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

Prepared For:

New Mexico Legislative Finance Committee

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About KNG Health Consulting, LLC

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

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

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Executive Summary

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

Our approach for conducting the fiscal analysis of the Health Security Plan consisted of three steps. First, we conducted a qualitative assessment of the HSP as specified in the 2019 Health Security Act to understand key features of the HSP as well as identify policy assumptions needed to conduct the fiscal analysis. Second, we solicited public feedback on our analytic approach and policy assumptions. Third, we conducted a quantitative analysis of the HSP using a microsimulation model and assessed the impact of alternate reform options ("scenarios"). This involved simulating the effects of each scenario on insurance coverage and health spending. We then translated these results into a budgetary impact for the state.

Policy Assumptions. In our base scenario, we simulated the effects of the HSP as specified in the 2019 Health Security Act and under the policy assumptions presented in Table ES1. In addition, we examined several other scenarios, including the exclusion of Medicaid beneficiaries and alternative cost-sharing approaches for HSP beneficiaries and employers to help fund the plan.

Table ES1. Health Security Plan Policy Assumptions for the Base Scenario

Policy Issue	Modeling Assumptions
Implementation Date	January 1, 2024
Treatment of Medicaid & Medicare Beneficiaries	Medicaid beneficiaries would be folded into the HSP upon implementation of the plan; Medicare beneficiaries would remain outside of the HSP during the initial 5-year modeling period.
Employer HSP Participation and Contributions	Employers offering a self-insured employer plan may participate in the HSP or offer their own plan. Employees at all other firms enroll in the HSP. Employers that do not offer a self-insured employer plan would pay to cover part of their employees' premium costs.
HSP Eligibility of Employees at Self-Insured Employers	Employees with access to self-insured employer plans may enroll in the HSP but would only decide to do so if their employer's coverage was not affordable.
Tax Treatment of Employer and Individual Contributions toward Premiums	Employer and individual contributions to premiums would be tax-exempt.
Enrollment Mechanisms	Retroactive eligibility for those who would be eligible for the HSP. Voluntary enrollment for self-insured employer coverage enrollees and employers.

Policy Issue	Modeling Assumptions
Benefits and Cost-Sharing	Comprehensive benefits package comparable to what is currently available to state employees. No long-term care benefits. Cost-sharing would be similar to the average employer plan (based on actuarial value). No cost-sharing on preventative services. No cost-sharing for Native Americans or Medicaid-eligible enrollees.
Premiums	Individual responsibility for premiums would be modeled on the average employer plan. HSP beneficiaries who would be eligible for lower premiums on the Affordable Care Act (ACA) Marketplaces would pay less. HSP beneficiaries who are Medicaid eligible would pay no premiums.
Payment Rates to Providers	Payment rates would be established such that total payments for the provider category were comparable to what the provider was paid prior to the implementation of the HSP. Prices would also be adjusted for medical inflation as determined by the Consumer Price Index for Medical Care Prices.

Methods. We used a microsimulation model to estimate the effects of HSP on health insurance coverage and spending from 2024 (assumed initial year of the HSP) through 2028. We developed a baseline projection for the study period, which reflected health care coverage and spending under current law. We then compared the baseline to projected outcomes under the HSP. To simulate the impact of the HSP on insurance coverage, health care utilization, and spending, we started with the KNG-Health Reform Model (KNG-HRM), a microsimulation model capable of estimating the impact of health reform efforts. We then modified the model to incorporate New Mexico-specific data on the state's population and health care utilization, and to reflect HSP policies. The model uses an iterative process to estimate coverage choices, health care service use, spending, and premiums, as coverage affects health care use and spending, which in turn impact premiums and coverage choice.

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

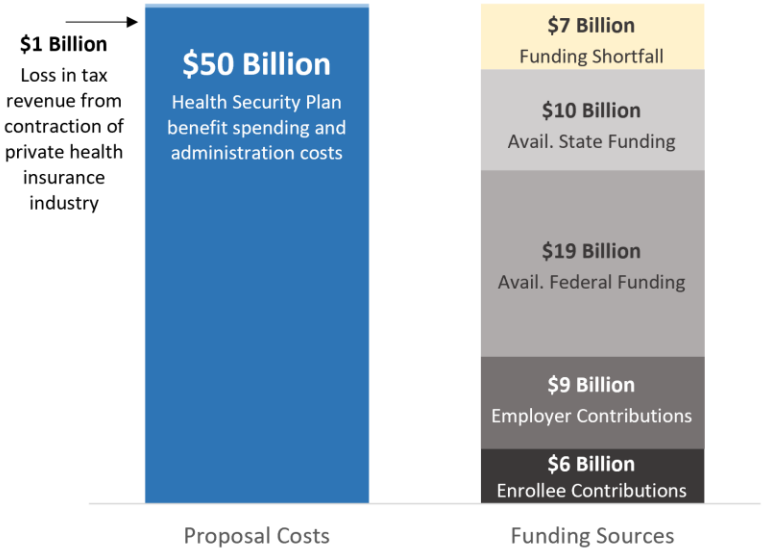
We accounted for three primary revenue sources to pay for the HSP. These include (1) premium and out-of-pocket spending by New Mexicans enrolled in the HSP; (2) employer contributions; and (3) repurposed federal and state spending for Medicaid, enrollment on the Marketplace, and public workers. Also, health insurers in the state pay a premium tax and surtax of 3.003 and 1 percent, respectively. While self-insured employers do not pay the premium tax, they are responsible for paying the premium surtax of 1 percent. Therefore, we accounted for lost premium tax revenue when assessing revenue sources to cover the cost of the HSP.

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

Key Findings. Implementation of the HSP would have impacts on health insurance coverage, health care spending by households, employers, and budgetary impacts for the state. Under our base scenario, we found the following:

- Coverage. The HSP would enroll most of the state's population into a state-administered health insurance program. Doing so could bring near-universal health insurance coverage to New Mexico.
- Spending. Improved access to comprehensive health insurance would drive higher use of services, particularly among those who otherwise would have been uninsured. While higher service use would drive increased spending, savings from reduced payer-side (state) administrative costs could offset these increases. In the long-term (beyond the initial 5 years), we project that the HSP would decrease total health spending if administrative costs are kept at levels proposed by the HSA.
- Effects on Households. By offering reduced premiums for certain New Mexicans, the HSP may also decrease the financial burden of health expenses for some households, particularly for low-income families not currently enrolled in Medicaid.
- Effects on Employers. The net impact on employers is dependent on how policymakers implement employer contribution requirements, including the level of contribution and which employers are exempt from contributions. Under our base scenario, we estimated that the HSP would increase employer contributions to the health care system. These cost increases would fall on businesses that were previously not offering health benefits and businesses that continued offering self-insured health plans to their employees.
- Budgetary Impact. Although we assumed significant reductions in costs to administer the program, we found that the HSP would be underfunded by approximately $7 billion over the first 5 years of the program (Figure ES1) based on currently available revenue sources. Fully funding the HSP would require some combination of additional employer contributions, reduced payment rates to providers, and/or higher enrollee costs.

Figure ES1. HSP Budgetary Impact, 2024-2028



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

- **Federal Waivers – Medicaid and Marketplace.** In our base model, we assumed that New Mexico would receive waivers for Medicaid and the Marketplace to fold these programs into the HSP.

Whether the state could obtain such waivers is uncertain. The HSP limits eligibility to those who have resided in the state for at least one year. Many of those who fail the residency requirement may be eligible for Federal Marketplace subsidies. The HSP would likely effectively eliminate the ACA Marketplaces, leaving some people unable to access Marketplace coverage or the HSP. The Federal government may be less willing to grant a federal waiver to repurpose Marketplace funding for the HSP, if not all Marketplace-eligible residents are eligible for HSP.

- Continuation of ACA and Federal Funding. Our results assumed that the ACA and associated federal funding will continue to be available to the state. Under the ACA, the Federal Medicaid Matching Rate applied for newly eligible adults under Medicaid expansion is 90 percent for 2020 and beyond. In addition, the ACA provides for federal financial assistance to those eligible on the Marketplace. Together, these federal assistance programs contribute an estimated at $2.1 billion to New Mexico.[1] California v. Texas, a pending case before the Supreme Court, could potentially strike down the entire ACA as unconstitutional. If this did occur, funding the HSP would become more challenging.

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

- Administrative Savings from the HSP. In our model, a key driver of savings would be reduced state administrative costs. The 2019 HSA would limit administrative costs of the HSP to no more than 5 percent of total spending starting in the sixth year. We assume that administrative costs represent 9 percent of total HSP spending in 2024 and fall to 5 percent by 2028. Our assumed administrative cost levels represent significantly lower costs as a percentage of total spending than is currently achieved by the state Medicaid program or by the national Medicare program. Spending on administrative costs accounted for roughly 12.4 percent of total New Mexico Medicaid spending in 2017.[2] According to the National Health Expenditure Accounts from the Centers for Medicare & Medicaid Services, administrative costs accounted for approximately 7 percent of Medicare spending. Thus, the state may find it challenging to achieve a 5-percent administrative cost factor, without compromising some aspect of the program.

- Tax Treatment for Employer and Employee HSP Contributions. There are considerable tax benefits to employer-sponsored insurance (ESI) because contributions by employers are not subject to federal taxes and employee contributions are made using pre-tax dollars, lowering employee's tax liability.

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

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

We assumed that these tax benefits would also apply under the HSP. Whether such preferential tax benefits would be applied to the HSP is uncertain and a full legal assessment of this issue is beyond the scope of the study. However, the tax treatment of contributions by employers and employees is an important issue that the state would need to resolve. Without this tax advantage, which is effectively a federal subsidy for the HSP, the costs of HSP would be greater than those estimated in this study.

- Employee Retirement Income Security Act (ERISA) Compliance Plan. In our analysis, we assumed that the state would be able to develop an ERISA-compliant approach whereby the state would collect funds through a payroll fee on employers whose employees obtain coverage through the HSP. We also considered an alternative scenario where the HSP is funded, in part, through a payroll tax on all employers. ERISA's "preemption clause" limits the ability of the state to make laws governing employer-based insurance to the extent that they "relate to" employer-sponsored health plans. We sought information on the likelihood that our assumptions would be consistent with ERISA. While no definitive conclusions were drawn, a general view could be surmised that it may be possible to design approaches that are materially similar to those assumed. This view is consistent with the approach followed by Mathematica Policy Research in its assessment of health care reform options for extending coverage in New Mexico. Nevertheless, the development of ERISA-compliant approaches to implement the HSP, to achieve its goals, could face legal challenges, which were not addressed in our study.

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

I. Introduction

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

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

A. Overview of the Health Security Plan

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

Ensuring Coverage to all New Mexicans. Prior to the Affordable Care Act (ACA), New Mexico had one of the highest uninsured rates in the nation, at 19 percent uninsured in 2013 as compared to the national rate of uninsured at 15 percent.[3] New Mexico experienced a significant reduction in the percentage of uninsured individuals after Medicaid expansion, with roughly the same percentage of its population uninsured (9%) as the national average in 2018.[4] Nevertheless, the uninsured rate remains high for some segments of the New Mexico population, including those who do not qualify for Medicaid (incomes above 138 percent of the Federal Poverty Level (FPL)) and Native Americans.[5]

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

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

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

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

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

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

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

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

Improve Health Care of all New Mexicans. The HSA envisions improvements to the health care of all New Mexicans through several mechanisms. These include expanded coverage to the uninsured, insurance benefits that are at least as good as those offered by the state employee health plan, no-cost access to preventative services, and care coordination, where appropriate. New Mexico has a shortage of primary care providers, with 32 of New Mexico's 33 counties classified as full or partially federally designated Health Professional Shortage Areas (HPSA) for primary medical care.[6] Almost 25 percent of the population

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

lives in a rural area, with 40 percent living in an HPSA. Therefore, the HSA directs the Health Care Commission to ensure the provision of health care services in rural and underserved areas (HB 295 § 14). Additionally, health care providers may not deny care due to nonpayment for previous services (HB 295 § 26). Finally, the HSA calls for the establishment, in conjunction with other state agencies, of a comprehensive system to collect and analyze health care data to improve the quality, efficiency, and effectiveness of health care services in the state (HB 295 § 11).

B. Study Approach Overview

Our approach for conducting the fiscal analysis of the HSP consisted of three steps. First, we conducted a qualitative assessment of the HSP to understand key features as well as identify policy assumptions needed to conduct the fiscal analysis. This assessment involved reviewing the proposal to identify features of the HSP and reviewing literature to identify coverage reform options for those elements not fully specified in the legislation. Second, we solicited public feedback on our analytic approach and HSP policy assumptions. We received public comments at a public meeting at The University of New Mexico in Albuquerque held on December 4, 2019, and a second public meeting in the New Mexico State Capitol in Santa Fe on March 3, 2020. Additionally, we accepted written comments on our analysis plan. We provide a summary of the public comments and our responses to these comments in the appendix. Third, we conducted a quantitative analysis of the HSP using a microsimulation model and assessed the impact of alternate reform options ("scenarios"). This involved simulating the effects of each scenario on key health-related measures, including insurance coverage, and health spending. We then translated these results into a fiscal impact for the state, including the downstream economic impacts on the state. While a key goal of the HSP is to improve health care for all New Mexicans, we did not explicitly incorporate this goal into our fiscal analysis. However, we did assess the long-term effects of improved access to care, preventative services, and care coordination on HSP beneficiaries and the state. A detailed description of our study approach is described in our methods section (Section III).

C. Structure of the Report

This report is designed to assist policymakers in assessing the potential impact of the HSP. We simulated the costs of the HSP using a range of different policy options and assumptions. As with any simulation model, our results are sensitive to underlying assumptions. Therefore, we conducted a sensitivity analysis of some of the assumptions.

The report is organized as follows. We first present a description of the HSP features and model assumptions, including the policy assumptions we used to develop alternate proposals in the microsimulation modeling approach. Next, we describe our methods, such as the microsimulation database and the KNG Health Reform Model. We then present our findings for the current coverage and expenditures and financing in New Mexico, followed by the change in coverage and costs under the reform models by scenario. We present the economic impacts and other potential effects separately. We then end with a discussion and conclusion section.

II. Health Security Act: Plan Features and Policy Assumptions

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

A. Features of the Health Security Plan

The HSA as introduced during the 2019 New Mexico legislative session as HB 295 and SB 279 specifies several features of the HSP. These proposed features need to be part of any option considered under the study. The HSP-specified features are related to eligibility and enrollment, benefits and cost sharing, premiums, and providers. However, we needed other design features left unspecified in the HSA to model the potential costs of the HSP.

In Table 2.1, we present a summary of the proposed features of the HSP. We also provide notes on the non-proposed features of the HSP. There are open questions surrounding benefits (minimum standards are established by the HSA), premiums, and subsidies; the costs to employers; and plan financing. In the following section, we present our treatment of HSP policy aspects used for our modeling approach.

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

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

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

Eligibility – Employers	• All employers may offer coverage through the HSP. • Employers may offer comprehensive health benefits outside of the HSP if they self-insure.	• The HSA envisions that the HSP would receive payments from all participants, including employers whose employees obtain coverage through the HSP. • The HSA does not specify the exact mechanism by which employers would contribute to the HSP.
Enrollment	• Enrollment into the HSP would be required for all eligible enrollees, including employees at firms that do not offer a self-insured plan. • Enrollment would be voluntary for self-insured employers and tribal governments.	• The legislation does not address retroactive coverage for eligible populations who do not apply for coverage before consuming services.
Benefits and Cost-Sharing		
Benefits	The HSP must cover the benefits currently offered by the state employee health plan.	• The HSP does not limit benefits to those covered by the state employee health plan.

Category	Proposed Features	Non-Proposed Features
Cost-Sharing Amounts	The HSP must not apply cost-sharing for preventative services or to any services received by Native American enrollees.	• The legislation does not specify cost-sharing requirements for non-preventative services delivered to non-Native American enrollees.
Cost-Sharing Subsidies	No detail provided.	• A cost-sharing subsidy structure is not specified.
Premiums		
Premium Amounts	• A single per-person premium amount may be applied. • The premium level may be established to fund both benefits spending for HSP enrollees and HSP administrative costs. The administrative portion of the premium amount would be capped at 5% of total spending after five years.	• Unspecified in the legislation is the obligation of eligible populations who have not applied for coverage to pay premiums and, if so, how premiums would be collected.
Premium Subsidies	No detail provided.	• The legislation does not specify how premium subsidies should vary by income or if premium subsidies should vary by family size.
Providers		
Provider Participation	Health care providers may not deny care due to non-payment for previous services. A health resource certificate must be obtained by a health facility or health care provider participating in the HSP before making a major capital expenditure.	
Provider Payments	Provider reimbursement rates would be negotiated with the Health Care Commission. Health facilities would be subject to global budgets. Annual HSP provider rate increases would be limited to growth in the medical component of the Consumer Price Index. Supplemental payments may be provided to ensure access in rural and underserved areas.	• The HSA does not specify provider rates but leaves it to be negotiated with the Health Care Commission. Additionally, it does not specify the extent additional payments would be made to underserved and rural communities.

