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Evaluating Medicaid Buy-In Options for New Mexico

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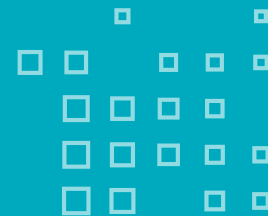


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Executive Summary

New Mexico is considering a Medicaid buy-in solution in the context of rising costs for health coverage, uncertainty regarding stability of the individual market and the state's persistently high uninsurance rate of more than 9%. Against this backdrop, New Mexico is contemplating new ways to leverage its Medicaid program—the largest payer in the state, covering more than 40% of the state population—to increase affordability, expand coverage and improve access to care. Specifically, the state is exploring a state-sponsored coverage option that uses the Medicaid program in some way—via its “purchasing power” as the state's largest payer, its well-established Medicaid managed care plans, its Medicaid provider network and provider reimbursement rates—to offer a more accessible and affordable statewide coverage option.

During the 2018 legislative session, New Mexico's legislature passed Senate Memorial 3 and House Memorial 9 tasking the Legislative Health and Human Services Committee with **“exploring the policy and fiscal implications of offering a Medicaid buy-in coverage option to New Mexico residents...”** In accordance with that directive, Health Action New Mexico and the New Mexico Center on Law and Poverty, with support from the Laura and John Arnold Foundation, engaged Manatt Health to conduct a study of Medicaid buy-in. The study involves two phases designed to inform state decision makers with regard to pursuing a Medicaid buy-in: a Phase 1 paper that provides a qualitative assessment of several Medicaid buy-in options for New Mexico, and a Phase 2 actuarial assessment of a subset of these options. This report is the culmination and product of Phase 1.

During Phase 1, a diverse group of New Mexico stakeholders (listed in the Appendix) provided feedback regarding the goals and objectives for a New Mexico Medicaid buy-in. There was remarkable consistency in stakeholder points of view related to three core goals:

- Increasing health insurance coverage and reducing the uninsured rate
- Increasing affordability of coverage and care, while supporting adequate provider reimbursement rates
- Simplifying healthcare coverage for beneficiaries and families

With these goals in mind, Manatt, together with Health Action New Mexico, New Mexico Center on Law and Poverty, Partnership for Community Action, and Strong Families New Mexico, crafted four potential buy-in options for assessment and discussion with stakeholders. These proposals vary in their complexity, required federal authority and risks, as well as their “reach” in covering uninsured New Mexicans. Notably, these options are not mutually exclusive and could be implemented separately, sequentially or in combination with one another. Based on Manatt's assessment, all of these models would help New Mexico make headway in its quest to expand coverage, improve affordability and increase access to care.

There are several key considerations with which New Mexico must grapple in order to design and implement one or more of these models. These include:

- **Reimbursement Rates.** All of the options assume that the buy-in will be lower cost than existing individual market coverage, in large part due to anticipated reduced medical costs. This

Overview of Buy-In Options for New Mexico

Option One	Option Two	Option Three	Option Four
Targeted Medicaid Buy-In	Qualified Health Plan (QHP) Public Option	Basic Health Program (BHP)	Medicaid Buy-In for All
State offers Medicaid-like coverage off the Marketplace to those not eligible for Medicaid, Medicare or subsidized Marketplace coverage. New Mexico could subsidize coverage for those who need financial assistance.	State offers lower cost product on the Marketplace to individuals and small employers; would be offered as a QHP, likely in partnership with an existing insurer. New Mexico could capture potential savings under a waiver to further increase affordability.	State offers BHP for individuals with incomes up to 200% of the federal poverty level who are not Medicaid-eligible (including people who would be Medicaid eligible but for their immigration status). Over time, New Mexico could expand BHP through buy-in.	State offers Medicaid-like coverage to everyone (except individuals covered by Medicare); would be offered as a lower-cost option off the Marketplace. Subsidy-eligible individuals could apply their subsidies to the cost of coverage.
Off Marketplace	On Marketplace	Off Marketplace, Outside of Individual Market	
No Federal Approval Needed	QHP Certification (and 1332 Waiver to Capture Savings)	1331 Authority (and 1332 Waiver for Buy-in)	1332 Waiver
Low Potential Enrollment	Moderate Potential Enrollment	Moderate Potential Enrollment	High Potential Enrollment
Low/Medium State Financial Responsibility	Low/Medium State Financial Responsibility	Low/Medium State Financial Responsibility	High State Financial Responsibility

assumption is based in part on the notion that the state (or its health plan contractor) will negotiate lower provider reimbursement levels under the buy-in program than in commercial coverage. Providers in New Mexico have concerns regarding the level of buy-in reimbursement and the extent to which a buy-in has the potential to

cause people with commercial coverage today (for whom providers receive commercial rates) to switch to lower-cost buy-in coverage (under which providers may receive lower rates). Balancing the desire for a more affordable coverage option that attracts currently uninsured New Mexicans against ensuring adequate

provider reimbursement is a central design consideration for all buy-in options being considered.

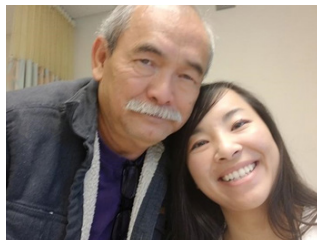
- **Market Stability.** The buy-in could have positive, negative or neutral impacts on the current individual and employer markets. Stakeholders, particularly insurers, have concerns about the effect of certain buy-in options (i.e., the Basic Health Program and Medicaid Buy-In for All) in segmenting the current market. To the extent that the population that moves out of the current markets is healthier, these concerns increase. Further analysis is needed to model the potential market impacts of these options.
- **Data Limitations.** As part of Phase 1, and in

preparation for Phase 2, Manatt has reviewed current data available to New Mexico to analyze the effects of a buy-in program. Today, there is insufficient data to fully assess these models; this is particularly the case for the Basic Health Program and Medicaid Buy-In for All options. Manatt and its partners recommend that New Mexico collect necessary data through a data request of insurers by the Office of the Superintendent of Insurance, to help inform the state's decision making and the design and implementation of a potential buy-in program.

As a next step in advancing a potential buy-in coverage option in New Mexico, and taking into account the Phase 1 assessment and key

Access and Affordability Issues in New Mexico

"While in college, I had a persistent cough. I eventually discovered that 90% of my lungs were covered in tumors. I had Stage 4 Hodgkin's lymphoma... Even with employer-based health insurance, my overall out-of-pocket expenses that year alone amounted to \$17,000... As we searched for a bone-marrow donor for me, my father was diagnosed with Stage 2 Non-Hodgkin's lymphoma. He had just retired [and transitioned from employer insurance to individual market insurance], and the cost went from \$34 a month to a staggering \$900 a month. Not only were we dealing with the news of my battle and my father's battle, but we were also again facing financial ruin to save our lives. I had to consider mortgaging my home to save my father."



—Lan,
Albuquerque

People with Chronic Conditions

Despite gains under the Affordable Care Act, many people with chronic conditions continue to face high healthcare costs. Employer insurance and individual insurance still has high deductibles and other out-of-pocket costs.

Lan's family has a history of cancer and has experienced financial devastation trying to afford the cost of care. Lan was recently denied coverage for a clinical trial, which would cost \$600,000 to \$1 million out-of-pocket.



considerations, the Manatt team recommends proceeding with Phase 2 modeling of the Targeted Medicaid Buy-In option and the potential to pair it with or transition to one of the other options. The qualitative assessment discussed in this paper, paired with a robust quantitative analysis, will illuminate the possibilities for New Mexico to adopt a coverage strategy that either begins with a targeted approach to buy-in or pairs two buy-

in options together to advance the state's goals. Additionally, the Phase 2 analysis will provide a foundation for understanding the potential implications and savings of a buy-in program, on which the state can build as it collects additional data to model the QHP Public Option or the more expansive options, including the Basic Health Program and the Medicaid Buy-In for All options.

