NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Healthcare Cost Drivers in New Mexico and Medicaid Oversight

Private and Medicaid Markets

Legislative Finance Committee • June 2026

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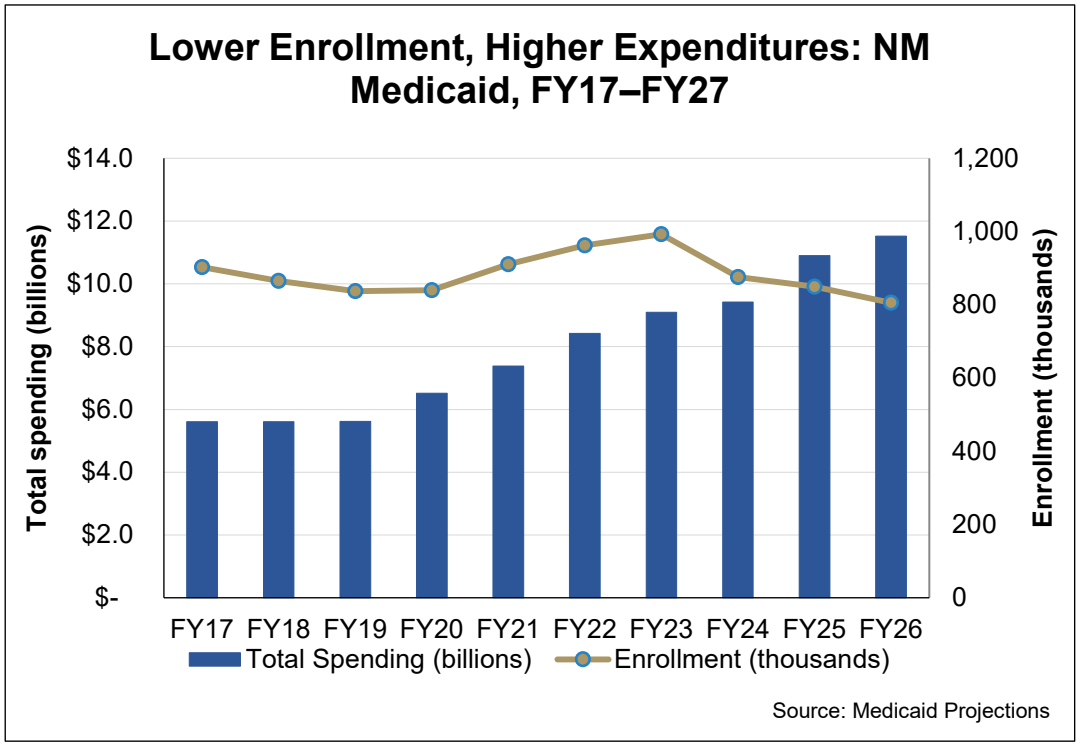
Lower enrollment, more money



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Medicaid spending more than doubled, FY17–FY26

–21%

Enrollment down over a fifth since the FY23 peak

Spending more than doubled while enrollment fell by more than a fifth, after the COVID continuous-enrollment unwinding — the growth is in cost per enrollee, not headcount.

Four drivers examined here:

