	0	-10	-2	-13
42	Wholesale Trade	0	-4	-5	-9
44-45	Retail Trade	1,092	7	-28	1,071
48-49	Transportation & Warehousing	0	-1	-4	-5
51	Information	0	9	-3	6
52	Finance and Insurance	0	-1	-7	-8
53	Real Estate & Rental Leasing	0	-3	-9	-12
54	Professional, Scientific, & Technical	0	-7	-6	-13
55	Mgt of Companies & Enterprises	0	11	-1	10
56	Admin & Support & Waste Mgt & Remed	0	-35	-8	-42
61	Educational Services	0	-1	-6	-6
62	Health Care & Social Assistance	-749	-1	-34	-783
71	Arts, Entertainment, & Recreation	0	4	-6	-2
72	Accommodation & Food Services	0	-10	-22	-33
81	Other Services	0	-1	-17	-18
92	Public Administration	9	0	-2	7
	Total	353	-41	-164	147

TABLE G.3.1 *(continued)*

HEALTH SECURITY ACT 1 - MEDICAL SERVICES IMPACTS, p. 2

Rural Areas

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	708	20,995	21,703
21	Mining	0	26,855	26,592	53,447
22	Utilities	0	55,946	26,420	82,366
23	Construction	0	46,878	12,460	59,338
31-33	Manufacturing	0	105,709	26,698	132,407
42	Wholesale Trade	0	7,607	53,118	60,725
44-45	Retail Trade	10,531,952	111,837	267,411	10,911,200
48-49	Transportation & Warehousing	0	190,606	62,845	253,451
51	Information	0	181,261	29,458	210,719
52	Finance and Insurance	0	77,946	73,988	151,934
53	Real Estate & Rental Leasing	0	75,439	31,355	106,794
54	Professional, Scientific, & Technical	0	170,467	45,019	215,486
55	Mgt of Companies & Enterprises	0	119,710	7,011	126,721
56	Admin & Support & Waste Mgt & Remed	0	-45,635	44,303	-1,332
61	Educational Services	0	1,037	19,912	20,949
62	Health Care & Social Assistance	6,876,586	64,094	426,035	7,366,715
71	Arts, Entertainment, & Recreation	0	6,040	29,594	35,634
72	Accommodation & Food Services	0	68,121	130,164	198,285
81	Other Services	0	61,730	113,436	175,166
92	Public Administration	83,565	70,344	51,987	205,896
	Total	17,492,103	1,396,700	1,498,801	20,387,604

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	-16,113	-33,263	-49,376
21	Mining	0	29,126	-45,866	-16,740
22	Utilities	0	96,226	-87,253	8,973
23	Construction	0	33,339	-45,598	-12,259
31-33	Manufacturing	0	-694,430	-142,148	-836,578
42	Wholesale Trade	0	-210,545	-248,982	-459,527
44-45	Retail Trade	28,729,820	175,637	-791,857	28,113,600
48-49	Transportation & Warehousing	0	-116,662	-181,567	-298,229
51	Information	0	412,792	-113,363	299,429
52	Finance and Insurance	0	-185,938	-363,769	-549,707
53	Real Estate & Rental Leasing	0	-64,717	-190,519	-255,236
54	Professional, Scientific, & Technical	0	-435,216	-281,255	-716,471
55	Mgt of Companies & Enterprises	0	676,576	-57,431	619,145
56	Admin & Support & Waste Mgt & Remed	0	-829,224	-187,541	-1,016,765
61	Educational Services	0	-19,477	-114,688	-134,165
62	Health Care & Social Assistance	-43,676,766	-51,650	-1,295,465	-45,023,881
71	Arts, Entertainment, & Recreation	0	29,855	-86,543	-56,688
72	Accommodation & Food Services	0	-161,651	-364,264	-525,915
81	Other Services	0	-14,069	-362,597	-376,666
92	Public Administration	276,814	-903	-95,727	180,184
	Total	-14,670,132	-1,347,044	-5,089,696	-21,106,872

TABLE G.3.1 *(continued)*

HEALTH SECURITY ACT 1 - MEDICAL SERVICES IMPACTS, p. 3

Rural Areas

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	4,051	69,414	73,465
21	Mining	0	145,608	122,967	268,575
22	Utilities	0	283,566	138,971	422,537
23	Construction	0	118,058	33,361	151,419
31-33	Manufacturing	0	365,645	303,209	668,854
42	Wholesale Trade	0	20,235	141,302	161,537
44-45	Retail Trade	24,912,384	300,069	680,096	25,892,549
48-49	Transportation & Warehousing	0	363,966	161,951	525,917
51	Information	0	808,490	154,118	962,608
52	Finance and Insurance	0	268,176	263,634	531,810
53	Real Estate & Rental Leasing	0	398,043	150,202	548,245
54	Professional, Scientific, & Technical	0	418,813	103,900	522,713
55	Mgt of Companies & Enterprises	0	325,361	19,056	344,417
56	Admin & Support & Waste Mgt & Remed	0	22,635	97,534	120,169
61	Educational Services	0	2,530	37,618	40,148
62	Health Care & Social Assistance	12,055,426	198,683	843,619	13,097,728
71	Arts, Entertainment, & Recreation	0	22,795	78,783	101,578
72	Accommodation & Food Services	0	223,710	433,473	657,183
81	Other Services	0	176,895	294,870	471,765
92	Public Administration	100,266	253,181	904,330	1,257,777
	Total	37,068,076	4,720,510	5,032,408	46,820,994

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	-49,353	-94,947	-144,300
21	Mining	0	137,342	-215,670	-78,328
22	Utilities	0	486,320	-436,941	49,379
23	Construction	0	62,261	-111,523	-49,262
31-33	Manufacturing	0	-3,370,438	-980,023	-4,350,461
42	Wholesale Trade	0	-560,279	-662,565	-1,222,844
44-45	Retail Trade	66,361,688	473,199	-1,999,361	64,835,526
48-49	Transportation & Warehousing	0	-80,489	-439,312	-519,801
51	Information	0	1,393,120	-552,450	840,670
52	Finance and Insurance	0	-245,794	-1,171,868	-1,417,662
53	Real Estate & Rental Leasing	0	-376,400	-1,011,606	-1,388,006
54	Professional, Scientific, & Technical	0	-795,616	-614,606	-1,410,222
55	Mgt of Companies & Enterprises	0	1,638,690	-139,099	1,499,591
56	Admin & Support & Waste Mgt & Remed	0	-1,346,431	-392,918	-1,739,349
61	Educational Services	0	-42,753	-226,758	-269,511
62	Health Care & Social Assistance	-79,305,780	-142,908	-2,451,401	-81,900,089
71	Arts, Entertainment, & Recreation	0	69,419	-214,386	-144,967
72	Accommodation & Food Services	0	-498,119	-1,119,552	-1,617,671
81	Other Services	0	24,155	-840,331	-816,176
92	Public Administration	252,071	39,275	-2,217,958	-1,926,612
	Total	-12,692,021	-3,184,799	-15,893,275	-31,770,095