Introduction

In 2018, the New Mexico House and Senate passed memorials commissioning a study on the implications of offering a state-sponsored Medicaid buy-in to New Mexico residents to improve coverage affordability and enrollment.¹ The legislature was motivated to act by the state's

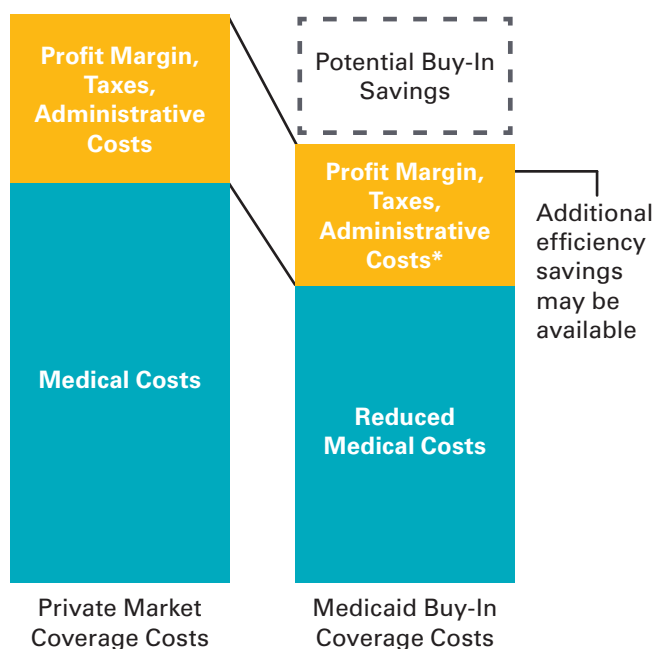
significant uninsured rate—particularly among individuals who earn less than 200% of the federal poverty level (around \$50,200 per year for a family of four)—and high levels of cost-sharing.

A Medicaid buy-in would allow individuals who are **not** eligible for Medicaid, such as individuals with income above Medicaid eligibility levels (138% of the federal poverty level for adults in New Mexico, or roughly \$34,600 for a family of four), to purchase a new healthcare coverage option. Individuals enrolled in buy-in coverage would pay premiums and cost-sharing, including copayments, but the buy-in would leverage the infrastructure of the Medicaid program, the state's largest payer. By leveraging Medicaid's purchasing power, provider networks and reimbursement rates, it is expected that the cost of the buy-in coverage would be less than the cost of private coverage. (See Figure 1.) Further, state sponsorship of such a program would enable tighter state oversight and greater coverage stability in the face of market changes that affect private insurers.

A Medicaid buy-in program in New Mexico could potentially address several policy goals:

- **Increasing health insurance coverage and reducing the uninsured rate.** A buy-in could

Figure 1. Achieving Lower-Cost Coverage Through State-Sponsored Buy-In



*Taxes will vary by state and profit margins will vary by the chosen buy-in design

Access and Affordability Issues in New Mexico

“Last year, I had pneumonia and it could have been prevented if I had access to healthcare. When I began to feel ill and tried to make an appointment, I was told I had to wait a year for the next available appointment. When it worsened, I went to the hospital.”

—Blanca, Albuquerque



Undocumented and Mixed Status Families

Many New Mexicans are unable to get the care they need because of their citizenship status. Undocumented immigrants aren't eligible to purchase Marketplace coverage, even at full cost. Health plans in New Mexico are not currently offering individual coverage to this population. Even if that coverage was available to purchase, it is often cost-prohibitive for low- and middle-income families.

Blanca, an undocumented parent, is uninsured along with her oldest child and husband, because they cannot afford the high cost of health insurance. Due to deferred treatment, Blanca's health worsened until she had no choice but to go to the hospital. The hospital asked for a referral from her primary care doctor, which she didn't have because of the lack of access. Eventually, the hospital treated her.



potentially expand coverage to the uninsured who are not eligible for Medicaid or federal subsidies due to their immigration status or the Affordable Care Act's "family glitch," as well as other residents who find current coverage options to be unaffordable.²

- **Increasing affordability of coverage and care, while supporting adequate provider reimbursement rates.** By taking advantage of administrative savings and state bargaining power, a buy-in can provide a lower-premium option for New Mexico residents. Depending on the program design, the buy-in could potentially

also offer lower deductibles and reduced cost-sharing. While the buy-in would be designed to lower consumer costs, the program design would need to balance this goal with the need for sustainable provider reimbursement rates.

- **Simplifying healthcare coverage for beneficiaries and families.** A buy-in could potentially improve continuity of coverage for populations moving between Medicaid and the individual market, and cover more family members under the same plan, with the same network providers, with more similar benefits and utilization management rules.

Health Action New Mexico and the New Mexico Center on Law and Poverty engaged Manatt Health to conduct the legislatively mandated study, made possible through the generous support of the Laura and John Arnold Foundation. The study includes two phases:

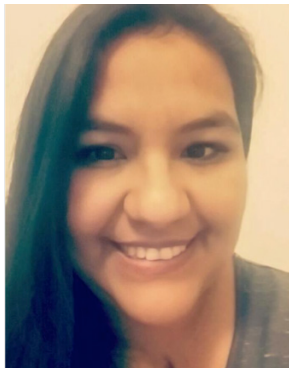
- **Phase 1: Qualitative Assessment of Medicaid Buy-In Options.** During this phase, Manatt—along with Health Action New Mexico, the New Mexico Center on Law and Poverty, Partnership for Community Action, and Strong Families New Mexico—assessed potential buy-in options for New Mexico, engaged with stakeholders to inform a consideration of the options and prepared a paper to summarize its qualitative evaluation of the options.
- **Phase 2: Quantitative Evaluation of Select Medicaid Buy-In Options.** Upon completion of Phase 1, Manatt, in collaboration with

its actuarial partner Wakely, will conduct a quantitative assessment of a subset of the buy-in options explored in Phase 1. This deeper-divide evaluation will determine the estimated impact and cost of a buy-in, with the goal of helping inform state decision making and future stakeholder engagement.

This paper, which represents the culmination of Phase 1, provides the context for and summary overview of the four buy-in options, a comparison of the options, and discussion of key considerations for New Mexico as it contemplates buy-in design and implementation. It concludes by recommending a deeper, quantitative evaluation of one option and the potential to combine it with or transition it to one of the other options. This evaluation will occur in Phase 2 of the study, which will conclude by the end of 2018.

Access and Affordability Issues in New Mexico

“When my husband was unemployed, we did not have health insurance. When he found a new job, he had to wait six months until he qualified for health insurance through his employer. Medicaid did not cover these six



months because our family income was just above the threshold for Medicaid. So, I had to decide whether to pay for healthcare insurance or gas for my car.”

—Reyna,
Albuquerque

Coverage Transitions Cause Families to Become Uninsured

Many families become uninsured when they lose employment or become newly employed. For lower and moderate income families, this can lead to financial instability or a lapse in access to care.

Reyna’s family had to go without health insurance because her family did not qualify for Medicaid and missed the deadline to sign up for Marketplace coverage.