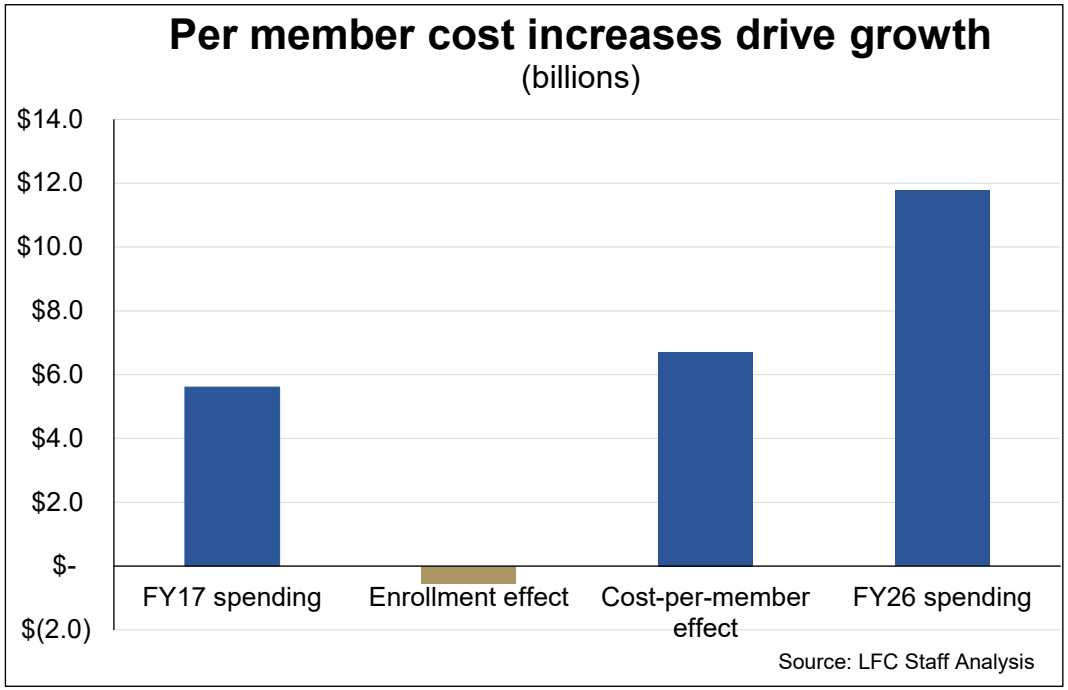
–Hospital costs

–Pharmaceutical spending

–Patient mix

–Medical loss ratios (MLRs)

What drove Medicaid spending growth: cost per member, not enrollment



+$6.7B

added by cost per member

–$0.6B

subtracted by falling enrollment

Splitting Medicaid's FY17–FY26 spending change in two:

–Enrollment fell, which on its own would have cut spending ~$0.6B.

–Rising cost per member added ~$6.7B.

Net change of +$6.2B is almost entirely per-member cost.

Medicaid cost per-member per-month (PMPM) is climbing across populations

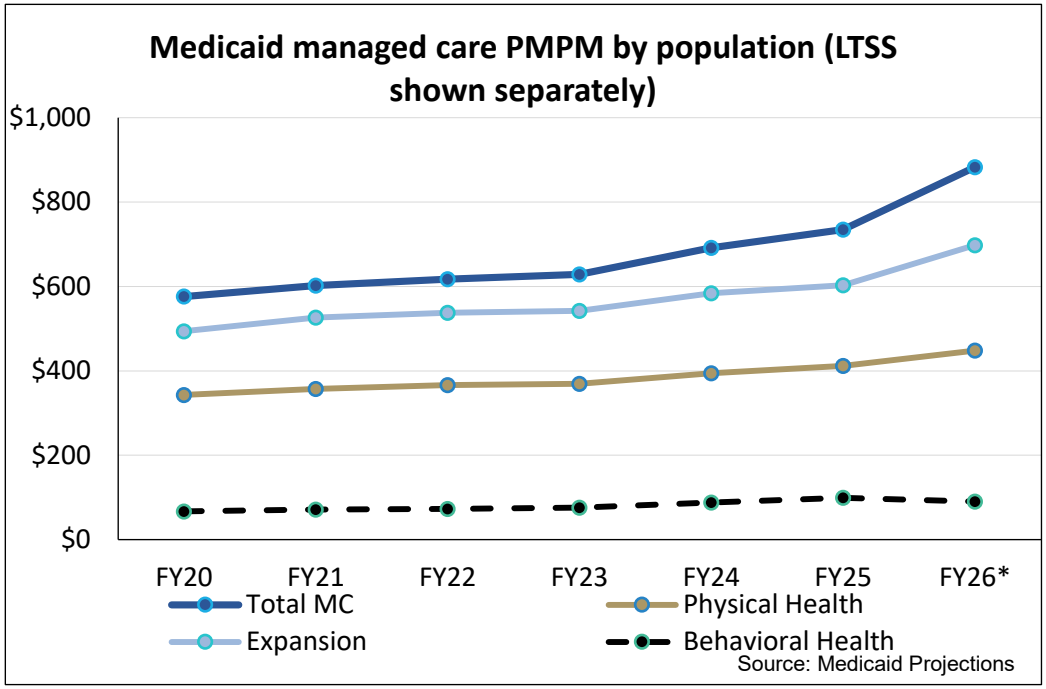
Managed care PMPM rose for every population, FY2020–FY2026:

–Total managed care: $576 → $735 (FY25); preliminary $883 in FY26.