TABLE G.3.1 *(continued)*

HEALTH SECURITY ACT 2 - MEDICAL SERVICES IMPACTS

Rural Areas

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	2	2
21	Mining	0	1	1	2
22	Utilities	0	1	1	2
23	Construction	0	3	1	4
31-33	Manufacturing	0	3	2	5
42	Wholesale Trade	0	2	5	7
44-45	Retail Trade	435	8	35	478
48-49	Transportation & Warehousing	0	11	5	16
51	Information	0	8	2	10
52	Finance and Insurance	0	5	6	10
53	Real Estate & Rental Leasing	0	7	4	11
54	Professional, Scientific, & Technical	0	10	4	14
55	Mgt of Companies & Enterprises	0	3	1	4
56	Admin & Support & Waste Mgt & Remed	0	13	5	18
61	Educational Services	0	0	3	3
62	Health Care & Social Assistance	471	3	38	512
71	Arts, Entertainment, & Recreation	0	1	5	7
72	Accommodation & Food Services	0	13	30	43
81	Other Services	0	6	22	28
92	Public Administration	6	2	3	12
	Total	911	101	174	1,186

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	2	2
21	Mining	0	1	1	3
22	Utilities	0	3	2	5
23	Construction	0	5	3	8
31-33	Manufacturing	0	7	6	12
42	Wholesale Trade	0	4	11	15
44-45	Retail Trade	1,092	18	62	1,172
48-49	Transportation & Warehousing	0	17	9	27
51	Information	0	16	6	22
52	Finance and Insurance	0	11	15	26
53	Real Estate & Rental Leasing	0	40	20	60
54	Professional, Scientific, & Technical	0	26	13	39
55	Mgt of Companies & Enterprises	0	17	2	19
56	Admin & Support & Waste Mgt & Remed	0	51	17	68
61	Educational Services	0	1	12	13
62	Health Care & Social Assistance	190	2	73	265
71	Arts, Entertainment, & Recreation	0	9	14	23
72	Accommodation & Food Services	0	15	49	64
81	Other Services	0	10	38	48
92	Public Administration	9	3	4	17
	Total	1,291	255	359	1,905

TABLE G.3.1 *(continued)*

HEALTH SECURITY ACT 2 - MEDICAL SERVICES IMPACTS, p. 2

Rural Areas

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	10,098	64,265	74,363
21	Mining	0	69,707	81,396	151,103
22	Utilities	0	83,655	80,875	164,530
23	Construction	0	87,035	38,143	125,178
31-33	Manufacturing	0	295,622	81,724	377,346
42	Wholesale Trade	0	67,439	162,597	230,036
44-45	Retail Trade	10,531,952	175,139	818,548	11,525,639
48-49	Transportation & Warehousing	0	434,765	192,366	627,131
51	Information	0	245,434	90,169	335,603
52	Finance and Insurance	0	192,652	226,480	419,132
53	Real Estate & Rental Leasing	0	174,490	95,980	270,470
54	Professional, Scientific, & Technical	0	378,303	137,804	516,107
55	Mgt of Companies & Enterprises	0	155,714	21,461	177,175
56	Admin & Support & Waste Mgt & Remed	0	324,235	135,608	459,843
61	Educational Services	0	3,635	60,947	64,582
62	Health Care & Social Assistance	22,756,751	98,955	1,304,064	24,159,770
71	Arts, Entertainment, & Recreation	0	10,469	90,585	101,054
72	Accommodation & Food Services	0	181,090	398,431	579,521
81	Other Services	0	132,419	347,215	479,634
92	Public Administration	83,565	136,332	159,136	379,033
	Total	33,372,268	3,257,188	4,587,794	41,217,250

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	12,417	72,615	85,032
21	Mining	0	107,369	100,136	207,505
22	Utilities	0	244,617	190,509	435,126
23	Construction	0	209,484	99,529	309,013
31-33	Manufacturing	0	366,711	310,297	677,008
42	Wholesale Trade	0	200,972	543,535	744,507
44-45	Retail Trade	28,729,820	471,056	1,728,538	30,929,414
48-49	Transportation & Warehousing	0	763,407	396,316	1,159,723
51	Information	0	744,063	247,465	991,528
52	Finance and Insurance	0	569,262	794,046	1,363,308
53	Real Estate & Rental Leasing	0	800,651	415,994	1,216,645
54	Professional, Scientific, & Technical	0	1,177,055	613,941	1,790,996
55	Mgt of Companies & Enterprises	0	1,057,234	125,366	1,182,600
56	Admin & Support & Waste Mgt & Remed	0	1,213,124	409,365	1,622,489
61	Educational Services	0	20,728	250,205	270,933
62	Health Care & Social Assistance	11,053,709	104,105	2,827,804	13,985,618
71	Arts, Entertainment, & Recreation	0	75,050	188,874	263,924
72	Accommodation & Food Services	0	255,482	795,045	1,050,527
81	Other Services	0	282,996	791,343	1,074,339
92	Public Administration	276,814	145,822	208,968	631,604
	Total	40,060,343	8,821,605	11,109,891	59,991,839

TABLE G.3.1 *(continued)*

HEALTH SECURITY ACT 2 - MEDICAL SERVICES IMPACTS, p. 3

Rural Areas

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	37,250	212,477	249,727
21	Mining	0	328,858	376,404	705,262
22	Utilities	0	425,859	425,394	851,253
23	Construction	0	222,999	102,114	325,113
31-33	Manufacturing	0	1,060,671	928,134	1,988,805
42	Wholesale Trade	0	179,398	432,530	611,928
44-45	Retail Trade	24,912,384	469,907	2,081,793	27,464,084
48-49	Transportation & Warehousing	0	789,167	495,724	1,284,891
51	Information	0	1,130,892	471,755	1,602,647
52	Finance and Insurance	0	574,730	806,997	1,381,727
53	Real Estate & Rental Leasing	0	932,742	459,773	1,392,515
54	Professional, Scientific, & Technical	0	892,684	318,038	1,210,722
55	Mgt of Companies & Enterprises	0	423,216	58,329	481,545
56	Admin & Support & Waste Mgt & Remed	0	724,306	298,543	1,022,849
61	Educational Services	0	8,616	115,142	123,758
62	Health Care & Social Assistance	42,172,799	306,773	2,582,257	45,061,829
71	Arts, Entertainment, & Recreation	0	39,456	241,144	280,600
72	Accommodation & Food Services	0	596,643	1,326,856	1,923,499
81	Other Services	0	363,845	902,569	1,266,414
92	Public Administration	100,266	467,451	2,768,094	3,335,811
	Total	67,185,449	9,975,463	15,404,067	92,564,979

