New Mexico Legislative Finance Committee
Program Evaluation No. 25-01

The Health Care Affordability Fund

June 25, 2025

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Charles Sallee
Director

April 29, 2024

Ms. Kari Armijo, Secretary
Health Care Authority
P.O. Box 2348
Santa Fe, New Mexico 87504

Dear Secretary Armijo:

The Legislative Finance Committee (LFC) is pleased to transmit the evaluation *Health Care Affordability Fund: Impacts and Opportunities*. The program evaluation examined the impact of the increase in the health insurance premium surtax as required by legislation. An exit conference was held with you and your staff on April 15, 2025 to discuss the contents of the report.

The report will be presented to the LFC on April 29, 2025. LFC would like plans to address the recommendations within this report from the Health Care Authority within 30 days of the hearing.

I believe this report addresses issues the LFC asked us to review and hope HCA will benefit from our efforts. We very much appreciate the cooperation and assistance we received from you and your staff.

Sincerely,

Charles Sallee, Director

Cc: Representative Nathan P. Small, Chairman, Legislative Finance Committee
Senator George K. Muñoz, Vice-Chairman, Legislative Finance Committee
Wayne Propst, Secretary of the Department of Finance and Administration

Contents

Summary

The health insurance premium surtax generates more money than subsidy programs need, and HCAF performance measures could be refined.

In 2021, the New Mexico Legislature passed Senate Bill 317 (SB317, or Chapter 136 of Laws 2021), marking a significant shift in the state's approach to making healthcare more affordable. This legislation raised the health insurance premium surtax from 1 percent to 3.75 percent, creating a sustainable funding stream to establish the Health Care Affordability Fund (HCAF). The Legislature designed the HCAF to improve healthcare affordability for New Mexicans through premium reduction, cost-sharing subsidies, and expanded coverage for uninsured populations. This program evaluation of the HCAF was an additional requirement of SB317.

The Legislature envisioned the HCAF as a way to finance health insurance subsidies for three groups—small businesses, low- to moderate-income individuals and families, and the uninsured. The Health Care Authority (HCA) has initiated programs to serve the first two groups but has not yet implemented a program for the uninsured who do not have access to other types of health insurance coverage.

Since SB317, the health premium surtax has generated about $136 million for the HCAF annually from January 2022 to July 2025 and is expected to generate roughly $220 million annually through FY29. The HCAF revenue has far exceeded demand for health insurance subsidies, even as HCA expanded the subsidies to individuals at higher income levels. Between FY22 and FY25, the HCAF ended the fiscal year with an average of $146.6 million in reserves. In response, the Legislature has tapped unused HCAF balances for other health initiatives over that time.

HCAF revenues are likely to face new expenditure pressures in the near future. Enhanced federal health insurance subsidies are scheduled to expire at the end of 2025. Without them, the HCAF could face a sharp rise in costs—estimated between $72 million and $189 million through FY28—if the state maintains existing affordability levels. Further, HCA projections assume the implementation of their Coverage Expansion Program (CEP) to provide coverage for the uninsured population will cost up to $63.6 million annually to cover up to 7,700 individuals in FY26.

Even with these new costs, HCA is well-positioned to increase the affordability of health insurance in New Mexico. To realize this potential, HCA will need to focus on optimizing its programs to serve the most people at the lowest cost and refine and expand the required performance measures and monitoring practices to determine if improvements can be made.

Table 1. Status and Start Date of HCAF Subsidy Programs

Group	Status	Start Date
Small Business Premium Relief Program	Up and Running	July 2022
Marketplace Affordability Program	Up and Running	Jan. 2023
Coverage Expansion Program	Planning	*

Note: *On Wednesday April 30, 2025 HCA terminated their contract with the New Mexico Medical Insurance Pool to administer the coverage expansion plan. This came after a technical revelation that NMMIP is not eligible for a Government Service Agreement, so HCA will be issuing an RFP for the administration of the CEP.

Source: LFC Analysis

Key Findings

- HCAF revenues from the premium surtax have far exceeded the health insurance subsidy needs; and
- HCA could refine and expand HCAF performance measures.

Key Recommendations

The Legislature should consider:

- Requiring HCA to set and report progress towards a targeted five-year uninsurance rate for individuals and families that are eligible for their subsidy programs.

The Health Care Authority should:

- In consultation with the New Mexico Health Insurance Exchange (NMHIX) and the Tax and Revenue Department (TRD), work with LFC and DFA to refine the existing HCAF performance measures and establish additional measures that help the state achieve health insurance outcomes.
- In consultation with NMHIX, TRD, and the New Mexico Medical Insurance Pool (NMMIP), work with LFC and DFA to conduct an annual review of the share of the surtax required for the HCA to meet their annual performance targets;
- Develop and report annual outreach campaigns to increase the number of qualified people enrolled in subsidized plans to reduce the uninsurance rate among low- to moderate-income New Mexicans;
- Work with the Legislative Finance Committee (LFC) and the Department of Finance and Administration (DFA) to review and make recommendations on the share of the surtax required for the HCA to meet annual program performance goals;
- Evaluate the Small Business Health Insurance Premium Relief Initiative design specifications to maximize the value to consumers and minimize the cost to the state; and

Background

In 2021, the New Mexico Legislature passed Senate Bill 317 (Laws 2021, Chapter 136). The bill increased the health insurance premium surtax from 1 percent to 3.75 percent and dedicated a portion of the revenue generated from the surtax to a new health care affordability fund (HCAF) for

1) Reducing health insurance premiums and cost-sharing for qualified individuals and families who purchase health insurance on BeWell, the New Mexico Health Insurance Marketplace;
2) Reducing premiums for small businesses and their employees that purchase health insurance in the fully insured small group market; and
3) Providing resources for healthcare coverage initiatives for uninsured New Mexicans.

Table 2. Example of Federal Poverty Level for 2025

Size	100%	138%	400%
1	$15,650	$21,597	$62,600
2	$21,150	$29,187	$84,600
4	$32,150	$44,367	$128,600

Source: LFC Files

Historically, low- to moderate-income families, small businesses, and uninsured New Mexicans without access to other affordable coverage. The HCAF programs are designed to mitigate affordability burdens faced by these groups by developing subsidy programs coupled with affordability and coverage parameters for insurance companies to use to design insurance plans. Laws 2021, Chapter 136 required the LFC to conduct a program evaluation by July 1, 2025, "to measure the impact of changes to the health insurance premium surtax and the creation of the health care affordability fund as it relates to the purposes of the fund."

The New Mexico Health Care Authority (HCA) administers the healthcare affordability fund in partnership with other state agencies.

When established in 2021, the Legislature designated the Office of the Superintendent of Insurance (OSI) as the entity overseeing the HCAF. Senate Bill 14, passed during the 2024 regular session, amended Laws 2023, Chapter 205, so HCA could manage the HCAF. During the latter half of FY22 and FY23, OSI's health insurance policy staff developed the framework and operating procedures to deliver small business premium subsidies and marketplace affordability programs. Beginning July 1, 2024, the HCAF and staff transferred to HCA. Under HCA's Division of Health Care Coverage Innovations, the Health Care Affordability Bureau administers the day-to-day operations of the HCAF affordability programs.

The bureau works with OSI and the New Mexico Health Insurance Exchange (NMHIX) to establish and refine the parameters for insurance plans to be qualified for state HCAF subsidies. Plan criteria are then provided to insurance companies who use the criteria to develop consumer insurance products that satisfy the requirements.

The health insurance premium surtax finances subsidy programs to reduce health insurance cost burdens.

HCA has used the HCAF for the Marketplace Affordability Program and the Small Business Health Insurance Premium Relief Initiative and plans to implement the Coverage Expansion Program in FY26. HCA is responsible for establishing each program's eligibility and affordability criteria.

The Marketplace Affordability Program (MAP) uses the HCAF appropriations to subsidize health insurance premiums and out-of-pocket costs for eligible New Mexicans purchasing health insurance on BeWell. The Marketplace affordability programming is composed of the New Mexico Premium Assistance (NMPA) program, the State Out-of-Pocket Assistance (SOPA) program, and the Native American Premium Assistance (NAPA) program. The state also added the Medicaid Transition Premium Relief (MTPR) program late in 2022 after the federal government rescinded pandemic-related continuous Medicaid enrollment requirements in March 2023.

The NMPA subsidy program is for New Mexicans who earn too much income for Medicaid and don't have access to an affordable employer-sponsored plan. The NMPA subsidizes monthly insurance premiums on top of federal premium tax credit subsidies. Qualified individuals and families that earn less than 200 percent of the federal poverty level (FPL) qualify for zero-cost monthly premium options, though some still choose plans with a premium. Qualified consumers earning between 200 percent and 250 percent of FPL are eligible for subsidies so that premiums will cost no more than 2 percent of their income. Whereas consumers between 250 percent and 300 percent of FPL are eligible for subsidies so that they pay no more than 5 percent of their income, consumers with income between 300 percent and 400 percent of FPL are eligible for subsidies so that they pay up to 8.5 percent of their income. These limitations on the percent of households spent on Marketplace health insurance are based on the cost of the second-lowest cost Silver plan available to the consumer (See Table 8. for more details).

The SOPA subsidy program aims to reduce the other out-of-pocket costs beyond premiums. In other words, the SOPA subsidy increases an insurance plan's actuarial value (AV) so that the consumer is financially responsible for a smaller share of healthcare costs. The SOPA is available when qualified consumers select a turquoise plan. Turquoise plans are New Mexico's version of the platinum plan on the federal marketplace and have actuarial values of at least 90 percent. Qualified consumers with income below 150 percent of FPL are eligible for a turquoise 1 plan with an actuarial value of 99 percent. Consumers with income between 150 percent and 200 percent of FPL are eligible for a turquoise 2 plan with an actuarial value of 95 percent and qualified consumers with income between 200 and

Table 3. Out-of-Pocket Costs

Term	Definition
Premiums	Payments made to maintain insurance coverage.
Copayments	Fixed amounts paid by the policy holder for specific services, like a $40 fee for a doctor's visit.
Deductibles	The amount a policyholder must pay out-of-pocket before insurance begins covering expenses.
Coinsurance	A percentage of costs shared between the policyholder and the insurer after meeting the deductible (e.g., 80/20 split).

Source: Affordable Care Act

Table 4. Affordability Criteria: State Out-Of-Pocket Assistance for Plan Year 2025

Plan	Federal Poverty Level	Actuarial Value
Turquoise 1	Up to 150%	99% AV
Turquoise 2	150% - 200%	95% AV
Turquoise 3	200% - 400%	90% AV

Source: 2025 HCAF Program Policy and Procedures

400 percent are eligible for the turquoise 3 plan with an actuarial value of 90 percent.

