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Healthcare Options:
Slowing Cost Growth Where the State Pays

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November 19, 2026

New Mexico faces four linked problems: cost, access, quality, and administration

Cost

2× Medicaid spending

FY17 to FY27, while enrollment fell

Exchange premiums up 69% over two years; state employee premiums up 20%, 10%, 10%

Access

43% accepting new patients

primary care practices, 2023 secret-shopper survey

60% of new-patient appointments were more than 30 days out

Quality

47th of 51

prevention and treatment (Commonwealth Fund, 2025)

31st overall; 45th on access and affordability

Administration

18% vs. 4.7%

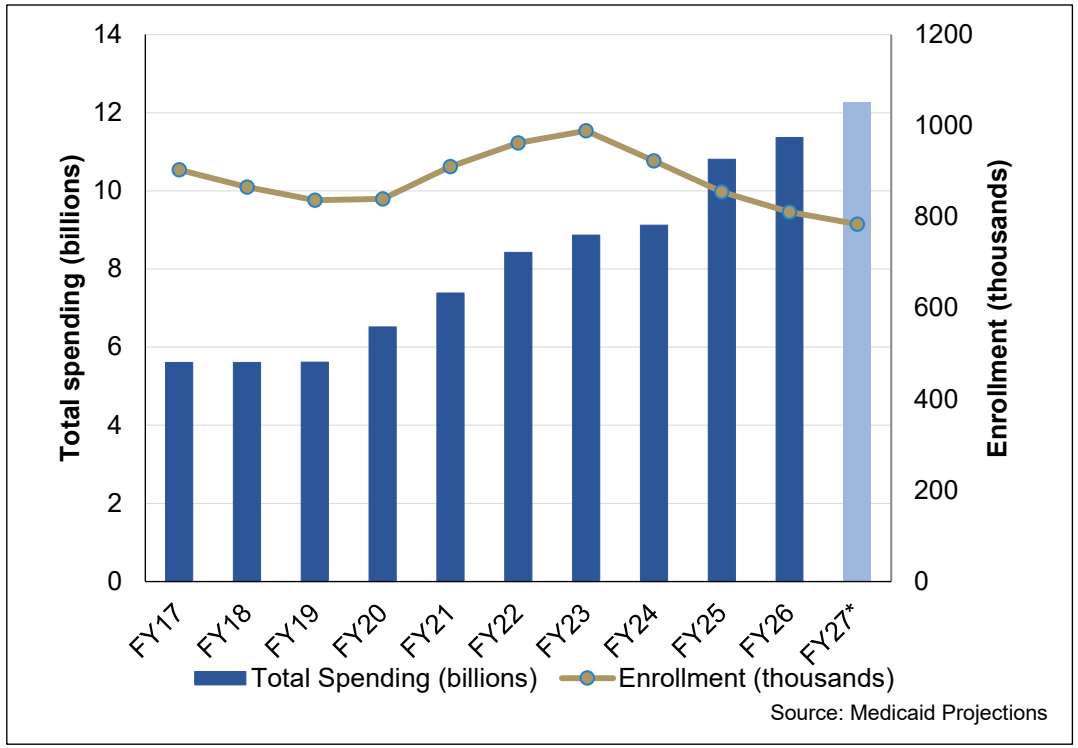
provider revenue lost to administration: Medicaid managed care vs. Medicare

Prior authorization denial rates range from 9% to 27% by market

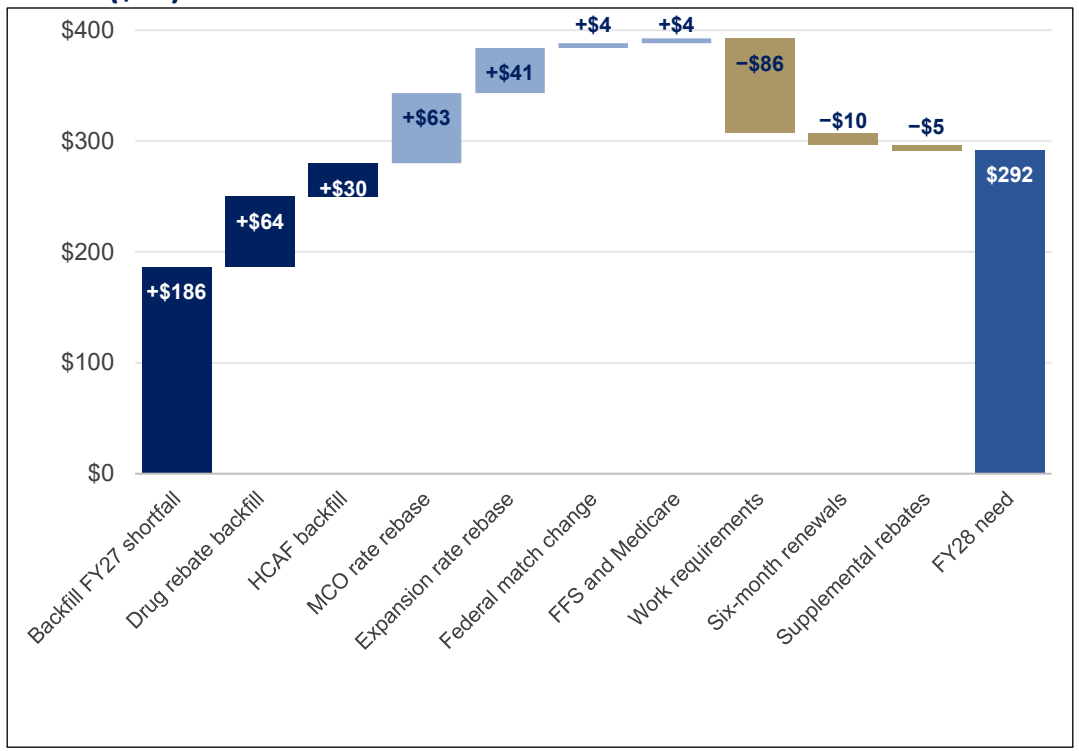
Sources: HCA Medicaid projections; HCA state health benefits; Office of Superintendent of Insurance; Guidehouse (2024); Commonwealth Fund 2025 Scorecard; Columbia University interim report (2025).

Medicaid spending doubled while enrollment fell; HCA projects a $292 million general fund need for FY28

Spending ($ billions) and enrollment (thousands)



FY28 general fund projected need above FY27 appropriation, by driver ($M)



Sources: HCA Medicaid budget projections (benefit spending; FY27 spending and FY28 need from the October 2026 projection; FY27 enrollment from the March 2026 projection).

Insurance cost growth traces to four sources: hospitals, prescription drugs, state mandates, and behavioral health

Hospitals

$141 of $385

Medicaid cost-per-member increase from hospital services and directed payments, FY23–FY26

2027 exchange rates cite hospital system reimbursement

Prescription drugs

15% → 20%

net pharmacy share of commercial claims, 2017–2024

Medicaid pharmacy added $29 per member, FY23–FY26

State mandates

$35 million a year

estimated cost of coverage mandates enacted since 2019

Across school, state employee, retiree, and Medicaid plans

Behavioral health

$68 → $143

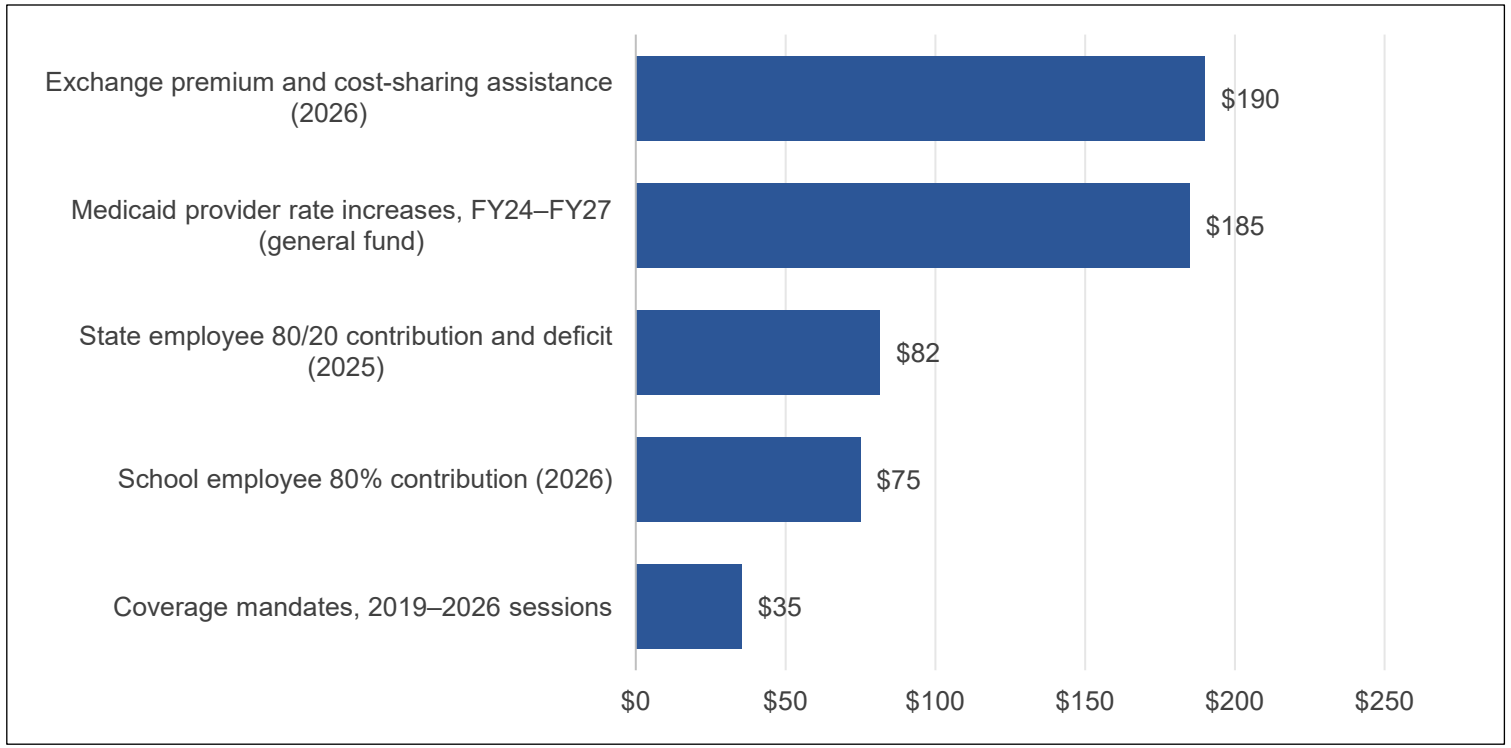
Medicaid behavioral health cost per member, FY23–FY26

Second-largest source of within-population Medicaid growth

Sources: MCO financial reports (Reports 1 and 1A); CMS medical loss ratio filings; Office of Superintendent of Insurance 2027 rate review; LFC fiscal impact reports.

