HUMAN SERVICES DEPARTMENT

COVERAGE AND AFFORDABILITY INITIATIVES
PRESENTATION TO LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE
11/12/19

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A CASE STUDY: FRANCES – 27-YEAR-OLD MOM WITH TWO KIDS (AGES 8 & 5)

- Frances has diabetes
- She just graduated with her Bachelor's degree from NMSU
- Frances works at a small business in Las Cruces
- While in school, she and her kids were able to get Medicaid/CHIP, with no premiums, deductibles or co-pays
- Now, Frances is making $54,000/year (Approximately 253% FPL);
- Due to her income, **only** one of her kids can remain on CHIP coverage
- Her employer does not offer healthcare coverage

FRANCES' STORY CONTINUED…

- Frances must buy a plan on the Exchange for her and her 8-year-old daughter
- Between all her expenses – rent, food, childcare, etc. – Frances can only afford a Bronze level plan
- After tax credits from the federal government that help pay for her premium, she finds a Bronze plan that will cover her and her daughter for $224/month
- That's not an ideal premium given her family budget, but Frances knows she needs the plan to stay healthy so that she can work and provide for her family
- The plan also has an $8,000 individual deductible; $16,000 for the family
- Despite the high deductible, Frances knows it is the only plan she can fit into her family budget
- She purchases the Bronze plan, struggling to pay for her diabetes treatment because of the high-deductible

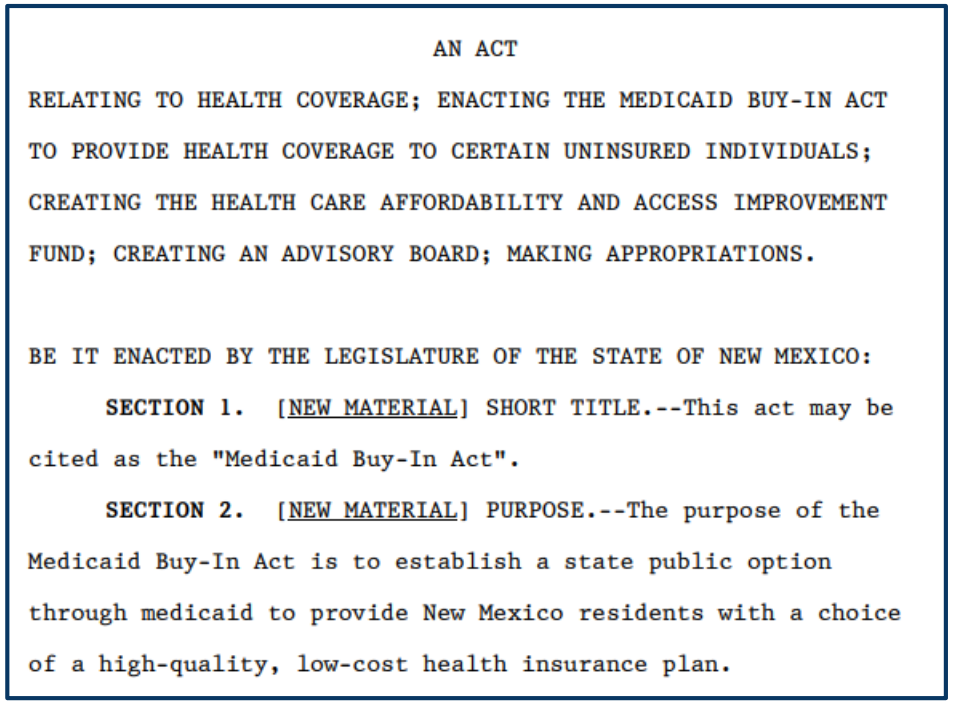
❖ *Note: Frances' story is fictionalized but we all know New Mexicans who face similar stories in trying to find affordable healthcare options that make sense for them and their families.*

THE CHALLENGE

- Pre-Affordable Care Act – Approximately 1 in 5 New Mexicans lacked health insurance
- Affordable Care Act – Cut uninsured rate in half in New Mexico
  - Medicaid Expansion – over 250,000 adults gained coverage
  - NM Health Exchange (beWellNM) – approximately 40,000 New Mexicans covered
  - Critical consumer protections
- Still, we have over 180,000 New Mexicans (under age 65) who lack health insurance coverage
- Top concern = Affordability
  - Even with subsidies, coverage still out of reach for some families
  - Some families are able to “afford” premium for coverage but face high out-of-pocket costs such as deductibles and co-pays, leaving them “underinsured.”
- NM is leading with other states looking to address coverage expansion and affordability

ONE RESPONSE TO THE CHALLENGE: "MEDICAID BUY-IN"

- 2018
  - During 2018 legislative session: HM 9/SM 3 passed, tasking LHHS to study the "Medicaid Buy-In"
  - 2018 interim: LHHS coordinated with community groups through NM Together for Healthcare campaign to conduct stakeholder engagement
  - Manatt Health conducted two-phase study
    - Phase I – Qualitative analysis of the Medicaid Buy-In model options for New Mexico
    - Phase II – Quantitative analysis of a Targeted Medicaid Buy-In model
- 2019
  - 2019 legislative session: HB 416/SB 405 introduced – "Medicaid Buy-In Act"
    - Based on a model targeted to New Mexican residents locked out of coverage system
      - "Family glitch", Immigration status, and residents above 400% of the federal poverty level
      - State-funded only; no leveraging of federal funding
      - Did not pass
    - Jr. budget bills (HB 548/SB 536) – Appropriated $142,000 to HSD for study and administrative development of a "Medicaid Buy-In" plan



AN ACT

RELATING TO HEALTH COVERAGE; ENACTING THE MEDICAID BUY-IN ACT TO PROVIDE HEALTH COVERAGE TO CERTAIN UNINSURED INDIVIDUALS; CREATING THE HEALTH CARE AFFORDABILITY AND ACCESS IMPROVEMENT FUND; CREATING AN ADVISORY BOARD; MAKING APPROPRIATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--This act may be cited as the "Medicaid Buy-In Act".

SECTION 2. [NEW MATERIAL] PURPOSE.--The purpose of the Medicaid Buy-In Act is to establish a state public option through medicaid to provide New Mexico residents with a choice of a high-quality, low-cost health insurance plan.

HB 416/SB 405 (2019)

COVERAGE AND AFFORDABILITY INITIATIVES IN THE NEW ADMINISTRATION

- Determine who the uninsured are in NM – where they live, their demographics, and whether they are currently eligible for subsidized coverage
- Leverage and maximize federal funding
  - Identify and address barriers to enrollment for Medicaid-eligible but unenrolled; Develop targeted outreach and enrollment efforts to reach them
  - Support coordinated efforts to enroll people in the Exchange and Medicaid, assisting people in obtaining the coverage for which they're eligible
- Identify policy options for the uninsured and the underinsured
  - Address affordability challenges for those who cannot afford the coverage available to them or the out-of-pocket costs (e.g., high deductible plans)
  - Maintain the stability of the Health Insurance Exchange and promote a competitive marketplace
  - Ensure our state healthcare system provides adequate reimbursement to our healthcare providers
  - Learn from other states' initiatives to help develop options unique to the needs of NM

COVERAGE AND AFFORDABILITY INITIATIVES IN THE NEW ADMINISTRATION - CONTINUED -

- Hired Coverage Innovation Officer – August 2019
- In final stages of completing uninsured demographic study with the Urban Institute (Report should be finished and made public by end of November)
  - Snapshot of Urban Institute Findings:
    - 187,000 uninsured New Mexicans under age 65
      - 55,000 are eligible but unenrolled in Medicaid
      - 43,000 are eligible for subsidies on the Exchange but not enrolled
      - 88,000 who are uninsured and:
        - above ACA subsidy threshold (over 400% FPL);
        - ineligible for subsidies because of an offer of employer-sponsored insurance; or
        - non-citizens
- Next Steps:
  - Develop a targeted outreach and enrollment plan for reaching Medicaid-eligible but unenrolled
  - Study several coverage affordability options to reach remaining uninsured and underinsured

The characteristics of the uninsured in New Mexico (under age 65)

URBAN INSTITUTE'S HEALTH INSURANCE POLICY SIMULATION MODEL (HIPSM)