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	26,897	207,285	234,182
21	Mining	0	503,484	470,856	974,340
22	Utilities	0	1,227,936	954,016	2,181,952
23	Construction	0	491,084	243,416	734,500
31-33	Manufacturing	0	1,550,412	2,139,528	3,689,940
42	Wholesale Trade	0	534,804	1,446,394	1,981,198
44-45	Retail Trade	66,361,688	1,269,112	4,364,397	71,995,197
48-49	Transportation & Warehousing	0	1,431,594	958,910	2,390,504
51	Information	0	2,918,564	1,205,968	4,124,532
52	Finance and Insurance	0	1,584,514	2,557,879	4,142,393
53	Real Estate & Rental Leasing	0	4,468,898	2,208,928	6,677,826
54	Professional, Scientific, & Technical	0	2,686,106	1,341,603	4,027,709
55	Mgt of Companies & Enterprises	0	2,560,656	303,640	2,864,296
56	Admin & Support & Waste Mgt & Remed	0	2,410,311	857,663	3,267,974
61	Educational Services	0	46,939	494,727	541,666
62	Health Care & Social Assistance	20,224,768	287,639	5,351,008	25,863,415
71	Arts, Entertainment, & Recreation	0	187,169	467,882	655,051
72	Accommodation & Food Services	0	772,803	2,443,549	3,216,352
81	Other Services	0	762,863	1,833,970	2,596,833
92	Public Administration	252,071	449,572	4,840,106	5,541,749
	Total	86,838,527	26,171,357	34,691,725	147,701,609

TABLE G.3.1 *(continued)*

HEALTH CHOICES 1 - MEDICAL SERVICES IMPACTS,

Rural Areas

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	2	3
21	Mining	0	1	1	2
22	Utilities	0	1	1	3
23	Construction	0	3	1	4
31-33	Manufacturing	0	4	2	6
42	Wholesale Trade	0	2	6	8
44-45	Retail Trade	479	9	42	530
48-49	Transportation & Warehousing	0	12	6	19
51	Information	0	9	3	12
52	Finance and Insurance	0	5	7	12
53	Real Estate & Rental Leasing	0	8	5	13
54	Professional, Scientific, & Technical	0	12	5	17
55	Mgt of Companies & Enterprises	0	4	1	4
56	Admin & Support & Waste Mgt & Remed	0	17	6	23
61	Educational Services	0	0	4	4
62	Health Care & Social Assistance	549	3	46	598
71	Arts, Entertainment, & Recreation	0	2	7	8
72	Accommodation & Food Services	0	15	36	51
81	Other Services	0	7	27	34
92	Public Administration	6	3	4	13
	Total	1,034	119	211	1,364

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	3	3
21	Mining	0	2	2	3
22	Utilities	0	3	3	6
23	Construction	0	7	3	10
31-33	Manufacturing	0	10	7	17
42	Wholesale Trade	0	5	15	20
44-45	Retail Trade	1,243	22	81	1,346
48-49	Transportation & Warehousing	0	22	12	34
51	Information	0	19	7	27
52	Finance and Insurance	0	14	20	33
53	Real Estate & Rental Leasing	0	49	27	77
54	Professional, Scientific, & Technical	0	33	18	50
55	Mgt of Companies & Enterprises	0	19	3	22
56	Admin & Support & Waste Mgt & Remed	0	66	23	89
61	Educational Services	0	1	16	17
62	Health Care & Social Assistance	336	3	97	436
71	Arts, Entertainment, & Recreation	0	11	19	29
72	Accommodation & Food Services	0	20	64	84
81	Other Services	0	12	50	62
92	Public Administration	11	4	6	20
	Total	1,590	320	474	2,384

TABLE G.3.1 *(continued)*

HEALTH CHOICES 1 - MEDICAL SERVICES IMPACTS, p. 2

Rural Areas

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	11,528	77,608	89,136
21	Mining	0	81,957	98,296	180,253
22	Utilities	0	94,227	97,668	191,895
23	Construction	0	99,768	46,062	145,830
31-33	Manufacturing	0	354,637	98,693	453,330
42	Wholesale Trade	0	80,868	196,359	277,227
44-45	Retail Trade	11,595,093	200,537	988,513	12,784,143
48-49	Transportation & Warehousing	0	507,898	232,310	740,208
51	Information	0	281,661	108,894	390,555
52	Finance and Insurance	0	222,633	273,509	496,142
53	Real Estate & Rental Leasing	0	202,168	115,912	318,080
54	Professional, Scientific, & Technical	0	441,148	166,421	607,569
55	Mgt of Companies & Enterprises	0	178,126	25,917	204,043
56	Admin & Support & Waste Mgt & Remed	0	426,159	163,763	589,922
61	Educational Services	0	4,047	73,600	77,647
62	Health Care & Social Assistance	26,553,211	111,963	1,574,828	28,240,002
71	Arts, Entertainment, & Recreation	0	12,169	109,393	121,562
72	Accommodation & Food Services	0	209,728	481,162	690,890
81	Other Services	0	151,917	419,307	571,224
92	Public Administration	92,000	155,771	192,179	439,950
	Total	38,240,304	3,828,910	5,540,394	47,609,608

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	15,937	95,858	111,795
21	Mining	0	128,281	132,182	260,463
22	Utilities	0	290,462	251,474	541,936
23	Construction	0	255,287	131,384	386,671
31-33	Manufacturing	0	553,418	409,611	963,029
42	Wholesale Trade	0	264,013	717,487	981,500
44-45	Retail Trade	32,704,906	565,030	2,281,754	35,551,690
48-49	Transportation & Warehousing	0	966,112	523,159	1,489,271
51	Information	0	889,999	326,666	1,216,665
52	Finance and Insurance	0	706,734	1,048,182	1,754,916
53	Real Estate & Rental Leasing	0	990,949	549,115	1,540,064
54	Professional, Scientific, & Technical	0	1,506,248	810,434	2,316,682
55	Mgt of Companies & Enterprises	0	1,237,781	165,489	1,403,270
56	Admin & Support & Waste Mgt & Remed	0	1,588,275	540,385	2,128,660
61	Educational Services	0	25,197	330,306	355,503
62	Health Care & Social Assistance	19,786,340	142,645	3,732,848	23,661,833
71	Arts, Entertainment, & Recreation	0	90,585	249,327	339,912
72	Accommodation & Food Services	0	333,329	1,049,514	1,382,843
81	Other Services	0	347,865	1,044,635	1,392,500
92	Public Administration	315,115	178,806	275,846	769,767
	Total	52,806,361	11,076,953	14,665,656	78,548,970