Native Americans report having health insurance at lower rates than non-Native Americans in New Mexico, and Native Americans are more likely than non-Native Americans in New Mexico to experience adverse health outcomes that are costly throughout a lifetime. Native American consumers have access to Indian Health Services, a federal partnership between Congress and tribal governments. Indian Health Services covers some of the healthcare needs of Native American populations but not the complete list of essential health benefits that the qualified health plans on BeWell provide. Indian Health Services can bill third-party insurance companies for services offered or for referring patients with health insurance to specialists. The federally sponsored Patient Protection and Affordable Care Act provided Native Americans with greater access to Medicaid and marketplace coverage by reducing costs and barriers for qualified Native American consumers. HCA builds on these provisions with the HCAF-funded Native American Premium Assistance (NMPA) program. In 2023, just 500 Native Americans were enrolled in coverage through BeWell. As of April 1, 2025, 2,257 Native Americans are enrolled in BeWell coverage.

The public health emergency caused by the Covid-19 pandemic led to the federal government establishing a continuous enrollment policy for Medicaid, resulting in Medicaid enrollment growing by roughly 150 thousand between 2021 and 2023. Post-pandemic, the federal government required the states to unwind their Medicaid enrollment, which led policymakers to expand the HCAF funding to include the Medicaid Transition Relief Program (MTPR). Consumers who are qualified for the MTPR are eligible for a subsidy that covers their first month's premium on BeWell. Policymaker forecasts at the time were that roughly 28 thousand New Mexicans who lost their Medicaid coverage would need subsidized coverage on BeWell. In the end, less than 11 thousand transitioned from Medicaid to BeWell.

Table 5. HCAF Marketplace Affordability Program Subsidies

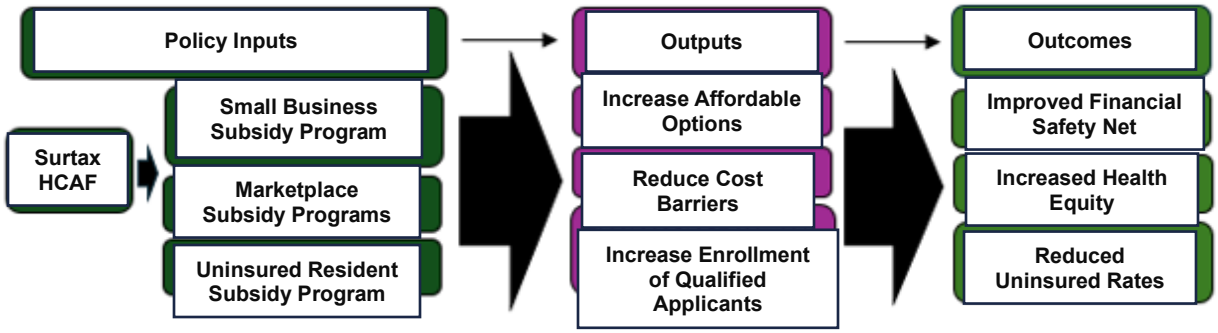
Program	Definition
New Mexico Premium Assistance (NMPA)	Subsidy that increases the affordability of monthly health insurance premiums on BeWell. These subsidies are built on top of the federal Premium Tax Credit.
State Out-of-Pocket Assistance (SOPA)	Subsidy to reduce the share of out-of-pocket costs that the consumer faces when using their health insurance plan.
Native America Premium Assistance (NAPA)	Subsidy that covers the portion of the premium that the federal Premium Tax Credit and the NMPA don't cover.
Medicaid Transition Relief Program (MTPR)	Subsidy that covers the first month's premium for consumers that transfer to BeWell from Medicaid.

Source: 2025 HCAF Program Policy and Procedures

The HCAF's Small Business Premium Relief Program subsidizes premiums for eligible New Mexico small businesses (those with 50 or

fewer full-time equivalent (FTE) employees). HCA has the authority to set the subsidy levels based on available appropriations. To illustrate how the program functions, suppose HCA sets the subsidy at 10 percent of the total gross monthly premiums. Under that scenario, a company with four FTE employees and total monthly premiums of $2,350 would only be charged $2,115 by its health insurance provider. The insurance provider then sends HCA an invoice for $235. HCA uses the HCAF to reimburse the insurance company for the discount. The state notified insurers and businesses in June 2024 that it was doubling the discount to 20 percent between January 2024 and June 2024. Insurance companies distributed a lump sum to businesses for an additional 10 percent.

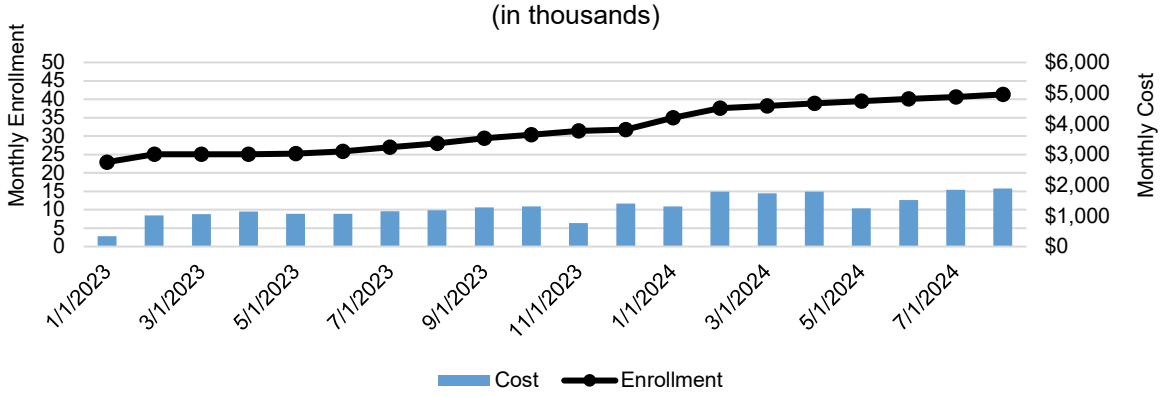
Figure 1. A Logic Model for the Health Insurance Premium Surtax



Source: HCA

The overall cost of the marketplace affordability programs was $19 million while $28 million was appropriated FY24. The state out-of-pocket assistance program is the most expensive component of the marketplace affordability programs and accounts for about 56 percent of expenses. During FY23, the Medicaid transition program (MTPR) accounted for roughly two-tenths of one percent of the expenses, whereas in FY24, the MTPR program accounted for 8 percent of the MAP subsidies. The Native American subsidy program (NAPA) accounted for roughly $2,700 per month, on average, during FY23, and roughly $6,400 per month, on average, during FY24. On average, the MAP program costs $45 per member per month.

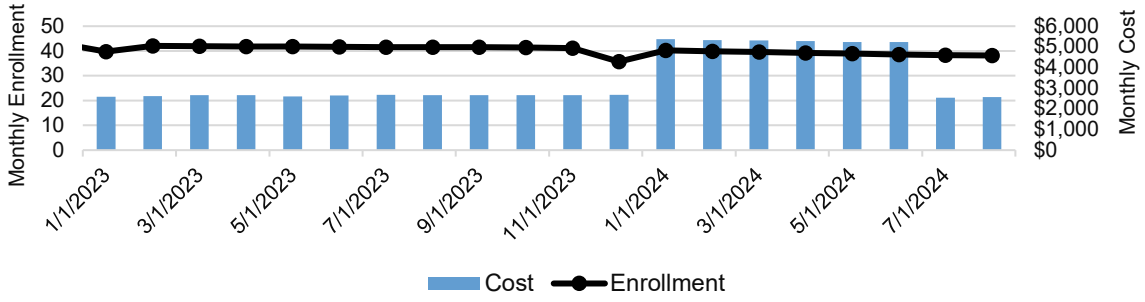
Chart 1. Monthly Enrollment and Monthly Expense to the HCAF for the Marketplace Affordability Programs
(in thousands)



Source: SHARE

The FY24 cost of the Small Business Premium Relief Program was roughly $33 million of the roughly $40 million that was appropriated. In FY23, the overall cost was roughly $29 million of the $30 million appropriated. The Small Business Premium Relief Program started in FY23 with five insurance companies participating in the small business program and ended the year with three. Blue Cross Blue Shield invoiced for roughly 39 percent, Presbyterian claimed 33 percent, United claimed about a fifth of the appropriation while less than 10 percent was claimed by the two companies that exited. Overall, the number of small businesses participating in the health insurance premium relief program fell by 23 percent between July 2022 and July 2024 from about 6,000 to 4,700 small businesses, leading to a 13 percent decline in the number of individuals covered by these policies. On average, the program costs roughly $65 per member per month when the subsidy is 10 percent and $135 per member per month when the subsidy is 20 percent.

Chart 2. Monthly Enrollment and Monthly Expense to the HCAF for the Small Business Premium Relief Program
(in thousands)



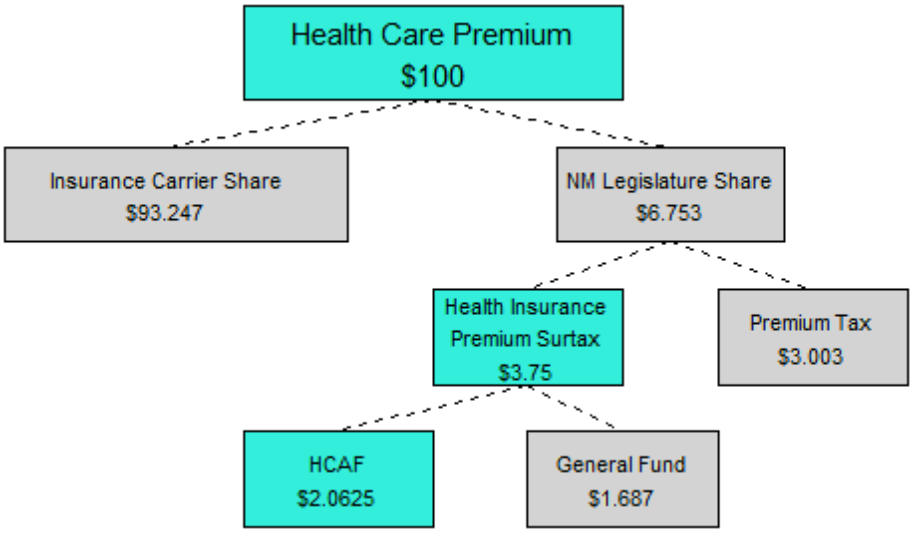
Source: SHARE

The premium surtax generated about $136 million for the HCAF annually from January 2022 to July 2025 and is expected to generate roughly $220 million annually through FY29.

By state law, insurance companies estimate and report their quarterly and annual premiums to the Tax and Revenue Department. The surtax paid on those premiums is the larger of a quarter of the payments made in the prior calendar year or a fifth of the actual payment due for the current year.

Per Senate Bill 317 in 2021, for the last two quarters of FY22, 52 percent of the surtax was distributed to the HCAF. During FY23 and FY24, 55 percent of the surtax was distributed to the HCAF, and, per the schedule, 30 percent was to be transferred in FY25 and beyond. However, House Bill 7, passed during the 2024 regular session (Laws 2024, Chapter 39), amended the distribution schedule, restoring the 55 percent distribution beginning September 1, 2025, and into the future. This 55 percent distribution results in the HCAF receiving roughly $2.06 for every $100 of applicable health insurance premiums.