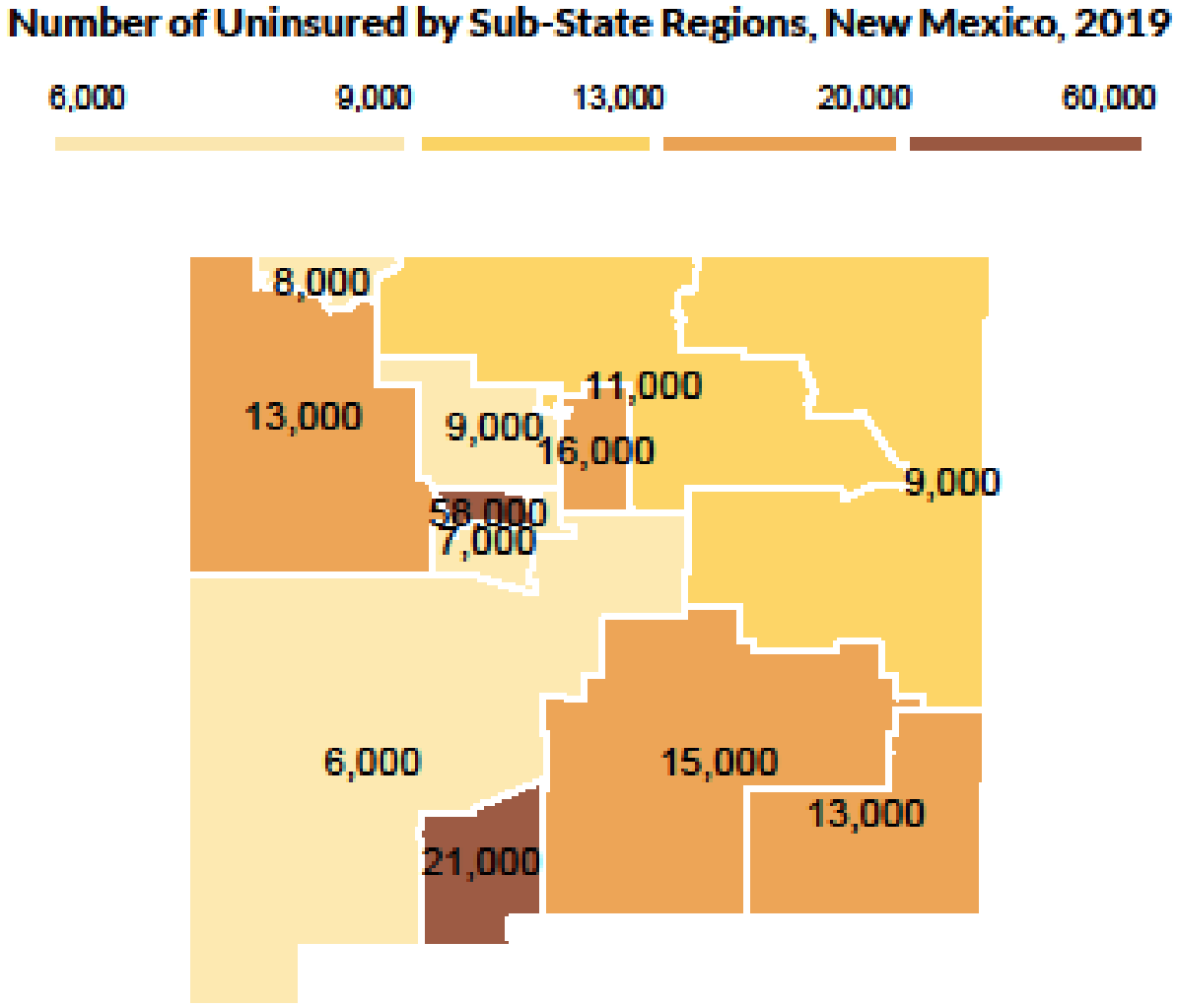
- HIPSM:
  - Is designed to estimate the cost and coverage effects of proposed health care policy options
  - Can be adapted to analyze a wide variety of scenarios, including looking at state-specific policy proposals, and can describe the effects of a policy option over several years
  - Is based on a large, representative sample of individuals and families. The sample size is large enough to allow for state-level and sub-state estimates*

URBAN INSTITUTE
ELEVATE · THE · DEBATE

*NOTE: The American Community Survey (ACS) data Urban Institute's model is based upon uses Public Use Microdata Areas (PUMAS). Each PUMA must have a minimum population of 100,000. So the PUMAS do not always align cleanly with county boundaries, meaning some of the information is grouped regionally instead of on a county-by-county level.

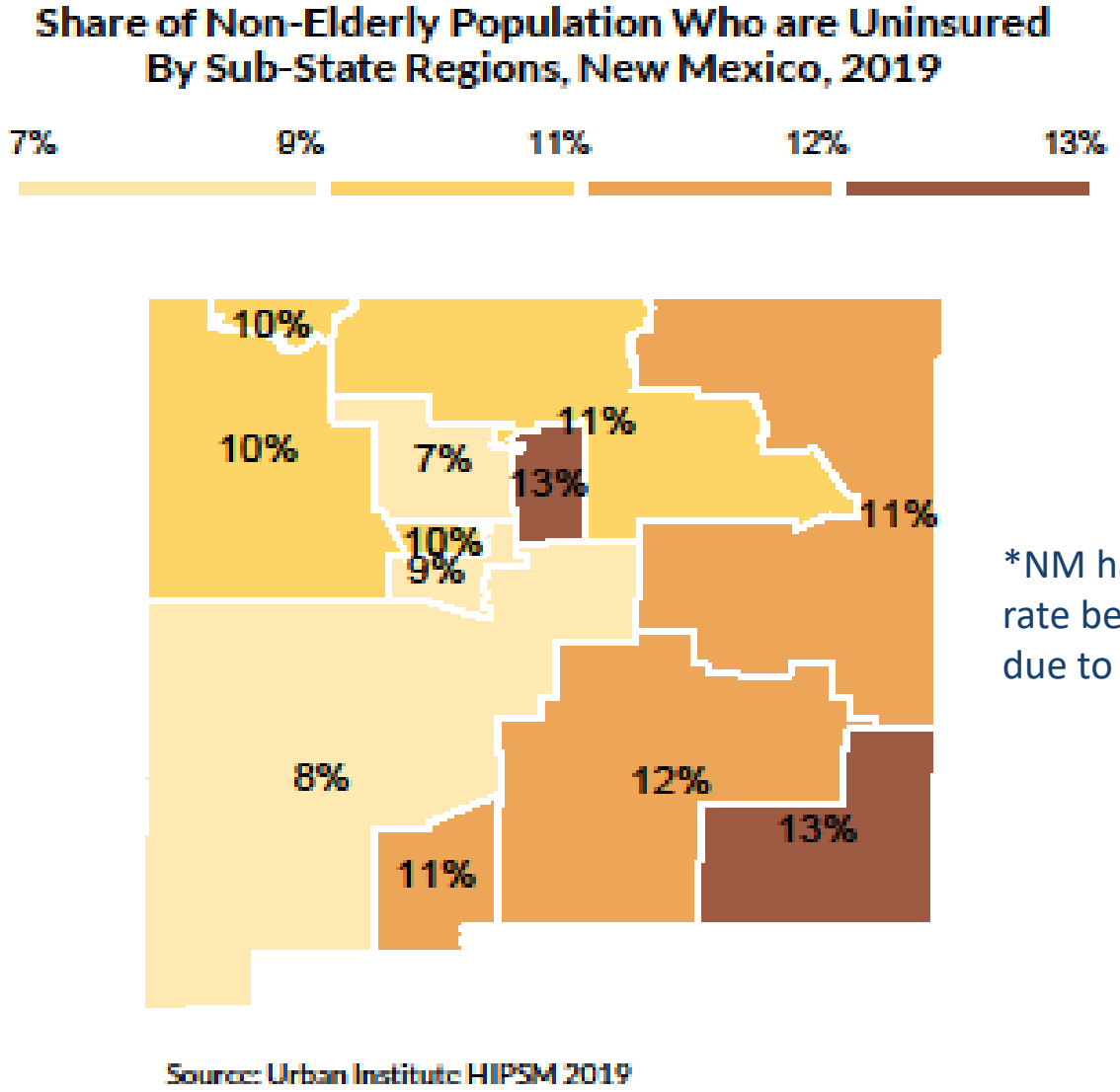
More information: http://www.urban.org/hipsm

URBAN INSTITUTE ESTIMATES THAT THERE ARE 187,000 UNINSURED NEW MEXICANS (UNDER AGE 65).