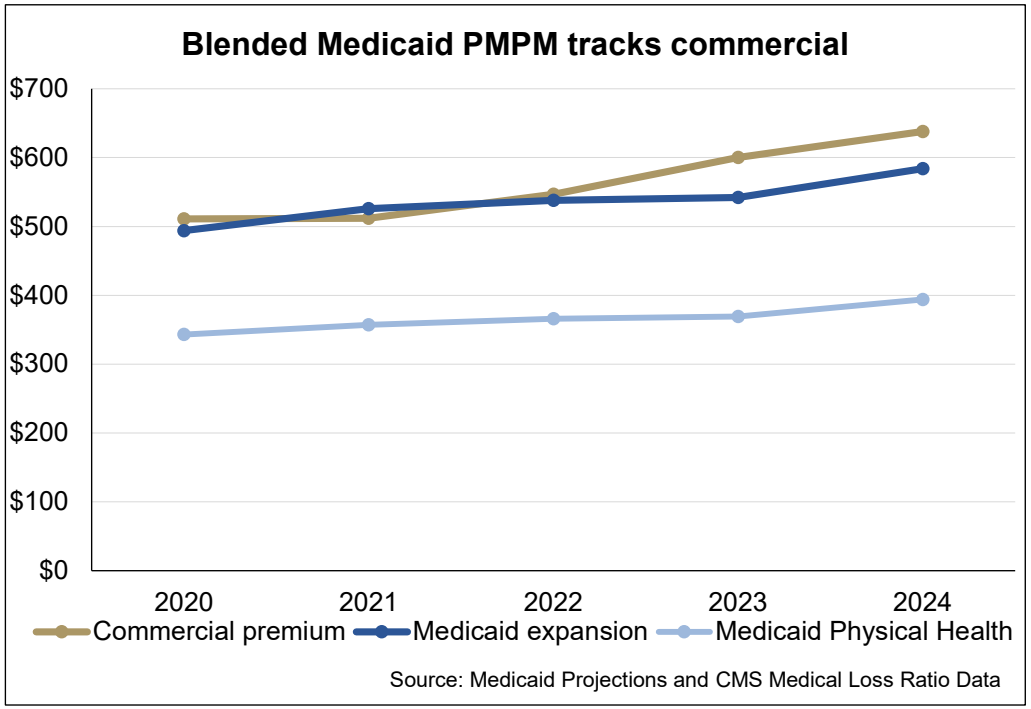
–Physical care rose more modestly: $343 → $448 preliminary.

–Long-term services (LTSS) are far higher — $1,916 → $3,169 — and lift the blended figure (not shown here).

FY26 is preliminary (partial year).



Cost per member: Medicaid vs. the commercial market



–Medicaid expansion PMPM ($494→$584 in 2024) runs close to commercial premiums ($511→$638).

–But Medicaid's base population (physical health) PMPM ($343→$394) sits well below commercial — however, long-term care increases this substantially.

–Commercial premium data does not include ACA-marketplace, and self-insured employer plans.

Not benefit-adjusted: the two cover different populations, benefits, and risk pools.

Why cost per member is rising: price, utilization, and risk mix

PMPM growth is the product of three forces:

PRICE
Unit cost per service

Hospital rates, drug prices, and provider wages per unit of care.

UTILIZATION
Services used per member

Visits, admissions, procedures, and prescriptions per person.

INTENSITY / RISK MIX
Costlier services & sicker members

A shift toward higher-acuity care and a sicker covered population.

In New Mexico, most of the growth is price and risk mix — not members using more care.

Forces pushing up cost in both markets

Five forces push cost up in Medicaid and the commercial market alike:

–**Hospital prices** are a dominant driver. The HDAA directed-payment program is, by design, raising Medicaid hospital payments toward commercial rates, on the commercial side, hospital consolidation, and market power drive unit prices.

–**Pharmacy — specialty drugs and GLP-1s** the doubling in gross drug cost is a both-markets phenomenon, which include high-list, high-rebate specialty drugs.

–**Workforce and wages** — post-COVID provider, nursing, and behavioral-health labor costs.

–**Baseline medical inflation** — compounds each year.

–**Legislative Changes** — No behavioral health cost sharing ($12.3 million impact across NMPSIA, SHB, and RHCA), other provider rate increases (~$500 million impact)

What's unique to each market

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–Unwinding acuity — about 200,000 people left the rolls; those remaining are sicker on average, so cost per member rises even as enrollment falls.

–Long-term care and aging — LTSS PMPM exceeds $3,000 and is rising fastest.

–Directed payments — the HDAA and other rate increases lift hospital reimbursement toward commercial rates.

–Behavioral-health demand — rising utilization across populations.

COMMERCIAL

–Cost-shift — providers recoup perceived public underpayment through higher private rates.

–Adverse selection — a shrinking, sicker individual market (the 104% loss ratio)