Other Potential Solutions

Throughout the stakeholder engagement process, Manatt Health, Health Action New Mexico and the New Mexico Center on Law and Poverty heard about a broad set of challenges that exist in New Mexico's health system, many of which are beyond the scope of this study and may not be addressed by a buy-in solution. For example:

- Inadequate reimbursement levels in the current Medicaid program
- Poor access to care among Native American communities
- Persistent uninsurance among New Mexicans who are eligible for Medicaid

While a buy-in program is unlikely to address these issues, it could be an important tool to reform healthcare coverage and delivery and could be implemented as one of a series of initiatives to improve coverage affordability and access issues in New Mexico. Other potential initiatives could include (but not be limited to):

- Strengthening outreach efforts to enroll those currently eligible for Medicaid and subsidized Marketplace coverage;
- Further incentivizing the purchase of Marketplace coverage through state subsidies and/or a state individual mandate penalty;
- Implementation of Marketplace stability proposals; and
- Investment of state funds to leverage federal funding of insurance.

Access and Affordability Issues in New Mexico

"My youngest children don't meet the [Native American] blood quantum guidelines so they [don't qualify for Indian Health Services (IHS)]. They have care now, through Medicaid, and we are grateful for that. It is hard to watch their dad [who is uninsured] not go to doctor because we have to make sure our babies have the care they need. We often have to choose between healthcare for



our children and pampers or food. We have to make hard choices. My husband is putting his health at risk for the health of our family."

—Kena, Santa Cruz

Fragmented Coverage System

Many families must navigate a complicated healthcare system that makes it difficult to maintain coverage and care. Some individuals face a difficult transition moving from Medicaid to Marketplace coverage. Others see their family's coverage fragmented between multiple payers and providers.

For example, while Kena's kids are eligible for Medicaid, they aren't eligible for services at Indian Health Service clinics. That means they have to go to different providers to get care. Meanwhile, her husband is uninsured and can't access the services he needs to stay healthy.



Healthcare Coverage in New Mexico

Current Coverage Landscape

Of New Mexico's more than 2 million residents, nearly 190,000 were uninsured in 2017; this results in a state uninsurance rate of more than 9%.³ **See Figure 2.** Among New Mexicans with healthcare coverage, Medicaid is the largest insurer, covering approximately 830,000 people, or 40% of the state's population—a greater share than in any other state in the country.⁴ The state's health insurance Marketplace, BeWellNM, covers about 50,000 individuals, or 2% of the population.

New Mexico Marketplace Demographics

In 2018, New Mexico's 50,000 Marketplace enrollees are disproportionately low-income, with 45% (19,620) earning below 200% of the federal poverty level. Nearly all (94%) earn less than 400% of the federal poverty level.⁵ **See Figure 3.**

Figure 2. Uninsured by Federal Poverty Level in New Mexico, 2017

Uninsured by Federal Poverty Level (FPL)	
Below 138% FPL	71,654 (39%)
Between 138% and 399% FPL	90,759 (49%)
At or above 400% FPL	23,518 (13%)
Total	186,996 (100%)

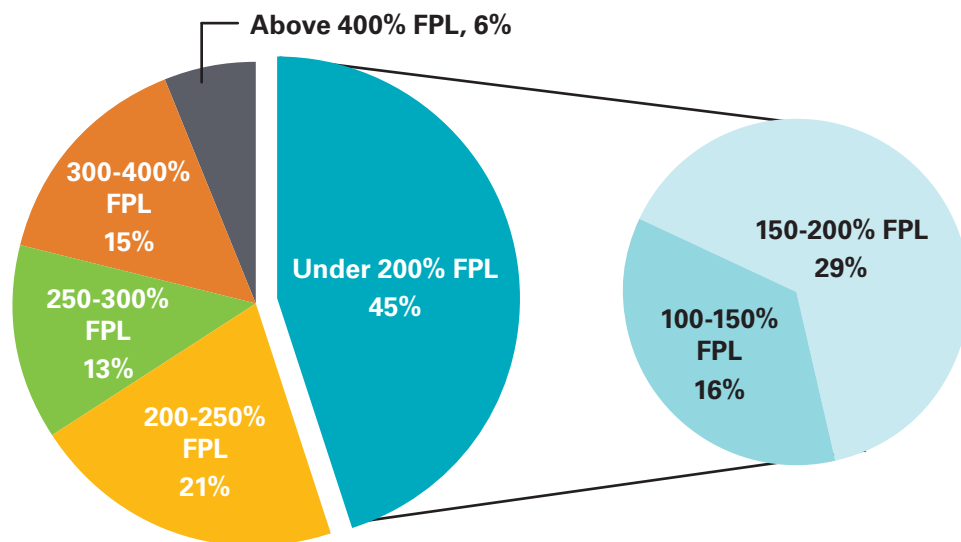
Source: U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates

New Mexico Marketplace Premium and Cost-Sharing Experience

More than three-quarters (39,000) of New Mexico Marketplace enrollees receive federal subsidies to purchase healthcare coverage on BeWellNM. These subsidies include premium tax credits that are available for individuals who qualify below 400% of the federal poverty level. For enrollees earning less than 200% of the federal poverty level, Marketplace qualified health plan (QHP) premiums in 2018 are capped between 2.04% and 6.34% of income and may be affordable for many: In 2018, the average premium on the New Mexico individual Marketplace was \$538 per month, but the average premium after taking into account the Advanced Premium Tax Credit (APTC) among consumers receiving a tax credit was \$88 per month. (The average value of the APTC among consumers receiving it was \$476 per month.)^{6,7} Nevertheless, many individuals who are eligible for subsidies remain uninsured due to affordability concerns or other reasons.

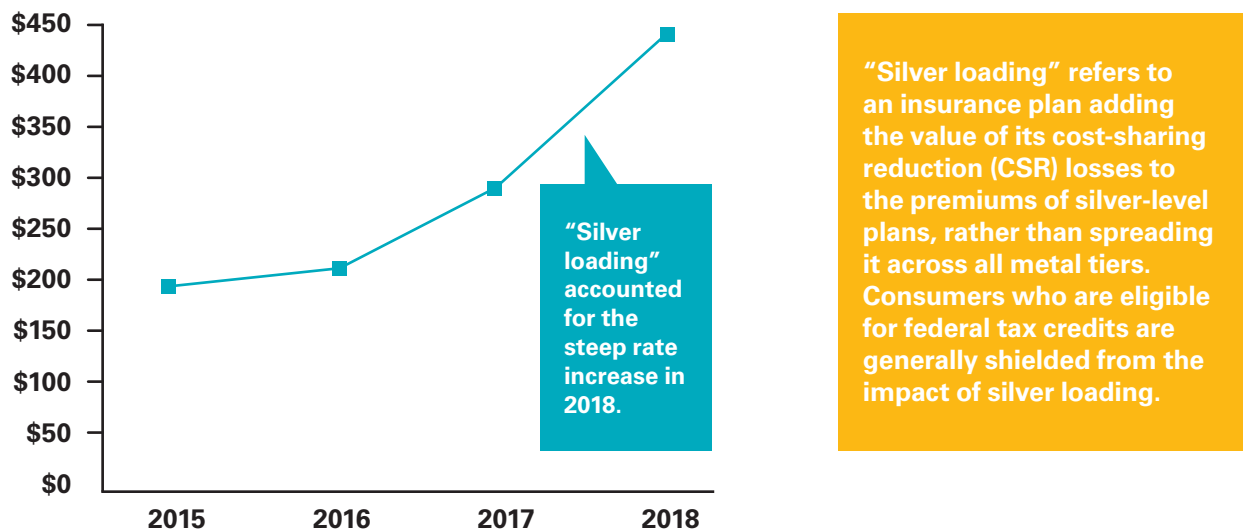
For individuals **ineligible** for subsidies, affordability remains a substantial barrier to accessing coverage. This is particularly true given that the premium for the second-lowest-cost silver plan in the New Mexico Marketplace, called the "benchmark plan," has risen substantially over time, particularly over the last year, increasing from \$198 per month in 2015 to \$414 in 2018.⁸ After four years of increases, the premium costs will decrease 1% on average in 2019.⁹ **See Figure 4.**