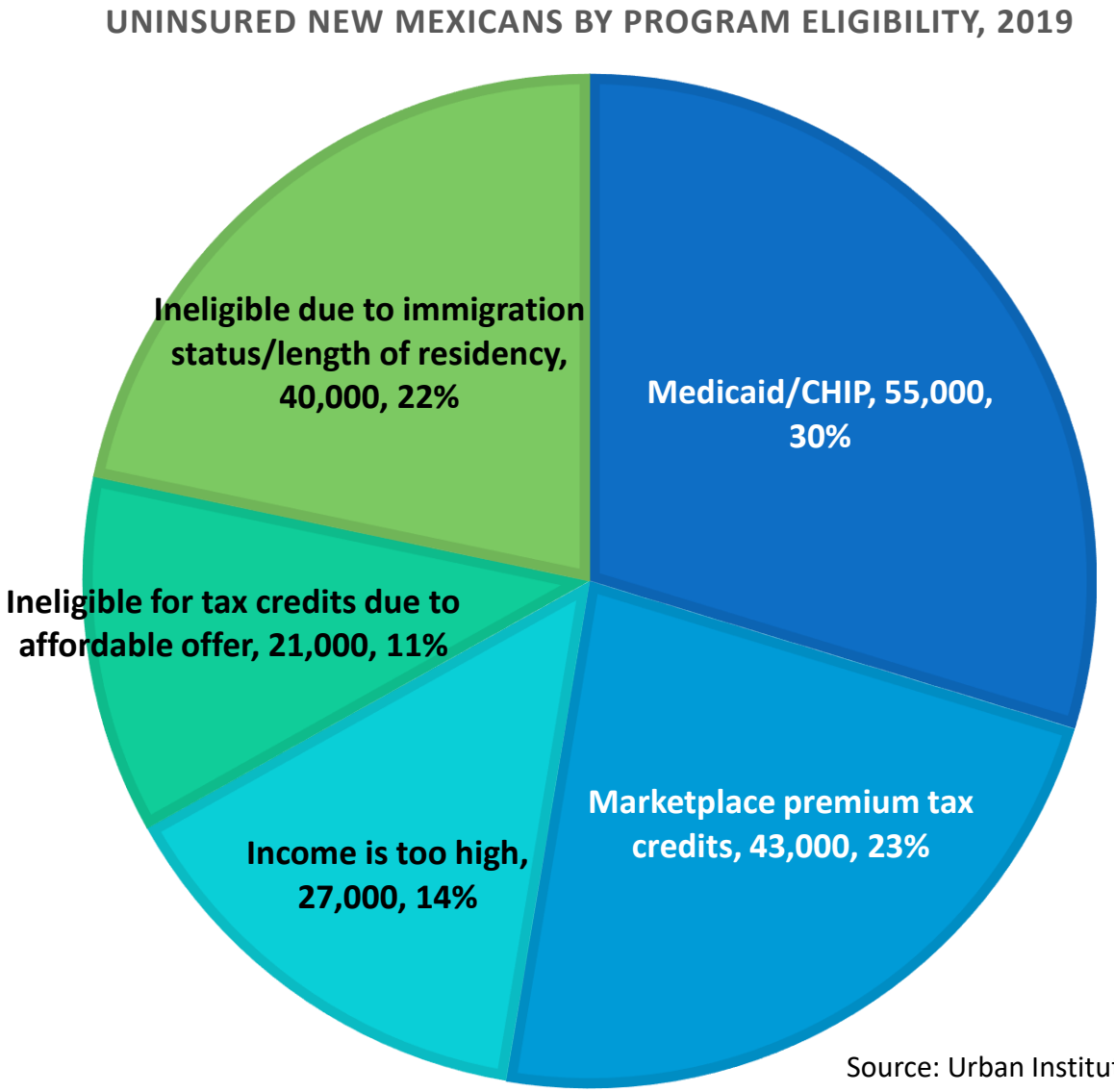
Source: Urban Institute HIPSM 2019

10.5 PERCENT OF NON-ELDERLY (UNDER AGE 65) NEW MEXICANS ARE UNINSURED (8.7% OF ALL NEW MEXICANS), VERSUS 11.2 PERCENT NATIONWIDE.*



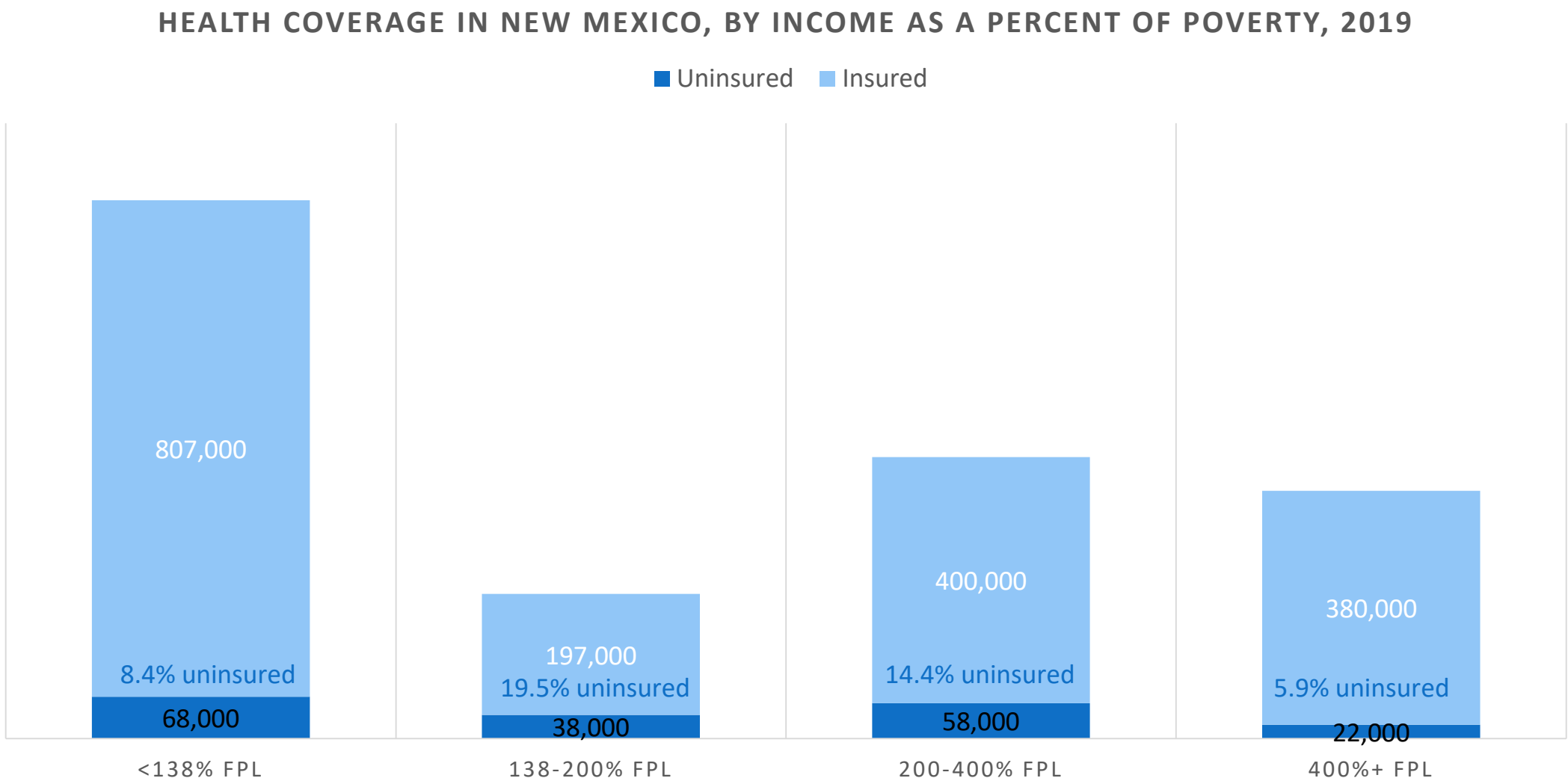
*NM has been able to keep the uninsured rate below the national average primarily due to Medicaid Expansion

MORE THAN HALF OF THE UNINSURED (53%) ARE ELIGIBLE FOR MEDICAID OR TAX CREDITS IN THE MARKETPLACE



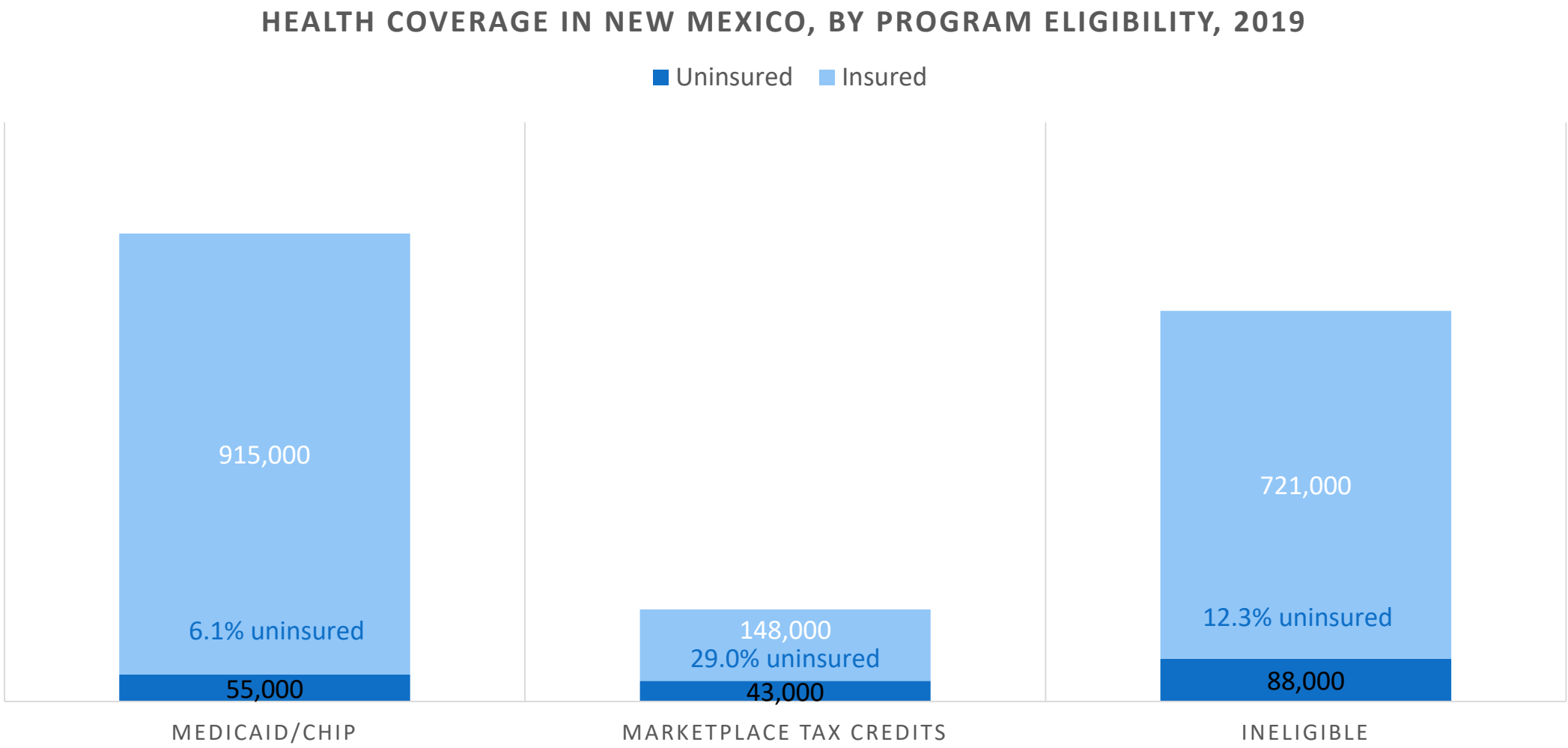
Source: Urban Institute, HIPSM 2019

NEW MEXICANS BELOW 138% OF POVERTY HAVE A *LOW* UNINSURED RATE BUT COMPRISE THE LARGEST NUMBER OF UNINSURED PEOPLE (UNDER AGE 65) RELATIVE TO HIGHER INCOME GROUPS.