TABLE G.3.1 *(continued)*

HEALTH CHOICES 1 - MEDICAL SERVICES IMPACTS, p. 3

Rural Areas

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	41,879	256,595	298,474
21	Mining	0	383,057	454,564	837,621
22	Utilities	0	479,696	513,727	993,423
23	Construction	0	255,820	123,316	379,136
31-33	Manufacturing	0	1,253,834	1,120,857	2,374,691
42	Wholesale Trade	0	215,120	522,344	737,464
44-45	Retail Trade	27,427,146	538,058	2,514,066	30,479,270
48-49	Transportation & Warehousing	0	918,640	598,658	1,517,298
51	Information	0	1,303,404	569,713	1,873,117
52	Finance and Insurance	0	668,115	974,569	1,642,684
53	Real Estate & Rental Leasing	0	1,080,857	555,242	1,636,099
54	Professional, Scientific, & Technical	0	1,039,664	384,075	1,423,739
55	Mgt of Companies & Enterprises	0	484,129	70,441	554,570
56	Admin & Support & Waste Mgt & Remed	0	922,557	360,533	1,283,090
61	Educational Services	0	9,601	139,047	148,648
62	Health Care & Social Assistance	48,811,437	347,099	3,118,414	52,276,950
71	Arts, Entertainment, & Recreation	0	45,887	291,209	337,096
72	Accommodation & Food Services	0	690,587	1,602,369	2,292,956
81	Other Services	0	415,928	1,089,965	1,505,893
92	Public Administration	110,387	533,145	3,342,838	3,986,370
	Total	76,348,970	11,627,077	18,602,542	106,578,589

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	34,650	273,623	308,273
21	Mining	0	601,463	621,543	1,223,006
22	Utilities	0	1,457,686	1,259,314	2,717,000
23	Construction	0	599,993	321,325	921,318
31-33	Manufacturing	0	2,216,467	2,824,242	5,040,709
42	Wholesale Trade	0	702,561	1,909,298	2,611,859
44-45	Retail Trade	75,543,560	1,522,296	5,761,217	82,827,073
48-49	Transportation & Warehousing	0	1,787,912	1,265,818	3,053,730
51	Information	0	3,521,457	1,591,933	5,113,390
52	Finance and Insurance	0	1,970,256	3,376,551	5,346,807
53	Real Estate & Rental Leasing	0	5,530,529	2,915,790	8,446,319
54	Professional, Scientific, & Technical	0	3,418,373	1,770,985	5,189,358
55	Mgt of Companies & Enterprises	0	2,997,947	400,819	3,398,766
56	Admin & Support & Waste Mgt & Remed	0	3,119,816	1,132,162	4,251,978
61	Educational Services	0	57,045	653,103	710,148
62	Health Care & Social Assistance	34,898,573	394,162	7,063,615	42,356,350
71	Arts, Entertainment, & Recreation	0	226,468	617,642	844,110
72	Accommodation & Food Services	0	1,009,173	3,225,651	4,234,824
81	Other Services	0	928,464	2,420,987	3,349,451
92	Public Administration	286,948	546,535	6,389,394	7,222,877
	Total	110,729,081	32,643,253	45,795,012	189,167,346

TABLE G.3.1 *(continued)*

HEALTH CHOICES 2 - MEDICAL SERVICES IMPACTS,

Rural Areas

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	2	3
21	Mining	0	1	1	3
22	Utilities	0	1	1	3
23	Construction	0	3	2	5
31-33	Manufacturing	0	5	3	7
42	Wholesale Trade	0	3	6	9
44-45	Retail Trade	480	10	46	536
48-49	Transportation & Warehousing	0	13	7	20
51	Information	0	9	3	13
52	Finance and Insurance	0	6	7	13
53	Real Estate & Rental Leasing	0	9	5	14
54	Professional, Scientific, & Technical	0	13	5	18
55	Mgt of Companies & Enterprises	0	4	1	5
56	Admin & Support & Waste Mgt & Remed	0	19	7	25
61	Educational Services	0	0	4	4
62	Health Care & Social Assistance	608	3	51	662
71	Arts, Entertainment, & Recreation	0	2	7	9
72	Accommodation & Food Services	0	17	39	56
81	Other Services	0	7	30	37
92	Public Administration	6	3	4	14
	Total	1,095	127	231	1,453

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	1	3	4
21	Mining	0	2	2	3
22	Utilities	0	3	3	7
23	Construction	0	7	4	12
31-33	Manufacturing	0	13	10	22
42	Wholesale Trade	0	6	17	24
44-45	Retail Trade	1,309	24	97	1,431
48-49	Transportation & Warehousing	0	25	15	39
51	Information	0	21	9	30
52	Finance and Insurance	0	15	24	39
53	Real Estate & Rental Leasing	0	56	32	88
54	Professional, Scientific, & Technical	0	38	21	59
55	Mgt of Companies & Enterprises	0	21	3	24
56	Admin & Support & Waste Mgt & Remed	0	78	27	105
61	Educational Services	0	1	19	20
62	Health Care & Social Assistance	484	4	116	604
71	Arts, Entertainment, & Recreation	0	12	22	34
72	Accommodation & Food Services	0	24	77	100
81	Other Services	0	13	61	74
92	Public Administration	11	4	7	22
	Total	1,804	368	568	2,740

TABLE G.3.1 *(continued)*

HEALTH CHOICES 2 - MEDICAL SERVICES IMPACTS, p. 2

Rural Areas

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	12,269	85,374	97,643
21	Mining	0	87,088	108,132	195,220
22	Utilities	0	97,596	107,439	205,035
23	Construction	0	105,394	50,670	156,064
31-33	Manufacturing	0	396,687	108,566	505,253
42	Wholesale Trade	0	88,396	216,005	304,401
44-45	Retail Trade	11,635,799	209,796	1,087,416	12,933,011
48-49	Transportation & Warehousing	0	546,738	255,551	802,289
51	Information	0	295,334	119,786	415,120
52	Finance and Insurance	0	236,681	300,876	537,557
53	Real Estate & Rental Leasing	0	215,515	127,507	343,022
54	Professional, Scientific, & Technical	0	475,391	183,070	658,461
55	Mgt of Companies & Enterprises	0	183,360	28,510	211,870
56	Admin & Support & Waste Mgt & Remed	0	482,225	180,148	662,373
61	Educational Services	0	4,202	80,961	85,163
62	Health Care & Social Assistance	29,399,855	121,745	1,732,379	31,253,979
71	Arts, Entertainment, & Recreation	0	12,935	120,336	133,271
72	Accommodation & Food Services	0	226,196	529,301	755,497
81	Other Services	0	160,591	461,255	621,846
92	Public Administration	92,323	164,051	211,406	467,780
	Total	41,127,977	4,122,190	6,094,688	51,344,855

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	18,764	114,798	133,562
21	Mining	0	141,764	158,301	300,065
22	Utilities	0	318,990	301,160	620,150
23	Construction	0	286,969	157,348	444,317
31-33	Manufacturing	0	727,730	490,563	1,218,293
42	Wholesale Trade	0	316,138	859,264	1,175,402
44-45	Retail Trade	34,443,592	625,626	2,732,646	37,801,864
48-49	Transportation & Warehousing	0	1,120,758	626,542	1,747,300
51	Information	0	982,748	391,216	1,373,964
52	Finance and Insurance	0	807,969	1,255,315	2,063,284
53	Real Estate & Rental Leasing	0	1,129,224	657,610	1,786,834
54	Professional, Scientific, & Technical	0	1,765,992	970,581	2,736,573
55	Mgt of Companies & Enterprises	0	1,338,741	198,190	1,536,931
56	Admin & Support & Waste Mgt & Remed	0	1,888,129	647,171	2,535,300
61	Educational Services	0	28,394	395,595	423,989
62	Health Care & Social Assistance	28,598,594	180,442	4,470,495	33,249,531
71	Arts, Entertainment, & Recreation	0	100,852	298,601	399,453
72	Accommodation & Food Services	0	397,056	1,256,920	1,653,976
81	Other Services	0	394,217	1,251,086	1,645,303
92	Public Administration	331,867	202,159	330,355	864,381
	Total	63,374,053	12,772,662	17,563,757	93,710,472