Figure 3. BeWellINM 2018 Marketplace Participation, by Income Level



Source: Stakeholder Advisory Committee Presentation, July 2018

Figure 4. Changes in Benchmark Plan Premium on the Marketplace (Before Federal Subsidies)



Source: Kaiser Family Foundation, Marketplace Average Benchmark Premiums (premiums were analyzed using the second-lowest cost silver (“benchmark”) premium for a 40-year-old in each county and weighted by county plan selections)

Cost-sharing affordability for New Mexico consumers is also an issue. Bronze-level plans offered on the New Mexico Marketplace have deductibles that are at least \$6,400 per year.¹⁰ For non-cost-sharing reduction (CSR) silver plans sold on the Marketplace, the median deductible

in New Mexico was \$2,850 in 2018.¹¹ While people with incomes under 250% of the federal poverty level have much of their cost-sharing paid for if they choose a silver plan, cost-sharing can be a substantial barrier to accessing care, even for higher-income individuals.

Access and Affordability Issues in New Mexico

"My sister has taken out two 401Ks to be able to cover her husband's treatment... He has 7 kidney stones. Her insurance covers 80%, but it still leaves her with expensive bills to pay



out of pocket. He is retired, and she works at least two jobs to be able to afford treatment. He needs to go to the doctor every week."

—Maria,
Sunland Park

Low and Middle-Income Families Struggle To Afford Private Insurance

The cost of private insurance puts financial stress on low- and moderate-income families. Even with relatively generous insurance, the cost of premiums and out-of-pocket costs can overwhelm family budgets.

Maria, who is a community health worker, has faced her own issues with affording healthcare. Her sister's family is currently struggling to afford private insurance, with one person working two jobs and the other facing chronic conditions that prevent him from working.



Buy-In Options for New Mexico

During Phase 1 of this study, Manatt evaluated four options for implementing Medicaid buy-in in New Mexico. **See Figure 5.** These options, which are described in greater length later in this section, are grounded in the Memorials and stated priorities

of buy-in supporters in New Mexico, to leverage Medicaid to drive more affordable, comprehensive coverage options, particularly for families with incomes under 200% of the federal poverty level.

Figure 5: Overview of Buy-In Options Evaluated

Option One	Option Two	Option Three	Option Four
Targeted Medicaid Buy-In	Qualified Health Plan (QHP) Public Option	Basic Health Program (BHP)	Medicaid Buy-In for All
State offers Medicaid-like coverage off the Marketplace to those not eligible for Medicaid, Medicare or subsidized Marketplace coverage. New Mexico could subsidize coverage for those who need financial assistance.	State offers lower cost product on the Marketplace to individuals and small employers; would be offered as a QHP, likely in partnership with an existing insurer. New Mexico could capture potential savings under a waiver to further increase affordability.	State offers BHP for individuals with incomes up to 200% of the federal poverty level who are not Medicaid-eligible (including people who would be Medicaid eligible but for their immigration status). Over time, New Mexico could expand BHP through buy-in.	State offers Medicaid-like coverage to everyone (except individuals covered by Medicare); would be offered as a lower-cost option off the Marketplace. Subsidy-eligible individuals could apply their subsidies to the cost of coverage.
Off Marketplace	On Marketplace	Off Marketplace, Outside of Individual Market	
No Federal Approval Needed	QHP Certification (and 1332 Waiver to Capture Savings)	1331 Authority (and 1332 Waiver for Buy-in)	1332 Waiver
Low Potential Enrollment	Moderate Potential Enrollment	Moderate Potential Enrollment	High Potential Enrollment
Low/Medium State Financial Responsibility	Low/Medium State Financial Responsibility	Low/Medium State Financial Responsibility	High State Financial Responsibility

Evaluation Framework

To assess each of these options, Manatt considered the following design parameters.

- **Eligibility:** To whom would the option be available?
- **Benefit package:** Would the coverage mirror the Medicaid benefit package (which includes vision, transportation and dental services) or the Marketplace Essential Health Benefit benefit package?
- **Offeror of coverage:** Would the state provide the coverage (e.g., through fee-for-service Medicaid)? If not, what type of health plan would provide coverage?
- **Risk pool:** Which risk pool would the option utilize (individual, employer and/or another pool)?
- **Impact on individual market:** What impact would the option have on the current individual Marketplace?
- **Impact on employer coverage:** What impact would the option have on employer-sponsored coverage?
- **Federal authority needed:** Is federal authority needed to implement the option? If so, what authority?
- **Source(s) of funding:** How would the option be funded (e.g., through state dollars, federal dollars, consumer dollars, other funding sources)?
- **Risk to the state:** What is the level of potential administrative and financial risk for the state to pursue the option?
- **Potential variations:** Are there potential variations of the option?

Stakeholder Perspectives

Each of the Medicaid buy-in options under consideration will affect New Mexico residents, businesses, healthcare providers, health plans and the state in different ways. Over the past several months, Manatt Health, Health Action New Mexico, the New Mexico Center on Law and Poverty, Partnership for Community Action, and Strong Families New Mexico have engaged dozens of stakeholders to better understand their perspectives. (See the Appendix for a list of stakeholders who provided input on this study.) At a high level, each of these groups has its own set of priorities and concerns relating to buy-in:

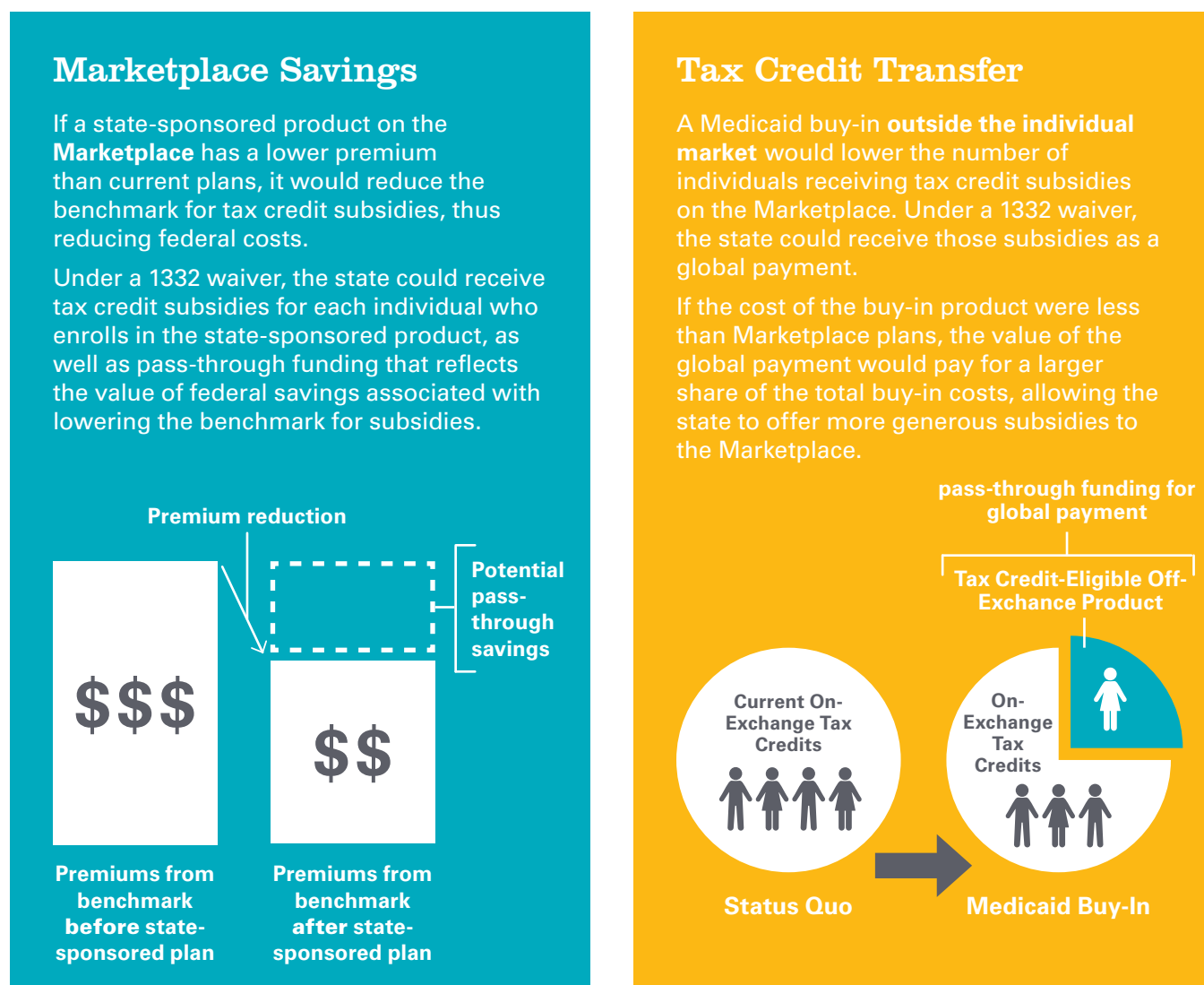
- **Individuals and families:** Support more affordable coverage and care (e.g., through reductions in premiums and cost-sharing) and more consumer-friendly, simplified healthcare processes and systems.
- **Employers:** Seek availability of lower-cost coverage options that qualify for employer tax benefits; support a greater number of coverage option choices; prefer less regulation of their coverage options and requirements.
- **Providers:** Support expanding coverage to populations who are currently uninsured; concerned about Medicaid-level reimbursement in the buy-in, especially reduction in reimbursement for current commercially insured individuals relative to current reimbursement (e.g., shift from commercial rates to Medicaid rates).
- **Insurers:** Support new opportunities to provide coverage (either through a new program or increased enrollment in current programs); concerned about potential destabilization of current markets and initiatives that result in premium reductions.

- **State:** Supports extending coverage to populations who are currently uninsured or lack access to care due to costs; supports making use of federal funding opportunities to increase affordability and expand coverage; concerned about level of state resources needed (e.g., for program administration or state-funded subsidies) and the potential financial obligation for New Mexico.

Deficit Neutrality

In order to obtain a 1332 waiver, a state must demonstrate “deficit neutrality,” which means that the waiver will not increase the federal deficit.¹² As part of its deficit neutrality evaluation, the federal government will weigh the federal savings from reductions in tax credits against any increase in federal spending (e.g., due to higher Marketplace

Figure 6. Potential Pass-Through Funding Mechanisms



utilization and/or enrollment) or any decrease in federal revenues (e.g., lower user fees paid to the federally facilitated Marketplace) that would result from a 1332 waiver, compared with the “without waiver” status quo. If a state’s 1332 proposal reduced federal premium tax credit spending, the state could receive “pass-through” funding in the amount of the savings to the federal government. **See Figure 6.**

The level of pass-through funding that New Mexico might receive to support a buy-in program will vary considerably under the options considered in this paper—as will the risks to the state—and it is important to note that this waiver process could be challenging. Another important consideration is that waivers that increase the overall number of people receiving premium tax credits (relative to current state) may result in lower federal pass-through funding.

Description of Buy-In Options

Below are four models for Medicaid buy-in options. These options are not mutually exclusive and could be phased in over time or implemented in stages.

Option 1: Targeted Medicaid Buy-In

Under this option, New Mexico would make lower-cost coverage available to individuals who are currently ineligible for subsidized coverage. The state could use state dollars to subsidize buy-in coverage for lower-income individuals.

Overview: Individuals eligible to purchase Targeted Medicaid Buy-In coverage would include New Mexicans who lack access to other subsidized coverage, including those ineligible for Medicaid, Medicare and Marketplace subsidies (e.g., individuals who do not qualify because of immigration status, individuals in the family

glitch and individuals with incomes above 400% of the federal poverty level). The benefit package would mirror New Mexico’s current Medicaid benefit package with certain exclusions (such as long-term care services and Early and Periodic Screening, Diagnostic and Treatment, or EPSDT, services for 19- and 20-year-olds). This option would require individuals to pay the full cost of the premium and cost-sharing associated with coverage; however, New Mexico could appropriate state funds to offset some of the cost of coverage by establishing sliding scale premium and cost-sharing assistance based on income. This option could leverage the existing Medicaid managed care delivery system and health plans. Coverage could be offered in the individual market risk pool (in which case it would need to meet all applicable rating and benefit requirements) or outside of the individual market risk pool, but in either case it would be offered **off** the BeWellNM Marketplace.

Estimated Impacts: Because this coverage primarily targets currently uninsured populations and potentially individual market participants looking for more-affordable unsubsidized options, it should have a relatively limited impact on current Marketplace coverage. If the Targeted Medicaid Buy-In were to attract healthy people who are currently not covered and were offered in the individual market, it could, in fact, improve the stability of the market overall by strengthening the individual market risk pool.

No federal authority would be required to implement this targeted buy-in. State funding to help subsidize coverage for lower-income individuals and families could be provided at New Mexico’s option. The state’s risk under this proposal primarily lies in securing and ensuring sufficient funding for consumer subsidies and appropriately pricing the product to reflect the population it attracts.

Option 2: Qualified Health Plan (QHP) Public Option

Under this option, New Mexico would make a lower-cost “public option” available to individuals and small employers on the Marketplace.

Overview: Those eligible to purchase the QHP Public Option would include individuals and employers who are currently able to purchase coverage on the Marketplace (i.e., using Affordable Care Act rules). Because this buy-in option is on the BeWellNM Marketplace, the benefit package would align with the Essential Health Benefit package provided through QHPs today. Individuals and families covered under this buy-in option would be in the individual market risk pool, and small employers covered would be in the small group risk pool. If the state were to choose to expand this option, it could be made available outside of BeWellNM for individuals who are not eligible to purchase coverage on the Marketplace (e.g., undocumented residents).

Offering such a “public option” in the Marketplace would provide a lower-premium option for New Mexicans who currently lack access to federal subsidies (e.g., individuals who do not qualify because of immigration status, individuals in the family glitch and individuals with incomes above 400% of the federal poverty level). For individuals who currently receive tax credits, however, this option would not immediately lower costs; given that the cost of the benchmark plan would go down under this option, it is the federal government that would incur short-term savings in the form of lower tax credit subsidies. These savings would also accrue to consumers who do not receive subsidies. To make use of all possible federal funding opportunities, New Mexico could seek a 1332 waiver to capture the federal savings generated by the public option and apply them to improve affordability for consumers by providing

premium assistance, lowering cost-sharing or some other subsidy mechanism.

Estimated Impacts: The impacts of this option will depend on its design and how much lower in cost the buy-in option is relative to current coverage options on BeWellNM. This buy-in option could have a positive impact on the market through increased competition; alternatively, it could decrease competition if private insurers struggle to compete with lower-cost options and exit the market. Accurate pricing by the state of the public option would be critical, although notably, the QHP Public Option would participate in risk adjustment because it is part of the individual risk pool.¹³ New Mexico would also need to meet 1332 waiver and deficit neutrality requirements, which can be a lengthy and labor-intensive process; it is also unclear how amenable the current administration would be to approving such a waiver.