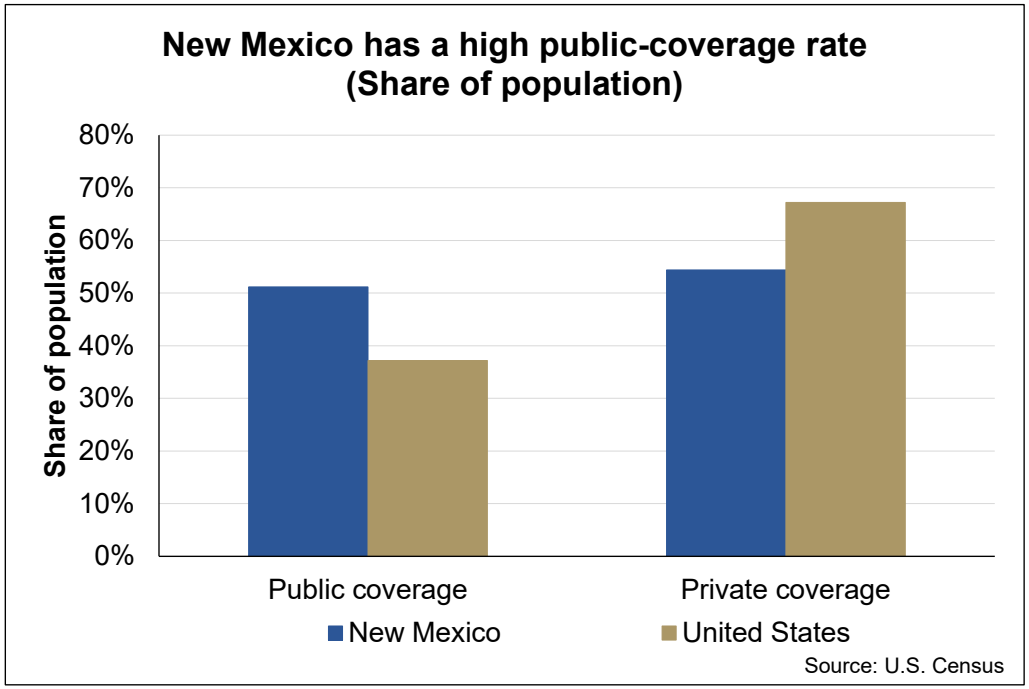
–Consolidation — fewer carriers and providers mean less price competition.

Patient mix: the most public-coverage-heavy state

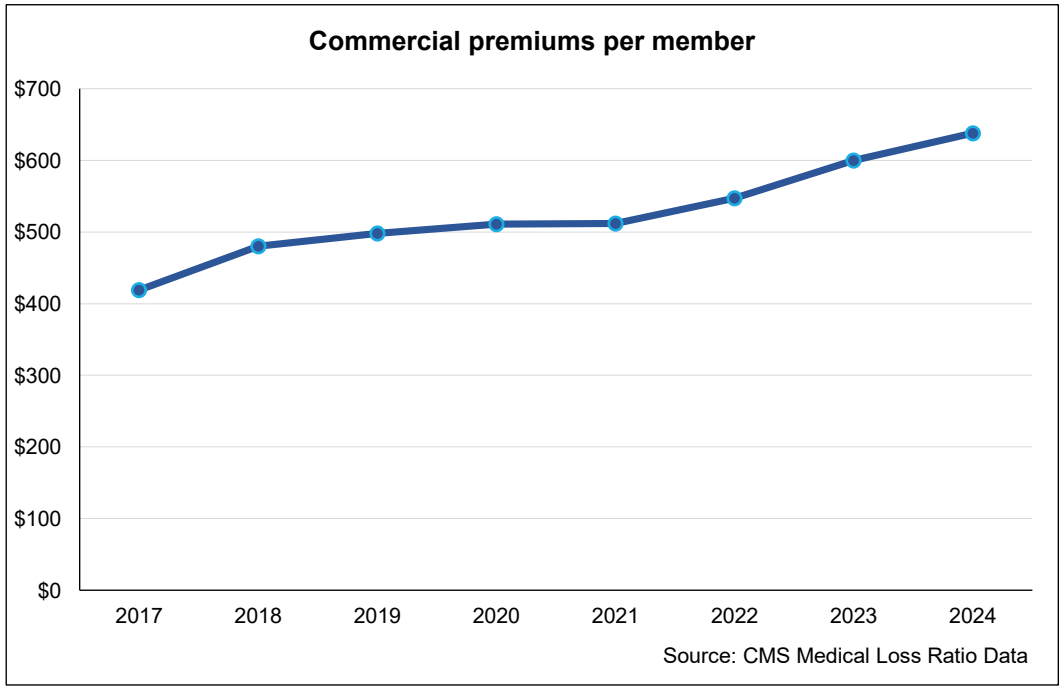
By enrollment, Medicaid covers ~2 in 5

New Mexicans — about 830,000 of ~2.1 million (~990,000 at the FY23 peak).

–NM has the highest public-coverage share (51%) and lowest private share (54%) of any state; ~8% are uninsured (2022 ACS).