Figure 2. Health Insurance Premium Surtax Distributions Beginning Sept. 2025



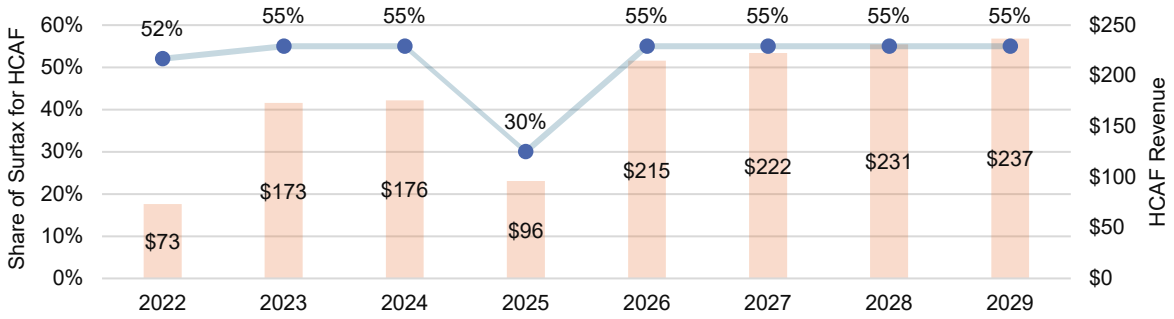
Source: LFC Files

Table 6. How the Share of the Health Insurance Premium Surtax Impacts the HCAF Revenues

Share of Surtax	HCAF Distribution per $100 (in ones)	HCAF Distribution Per $2 billon (in thousands)
25%	$0.94	$18,750
30%	$1.13	$22,500
35%	$1.31	$26,250
40%	$1.50	$30,000
45%	$1.69	$33,750
50%	$1.88	$37,500
52%	$1.95	$39,000
55%	$2.06	$41,250
60%	$2.25	$45,000
65%	$2.44	$48,750
70%	$2.63	$52,500
75%	$2.81	$56,250

Source: LFC Files

Chart 4. Actual and Projected Health Care Affordability Fund Revenues (in millions)



Source: CREG Estimates from 12/24

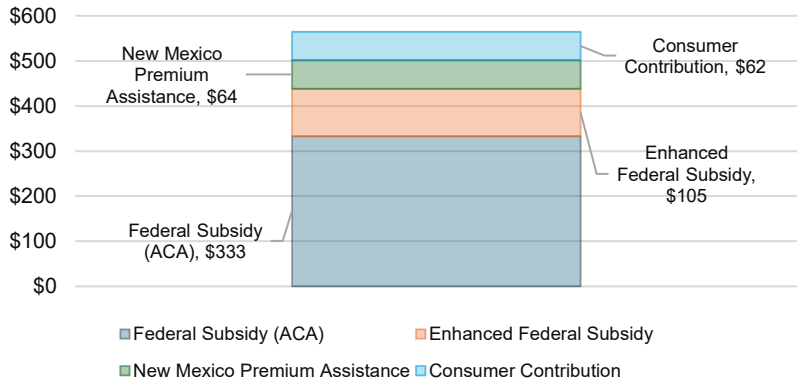
The state's surtax-funded HCAF programs supplement federal subsidies for low- to moderate-income individuals and families.

Congress passed the Patient Protection and Affordable Care Act (ACA) in 2010. The ACA established a marketplace or exchange where individuals, families, and small business groups could purchase qualified health insurance policies that cover essential health benefits. In 2014, the federal government created federal tax credits to subsidize premiums and out-of-pocket costs for eligible individuals and families with reported adjusted annual income between 138 percent and 400 percent of FPL. In response to the pandemic, the federal government introduced enhanced premium tax credits in 2021 and extended them through the end of the federal tax year 2025. The enhanced federal subsidies also provided financial aid for consumers with annual adjusted income above 400 percent of FPL if the health insurance plan cost is above a federally set income threshold or affordability criteria (8.5 percent).

HCA links the HCAF-funded Marketplace Affordability Program subsidies to the federal subsidies in that they further reduce the portion of income that people between 138 and 400 percent of the FPL would need to pay for health insurance.

Chart 5. illustrates how these subsidies stack to reduce premiums. For a 40-year-old with an adjusted annual income of 250 percent of FPL, or approximately $3,100 per month ($37,200 per year), the ACA federal tax credits limited the maximum payment to 7.33 percent of their income. The enhanced federal subsidy lowered the premium limit to 4 percent of income and the New Mexico Marketplace Affordability Program subsidy further lowered the limit to 2 percent. The Office of the Superintendent of Insurance contracted with Mayers and Stauffer to conduct and analyze focus groups with key stakeholders to inform to process of setting affordability criteria.

Chart 5. Composition of a $560 Monthly Premium for a 40-year-old Making $3,100 per Month
(250 percent FPL)



Source: LFC Files, Kaiser Family Foundation

HCA is authorized by the law to set the income thresholds for Marketplace Affordability Program subsidies, which may not equal the federal affordability criteria

Table 8. Federal and New Mexico Thresholds for Health Insurance as a Percent of Adjusted Income by Federal Poverty Level (2024)

FPL	Federal ACA Limit	Enhanced Federal Limit	New Mexico Limit
Up to 150% FPL	3.64%	0.00%	0.00%
150-200% FPL	5.73%	0.00 - 2.00%	0.00%
200-250% FPL	7.33%	2.01 - 4.00%	0.00 - 2.00%
250-300% FPL	8.65%	4.01 - 6.00%	2.01 - 5.00%
300-400% FPL	8.65%	6.01 - 8.50%	5.01 - 8.50%

Source: LFC Files

New Mexico is one of nine states providing additional state-funded subsidies for exchange-purchased health insurance premiums and out-of-pocket costs. State healthcare affordability subsidies vary by eligibility limits linked to the federal poverty level and subsidy type. New Mexico is relatively generous in that both premium and cost-sharing reductions are available for residents with an adjusted annual income of up to 400 percent of FPL through turquoise plans on the BeWell exchange. Massachusetts implemented the first marketplace subsidy program in 2006, providing premium assistance and cost-sharing subsidies for eligible residents with adjusted annual incomes up to 500 percent of FPL.

Table 7. ACA Terms

Term	Definition
Actuarial Value (AV)	The portion of the covered health benefits that will be covered by the insurance policy.
Bronze Plan	The metal tier used to categorize plans with an actuarial value of 60 percent.
Silver Plan	The metal tier used to categorize plans with an actuarial value of 70 percent.
Gold Plan	The metal tier used to categorize plans with an actuarial value of 80 percent.
Platinum Plan	The metal tier used to categorize plans with an actuarial value of 90 percent.
Turquoise Plan	New Mexico plans for state out-of-pocket subsidies. Three tiers based on income.
Cost-Sharing Reductions (CSRs)	Federal cost savings on out-of-pocket costs.
Essential Health Benefits	Ten essential health benefits that the ACA requires health plans to cover for individuals, families, and small businesses.
Qualified Health Plans	QHPs are insurance plans that have been certified by OSI as meeting the ACA affordability and coverage requirements.
Standardized Health Plans	SHPs are insurance plans that are designed by NMHIX that have the same cost-sharing structures so that consumers can easily compare across insurance networks.
Medical Loss Ratio	MLR is the ratio of Reimbursements to Premiums for an insurance company. ACA constrains the MLR to at least 80 percent, which means that the insurance company must spend at least 80 percent of premiums on reimbursements for direct care goods or services.

Source: HealthCare.gov

Table 9. States with Additional ACA Marketplace Subsidies

State	FPL	Premium Assistance	Cost Sharing Reduction	Other
California	250%	No	Yes	
Colorado	250%	Yes	Yes	11,000 slots open for undocumented residents with income up to 300 FPL
Connecticut	175%	Yes	Yes	Sliver plans only
Maryland	400%	Yes	No	Age 18-37 only
Massachusetts	500%	Yes	Yes	
New Mexico	400%	Yes	Yes	New Mexico is developing state subsidy program for undocumented residents in which eligibility will be income-based.
New York	400%	No	Yes	Basic health plan up to 250 FPL
Vermont	300%	Yes	Yes	
Washington	250%	Yes	No	Undocumented can enroll, given income thresholds.

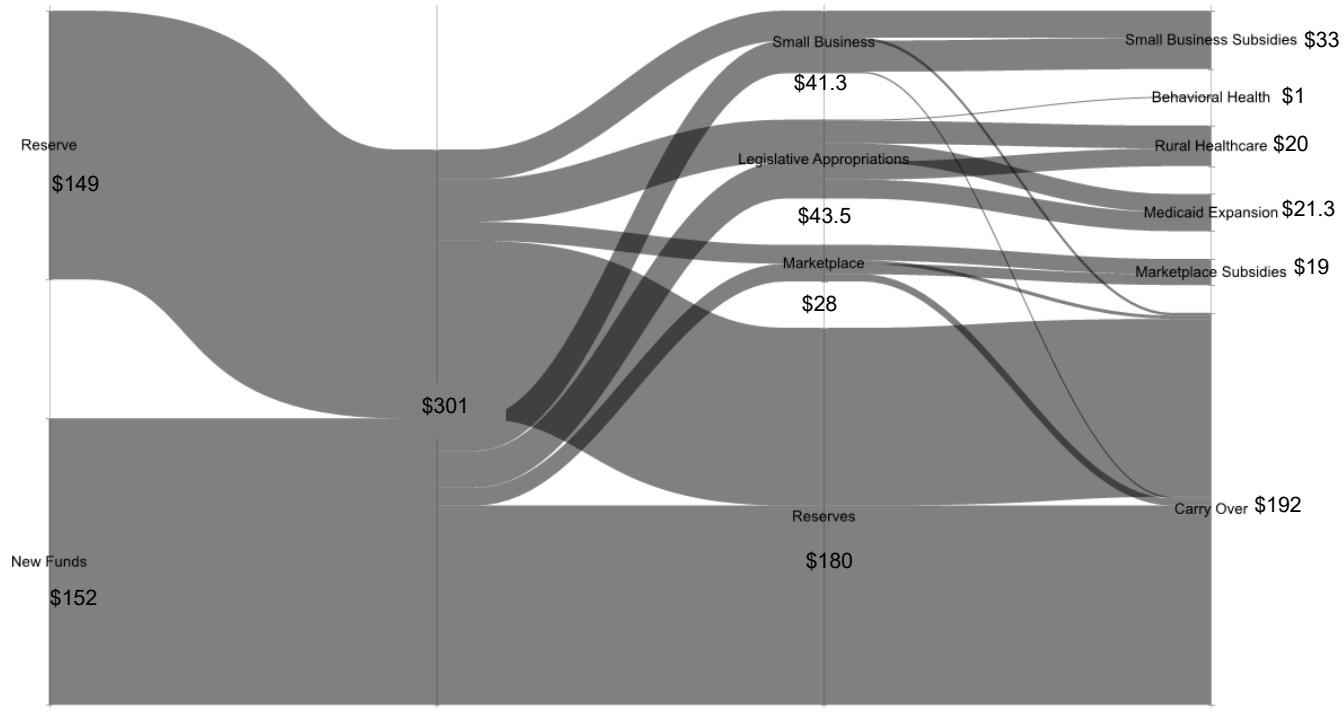
Source: HealthInsurance.org

HCAF revenue from the premium surtax far exceeded the health insurance subsidy needs.