B. Policy Assumptions for the Health Security Plan

To model the costs of the HSP, we required specific assumptions regarding the policies governing the HSP and specific plan features. In this section, we provide a discussion of our assumptions on key issues related to the implementation of the HSP. We summarize our policy assumptions in Table 2.2 and provide more details on our assessment in the sections below.

Table 2.2. HSP Policy Assumptions for the Baseline

Policy Issue	Modeling Assumptions
Implementation Date	January 1, 2024
Treatment of Medicaid & Medicare Beneficiaries	Medicaid beneficiaries would be folded into the HSP upon implementation of the plan; Medicare beneficiaries would remain outside of the HSP during the initial 5-year modeling period.
Employer HSP Participation and Contributions	Employers offering a self-insured employer plan may participate in the HSP or offer their own plan. Employees at all other firms enroll in the HSP. Employers that do not offer a self-insured employer plan would pay to cover part of their employees' premium costs.
HSP Eligibility of Employees at Self-Insured Employers	Employees with access to self-insured employer plans may enroll in the HSP but would only decide to do so if their employer's coverage was not affordable.
Tax Treatment of Employer and Individual Contributions toward Premiums	Employer and individual contributions to premiums would be tax-exempt.
Enrollment Mechanisms	Retroactive eligibility for those who would be eligible for the HSP. Voluntary enrollment for self-insured employer coverage enrollees and employers.
Benefits and Cost-Sharing	Comprehensive benefits package comparable to what is currently available to state employees. No long-term care benefits. Cost-sharing would be similar to the average employer plan (based on actuarial value). No cost-sharing on preventative services. No cost-sharing for Native Americans or Medicaid-eligible enrollees.
Premiums	Individual responsibility for premiums would be modeled on the average employer plan. HSP beneficiaries who would be eligible for lower premiums on the Affordable Care Act (ACA) Marketplaces would pay less. HSP beneficiaries who are Medicaid eligible would pay no premiums.
Payment Rates to Providers	Payment rates would be established such that total payments for the provider category were comparable to what the provider was paid prior to the implementation of the HSP. Prices would also be adjusted for medical inflation as determined by the Consumer Price Index for Medical Care Prices.

1. Treatment of Medicaid and Medicare Beneficiaries

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

Because of administrative savings and other benefits of including Medicaid in the HSP, we simulated the effects of the HSP where Medicaid enrollees are enrolled in the HSP. However, in recognition that obtaining a federal waiver for Medicaid is uncertain, we also modeled a scenario where Medicaid enrollees are not eligible for the HSP.

The treatment of Medicare enrollees is not specified by the HSA, although it specifically directs the Health Care Commission to apply for all waivers of requirements that would allow the HSP to receive federal payments for services provided to Medicare beneficiaries. Including Medicare beneficiaries within the HSP would be administratively complex. Medicare beneficiaries' selection into the HSP would need to be voluntary. Prior research from Mathematica Policy Research suggested that the HSP could potentially be offered as a Medicare Advantage (MA) plan, which would allow for voluntary participation in the HSP.[7] Doing so would require the state to verify that the HSP complied with regulatory requirements for MA plans. This could either limit the state's flexibility in designing the HSP or require the state to offer an alternative version of the HSP specific to Medicare enrollees. In addition, the Centers for Medicare & Medicaid Services (CMS) has an established process for setting premiums for MA plans based on a plan's bid and other information. Thus, even if New Mexico was able to create an MA HSP, premiums would likely be established separately from the main HSP for non-Medicare enrollees, enrollment would be voluntary, and funding would come from current Medicare funding sources. For purpose of simulating the effects of the HSP, we assumed that Medicare beneficiaries are not eligible to enroll in HSP during the initial five-year period, because, while it might be possible for the state to establish an HSP in MA, this plan would likely be separate from the main HSP from a revenue and cost perspective.

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

2. Employer Participation and Contributions to the HSP

The implementation of the HSP and enrollment of individuals currently covered under public (Medicaid and Medicare) and employer-sponsored insurance is made complicated by federal laws and regulations. ERISA governs fully insured and self-insured employer plans. Because ERISA preempts all state laws related to employer-sponsored benefits, it imposes a significant challenge to states attempting to bring employer coverage under a state health plan.[8] However, states regulate insurers and can, therefore, exert more control over employers with full-insured health plans. Section 40 of the HSA relates to the voluntary purchase of other insurance. It states that the HSA does not affect coverage pursuant to ERISA unless the state is granted a congressional exemption or waiver. It further notes that health plans that are covered by ERISA may elect to participate in the HSP.

After consultation with the LFC, we assumed that the intent of the proposal is to enroll employers and their employees with fully insured plans in the HSP. This view of the proposal was also articulated in public comments we received on the HSA. In addition, although the current HSA language does not specifically differentiate between fully insured or self-insured employer plans, earlier versions of the plan grants self-insured plans the ability to "opt-out" of the HSP. Thus, for purposes of our model, we assumed that the state will be able to take actions that are both compliant with ERISA but also results in the enrollment of employees at firms that do not offer a self-insured employer plan. Moreover, the plan would allow employers offering self-insured plans to participate in the HSP (this can be viewed as an "opt-in" provision).

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

To estimate participating employer contributions to the HSP, we examined two options. Consistent with the co-op nature of the HSP, the primary approach would require only employers participating in the HSP to make contributions to the HSP on behalf of their employees. First, we estimated the amount of money contributed towards premiums by employers for fully insured employer plans. Second, we calculated total premium contributions as a percentage of total payroll across all employers that do not offer a self-insured plan. This fixed percentage was established as the contribution required for employers who

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

participate in the HSP. Additionally, we also assessed for comparison purposes an approach where all employers (participants in the HSP and employers offering a self-insured plan) make contributions to pay for the HSP.

3. HSP Eligibility of Employees at Self-insured Employers

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

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

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

4. Tax Treatment of Employer and Employee Contributions toward Premiums

One advantage of employer-based health insurance coverage is that contributions toward premiums by individuals and their employers are tax-exempt. We assumed that the HSP would be set up to allow both employer and individual contributions to premiums to be tax-exempt. This assumption effectively neutralizes the effects of the tax preference for ESI coverage on employers' decisions to continue to offer a self-insured employer plan or enroll employees in the HSP, since contributions to coverage are treated the same under each situation. However, there may be other factors that employers may consider in deciding to offer insurance coverage to employees.

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

The creation of a public coverage program will not necessarily result in universal coverage. For example, according to a recent report by the Urban Institute, approximately 30 percent of uninsured New Mexico residents are already eligible for Medicaid and 23 percent are eligible for subsidies on the New Mexico

Health Insurance Marketplace but are not enrolled.[9] These residents could obtain coverage at little or no cost but have elected not to enroll in the program. The 2019 HSA would not impose an insurance coverage mandate on individuals or employers. The state may attempt to automatically enroll all eligible persons. However, this requires an administrative mechanism to verify eligibility (i.e., the one-year residency requirement) and collect premiums when applicable. In our environmental scan of state universal coverage legislative proposals, we did not identify any proposals that described an automatic enrollment process.

The state has not yet implemented verifying eligibility and enforcing premium payments on a continuous basis. One solution would be for the state to adopt retroactive eligibility, in which providers can be paid for services by enrolling eligible patients after care has already been received. Retroactive eligibility is currently used in New Mexico's Medicaid program. The state would likely need to collect unpaid premiums through end-of-year tax returns. The state would need to decide whether non-enrolled individuals who had de facto coverage through retroactive eligibility would be required to pay a premium amount when filing their taxes. If so, some individuals may perceive the premiums as taxes. If not, individuals may choose not to enroll in the HSP until they need care.

We assumed that the state achieves universal coverage among eligible populations through retroactive eligibility. In addition, we assumed that all individuals would be required to pay premiums (collected through tax filings, if necessary) regardless of whether or not they actively enrolled in the HSP. However, we did not assume that the uninsured who now gain coverage under the HSP (in part, from retroactive eligibility) would seek care to the same extent that someone who was previously insured. Instead, some may continue to seek care to the same extent they sought care while uninsured. This assumption reflects the reality that having access to care may not change behavior for those who choose to be uninsured, because of financial, cultural, or other reasons.

6. Benefits and Cost-Sharing

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

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

Section 18 of the legislation calls for the appointment of an advisory "long-term care committee" one year after the implementation date of the HSP to determine if and how long-term care benefits should be included in the plan. Medicaid covers long-term care (LTC) benefits and accounts for more than half of total LTC services (after excluding short-term stays in skilled nursing facilities and home health).[10] We assumed that LTC benefits will not be included in the HSP within the 5-year projection window. While we allowed for Medicaid enrollees to be included in the HSP, we assumed that LTC benefits would be provided to this population outside of the HSP.

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

The legislation provides little detail on enrollee cost-sharing requirements (e.g., coinsurance, and copayments). Section 33 states that the Health Care Commission "may establish a copayment schedule if a required copayment is determined to be an effective cost-control measure." The HSP could have cost-sharing levels comparable to typical Marketplace plans, typical employer plans, or have no cost-sharing at all. The state may consider subsidies for low-income enrollees, like the Marketplace cost-sharing reduction plans. The state's federal Medicaid waiver would likely not allow the state to charge most Medicaid-eligible HSP enrollees any cost-sharing. Lower levels of cost-sharing would have a fiscal impact on the policy, both by reducing enrollee contributions and by inducing additional demand for services. Higher levels of cost-sharing may be burdensome for enrollees and lead patients to delay or forego high-value medical services.

In our review of state and federal regulations, we observed significant variation in proposed premium and cost-sharing levels. Most proposals had little or no enrollee costs at all. We modeled the fiscal impact of the HSP under a variety of premium and cost-sharing policy scenarios as shown in Table 2.3, including: (1) ACA Marketplace; (2) Common Employer Plan; (3) Medicare for America Act of 2019[11]; and (4) No cost-sharing. These four scenarios represent a range of cost-sharing and premium arrangements. Our base model used a common employer plan cost-sharing and premium policy, since this represents around the average generosity, while the ACA Marketplace represents the less generous, and the Medicare for America Act with and without cost-sharing represents the most generous.

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

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

Table 2.3. Enrollee Cost Assumptions across Scenarios

	Cost-Sharing (Actuarial Values (AV))	Premiums
ACA Marketplaces	<138% FPL: 100% AV 138% - 150% FPL: 94% AV 151% - 200% FPL: 87% AV >200% FPL: 70% AV	Premiums would be set so that families must pay no more than a fixed percentage of their income on plan premiums. This would range from 3.09% for families with incomes at 138% FPL to 9.78% for families with incomes above 400% FPL. Families with incomes below 138% FPL would have no premium obligations.
Employer Plan	<138% FPL: 100% AV >138% FPL: 83% AV	Premiums would be set so that families must pay no more than a fixed percentage of their income on plan premiums. This would range from 3.09% for families with incomes at 138% FPL to 9.78% for families with incomes above 400% FPL. The minimum subsidy would equal 75% of the full premium cost. Families with incomes below 138% FPL would have no premium obligations.
Medicare for America	<200% FPL: 100% AV >200% FPL: 90% AV	Premiums would be set so that families must pay no more than a fixed percentage of their income on plan premiums. This would range from 0% for families with incomes at 200% FPL to 8% for families with incomes above 600% FPL. Families with incomes below 200% FPL would have no premium obligations.
No Cost-Sharing	100% AV	Same as Medicare for America.

7. Establishment of Provider Payment Rates

In the proposal, the Health Care Commission would prepare a budget and negotiate with providers. If payment rates are set too low, enrollees may struggle to find providers. There is already significant concern regarding the availability of primary and specialty care, particularly in rural areas in New Mexico.[12] On the other hand, by covering most individuals in New Mexico under a single plan, the administrative costs for providers may be reduced, which may allow for lower provider payments.

A key assumption in proposals for single-payer systems is that provider administrative costs would be reduced and, thereby, allow provider payment rates to be reduced without inducing negative supply responses. Reductions in provider administrative costs are viewed as one key source of savings under a single-payer system or similar health reform efforts. Based on feedback at the public meeting, however, we assumed in our base model that HSP payment rates are established to be "budget neutral" in aggregate; that is, the total payment to providers would be set in our model to equal total payment rates

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

prior to the implementation of the HSP. We examined the potential impact of administrative savings on providers from the adoption of the HSP and also assessed the impact of changes in reimbursement rates under the HSP.

Global budgeting is an innovative concept that moves reimbursement away from fee-for-service to a prospectively set amount of revenue given to hospitals.[13] The idea is to create an incentive for hospitals and other health care facilities to reorganize how they deliver care. The legislation stipulates that health care facilities would be subject to global budgets under the HSP, although limited detail is offered for how global budgets would be established or how non-health facility providers would be paid. [14]

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

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

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

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

- What would New Mexico's Health Security Plan cost the state?
- Would current revenue sources be sufficient to cover the cost of the HSP?
- What would be the economic impact of adopting the HSP on New Mexico and state tax revenue?

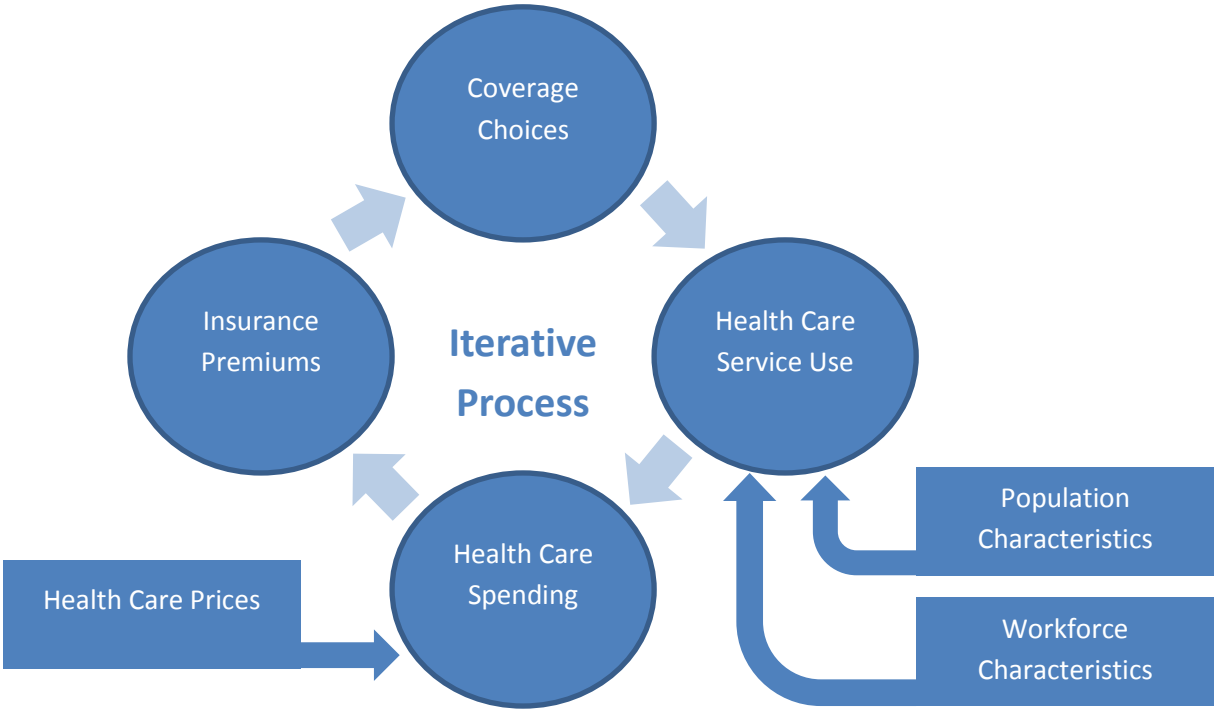
In this section, we present an overview of our approach, the development of the analytic database to conduct the study, and specific model assumptions.