Source: Urban Institute, HIPSM 2019

PERSONS ELIGIBLE FOR PREMIUM TAX CREDITS IN THE MARKETPLACE HAVE A HIGHER RATE OF UNINSURANCE THAN OTHER ELIGIBILITY GROUPS (UNDER AGE 65).



Source: Urban Institute, HIPSM 2019

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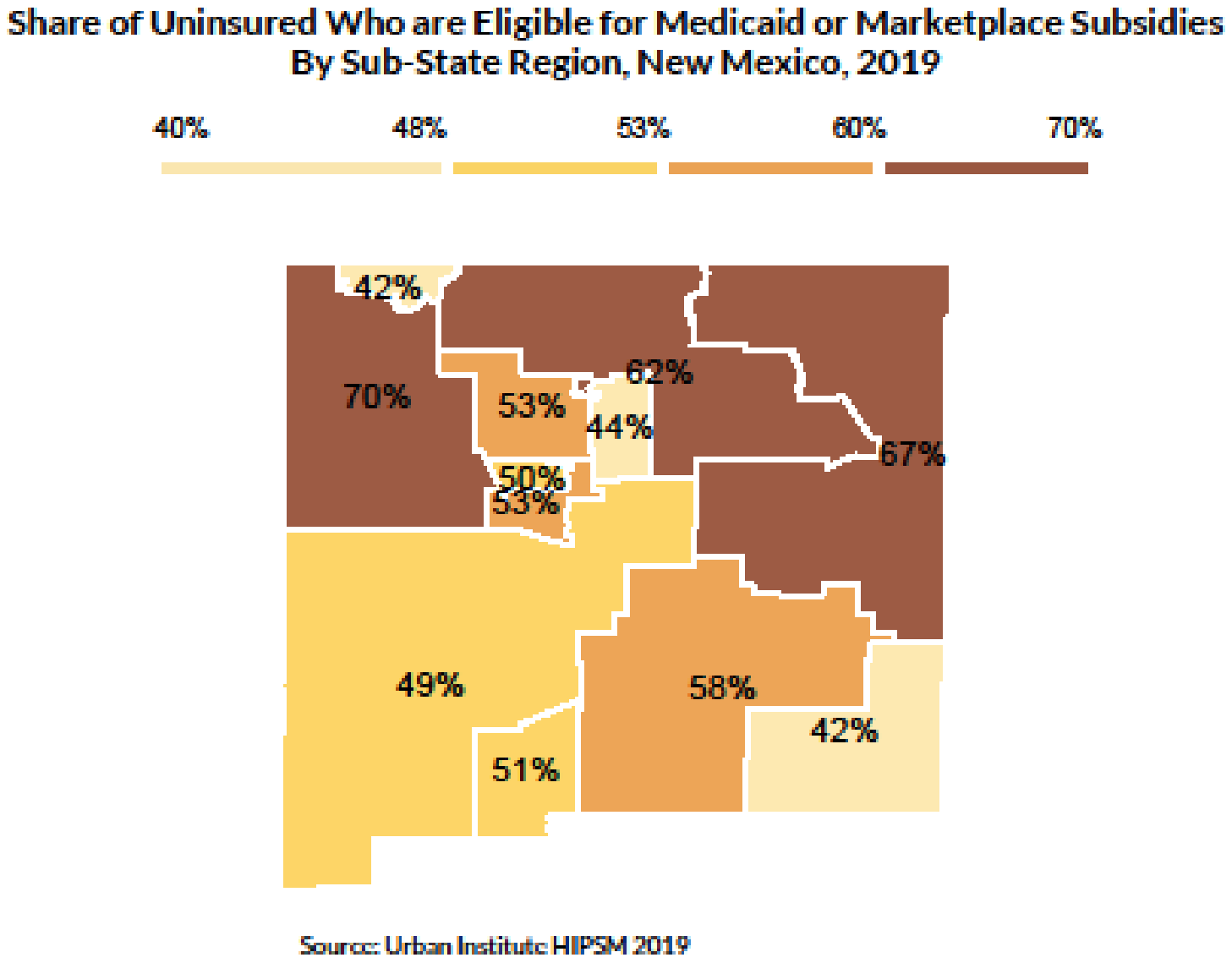
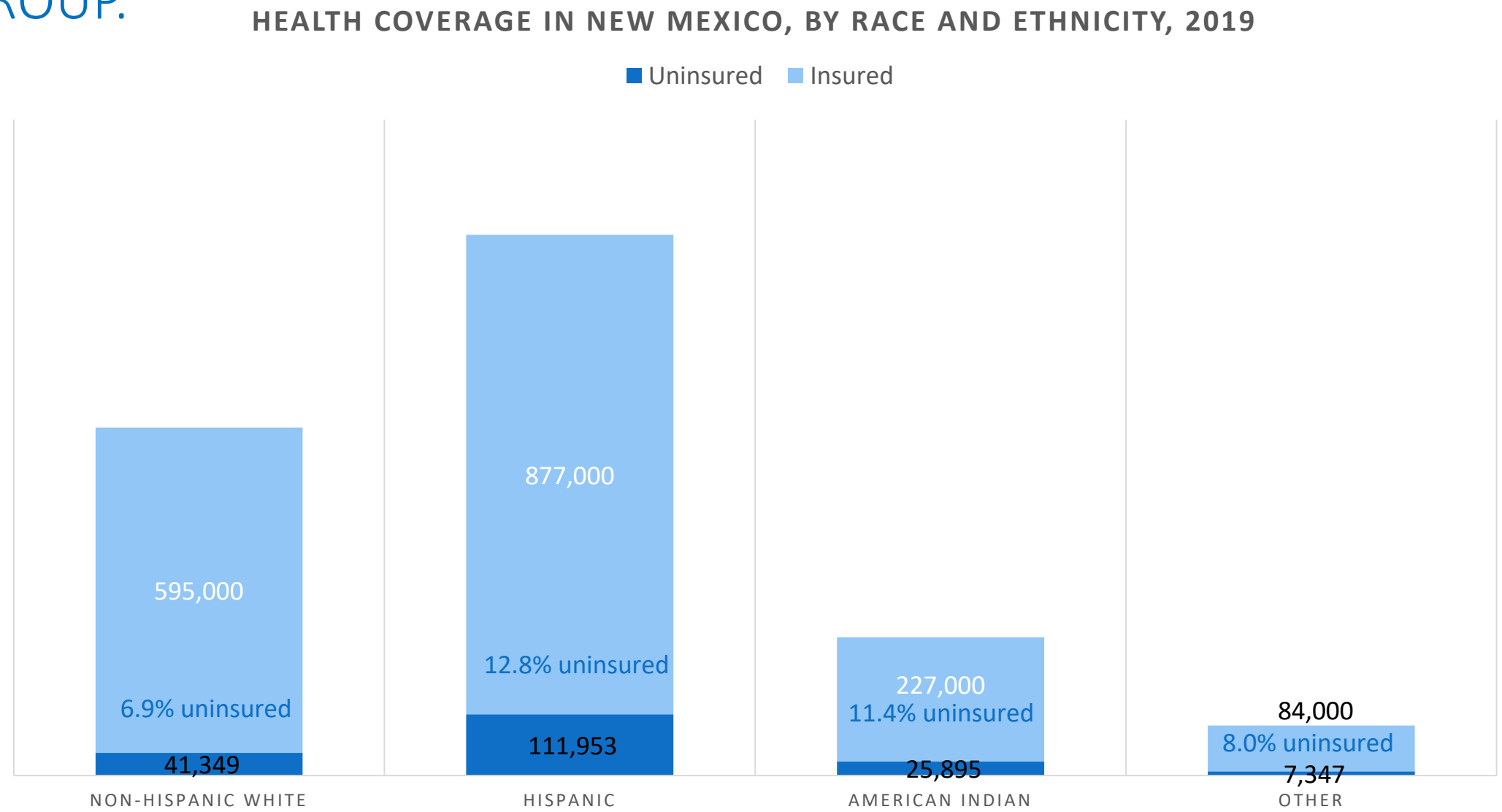
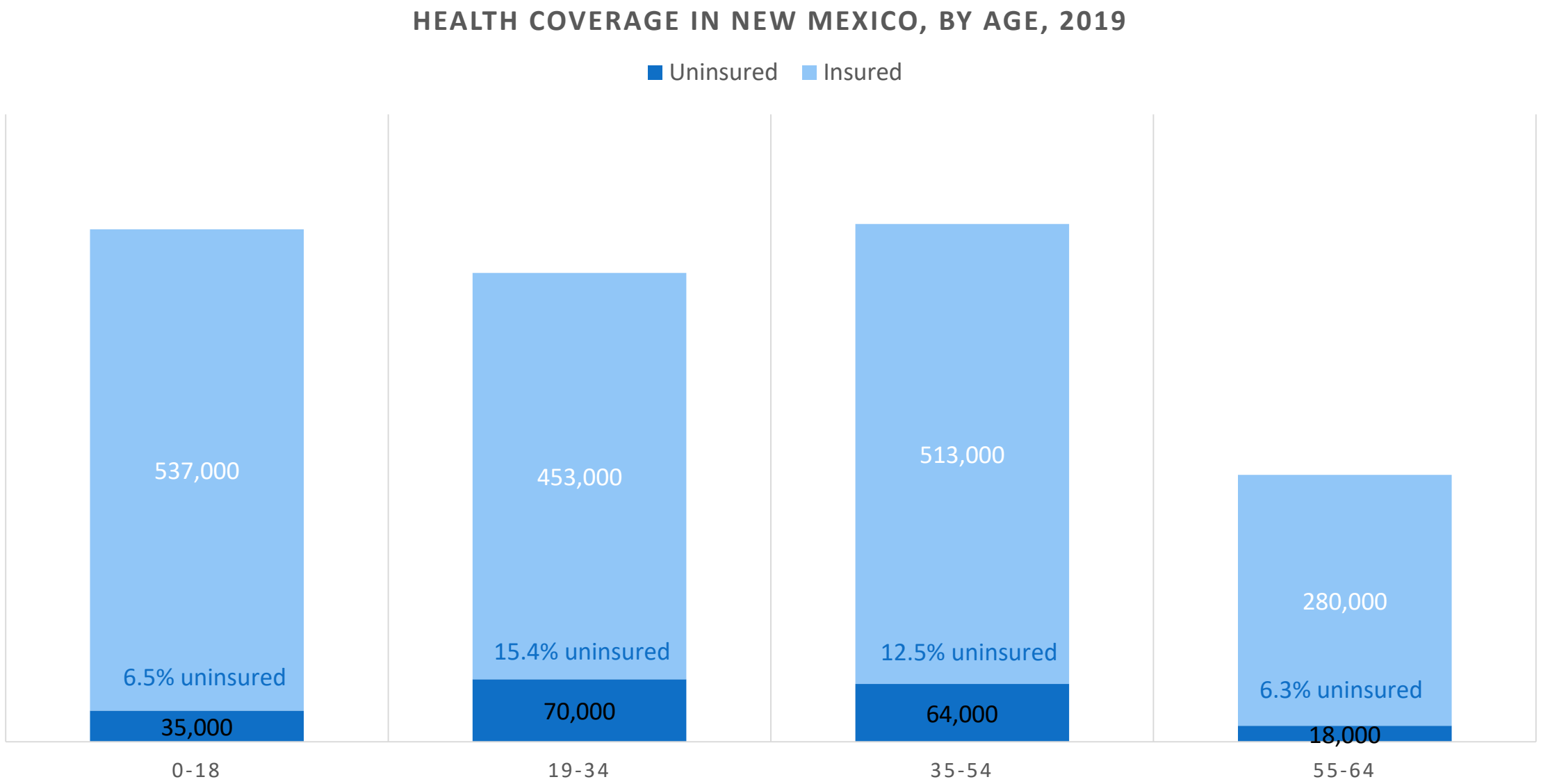
THE SHARE OF UNINSURED (UNDER AGE 65) WHO ARE ELIGIBLE FOR ASSISTANCE VARIES BY REGION