Recent state actions sought to expand access and affordability, but also added cost

Annual cost of selected state actions ($ millions)



$1.26 billion

hospital directed payments through Medicaid managed care, FY25

Spending added through rates, subsidies, and benefits grows each year as premiums and prices rise

Sources: General Appropriation Acts 2023–2026; LFC exchange progress report (Aug. 2026); fiscal impact reports for SB376 (2025), HB47 (2026), and mandate bills; MCO financial reports.

Access pinch points differ by payer and persist despite recent workforce investments

Medicaid: primary care

43%	of primary care practices accepting new patients
53%	of those accepting Medicaid
60%	of new-patient appointments more than 30 days out

Commercial: specialty care (reported)

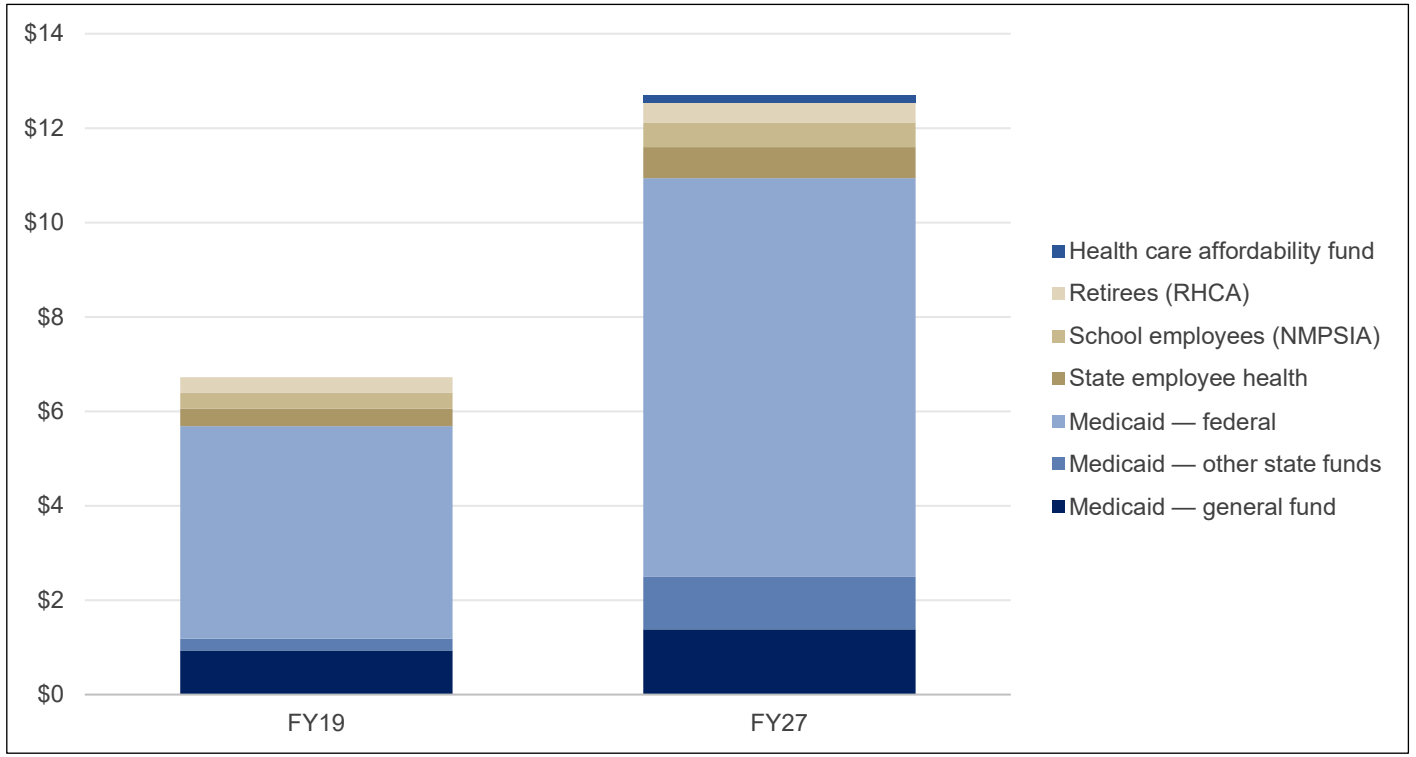
83%	of needed health professionals in place statewide (HRSA, 2025)
No data	evidence is anecdotal; no cross-payer wait-time or network data
Year 1	claims data at HCA would measure the gap

Already invested: Medicaid primary care at 150% of Medicare since FY25; $60 million for health professional loan repayment and $24 million for rural residencies (2024–2026 GAAs)

Sources: Guidehouse, NM Physician Access and Reimbursement Analysis (2024); HRSA workforce projections (2025); General Appropriation Acts of 2024–2026.

The state is New Mexico's largest health care purchaser, but it is fractured across numerous agencies and programs

State-funded health coverage appropriations ($ billions)



$12.7 billion

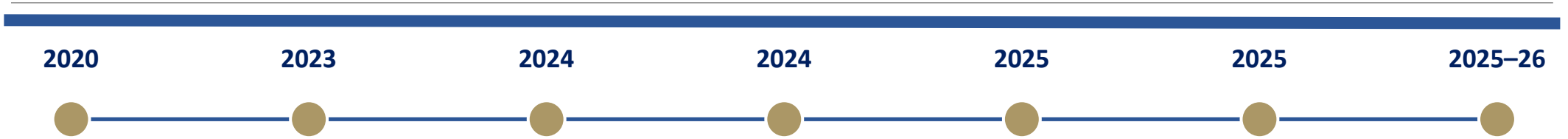
appropriated in FY27, up from $6.7 billion in FY19; $4.3 billion non-federal

Program	Covered lives
Medicaid	825,000
Exchange (BeWell)	83,000
Retirees (RHCA)	65,000
State and local employees	60,000
School employees (NMPSIA)	48,000
Total, about half of NM	**1.08 million**

Plus $494 million in federal premium tax credits for exchange enrollees, 2026 (not appropriated)

Sources: General Appropriation Acts of 2018 and 2026; HCA; RHCA; LFC; LFC exchange progress report (Aug. 2026). Appropriations, not expenditures; employee and retiree plans include member premiums. Covered lives are latest available counts.

Six years of research conducted or commissioned by LHHS and LFC point to the same foundations



KNG Health
Single payer: 1 of 4 scenarios near budget-neutral

NORC
Global budgets: not ready; need data, capacity, a champion

Guidehouse
Physician access: thin commercial base limits revenue

DMoller
Drug purchasing: fragmented buyers; consortium option

Manatt
Behavioral health: crisis, housing, navigation gaps

Gusmano
Connecticut ASO: more transparency and provider participation

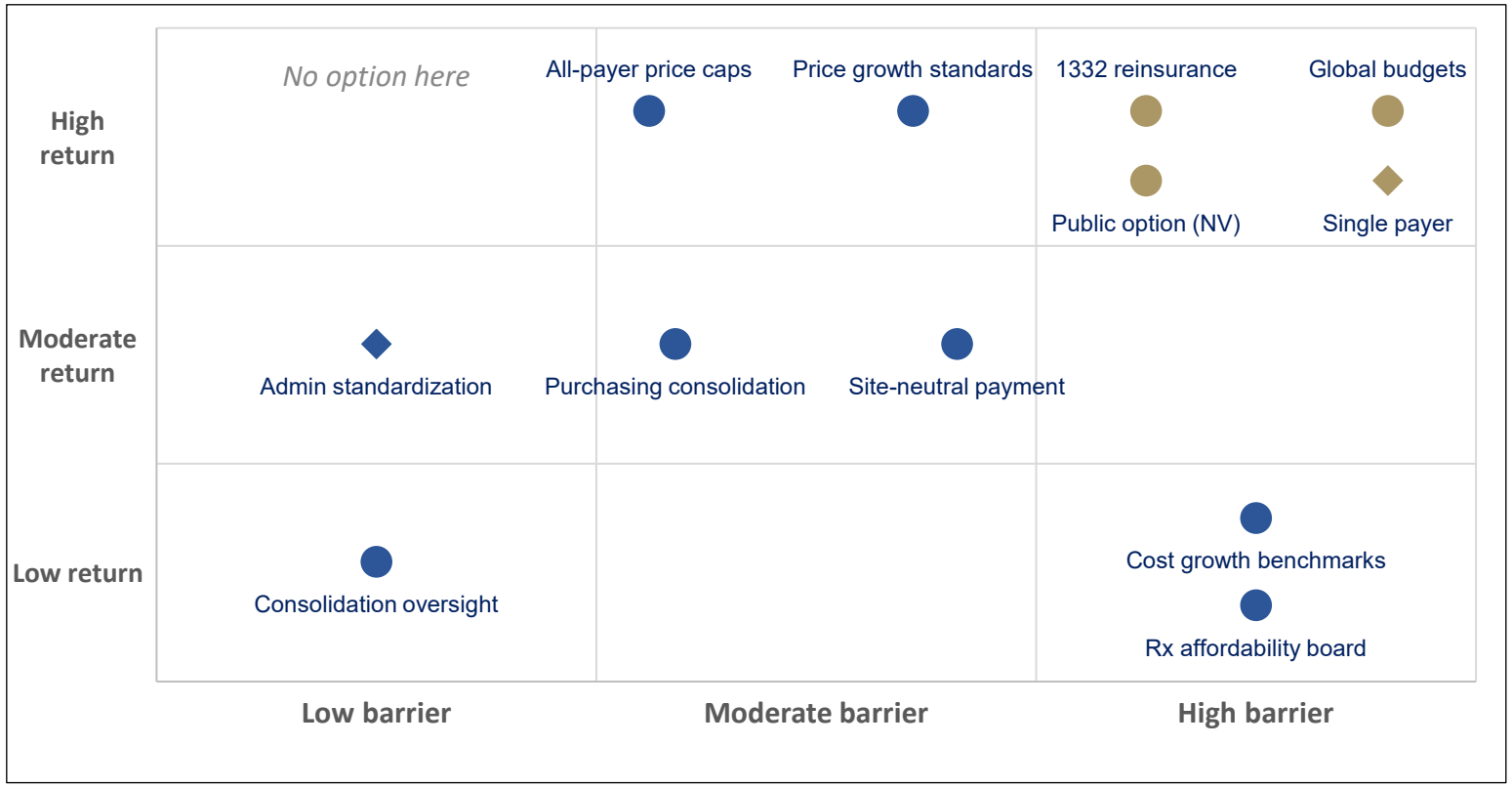
Columbia
Admin costs: standardize prior authorization, credentialing