A. Overview of Approach

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

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

Figure 3.1. Overview of the KNG Health Reform Model



The Costs of the HSP. Understanding the costs of the HSP requires estimates of the number of covered individuals and the cost (to the state) of the health care services they receive plus administrative costs. The intent of the HSP is to cover all New Mexico residents, except for those with available coverage at a self-insured firm and individuals not eligible for the HSP (generally those with <12 months of New Mexico residency). We assumed automatic enrollment of eligible individuals based on a retrospective enrollment process. Thus, in our model, all individuals eligible for the HSP may immediately access covered services, although our model did not assume that they all access care immediately. Instead, our model recognized that some newly-insured individuals in New Mexico would fully access services, while others would not and continue to behave as if they are uninsured even if they are eligible to receive services under the HSP at little or no cost.[15]

While enrollment is automatic for those eligible for the HSP, there is still uncertainty over the size of the population enrolled in the HSP because of uncertainty regarding employer behavior in the state. The introduction of the HSP could result in self-insured plans dropping coverage and their employees participating in the HSP. It is also possible that employers who previously offered fully-insured coverage may switch to offering self-insured coverage. Therefore, we modeled the decision of self-insured firms to

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

continue to offer coverage. However, we assumed that fully-insured firms would not become self-insured and, instead, their employees would obtain coverage through the HSP.

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

Revenue Sources to Pay for the HSP. We accounted for three primary revenue sources to pay for the HSP. These include (1) premium and out-of-pocket spending by New Mexicans enrolled in the HSP; (2) employer contributions; and (3) repurposed federal and state spending for Medicaid and enrollment on the Marketplace. Also, health insurers in the state pay a premium tax and surtax of 3.003 and 1 percent, respectively. While self-insured employers do not pay the premium tax, they are responsible for paying the premium surtax of 1 percent. Therefore, we accounted for lost premium tax revenue when assessing revenue sources to cover the costs of the HSP.

Economic Impact of the HSP. Health care spending changes from the HSP would result in additions to output and income as the demand for, and provision of, health care services increases, from more intense utilization of existing resources and the addition of capital investment in the state. We calculated the in-state economic contribution of spending under the HSP using the IMPLAN model of the New Mexico economy, which explicitly models the degree to which service inputs are provided from businesses in the state. We generated direct and indirect impacts of the new spending on related state sectors – for example, an increase in physician office visits generates an indirect demand for office space, medical support staff, etc. Moreover, the sales and income earned in these related sectors further generate demand for other goods and services in the state. These demands result in revenue and output of goods and services in health care and other industries. The full direct, indirect, and induced impacts on households and businesses in each sector are reported as changes relative to the baseline from the date of plan implementation to 5 years beyond.

B. Analytic Database

To complete the study, we developed a comprehensive analytic file that includes information on New Mexican residents and employers. The resident file includes baseline estimates for demographic information, chronic conditions, utilization rates, and spending patterns. We developed the analytic database to cover our assumed initial year of the HSP (2024) and the four subsequent years to include 5-year estimates. The employer file includes baseline data on a set of synthetic firms offering coverage and characteristics of offered health plans. We grouped employed New Mexicans to a synthetic firm.

Our analytic file is based in the American Community Survey (ACS) and includes broad information for a large nationally representative sample.[16,17] We combined 2016, 2017, and 2018 ACS data and limited it to individuals in New Mexico. We excluded those on Medicare, residing in group quarters, and those covered under a military health insurance program. Our final sample includes 41,783 observations representing individuals residing in New Mexico. We supplemented the ACS with New Mexico and national data sources to populate our analytic file with necessary fields (Table 3.1).

Table 3.1. Key Data Sources

Data Base	Description	Uses
American Community Survey (ACS)[18]	2016-2018 Representative Survey of New Mexicans.	Baseline demographic, disability, health insurance coverage, and income for analytic file.
CMS Monthly Medicaid Enrollment File[19]	State Medicaid enrollment.	Calibrate New Mexico Medicaid enrollment in the analytic file to administrative data.
CMS Medical Loss Ratio Public Use File[20]	Health insurance companies spending on health care and administrative costs, such as salaries and marketing.	Calibrate non-group enrollment in New Mexico.
HCCI Annual Report[21]	2017 Employer-sponsored insurance utilization, price, and spending data.	Scaling of health care prices, utilization, and spending on ESI and non-group coverage and the uninsured.
Managed Care Expenditure Reports[22]	2018 Medicaid enrollment and health care utilization for each of New Mexico's Medicaid Managed Care Organization (MCO) plans from the New Mexico Human Services Department.	Scaling aggregate Medicaid spending and health care service utilization to match administrative data benchmarks.

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

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

[18] U.S. Census Bureau. (2019) American Community Survey [Data set]. https://www.census.gov/programs-surveys/acs

[19] Centers for Medicare & Medicaid Services. (2017). *CMS Monthly Medicaid Enrollment* [Data file]. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html

[20] Centers for Medicare & Medicaid Services. (2019). *Medical Loss Ratio Data and System Resources* [Data set]. https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr

[21] Health Care Cost Institute. (2019). *2017 Health Care Cost and Utilization Report* [Data set]. https://bit.ly/3b2K89y.

[22] Provided by the Legislative Finance Committee to the KNG Health team

Data Base	Description	Uses
Medical Expenditure Panel Survey (MEPS)[23]	Large-scale surveys of families and individuals, their medical providers, and employers.	Estimate health care utilization and spending for observations in an analytic database; Scaling health care spending for those on ESI to match New Mexico-specific employer-based premiums.
New Mexico Emergency Department (ED) Encounter Data[24]	2017 state ED database containing encounters for all ED visits in New Mexico.	Scaling estimated ED utilization in New Mexico to match administrative data.
New Mexico Hospital Inpatient Database[25]	2017 state inpatient database containing discharge records for all hospital discharges in New Mexico.	Scaling estimated inpatient hospital utilization in New Mexico to match administrative data.

Calibrating Coverage in ACS. We compared New Mexico Medicaid enrollment and non-group enrollment in the ACS to enrollment reported in several administrative data sources.[26,27] In the ACS, Medicaid enrollment was lower than enrollment counts reported in the CMS monthly Medicaid enrollment reports. Conversely, non-group enrollment was higher than enrollment estimates from the Medical Loss Ratio Public Use Files. Similar discrepancies in the ACS have been observed by other researchers.[28] To match these administrative benchmarks, we reclassified some non-group enrollees to having Medicaid coverage in the baseline. When reclassifying respondents to Medicaid coverage, we prioritized those respondents who are Medicaid-eligible and preserved the ratio of adults to children in each program. We also reclassified a small number of Medicaid-eligible individuals with Medicare or military coverage into Medicaid.

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

[23] Agency for Health care Research & Quality. (2019) *Medical Expenditure Panel Survey* [Data set]. https://www.meps.ahrq.gov/mepsweb/
[24] New Mexico Department of Health. (2017) *Emergency Department Data Annual Report* [Data set]. https://nmhealth.org/data/view/systems/2229/
[25] New Mexico Department of Health. (2017). *Hospital Inpatient Discharge Data Annual Report* [Data set]. https://nmhealth.org/data/view/systems/2216/
[26] Center for Medicare & Medicaid Services. (2018). *Medical Loss Ratio Public Use File* [Data set]. https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr
[27] Kaiser Family Foundation. (2018) *Total Monthly Medicaid and CHIP Enrollment* [Data Set]. https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment
[28] Lynch, V. et al. (2011). *Improving the validity of the Medicaid/CHIP estimates on the American Community Survey: The role of logical coverage edits*. U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/working-papers/2011/demo/improving-the-validity-of-the-medicaid-chip-estimates-on-the-acs.pdf

Estimating Health Care Utilization and Spending. We assigned health care utilization rates and prices to each individual in our ACS sample. Since a comprehensive all-payer claims database does not exist for New Mexico, we developed utilization and spending estimates using a regression-based approach based on data from the MEPS [29] and scaled these data to match administrative and other data specific to New Mexico.

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

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

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

We adjusted our estimates of health care service utilization by Native Americans. Our modeling approach suggests a relatively high utilization of services by Native Americans because they have high rates of disability and chronic conditions, relative to others with similar insurance coverage. However, our results on service utilization (which will translate to higher spending) run counter to federal spending on health services for Native Americans as well as anecdotal evidence. In 2017, for example, the Indian Health Service (IHS) spent $4,078 per user of IHS health care services, where U.S. national health care spending was more than 2.3 times higher.[30] While Native Americans receive care from non-IHS funded providers, it may not be reasonable to assume higher utilization and spending among Native Americans than the national average amounts. Therefore, we used MEPS to estimate spending for Native Americans and others by broad age groups. We then calculated a ratio of average per person spending by age group between Native Americans and the overall average. We adjusted all utilization for Native Americans in our database by these ratios.

To develop estimates of spending we multiplied our estimates of health care utilization by prices, using service-specific unit prices which vary by payer. Prices vary by age, gender, and location within the state. Initial prices are set for commercial and Medicaid enrollees using data from the HCCI and the New Mexico Human Services Department (HSD). Following findings from the literature, we assumed uninsured individuals pay Medicare prices for hospital care and commercial prices for physician services.[31,32] We

[29] U.S. Agency for Health care Research and Quality. (X). Medical Expenditure Panel Survey.
[30] Indian Health Service. (2020) *IHS Profile.* Indian Health Service. https://www.ihs.gov/newsroom/factsheets/ihsprofile/
[31] Melnick, G.A. & Fonkych, K. (2008). Hospital Pricing And The Uninsured: Do The Uninsured Pay Higher Prices? *Health Affairs*: 27 (Suppl 1). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.w116
[32] Gruber, J. & Rodriguez, D. (2007). How much uncompensated care do doctors provide? *J Health Econ* 26:1151-1169. https://economics.mit.edu/files/6423

inflated prices to 2024 using projections from the National Health Expenditures Accounts. For future periods, we inflated prices by the Consumer Price Index for Medical Care Prices, as specified in the HSA.

We assumed individuals would pay different prices if they changed insurance coverage. For each payer and service category, we developed assumptions for average payment levels (prices) relative to Medicare in New Mexico. For this exercise, we reviewed a variety of published resources from the Congressional Budget Office[33,34], the HCCI[35], the Kaiser Family Foundation[36], the RAND Corporation[37], and the Medicaid and CHIP Payment and Access Commission.[38] Figure 3.2 shows the price ratios that we used to adjust spending.

Our model assumes that health care provider supply would be adequate to meet any increases in demand for health care services under the HSP. We conducted an analysis, reported in the appendix, to assess this assumption.

[33] Pelech, D. (2018*). Working Paper: An Analysis of Private-Sector Prices for Physicians' Services: Working Paper 2018-01*. Congressional Budget Office. https://www.cbo.gov/publication/53441

[34] Maeda, J.L. & Nelson, L. (2017). *An Analysis of Private-Sector Prices for Hospital Admissions: Working Paper 2017-02*. Congressional Budget Office. https://www.cbo.gov/system/files/115th-congress-2017-2018/workingpaper/52567-hospitalprices.pdf

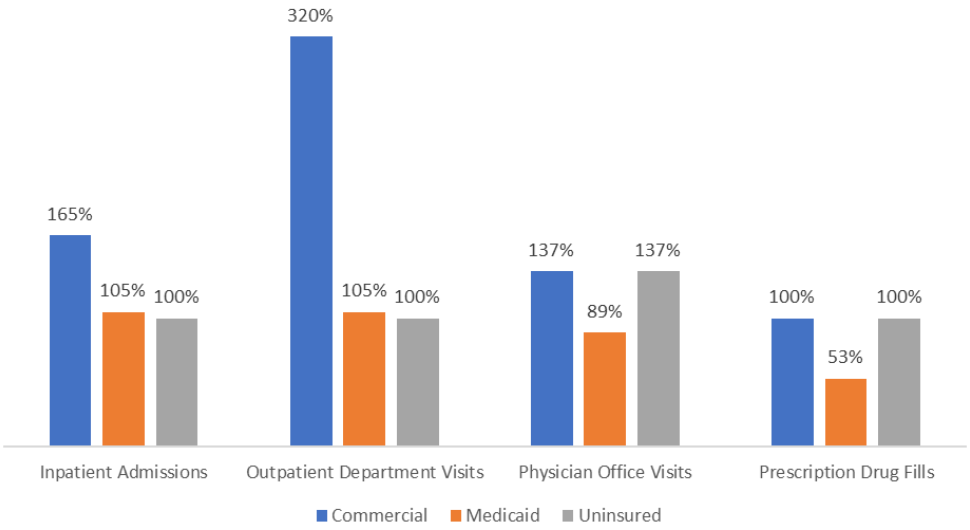
[35] Johnson, B., et al. (2020). *Healthy Marketplace Index*. Health Care Cost Institute. https://www.healthcostinstitute.org/research/hmi.

[36] Kaiser Family Foundation. (2016). *Medicaid-to-Medicare Fee Index*. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

[37] White, C. & Whaley, C. (2019). *Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely*. RAND Corporation. https://www.rand.org/pubs/research_reports/RR3033.html

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

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



Source: KNG Health Consulting

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

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

New Mexico Synthetic Firm File Development. The datasets used in the synthetic firm analysis are the ACS (2016-2018) and the Current Population Survey (CPS, 2016-2018). We grouped working ACS respondents into a synthetic firm. The ACS indicates whether the respondents are employed but does not include information on the size of the firm where they are employed. Because employer insurance varies significantly by firm size, we used the CPS data to impute firm size. Firms were classified into 5 firm size categories: (1) fewer than 10 workers; (2) 10 to 49 workers; (3) 50 to 100 workers; (4) 100 to 999 workers; and (5) more than 1,000 workers. We calibrated the imputed ACS private sector firm size to match the distribution for New Mexico in MEPS-Insurer/Employer Component (IC).

We assigned each ACS worker's initial offer status using various MEPS-IC tables (by firm size, industry, and income quartile) and made adjustments as necessary to ensure consistency between ESI offer and ESI enrollment. Next, we combined the ACS workers into synthetic firms based on the following hierarchy of characteristics: offer status, firm size, industry, region, and state. We populated each ASC synthetic firm until it has the midpoint of the firm size category number of employees. We treated all federal government employees as working for the same firm. We treated other government employees residing

in New Mexico as being employed by the same firm. We also assumed that all local, state, and federal government employees have access to ESI coverage and work in a firm with more than 1,000 employees.

C. Simulating Health Reform Proposals

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

1. Enrollment

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

- Uninsured populations;
- Non-group enrollees;
- Fully-insured employer enrollees; and
- Medicaid enrollees (under some scenarios).

For individuals covered by self-insured employer plans, enrollment would be voluntary. We assumed a portion of this population would choose to enroll in HSP based on the cost of coverage and their income (Table 3.2). However, those with employer coverage may favor staying with that employer coverage, if available, and only choose to enroll in the HSP if their employer coverage is unaffordable.

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

Table 3.2. Assumptions Guiding Individual Enrollment Decisions

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

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

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

2. Health Care Spending Impacts under the HSP

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

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

Health Care Prices. For the HSP, we dynamically set initial prices so that average prices paid for program enrollees are similar to what would have been paid for those enrollees under current law. As most HSP enrollees previously had Medicaid or commercial coverage, this resulted in HSP prices approximately halfway between Medicaid and commercial rates. As proposed by the legislation, we inflated HSP prices using projected growth in the Consumer Price Index for Medical Care Prices for All Urban Consumers.

Administrative Costs and Savings. A key potential cost savings from the adoption of the HSP would be reduced administrative costs from both the payer and provider perspective. We discuss our assumptions regarding payer administrative costs in the sections describing our development and assumptions regarding premiums (see below). With respect to provider administrative costs, research suggests that U.S. hospital administrative costs are much higher than in other countries that either have single-payer systems or more tightly regulated multi-payer systems.[39] Based on public feedback, our base model did not assume a reduction in price for health care services as a result of lower administrative costs.

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

However, in sensitivity analyses, we did assess the potential impact of lower provider reimbursement so that the state may capture some of the administrative costs savings on the provider side.

Many scholars have conducted surveys to estimate the time physicians and nurses spend on billing and insurance-related activities relative to the time delivering care. The cost of administrative time may be reduced if providers can deal with a much smaller number of payers with more standardized processes and rules. Studies have also shown that hospital administrative costs are larger in a multi-payer system due to time spent on billing and insurance-related costs. We estimated the portion of provider-specific costs which is linked to administrative activities and could potentially be reduced under the HSP.

- *Total health care-related administrative costs in hospitals*. Following the methodology in Himmelstein et al. (2020)[40], we used the Medicare cost reports to classify hospital expenses as "administrative," "clinical," "mixed," and "other" expenses. The administrative load is calculated as Administrative costs/ (Administrative costs + Net Clinical Expenses). Administrative costs include administrative expenses plus a portion of expenses which are classified as "mixed." Examples of mixed expenses include interest expenses, employee benefits expenses, and maintenance expenses. The portion of mixed expenses that is included in administrative costs is based on the share of administrative expenses in the hospital's operating expenses. Net Clinical expenses are calculated using the "clinical" category of expenses and deducting expenses classified as "other." Examples of other expenses include intern and resident program costs, research costs, and nursing home costs.