HISPANICS MAKE UP A MAJORITY OF THE UNINSURED (UNDER AGE 65) AND HAVE THE HIGHEST UNINSURED RATE OF ANY RACIAL/ETHNIC GROUP.



MOST OF THE UNINSURED (UNDER AGE 65) ARE ADULTS AGES 19 TO 54, AND THEY HAVE THE HIGHEST UNINSURED RATES.

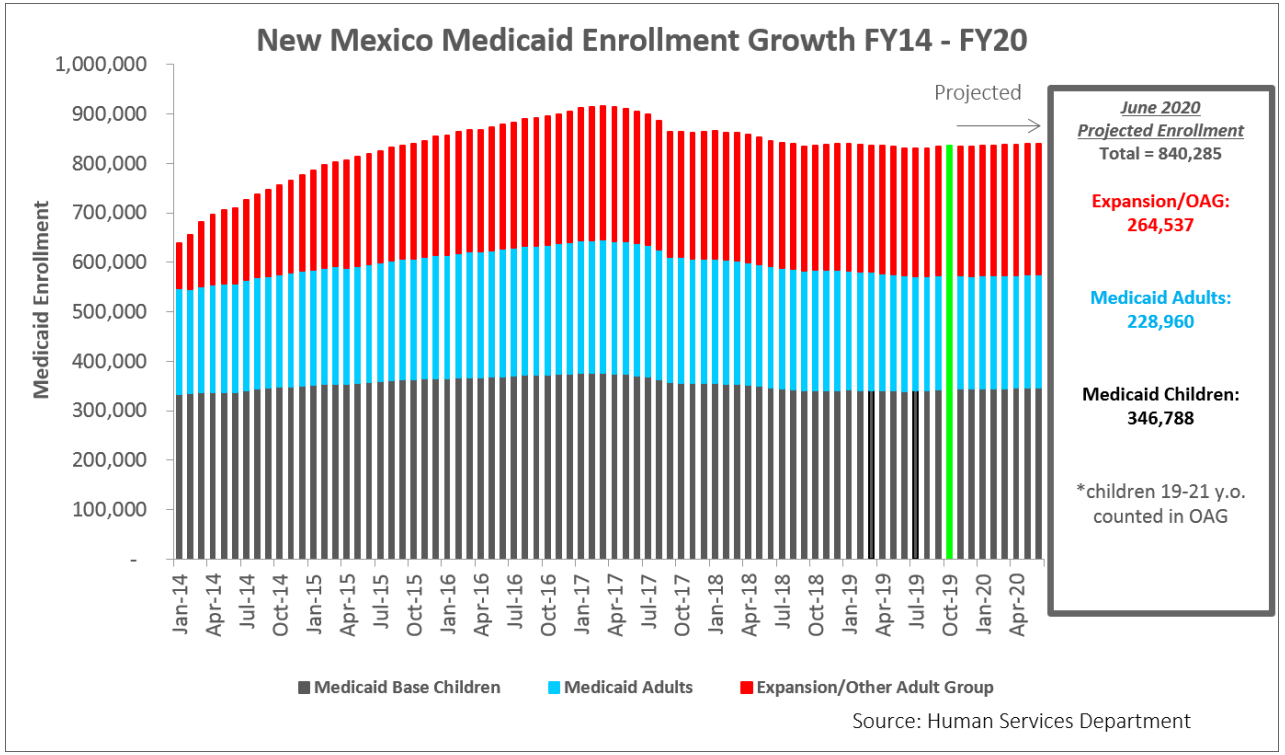


IMPLICATIONS FOR NEW MEXICO POLICY AND OUTREACH PROGRAMS

MEDICAID AND CHIP

- Current participation rate is high, as seen by the low uninsured rate among those eligible (6.1%), but the uninsured are large in number

- Medicaid/CHIP outreach and application assistance could potentially reach:
  - 30 percent of all uninsured (under age 65)
  - 40 percent of uninsured Native Americans
  - About 64 percent of all uninsured children



OUTREACH & ENROLLMENT EFFORTS

- Reinstate Retroactive Eligibility (still waiting for CMS approval)
- Real-Time Eligibility – Piloted for 3 weeks in San Juan, San Miguel, Luna, and southern Doña Ana; added 9 new counties to pilot last week; projected to go live statewide by end of November
- Continuous Eligibility/Automated Renewals (7/2020, pending federal approval)
- Program independence between SNAP and Medicaid
- Data sharing between DOH and HSD
- Partnering with beWellNM on Open Enrollment events throughout November and December
- Using Urban Institute uninsured demographic data to develop targeted outreach plan for reaching Medicaid-eligible but unenrolled