TABLE G.3.1 *(continued)*

HEALTH CHOICES 2 - MEDICAL SERVICES IMPACTS, p. 3

Rural Areas

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	44,270	282,266	326,536
21	Mining	0	405,030	500,043	905,073
22	Utilities	0	496,839	565,126	1,061,965
23	Construction	0	270,516	135,654	406,170
31-33	Manufacturing	0	1,367,398	1,233,000	2,600,398
42	Wholesale Trade	0	235,146	574,605	809,751
44-45	Retail Trade	27,523,434	562,890	2,765,602	30,851,926
48-49	Transportation & Warehousing	0	983,278	658,549	1,641,827
51	Information	0	1,371,957	626,713	1,998,670
52	Finance and Insurance	0	712,966	1,072,080	1,785,046
53	Real Estate & Rental Leasing	0	1,152,281	610,797	1,763,078
54	Professional, Scientific, & Technical	0	1,118,284	422,501	1,540,785
55	Mgt of Companies & Enterprises	0	498,356	77,488	575,844
56	Admin & Support & Waste Mgt & Remed	0	1,027,957	396,600	1,424,557
61	Educational Services	0	9,972	152,956	162,928
62	Health Care & Social Assistance	53,729,266	377,429	3,430,388	57,537,083
71	Arts, Entertainment, & Recreation	0	48,774	320,341	369,115
72	Accommodation & Food Services	0	744,796	1,762,683	2,507,479
81	Other Services	0	438,050	1,199,005	1,637,055
92	Public Administration	110,775	559,848	3,677,266	4,347,889
	Total	81,363,475	12,426,037	20,463,663	114,253,175

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	41,042	327,686	368,728
21	Mining	0	664,607	744,353	1,408,960
22	Utilities	0	1,600,483	1,508,136	3,108,619
23	Construction	0	676,004	384,825	1,060,829
31-33	Manufacturing	0	2,825,491	3,382,302	6,207,793
42	Wholesale Trade	0	841,272	2,286,579	3,127,851
44-45	Retail Trade	79,559,664	1,685,555	6,899,677	88,144,896
48-49	Transportation & Warehousing	0	2,051,793	1,515,962	3,567,755
51	Information	0	3,918,826	1,906,507	5,825,333
52	Finance and Insurance	0	2,253,978	4,043,809	6,297,787
53	Real Estate & Rental Leasing	0	6,301,673	3,491,881	9,793,554
54	Professional, Scientific, & Technical	0	3,989,569	2,120,949	6,110,518
55	Mgt of Companies & Enterprises	0	3,242,478	480,024	3,722,502
56	Admin & Support & Waste Mgt & Remed	0	3,677,900	1,355,891	5,033,791
61	Educational Services	0	64,266	782,195	846,461
62	Health Care & Social Assistance	49,704,648	498,637	8,459,458	58,662,743
71	Arts, Entertainment, & Recreation	0	252,684	739,704	992,388
72	Accommodation & Food Services	0	1,202,994	3,863,105	5,066,099
81	Other Services	0	1,043,279	2,899,443	3,942,722
92	Public Administration	302,202	613,210	7,652,179	8,567,591
	Total	129,566,514	37,445,741	54,844,665	221,856,920

TABLE G.3.1 *(continued)*

NM HEALTH COVERAGE - MEDICAL SERVICES IMPACTS

Rural Areas

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	1	1
21	Mining	0	0	1	1
22	Utilities	0	0	1	1
23	Construction	0	1	1	2
31-33	Manufacturing	0	2	1	3
42	Wholesale Trade	0	1	2	3
44-45	Retail Trade	175	4	17	196
48-49	Transportation & Warehousing	0	6	3	8
51	Information	0	4	1	5
52	Finance and Insurance	0	2	3	5
53	Real Estate & Rental Leasing	0	4	2	6
54	Professional, Scientific, & Technical	0	6	2	8
55	Mgt of Companies & Enterprises	0	1	0	1
56	Admin & Support & Waste Mgt & Remed	0	4	3	7
61	Educational Services	0	0	2	2
62	Health Care & Social Assistance	370	4	19	393
71	Arts, Entertainment, & Recreation	0	1	3	3
72	Accommodation & Food Services	0	9	15	23
81	Other Services	0	3	11	14
92	Public Administration	2	1	2	5
	Total	547	53	87	688

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Employment	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	0	2	2
21	Mining	0	1	1	2
22	Utilities	0	2	2	4
23	Construction	0	5	2	7
31-33	Manufacturing	0	7	5	12
42	Wholesale Trade	0	4	10	14
44-45	Retail Trade	1,003	17	58	1,077
48-49	Transportation & Warehousing	0	16	9	25
51	Information	0	15	5	20
52	Finance and Insurance	0	10	14	24
53	Real Estate & Rental Leasing	0	36	19	55
54	Professional, Scientific, & Technical	0	23	12	36
55	Mgt of Companies & Enterprises	0	15	2	17
56	Admin & Support & Waste Mgt & Remed	0	44	16	60
61	Educational Services	0	1	11	12
62	Health Care & Social Assistance	196	1	69	266
71	Arts, Entertainment, & Recreation	0	8	13	21
72	Accommodation & Food Services	0	14	46	59
81	Other Services	0	9	36	44
92	Public Administration	9	3	4	15
	Total	1,207	229	336	1,772

TABLE G.3.1 *(continued)*

NM HEALTH COVERAGE - MEDICAL SERVICES IMPACTS, p. 2

Rural Areas

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	5,645	32,117	37,762
21	Mining	0	33,488	40,678	74,166
22	Utilities	0	40,661	40,417	81,078
23	Construction	0	45,767	19,062	64,829
31-33	Manufacturing	0	202,678	40,843	243,521
42	Wholesale Trade	0	38,201	81,257	119,458
44-45	Retail Trade	4,237,702	79,071	409,065	4,725,838
48-49	Transportation & Warehousing	0	237,442	96,136	333,578
51	Information	0	117,134	45,060	162,194
52	Finance and Insurance	0	99,181	113,183	212,364
53	Real Estate & Rental Leasing	0	91,702	47,966	139,668
54	Professional, Scientific, & Technical	0	227,404	68,866	296,270
55	Mgt of Companies & Enterprises	0	51,315	10,725	62,040
56	Admin & Support & Waste Mgt & Remed	0	99,403	67,769	167,172
61	Educational Services	0	1,838	30,458	32,296
62	Health Care & Social Assistance	17,515,978	132,697	651,697	18,300,372
71	Arts, Entertainment, & Recreation	0	5,111	45,268	50,379
72	Accommodation & Food Services	0	113,733	199,114	312,847
81	Other Services	0	70,980	173,517	244,497
92	Public Administration	33,624	70,213	79,527	183,364
	Total	21,787,304	1,763,664	2,292,725	25,843,693