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

- *Calculating the administrative load in physicians' offices*. We used data from the ACS 2014-2018 limited to employees in physician offices in New Mexico. Following Himmelstein et al. (2020), we categorized employees into 4 categories: "Nurses," "Clerks," "Managers," and "Physicians." We used data on average working hours and annual incomes to calculate the total costs in physician offices in New Mexico. To calculate administrative load, we used estimates from Morra et al. (2011)[41] for practice-wide time spent on administration related activities per physician. These activities included time spent on formularies, claims/billing, credentialing, quality data, and prior authorizations. Using these estimates, we estimated administrative costs account for 27.6 percent of physician practice costs (Himmelstein et al. (2020) reported a national administrative load in physician offices of 21.8%).

In studies comparing provider administrative costs between countries with different payer systems, single-payer or tightly regulated multi-payer systems had lower administrative costs of up to 60 percent.[42]

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

In some sensitivity analyses, we assumed that provider administrative cost savings are shared between providers and the state through partially lower prices for health care service.

Utilization Changes due to Coverage Gains. As individuals gain coverage and gain better access to care, their utilization is likely to increase, although some utilization – particularly in the long-term, may be offset by reductions in other types of services. Using a randomized controlled trial approach, the Oregon Health Insurance Experiment studied the effect of expanding Medicaid on several key outcomes, including health care use and patient outcomes, during the first two years of the program.[43] To randomized enrollees, the state drew names by lottery for its Medicaid program for low-income and uninsured adults. An evaluation of the Oregon Health Insurance Experiment found that previously uninsured people gaining Medicaid coverage increased inpatient utilization by 30 percent, ER utilization by 68 percent, physician visits by 50 percent, and prescription drug usage by 15 percent.[44] As a randomized experiment, the Oregon Health Insurance Experiment offers the strongest evidence on the impact of gaining coverage on the utilization of services.

We used the results from the Oregon Health Insurance Experiment to adjust utilization for New Mexicans gaining coverage under the HSP. However, we adjusted the estimated effects to recognize that not all those currently eligible for no or low cost health care in the state are currently enrolled in available health insurance coverage. Thus, it is reasonable to assume that gaining coverage in the HSP through retroactive enrollment may not induce the previously uninsured to utilize services the way an insured individual would utilize services. We multiplied the effects from the Oregon Health Insurance Experiment by the estimated proportion of individuals eligible for Medicaid and subsidies on the Marketplace who take up coverage in New Mexico (approximately 88 percent).

Utilization Changes due to Cost-Sharing Reductions. Lower cost-sharing is likely to induce additional utilization. For example, the RAND Health Insurance Experiment found that a 10-percent decrease in cost-sharing was associated with a 2-percent increase in utilization.[45] We used this empirical relationship to adjust utilization for changes in coverage generosity.

Utilization Decrease due to Global Budgets. Global budgets de-link health facility revenue with volume, which encourages more efficient operation. For example, researchers have found that global budgets in Maryland resulted in inpatient admission declines of 4.0% for Medicare beneficiaries but not on commercial plans.[46] We assumed global budgeting would result in a 2-percent reduction in spending for health care facilities.

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

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

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

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

3. Premiums and Out-of-Pocket Costs

Premiums are driven by enrollment, health spending, benefit generosity, and administrative costs. We calculated premiums for HSP enrollees and self-insured employer-based coverage enrollees. In both cases, the calculation of premiums followed four steps. First, we calculated total benefit spending for the risk pool. Second, we partitioned benefit spending into out-of-pocket costs and plan liability based on the plan's cost-sharing parameters. Third, we inflated plan liability by an administrative loading factor. Fourth, we allocated premiums to families on a per-enrollee basis.

As proposed by the HSA, no more than 5 percent of total spending should be on administrative costs by the sixth and subsequent years of the HSP. Since we are modeling the first five years of the plan, we assumed that administrative costs are 9, 8, 7, 6, and 5 percent in years one through five of its operation. By comparison, in 2018, about 13.2 percent of private health insurance spending went towards administration, compared to 7 percent of Medicare spending.[47] We also assumed that both the HSP and self-insured employer plans would practice community rating, where premiums do not vary based on enrollee characteristics. While the HSP would use a single rating pool, self-insured employer plans would each be pooled separately. Premium levels would affect enrollment decisions, which would require premiums to be recalculated. This process would be repeated until enrollment and premiums stabilize.

D. Downstream Economic Impacts

The health care industry, however it is financed, is an important part of the New Mexico economy. Personal health care expenditures in New Mexico were estimated to be $13.5 billion in 2018.[48] This represents about 13 percent of the state's gross domestic product.

The spending increases from the HSP may result in additions to this output and income as the demand for, and provision of, health care services increases, from more intense utilization of existing resources and the addition of capital investment in the state. (Note that not all the increases would represent in-state sales and directly contribute to increased economic output – for instance, prescription drugs imported from out-of-state are a notable exception). We calculated the in-state economic contribution of spending under the HSP using the IMPLAN model of the New Mexico economy, which explicitly models the degree to which service inputs are provided from businesses in the state. (The IMPLAN model is an input-output model where the production of goods or services depends upon the purchase of a set of specific inputs, that is, labor and required materials.)

This IMPLAN analysis generates direct and indirect impacts of the new spending on related state sectors – for example, an increase in physician office visits generate an indirect demand for office space, medical support staff, etc. Moreover, the sales and income earned in these related sectors further generate demand for other goods and services in the state. These demands result in revenue and output of goods

[47] Centers for Medicare & Medicaid Services. (2019). *National Health Expenditure Data* [Data set]. https://go.cms.gov/36tomIQ.
[48] U.S. Bureau of Economic Analyses. (2019). *Regional Economic Accounts* [Data set]. https://www.bea.gov/data/gdp/gdp-state.

and services in health care and other industries. Our state economic model projected these induced effects for New Mexico.

E. Budgetary Analysis

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

1) Total administrative and benefit spending for plan enrollees;
2) The amount HSP enrollees would contribute to premiums;
3) Repurposed Federal Marketplace and Medicaid spending;
4) The state's share of Medicaid spending; and
5) The net impact on state income tax revenues.

The first, second, third, and fourth factors are an output of our health reform analysis. The fifth factor is an output from our downstream economic impact analysis.

IV. Current Coverage and Expenditures in New Mexico

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

A. Coverage

Our analytic database includes 41,783 observations representing, after application of sample weights to ensure our sample is representative of the New Mexico population, roughly 1.7 million New Mexicans under the age of 65 in baseline (Table 4.1). In 2024 most residents will have employer-sponsored coverage (44.0%), followed by Medicaid (40.9%), which together will account for approximately 85 percent of the state's population. We estimated that in 2024 roughly 12 percent of New Mexicans will be uninsured. Of those with coverage through an employer, most individuals are employed at a firm offering a self-insured plan (73%), because most workers are employed at large firms that tend to provider self-insured employer plans. The majority of New Mexico's workforce with insurance coverage is employed at private sector companies, with another 35.9 percent employed by federal, state, or local governments (not shown).

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

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

	N (Thousands)	% of Total	% of Major Category
Total Population	1,700	100.0	
Employer-sponsored Insurance (ESI)	751	44.2	
Coverage through Self-insured Firm Plan	550	32.3	73.2
Coverage from Fully Insured Firm Plan	201	11.8	26.8
Employees with ESI by Firm Size			
Firms with Fewer than 10 Employees	36	2.1	4.7
Firms with 10-49 Employees	42	2.5	5.5
Firms with 50-99 Employees	23	1.3	3.0
Firms with 100-999 Employees	75	4.4	10.0
Firms with 1,000 or More Employees	576	33.9	76.7
Marketplace and Non-group Coverage	66	3.9	
Medicaid	696	40.9	
Uninsured	188	11.0	

Source: Analysis by KNG Health Consulting

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

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

		Percentage of Total Population			
	Total (Thousands)	ESI	Medicaid	Marketplace & Non-group	Uninsured
Total	1,700	44.2	40.9	3.9	11.0
Race					
White	1,230	47.6	38.4	4.4	9.6
Black	32	45.8	42.0	3.9	8.3
Native American	178	22.9	54.6	0.9	21.6
Asian	31	64.5	24.4	6.5	4.6
Other Race	158	38.4	45.3	2.2	14.0
Two Major Races	70	41.0	48.0	3.8	7.2
Ethnicity					
Hispanic	958	40.5	45.2	2.7	11.6

Source: Analysis by KNG Health Consulting

B. Spending

We project baseline total health care spending in 2024 to be nearly $11 billion in New Mexico (Table 4.3) among those eligible for coverage under the HSP. Spending on hospital inpatient care is estimated to be $2.1 billion, about 19 percent. Visits that occur in hospital outpatient departments, EDs, or physician offices together account for another $3 billion. The state is estimated to spend $1.5 billion for prescription drugs at baseline plus $4.1 billion in other medical costs such as laboratory services and medical equipment. The proportion spent on hospital-based care (inpatient plus outpatient) of 29.4 percent is comparable to national estimates of 32.7 percent in 2017.[49] Although the total number of enrollees in Medicaid and individuals with ESI is similar, more than half of all spending ($5.9 billion) is concentrated in ESI. Medicaid is the next largest payer for health care at $3.9 billion.

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

	Total		ESI		Medicaid		Marketplace & Non-group		Uninsured	
	$ Millions	%	$ Millions	%	$ Millions	%	$ Millions	%	$ Millions	%
Total Spending	10,992	100.0	5,885	100.0	3,877	100.0	584	100.0	645	100.0
Hospital Inpatient	2,064	18.8	1,026	17.4	795	20.5	108	18.5	134	20.7
Hospital Outpatient	1,168	10.6	639	10.9	427	11.0	69	11.8	33	5.1
Emergency Department	857	7.8	587	10.0	189	4.9	48	8.2	34	5.3
Physician Visits	947	8.6	399	6.8	449	11.6	37	6.3	62	9.7
Pharmacy	1,599	14.6	903	15.3	402	10.4	96	16.4	198	30.7
Other Outpatient	4,358	39.6	2,331	39.6	1,615	41.7	227	38.9	184	28.6

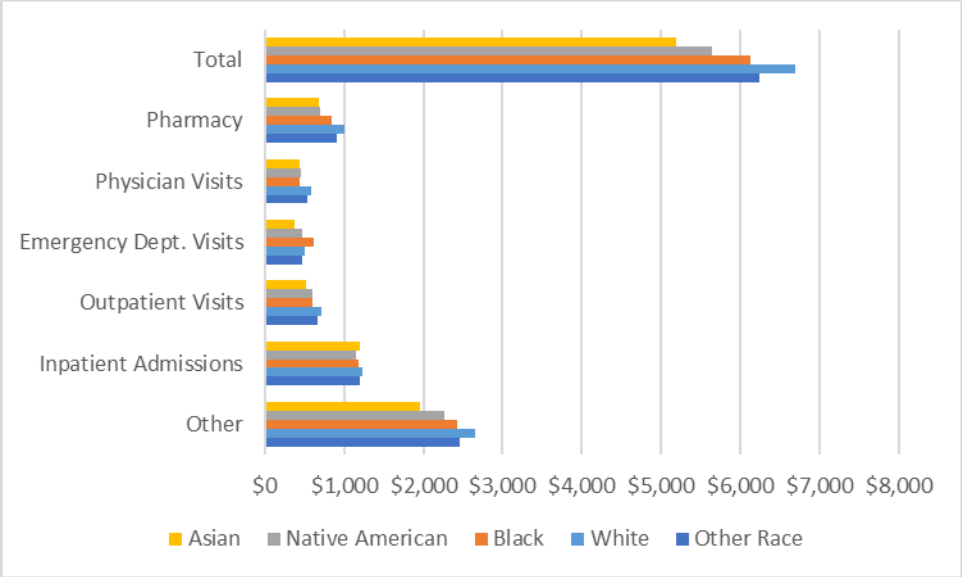
Source: Analysis by KNG Health Consulting

On a per-capita basis, we estimate baseline health care spending of $6,467 per New Mexican (excluding long-term care services) among eligible HSP enrollees, ranging from around $45195 for Asians to $6,686for Whites (Figure 4.1). We project that per capita health care spending for Native Americans will be approximately $5,649 in 2024. Spending is influenced by insurance coverage (e.g., the uninsured are assumed to access health care less than those with insurance coverage; provider reimbursement rates or prices also vary by payer) as well as age, gender, disability, presence of chronic conditions. Under our model, we assumed an increase in the use of services (and thus spending) for those who gain coverage under the HSP. However, spending is lower for individuals who switch from ESI coverage to the HSP,

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

because we assumed no change in utilization of services but that health care prices are lower under the HSP than those paid by ESI.

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



Source: Analysis by KNG Health Consulting

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

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

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

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

	Spending per Resident (in dollars)						
Coverage Type	Inpatient Admissions	Outpatient Visits	ED. Visits	Physician Visits	Pharmacy	Other	Total
Total	1,214	687	504	557	941	2,564	6,467
Employer-sponsored Insurance	1,367	851	782	531	1,202	3,105	7,838
White	1,338	865	761	548	1,252	3,126	7,892
Black	1,347	796	999	416	1,120	3,122	7,800
Native American	1,668	993	1,055	463	1,044	3,612	8,837
Asian	1,429	599	477	445	770	2,176	5,896
Other race	1,347	815	806	484	1,176	3,025	7,653
Two races	1,547	634	856	495	813	2,770	7,114
Medicaid	1,142	614	271	645	578	2,321	5,572
White	1,169	620	264	674	614	2,361	5,702
Black	1,138	479	255	520	494	1,923	4,810
Native American	1,042	600	310	523	440	2,161	5,076
Asian	758	394	185	476	419	1,642	3,873
Other race	1,184	679	265	660	623	2,407	5,817
Two races	1,054	550	290	658	440	2,350	5,342
Marketplace, Other Non-group	1,646	1,053	733	558	1,460	3,467	8,918
White	1,704	1,100	736	579	1,541	3,580	9,241
Black	1,252	772	1,043	368	1,420	3,099	7,954
Native American	1,744	1,255	972	501	1,271	4,058	9,801
Asian	931	604	339	400	877	1,944	5,095
Other race	1,605	948	768	541	1,238	3,345	8,444
Two races	1,241	625	660	401	701	2,400	6,029
Uninsured	712	175	181	333	1056	982	3439
White	663	177	167	347	1115	987	3456
Black	554	128	180	243	776	778	2658
Native American	861	188	233	304	937	1025	3547
Asian	513	106	87	281	635	683	2305
Other race	739	159	173	327	1062	939	3398
Two races	754	165	168	319	822	914	3141

Source: Analysis by KNG Health Consulting

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

	Spending per Resident (in dollars)						
Coverage Type	Inpatient Admissions	Outpatient Visits	ED Visits	Physician Visits	Pharmacy	Other	Total
Total	$1,214	$687	$504	$557	$941	$2,564	$6,467
Employer-sponsored Insurance	1,367	851	782	531	1,202	3,105	7,838
Not Hispanic	1,416	984	787	575	1,343	3,394	8,499
Hispanic	1,322	726	776	490	1,071	2,836	7,222
Medicaid	1,142	614	271	645	578	2,321	5,572
Not Hispanic	1,306	703	296	666	643	2,486	6,100
Hispanic	1,043	561	255	633	539	2,222	5,252
Marketplace, Other Non-group	1,646	1,053	733	558	1,460	3,467	8,918
Not Hispanic	1,774	1,186	718	600	1,598	3,724	9,599
Hispanic	1,448	848	757	493	1,247	3,069	7,861
Uninsured	712	175	181	333	1056	982	3439
Not Hispanic	739	201	197	345	1110	1062	3654
Hispanic	694	158	170	325	1019	927	3291

Source: Analysis by KNG Health Consulting

V. Change in Coverage and Costs under Reform Models

A. Overview

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

Key Findings

- Coverage. The HSP would enroll most of the state's population into a state-administered health insurance program. Doing so could bring near-universal health insurance coverage to New Mexico.
- Spending. Improved access to comprehensive health insurance would drive higher use of services, particularly among those who otherwise would have been uninsured. While higher service use would drive increased spending, savings from reduced payer-side administrative costs could offset these increases. In the long-term, we project that the HSP would have a neutral effect on total health spending if administrative costs are kept at levels proposed by the HSA.
- Effects on Households. By offering reduced premiums for certain New Mexicans, the HSP may also decrease the financial burden of health expenses for some households, particularly for low-income families not currently enrolled in Medicaid.
- Effects on Employers. The net impact on employers is dependent on how policymakers implement employer contribution requirements, including the level of contribution and which employers are exempt from contributions. Under our base scenario, we estimated that the HSP would increase employer contributions to the health care system. These cost increases would fall on businesses who were previously not offering health benefits and by businesses that continued offering self-insured health plans to their employees.
- Budgetary Impact. It is unlikely that existing funding from the federal government, state government, and employers would be sufficient to cover the full cost of the HSP. Fully funding the HSP would require some combination of additional employer contributions, reduced payment rates to providers, and/or higher enrollee costs.