Cost-shift: a small commercial market absorbs the pressure



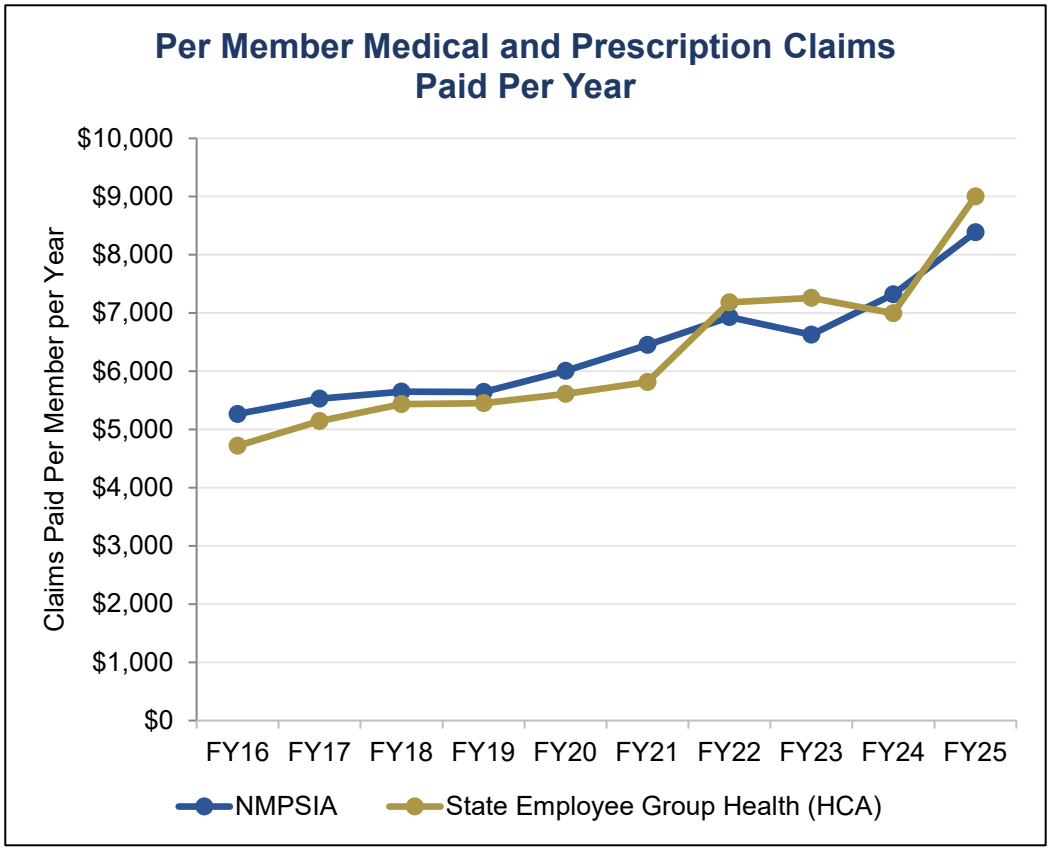
–Commercial premiums per member rose from $419 to $638 (2017–2024).

–Hospitals attribute high private rates to public underpayment; per KFF, private hospital prices run nearly double Medicare.

–A shrinking commercial pool (~15% fewer covered lives) absorbs that cost-shift, pressuring premiums.

Raising Medicaid hospital pay toward commercial rates (next) aims to weaken that justification.

State funded Public School Insurance Authority and State Health Benefits per member costs increasing



–State Health benefits annual claims paid increased from $4,719 to $9,001 (FY16-FY25)

–Similarly, Public School Insurance Authority annual claims paid increased from $5,267 to $8,386

–However, given 80 percent state premium coverage, the state is significantly exposed

Both programs experiencing significant cost increases over the past 10 years.

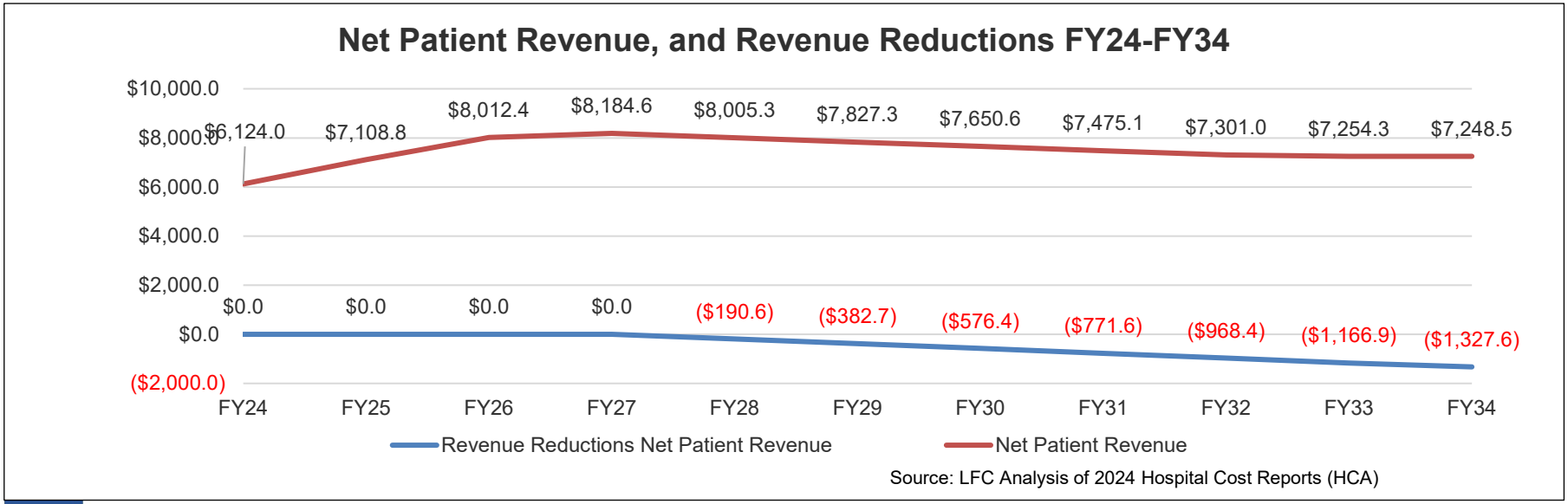
Hospital directed payments: closing the Medicaid–commercial gap