Option 3: Basic Health Program

The state would create a new Basic Health Program (BHP) for lower-income populations who are eligible for Marketplace coverage.

Overview: New Mexico could implement a BHP, a state option under the Affordable Care Act that gives states the option to create a coverage program for low-income residents who would otherwise be eligible to purchase coverage through the Marketplace. States implementing this option receive federal funding equal to 95% of the amount of the federal subsidies that would have otherwise been provided to (or on behalf of) eligible individuals, if these individuals had enrolled in QHPs through the Marketplace.¹⁴

BHP-eligible individuals include individuals with incomes between 138% and 200% of the federal poverty level (just above Medicaid eligibility levels) and certain individuals who would be eligible for Medicaid based on their income but cannot enroll due to their immigration status.

Under this option, eligible individuals would have to enroll in BHP in order to access coverage (i.e., there would not be the option for them to purchase QHP coverage). Under BHP authority, the state has flexibility to design the BHP to align with Medicaid or QHP coverage (though per federal statute, the BHP has to cover at least the Essential Health Benefit that enrollees would have received had they enrolled in a Marketplace QHP). Benefits could look more like the Medicaid benefit package or the Essential Health Benefit package. The state would need to establish premiums and cost-sharing levels consistent with parameters established in statute: The enrollee's premium obligation cannot exceed what it would have been had they purchased the silver benchmark plan in the Marketplace, and their cost-sharing must be at least as generous as the equivalent platinum plan for individuals earning below 150% of the federal poverty level and the equivalent gold plan for individuals earning between 150% and 200% of the federal poverty level.¹⁵ As in other options, coverage could be provided through health plans, either Medicaid managed care plans or QHP offerors. Importantly, BHP coverage would be in a new risk pool, separate from the individual market.

Estimated Impacts: Given that 45% (19,620) of current Marketplace enrollees have incomes below 200% of the federal poverty level, implementing this option would shift a sizable segment of Marketplace enrollment into a new risk pool. This shift would likely make the individual market less attractive to plans, both because it would shrink the size of the pool and, if the population moving away from the Marketplace is healthier, worsen the risk pool. Alternatively, if the BHP-eligible population were less healthy and thus higher-cost, this shift could have a positive impact on the individual Marketplace risk pool. Depending on how the state chose to design the program, BHP-eligible individuals would likely benefit from

more-affordable coverage and, if aligned with Medicaid, greater continuity of coverage and care, given the potential for churn into/out of Medicaid and the BHP.

Funding for the BHP (under 1331 authority) is on a per-person basis, which means that the state would not be at financial risk if enrollment in the BHP increases. However, individuals have benefited from "silver loading" (see Figure 4), and moving to BHP would erode this benefit for New Mexicans remaining in the Marketplace over time as the bulk of the subsidized population is transitioned to a separate risk pool.¹⁶ The effect of the smaller Marketplace risk pool, potential for healthier, lower-risk individuals moving to the BHP, and erosion of silver-loading benefits over time would likely result in increased premiums in the Marketplace for individuals with incomes over 200% of the federal poverty level who remain in the Marketplace.

Potential Variation: Once New Mexico has established a BHP, it could seek federal approval to extend BHP coverage to a broader population of residents—such as individuals above 200% of the federal poverty level—through a BHP buy-in option. This approach would require the state to pursue and obtain a 1332 waiver from the federal government to allow tax credit subsidies to be used for BHP coverage. A BHP buy-in would likely have a much more significant impact on the individual market as well. If BHP buy-in coverage is less expensive than Marketplace coverage and open to anyone, a large enrollment shift would be probable and could deteriorate the individual Marketplace.

Option 4: Medicaid Buy-In for All

Under this option, New Mexico would allow anyone to purchase lower-cost, Medicaid-like coverage; individuals currently receiving subsidies on the Marketplace could apply subsidies to the cost of buy-in coverage.

Overview: Of the four options, this option has the broadest eligibility and would be available to any individual who is not currently eligible for Medicaid or Medicare. Employers would also be able to choose to offer this option to their employees. The option's benefit package could mirror Medicaid, and the state could leverage its existing Medicaid delivery system, made up primarily of managed care plans, to deliver coverage. The state would need to establish premiums and cost-sharing for the product. Similar to the BHP option, this option would create a new risk pool, separate from the individual market and Medicaid. In order to allow individuals to use their federal tax subsidies to purchase this option, the state would need to obtain a 1332 waiver from the federal government.

Estimated Impacts: This option's impacts are potentially significant, though they depend on its design. Given its broad eligibility and potentially comprehensive benefit package, this option could shift enrollment and healthier individuals out of the individual and small group markets. Depending on the size and risk profile of the enrollment shift, both markets may be destabilized. Additionally, the state faces the most risk with this option because its effects are uncertain. For example, it may be difficult to predict consumer interest in this option; the population choosing this option could be healthier than expected (and increase premiums for Marketplace) or sicker than expected (and increase costs for the state). Further, Marketplace premium increases could impact the state's ability to obtain a 1332 waiver.

Comparison of Buy-In Options

The table below presents "pros" and "cons" of each option, along with high-level key takeaways that illustrate comparative features of each.

As noted previously, each of these options could be implemented in combination with another option(s) and phased in over time. For example, the Targeted Medicaid Buy-In (Option 1) could be a precursor to the QHP Public Option (Option 2), or it could be implemented concurrently with the QHP Public Option or the BHP (Option 3). Alternately, the QHP Public Option could be an initial step toward implementation of the Medicaid Buy-In for

All (Option 4). If the state were to pursue multiple options (either in combination or over time), some design changes may be needed to streamline implementation (e.g., if New Mexico decided to implement the Targeted Buy-In, then transition to a QHP Public Option, it should consider aligning the benefit packages and product characteristics from the start.) The table below considers each option on its own; a decision to pursue more than one option may have slightly different impacts than merely combining the pros and cons included for each.

Comparison of Four Buy-In Options

Option	Pros	Cons
Option 1: Targeted Medicaid Buy-In	Key Takeaway: Offers a lower-cost option to individuals who currently are ineligible for Medicaid, Medicare and federal tax subsidies offered on the Marketplace; would likely require New Mexico to subsidize coverage in order for lower-income families to be able to afford it.	
	<ul style="list-style-type: none"> • Of all of the options, likely the least disruptive to the Marketplace. Because this option would be targeted to people to who do not have access to tax credits, Marketplace enrollment and risk pools would be minimally impacted by this option. • Easiest to implement; could be a first step toward implementing other options. This option would not require federal approval unless New Mexico wanted to expand coverage to certain populations, e.g., five-year bar immigrants, and capture federal funding to apply toward tax credits. • Would reduce the number of uninsured, albeit marginally. This option could benefit providers that serve the currently uninsured. 	<ul style="list-style-type: none"> • Would extend coverage to fewer people than the other options. Because this option is targeted to a limited number of individuals, it has less impact on the uninsurance rate. • Would need to be funded by individuals or New Mexico. There would be no federal funding available for this option; New Mexico may need to devote state funds to this coverage in order to attract lower-income individuals.
Option 2: QHP Public Option	Key Takeaway: Effective at providing lower-premium cost option to those who don't receive subsidies; would require 1332 waiver to capture federal funding, which would not be easy under the current federal administration.	
	<ul style="list-style-type: none"> • Minimally disruptive to the Marketplace. The public option would be one QHP option among several offered on the Marketplace and would likely lead to more competition on the Marketplace. It would also have relatively little impact on people who purchase other coverage on the Marketplace. 	<ul style="list-style-type: none"> • 1332 waiver authority required for the state to capture savings; deficit neutrality calculation may be tricky and federal approval uncertain. Preparation of such a waiver can be labor-intensive and federal approval is uncertain. Depending on 1332 deficit neutrality calculations, the level of federal "pass-through" savings could be lower than anticipated.