Where they converge:

- Price and claims data
- Purchasing leverage
- Administrative simplification
- An accountable entity

Sources: LFC and Legislative Council Service commissioned studies, 2020–2026.

No option is both high return and low barrier



- State authority only
- Requires federal approval
- Not scored in LFC analysis

State authority

Highest-return options: hospital price caps and price growth standards

Federal approval

Strongest evidence (global budgets, reinsurance) needs CMS action

Source: LFC cost control strategies analysis, drawing on CBO, RAND, Brookings, and peer-reviewed studies. Positions within a cell are offset for legibility.

Four state-authority options, each with a New Mexico starting point

All-payer price caps

What it does
Caps what hospitals charge commercial insurers, tied to a share of Medicare

Evidence (modeled)
1.7%–6.5% lower spending (RAND); 8.7% lower inpatient with growth caps

Where
Indiana, Vermont enacted; results pending

NM starting point
Reference pricing in state and school plans

Price growth standards

What it does
Limits annual hospital price growth through insurance rate review

Evidence (observed)
Rhode Island: 9.1% lower hospital prices, about $87.7M a year

Where
Rhode Island; Delaware, Colorado

NM starting point
Superintendent's prior-approval rate review

Purchasing consolidation

What it does
Combines public purchasers to negotiate provider and drug prices

Evidence
Colorado Peak: 13%–17% lower premiums (one study); Washington drug list ~$20M/yr

Where
Colorado, Washington, California

NM starting point
HCA coordination; drug list procurement

Site-neutral payment

What it does
Caps insurer payments for routine hospital outpatient care at office rates

Evidence (modeled)
About $16M a year in NM; 5% lower employer premiums over 10 years

Where
No state yet; New York proposed

NM starting point
2026 patient facility fee ban; plan reference pricing

Source: LFC cost control strategies analysis, drawing on RAND, Brookings, CBO, Health Affairs, and state reports.

Two marketplace options depend on a federal waiver

1332 reinsurance waiver

What it does
State reinsurance pays insurers' highest-cost claims, lowering premiums; federal pass-through funds offset part of the cost

Evidence
17 states: premiums 10%–19% lower (average 15%); net savings roughly equal reinsurance funding

Where
Colorado received $245 million in pass-through funding in 2023

NM starting point
2021 OSI analysis: $15M–$49M state cost for 5%–15% lower premiums; OSI may apply under current law

Public option (Nevada model)

What it does
Requires Medicaid MCOs to offer marketplace plans with premiums 15% below benchmark within four years

Evidence
4.6% market-wide premium reduction reported in year one (2026), alongside reinsurance

Where
Nevada; CMS projects $322 million in net federal savings, 2026–2030, with reinsurance

NM starting point
Existing requirement that Medicaid MCOs offer marketplace plans

Sources: LFC cost control strategies analysis; CMS Nevada section 1332 waiver fact sheet; Nevada Health Authority.

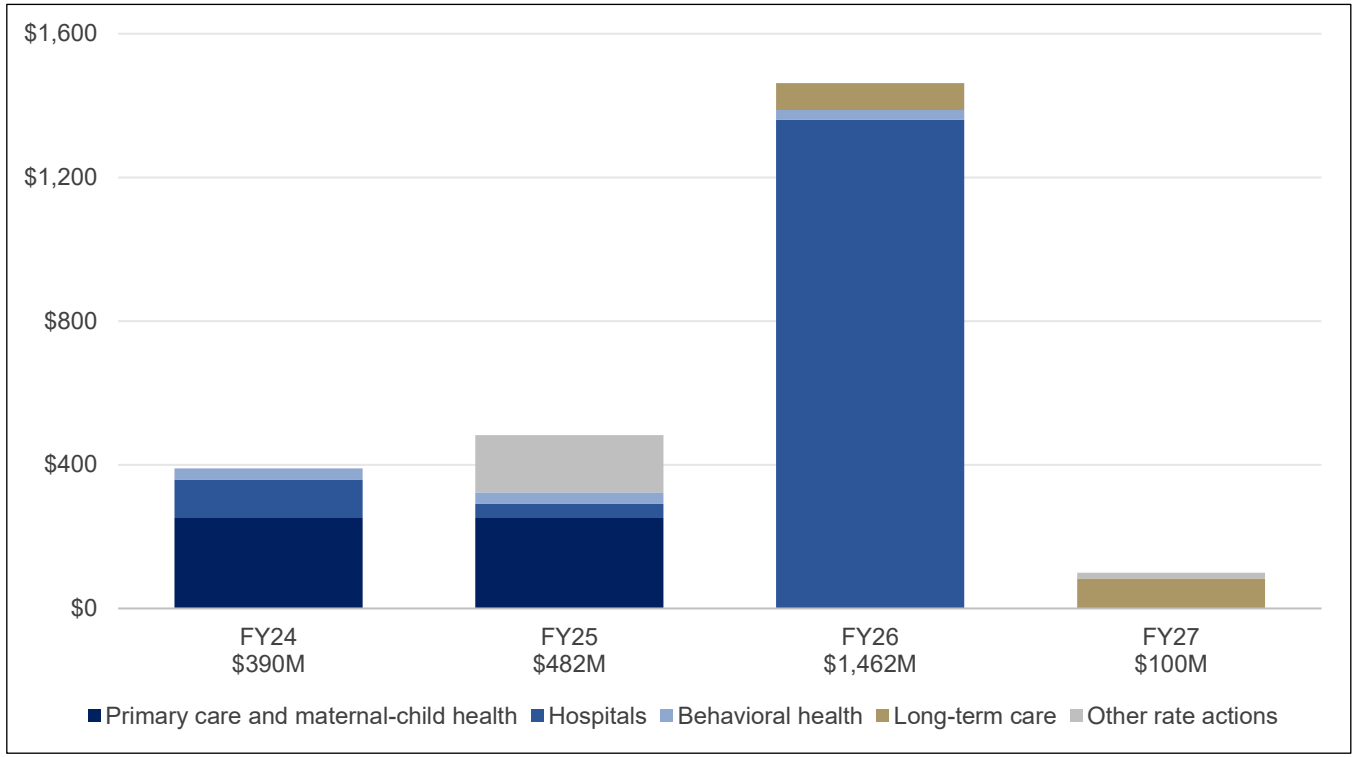
Large overhauls depend on federal approvals the state does not control

Option	Evidence	Federal approvals needed	Fiscal exposure and downside risk
Single payer (Health Security Plan)	1 of 4 modeled scenarios near budget-neutral (2020)	Medicaid and marketplace waivers redirecting about $2.1 billion a year	Federal funds at risk if waivers are denied. 3 of 4 scenarios need a new payroll tax (0.3%–2.3%) on top of a 7%–8% employer contribution. Displaces most private insurance and its premium tax revenue
Hospital global budgets	Maryland: $796 million Medicare hospital savings over 4.5 years	CMMI model, Medicaid 1115 waiver, managed care payment approval	LFC estimates $200–300 million a year, mostly from a few high-margin hospitals. 8 of 44 hospitals below a 2.5% margin would need support. Federal models can end early, as Making Care Primary did
Public option (Nevada model)	First year; 4.6% premium reduction reported alongside reinsurance	Section 1332 waiver	Premium targets rely on paying providers less than commercial rates (Nevada's floor is Medicare). Carriers warn of narrower rural networks. In NM, commercial pays only ~14% of hospital revenue

Sources: KNG Health fiscal analysis of the Health Security Plan (2020); LFC global budget brief (October 2026); CMS AHEAD model overview (fall 2025); Nevada 1332 waiver.

The state has invested heavily in access and quality; the pathway builds on that work

Medicaid provider rate adjustments ($ millions, state and federal funds)



Workforce pipeline, 2024–2026

$60M loan repayment · $24M rural residencies · $600M new UNM school of medicine · licensure compacts passed

Quality already built in

Hospital assessment ties 40% of directed payments to quality; up to 5% of Medicaid MCO payments at risk on targets

Continuing to evaluate the access effect of higher rates

Sources: LFC analysis of Medicaid rate adjustments (FY26 hospitals from the HDAA fiscal impact report); General Appropriation Acts 2024–2026; UNM Health Sciences; Health Care Delivery and Access Act; Turquoise Care CY2026 rate certification.