~$1.9B

directed payments above base, FY24 (~75% federal)

The Healthcare Delivery and Access Act (HDAA) adds directed payments to raise Medicaid hospital reimbursement up to the average commercial rate.

Federal HR1 will start modestly reducing these payments over time beginning in 2028.



Source: LFC Analysis of 2024 Hospital Cost Reports (HCA)

Pharmacy: an accelerating cost driver

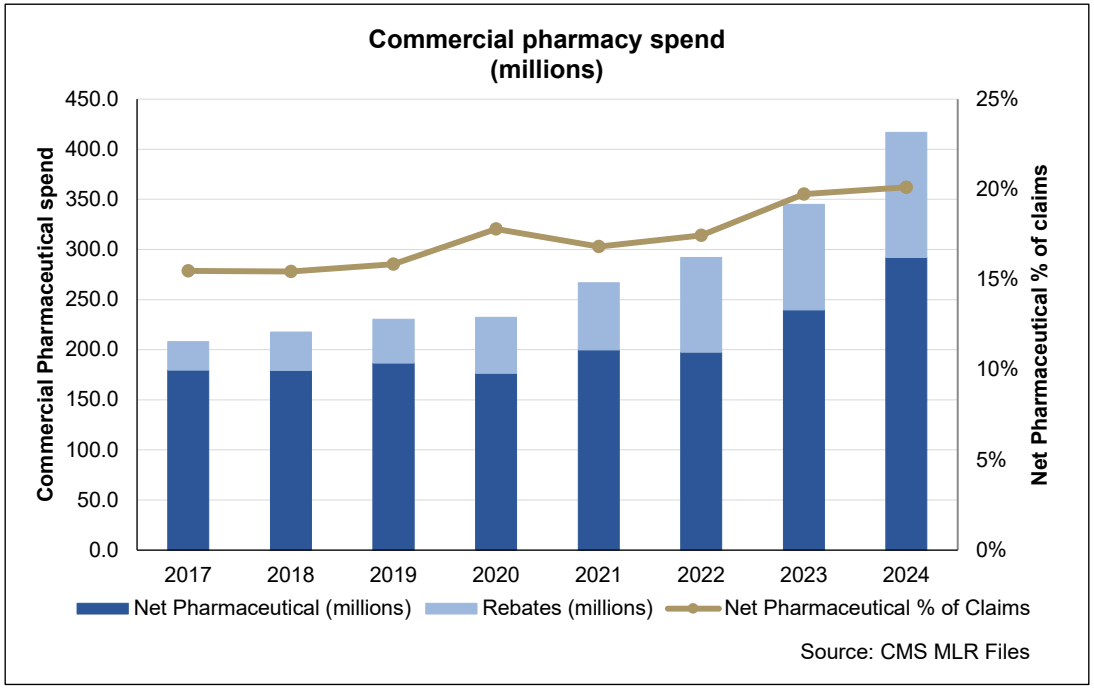
Commercial market, 2017–2024:

–Gross drug costs doubled while rebates grew more than fourfold — list prices rising far faster than net cost.