Option 2: QHP Public Option (continued)	<ul style="list-style-type: none"> • Available to a broad range of people. The option would be offered to everyone on and off the Marketplace—no matter the income level or whether one receives subsidies. • Flexible spending of any potential savings. The state could choose to apply any savings captured through a 1332 waiver for this option toward additional subsidies for coverage/care broadly or for targeted populations (e.g., a specific income level). 	<ul style="list-style-type: none"> • Potential for reduced competition. If the public option achieves much lower premiums and has higher-than-expected enrollment, it could make Marketplace participation less attractive to other insurers and reduce competition.
Option 3: Basic Health Program	<p>Key Takeaway: Likely the most effective at helping individuals and families with incomes between 138% and 200% of the federal poverty level, but could disrupt the coverage of those with higher incomes.</p> <ul style="list-style-type: none"> • Straightforward access to federal funding. With BHP authority (Section 1331) set in law, implementation of the BHP alone would require submission of a Blueprint to CMS, not a waiver. • Greater flexibility in design. Under a BHP, New Mexico could have more leeway to structure benefits and cost-sharing. The other states implementing the BHP (New York and Minnesota) have been able to offer more affordable coverage to BHP-eligible populations, compared with QHP coverage. • Could produce more savings for the state and be more attractive to the currently uninsured. Because the BHP would be mandatory for those under 200% of the federal poverty level, more tax-credit-eligible people might be affected and the state might realize more savings that can be used to ensure more affordable benefit designs. It would also be more likely to attract currently uninsured people into coverage (assuming it is more affordable) and do so with less risk to the state because BHP funding is enrollment-based. 	<ul style="list-style-type: none"> • Potentially negative impact on the Marketplace, particularly with the BHP-buy-in variation. Implementation of the BHP (which would be the only coverage option available to BHP-eligible individuals) would result in close to half of the current Marketplace population moving out of the Marketplace risk pool and into a separate BHP risk pool. This may result in higher premiums for people purchasing coverage on the Marketplace who are ineligible for the BHP. A BHP buy-in—which would require a 1332 waiver (in addition to 1331)—would likely move an even more significant number of enrollees from the Marketplace into the BHP, weakening Marketplace enrollment and its risk pool. • Stakeholder resistance. There could be opposition to the BHP among stakeholders due to concerns about harming the state’s Marketplace. Such opposition would make the BHP harder to implement. • BHP funding formula uncertainty. While 1331 authority is more streamlined, CMS has yet to release the 2019 BHP payment notice, leading to some uncertainty regarding BHP funding.

Option 4: Medicaid Buy-In for All	<p>Key Takeaway: Has potential to improve affordability for the greatest number of people; however, uncertainty relating to enrollment could mean greater financial risk to the state and disruption to existing individual and employer markets.</p> <ul style="list-style-type: none"> More flexibility for New Mexico to improve cost-sharing and premiums. Under this option, buy-in coverage does not need to meet Marketplace requirements, so New Mexico can vary the premiums and cost-sharing more easily. Might attract more families that are currently uninsured or employers not offering insurance to purchase coverage. Because the buy-in benefit could potentially be more generous, it could attract more people who are currently uninsured into coverage, relative to the other options. Financial risk to the state through 1332 deficit neutrality. Under this option, people with tax credits would be moving into a new risk pool, which means that New Mexico would get the full amount of tax credit funding for those individuals. However, if enrollment estimates were much higher than anticipated, and if the population were sicker than expected, the funding from the federal government might be insufficient and the state would need to cover the shortfall. Poses the greatest uncertainty on the impact to the individual and small group market. If this option were to attract individuals or employers currently enrolled in Marketplace coverage who are healthier than those who remain, premiums in the other markets could rise. Likewise, the opposite could be true—less healthy people or people of similar health risk could enroll in buy-in coverage, leading to other markets benefiting. The effect is uncertain, particularly if enrollment in the buy-in would be open to everyone. Uncertainty about federal approval. As with the QHP Public Option and BHP buy-in variation, 1332 approval is uncertain and could prove labor-intensive for the state.
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Discussion

All of the buy-in options described above assume that buy-in coverage will be lower cost relative to current individual market coverage—an assumption that will be tested as part of Phase 2 of this study. The basis of this assumption is that the state will be able to leverage the purchasing power of the state Medicaid program, which covers 40% of New Mexicans, to pay providers at lower rates than those paid by commercial payers, although likely higher than current Medicaid rates. Even if the state pays providers (or requires that plans pay providers) Medicare-equivalent rates under the buy-in, there is the potential for cost reductions. (Of note, New Mexico already has Medicaid managed care plans that offer coverage in its Marketplace, which will be a factor in the analysis.) Streamlined administration—including fewer or aligned coverage options—could yield additional cost reductions (e.g., to providers in the form of administrative simplification).

Across all of the buy-in options discussed in this paper, there are several key considerations that New Mexico must contemplate, among them provider reimbursement rates, market stability and the data required to meaningfully evaluate potential paths forward.

- **Reimbursement Rates.** Given that the success of any buy-in program relies, at least to some extent, on a reduction in medical costs (see Figure 1), adequate provider reimbursement is necessarily a central issue to all buy-in options considered. Currently uninsured populations purchasing buy-in coverage would result in **increases** in provider revenue. Providers, including hospitals, may currently provide a significant amount of uncompensated care to low-income, uninsured patients. By providing coverage to the uninsured, the buy-in option could shift some of providers'

uncompensated care losses into new coverage-related revenue. However, providers may realize revenue decreases if individuals currently covered by plans that pay providers at commercial insurance rates move to buy-in coverage, assuming the buy-in option includes lower rates relative to the average commercial plan. Such changes in reimbursement could lead providers to opt out of the buy-in option's network, with corresponding negative effects on enrollee access to care.

The broader the population enrolled in buy-in coverage, the greater the concern among providers regarding adequate reimbursement. Yet if the buy-in option and/or other state initiatives are successful at lowering the uninsured rate, overall revenue to providers could rise.

- **Market Stability.** As noted above, the impact of a buy-in program on current Marketplace coverage varies according to several factors: (a) whether the buy-in option is a part of or separate from the current individual market risk pool, (b) the number of individuals (including currently uninsured individuals or individuals currently enrolled in other coverage options) who purchase the buy-in option and (c) the health risk profile of the individuals who purchase buy-in coverage.

The buy-in option could have positive, negative or neutral impacts on the current individual and employer markets depending on how these factors play out for each option. Stakeholders, particularly insurers, have concerns about the effect of the BHP and Medicaid Buy-In for All (Options 3 and 4, respectively) segmenting the current market; to the extent that the population that moves out of the current markets is healthier, these concerns increase. Further analysis is needed to model the most likely impact in New Mexico.

- Data Limitations.** To prepare for Phase 2, Manatt and Wakely have reviewed current data available to New Mexico. Should a core goal of New Mexico be to preserve the individual Marketplace, the state will need to collect and analyze additional data in order to fully assess the BHP and Medicaid Buy-In for All options. Because either of these options would shift a potentially sizable population to a new risk pool, additional information is needed in order to fully understand the potential effects on the remaining individual market. This would include, for example, data on the characteristics (e.g., age, sex, geography, income) of current Marketplace and other individual market enrollees, as well as their associated healthcare spending and utilization. Much of this information could be collected by the Office of the Superintendent of Insurance through a data request of insurers that details the specific data needed, though potential resource constraints may have to be addressed to facilitate the data collection process.