The possible pathway: consolidate purchasing, set targets, then tie subsidies to lower-cost plans

Year 1	Year 2	Year 3
Consolidate public purchasing: state health benefits and NMPSIA	Merge pools and standardize plans	Tie the state 80/20 contribution to lower-cost state plans
Cost growth monitoring: move claims data to HCA	Move subsidies to lower-cost plans	Exchange subsidies prefer lower-cost plans
Universal primary care, phase 1	**Anchor increases to state targets: create the affordability council**	Re-evaluate price caps: add teeth if growth exceeds the target
Quality: hospitals reinvest 100% of assessment funds in NM	**Quality: one set of quality measures across payers**	**Quality: add quality to the target; weigh it in HDAA renewal**

Each step builds on the one before; blue outlines mark the quality steps, and the slides that follow take each year in turn

Source: LFC.

Year 1: consolidate public purchasing, move cost data to HCA, and begin universal primary care

The pathway

Year 1 · Purchasing, data, primary care

Year 2 · Pools and state targets

Year 3 · Subsidies follow lower-cost plans

Consolidate purchasing

APS joins NMPSIA in FY28; then one procurement, PBM, and data platform with state health benefits

Cost growth monitoring

Move the all-payer claims database to HCA to track cost by payer and provider

Universal primary care, phase 1

Possibly move public health offices to UNM Health Sciences to add primary care with medical school rotations, and expand FQHCs

Quality: hospital reinvestment

Require hospitals to reinvest 100% of net assessment funds in NM, up from 75%

$10M–$36M

projected savings from adding APS to NMPSIA by the end of FY28 (NMPSIA actuary)

Sources: LFC hearing brief, public employee health benefits (2026), citing NMPSIA actuarial projections; HB47 (2026); DMoller drug purchasing report (2024).

Year 2: merge pools, standardize plans, and anchor increases to a state target

The pathway

Year 1 · Purchasing, data, primary care

Year 2 · Pools and state targets

Year 3 · Subsidies follow lower-cost plans

Merge pools, standardize plans
One risk pool and common plan designs for state, local, and school employees

Move subsidies to lower-cost plans
State contribution follows the lower-cost options

Anchor increases to state targets
Create the affordability council; tie increases to its target and set common administrative rules

Quality: one measure set
Council adopts common quality measures across Medicaid, state plans, and the exchange

$55M+/yr

projected FY27 savings from 2025 reference pricing: the base to build on

Sources: LFC hearing brief, public employee health benefits (2026); Segal, Cost of Legislative Bills (NMPSIA); Colorado Peak Health Alliance study.

Create a health care affordability council to hold cost growth to a state target

Health Care Affordability Council

One statewide cost growth target for state-funded and regulated spending

Set

Annual statewide cost growth target

Measure

Cost and quality by payer and provider, using claims data at HCA

Anchor

Tie rate approvals, state plan premiums, and Medicaid increases to the target

Standardize

Common quality measures, prior authorization, and reporting rules

Review

Hospital and provider transactions

Enforce

Public reports, improvement plans, and penalties

9.1% lower

hospital prices under Rhode Island's affordability standards, enforced through rate review

3.5% → 3.0%

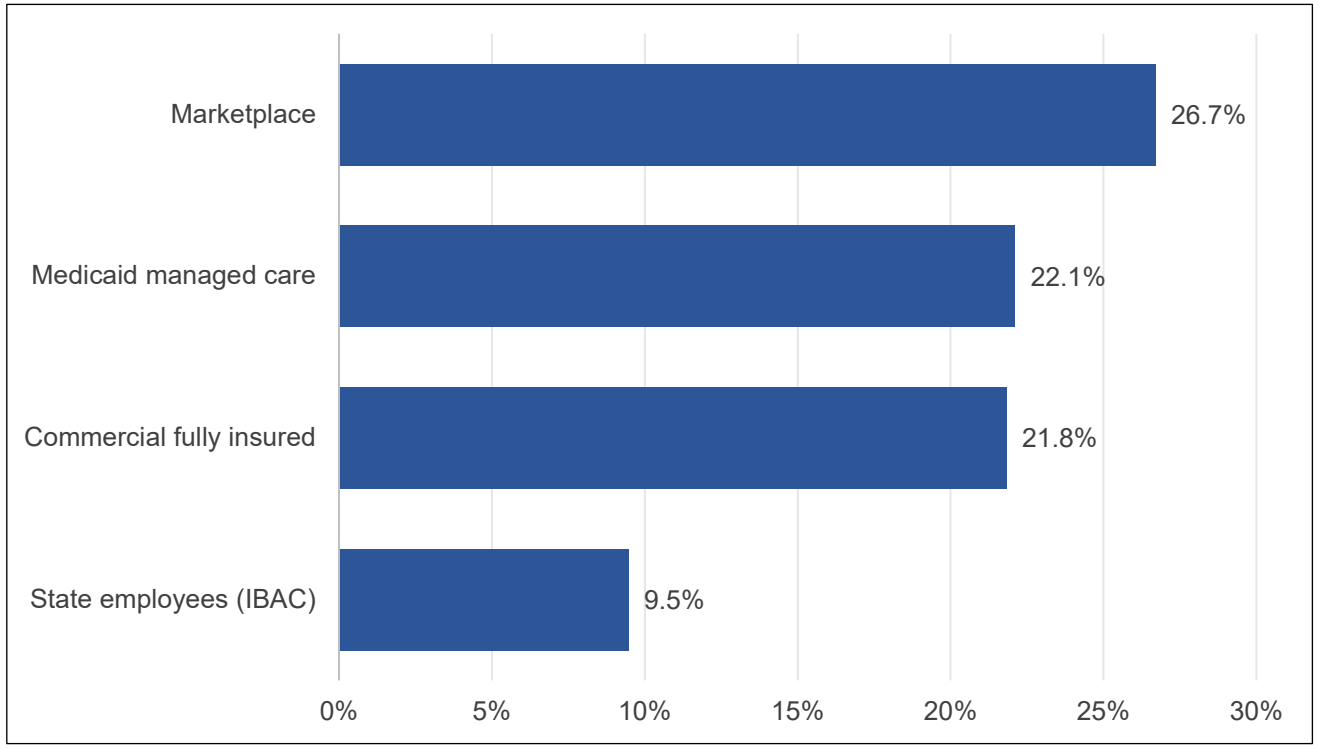
California's statewide target, 2025–2029, enforceable from 2026

Targets work when tied to a lever: monitoring alone has not lowered costs

Sources: Health Affairs study of Rhode Island affordability standards; California Office of Health Care Affordability; peer-reviewed eight-state benchmark study; LFC cost control strategies analysis (March 2026).

Year 2: the council sets common rules for prior authorization, credentialing, and reporting

Prior authorization denial rates by market, 2021



9% to 27%

range in denial rates across markets, nearly threefold

Approaches from the Columbia study

1. Standardize prior authorization, billing, quality measures, and contracts across payers
2. Assign this work to the affordability council, alongside its authority over cost growth, spending oversight, and state health data

Sources: Office of Superintendent of Insurance data and national studies as reported in Columbia University interim report (2025).

Year 3: tie subsidies to lower-cost plans and re-evaluate price caps

The pathway

Year 1 · Purchasing, data, primary care

Year 2 · Pools and state targets

Year 3 · Subsidies follow lower-cost plans

State employee 80/20
State pays 80% of the lower-cost plan; employees choosing higher-cost plans pay the difference

Exchange subsidies
State premium assistance pegged to lower-cost plans, not 110% of the benchmark

Re-evaluate price caps
If growth exceeds the target, weigh all-payer caps or price growth limits with more teeth

Quality: add it to the target
Council target adds quality; HDAA renewal (repeals July 2030) weighs a larger quality share

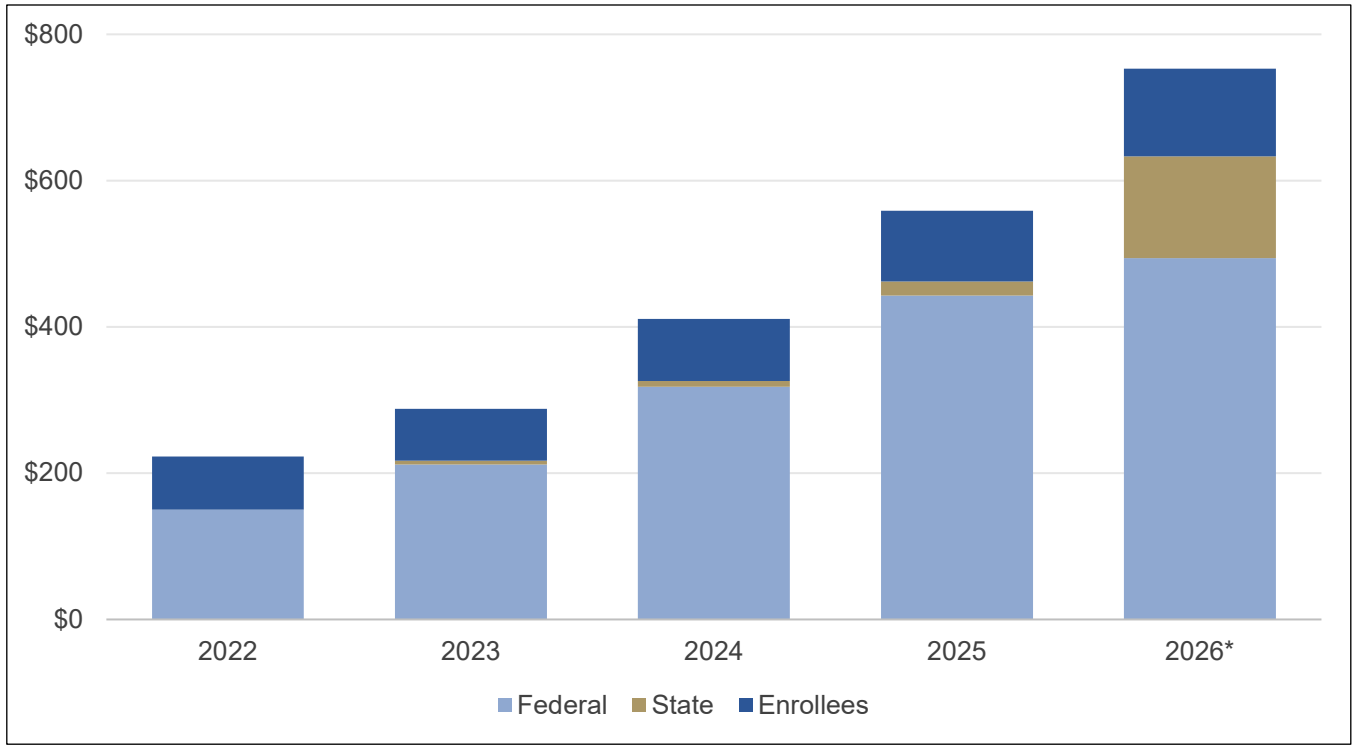
99%

of state employees chose gold or platinum plans for FY27 under the 80% subsidy; 46% of local government employees chose silver