In reporting specific findings, we made assumptions on HSP implementation decisions related to employer and enrollee contributions, and Medicaid enrollment. Unless stated otherwise, the specific findings reported come from our base scenario, which relies on the following assumptions:

- **Employer Contributions.** Employers participating in the HSP (and not offering a separate health insurance plan) would support the cost of the HSP by contributing a set percentage of their payroll. These payroll contributions would be set so that, in total, employer contributions to the HSP would replace employer premium contributions to the private ESI plan offered to employees in the baseline scenario (without the HSP).

- Enrollee Contributions. HSP beneficiary cost levels, including premiums and cost-sharing, would be comparable to those costs typically paid by enrollees in ESI.

- Medicaid Enrollment. Individuals eligible for Medicaid would obtain coverage under the HSP.

B. Effects on Health Insurance Coverage

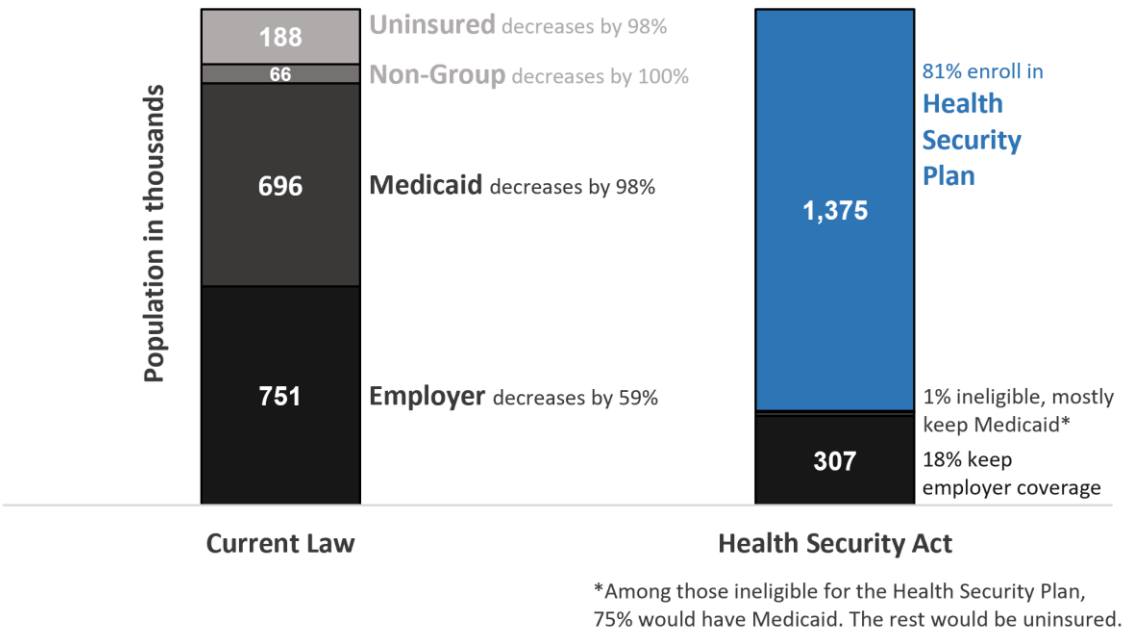
In 2024, we estimate that 1.4 million people would enroll in the HSP, covering 81 percent of the non-Medicare population in the state (Figure 5.1). Most HSP enrollees would have otherwise had Medicaid (50%) or employer coverage (32%), while the rest would have been uninsured (13%) or had non-group coverage (5%). Many self-insured employers would choose to stop offering coverage and have their employees instead enroll in the HSP. About half (52%) of individuals enrolled in an employer's self-insured plan in the baseline would work at firms that stopped offering independent coverage. For some low-income families, coverage under the HSP would be available at little or no costs. Some of these individuals and families would enroll in the HSP even if they continued to have access to an employer's self-insured health plan.

The HSP would create near-universal coverage in the state, resulting in the uninsured rate falling from 11.0 percent to 0.3 percent (Table 5.1). Among those who do not enroll in the HSP, nearly all (95%) would be workers or dependents enrolled in an employer-based self-insured health plan. There also would be a small number of remaining Medicaid enrollees (13k) and uninsured individuals (4k). These individuals would be ineligible for the HSP due to the 1-year residency requirement.[50] A small percentage of remaining uninsured individuals previously had non-group coverage (16%). The HSP would result in a significant contraction in the private non-group insurance market to the point that such plans may not have enough potential enrollees to be viable. This would leave a small number of individuals, who would have received non-group coverage in the baseline, with no source of coverage because of HSP ineligibility.

We estimate enrollment in the HSP will increase slightly between 2024 and 2028, with the share of the population enrolled in the public plan increasing from 81 to 84 percent. The relative effects of the HSP on enrollment in different coverage categories are broadly consistent across years (Figure 5.2).

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

Figure 5.1. HSP Impact on Health Insurance Coverage in New Mexico in 2024



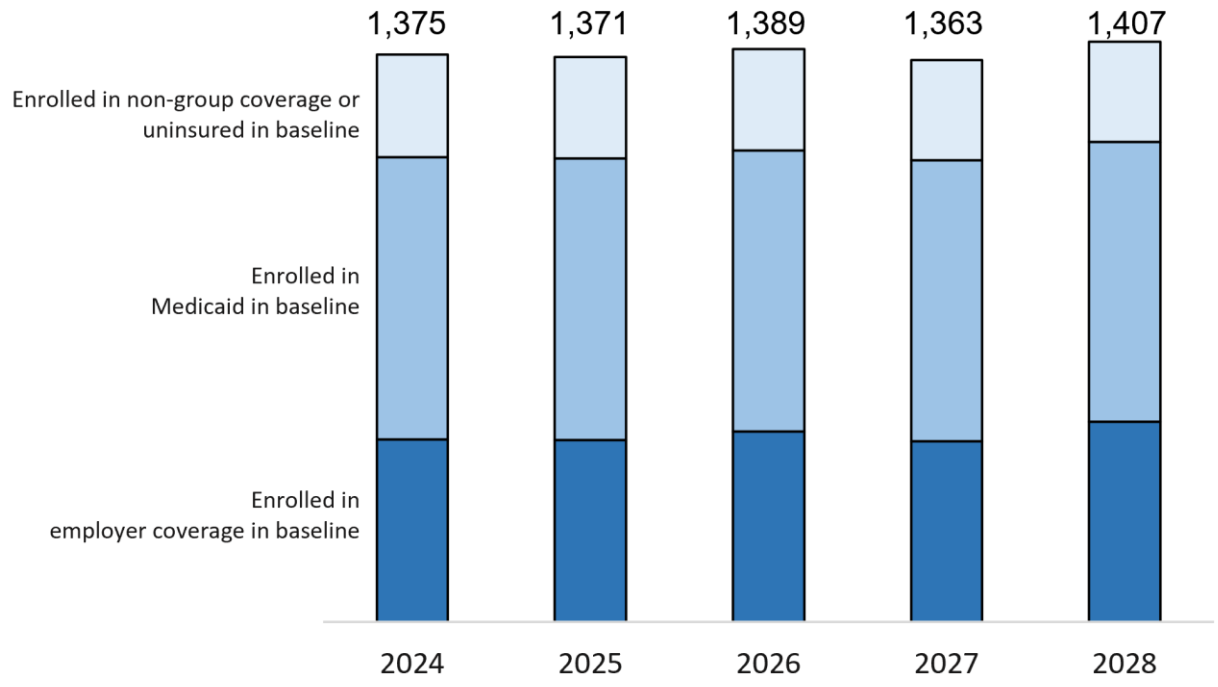
Source: Analysis by KNG Health Consulting
Note: Numbers may not add due to rounding.

Table 5.1. HSP Impact on Health Insurance Coverage in New Mexico (in thousands)

Year	Coverage	Current Law	HSP	# Impact	% Impact
2024	ESI	751	307	-444	-59%
	Medicaid	696	13	-682	-98%
	Non-Group	66	0	-66	-100%
	Uninsured	188	4	-183	-98%
	HSP	0	1,375	1,375	
2025	ESI	748	306	-442	-59%
	Medicaid	694	13	-681	-98%
	Non-Group	65	0	-65	-100%
	Uninsured	187	4	-182	-98%
	HSP	0	1,371	1,371	
2026	ESI	745	282	-463	-62%
	Medicaid	694	14	-680	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	186	4	-181	-98%
	HSP	0	1,389	1,389	
2027	ESI	742	302	-440	-59%
	Medicaid	693	13	-679	-98%
	Non-Group	64	0	-64	-100%
	Uninsured	185	4	-180	-98%
	HSP	0	1,363	1,363	
2028	ESI	740	253	-486	-66%
	Medicaid	691	13	-678	-98%
	Non-Group	63	0	-63	-100%
	Uninsured	184	4	-179	-98%
	HSP	0	1,407	1,407	

Source: Analysis by KNG Health Consulting

Figure 5.2. HSP Enrollment between 2024 and 2028 (in thousands)



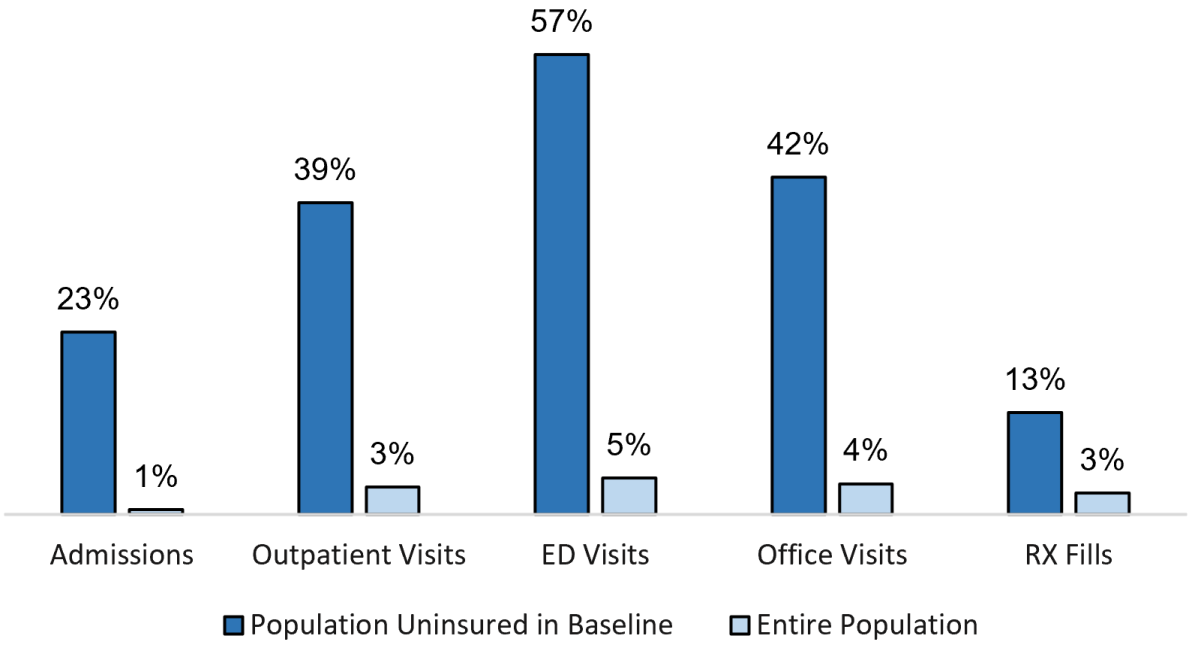
Source: Analysis by KNG Health Consulting

C. Effects on Health Care Usage

We forecast that the HSP would result in increased service use (Figure 5.3). These effects would be larger for those who are uninsured in baseline (Figure 5.3). For the uninsured who would gain coverage under the HSP, we assumed large utilization increases in all service categories, including hospital admissions (+24%), outpatient visits (+40%), ED visits (+59%), physician office visits (+43%), and prescription drug (RX) fills (+13%). We also estimated utilization increases among those who would have otherwise had non-group coverage, as we assumed the HSP would have lower levels of cost-sharing than plans typically obtained in the individual market.

Those who otherwise would have had Medicaid or employer coverage would face similar cost-sharing under the HSP. Therefore, we project little change in service use among these populations (Figure 5.4). As most of our simulation population (82% in 2024) would have either had employer or Medicaid coverage, the overall population impacts on health care service use are small, relative to corresponding effects assumed for the uninsured. The HSP would subject health care facilities to global budgets. This would encourage providers to improve efficiency and reduce volume. We assumed that this would decrease health facility admissions and outpatient visits, which partially offsets the increase in utilization from coverage improvements.

Figure 5.3. Impact of the HSP on Utilization of Health Care Services, 2024-2028



Source: Analysis by KNG Health Consulting

D. Effects on Health Care Prices

We establish prices under the HSP so that average prices across payers for services would not change. This results in prices that are higher than those typically paid by Medicaid or the uninsured, but lower than those typically paid by private insurance. In 2024, we set inpatient prices to be 24 percent above Medicare, outpatient prices to be 58 percent above Medicare, ER prices to be 82 percent above Medicare, physician prices to be 6 percent above Medicare, and RX prices to be 22 percent below Medicare.

By simplifying the payer landscape, the HSP could reduce provider-side administrative costs. This could offer a rationalization for reducing provider reimbursement, which could help fund the plan. However, in our base scenario, we kept average payment levels the same as in baseline. Our base scenario also assumed that the HSP would be able to maintain access to discounts from the Medicaid Drug Rebate Program, which would require a Federal waiver. If the state were unable to keep these discounts, the incremental cost of including Medicaid enrollees within the HSP would increase significantly.

E. Effects on Health Care Spending

Overall spending effects. Over our five-year projection window, the HSP would have a neutral effect on health care spending (Figure 5.4). In general, health reforms could affect health care spending through three mechanisms:

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

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

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

As the price effect is neutral, the net effect of the HSP on spending is determined by the relative magnitudes of the service-use increase and the administrative spending decrease (Figure 5.5). We find that in 2024 and 2025, overall health care spending would increase under the HSP. However, in 2026 through 2028, we begin to observe a reduction in health spending. If we extend our modeling window outward, we would expect these savings to persist. Thus, we would expect the HSP would decrease long-term spending by about 2 percent, driven by our assumptions that administrative costs represent 5 percent of total HSP spending in the long run as proposed by HSA.

Effects on Administrative Costs. Administrative cost reductions under the HSP result in a contraction in the private health insurance industry. Spending on private health insurance administration would decline by 83 percent. This reduction includes a 68-percent reduction in administrative costs for employer-based plans, a 98-percent reduction in administrative spending for Medicaid managed care organizations, and a 100-percent reduction in administrative spending for individual market plans. The remaining Medicaid

population would be so small, the state would likely consider reverting to a fee for service model rather than continuing to retain Medicaid managed care organizations.

Effects on Employer Premiums. The share of health spending borne by employers would increase from 25 to 26 percent. This reflects a 7-percent increase in spending from employers (Figure 5.5). In "employer premiums," we included (1) subsidies paid by the employer to directly sponsor private health insurance coverage for workers and dependents; and (2) employer payroll contributions made into the HSP among firms not offering coverage. The HSP would decrease the first type of employer premiums, as fewer firms would directly offer coverage to their workers. We set the employer payroll contribution toward the HSP so that they equaled the total contribution of employers to premiums in the baseline. We estimated that firms not offering coverage would need to be about 8 percent of payroll to replace foregone employer premiums.

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

- Firms that neither provide coverage under current law or under the HSP. These firms, which overwhelmingly tend to be small (<100 workers), do not subsidize employer-based health insurance coverage under current law. However, these firms would contribute to the health system under the HSP, as we estimate they would have to pay 8 percent of their payroll towards the HSP. Thus, these firms would pay more into the health care system under the HSP.

- Firms that provide coverage under current law but do not under the HSP. These firms do subsidize employer-based health insurance coverage under current law and would contribute 8 percent of their payroll into HSP. These HSP contributions would be less than what these firms would have paid toward employee premiums in the baseline, as the burden of replacing forgone employer contributions is also being shared by firms that would not have offered coverage in the baseline. This set of firms, which includes firms of all sizes, would pay less into the health care system under the HSP.

- Firms that both provide coverage under current law and under the HSP. These firms subsidize employer-based health insurance coverage under both current law and the HSP. As these firms would still be directly supplying coverage to their workers, they would not contribute to the HSP. As other employers drop coverage, our model predicts that dual-income spouses will migrate to the employer-based plans that remain. Among those remaining firms, this will increase employee participation rates as well as the average number of enrolled dependents. Employer benefit spending among these firms, which tend to be larger (>100 workers), would thereby increase under the HSP.