The HCAF has carried over unspent balances between $40 million and $192 million since its establishment in FY22. HCA and OSI have successfully developed complex health insurance subsidy programs with HCAF funding but have not spent all of the appropriations for the subsidy programs.

Because the health insurance premium surtax replenishes the HCAF, the HCAF does not need a large reserve, and the Legislature could consider increasing or decreasing the share of the surtax distributed to the HCAF based on the expected needs. That said, changes to federal and state health insurance policy could require additional resources from the HCAF.

Figure 3. Stock and Flow of FY24 HCAF Funds Through Appropriations to Subsidies
(in millions)



Source: SHARE, LFC Files

In addition to the HCAF subsidy programs, the Legislature has used unspent HCAF balances as a source of funds for other health-related needs. Even with the Legislature using the HCAF for other needs, the HCAF still carries a large reserve balance. Because the HCA links the marketplace subsidies to the federal subsidies, any changes in the federal subsidies will impact the HCAF. If the federal government lets the enhanced federal

subsidies expire, and the affordability criteria set by HCA remain unchanged, then the cost of administering the MAP program will increase from $45 per member per month ($22 million per year) to between $82 and $140 per member per month, on average ($42 million to $70 million per year). Furthermore, if Congress introduces work requirements for Medicaid participation, then some consumers will likely switch from Medicaid to subsidized BeWell insurance, which will cost the HCAF.

Demand for health insurance subsidies has been less than appropriated HCAF funds.

HCA and OSI have established complex subsidy programs that require ongoing partnerships across state agencies. However, the demand for these programs has not reached a level where the state has fully spent the appropriated HCAF funds. This underspending has occurred across all budget categories—personnel and employee benefits, contracts, and other expenses. To date (March 2025) HCA spent approximately $145 million, 62 percent, of the appropriations for the subsidy programs and administration from the HCAF. Approximately 49 percent of appropriations for personal services and employee benefits from FY23 and FY24 were carried over, roughly 21 percent for contractual services, and about 25 percent of appropriations, from FY23 and FY24, for other services were carried over.

HCA successfully spent most ($33 million) of the $41.3 million appropriated for the Small Business Premium Relief Program in FY24 but had to temporarily double the subsidy from January 2024 through June 2024 to do so. Even with the increased subsidy, demand for the program has decreased. This expanded state subsidy for small businesses increased the cost to the HCAF by an approximately $17 million and translated into increased affordability for small businesses.

Participation in HCAF subsidized insurance has increased since the introduction of HCAF subsidies, though it is likely that much the growth in enrollment is due to the federal enhanced tax credits. The Marketplace Affordability Programs have cost much less than appropriated funds. For FY24, the Legislature appropriated $28 million, but qualified enrollees only required a total of $19 million to meet the subsidy requirements of limiting health insurance costs to a small portion of total income.

This $19 million, while still $9 million less than appropriated, is much larger than the underspend from FY23. In FY23, the Legislature appropriated $28 million from the HCAF to the Marketplace Affordability Program subsidies, and HCA spent $5.7 million on reimbursements for MAP subsidies. The remainder of the appropriation stayed in the HCAF as a carryover balance. The large (80 percent) carryover resulted from both, the fact that the MAP subsidies only operated for six months during FY23 and an unrealized demand that approximately 28 thousand New Mexicans

would transition from Medicaid to BeWell due to the unwinding of the post-pandemic Medicaid. In actuality, only 10.5 thousand transitioned.

The MAP programs performed better or spent more money in FY24 likely because the subsidy programs operated for the full 12-month fiscal year and because enrollment continued to experience 1-2 percent per month. Finally, the expense of the Medicaid transition relief program hit the HCAF appropriation harder in FY24 relative to FY23. In FY23 the Medicaid transition relief program accounted for less than one percent of the MAP expenditures and about 8 percent in FY24.

Table 10. HCAF Budget to Actuals
(in thousands)

FY	State Payment Accounts	Budget	Expense	Percentage Remaining
2023	Personal Services and Employee Benefit Payments	$180.8	$148.0	18.1%
2024	Personal Services and Employee Benefit Payments	$325.2	$110.4	66.1%
2025	Personal Services and Employee Benefit Payments	$548.4	$257.0	53.1%
2023	Contractual Services Payments	$750.0	$613.9	18.2%
2024	Contractual Services Payments	$950.0	$717.4	24.5%
2025	Contractual Services Payments	$3,335.0	$345.6	89.6%
2023	Other Payments	$58,074.7	$35,075.4	39.6%
2024	Other Payments	$79,070.7	$67,116.4	15.1%
2025	Other Payments	$82,713.9	$37,746.8	54.4%

Note: 2025 is in motion as of March 2025 and are expected to further deplete through June 2025.

Source: SHARE

The Legislature has appropriated portions of the HCAF for other health-related programs.

In addition to the subsidy programs, the Legislature appropriated nearly $141.5 million from the HCAF for other health-related needs between FY22 and FY25. Even with the Legislature using the HCAF for other health-related needs, the fund runs a large reserve balance. Approximately 60 percent of the HCAF balance has been carried over from year to year. In other words, the HCAF subsidy programs and other health-related spending costs roughly only 40 percent of the funds available in the HCAF. The surtax has generated roughly $735 million for the HCAF and roughly $535.5 million has been used for HCAF subsidies and other health-related needs. More than half of the surtax distribution to the HCAF is carried over, unspent from one year to the next.

Table 11. Other Health-related HCAF Appropriations
(in thousands)

Other Health-Related Needs	FY23	FY24	FY25	FY26
Medicaid Expansion	$31,755	$21,300	-	$30,000
Labor Costs - Covid-19	$10,000	-	-	-
GSD-Shortfalls	$10,000	-	-	$25,000
OSI-Operational Replenishment	$250	-	-	-
State Medicaid	$13,970	-	-	-
Rural Healthcare	-	$20,000	$30,000	-
NMMIP - Lost Premiums	$1,500	$750	-	-
Behavioral Health Needs	-	$1,000	$1,000	-
State Group Health Benefits	-	-	-	$78,500

Source: SHARE

Table 12. HCAF Fund Balance versus Expenses
(in millions)

	FY22	FY23	FY24	FY25*	FY26*	FY27*
Carry-over	$0	$39.83	$149.42	$192.27	$173.42	$197.50
New Funds from Surtax	$73.96	$175.94	$175.60	$96.30	$214.70	$222.40
HCAF Balance	$73.96	$215.77	$325.02	$288.57	$388.12	$419.89
HCAF Expenses	$34.13	$66.35	$109.45	$116.55	$209.00	$148.00
Percentage Remaining	54%	69%	66%	0%	46%	65%

Note: Carry-over arises from unspent funds in the HCAF. For example, in FY23, HCAF had $215.77 million at the start of the FY, they spent $66.35 million and carried over $149.42 million into FY24.
*Projected

Source: 2024 HCA Report to Legislature and SHARE

Table 13. Effect of the Expiration of Enhanced Federal Subsidies on Monthly Premiums by the Consumer FPL and Family Size–No HCAF Subsidies

Family Size	FPL	Monthly premium with Enhanced Subsidies	Monthly Premium without Enhanced Subsidies
1	150%	$0	$69
1	200%	$50	$144
1	250%	$126	$230
1	300%	$226	$326
4	150%	$0	$142
4	200%	$104	$298
4	250%	$260	$476
4	300%	$468	$675

Note: Individuals that earn 150 percent of FPL report adjusted income of $23,475 annually;$31,300 (200 FPL); $39,125 (250 FPL); and $45,180 (300 FPL).

For a family of 4, $48,225 (150 FPL); $64,600 (200 FPL); $80,375 (250 FPL); and $96,450 (300 FPL).

Source: LFC Analysis of KFF Calculator

Potential changes in federal health insurance funding policies may increase the costs to the HCAF.

Several adjustments to the federal health insurance policy landscape may change the demand for HCAF funding. If the enhanced federal subsidies for tax credits expire at the end of 2025, the federal subsidy level will decrease, and HCAF funds will be required to supplant the lost federal funds. The extent to which the HCA maintains the current premium assistance affordability criteria is a policy question and should be reviewed in light of other potential changes to the federal health subsidy policies. For example, establishing federal work requirements for Medicaid recipients could increase the demand for HCAF subsidy programs while decreasing the demand for Medicaid programs.

If the enhanced subsidies expire, then the per member per month cost of the MAP subsidies is expected to increase from approximately $45 to $130, or 189 percent. The monthly MAP subsidies cost the HCAF nearly $1.9 million in August 2024. If the enhanced federal subsidies were cut, the cost

to the HCAF for the more than 41 thousand enrollees would have been approximately $5.3 million per month or roughly $60 million per year instead of $23 million per year.

The expiration of the enhanced federal subsidies may cost the HCAF an additional $25 million to $65 million per year over the next three years (FY26 to FY28) if the state chooses to replace the temporary federal subsidies. The enhanced federal subsidies are a substantial source of financial aid for eligible New Mexicans who purchase subsidized health insurance on BeWell. By design, the enhanced federal subsidies are scheduled to sunset at the end of 2025. The expiration of the enhanced subsidies will reduce federal subsidies for health insurance purchased on BeWell.

HCA and OSI work with the technical planning firm Wakely for actuarial and program planning through a contract with Myers and Stauffer. Wakely estimates that the expiration of the enhanced subsidies will cost the HCAF an additional $37 per member per month, on average. Whereas, using the Kaiser Family Foundation Calculator, LFC staff estimate an average increase in the cost to the HCAF of roughly $85 per member per month.

The extent to which the HCAF subsidies should replace the enhanced federal subsidies is a policy question. If HCA retains the current affordability criteria in the absence of the enhanced federal subsidies, then the cost to the HCAF for the MAP subsidies will more than double. However, state law emphasizes that the HCAF subsidies should prioritize lower-income, uninsured New Mexican residents and small businesses, and, as a result, HCA could modify the affordability criteria to focus subsidies on lower-income individuals to contain costs.

State Policy Levers for Cost Control are the Affordability Criteria for Premium Assistance and the Actuarial Values of State Subsidized Insurance Plans

- The extent to which the HCAF subsidies should fully replace the enhanced federal subsidies is a policy question.
- HCA could adopt premium affordability criteria that mirrors the federal government or criteria that are more generous.
- The actuarial value of the Turquoise plans that are eligible for state out-of-pocket assistance is also a policy lever to control costs.