Sources: LFC hearing brief, public employee health benefits (2026); LFC FY28 budget preview (October 2026); LFC exchange progress report (August 2026).

Year 3: peg exchange assistance to lower-cost plans so carrier increases are not passed to the state

Exchange premium spending by payer ($ millions)



$19M → $139M

state premium spending, 2025 to 2026

Ways to stop the pass-through

- Peg assistance to lower-cost plans, not 110% of the benchmark
- Hold state contribution growth to the council target
- Apply the target in insurer rate review
- Keep cost sharing for higher incomes

*Source: LFC, Progress Report: New Mexico Health Insurance Exchange (August 2026), from BeWell data. *2026 projected from spending through July.*

Prescription drugs across the pathway: buy together, then regulate, then set prices if needed

Year 1 · Purchaser	Year 2 · Regulator	Year 3 · Price setter, if needed
One PBM for state plans Transparent pass-through pricing; ArrayRx consortium model	**PBM rules** Ban spread pricing; pass rebates to plans (Illinois)	**Affordability board** Upper payment limits; Colorado's first takes effect 2027
Common drug list Medicaid and state plans; Washington saves ~$20M a year	**Transparency** Manufacturer price reporting and 60-day increase notice (Oregon)	**Caution** Legal challenge in Colorado; two states ended boards in 2025

Already working: state health benefits saved an estimated $10.4 million from PBM contract changes and $2 million from formulary changes

Sources: LFC hearing brief, public employee health benefits (2026); DMoller drug purchasing report (2024); Illinois and Oregon statutes; Colorado Prescription Drug Affordability Board; OSI transparency report (2025).

What the 2027 session would need to act on

Authority	Data	Subsidies	Timeline
• Create the health care affordability council • Consolidate state health benefits and NMPSIA purchasing • Raise hospital reinvestment in NM to 100%	• Move the all-payer claims database to HCA • Medicaid encounter data to separate price from use	• Tie the state 80/20 contribution to lower-cost plans • Peg exchange assistance to lower-cost plans	• FY28: purchasing, data, primary care, HDAA reinvestment • FY29: pools, council, quality measures • FY30: subsidies, price-cap review, HDAA renewal

Source: LFC.

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For More Information

- http://www.nmlegis.gov/lcs/lfc/lfcdefault.aspx
- Session Publications – Budgets
- Performance Report Cards
- Program Evaluations

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Appendix

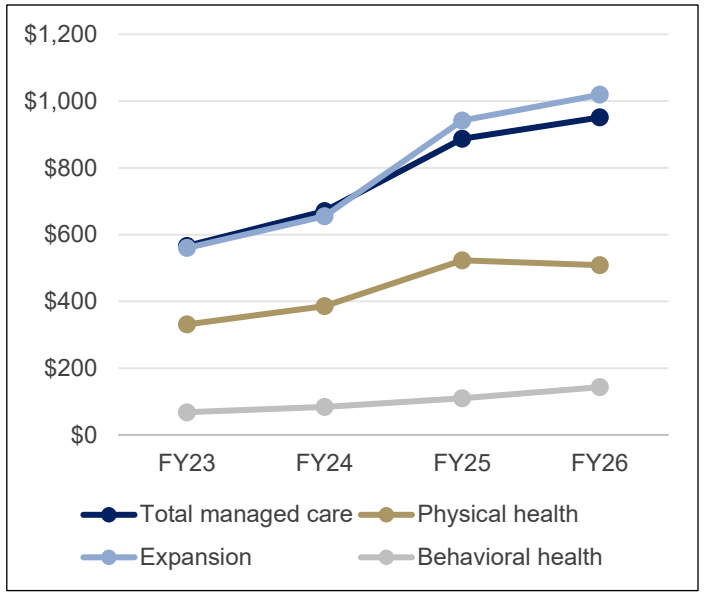
Recommendations by problem addressed

Year	Recommendation	Cost	Access	Quality	Admin.
Year 1	Consolidate SHB and NMPSIA purchasing, including APS	●			●
Year 1	One pharmacy benefit manager and a common drug list	●			
Year 1	Move all-payer claims data to HCA to measure cost and quality	●		●	
Year 1	Universal primary care phase 1: possibly move public health offices to UNM; expand FQHCs		●		
Year 1	Hospitals reinvest 100% of assessment funds in NM (now 75%)		●	●	
Year 2	Merge NMPSIA and SHB pools; standardize plan designs	●			●
Year 2	Move state employee subsidies toward lower-cost plans	●			
Year 2	Create the affordability council; anchor increases to its target	●			
Year 2	Council sets common prior authorization, credentialing, and reporting rules		●		●
Year 2	Council adopts one set of quality measures across payers			●	●
Year 2	PBM rules and drug price transparency	●			
Year 3	Tie the 80/20 contribution to lower-cost state plans	●			
Year 3	Peg exchange premium assistance to lower-cost plans	●			
Year 3	Re-evaluate price caps; add teeth if growth exceeds the target	●			
Year 3	Add quality to the council target; larger quality share at HDAA renewal			●	
Outside pathway	Implement interstate licensure compacts (funded in 2025)		●		
Outside pathway	Target loan repayment to shortage specialties		●		
Outside pathway	Measure access after Medicaid rate increases		●		
Items	**Count by problem**	**10**	**6**	**4**	**4**