These effects on employers do not account for changes in federal and state income tax deductions. As we assumed that both HSP premiums and employer-based coverage premiums would be tax-deductible, we would not expect significant changes in tax deductions. However, the ability to deduct increases in premium contributions from taxes would partially offset the 7-percent increase in employer spending. After accounting for tax offsets, the increase in employer spending would be about 5 percent.

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

Effects on Household Premiums. We show household premiums falling from 14 percent of spending to 13 percent of total spending. This reflects a 9-percent reduction in total household premiums. Household premiums for those obtaining insurance through the non-group market in baseline would decrease disproportionately (-63%). Many of these families would be ineligible for the ACA Marketplace premium subsidies and under current law would pay the full premium price. Even non-group enrollees eligible for non-group premium subsidies, but near the income-eligibility cutoff, would pay much lower premiums under our HSP base scenario. This is because we established HSP premiums paid by beneficiaries based on a typical employer plan, which tends to be lower cost than a Marketplace plan for higher-earning families. To illustrate, in 2018, an individual earning $48,000 (i.e., just under 400% of the FPL) might pay about $4,500 per year with federal assistance for a Marketplace plan, but $1,500 per year for an employer-based plan.

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

Effect on Other Sources of Spending. Spending from other sources includes household out-of-pocket spending, spending from other public programs including IHS, and charity care. We find spending from other sources decreases under the HSP by 55 percent from 15 percent of total spending to 7 percent of total spending. This change is mostly the result of coverage expansions under the HSP. For those who would have otherwise been uninsured, we project spending from other sources to fall by 89 percent under the HSP. In addition, we expect spending from other sources to decrease for families not subject to cost-sharing under the HSP. This includes both families with incomes below 138 percent of the FPL and Native Americans.

Effect on Government Spending. We assumed that under the HSP, the state would be able to preserve federal funding currently being paid on behalf of Medicaid and Marketplace enrollees. However, nearly all of this funding would be redirected to pay for the HSP. Both under current law and under the HSP, we project 29 percent of health spending to be financed by the federal government. This amount does not include federal tax subsidies for employer-based coverage or the HSP. If we included these tax subsidies in this calculation, we would have reported an increase in the federal contribution to New Mexico's health spending.

We project the state's share of health spending in New Mexico to increase from 17 to 25 percent. This represents a 49-percent increase in state health spending. Baseline state spending includes the state's share of Medicaid spending and also premium contributions paid for public workers. Under the HSP, the

state keeps these obligations, while also covering many more people in the state. State spending increases reflect the cost of providing insurance coverage to those uninsured in the baseline, improving subsidies for those enrolled in non-group coverage in the baseline, and reducing cost-sharing for low-income and Native American beneficiaries (Figure 5.6). This leads to a significant increase in the share of the health spending assumed by the state, which mirrors the decline in household premiums and spending from other sources.

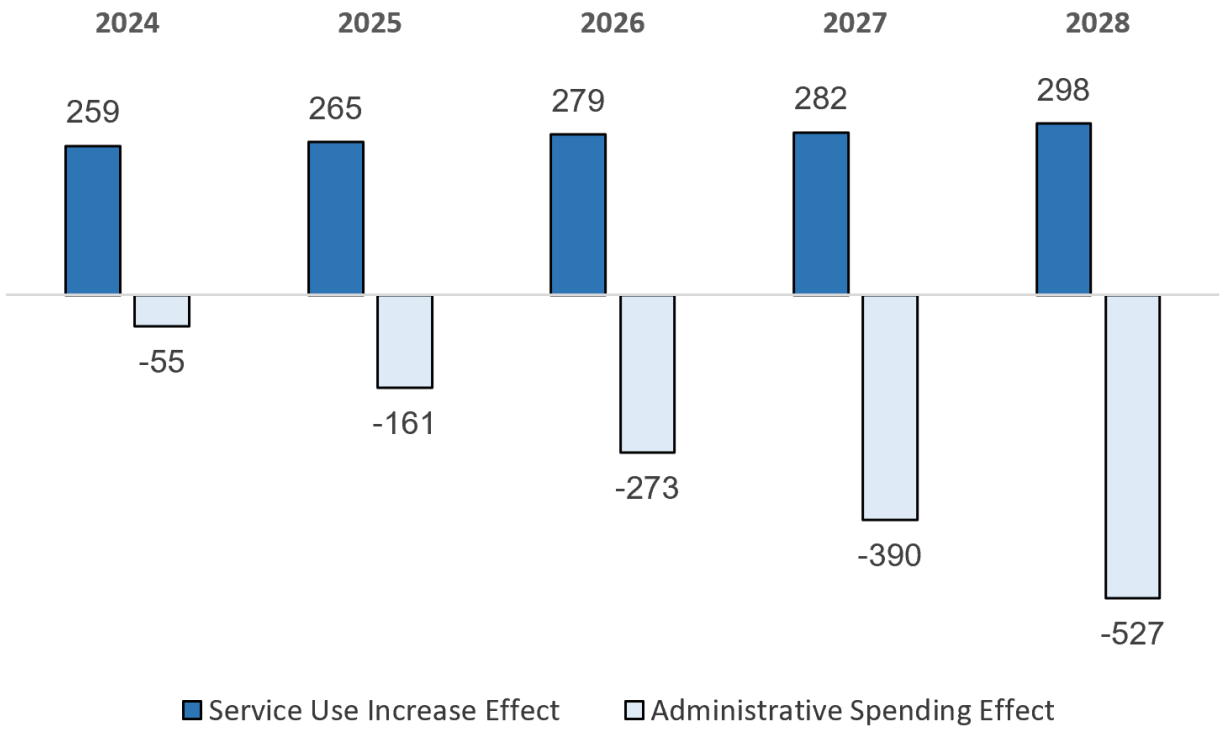
Effect on Native American Health Care Spending. HSP would disproportionately affect Native American populations in several ways. First, Native Americans are more likely to be uninsured than other residents. As Native Americans would be eligible for HSP, they would represent a disproportionate share of those gaining coverage under the HSP. Second, Native Americas would be exempt from cost-sharing under the HSP. We find, in baseline, lower rates of service use among Native Americans, despite the population having above-average rates of chronic conditions. This suggests access to care problems that may be reduced by the elimination of cost-sharing. Third, we do not assume that HSP would replace Indian Health Service (IHS) benefits. Native Americans could continue to use their IHS benefits in addition to HSP. However, as more Native American families are covered under HSP, spending on IHS facilities and providers may be lower.

Table 5.2. Total Health Care Spending under Baseline and the HSP Scenarios by Baseline Coverage Source (in million dollars), 2024-2028

		Current Law ($ millions)								HSP ($ millions)							
Year	Baseline Coverage	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total	Inp. Adm.	Out. Visits	ER Visits	Office Visits	RX Fills	Other Services	Admin	Total
2024	Employer	1,050	610	635	410	895	2,338	524	6,461	1,026	466	546	420	905	2,015	438	5,817
	Medicaid	795	427	188	449	402	1,615	431	4,307	706	469	276	474	414	1,922	422	4,683
	Non-Group	107	70	49	37	99	230	110	700	98	39	39	37	92	166	39	509
	Uninsured	134	33	34	63	198	184	0	645	249	84	132	91	216	426	110	1,309
2025	Employer	1,100	638	667	429	936	2,449	548	6,767	1,072	487	573	439	944	2,106	425	6,047
	Medicaid	826	445	196	472	418	1,678	448	4,483	737	490	289	500	432	2,002	389	4,839
	Non-Group	110	72	51	38	102	238	114	725	101	40	40	38	96	171	35	522
	Uninsured	140	34	36	65	207	193	0	675	259	87	138	95	225	443	101	1,348
2026	Employer	1,141	661	693	445	970	2,540	569	7,019	1,116	500	593	456	980	2,176	405	6,225
	Medicaid	859	463	205	491	435	1,749	467	4,669	767	512	303	520	450	2,090	352	4,994
	Non-Group	113	74	53	39	105	245	117	746	104	42	42	40	99	177	31	535
	Uninsured	145	36	37	68	215	200	0	700	269	91	144	98	233	461	91	1,386
2027	Employer	1,184	685	722	462	1,005	2,637	590	7,286	1,155	523	619	473	1,015	2,267	388	6,441
	Medicaid	896	482	214	512	453	1,825	487	4,870	799	530	314	542	468	2,171	312	5,136
	Non-Group	117	76	54	41	108	253	120	769	107	43	43	41	102	182	27	546
	Uninsured	150	37	38	71	223	207	0	726	279	93	149	102	242	477	79	1,421
2028	Employer	1,227	711	751	480	1,042	2,737	613	7,561	1,203	531	640	493	1,057	2,335	355	6,613
	Medicaid	932	502	223	534	471	1,901	507	5,071	830	557	331	562	486	2,272	270	5,309
	Non-Group	120	78	56	42	111	260	124	791	111	45	45	42	105	190	24	561
	Uninsured	155	38	40	73	231	215	0	753	288	98	156	106	250	498	68	1,464
2024	Across All Coverage Sources	2,085	1,140	906	958	1,593	4,367	1,064	12,113	2,079	1,058	993	1,023	1,627	4,528	1,009	12,317
2025		2,176	1,189	950	1,005	1,663	4,558	1,110	12,651	2,170	1,104	1,040	1,072	1,697	4,723	950	12,756
2026		2,258	1,234	988	1,044	1,724	4,734	1,152	13,134	2,256	1,144	1,082	1,114	1,761	4,904	879	13,140
2027		2,347	1,281	1,029	1,086	1,789	4,922	1,198	13,651	2,340	1,189	1,125	1,158	1,826	5,098	807	13,543
2028		2,435	1,329	1,070	1,128	1,855	5,113	1,243	14,175	2,432	1,230	1,173	1,203	1,898	5,294	717	13,947

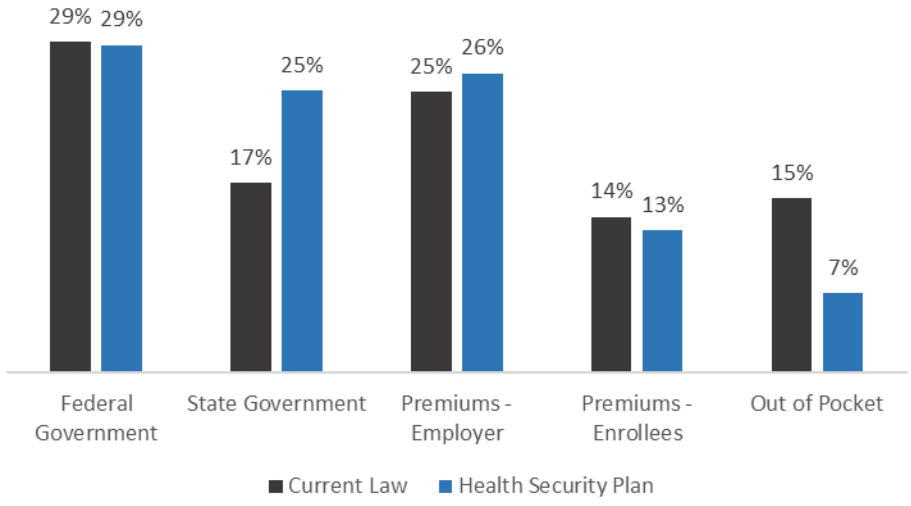
Source: Analysis by KNG Health Consulting

Figure 5.4. Effects of Increased Service Use and Reduced Administrative Spending (in millions $)



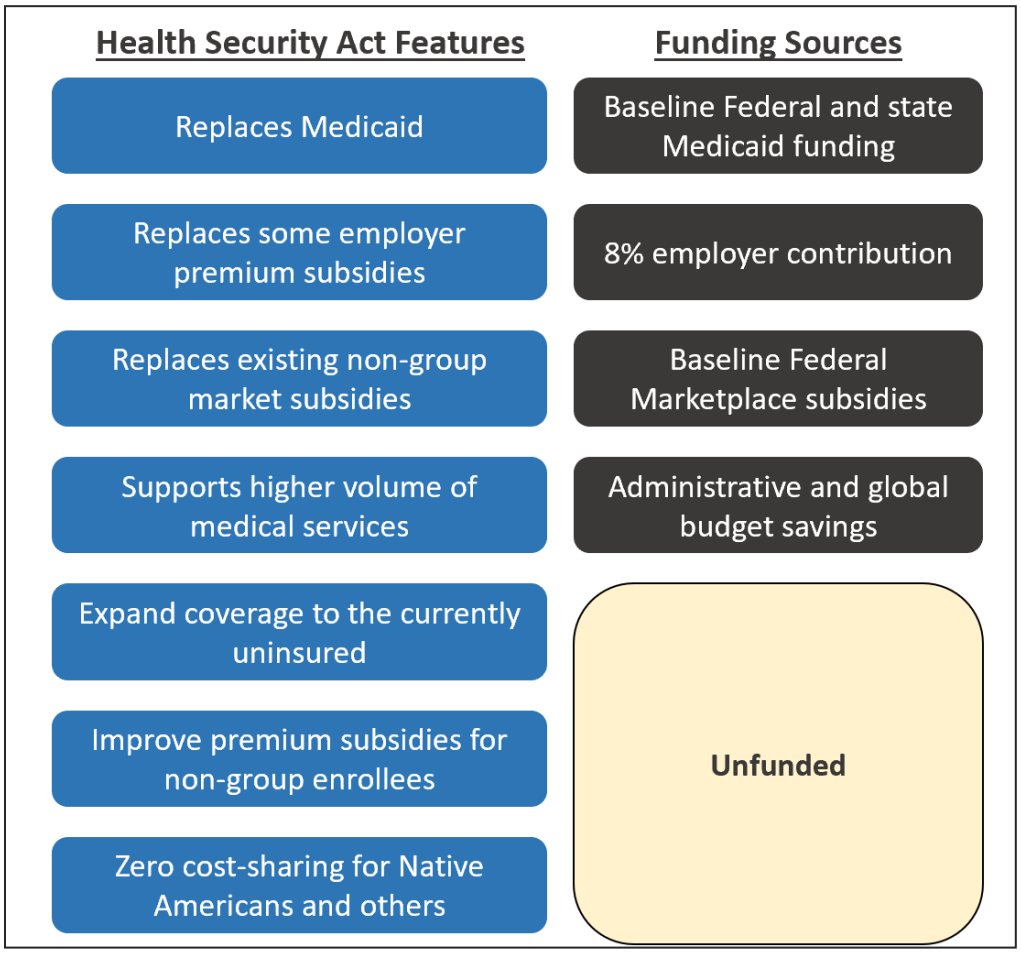
Source: Analysis by KNG Health Consulting

Figure 5.5. Percentage of Health Spending by Source of Funds, 2024-2028



Source: Analysis by KNG Health Consulting

Figure 5.6. Intuition for How the HSP Increases State Spending



Source: Analysis by KNG Health Consulting

F. Budgetary Impact

The HSA would create a large entitlement program for the state. In 2024, we estimate total state benefit spending and administrative costs for HSP enrollees would be $9 billion. This would increase to $11 billion by 2028. Over the 5-year period, total spending would be $50 billion dollars (see Figure 5.7 and Table 5.3). In addition, the state would lose $1 billion in revenue from taxes paid by private insurance companies, which would decrease as the private health insurance industry contracts.