MARKETPLACE COVERAGE WITH PREMIUM TAX CREDITS

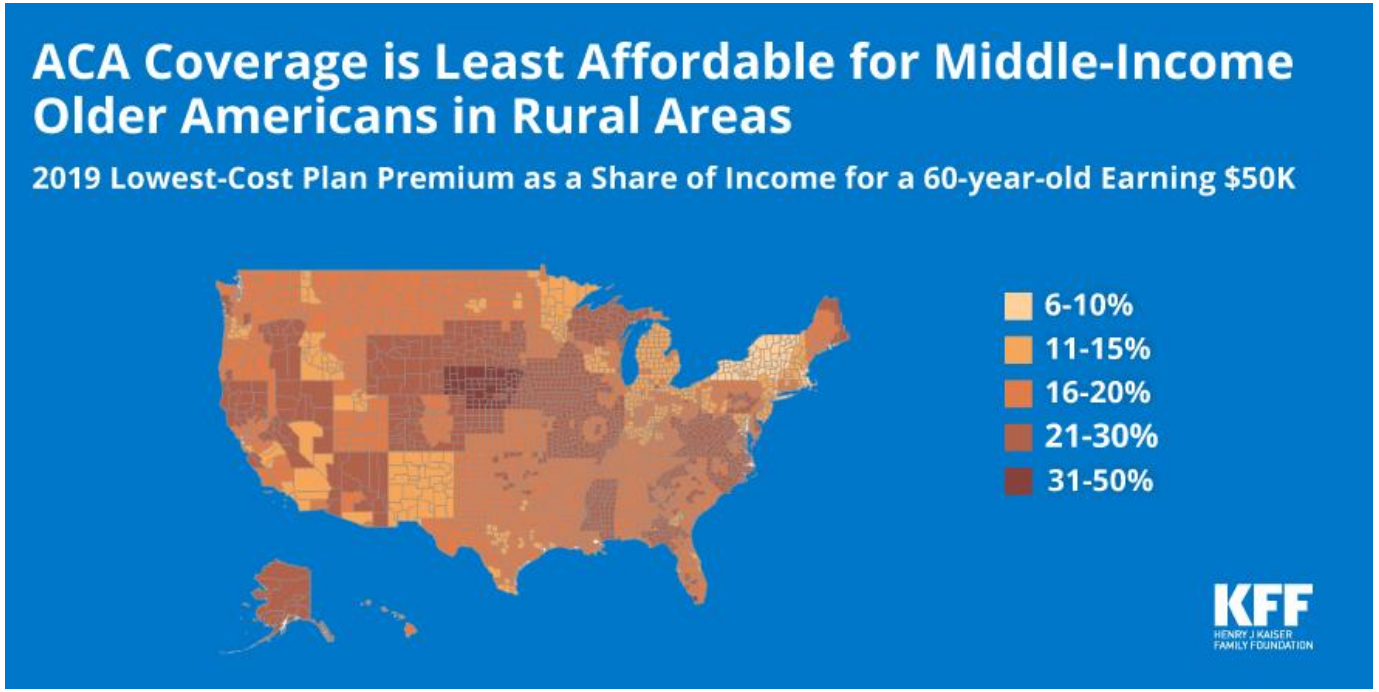
- Nearly a quarter (23%) of all uninsured New Mexicans (under age 65) are eligible for tax credits
- Marketplace participation is lower than in Medicaid and CHIP
- Outreach and application assistance could increase enrollment, but affordability is a major factor in the decision not to enroll. New state policy initiatives could increase tax credits

UNINSURED AND NOT ELIGIBLE FOR MEDICAID OR ACA PREMIUM SUBSIDIES

- One quarter of uninsured New Mexicans have incomes too high to qualify for assistance or are disqualified by an employer offer of coverage in their family deemed affordable under the ACA

- State policy changes such as reinsurance that lower non-group premiums could lead to higher enrollment among these people

- A state program offering subsidized coverage above 400% FPL could reach those whose incomes are currently too high to qualify



WHAT MIGHT A COVERAGE AFFORDABILITY STUDY LOOK LIKE?

SOME POTENTIAL APPROACHES:

- Basic Health Plan (BHP)
- Qualified Health Plan (QHP) Public Option
- State-funded Subsidies
- Targeted Medicaid Buy-In
- Reinsurance
- Standardized Plans

- Note: These options are not exclusive; New Mexico could stack some of them together as necessary to address multiple aspects of coverage expansion and affordability.

BASIC HEALTH PLAN (BHP) – FOR THOSE ELIGIBLE FOR MARKETPLACE SUBSIDIES UNDER 200% FPL

- Option authorized under Section 1331 of the Affordable Care Act
- State would offer a public plan to individuals and families with incomes below 200% of the federal poverty level, who are ineligible for Medicaid, instead of enrolling in the Exchange
- State receives 95% of the amount of tax credits that an individual would have received in the Exchange marketplace

- Pros: Improves premium affordability; Improves cost-sharing affordability; leverages federal dollars; lots of state administrative flexibility; Can ease "churn" effect when people become ineligible for Medicaid

- Cons: Only addresses affordability below 200% FPL; Splits individual market; Could lead to increase in costs for above 200% FPL populations unless paired with mitigation strategies

New York

- Premiums:
  - Below 150% FPL: $0 premium;
  - 151-200% FPL: $20/month
- Cost-sharing: no-deductible; minimal cost-sharing (for all enrollees)

Minnesota

- Premiums:
  - 0-34% FPL: $0/month
  - 35-200% FPL: $4-80/month (based on income)
- Cost-sharing: no-deductible; minimal cost-sharing (for all enrollees)

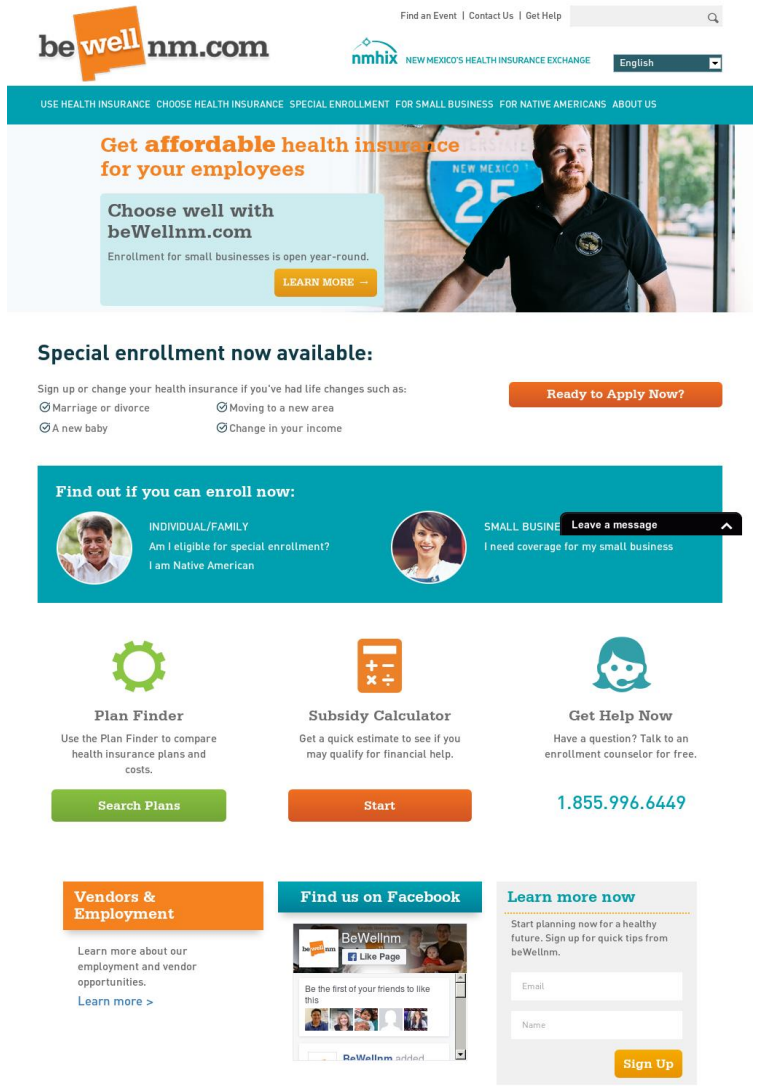
QUALIFIED HEALTH PLAN (QHP) PUBLIC OPTION – OFFERED ON THE EXCHANGE

- State contracts with insurers to offer a state-sponsored qualified health plan (QHP) on the Exchange

- Can also offer an off-Exchange option to those who do not qualify for marketplace coverage (ex: immigration status)

- Pros: Moderate enrollment increase; Potential to improve affordability (has limitations); can leverage federal dollars that can be reinvested to improve affordability; limited general fund impact on its own

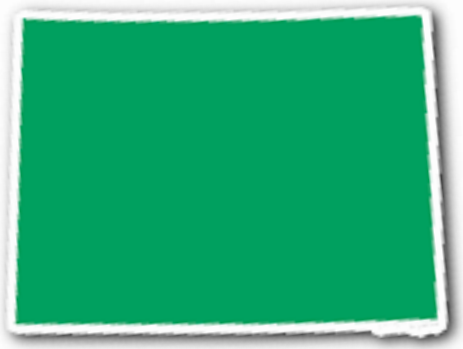
- Cons: Affordability improvements impact mostly those above 400% FPL; potential to reduce competition in the market; does not simplify coverage system



QHP PUBLIC OPTION: WASHINGTON AND COLORADO

Washington

- Contracting with insurers to offer QHPs on Exchange in 2021;
- Caps provider payment rates at 160% of Medicare with special floor rules for primary care services and rural hospitals;
- In 2019 – 14 of 39 counties have one insurer offering plans;
- 65% of Exchange enrollees receive subsidies (one of lowest rates in nation)



Colorado

- Recently released draft proposal to contract with insurers to offer QHP on Exchange in 2022;
- Caps provider payments between 175-225% of Medicare.
- In 2018 – 16 of 64 counties had one insurer offering plans on Exchange;
- Average benchmark premiums higher than national average, especially in rural parts;
- High hospital rates