Source: LFC Analysis

Table 14. Potential Impacts of Federal Enhanced Subsidy Expiration
(in millions)

Wakely Estimates					
Marketplace Affordability Program	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**
Enhanced federal subsidies	$27.2	$37.5	$58.6	$66.6	$68.5
No enhanced federal subsidies	$27.2	$37.5	$72.3	$95.2	$99.1
LFC Estimates Using Kaiser Calculator					
Marketplace Affordability Program					
Enhanced federal subsidies	$27.2	$37.7	$57.9	$66.6	$68.5
No enhanced federal subsidies	$27.2	$37.7	$117.1	$123.8	$125.8

Source: LFC Analysis

If the federal government establishes a work requirement for Medicaid participation, LFC simulation analysis projects that the demand for HCAF subsidized coverage could increase by 41.6 thousand adults. Which is expected to cost the state roughly, between roughly $41 million and $70 million per year, depending on if the enhanced subsidies expire. The Medicaid unwinding process increase demand for HCAF subsidized coverage on BeWell. Similar transitions would surely occur if the federal

government established work requirements for Medicaid. (See Appendix B. for more about the Monte Carlo simulation).

Table 15. LFC Estimates of the Impact of a Medicaid Work Requirement on BeWell

Simulated Quantity	Min	Mid-Point	Max
Number of people in Expansion group to exit Medicaid	64,760	82,791	103,446
Number of people that exit Medicaid and take-up on BeWell	31,369	41,460	51,684
Estimated Savings and Costs	**in millions**	**in millions**	**in millions**
State Savings	$44.2	$56.3	$70.4
State Cost *with* Enhanced Subsidies	$26.4	$40.5	$62.5
State Cost *without* Enhanced Subsidies	$44.3	$70.0	$109.4

Source: LFC Analysis

HCA estimates an additional $23 to $72 million annual expense to the HCAF to stand up the Coverage Expansion Program (CEP).

HCA was quick to stand up the small business premium relief program and the MAP subsidies for low- to moderate-income individuals and families but has struggled to stand up the Coverage Expansion Program (CEP).

HCA's Coverage Expansion Program (CEP) is a subsidy program for low- to moderate-income uninsured residents. HCA planned for a mid-March 2025 launch of the CEP subsidy program, but as of March 2025, the program is not yet active. HCA reports that the CEP has been delayed by the details of the implementation plan, such as the sustainability of the financing plan and the governance structure. Once implemented, the HCA expects the CEP to cover between 6,000 and 13 thousand members and cost the HCAF between $300 and $500 per member per month, or roughly $64 million per year. A lower enrollment cap will be set during the first several months of the program to ensure cost projections are not exceeded.

HCA's current proposal for this program is to subsidize health insurance plans that cover the 10 essential health benefits for eligible residents with reported income of up to 200 percent of FPL. The CEP will layer on top of any Emergency Service coverage programs for which CEP members may be eligible. The plan, until late April 2025, was that the high-risk New Mexico Medical Insurance Pool (NMMIP) would administer the CEP; however, the CEP would be financed separately from the NMMIP. Moreover, because NMMIP members have comparably higher costs than BeWell members, CEP rates would be set at either commercial or Medicaid rates to prevent NMMIP migration into CEP.

The Coverage Expansion Program was set to Launch July 1, 2025 but has been put on hold while HCA issues an RFP for program administration.

HCA terminated the remainder of a Government Services Agreement (GSA) with the New Mexico Medical Insurance Pool as soon as it became clear that NMMIP was not classified as a government entity. HCA plans to issue an RFP to identify a qualified organization to administer the CEP.

Source: HCA

Several states have discontinued their high-risk pool as the ACA prevents insurance companies from discriminating against consumers with pre-existing conditions. If, on average, CEP members are healthier than the NMMIP members, then, other things remain constant, adding the CEP risk to the NMMIP risk pool may lead to lower premiums, on average, for NMMIP members, while at the same time providing access to health insurance coverage for traditionally uninsured residents. With more experience with the CEP and NMMIP risk pools, HCA should be able to determine if merging these pools with the BeWell pool would be advantageous.

Table 16. Estimated Annual Costs to the HCAF for the Coverage Expansion Program

Coverage Expansion Payment Levels	FY2025	FY2026	FY2027	FY2028
Overall costs	In millions	In millions	In millions	In millions
Medicaid reimbursement level	$23.4	$46.7	$45.5	$53.7
Commercial reimbursement level	$31.9	$63.6	$65.6	$72.3
Per Member Per Month costs	In ones	In ones	In ones	In ones
Medicaid reimbursement level	$582.0	$505.0	$418.0	$388.0
Commercial reimbursement level	$792.0	$688.0	$567.0	$522.0
Number of participants	Count	Count	Count	Count
Expected Take-up	6,700	7,700	9,650	11,550

Source: LFC Wakely Report to HCA

Recommendations

The Health Care Authority should:

- Work with the LFC and DFA to review and make recommendations on the share of the surtax required for the HCA to meet annual program performance goals;
- In consultation with New Mexico Health Insurance Exchange, TRD and New Mexico Medical Insurance Pool, work with LFC and DFA to conduct an annual review of the share of the surtax required for HCA to meet their annual performance targets; and
- Codify the learning from the Medicaid outreach and develop and outreach campaigns to increase the number of qualified people enrolled in health insurance on BeWell with the intention of reducing the uninsurance rate among the targeted subsets of New Mexicans.

HCA could refine and expand HCAF performance measures.

LFC expects that agencies develop and report AGA performance measures that directly relate to the core function of government programs and indicate progress toward an annual performance target. Further, LFC expects agency management to use performance data to optimize spending and internal functions to meet those annual targets.

Senate Bill 317 (SB317) from 2021 establishing the HCAF required OSI, now HCA, to provide annual reports to the Legislature that summarize the agency's affordability criteria for providing subsidies, the number of New Mexicans enrolled in subsidized exchange plans, and the amount in reduced costs and coverage assistance the initiatives provided in the current and previous calendar years by income level, county, and coverage source. Each agency has provided this report annually.

SB317 also required OSI (now HCA) to work with LFC and DFA to develop and report on performance measures relating to HCAF programs. In response, HCA introduced four new Accountability in Government Act (AGA) performance measures for the HCAF for FY26, which are slightly more relevant than OSI's prior year HCAF measures but could still be improved for future years. Neither these new AGA performance measures nor the annual report fully cover the breadth and depth of the HCAF subsidy programs and HCA could refine and add AGA measures to meet LFC's elements of good performance measures.

Table 17. FY26 HCAF Performance Measures

Performance Measure	Target
Increase in percent of marketplace enrollees in Turquoise Plans	10 % increase
Increase in percent of small-group enrollees in Platinum Plan	10 % increase
Total dollars saved for consumers across all programs	$200 million
Total enrollment in the Coverage Expansion Plan	7,700

Source: LFC FY26 Volume 2

LFC's Elements of Good Performance Measures

Ideal performance measures should be

- **Useful:** Provide valuable and meaningful information to the agency and policymakers
- **Results-Oriented:** Focus on outcomes
- **Clear:** Communicate in a plain and simple manner to all stakeholders (employees, policymakers, and the general public)
- **Responsive:** Reflect changes in performance levels
- **Valid:** Capture the intended data and information
- **Reliable:** Provide reasonably accurate and consistent information over time
- **Economical:** Collect and maintain data in a cost-effective manner
- **Accessible:** Provide regular results information to all stakeholders
- **Comparable:** Allow direct comparison of performance at different points in time
- **Benchmarked:** Use best practice standards
- **Relevant:** Assess the core function of the program or significant budget expenditures

The current AGA performance measures are insufficient for HCA to demonstrate the impact of HCAF subsidy programs.

In Senate Bill 317 from 2021, the Legislature explicitly stated that the purpose of the HCAF was to reduce uninsurance rates for make health insurance more affordable for New Mexicans and small businesses. In all cases, SB317 directed HCA to prioritize subsidizing the lowest-income people. As such, for FY27 and beyond, HCA could add more

straightforward outcome measures and targets to measure results quarterly. Those could include:

Related to the uninsured:

- The number of uninsured New Mexico residents that are eligible for HCAF supported subsidies

Related to SB317 priority low-income New Mexicans:

- The average monthly MAP premium subsidy provided to enrollees under 200 percent FPL
- The average monthly out-of-pocket MAP subsidy provided to enrollees under 200 percent FPL
- The number of uninsured New Mexican residents with income under 200 percent of FPL who are eligible for the CEP
- The number of uninsured New Mexican residents with income under 200 percent of FPL enrolled in the CEP

Related to moderate-income New Mexicans:

- The average monthly MAP premium subsidy provided to enrollees between 200 and 400 percent FPL
- The average monthly out-of-pocket MAP subsidy provided to enrollees between 200 and 400 percent FPL
- The number of uninsured New Mexican residents with income 200 or more of FPL who are eligible for the CEP
- The number of uninsured New Mexican residents with income 200 percent or more of FPL enrolled in the CEP

Related to small businesses:

- Number of businesses participating in the Small Business Premium Relief Program
- Average per member per month cost of participating small business health insurance plans before subsidies
- Average per member per month small business premium subsidy

Related to revenue adequacy:

- Total expenditures on HCAF programming
- Total premium surtax funds deposited into the HCAF

The underlying importance of ensuring people of all income levels access health insurance is to promote preventative care and treatments and reduce uncompensated care in hospitals and other healthcare settings. However, even subsidized turquoise plans require some out-of-pocket payments by enrollees, which could deter people on subsidized plans from accessing healthcare. The HCA could use the Department of Health's All-Payer Claims Database to measure MAP enrollees' use of preventative or regular care to determine if out-of-pocket costs remain detrimental to full healthcare use.

HCA could use per member per month performance to guide program design revisions for the MAP and Small Business Programs.

The actuarial analysis that Wakely reported to HCA's Health Care Affordability Bureau suggests that the per member, per month cost to the HCAF for the Small Business Premium Relief program is much more than the Marketplace Affordability Program. Both programs subsidize qualified health plans. Between January 2023 and FY24, MAP programs cost the HCAF roughly $45 per member per month, and the small business program cost roughly $79 per member per month.

Small business program enrollees have access to more comprehensive platinum plans, whereas MAP participants have access to turquoise plans which are slightly more affordable than platinum plans.

Table 19. Per Member Per Month Cost to the HCAF

Program	FY25	FY26	FY27	FY28
Small Business	$109.00	$158.00	$171.00	$184.00
MAP				
With Enhanced Subsidies	$55.00	$83.00	$93.00	$96.00
Without Enhanced Subsidies	$55.00	$104.00	$137.00	$143.00

Source: Wakely Report to HCA

The small business market has shrunk since the onset of the HCAF subsidy program, both in terms of consumer participation and the number of insurance companies that offer policies qualified for the subsidies. It is unclear whether the decrease in the small business market results from the enhanced premium tax credits coupled with more generous affordability criteria afforded by the MAP crowding out the small business plans or other factors. It could be less costly to the state and more effective for small businesses for HCA to deliberately combine aspects of the MAP with the small business premium relief program.