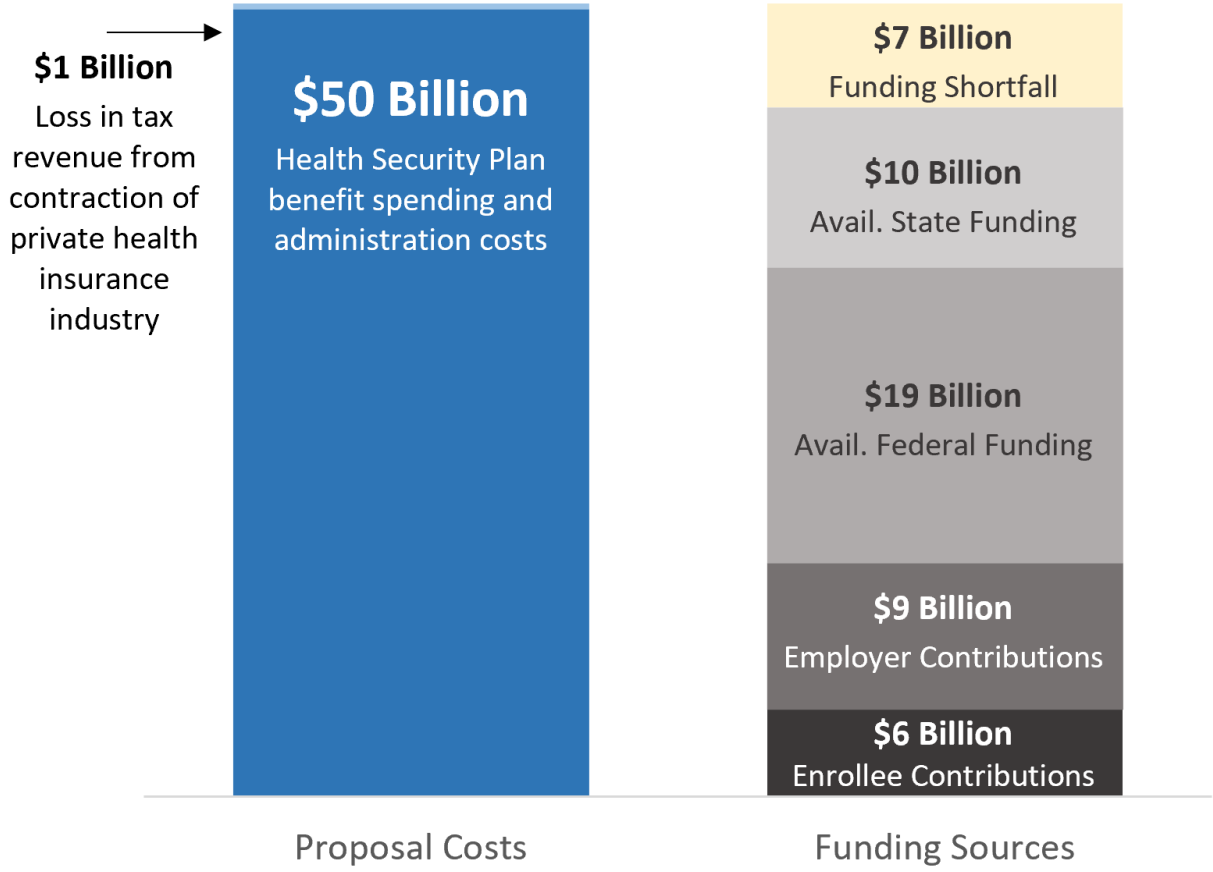
During this same 5-year period, premiums paid by enrollees would be $6 billion. The employer contributions paid by firms not offering health benefits would raise $9 billion. Through Medicaid and Marketplace waivers, the state could redirect $19 billion in federal funding into the HSP. In addition, the state could reallocate $10 billion in state funding towards the HSP. This implies a $7-billion funding shortfall for the initial 5-year period of the HSP.

The state would have a number of potential options to attempt to close this funding gap. These include:

- Increasing the employer contribution among firms participating in the HSP;
- Applying a payroll tax on all businesses in the state;
- Reducing rates paid by the HSP to health care providers;
- Increasing enrollee contributions into the plan; and/or
- Some combination of the above strategies.

Many of these policies would change incentives for families and employers, which could lead to differing levels of HSP enrollment. We attempted to explore the effects of these alternative funding strategies on the fiscal impact of the policy.

Figure 5.7. Aggregate Fiscal impact of the HSP on New Mexico, 2024-2028



Source: Analysis by KNG Health Consulting

Table 5.3. Fiscal impact of the HSP on the State of New Mexico (in million dollars), 2024-2028

Year	HSP Benefits and Admin.	Premiums Paid by Enrollees	Employer Contributions	Available Federal Funding	Available State Funding	Net State Income Taxes	Net Health Insurance Taxes	Unfunded
Total	**$49,702**	**$5,514**	**$9,207**	**$18,693**	**$10,064**	**$50**	**-$1,284**	**$7,458**
2024	9,259	962	1,617	3,440	1,845	9	-236	1,622
2025	9,549	1,015	1,694	3,582	1,925	9	-246	1,570
2026	9,997	1,113	1,884	3,730	2,015	13	-257	1,498
2027	10,104	1,131	1,824	3,890	2,084	6	-266	1,433
2028	10,793	1,293	2,187	4,050	2,195	14	-280	1,334

Source: Analysis by KNG Health Consulting

G. Alternative Funding Strategies

In this section, we quantify different strategies the state could employ to fully fund the HSP. These strategies may not be realistic and are not policy recommendations. In strategies one through four, we illustrate whether particular policy levers could (by themselves) close the funding shortfall, and if so, how much would those policy levers need to be adjusted. In strategy 5, we provide a potential policy compromise that fully funds the proposal, but shares the incremental cost between employers, enrollees, and providers.

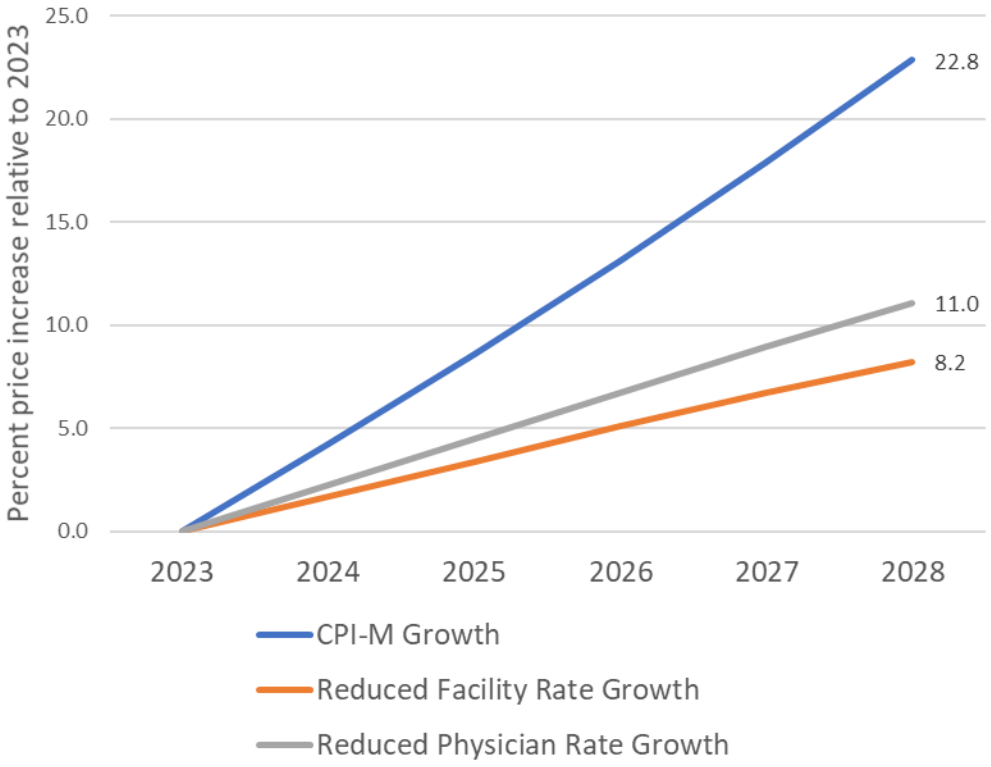
Strategy 1: Increase employer contributions for firms participating in the HSP. The state could cover the funding shortfall by increasing employer contributions paid by HSP-participating firms. For some firms, this elevated contribution would be comparable or even exceed the cost of directly offering health benefits to their workers. Virtually all self-insured employers would continuing offering coverage in this scenario, to avoid paying the contribution. To fully fund the costs of the HSP, the employer contribution would need to be roughly 16 percent of payroll.

Strategy 2: Apply a payroll tax to all firms. Instead of limiting employer contributions only to firms that do not offer coverage, the state could levy a payroll tax on all firms. We project doing so would lead virtually all firms to stop offering health benefits separate from the HSP, as doing so would require the employer to pay for two health benefits packages for their workers. Thus, under this scenario, we project virtually all of the state's non-Medicare population would enroll in the HSP. The payroll tax would need to be approximately 14 percent of income.

Strategy 3: Reduce rates paid to health care providers. The HSP may significantly reduce provider-side administrative costs by simplifying the payer landscape. For example, we estimate that baseline hospital administrative costs were about 24 percent of hospital spending in New Mexico. Similarly, baseline physician administrative costs are about 19 percent of physician spending. Much of these administrative costs are insurance and billing related. If the HSP offered an easily-navigated reimbursement system, perhaps provider-side administrative costs would be lower. The HSP could recover these savings by reducing payments, which would help fund the program.

We experimented with the effects of reducing payment rate increases to eventually remove half of the baseline administrative portion of spending. Figure 5.8 shows how these adjustments would affect health facility and physician price growth rates relative to the Consumer Price Index for Medical Care Prices-(CPI-M) growth.

Figure 5.8. Price Growth Effect from Recovering 50% of Provider-side Administrative Costs over Five Years



Source: Analysis by KNG Health Consulting

Under this scenario, by 2028, the HSP would pay 11 percent above Medicare for hospital admissions, 43 percent above Medicare for outpatient visits, 66 percent above Medicare for ED visits, and 3 percent below Medicare for physician care. Reducing payment rates in this matter would decrease the five-year funding shortfall from $7 billion to $5 billion. The funding shortfall in 2028, the year in which the described rate cuts would be fully phased-in, would be about $300 million. This is about 80 percent less than the 2028 funding shortfall in our base model.

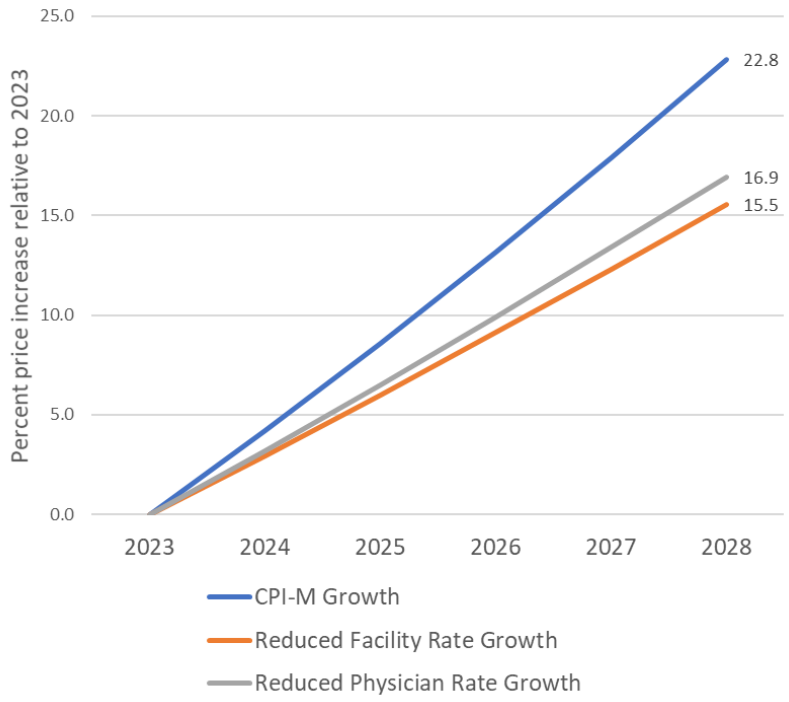
Strategy 4: Increase enrollee contributions into the plan. In our base model, we assumed enrollee costs for most HSP participants would be similar to enrollee costs under a typical employer plan. If we instead followed the cost structure used in the ACA Marketplaces, both enrollee premiums and cost-sharing would be higher for many families. For example, under a typical employer plan, the enrollee pays about 25 percent of the premium regardless of income. Conversely, under the ACA marketplaces, higher earners pay up to 100 percent of the premium. In addition, under a typical employer plan, about 20 percent of enrollee spending is paid out-of-pocket. Conversely, under a Marketplace Silver Plan, about 30 percent of enrollee spending is paid out-of-pocket.

We found that an ACA enrollee cost structure would increase the HSP per enrollee contribution from about $700 to about $1,300. It would increase the percentage of health spending covered by household premiums to 19 percent as compared to the estimated 14 percent share borne by households under

current law. Nearly all of this increase would be borne by middle- and high-income families. Many families that shifted from employer-based coverage into the HSP would pay 2 to 3 times more in premiums under this scenario. These enrollee costs increases would reduce the five-year funding shortfall from $7 billion to $3 billion.

Strategy 5: A combination of approaches. Under this scenario, we attempted to combine several moderated versions of the above policy options, including increased employer contributions, increased enrollee contributions, and provider rate cuts. Specifically, we set HSP premiums to be 50 percent higher than those typically paid by employer coverage enrollees. Families with incomes below 400 percent of the FPL were exempt from these increases. We also applied 50 percent of the rate cuts described above. These rate cuts would recover 25 percent of baseline provider-side administrative costs over five years (Figure 5.9).

Figure 5.9. Price Growth Effect from Recovering 25% of Provider-side Administrative Costs over Five Years



Source: Analysis by KNG Health Consulting

We closed the remaining funding shortfall by increasing the employer contribution paid to HSP by participating firms. This resulted in an employer contribution rate of about 12 percent -- about 50 percent higher than in our base scenario.

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

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

A. Economic Impact

The health care industry is an important part of the New Mexico economy. Total personal health care expenditures in New Mexico were estimated to be $13.5 billion in 2018, about 13 percent of the state's gross domestic product. With 122,000 private sector workers, the health care industry accounts for roughly 14.2 percent of the state's workforce, with an average annual salary of $43,400. The sector increased its share of state private employment from 12.4 percent in 2009 and is projected to increase its share further, to 15.0 percent by 2029. Medicaid expansion in 2014 under the Affordable Care Act contributed to the growth in the last decade, bringing the sector's share of the state's economy closer to the national average share of 14.3 percent.

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

Health Savings Plan Simulation. In its base scenario, we project that the HSP plan enrollment will be 1.329 million residents, a net increase in insurance coverage for 183,000 previously uninsured individuals. Health care spending under the HSP increases by $259 million in 2024, increasing to $298 million additional spending in 2028 versus baseline projections. At the same time, the state achieves administrative cost savings of $55 million in 2024 and this grow to $527 million by 2028. Together, health care spending is projected to increase in the first three years but be below the baseline spending for the 2027 through 2028. Across all 5 years, the effect on health care spending is neutral. We focus the economic contribution on increase spending to health care providers.

Economic Contribution. We used the IMPLAN model of the New Mexico economy, which explicitly models the degree to which goods and services inputs are provided from businesses in the state. The IMPLAN model is an input-output model where the production of goods or services depends upon the

purchase of a set of specific inputs, that is, labor and required equipment and materials. (The quantitative requirements are modeled by the detailed input-output production matrix estimated by the US Bureau of Economic Analysis.[51]) The IMPLAN model of New Mexico estimates the direct and indirect effects on jobs and incomes in the state (e.g., hospitals buy more supplies; physician offices and medical clinics contract for more accounting, maintenance, and legal services).

The in-state economic contribution of new spending under the HSP consists, first, of the direct spending at new or existing health care providers in New Mexico. This expansion adds jobs and income to the economy and is also measured by its contribution to gross state product, a measure of the value of goods and services produced in New Mexico. In addition, there is a positive indirect impact from that spending as suppliers of goods and services to the providers themselves employ more workers and in turn purchase additional goods and services as inputs to their own business. For example, additional physician office visits may generate an indirect demand for office space and medical support staff. This spending at hospitals, physician offices, and other health care providers supports an additional $95 million in indirect spending in 2024, growing to $108 million in 2028 (Table 6.1).

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

	Economic Impact ($ millions)	
Year	Direct	Indirect
2024	259	95
2025	265	97
2026	279	102
2027	282	103
2028	298	108

Source: Analysis by IHS Markit

The IMPLAN model of New Mexico provides sound estimates of the direct and indirect effects in terms of jobs and incomes in the state. Hospitals buy more supplies, physician offices and medical clinics contract for more accounting, maintenance, and legal services, etc. We estimate through IMPLAN that this new demand generates 3,700 additional jobs and about $180 million additional income for New Mexico residents. (The model acknowledges and accounts for the fact that some supplies are purchased from out-of-state.)

[51] U.S. Bureau of Economic Analyses. (2019). *Regional Economic Accounts* [Data set]. https://www.bea.gov/data/gdp/gdp-state.

In principle, these effects can also generate "induced" spending of the additional incomes earned by workers newly employed under the direct and indirect impacts. These would further expand the state economy. But the requirement of budget balance of governments and households requires that, in order to finance HSP spending, there must be corresponding reductions in other spending in the state. These direct spending flows enable and encourage employment and income responses from suppliers of the health care providers.

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

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

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

1. Government
2. Business
3. Households

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

In the base scenario, the HSP will result in increased government spending, financed by taxes, as it maintains a balanced budget. Health sector expansion will generate additional state tax revenues based

on increased revenue and incomes in the sector. We consider the implications for tax revenue of the HSP (Table 6.2).