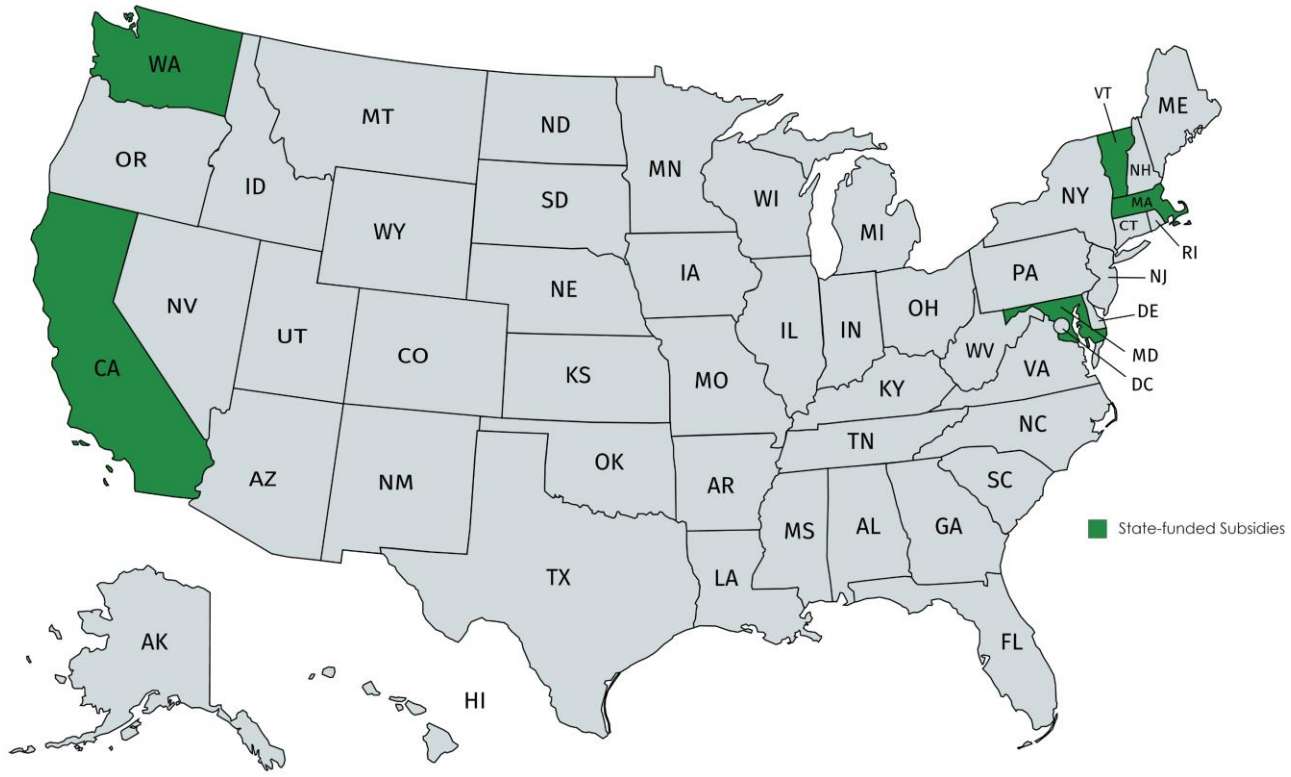
STATE-FUNDED SUBSIDIES – TO ADDRESS UNAFFORDABILITY OF CURRENT OPTIONS ON EXCHANGE

- Under the ACA, the federal government provides premium subsidies up to 400% FPL through an income-based sliding scale

- With this option, a state provides additional subsidies for premiums and/or cost-sharing, building on the existing ACA structure

- **Pros:** Can improve premium and cost-sharing affordability depending on state resources and targeting; enrollment increase (impact depends on level of assistance); can help improve market composition pulling down premium prices overall

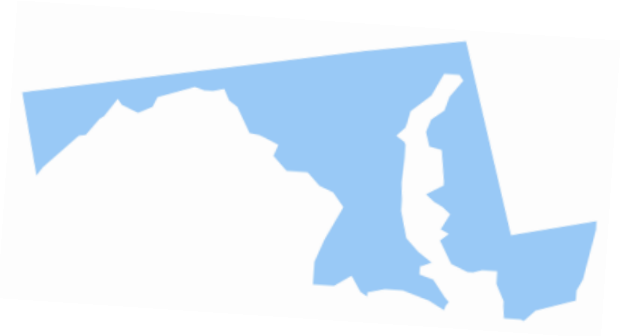
- Cons: All state-funded (amount depends on level of assistance and target populations); does not simplify coverage system; need state infrastructure to administer



STATE-FUNDED SUBSIDIES: CALIFORNIA, MARYLAND, WASHINGTON

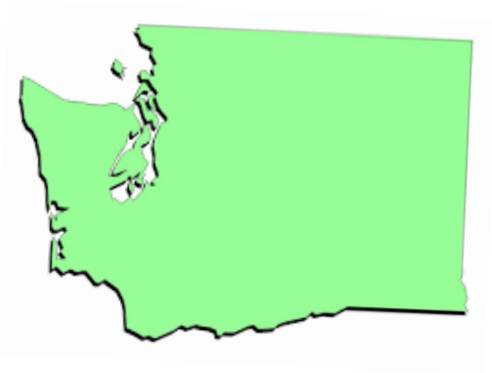
California

- Passed budget legislation in 2019 that authorizes temporary subsidies between 2020-2022
- Will provide premium assistance for individuals between 138-600% FPL



Maryland

- Studying providing targeted subsidies to young adults between 19-34 years old

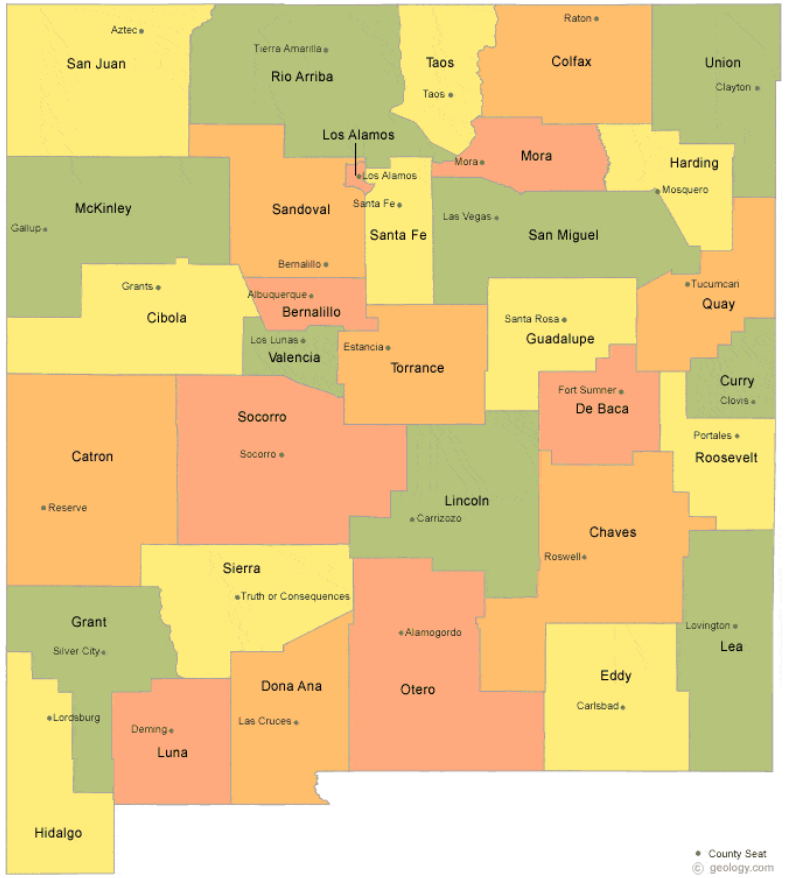


Washington

- As part of public option legislation, the state is also required to study a plan to provide subsidies up to 500% FPL
- Plan must cap what a individual/family would pay at no more than 10% of annual household income

TARGETED MEDICAID BUY-IN

- New Mexico's 2019 Medicaid Buy-In Act would have allowed targeted groups, who otherwise are ineligible for Medicaid, Medicare and federal subsidies to buy into a plan offered by HSD off-Exchange
  - "Family glitch"
  - People above 400% FPL
  - Non-citizens



- **Pros:** Addressed coverage access for New Mexicans locked out of coverage system; Improved consumer affordability; Simplification of coverage system by leveraging Medicaid infrastructure

- **Cons:** State-funding only; does not address affordability for those eligible for other coverage programs; Hard to isolate "family glitch" population for outreach/enrollment; Outreach/enrollment difficulties with immigrant populations due to chilling effect of "public charge" changes at federal level

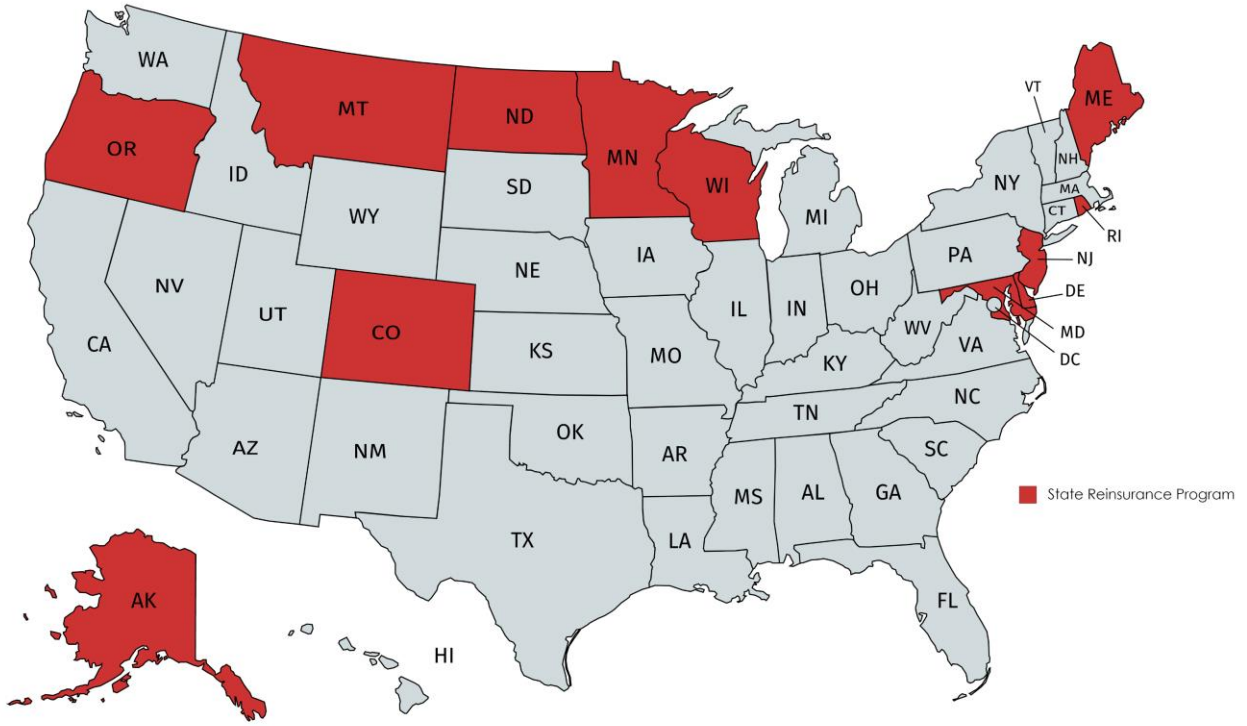
REINSURANCE – TO ADDRESS HIGH-COST ENROLLEES IN THE MARKETPLACE

- State sets up a program to partially reimburse insurers for certain high cost claims