Cost per member is rising in every program the state funds

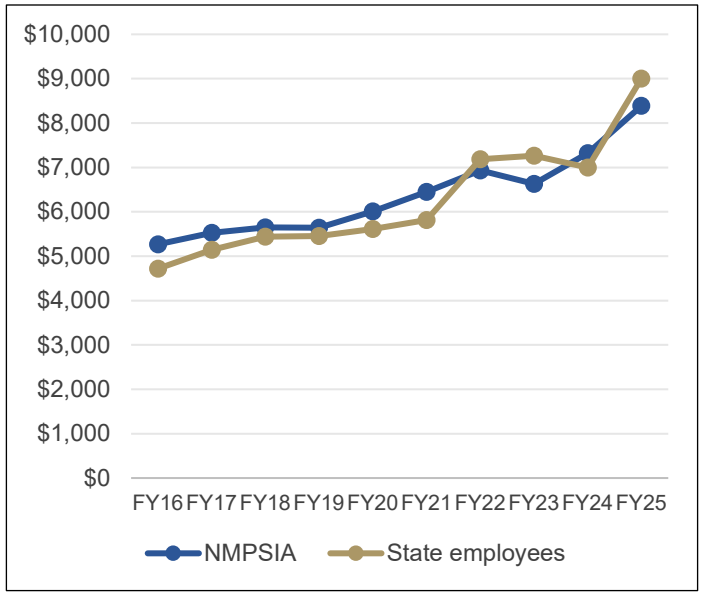
+68%

Medicaid managed care cost per member, FY23–FY26



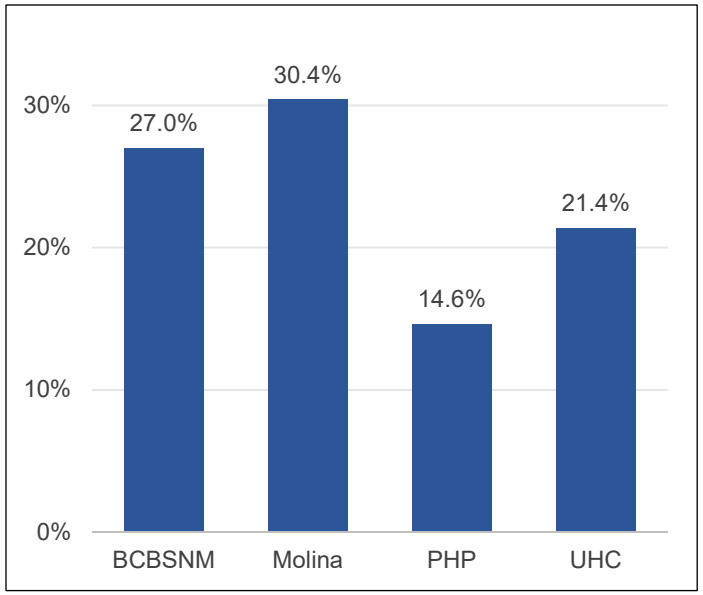
+91% / +59%

State employee and school plan claims per member, FY16–FY25



+15% to +30%

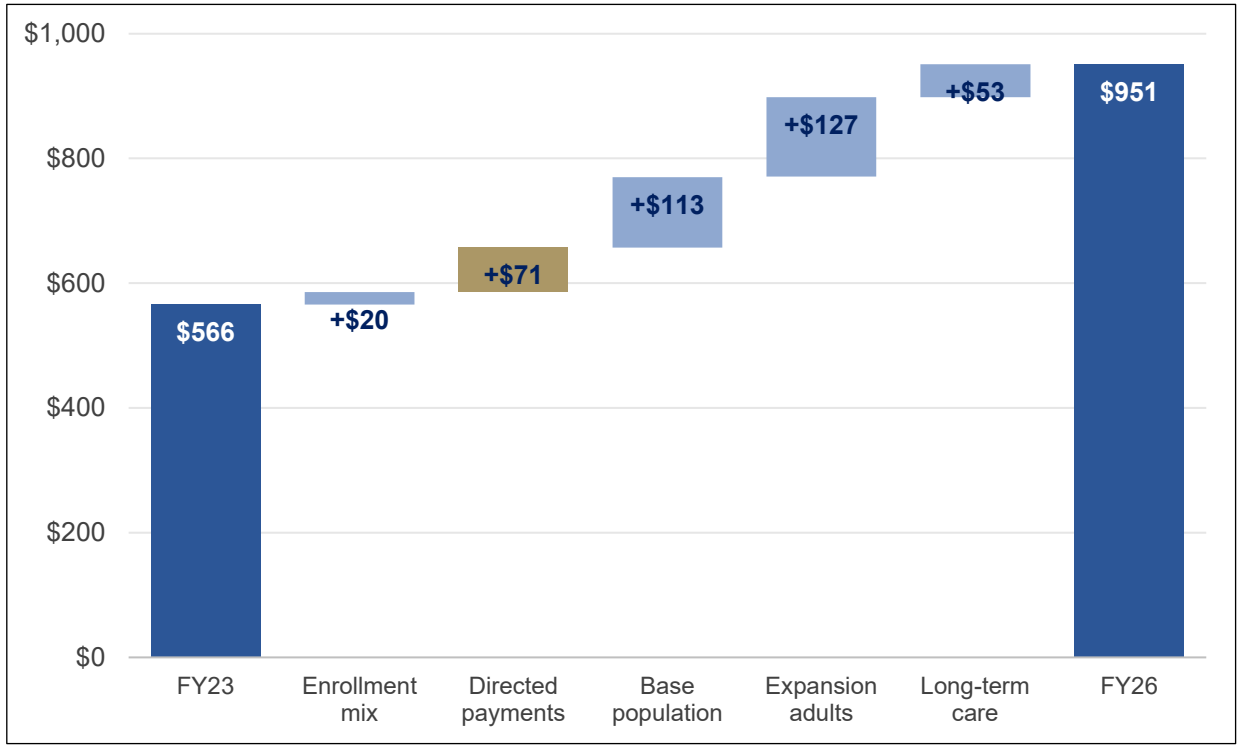
Approved 2027 exchange premium increases



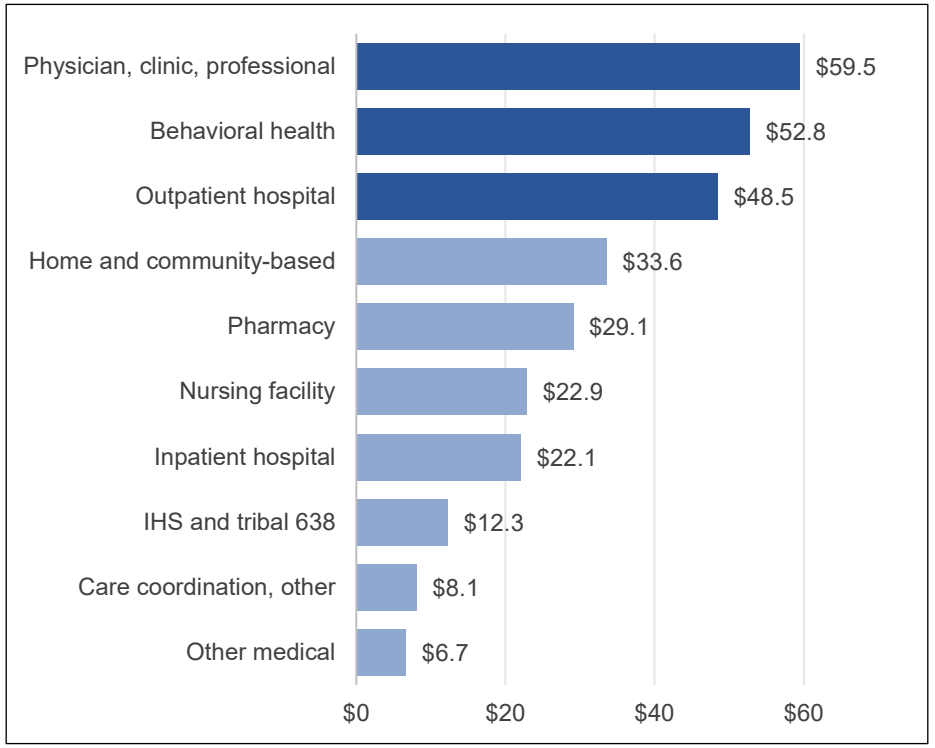
Sources: MCO financial reports (Report 1, includes directed payments); NMPSIA and HCA state employee group health claims; Office of Superintendent of Insurance 2027 rate review.

Most of the increase is higher cost within each population

Change in managed care cost per member, FY23 to FY26



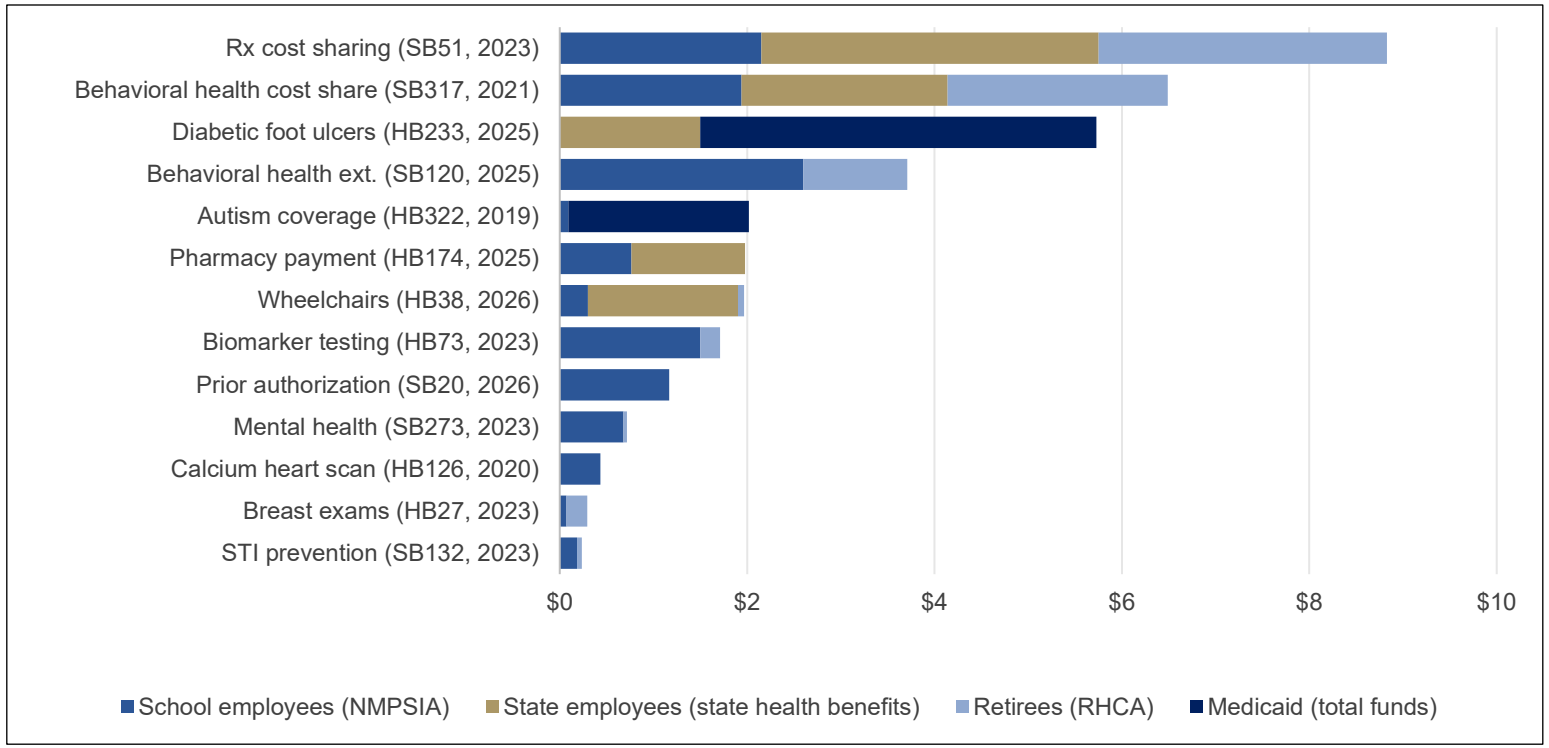
Within-population growth by service ($ per member)



Source: MCO financial reports, Reports 1 and 1A, FY23 and FY26. Dollars only; price and utilization cannot be separated without encounter data.