Massachusetts operates its Health Connector for Business, which offers health insurance options for businesses with up to 50 full-time equivalent employees. To simplify the health insurance process for small businesses, the marketplace offers three options. Employers can choose one plan in which all employees enroll in, one metal level, employees can then choose any carrier that offers the level of plan, or one carrier in which employees can choose among plans that vary by benefit level. In all cases, the employer contributes the same amount to each employee plan. Connect Well is a plan for employees to select and engage in at least one healthy activity in exchange for $100 gift cards per activity. If at least one-third of employees at an eligible small business engage in at least one activity, then the employer receives a 15 percent rebate on their contributions towards premiums.

Currently, HCA is considering a variable subsidy for small business premiums based on the metal tier of the plan selected by the organization. While this may encourage some plan switching for more generous, or higher actuarial value plans, this may not encourage both the employees and employers to engage in healthy activities. HCA should work with small business advocates to design a program that meets their needs, similar to how Massachusetts searched for a design that fits the market.

Recommendations

The Health Care Authority should:

- Develop and report annual outreach campaigns to increase the number of qualified people enrolled health insurance on BeWell with the intention of reducing the uninsurance rate among the targeted subsets of New Mexicans; and
- Evaluate the small business affordability program design specifications to maximize the savings to consumers and minimize the costs to the state;
- In consideration with stakeholders, to set and report progress towards a targeted five-year uninsurance rate for individuals and families that are eligible for HCAF subsidies; and
- Work with LFC, DFA and other stakeholder refine and expand the current HCAF performance measures.

Agency Response

HEALTH CARE AUTHORITY

May 9, 2025

Director Sallee,

The Health Care Authority (HCA) is grateful for the opportunity to respond to the Legislative Finance Committee's (LFC's) evaluation of the Health Care Affordability Fund (HCAF). The HCAF plays a critical role in ensuring New Mexicans have access to affordable health coverage. With significant changes to the coverage landscape proposed at the federal level, the Legislature's decision to increase the distribution of surtax revenue to the Fund from 30% to 55% will be critical. The HCAF statute was designed to respond to shifting federal policies and we expect HCA and the LFC will need to work together closely to ensure we meet our shared goal of New Mexicans maintaining access to quality, affordable health care coverage.

HCA's response provides additional context to LFC's evaluation. We thank the LFC's evaluators for their work on this statutorily required evaluation and look forward to continued collaboration.

HCAF Programs Have Made New Mexico a Leader in Coverage Affordability
Since HCAF programs launched, New Mexico's affordability initiatives have saved individuals, families, and small businesses millions of dollars in premiums and out-of-pocket costs. The Small Business Health Insurance Premium Relief Initiative saved small businesses and their employees $110 million since the program launched. New Mexico is the only state directly supporting small businesses with the growing costs of health insurance. FY26 appropriations will allow small businesses to leverage greater discounts.

The Health Insurance Marketplace Affordability Program (MAP) makes New Mexico's individual marketplace the most affordable in the nation. Marketplace enrollment has grown from 35,000 when the program launched in 2023 to more than 70,000 today. Two of every three enrollees are benefiting from the State Out-of-Pocket Assistance program, which lowers deductibles and co-pays. An HCA analysis found the maximum an individual at 300% of the Federal Poverty Level would pay in premiums and medical expenses for the lowest cost Gold option was 6% of household income, compared to 26% in California, 24% in Colorado and Kentucky. These programs provide a glidepath from Medicaid into private coverage for thousands of New Mexicans.

The Importance of HCAF in a Shifting Federal Landscape
With significant funding cuts for Medicaid and the Marketplace proposed at the federal level, the HCAF is a critical tool for helping New Mexicans maintain coverage.

Enhanced Marketplace Subsidies Are Scheduled to Expire at the End of 2025
Since mid-2021, Marketplace consumers have had access to enhanced federal subsidies through the American Rescue Plan Act and Inflation Reduction Act. With these subsidies scheduled to expire in 2025, it will cost the HCAF more to maintain existing affordability standards. During the 2025 legislative session, the Legislature appropriated sufficient funds to backfill the loss of federal subsidies with HCAF

funds for individuals up to 400% FPL during the second half of FY26. This will significantly increase the recurring general fund need for the MAP.

Proposals to Eliminate "Silver Loading" Will Increase Consumer Costs

In 2017, the Trump Administration eliminated funding for Cost Sharing Reductions (CSRs), which are payments to insurers that help lower out-of-pocket costs for lower-income consumers. However, insurers remained legally required to provide these benefits. To offset the loss of federal funding, insurers raised premiums on silver-tier plans, a strategy known as "silver loading." Since federal premium subsidies are tied to the cost of silver plans, this led to higher federal subsidies, which in turn reduced net premiums for many enrollees, including those who selected Gold plans.

Congress is exploring a proposal to restore CSR funding, which would eliminate the need for silver loading. This change would decrease federal premium subsidies and increase net premiums on plans for most enrollees in New Mexico due to decreased premium subsidies. In particular, the net premiums for Gold plans, which 69% of New Mexico's enrollees have purchased, are expected to increase substantially. This would also impact the structure and design of New Mexico's out-of-pocket assistance program. HCAF could help mitigate these increases and HCA is working with its actuaries to determine the potential effects of this policy decision.

Potential Federal Medicaid Funding Cuts and Program Changes

There are also potential Medicaid policy changes that could affect the Marketplace and the HCAF Coverage Expansion Program. As Congress considers federal spending cuts that could reduce Medicaid funding, many of its current proposals could reduce the number of people eligible for Medicaid. If that happens, some individuals may instead qualify for coverage through the Marketplace or the Coverage Expansion Program. These proposals include, but are not limited to:

- reduced federal matching rates for the Medicaid Expansion population;
- per capita caps;
- changes in provider taxes;
- premiums;
- co-pays for certain Medicaid enrollees;
- disallowing coverage of non-citizens; and,
- work requirements

Because the details of these changes are not yet known, it is difficult to predict the impact on HCAF programs. For example, while Medicaid work requirements could lead to loss of Medicaid coverage, it is unclear whether these individuals would become eligible for subsidized Marketplace coverage. If they are ineligible for Marketplace coverage, any financial assistance would likely come through the Coverage Expansion Program, which would be more expensive for the state when compared to MAP.

Federal and State Policy Uncertainty Drove Lower Than Expected Spending in Early Years

HEALTH CARE AUTHORITY

The Legislature designated the Office of the Superintendent of Insurance (OSI) as the entity to oversee the HCAF when it was established in 2021. (Senate Bill 14, passed during the 2024 regular session, amended Laws 2023, Chapter 205, to place management of the Fund under HCA). When OSI initially modeled costs for the first year of the Marketplace Affordability Program (MAP), it was operating in a very uncertain federal policy environment. Specifically, it was unclear when the COVID-19 Medicaid Continuous Coverage Requirement would end. Ultimately, this Requirement remained in effect for much of the HCAF's inaugural year. This reduced the number of individuals enrolled in the Marketplace during 2023 as many individuals remained enrolled in Medicaid.

In addition, enhanced federal subsidies were scheduled to expire when OSI submitted its FY23 budget request and OSI based its budget request on modeling that assumed these subsidies would expire. The Inflation Reduction Act extended the enhanced federal subsidies only four months before the HCAF programs were set to launch.

As a result of this Federal uncertainty related to the COVID-19 Medicaid Continuous Coverage Requirement, Marketplace enrollment was temporarily suppressed, and the passage of the enhanced Federal subsidies significantly reduced the HCAF need for that year. Since then, enrollment on BeWell, New Mexico's Health Insurance Marketplace, has increased substantially, and the likely loss of federal subsidies at the end of 2025 is going to significantly increase program costs to maintain coverage affordability.

Another factor that contributed to lower costs in early years of the program was the scheduled reduction in revenue distributed to HCAF in FY25, which would have reduced revenue from 55% of surtax revenues to 30%. This scheduled reduction prompted OSI to offer some of the affordability programs to fewer people and at reduced levels. During the 2024 session, the Legislature readjusted the share to 55% starting in FY26, which allowed key Marketplace programs to provide coverage to more people with greater certainty about future funding.

HCA's FY26 HCAF Budget Request Closely Matched FY26 Projected Revenues

HCA's FY26 budget request for HCAF programs was $210 million, which closely aligned with HCAF projected FY26 revenue of $215 million. Ultimately, $180 million was appropriated for core HCAF programs. As noted in the previous section, significant changes to the Marketplace and Medicaid policy at the federal level are likely to necessitate significant ongoing funding needs. While collaboration with other agencies and the Legislature is critical for program success and budget planning, the HCA believes changing the HCAF funding formula is not warranted at this time.

HCAF Reserves Are Now Less Than Half of a Year of Projected Program Costs

As noted above, the large HCAF reserves resulted from federal and state policy uncertainty and program launch delays. It has only been since FY25 that the Health Care Affordability Bureau could plan its budget knowing revenues would remain stable year-over-year. The projected fund balance for FY26 is $88.7 million, less than half a year of projected ongoing funding needs for HCAF programs.

HEALTH CARE AUTHORITY

FY 25 Fund Balance	$190,598.8
FY 26 Revenue	$212,800.0
FY26 Recurring Program	($148,000.0)
FY26 Medicaid	($30,000.0)
FY26 Special Appropriations	($33,200.0)
FY26 GSD Health Benefits Deficit	($25,000.0)
FY26 SB 376 Costs	($78,500.0)
Total Remaining FY26 Fund Balance	**$88,698.8**

The HCAF Bureau Will Be Fully Staffed at the End of May 2025
Personnel costs were lower than projected in FY24 and part of FY25 due to the Director position being vacant for a significant period and a delay in the implementation of the Coverage Expansion Program, which caused a delay in the creation of a Program Coordinator position. All existing HCAF positions will be filled by the end of May 2025 and HCA is already in the process of creating four new positions, authorized by the Legislature, to improve program management and community outreach.

Update on the Coverage Expansion Program
The purpose of the Coverage Expansion Program is to offer coverage to those who are not eligible for other types of employer-sponsored or public coverage, such as Medicaid, Medicare, or Marketplace coverage. The Legislature created the statutory authority with the intention to addressing gaps in the coverage landscape that leave New Mexicans uninsured.

Federal changes could have substantial impacts on the Coverage Expansion Program. For example, if federal Medicaid cuts result in loss of Medicaid eligibility, new gaps in coverage are likely to occur, making more individuals eligible for the Coverage Expansion Program. This could include working individuals who miss a work requirement deadline and temporarily lose Medicaid eligibility. Changes in federal rules, such as the Biden Administration's interpretation of Premium Tax Credit eligibility for those without affordable family insurance from an employer, could also expand the number of people who rely on the Coverage Expansion Program. In addition, if federal changes restrict states from providing coverage for non-citizens, HCA will need to re-evaluate program parameters and costs.