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Labor Income (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	10,497	68,019	78,516
21	Mining	0	95,381	93,796	189,177
22	Utilities	0	221,221	178,445	399,666
23	Construction	0	190,188	93,229	283,417
31-33	Manufacturing	0	357,751	290,661	648,412
42	Wholesale Trade	0	171,966	509,124	681,090
44-45	Retail Trade	26,377,534	429,155	1,619,114	28,425,803
48-49	Transportation & Warehousing	0	702,554	371,226	1,073,780
51	Information	0	684,243	231,796	916,039
52	Finance and Insurance	0	505,292	743,780	1,249,072
53	Real Estate & Rental Leasing	0	723,025	389,652	1,112,677
54	Professional, Scientific, & Technical	0	1,062,523	575,078	1,637,601
55	Mgt of Companies & Enterprises	0	962,159	117,429	1,079,588
56	Admin & Support & Waste Mgt & Remed	0	1,059,941	383,452	1,443,393
61	Educational Services	0	17,523	234,375	251,898
62	Health Care & Social Assistance	11,682,046	67,798	2,648,794	14,398,638
71	Arts, Entertainment, & Recreation	0	68,813	176,918	245,731
72	Accommodation & Food Services	0	232,216	744,722	976,938
81	Other Services	0	253,187	741,256	994,443
92	Public Administration	254,150	131,598	195,739	581,487
	Total	38,313,730	7,947,031	10,406,605	56,667,366

TABLE G.3.1 *(continued)*

NM HEALTH COVERAGE - MEDICAL SERVICES IMPACTS, p. 3

Rural Areas

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	22,075	106,184	128,259
21	Mining	0	163,459	188,108	351,567
22	Utilities	0	207,542	212,589	420,131
23	Construction	0	117,931	51,031	168,962
31-33	Manufacturing	0	647,757	463,829	1,111,586
42	Wholesale Trade	0	101,619	216,155	317,774
44-45	Retail Trade	10,023,901	212,155	1,040,367	11,276,423
48-49	Transportation & Warehousing	0	419,377	247,736	667,113
51	Information	0	544,498	235,757	780,255
52	Finance and Insurance	0	299,357	403,294	702,651
53	Real Estate & Rental Leasing	0	489,077	229,769	718,846
54	Professional, Scientific, & Technical	0	531,540	158,938	690,478
55	Mgt of Companies & Enterprises	0	139,470	29,150	168,620
56	Admin & Support & Waste Mgt & Remed	0	262,043	149,195	411,238
61	Educational Services	0	4,346	57,540	61,886
62	Health Care & Social Assistance	33,805,985	411,479	1,290,466	35,507,930
71	Arts, Entertainment, & Recreation	0	19,139	120,509	139,648
72	Accommodation & Food Services	0	376,769	663,090	1,039,859
81	Other Services	0	194,337	451,052	645,389
92	Public Administration	40,344	236,669	1,383,336	1,660,349
	Total	43,870,230	5,400,639	7,698,095	56,968,964

Metropolitan Statistical Areas (Albuquerque, Santa Fe, Las Cruces, Farmington)

	Change in Output (2007 $)	Direct	Indirect	Induced	Total
11	Agric, Forestry, Fishing, Hunting	0	22,184	194,160	216,344
21	Mining	0	447,240	441,045	888,285
22	Utilities	0	1,110,273	893,609	2,003,882
23	Construction	0	445,709	228,008	673,717
31-33	Manufacturing	0	1,338,769	2,004,071	3,342,840
42	Wholesale Trade	0	457,616	1,354,826	1,812,442
44-45	Retail Trade	60,928,248	1,156,224	4,088,110	66,172,582
48-49	Transportation & Warehousing	0	1,306,437	898,211	2,204,648
51	Information	0	2,684,993	1,129,623	3,814,616
52	Finance and Insurance	0	1,425,027	2,395,963	3,820,990
53	Real Estate & Rental Leasing	0	4,033,876	2,069,051	6,102,927
54	Professional, Scientific, & Technical	0	2,425,716	1,256,674	3,682,390
55	Mgt of Companies & Enterprises	0	2,330,382	284,418	2,614,800
56	Admin & Support & Waste Mgt & Remed	0	2,113,379	803,371	2,916,750
61	Educational Services	0	39,749	463,425	503,174
62	Health Care & Social Assistance	19,736,610	187,280	5,012,274	24,936,164
71	Arts, Entertainment, & Recreation	0	171,608	438,268	609,876
72	Accommodation & Food Services	0	702,468	2,288,880	2,991,348
81	Other Services	0	679,897	1,717,894	2,397,791
92	Public Administration	231,432	404,857	4,533,792	5,170,081
	Total	80,896,290	23,483,684	32,495,673	136,875,647