Coverage mandates enacted since 2019 add an estimated $35 million a year across state-funded plans

Estimated full-year cost by plan when enacted ($ millions)



$35 million

estimated annual cost of 13 bills, 2019–2026 sessions

By plan (millions a year)

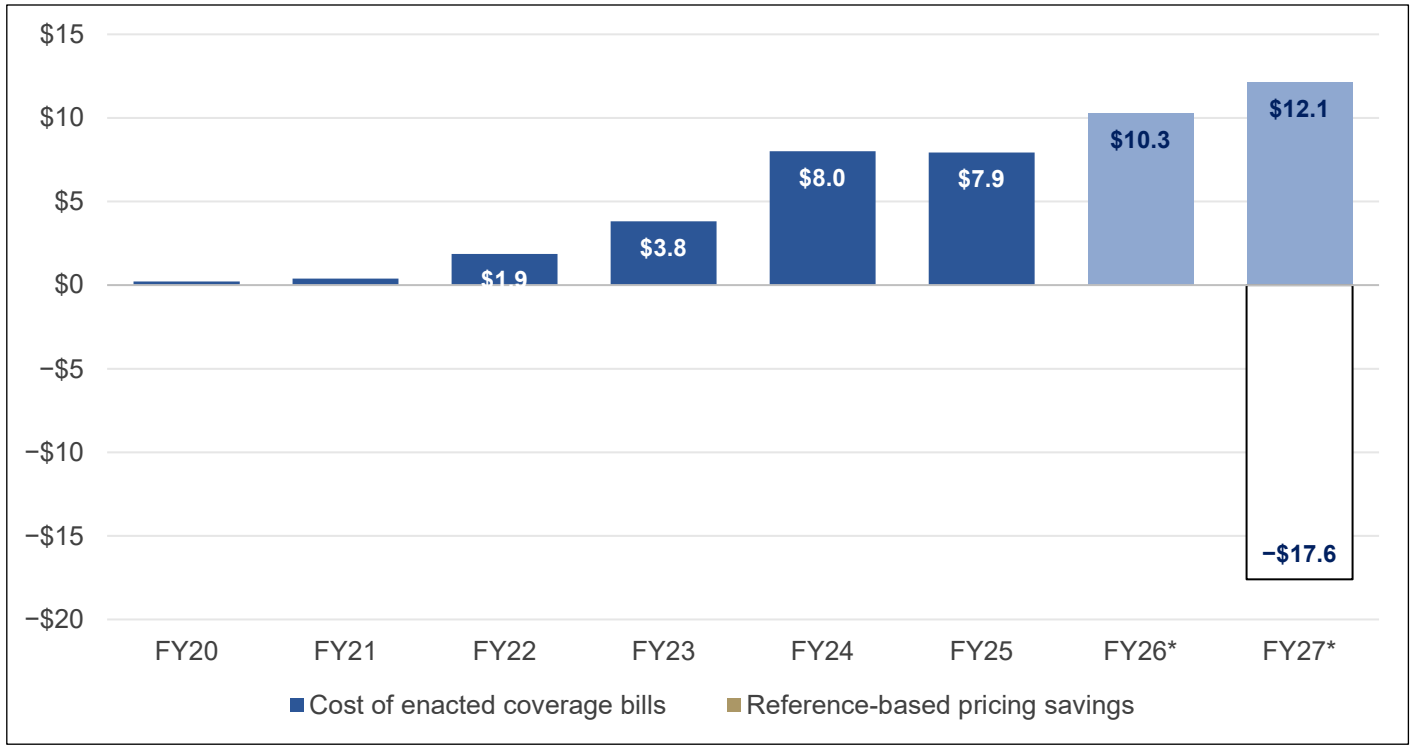
School employees $11.9
State employees $10.1
Retirees $7.1
Medicaid $6.2 ($1.1 general fund)

Largest: prescription and behavioral health cost sharing, $15 million together

Source: LFC fiscal impact reports, final version for each bill (agency estimates; range midpoints). Excludes Medicaid for HB38 and one-time costs. Bills estimated at no cost not shown.

For school employees, where actual costs are tracked, mandates reached about $8 million a year

NMPSIA cost of enacted coverage bills ($ millions)



$22.2 million

cumulative cost of bills from the 2019–2023 sessions, FY20–FY25

$10.3 million

projected FY26 cost, before reference pricing

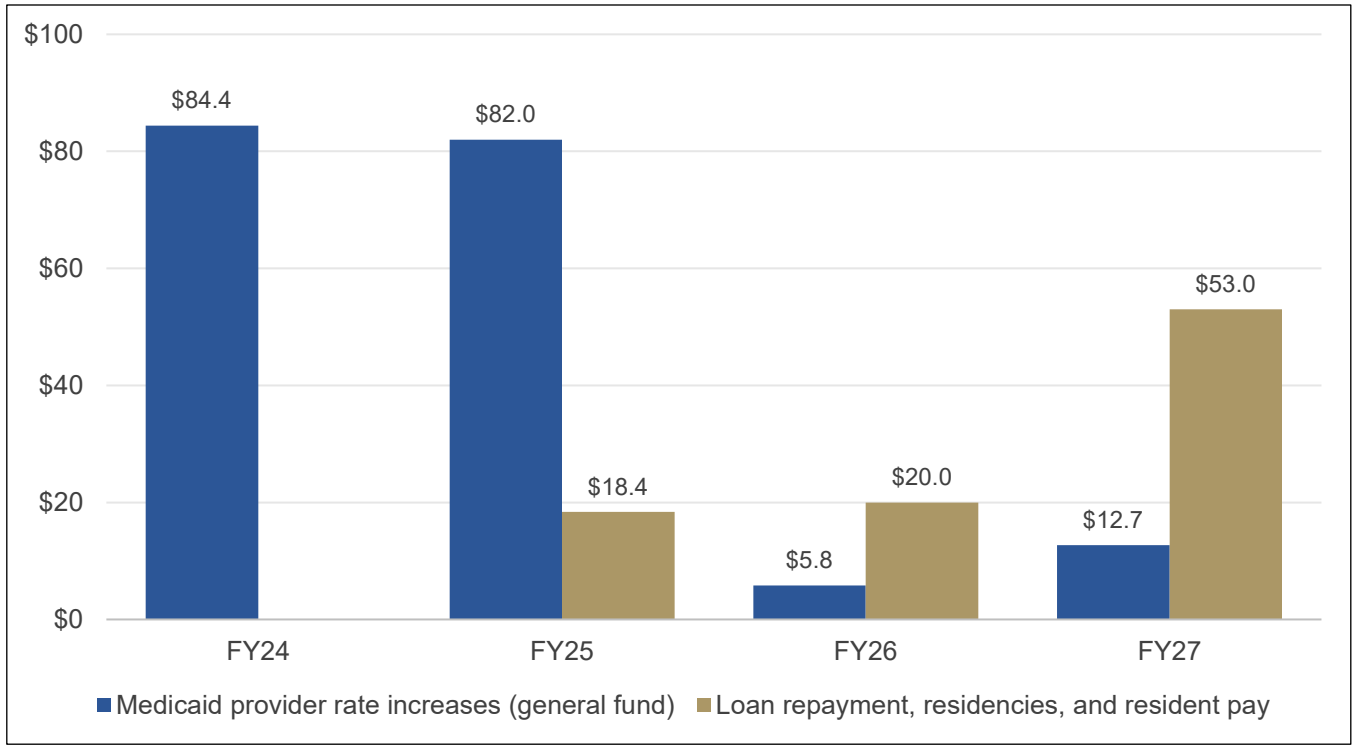
–$17.6 million

projected FY27 savings from hospital reference pricing (2025)

*Source: Segal, Cost of Legislative Bills, NMPSIA (FY20–FY25 actual; *FY26–FY27 projected). Covers bills from the 2019–2025 sessions; NMPSIA plans only.*

The state has invested in workforce through higher Medicaid rates and loan repayment

New workforce-related appropriations by GAA year ($ millions)



150% of Medicare

Medicaid primary care and maternal-child health rates since FY25

Next steps

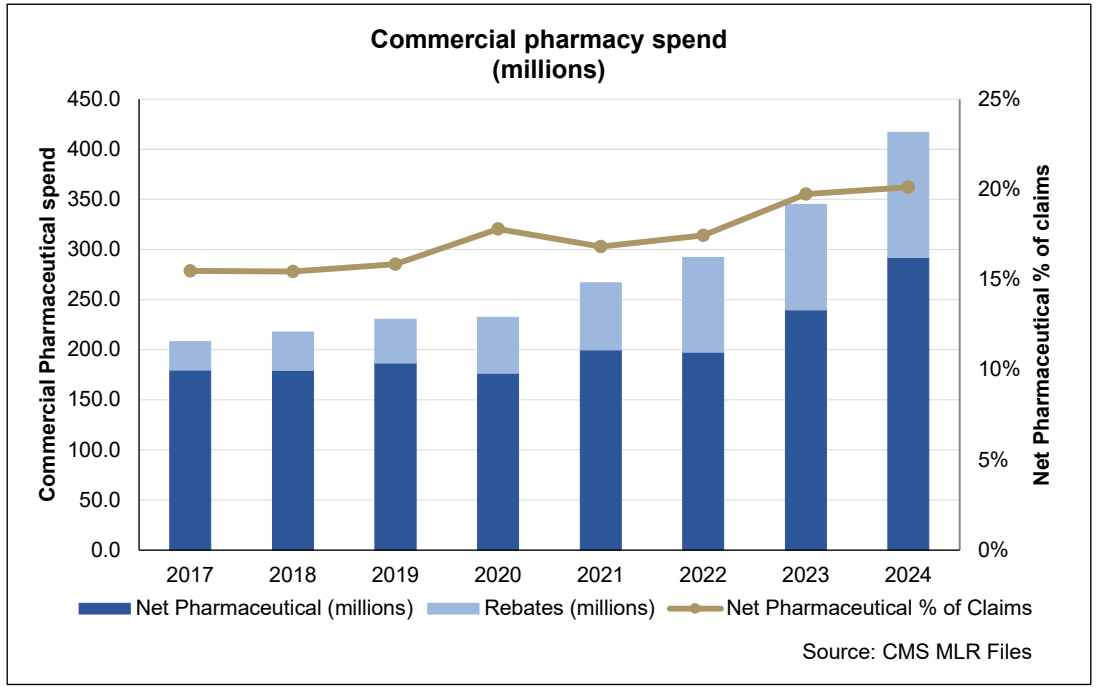
- Universal primary care, phase 1
- Implement interstate licensure compacts
- Target loan repayment to shortage specialties
- Measure access after the rate increases

Sources: General Appropriation Acts of 2023, 2024, 2025, and 2026; 2025 first special session. New items only; excludes recurring base funding.