The Coverage Expansion Program implementation date is January 1, 2026. A Request for Proposals will be released in Summer 2025.

HCA Agrees with the Need for Continuous and Targeted Outreach
LFC's recommendation that HCA conduct targeted outreach campaigns to promote HCAF programs is well received, and HCA is glad to report that efforts to drive awareness and education are already underway. Nevertheless, while BeWell's efforts to increase and retain enrollment have been effective, HCA continues to see opportunities to promote its programs in the community and will continue to engage BeWell. To support ongoing and effective outreach, HCA requires sufficient funding for outreach and respectfully requests LFC support the agency's FY27 outreach budget request.

HEALTH CARE AUTHORITY

While Setting Goals Around Increasing Insurance Uptake are Important, Some Critical Factors are Outside HCA's Control

We appreciate the LFC's willingness to update its recommendation pertaining to reducing the uninsured rate specific to those who are eligible for HCAF programs. While reducing the uninsured rate is an important goal, it is important to note that some of the factors that contribute to coverage rates are outside the direct control of the HCA. For example, the federal landscape is in flux regarding Marketplace rules. Specifically, a number of elements to the recent Centers for Medicare & Medicaid Services (CMS) 2025 Marketplace Integrity and Affordability Proposed Rule could negatively affect enrollment.

- Currently, Marketplace Open Enrollment occurs from November 1st through January 15th each year. The HCA is concerned about the proposal to shorten the current Open Enrollment Period (OEP) by 31 days, ending it on December 15th. This change would significantly reduce the time available for consumers to enroll in coverage and could have adverse impacts on enrollment outcomes across the Marketplace. In BeWell's most recent enrollment cycle, a substantial portion of consumers enrolled during the final weeks of the OEP: in Open Enrollment 2024, 56% of new BeWell consumers enrolled between December 16, 2024, and January 15, 2025—an increase from 43% during that same timeframe in the previous year.
- The HCA is concerned about the proposed elimination of the monthly special enrollment period (SEP) for applicants with income up to 150% of the Federal Poverty Level (FPL). This SEP is one of the most frequently used on BeWell's platform, accounting for 1,254 enrollments in Plan Year 2024.
- The HCA is concerned about the proposal to apply a $5 premium for enrollees with $0 plans, fully subsidized by the Advance Premium Tax Credit (APTC), who are automatically reenrolled without updating or confirming their eligibility determination. If finalized, such a policy is likely to result in a decline in Marketplace enrollment due to consumer confusion and additional administrative burdens. There is considerable evidence that lower-and-moderate-income consumers are price sensitive and even small health insurance premiums—as little as a few dollars per month (or less)—can result in loss of coverage. BeWell has 9,732 consumers who were auto-reenrolled in zero premium plans, which is approximately 27% of the total 36,465 consumers who were auto-reenrolled during the last OEP.
- CMS proposes to require Marketplaces to generate a data matching issue (DMI) when an applicant attests to a projected household income of 100–400% FPL while income data from trusted government sources indicate income below 100% of the FPL. This will create a further burden on consumers that could lead to disenrollment.

These types of changes go against best practices and a growing body of evidence shows seemingly minor administrative burdens can create significant reductions in uptake. While BeWell has been a great partner in minimizing administrative burdens and maximizing enrollment opportunities, if these federal changes are adopted, they will limit the degree to which Marketplaces can follow best practices.
Other broader changes, including changes to federal Medicaid/Marketplace financing and policy, will also limit HCA's ability to increase insurance uptake. As the federal government reconsiders its actions related to health care coverage access and affordability, HCA's priority may be to maintain recent coverage gains while also wisely investing future HCAF resources.

HEALTH CARE AUTHORITY

HCAF Performance Measures

The HCA appreciates LFC's recommended reporting measures and proposes only minor amendments; we will work with LFC this summer to finalize performance measures. While HCA believes it is appropriate to track and report Coverage Expansion Program enrollment, we caution against only reporting enrollment of certain groups of potential enrollees, such as undocumented individuals. As noted throughout this response, federal changes could significantly change the population who relies on the program.

Merging Programs is Worth Exploring- Stakeholder Engagement is Critical

The HCA appreciated LFC's suggestion that we evaluate whether aspects of MAP could be combined with the Small Business Premium Relief Initiative to save costs for both consumers and the State. As some small businesses continue to see the ability to offer health coverage to their employees as a hiring incentive, it is important to consider that as HCA proceeds. In addition, close collaboration with BeWell, OSI, and insurance carriers is critical to any such discussion.

Conclusion

The Health Care Affordability Fund is a cornerstone of New Mexico's efforts to ensure access to affordable, high-quality health coverage. As this response outlines, HCAF programs have delivered measurable savings to individuals, families, and small businesses—making New Mexico a national leader in coverage affordability. At the same time, federal uncertainty and proposed policy changes pose real risks to the progress the State has made. The HCA is committed to working closely with the Legislature, the LFC, and community partners to safeguard these gains, responsibly manage program resources, and prepare for a future in which HCAF's role may become even more vital. We appreciate the opportunity to provide this response and look forward to continued collaboration.

Appendix A. Evaluation Scope and Methodology

Evaluation Objectives

- Analyze the extent to which the objectives of the health insurance affordability programs are being achieved;
- Examine impact of the surtax with respect to the outcomes of HCAF subsidy programs; and
- Study implications of federal and state policy as it relates to the HCAF subsidy programs.

Scope and Methodology

- Reviewed academic studies, policy research, and program documentation to learn about program function;
- Analyzed enrollment and financial data received form HCA and BeWell to understand trends;
- Met with agency stakeholders to learn about program logic and intent; and
- Examined applicable laws, administrative rules, regulations, and policies.

Evaluation Team

Matthew P. Goodlaw, Project Lead, Program Evaluator
Sam Lesemann, Program Evaluator

Authority for Evaluation
LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences
The contents of this report were discussed with Kari Armijo, HCA Cabinet Secretary; Alex CastilloSmith, HCA Deputy Secretary; Colin Baillio, Director of the Health Care Coverage and Innovation Division; and Jessica Rosenthal, Chief of the Health Care Affordability Bureau on April 15, 2025

Report Distribution
This report is intended for the information of the Office of the Governor, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

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Deputy Director for Program Evaluation

Appendix B. Potential Implications of the Introduction of Medicaid Work Requirements with respect to Medicaid Enrollment and Enrollment in Subsidized Health Insurance Plans on BeWell.

The purpose of this section is to describe the approach taken as an approximation to the implications of a federal work requirement for adult Medicaid recipients. To accomplish the purpose, the first section provides an overview of the statistical program built to simulate data that approximates the number of adult Medicaid recipients that drop their Medicaid coverage as a result of work requirements and the number of the adults that drop Medicaid that enroll in a subsidized plan on BeWell. The second section describes the data and data sources. The third section describes the method taken to simulate the data and summarizes the results of the simulation. Finally, the limitations of this method are discussed.

Overview

The approach taken to simulate the data is like the well-known model of a random walk. Consider a childhood game of birthday coin-flip, where the child first sets up a sheet to tally and count the score, which starts at null and then uses their birthday coin to flip of off their thumb so that it twirls and flips in the air until he catches the coin in his hand and then turns it over one last time on to the dorsal side of his other hand. If a coin flip returns a head, the child adds a positive one to the tally sheet and adds negative one to the tally if the result is a tail. The child then repeats the process until the absolute value of the counter is 100. Once the coin has been flipped enough for the event to occur, the child plots the record of the counter variable on the vertical axis of a graph and the flip iteration on the horizontal axis of the graph, which is constructed on a large piece of graph paper. The child then admires the line, notes the features of the line that they observe as important and then they start the game over. Each game is represented by a jagged line, on the graph, that fluctuates up and down until it reaches the end.

In this case the game is to draw a sample of 1,000 random values which represent a range of possible proportions of adult New Mexicans who, based on the Medicaid group membership (Parent and Caregiver and Expansion) and employment status (Full-time, Part-time, and Unemployed), drop Medicaid as a result of a federal work requirement. Each of the 1,000 draws represents a possible outcome of the Medicaid work requirement for adults. The 1,000 draws are then summarized, and the game is repeated 1,000 times. After the 1,000 games are played, the results of each game are summarized and serve as the best guess at the unknown values, which in this case are the number who drop Medicaid and the number of these who take-up on BeWell.

Data and Sources

Given that the unit of analysis of this simulation is the proportion of adults that drop Medicaid and the subset of this proportion that take-up coverage on BeWell, the data we used to inform the simulation are at this level of aggregation.

Table 1. Data and Sources for Simulation

Data	Value	Source	Role*
New Mexico Population	2.13 million	Census.gov	Constant
Proportion of the population that are adult recipients of Medicaid	16 percent	HCA Dashboards	Beta Random Variable Mean = 16 SD = 2
Proportion of adult Medicaid recipients are Expansion Group	81 percent	HCA Dashboards	Beta Random Variable Mean = 81 SD = 4
Proportion of adult Medicaid recipients that are Parents and Caregivers Group	19 percent	HCA Dashboards	1 - Beta Random Variable Mean = 81 SD = 4
Proportion of adult Medicaid recipients Working at all	42 percent	HCA email correspondence	Beta Random Variable Mean = 42 SD = 2
Proportion of working adults that work full-time	35 percent	HCA email correspondence	Beta Random Variable Mean = 35 SD = 2
Proportion of working adults that work part-time	65 percent	HCA email correspondence	Beta Random Variable Mean = 65 SD = 2
Proportion of adult population that don't work	58 percent	HCA email correspondence	Beta Random Variable Mean = 58 SD = 2
Medicaid Savings	If Expansion Group, then $567 * 10%, else $487 * 28%	LFC Staff	Constant
Cost to BeWell	With enhanced subsidies $83, else $140	Wakely and KFF	Constant

*Note: Random variables are quantities that arise as a result of a process that involves uncertainty. A normal random variable is a quantity that is generated from “gaussian processes”. Normal random variables are characterized by the mean and standard deviation. A single draw of a random variable from a normal distribution, for example, is interpreted in relation to the mean and standard deviation of the normal distribution - 68 percent of random draws will be within one standard deviation from the mean. Beta random variables are drawn from a beta distribution which varies from 0 to 1 so is useful when simulating proportions. The beta distribution is characterized by two parameters – alpha and beta. Uniform random variable are drawn from uniform distributions. Uniform distributions are characterized by an upper and lower value. Each quantity between the lower and upper values are equally likely.