UNM BBER estimates using IMPLAN Model

APPENDIX G.4

TABLE G.4.1

ECONOMIC IMPACTS OF CHANGES IN HEALTH CARE EXPENDITURES
ON THE MEDICAL SERVICES INDUSTRIES

NEW MEXICO IMPACTS	HEALTH SECURITY ACT 1				HEALTH SECURITY ACT 2				HEALTHCARE CHOICE 1			
	New Mexico				New Mexico				New Mexico			
Change in Employment												
	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Lab apparatus & furniture mfg	0	0	0	0	0	0	0	0	0	0	0	0
Surgical & medical instrument mfg	0	-2	0	-2	0	0	0	1	0	1	0	1
Surgical appliance and supplies mfg	0	-2	0	-2	0	1	0	1	0	1	0	1
Dental equipment & supplies mfg	0	0	0	0	0	0	0	0	0	0	0	0
Ophthalmic goods mfg	0	0	0	0	0	0	0	0	0	0	0	0
Dental laboratories	0	-4	0	-4	0	4	0	4	0	6	0	6
Health & personal care stores	1,527	1	-1	1,526	1,527	2	5	1,534	1,722	2	7	1,731
Clothing &accessories stores	0	1	-2	-1	0	2	7	9	0	2	9	11
Nonstore retailers	0	3	-2	1	0	6	10	15	0	7	12	19
Insurance carriers	0	-1	-1	-2	0	1	4	4	0	1	5	6
General & consumer goods rental	0	0	0	0	0	1	2	3	0	1	2	3
Home health care services	0	0	-2	-2	0	0	12	12	0	0	16	16
Offices of physicians,dentists,other	-250	0	-6	-256	491	0	28	519	698	0	36	734
Oth ambulatory health care services	48	1	-1	47	48	5	6	58	49	6	8	63
Hospitals	-399	0	-3	-402	122	0	21	143	138	0	27	165
Nursing and residential care facilities	0	0	-3	-3	0	0	18	18	0	0	23	23
Total	926	-3	-22	902	2,188	21	112	2,320	2,607	26	144	2,777
Change in Labor Income (2007 $000s)												
	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Lab apparatus & furniture mfg	0	-1	0	-1	0	0	0	0	0	0	0	0
Surgical & medical instrument mfg	0	-140	-2	-142	0	44	10	54	0	66	13	79
Surgical appliance and supplies mfg	0	-149	-6	-155	0	40	16	56	0	64	21	84
Dental equipment & supplies mfg	0	-8	0	-9	0	6	1	6	0	9	1	10
Ophthalmic goods mfg	0	-2	-2	-4	0	1	4	5	0	1	5	6
Dental laboratories	0	-172	-4	-177	0	293	17	310	0	421	22	444
Health & personal care stores	39,262	21	-35	39,247	39,262	48	140	39,450	44,300	57	181	44,538
Clothing &accessories stores	0	18	-43	-25	0	43	146	188	0	51	189	239
Nonstore retailers	0	28	-27	1	0	65	108	174	0	78	140	217
Insurance carriers	0	-24	-67	-90	0	37	180	216	0	48	235	283
General & consumer goods rental	0	10	-9	1	0	33	47	80	0	41	60	101
Home health care services	0	0	-48	-48	0	0	264	264	0	0	338	338
Offices of physicians,dentists,other	-16,783	0	-406	-17,190	25,429	0	1,564	26,994	37,012	0	2,020	39,032
Oth ambulatory health care services	2,133	12	-66	2,079	2,133	203	282	2,618	2,208	254	363	2,825
Hospitals	-22,150	0	-182	-22,332	6,248	0	1,112	7,360	7,120	0	1,421	8,541
Nursing and residential care facilities	0	0	-84	-84	0	0	487	487	0	0	622	622
Total	2,462	-408	-982	1,072	73,072	812	4,376	78,261	90,640	1,091	5,630	97,360
Change in Output (2007 $000s)												
	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Lab apparatus & furniture mfg	0	-2	0	-2	0	0	0	1	0	1	0	1
Surgical & medical instrument mfg	0	-470	-9	-478	0	134	32	166	0	206	41	247
Surgical appliance and supplies mfg	0	-508	-21	-529	0	130	53	182	0	210	69	279
Dental equipment & supplies mfg	0	-21	0	-22	0	23	2	25	0	35	2	37
Ophthalmic goods mfg	0	-7	-6	-12	0	3	12	15	0	5	16	21
Dental laboratories	0	-282	-7	-289	0	477	28	505	0	686	36	723
Health & personal care stores	91,274	48	-81	91,242	91,274	112	325	91,711	102,971	133	420	103,523
Clothing &accessories stores	0	56	-136	-80	0	135	460	595	0	160	597	757
Nonstore retailers	0	134	-129	5	0	308	511	819	0	366	659	1,025
Insurance carriers	0	-100	-277	-377	0	167	811	978	0	219	1,057	1,276
General & consumer goods rental	0	18	-15	3	0	62	87	149	0	75	112	187
Home health care services	0	0	-85	-85	0	0	470	470	0	0	601	601
Offices of physicians,dentists,other	-27,287	0	-664	-27,950	42,722	0	2,596	45,319	61,973	0	3,352	65,325
Oth ambulatory health care services	6,182	55	-175	6,062	6,182	594	806	7,582	6,397	741	1,036	8,174
Hospitals	-46,145	0	-363	-46,508	13,494	0	2,353	15,847	15,340	0	3,004	18,344
Nursing and residential care facilities	0	0	-134	-134	0	0	809	809	0	0	1,035	1,035
Total	24,024	-1,078	-2,100	20,846	153,672	2,145	9,356	165,174	186,681	2,836	12,038	201,554

UNM BBER estimates using IMPLAN model

TABLE G.4.1

ECONOMIC IMPACTS OF CHANGES IN HEALTH CARE EXPENDITURES
ON THE MEDICAL SERVICES INDUSTRIES *(continued)*

NEW MEXICO IMPACTS	**HEALTHCARE CHOICE 2** New Mexico				**HEALTH COVERAGE** New Mexico			
Change in Employment	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Lab apparatus & furniture mfg	0	0	0	0	0	0	0	0
Surgical & medical instrument mfg	0	1	0	1	0	0	0	0
Surgical appliance and supplies mfg	0	1	0	1	0	1	0	1
Dental equipment & supplies mfg	0	0	0	0	0	0	0	0
Ophthalmic goods mfg	0	0	0	0	0	0	0	0
Dental laboratories	0	7	0	8	0	4	0	4
Health & personal care stores	1,789	2	8	1,800	1,178	2	5	1,184
Clothing &accessories stores	0	3	10	13	0	2	6	7
Nonstore retailers	0	7	14	21	0	4	7	12
Insurance carriers	0	1	6	7	0	1	3	4
General & consumer goods rental	0	1	2	4	0	1	1	2
Home health care services	0	0	18	18	0	0	10	10
Offices of physicians,dentists,other	890	0	42	932	448	0	22	471
Oth ambulatory health care services	50	7	9	66	58	5	5	67
Hospitals	152	0	31	182	60	0	16	76
Nursing and residential care facilities	0	0	27	27	0	0	14	14
Total	2,881	31	168	3,080	1,744	18	89	1,851
Change in Labor Income (2007 $000s)	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Lab apparatus & furniture mfg	0	0	0	1	0	0	0	0
Surgical & medical instrument mfg	0	87	15	102	0	31	8	39
Surgical appliance and supplies mfg	0	87	24	112	0	35	14	49
Dental equipment & supplies mfg	0	13	1	13	0	6	0	6
Ophthalmic goods mfg	0	2	6	8	0	1	3	4
Dental laboratories	0	542	26	568	0	271	14	285
Health & personal care stores	46,079	62	212	46,354	30,615	39	115	30,769
Clothing &accessories stores	0	56	223	278	0	35	123	159
Nonstore retailers	0	85	164	249	0	53	89	142
Insurance carriers	0	58	279	336	0	32	159	191
General & consumer goods rental	0	45	70	115	0	26	37	63
Home health care services	0	0	394	394	0	0	207	207
Offices of physicians,dentists,other	47,894	0	2,373	50,267	23,865	0	1,292	25,158
Oth ambulatory health care services	2,252	302	425	2,980	2,293	200	229	2,722
Hospitals	7,852	0	1,653	9,505	3,039	0	859	3,899
Nursing and residential care facilities	0	0	724	724	0	0	378	378
Total	104,078	1,338	6,589	112,005	59,813	730	3,530	64,072
Change in Output (2007 $000s)	Direct	Indirect	Induced	Total	Direct	Indirect	Induced	Total
Lab apparatus & furniture mfg	0	1	0	1	0	0	0	1
Surgical & medical instrument mfg	0	272	49	321	0	96	27	123
Surgical appliance and supplies mfg	0	290	82	372	0	115	48	162
Dental equipment & supplies mfg	0	46	3	49	0	23	1	24
Ophthalmic goods mfg	0	6	19	25	0	3	11	14
Dental laboratories	0	882	43	925	0	442	23	465
Health & personal care stores	107,083	145	492	107,720	70,952	90	267	71,309
Clothing &accessories stores	0	176	704	880	0	112	390	502
Nonstore retailers	0	401	774	1,174	0	249	420	669
Insurance carriers	0	261	1,252	1,513	0	142	707	849
General & consumer goods rental	0	84	130	213	0	48	68	116
Home health care services	0	0	701	701	0	0	367	367
Offices of physicians,dentists,other	80,034	0	3,936	83,970	39,940	0	2,139	42,079
Oth ambulatory health care services	6,524	875	1,212	8,611	6,989	598	647	8,234
Hospitals	16,876	0	3,490	20,366	6,614	0	1,806	8,420
Nursing and residential care facilities	0	0	1,203	1,203	0	0	626	626
Total	210,517	3,439	14,088	228,045	124,495	1,918	7,547	133,960