- Condition-based vs. Attachment Point models
  - Condition-based – Pay a portion of claims for consumers with certain medical conditions
  - Attachment Point – Reimburses a percentage of claims between specified dollar amounts

- **Pros:** Reduces premiums costs; Can leverage federal pass-through savings through 1332 waiver to offset program costs

- **Cons:** Minimal impact to coverage expansion; Affordability improved mainly for populations above 400% FPL; Doesn't address cost-sharing affordability; Expensive; Tends to be most helpful in states with very high premiums (NM has among lowest in the country for 2020)



12 States – Alaska; Colorado; Delaware; Oregon; Maine, Maryland, Minnesota, Montana, New Jersey, North Dakota, Rhode Island, Wisconsin

STANDARD PLANS – TO PROVIDE MORE AFFORDABLE AND CONSUMER-FRIENDLY OPTIONS ON THE EXCHANGE

- Exchange requires insurers to offer "standardized" plans with limited out-of-pocket costs for at least some services (ex. primary care and ambulatory); consumers can get more services they need before having to pay their deductible

- Pros: Workaround for cost-sharing affordability; improves value that consumer receives in their plan, has little negative impact on market; has potential to simplify purchasing coverage

- Cons: Does not address premium affordability; does not directly increase coverage; does not leverage federal dollars; tradeoffs between covered items/services; can be resource intensive

Table 2: 2019 Patient-Centered Benefit Designs by Metal Tier

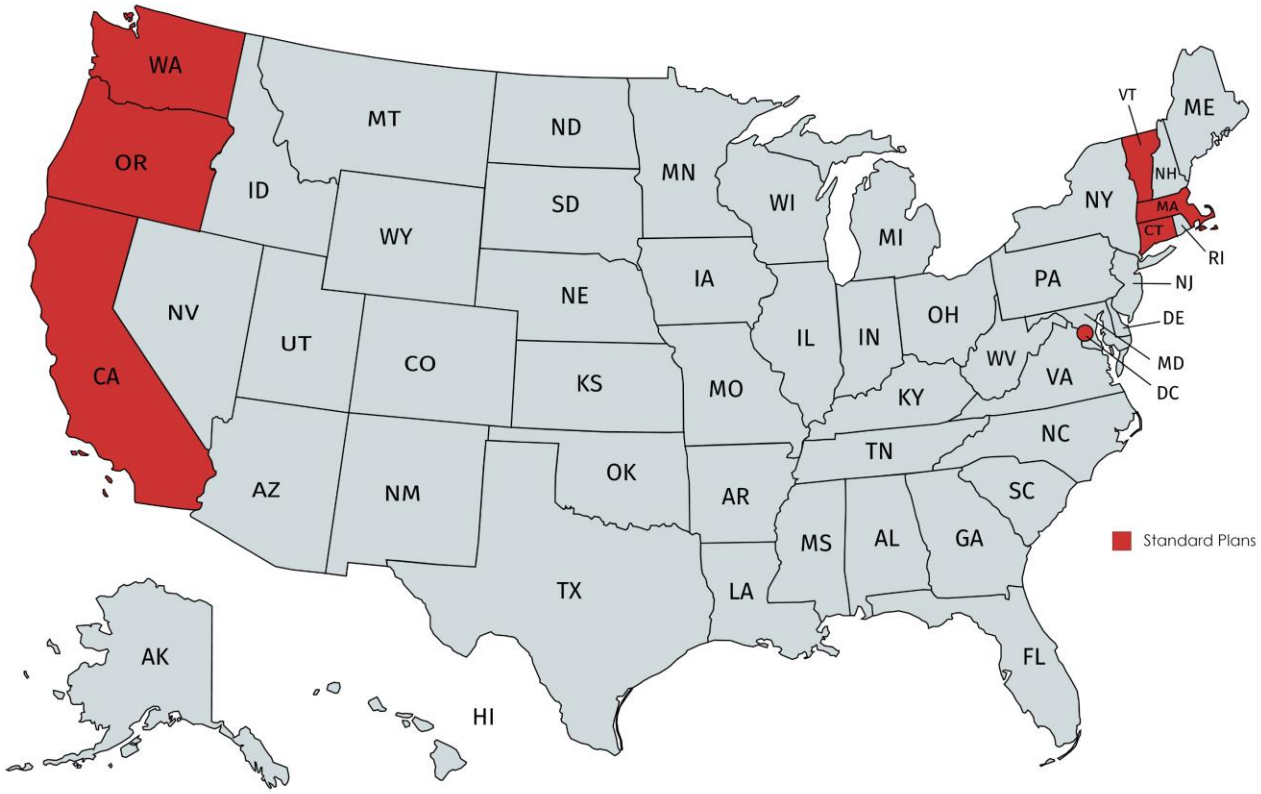
MEDICAL COST SHARES				
Coverage Category	Bronze	Silver	Gold	Platinum
	Covers 60% average annual cost	Covers 70% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Annual Wellness Exam	$0	$0	$0	$0
Primary Care Visit	$75	$40	$30	$15
Specialty Care Visit	$105	$80	$55	$30
Urgent Care Visit	$75	$40	$30	$15
Emergency Room Facility	Full cost until out-of-pocket maximum is met	$350	$325	$150
Laboratory Tests	$40	$35	$35	$15
X-Ray and Diagnostics	Full cost until out-of-pocket maximum is met	$75	$55	$30
Medical Deductible	Individual: $6,300 Family: $12,600	Individual: $2,500 Family: $5,000	N/A	N/A
Pharmacy Deductible	Individual: $500 Family: $1,000	Individual: $200 Family: $400	N/A	N/A
Annual Out-of-Pocket Maximum	$7,550 individual and $15,100 family	$7,550 individual and $15,100 family	$7,200 individual and $14,400 family	$3,350 individual and $6,700 family

Benefits shown in blue are not subject to any deductible.
White corner = subject to a deductible after first three visits. The copay is for any combination of services (primary care, specialist, urgent care) for the first three visits. After three visits, they will be at full cost until the medical deductible is met.

STANDARD PLANS: CA, OR, MA, VT, D.C. & WA (2021)

- California – **Only** allows standardized plans on Exchange; Primary and specialty ambulatory care visits not subject to deductible across most metal tiers (Bronze, Silver, Gold, Platinum); Co-pays for primary care lower than specialty and emergency room care.

- New York – Requires insurers to offer standard plans at each metal tier (Bronze, Silver, Gold, Platinum) and every county in which they offer Exchange coverage; Insurers can offer three “non-standardized” plans.



"VALUE PLANS" - MARYLAND

- "Value Plans" are a variation of the standardized plan idea
- Does not mandate standard design but instead requires insurers to incorporate "value-based principles" into plan design
- Sets deductible ceilings ($2500 Silver, $1000 Gold)
- Has variety of pre-deductible services (ex. Silver/Gold have unlimited physician visits and generic drugs pre-deductible)

Plan Metal Level	Bronze	Silver	Gold
Deductible	Up to $6200	Up to $2500	Up to $1000
Services offered before deductible	At least three office visits for primary care	Offered with copays before deductible: • Primary care visit • Outpatient Mental Health/Substance Use Disorder treatment • Urgent care visit • Specialist care visit • Laboratory tests • X-rays and diagnostics • Imaging • Generic drugs	Offered with copays before deductible: • Primary care visit • Outpatient Mental Health/Substance Use Disorder treatment • Urgent care visit • Specialist care visit • Laboratory tests • X-rays and diagnostics • Imaging • Generic drugs

SUMMARY

- 187,000 uninsured New Mexicans under age 65

- HSD is developing targeted outreach and enrollment plan to reach Medicaid-eligible but unenrolled who make up approximately 30 percent of remaining uninsured (under age 65)

- HSD will study coverage affordability initiatives and engage stakeholders to develop recommendations for the Governor for reaching the remaining uninsured and underinsured

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FRANCES REVISITED:

- The study of coverage affordability options will help us figure out ways to help individuals like Frances and her family
- For example:
  - If New Mexico implemented “value plans” like Maryland, Frances might be able to get generic prescriptions drugs before paying her deductible
  - If New Mexico implemented state-funded subsidies, it might make it easier on Frances to be able to afford her premium or maybe even purchase a higher level plan – such as a Gold plan - that better meets her needs

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QUESTIONS AND COMMENTS?