Source: LFC Analysis

Table 2. Range of Values for Drop-off and Take-up Rates

Data	Value	Proportion that take-up BeWell
Proportion of full-time, expansion group members that drop Medicaid	Random Uniform from 5 percent to 15 percent	Random Uniform between 40 percent and 60 percent
Proportion of unemployed, expansion group members that drop Medicaid	Random Uniform from 26 percent to 33 percent	Random Uniform between 40 percent and 60 percent
Proportion of part-time, expansion group members that drop Medicaid	Random Uniform from 26 percent to 60 percent	Random Uniform between 40 percent and 60 percent
Proportion of full-time, parent and caregiver group members that drop Medicaid	Random Uniform from 5 percent to 15 percent	Random Uniform between 40 percent and 60 percent
Proportion of unemployed, parent and caregiver group members that drop Medicaid	Random Uniform from 26 percent to 33 percent	Random Uniform between 40 percent and 60 percent
Proportion of part-time, parent and caregiver group members that drop Medicaid	Random Uniform from 26 percent to 60 percent	Random Uniform between 40 percent and 60 percent

Note: These values are economic elasticities which represent the change in demand for a given change in the price or other determinant of demand.

Source: LFC Analysis

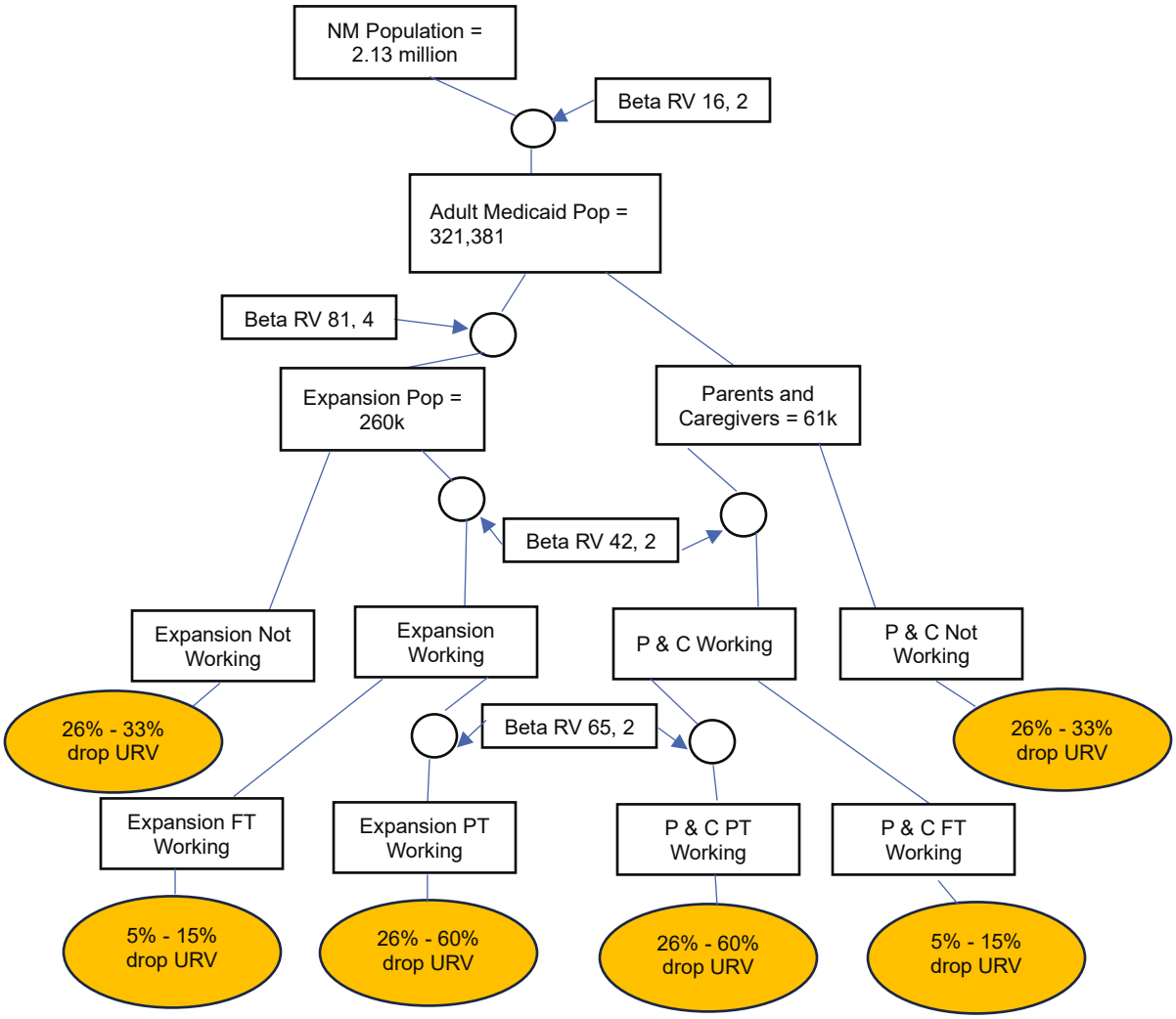
Methods

A simulation was set up using R Studio Version 2024.04.2+764.

The first step was to initiate the New Mexico Population size. Next, determine the number of adults in Medicaid by drawing a proportion from a random distribution and multiplying this random draw by the population size. The next step is to determine the size of the “expansion “population by drawing another value from a random distribution and multiplying this value by the adult Medicaid number. Then determine

the Parent and Caregiver population size by using the complement of the proportion drawn for the expansion group. Next, partition the group sizes by employment status by drawing random variables per the specifications in table 1. Given the estimated group sizes, draw random variables that represent the drop rate for each class of adult Medicaid recipient and multiply the drop rates by the estimated class sizes and get the estimated number of people who drop Medicaid, per group. Then draw random uniform variables that represent the BeWell Uptake rates and multiply this random draw by the estimated number of drops to get the estimated number that take up coverage on BeWell. Repeat this process 1,000 times and store the values, then repeat the whole game 1,000 times.

Figure 1: Flow Chart Depiction of Simulation



Note: A beta random variable with an expected value or mean of 16 and a standard deviation of 2, translates to a beta RV where alpha = 53.76 and beta = 282.24. Using R or a similar statistical programming software enables analysts to draw random values from a beta distribution. URV or uniform random variables are rectangular distribution in that all values between a low and a high value are equally likely, with the expected value being the midpoint between the two bounds.

Table 3. Example of 1 iteration of the 1,000 samples drawn to form 1 of 1000 trials

Term	Value	Type	Proportion that drop Medicaid	Number that drop Medicaid	Proportion that take-up BeWell	Number that take-up BeWell	Savings to Medicaid Per Month	Cost to BeWell Per Month (ARP)	Cost to BeWell Per Month (ACA)
Population Size	2130000	Constant							
Adult Medicaid Proportion	0.177	Random draw							
Adult Medicaid Size	377010	Result							
Proportion of Adult Medicaid that is Expansion	0.809	Random draw							
Number of Adults in Medicaid Expansion	305001	Result							
Proportion of Adult Expansion that Work	0.422	Random draw							
Number of Adult Expansion that Work	128710	Result							
Proportion of Working Expansion that are Full-Time	0.386	Random draw							
Number of Full-time Expansion	49,682	Result	0.08	3,975	0.47	1,868	$225,382.50	$155,044.00	$261,258.48
Number of Part-time Expansion	79,028	Result	0.58	45,836	0.53	24293	$2,598,901.20	$2,016,319.00	$3,397,618.98
Number of Unemployed Expansion	176291	Result	0.32	56,413	0.54	30,463	$3,198,617.10	$2,528,429.00	$4,260,555.18
Number of Adults in Medicaid Parent Caregiver	72009	Result							
Proportion of Adult Parent Caregiver that Work	0.434	Random draw							
Number of Adult Parent Caregiver that Work	31252	Result							
Proportion of Working Parent Caregiver that are Full-Time	0.342	Random draw							
Number of Full-time Parent Caregiver	10,688	Result	0.119	1,272	0.51	649	$173,449.92	$53,867.00	$90,769.14
Number of Part-time Parent Caregiver	20,564	Result	0.478	9,830	0.52	5,112	$1,340,418.80	$424,296.00	$714,964.32
Number of Unemployed Parent Caregiver	40,757	Result	0.329	13,409	0.46	6,168	$1,828,451.24	$511,944.00	$862,656.48

Source: LFC Analysis

Table 4. Summary of Simulation Results

Variable	Minimum	Average	Maximum
Number of People to Join BeWell	32,369	41,460	51,684
Cost to HCAF (ARPA) (in millions)	$26.4	$40.5	$62.5
Cost to HCAF (ACA) (in millions)	$44.3	$70.0	$109.4
Number of People to drop Medicaid	64,760	82,791	103,446
Savings to Medicaid From Expansion Group (in millions)	$51.3	$57.0	$62.6

Source: LFC Analysis

Limitations

This simulation is a first attempt to approximate the impact to Medicaid and BeWell in the event that the federal policy makers institute a work requirement for Medicaid. The veracity of the assumptions depends on the conditions at the time the policy is made as well as the parameters of the work requirements. The drop rates and take-up rates are economic elasticities and depend on several factors outside the scope of this simulation. For example, the HCA estimated 64 thousand adults to exit Medicaid if the federal government introduces a work requirement. If the drop off rates are adjusted so that the lower bound for the unemployed population is lowered from 26 percent to 15 percent and the upper bound for part-time employed Medicaid recipients is lowered from 60 percent to 40 percent, as displayed in Table 5, then an estimate that is similar to the HCA estimate obtained by the simulation, see Table 6.

Table 5. Adjusted Take-Up and Drop-Off Rates

Data	Value	Proportion that take-up BeWell
Proportion of full-time, expansion group members that drop Medicaid	Random Uniform from 5 percent to 15 percent	Random Uniform between 40 percent and 60 percent
Proportion of unemployed, expansion group members that drop Medicaid	Random Uniform from 15 percent to 33 percent.	Random Uniform between 40 percent and 60 percent
Proportion of part-time, expansion group members that drop Medicaid	Random Uniform from 26 percent to 40 percent	Random Uniform between 40 percent and 60 percent
Proportion of full-time, parent and caregiver group members that drop Medicaid	Random Uniform from 5 percent to 15 percent	Random Uniform between 40 percent and 60 percent
Proportion of unemployed, parent and caregiver group members that drop Medicaid	Random Uniform from 15 percent to 33 percent	Random Uniform between 40 percent and 60 percent
Proportion of part-time, parent and caregiver group members that drop Medicaid	Random Uniform from 26 percent to 40 percent	Random Uniform between 40 percent and 60 percent

Note: These values are economic elasticities which represent the change in demand for a given change in the price or other determinant of demand.

Source: LFC Analysis

Table 6. Summary of Simulation Results

Variable	Minimum	Average	Maximum
Number of People to Join BeWell	26,057	33,322	41,725
Cost to HCAF (ARPA) (in millions)	$21.2	$32.5	$50.2
Cost to HCAF (ACA) (in millions)	$35.7	$56.4	$88.1
Number of People to drop Medicaid	52,034	66,578	83,037
Savings to Medicaid From Expansion Group (in millions)	$35.4	$45.3	$56.5

Source: LFC Analysis