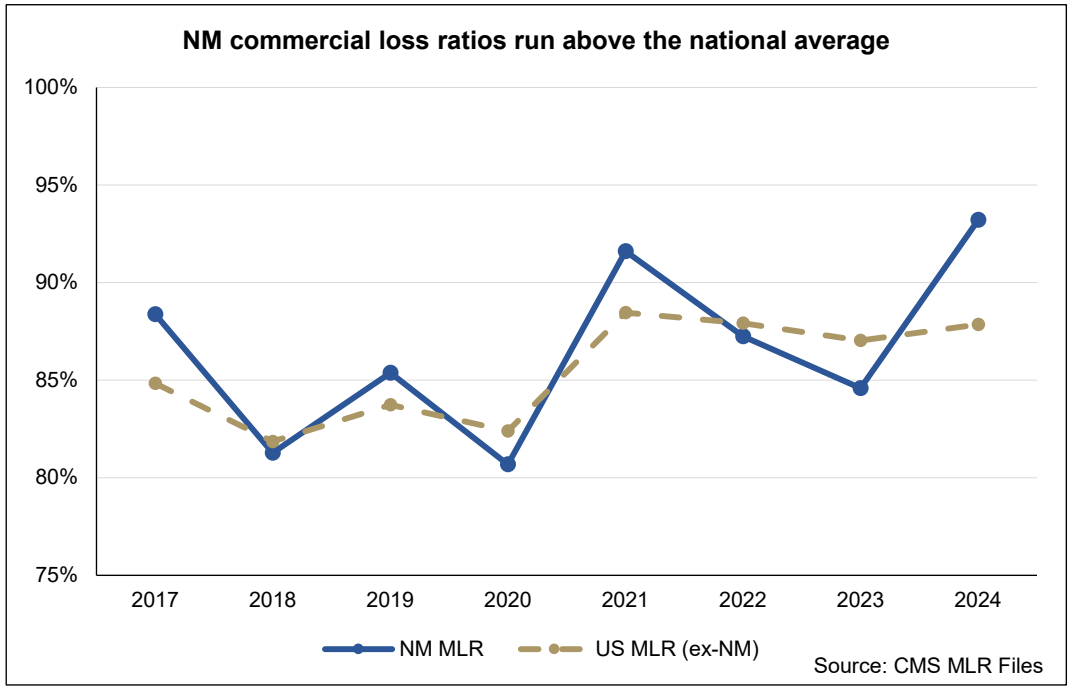
–Net pharmacy spend climbed from 15% to 20% of total claims.

2×
gross Rx cost

+335%
rebates



Medical loss ratios in the commercial market



MLR = the share of premium paid out as medical claims.

–NM commercial MLR reached 93% in 2024, above the 88% national average.

–The individual off-exchange segment ran a 104% loss ratio — claims exceeded premium.

Carriers paying out more than they collect signals pricing and risk-pool pressure in the individual market.

Where the dollars are growing

Ranked drivers of recent cost growth:

1. **Hospital directed payments** — HDAA adds ~$1.36–$1.46B to lift Medicaid hospital pay toward commercial rates (~75% federal).

2. **Cost per member** — Rising per-member cost — not enrollment — drove ~$6.7B of Medicaid growth since FY17.

3. **Pharmacy** — Gross commercial drug cost doubled; net Rx now 20% of claims.

4. **Patient mix** — The most public-coverage-heavy state; a small commercial pool absorbs cost-shift.

With enhanced federal premium tax credits expired, the state is backfilling marketplace affordability through the health care affordability fund.

Medicaid and Contractual Oversight

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The state is paying more per member — three questions

Managed-care cost per member

$576 → **$883**

per member per month, FY20 to FY26

$962 in Q3 FY26

1. Where does each dollar go?
2. Who bears the risk when costs climb?
3. Are outcomes improving?

Note: *the MLR discussed here is the Medicaid MCO floor — a different measure from the commercial-carrier MLR shown earlier.*

Example, where the managed care dollar goes

Managed care spend: **$7.8 billion** (state and federal) in capitation spending

Medical loss ratio denominator (adjusted premium): **$7.250B**

Medical claims	Administration & other	Profit (underwriting gain)	Taxes & assessments
$6.5B 83.3%	**$560M** 7.1%	**$145M** 1.9%	**$605M** 7.7%

$6.5B ÷ $7.2B = 90% — claims as a share of adjusted premium

Profit is priced at a flat 2.00% underwriting gain based on the rate certification — but the contract lets an MCO keep 95% of any gain up to 3% of total capitation.

Source: Mercer CY2026 Turquoise Care rate certification, Exhibits 6–7 (28 rate cells, weighted by capitation dollars).

How MCOs are paid: a fixed budget with two guardrails

The state pays each MCO a set amount per member (capitation) and lets it keep what it does not spend on care. Two rules sit on either side of that arrangement.

Medical loss ratio (MLR) — the floor

- At least 90¢ of every dollar must be spent on care.
- Spend less, and the MCO pays the difference back.
- Guards against underspending and pocketing the difference.

Gain / loss corridor — the two ends

- Caps how much the MCO keeps in a good year.
- Shares the cost of a bad year between MCO and state.
- This is where most of the risk sits.