Appendix: commercial pharmacy spending is accelerating

Commercial market, 2017–2024

Net pharmacy spending rose from 15% to 20% of claims while rebates grew more than fourfold.

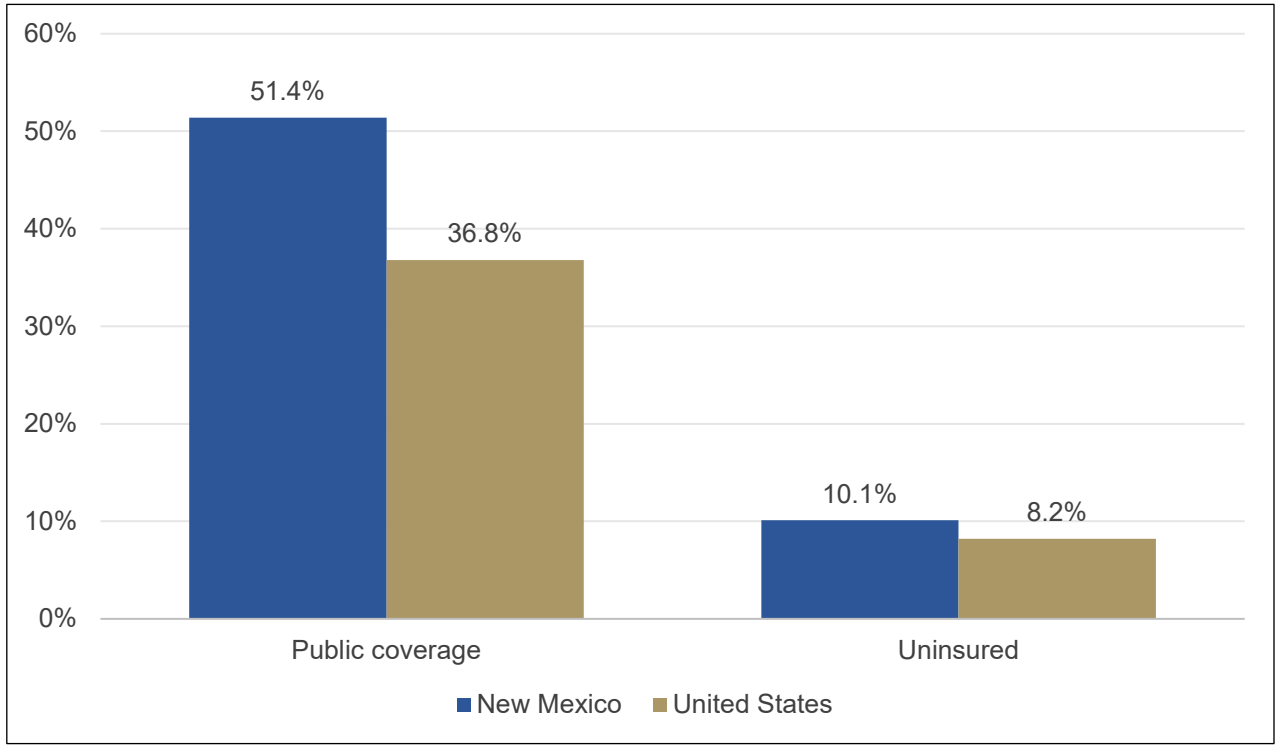


2×
gross Rx cost

+335%
rebates

More public coverage than any state; commercial payers are a small share of hospital revenue

Share of population, 2024



Sources: Census Bureau, 2024 American Community Survey 1-year; NORC (2023) from hospital cost reports.

51% vs. 37%

New Mexicans with public coverage, compared with the U.S.

About 14%

share of hospital revenue from commercial insurers (2019)

Cuts both ways: more purchasing leverage, and more federal dependence, than any other state

Connecticut moved Medicaid from managed care organizations to an administrative services model

Before 2012

Capitated, risk-based managed care organizations

After 2012

State pays providers directly; nonprofit administrator coordinates care

Why Connecticut changed

- Access barriers found in a 2006 secret-shopper survey
- MCO overpayments found in a 2009 audit
- Limited transparency and public accountability

Tradeoff: physician fees frozen since 2007; specialists paid about 57.5% of Medicare

+14.6% / +11.4%

primary care and specialist participation after the change

52% → 64%

children receiving recommended screenings (EPSDT)

No waiver

the transition used existing federal Medicaid authority

Source: Michael K. Gusmano, Connecticut's Medicaid Transition, interim report for the New Mexico Legislature (November 2025).

The behavioral health feasibility study groups its recommendations into four areas

1

Crisis and community teams

Expand assertive community treatment and crisis teams

2

Supportive housing

Grow permanent supportive housing

3

Care navigation

Streamline how people find and move between services

4

Tailored services

Children, substance use disorders, and brain injury

+$53 per member

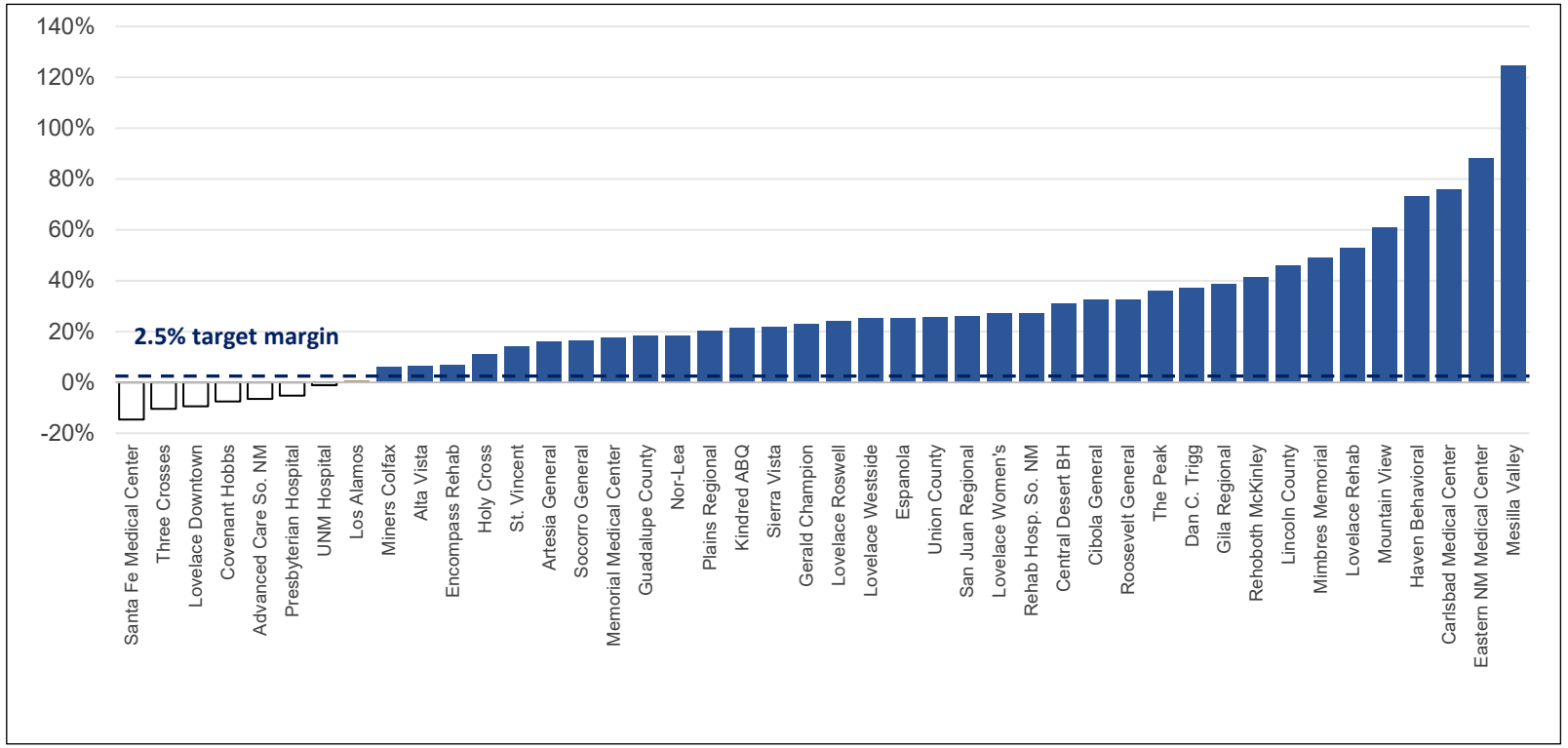
monthly, from behavioral health services, FY23–FY26

Behavioral health is the second-largest source of within-population Medicaid cost growth

Sources: Manatt Health, New Mexico behavioral health assessment and feasibility study; MCO financial reports, Reports 1 and 1A (FY23–FY26).

Later, if the foundation holds: targeted hospital global budgets

2025 hospital margins, 44 hospitals (net income ÷ operating expense)



Sources: LFC global budget brief (October 2026) from 2025 hospital cost reports; NORC (2023); CMS AHEAD model overview (fall 2025).

$200–300M

potential annual savings, concentrated in a few high-margin hospitals

8 of 44

hospitals below a 2.5% margin would need support

3 approvals

CMMI model, Medicaid 1115 waiver, managed care payment

Every path the Legislature might choose needs the same four foundations

Improved status quo

All-payer price regulation

Single payer

Possible end states (a policy choice)

Consolidated purchasing
One buyer for state-funded plans

Price and claims data
APCD and encounter data in use

Rate-setting capacity
Staff and authority to review prices

An accountable entity
Clear owner for cost growth

Foundations: required under every path, and useful on their own

Source: LFC synthesis of commissioned studies.