- **Individual Income Tax.** To the extent that payrolls expand with expanded health care under the HSP, the additional income tax collected on wages and salaries is a positive fiscal impact of the program. New Mexico has a progressive income tax with a top marginal rate of 4.9%. As that rate applies for annual income above an annual rate of $24,000 (for a household, $16,000 for an individual), most new income will be taxed at that rate. The increased income in the health care sector, plus the indirectly generated new income in other sectors is estimated to boost tax receipts by $15 million in 2024, increasing to $19 million in 2028.

- **Gross Receipts Tax (GRT).** Businesses in New Mexico are subject to a 5.135% tax on receipts from sales goods and services. As health care providers are themselves exempt from the tax, the HSP boosts GRT only to the extent that it stimulates indirect spending. The resulting revenues total $4 million in 2024, increasing to $5 million in 2028.

Table 6.2. Tax Revenue Impacts of the HAS (in million dollars), 2024-2028

	Tax Revenue Impact ($ millions)	
Year	Individual Income Tax	Gross Receipts Tax
2024	15	4
2025	16	5
2026	18	5
2027	18	5
2028	19	5

Source: Analysis by IHS Markit

B. Other Factors

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

Although those costs are factored into the microsimulation model, we do not estimate the magnitude of the reduction in payments by employers, workers, or drivers. The HSP calls for the superintendent of insurance to quantify these savings. Nevertheless, we can estimates the potential impact on workers' compensation.

- The National Health Expenditure report estimates 1.4% of the nation's $3.5 trillion health spending is for medical costs of treatment and insurance administration related to workers' compensation.
- Medical spending for New Mexico in 2018 was $13.5 billion (see above).
- At a rate of 1.4% New Mexico employers and employees may expect to share in reduced workers' compensation costs of $189 million as these workers' compensation medical costs are shifted to the HSP.
- Approximately 30% of that $189 million ($56.7 million) is administrative costs of medical care administration.

This estimate may understate savings to the extent that New Mexico has higher than average workers' compensation costs. Those higher costs may reflect a combination of the case mix profile of New Mexico employment (e.g., a greater proportion of employees in high claims labor categories such as mining vs. office work) or New Mexico's loss history relative to other states (e.g., medical expenses for losses in New Mexico may be higher across industry categories than other states). Similarly, the reduction in workers' compensation costs will accrue to employers with a greater fraction of employees in higher risk industry categories.

The administrative expense reduction from 30% presently to 6% under the HSP may overestimate savings attributable to this category because employers will still have to invest time in workplace injury determinations. Employers may face more such determinations after the state assumes the obligation from employers because workers potentially face less disincentive to claim workplace injuries and have correspondingly greater losses due to claims for lost wages. This may deduct from the savings expected to accrue from shifting medical expenses off of employers' ledgers.

Automobile insurance. Automobile insurance has four basic expense categories:

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

In principle, the HSP could eliminate uninsured motorist coverage because the uninsured motorist will have a primary source of medical care payment, a medical plan most commonly through the HSP. The expanded medical coverage may likewise reduce the cost of medical payments coverage for injuries to

the policyholder and passengers, and possibly for any medical liabilities. The cost of automobile insurance is likely to decline, but these categories may not zero out to the extent that some New Mexico residents will remain medically uninsured.

Potential Long Term Health Benefits. Health care expenditure savings may be realized over time as those newly insured by the HSP access preventive care, lowering the costs associated with preventable and manageable disease. The analytic horizon of the budget impact analysis is only 5 years, while much of the savings from improved access likely will be realized on a longer time horizon. IHS Markit used its Disease Prevention Microsimulation Model[52] to estimate long-term effects of expanded coverage and access to preventative services under the HSP. The simulation was run over 10 years for each person in the New Mexico population, once assuming status quo treatments/interventions for the uninsured and again simulating patient-centered, preventive care for the newly insured. The two sets of results were compared to estimate the gains and losses from universal coverage. We assumed that newly-insured adults under the HSP get patient-centered care resulting in lower blood pressure and cholesterol, some weight loss and smoking cessation, and better glycemic control (first scenario). An alternate scenario (second scenario) assumed that the patient-centered care resulted only in lower blood pressure and cholesterol, as well as better glycemic control (i.e., factors that could be controlled with medicine and didn't require behavioral change).

The gross savings from such care (noting that the cost to provide this preventive care is included in the simulation output) are estimated to be $330 million over the first 10 years under the first scenario and $184 million under the second scenario. Better health may be associated with increased productivity for the newly-insured, which could translate into higher income (estimate at over $2.7 billion over 10 years in the first scenario and almost $1.4 billion in the second scenario). The life years saved over 10 years under the first and second scenarios are 76,657 and 51,755 years, respectively. While the HSP may increase costs to the state, economic and life-year savings from the improved health of newly insured adults could offset some of these costs.

VII. Discussion

If implemented, the Health Security Act would be the most ambitious state-based health reform ever carried out in the United States. Under the HSP, the state's uninsured rate would likely fall well below 1 percent and the vast majority of the population would receive coverage through a public insurance program. The role for private insurance would be diminished, and some segments of the private

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

insurance market would likely disappear altogether. The HSP would affect access to health care, health care spending, household disposable income, compensation, employment, and public finances. The direction and magnitude of these effects depends on the structure and scope of the HSP, behavioral responses from households, employers, health care facilities, providers, insurance companies, and the state government – all of which, are highly uncertain. As these policies have never been tested in New Mexico or anywhere else in the United States, all predictions of potential effects are inherently speculative.

This study was conducted over six months and attempts to predict how the HSP would affect the state of New Mexico. Our approach included, first, engaging with the LFC to understand the content and intent of the proposal. Second, we conducted a review of state health reforms to understand how other states have approached similar policy questions. Third, we worked extensively with the state's HSD and Department of Health to obtain as much New Mexico-specific data as possible. Fourth, we participated in multiple in-person public meetings to communicate our approach and solicit public feedback. Finally, we incorporated these insights and data sources into a complex microsimulation model to simulate how the HSP would affect the state under a range of policy and methodological assumptions.

A. Summary of Key Findings

In this study, we examined the cost of the HSP under different scenarios and whether existing revenues would be sufficient to cover the cost of the plan. Under our base model, we assumed premium costs similar to a typical employer plan, where employees are only responsible for a relatively small share of premium costs. We assumed that low-income individuals would pay no premiums, similar to their premium costs under Medicaid or Marketplace coverage. Employers whose employees received coverage under the HSP would pay into the plan so that total payments from employers match their contributions under baseline. Although we assumed significant reductions in costs to administer the program (such that total program spending is less than baseline in the last year), we found that the HSP would be underfunded by approximately $1.5 billion a year in the first five years of the program.

In addition to our base model, we examined several other scenarios, including ones where the program is fully funded either through contributions from participating employers or a tax levied on all firms. In these two scenarios, the program is fully funded but costs would increase for firms. We considered a less generous cost-sharing scenario where we assumed premiums and cost-sharing (e.g., coinsurance, deductibles) would be similar to the limits established in the ACA Marketplaces. The HSP would be underfunded, but by less than in our base model. Excluding Medicaid enrollees would not significantly impact the funding shortfall, although it could affect the potential payer and provider administrative savings.

In general, we found relatively small economic impacts from the HSP, with impacts going from slightly positive in the first year to slightly negative in the fifth year. These small effects are due to the fact that by year five, the HSP would leave health care spending relative unchanged because administrative savings offset higher spending for health care services.

While overall economic impacts are small, the private insurance industry and its employees would see significant negative impacts as private insurance in the state would be greatly reduced. The private health insurance industry is a source of employment for several thousand workers in New Mexico. The HSP would limit the role of private insurers as insurance coverage and associated administrative activities for the HSP are done by the state. As a result, many workers in this industry would likely lose their jobs. While resources currently being devoted towards insurance administration could be redirected towards other productive economic activities, including additional public administrative duties necessary for the operation of HSP, the HSP could produce financial hardship to New Mexican families and businesses associated with the private insurance industry.

In the long term, if administrative costs are compliant with the 5-percent cap established by the HSA, we estimated that health care spending would be lower by year 5 of the plan than under the baseline. While lower long-term health care spending would have a negative economic impact on the state, lower health care costs due to lower administrative spending could benefit employers and New Mexicans. With lower health care spending, employers and individuals could spend more on other goods and services that may yield increases in New Mexicans' welfare. While our economic analysis assumed that budget shortfalls as a result of the HSP would be closed through a tax or similar mechanisms, HSP funding could be enhanced through establishing higher premiums. Using higher premiums to help fund the HSP could be economically beneficial in the long run as compared to taxing payroll, which could impact productivity. However, higher premiums could run counter to the goals of affordable health care coverage under the HSP.

B. Further Considerations and Study Limitations

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

Federal Waivers – Medicaid and Marketplace. In our base model, we assumed that New Mexico would receive waivers for Medicaid and the Marketplace to fold these programs into the HSP. Under this assumption, the state could repurpose federal support under these programs to the HSP to provide financial assistance to those eligible for Medicaid or receive subsidies under the Marketplace. The benefits of folding these programs into the HSP would largely be related to potential reductions in payer (in this case, the state) and provider's administrative costs. Additionally, the state may be able to negotiate better prices for pharmaceuticals, durable medical equipment, and other items that could be purchased in bulk. By assembling a larger program with more enrollees, the state may be able to generate greater administrative efficiencies through the elimination of duplicative administrative activities. Our model assumed significant reductions in payer-side administrative costs as a result of the HSP. While our base model did not anticipate reductions in provider-side administrative costs affecting the HSP costs (the mechanism that this would occur is through lower negotiated provider reimbursement rates), administrative costs generally are expected to be lower under the HSP as providers are faced with fewer payers (and, as a result, more standardized billing rules and utilization management techniques).

To the extent provider administrative costs are lower, providers may view the program more favorably, which could help with provider retention and recruitment to the state.

The HSP limits eligibility to those who have resided in the state for at least one year. Many of those who fail the residency requirement are eligible for Federal Marketplace subsidies. The HSP would likely effectively eliminate the ACA Marketplaces, leaving some people unable to access Marketplace coverage or the HSP. The federal government may be less willing to grant a federal waiver to repurpose Marketplace funding for the HSP, if not all Marketplace-eligible residents are eligible for the HSP.

Continuation of ACA and Federal Funding. Our results assumed that the ACA and associated federal funding will continue to be available to the state, which is significant. Under the ACA, the Federal Medicaid Matching Rate applied for newly eligible adults under Medicaid expansion is 90 percent for 2020 and beyond. In addition, the ACA provides for federal financial assistance to those eligible on the Marketplace. Together, these federal assistance programs contribute an estimated at $2.1 billion to New Mexico.[53] If the ACA was repealed and not replaced with a similar program, the costs of the HSP to New Mexico would be significantly higher.

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

We assume that the HSP achieves universal coverage among eligible populations. However, in practice, not all eligible individuals and families would choose to enroll. We assume the state could implement "automatic enrollment," where applicable premiums are collected through state income tax filings, and non-enrolled individuals are covered via retroactive eligibility. However, many uninsured New Mexican residents are already covered through retroactive Medicaid eligibility. Therefore, a significant portion of those we classify as "uninsured" in baseline, may already meet our coverage definition. In this sense, we may be overstating the coverage gains from the HSP. As many of those who "gain coverage" may not perceive themselves as covered, our model assumes utilization increases would be slightly lower than those estimated in the Oregon Health Insurance Experiment.

Administrative Savings from the HSP. In our model, a key driver of savings under the HSP is reduced state administrative costs. The 2019 HSA would limit administrative costs of the HSP to no more than 5

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

percent of total spending starting in the sixth year. In our base model, we assumed that administrative costs would start at 9 percent and fall by 1 percentage point each year so that by year five the plan is compliant with the HSA. Our assumed administrative cost levels represent significantly lower costs as a percentage of total spending than is currently achieved by the state Medicaid program or by the national Medicare program. Spending on administrative costs accounted for roughly 12.4 percent of total New Mexico Medicaid spending in 2017.[54] According to the National Health Expenditure Accounts from CMS, administrative costs accounted for approximately 7 percent of Medicare spending. Thus, the state may find it challenging to achieve a 5-percent administrative cost factor, without compromising some aspect of the program.

Tax Treatment for Employer and Employee HSP Contributions. There are considerable tax benefits to ESI because contributions by employers are not subject to federal taxes and employee contributions are made on pre-tax dollars, lowering employee's tax liability. We assumed that these tax benefits would also apply under the HSP. Whether such preferential tax benefits would be applied to the HSP is uncertain and a full legal assessment of this issue is beyond the scope of the study. However, the tax treatment of contributions by employers and employees is an important issue that the state would need to resolve. Without this tax advantage, which is effectively a federal subsidy for the HSP, the costs of HSP would be greater than those estimated in this study.

ERISA Compliance Plan. In our analysis, we assumed that the state would be able to develop an ERISA-compliant approach whereby the state would collect funds through a payroll fee on employers whose employees obtain coverage through the HSP. We also considered an alternative scenario where the HSP is funded, in part, through a payroll tax on all employers. ERISA's "preemption clause" limits the ability of the state to make laws governing employer-based insurance to the extent that they "relate to" employer-sponsored health plans. We sought information on the likelihood that our assumptions would be consistent with ERISA. While no definitive conclusions were drawn, a general view could be surmised that it may be possible to design approaches that are materially similar to those assumed. This view is consistent with the approach followed by Mathematica Policy Research in its assessment of health care reform options for extending coverage in New Mexico. Nevertheless, the development of ERISA-compliant approaches to implement the HSP, to achieve its goals, could face legal challenges, which were not addressed in our study.

C. Sensitivity Analyses: Pessimistic and Optimistic Scenarios

The scenarios we tested present the range of policy variation consistent with the HSA. As a test of the sensitivity of the results, we calculated what we call optimistic and pessimistic versions of the future and compare changes in budget shortfalls.

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

The optimistic scenario assumes that the state leverages its purchasing power from the consolidated HSP to achieve a 10-percent reduction in prescription drug spending. It further assumes the state could increase medical cost savings by 1 percent per year starting in 2025 (so by 4 percent in 2028). Finally, it assumes all firms that currently self-insure for medical coverage continue to offer a self-insured employer plan. In this situation, the state's budget shortfall goes from $7 billion to $6 billion over the 5-year period.

The pessimistic scenario assumes that the state can only achieve administrative costs of 9 percent rather than the target of 5 percent. We further assume the state not only cannot leverage its purchasing power to control medical and pharmacy costs but the state stops participating in the Medicaid prescription drug rebate program, which raises drug prices by 25 percent. In this situation, the state's budget shortfall goes from $7 billion to $11 billion over the 5-year period.

The scenarios highlight two critical success factors for the HSP. The state's consolidated purchasing power under the HSP in the form of reduced administrative expenses and negotiated medical and pharmacy discounts means a $4 billion difference in program costs.

D. Conclusion

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

VIII. Appendices

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

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

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

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

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

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

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

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

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

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

B. Workforce Adequacy

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

Estimates of the supply of physicians and nurses in New Mexico came from 2018 licensure data.[55] Demand projections for physicians (by specialty and setting) and registered nurses (by setting, as well as specialty for advanced practice registered nurses) were generated using IHS Markit's Health care Demand Microsimulation Model. This workforce model has been validated through modeling efforts for the federal government, state governments, professional associations, and hospitals and health systems. Modeling methods and findings have been published in academic journals and major reports.

Starting with a representative sample of the population in each county in New Mexico, the demand for health care services was simulated based on demographics, health risk factors, disease prevalence, medical insurance type, household income, and observed health care use patterns. Provider demand was estimated first under a status quo scenario, which modeled demand based on New Mexicans' current coverage market. Demand was also modeled under a universal coverage scenario[56], which applies health care demand levels observed for insured people (by demographic groups) to the whole population. Projected demand for health care services by type are used to estimate demand for physicians and nurses under the current system and under the HSP using national staffing patterns. Supply of physicians and nurses was compared to projected demand to assess adequacy of supply in 2018; then, factors related to projected changes in the future were analyzed to draw conclusions into the future.

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

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

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

Determining the extent of any current provider shortage in NM is beyond the scope of this project. However, given current practice patterns and the proportion of current demand that is met, the extra demand from insuring all New Mexicans is estimated to increase physician demand by about 1.8%. This is because most of the newly insured are young[57] and relatively healthy, the demographics that typically use fewer health care services; additionally, even when uninsured these individuals used some health care services or would have gained coverage under Medicaid under certain circumstances such as severe illness or pregnancy. Given this relatively small increase in physician demand, it is reasonable to assume that new demand for physicians predicted under HSA by the simulation model generally can be accommodated.

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

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

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

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

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

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

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

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