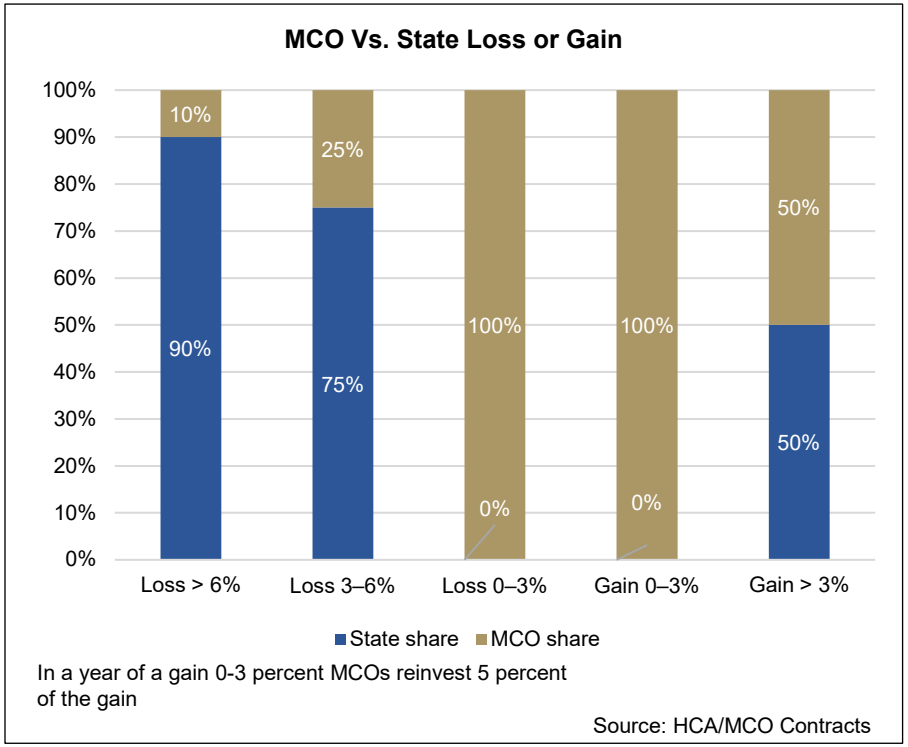
A one-sided bargain

Same 3% threshold, opposite treatment:

- Gains: MCO keeps 95% of gain up to 3% of net capitation revenue — about $217M (5% to community reinvestment); above that, the state recoups only 50%.
- Losses: the MCO bears the entire first 3%; beyond that the state absorbs 75¢ of every dollar (3–6%) and 90¢ (over 6%).
- The one-sidedness is in the tails — within the first 3%, the MCO is fully at risk both ways.

The state caps how much an MCO can win but shoulders most of what it can lose.

Source: Turquoise Care MCO contract §6.11 (p. 369) and §7.2.1 (p. 371).



Spending isn't the same as value

Hitting the 90% floor proves the money was spent on claims. It does not prove whether members got appointments — or got better.

What the MLR guarantees

- Dollars flowed to medical claims.
- Administration and profit stayed within the cap.
- The money is accounted for.

What it does not measure

- Whether access to care improved.
- Whether health outcomes moved.
- A plan can clear the floor every year while outcomes stall.

The levers meant to buy performance

Two separate withholds put up to 5% of capitation at risk — a 100-point Delivery System Improvement Performance Target (DSIPT) scorecard (2%) and a separate set of Healthcare Effectiveness Data Information Set (HEDIS) measures (3%).

DSIPTs — 100-point scorecard → up to 2%

Behavioral health outpatient visit	25
Value-based purchasing	25
Telemedicine	10
Personal care services fulfillment	10
Pharmacy — Hepatitis C treatment	10
Pharmacy — counseling billing	10
Non-emergency medical transportation	10
Total	**100**

HEDIS measures — separate → up to 3%

- A separate set of 13 quality measures (Attachment 12), not scored on the DSIPT scale.
- Penalty is 3% of annual capitation ÷ number of measures, per measure missed.
- Examples: well-child visits, prenatal & postpartum care, follow-up after a mental-health hospitalization, opioid-use-disorder pharmacotherapy, diabetes care.

Source: Turquoise Care MCO contract Attachment 2 (pp. 451–455), Attachment 12 (p. 500), §6.9.3 (p. 368), §7.3.3.6.7 items 18–19; CY2026 rate certification (p. 29).

The result: outcomes aren't following

Overdose deaths are the clearest example. The nation improved for a third straight year. New Mexico did not.

United States, 2025

▼ 14%

overdose deaths, after a 27% drop in 2024 — a third straight annual decline.

New Mexico, 2025

▲ 10%+

one of only three states (with Arizona and Colorado) where deaths rose.

Source: CDC National Center for Health Statistics, provisional data, May 13, 2026.

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