UNM BBER estimates using IMPLAN model

APPENDIX G.5

EMPLOYMENT IN THE HEALTH INSURANCE INDUSTRY

TABLE G.5.1

TOP OCCUPATIONS IN THE HEALTH INSURANCE INDUSTRY

TOP 12 OCCUPATIONS

NAICS 524114: DIRECT LIFE, HEALTH, AND MEDICAL INSURANCE CARRIERS AND REINSURANCE CARRIERS

Occupation	Occup Employ % of US Industry	This Occupation in New Mexico					May 2006 Wages	
		NM 2004 Actual	NM 2014 Forecast	NM % Ch.	US % Ch.	NM Ann. Job Openings	US Median Hourly	NM Median Hourly
Customer Service Representatives	12.44%	10,500	14,130	35%	23%	520	$13.62	$11.82
Insurance Claims and Policy Processing Clerks	8.13%	800	840	5%	5%	20	$14.96	$12.03
Insurance Sales Agents	6.71%	2,110	2,300	9%	7%	70	$21.09	$17.84
Claims Adjusters, Examiners and Investigators	6.04%	650	790	21%	15%	20	$24.36	$25.52
Office Clerks, General	3.57%	13,870	15,330	11%	8%	550	$11.40	$9.90
Computer Systems Analysts	3.54%	2,110	2,870	36%	31%	100	$33.54	$25.27
First Line Supervisors/Managers of Office and Administrative Support Workers	3.31%	6,380	7,170	12%	8%	220	$20.92	$17.31
Insurance Underwriters	2.89%	140	150	10%	8%	NA	$25.17	$23.24
Business Operations Specialists, All Other	2.76%	2,720	3,520	30%	27%	130	$26.76	$24.94
Executive Secretaries and Administrative Assistants	2.61%	8,520	9,640	13%	12%	300	$17.90	$16.15
Accountants and Auditors	2.55%	4,930	6,000	22%	22%	200	$26.26	$22.57
Management Analysts	2.15%	2,250	2,780	23%	20%	80	$32.72	$27.76

Sources:
1) Employment projections - 2004-2014 Bureau of Labor Statistics, Office of Occupational Statistics and Employment Projections; National
2) May 2006 employment and wage data - http://www.bls.gov/oes/current/oes last modified April 3, 2007
Note: Job Openings refers to the average annual job openings due to growth and net replacement.

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TABLE G.5.2

INDUSTRIES EMPLOYING HEALTH INSURANCE INDUSTRY TOP OCCUPATIONS

OCCUPATION EMPLOYMENT BY INDUSTRY

Customer Service Representatives		Insurance Claims and Policy Processing Clerks		Insurance Sales Agents		Claims Adjusters, Examiners and Investigators	
Percent	Group: Office, Clericial and Secretarial	Percent	Group: Business and Fianancial	Percent	Group: Sales and Related	Percent	Group: Business and Fianancial
5.8%	Depository Credit Intermediation (522100)	26.4%	Direct Insurance (except Life, Health, and Medical) Carriers (524120)	47.0%	Insurance Agencies and Brokerages (524210)	40.4%	Direct Insurance (except Life, Health, and Medical) Carriers (524120)
4.8%	Direct Insurance (Life, Health, and Medical) Carriers (524114)	25.8%	Direct Insurance (Life, Health, and Medical) Carriers (524114)	24.3%	Self Employed Workers - Primary Job	19.2%	Direct Insurance (Life, Health, and Medical) Carriers (524114)
4.6%	Insurance Agencies and Brokerages (524210)	25.7%	Insurance Agencies and Brokerages (524210)	13.4%	Direct Insurance (Life, Health, and Medical) Carriers (524114)	15.3%	Other Insurance Related Activities (524290)
4.5%	Telephone Call Centers	8.4%	Other Insurance Related Activities (524290)	8.0%	Direct Insurance (except Life, Health, and Medical) Carriers (524120)	7.1%	Insurance Agencies and Brokerages (524210)
3.8%	Employment Services (561300)	3.2%	Management of Companies and Enterprises (551000)	2.5%	Other Insurance Related Activities (524290)	3.5%	Management of Companies and Enterprises (551000)
3.3%	Management of Companies and Enterprises (551000)					3.1%	State Government, excluding education and hospitals
2.8%	Grocery Stores					2.1%	Self Employed Workers - Primary Job
2.4%	Wired Telecommunications Carriers						
2.1%	Wireless Telecommunications Carriers (except satellite)						
2.1%	Direct Insurance (except Life, Health, and Medical) Carriers (524120)						

First Line Supervisors/Managers of Office and Administrative Support Workers		Insurance Underwriters		Business Operations Specialists, All Other	
Percent	Group: Office, Clericial and Secretarial	Percent	Group: Business and Fianancial	Percent	Group: Business and Fianancial
7.2%	Depository Credit Intermediation (522100)	41.4%	Direct Insurance (except Life, Health, and Medical) Carriers (524120)	16.0%	Federal Government, excluding Post Office
4.3%	Offices of Physicians (621100)	22.8%	Direct Insurance (Life, Health, and Medical) Carriers (524114)	7.1%	State Government, excluding education and hospitals
4.1%	Local Government, excluding education and hospitals	5.0%	Other Insurance Related Activities (524290)	5.2%	State Government, educational services
3.8%	State Government, excluding education and hospitals	4.0%	Management of Companies and Enterprises (551000)	3.1%	Management of Companies and Enterprises (551000)
2.8%	Management of Companies and Enterprises (551000)	2.5%	Other Nondepository Credit Intermediation (522290)	3.9%	Local Government, excluding education and hospitals
2.2%	General Medical and Surgical Hospitals (622100)			2.6%	Labor Unions and similar organizations
				2.5%	Direct Insurance (Life, Health, and Medical) Carriers (524114)
				2.2%	Employment Services (561300)
				2.0%	Management, Scientific, and Technical Consulting Services (541600)