Manatt and its partners recommend that New Mexico begin the process of collecting this data now, as it will help inform the state's decision making and the design and implementation of a potential buy-in program.

Taking into account these considerations, stakeholder feedback and the possibility of pursuing a phased-in approach to buy-in, Manatt recommends focusing the Phase 2 quantitative evaluation on the Targeted Medicaid Buy-In (Option 1) and the potential to pair it with or transition to one of the other options over time.

Phase 2 analysis will include an in-depth review of the costs associated with a Targeted Medicaid Buy-In, including, for example, the pricing of a product that offers Essential Health Benefit coverage in the individual market. The analysis will also assess how New Mexico might effectively subsidize coverage for low-income individuals not eligible for subsidies (e.g., through potential sliding scale premium and cost-sharing assistance). Further, the analysis will consider the ability of the buy-in structure to attract currently uninsured individuals.

While Option 1 will be the focus of Phase 2, New Mexico may still want to consider implementing a QHP Public Option, the BHP or a Medicaid Buy-In for All option—in combination with or following a targeted buy-in. The analysis done in Phase 2 should be helpful in providing New Mexico with an understanding of the potential costs associated with subsidizing the populations that would be ineligible for federal funding and the potential magnitude of per capita savings available if the state were to pursue the QHP Public Option or one of the more expansive models (BHP and Medicare Buy-In for All). It can also provide the foundation for additional analysis, supported by data generated through an insurer data request.

Conclusion

A Medicaid buy-in holds promise for meeting New Mexico’s goals of providing access to affordable coverage to state residents at every income level, while ensuring financial stability for New Mexico providers and offering a more streamlined health coverage continuum in the state. The buy-in options evaluated in this paper vary in their complexity, required federal authority and risks, as well as in the numbers of New Mexicans they will “reach.” Importantly, the state can implement these buy-in models individually, in sequence or in combination, giving New Mexico substantial flexibility to advance its goals through a strategy that progresses over time. As a next step in advancing a potential buy-in coverage option in New Mexico, the Manatt team recommends proceeding with modeling Option 1—Targeted Medicaid Buy-In. The Phase 2 quantitative analysis, building off of this qualitative assessment, will not only support New Mexico policymakers in designing a buy-in, but also inform how New Mexico could pursue a strategy that begins with a single, targeted buy-in approach or implements two buy-in options at once. Additionally, the Phase 2 analysis will provide a foundation for understanding the potential implications of a buy-in program, on which the state can build as it collects additional data to model the more expansive options considered in this report (the BHP and Medicaid Buy-In for All).

Appendix

New Mexico Stakeholders Engaged During Phase 1 Study

Between July and October 2018, Manatt Health, Health Action New Mexico, the New Mexico Center on Law and Poverty, Strong Families New Mexico and the Partnership for Community Action engaged the following consumers, insurers, providers, government entities and business and labor groups. This stakeholder engagement was completed through in-person meetings and roundtables, conference calls and electronic questionnaires. Stakeholder feedback was incorporated into this report and helped inform the options presented, as well as their evaluation, and the recommendation.

- **Patients, Consumers and Caregivers:** Strong Families New Mexico, Partnership for Community Action, New Mexico Public Health Association, Voices for Children, Disability Rights New Mexico, Ole New Mexico, Lutheran Advocacy Ministry, Southwest Women's Law Center, Alliance for School-Based Health Centers, All Pueblo Council of Governors, Navajo Nation, Health Security Campaign, Equality New Mexico, Catholic Charities, Center for Civic Policy, National Alliance on Mental Illness, Native American Parent Professional Resources, Centro Savila, First Nations, Casa de Salud, St. Joseph, First Choice, United Veterans Council of New Mexico, Women Veterans of New Mexico, New Mexico Dream Team and Conservation Voters New Mexico
- **Insurers:** BlueCross BlueShield New Mexico, Presbyterian Health, Molina, Western Sky (Centene), New Mexico Health Connections, True Health New Mexico and America's Health Insurance Plan's (AHIP)
- **Providers:** New Mexico Pediatric Society, New Mexico Primary Care Association, New Mexico Hospital Association, Lovelace Hospital System, New Mexico Health Resources, American Medical Association (AMA), New Mexico Medical Society, New Mexico Nurses Association, New Mexico Association of Family Physicians, New Mexico Rural Hospital Network, University of New Mexico (UNM) Hospitals, UNM Medical Students, UNM Health Sciences Center, First Choice Community Healthcare, New Mexico Healthcare for the Homeless, DaVita, Behavioral Health Provider Association, New Mexico Academy of Family Physicians, New Mexico Chapter of the American Physical Therapy Association, First Nations Community Healthsource and Southwest Center for Health Innovation
- **Government Entities:** BeWellNM, New Mexico Medical Insurance Pool and New Mexico Office of the Superintendent of Insurance
- **Business and Labor:** Albuquerque Hispano Chamber of Commerce, Albuquerque Lesbian Gay Bisexual Transgender Queer (LGBTQ) Chamber of Commerce, New Mexico Association of Commerce and Industry, American Federation of State, County and Municipal Employees (AFSCME), American Federation of Teachers (AFT) and Alliance for Retired Americans

Overview of Federal Authorities

Several of these buy-in options require federal approval. Of note, approval of a 1332 waiver is discretionary. Further, 1332 waiver authority is newer and less tested: the Trump Administration has approved only a limited number of 1332 waivers for reinsurance programs.

• 1332: State Innovation Waivers

- Section 1332 of the Affordable Care Act (ACA) permits states to request waivers from the Department of Health and Human Services and the Treasury Department of four key components of the ACA:
 1. Individual mandate (eliminated for 2019)
 2. Employer mandate
 3. Benefits and subsidies
 4. Marketplace and QHPs
- States **cannot** waive guaranteed issue and related rating rules (e.g., fair play rules).
- A state waiver application must satisfy four “guardrails” in order to be granted by the federal government:
 1. Scope of coverage – Must provide coverage to at least as many people as the ACA would provide without the waiver.
 2. Comprehensive coverage – Must provide coverage that is at least as “comprehensive” as coverage offered through the Marketplace.

3. Affordability – Must provide “coverage and cost sharing protections against excessive out-of-pocket” spending that is at least as “affordable” as Marketplace coverage.

4. Deficit neutrality – Must not increase the federal deficit.

• 1331: Basic Health Plan Authority

- Section 1331 of the ACA permits states to create a Basic Health Program (BHP)—a health benefits coverage program for low-income individuals with incomes below 200% of the federal poverty level who are not eligible for Medicaid (including lawfully present noncitizens), who would otherwise be eligible to purchase coverage through the Marketplace.
- BHP benefits must include at least the Essential Health Benefits specified in the ACA, and monthly premium and cost-sharing cannot exceed what eligible individuals would have paid for QHP coverage on the Marketplace.
- States receive federal funding equal to 95% of the amount of federal premium tax credits and cost-sharing reductions that would have been available had the BHP-eligible individuals purchased coverage through the Marketplace. States receive funding on a per capita basis. States must submit a “BHP Blueprint” to the federal government.

¹ Senate Memorial 3, available at <http://www.sos.state.nm.us/uploads/files/SM3-2018.pdf>; House Memorial 9, available at <https://www.nmlegis.gov/Sessions/18%20Regular/final/HM009.pdf>.

² Individuals in the “family glitch” are ineligible for subsidies because of a family member’s access to employer-sponsored coverage that is deemed “affordable” for both the individual employee and his or her family based solely on the cost of individual coverage, rather than the cost of a family plan.

³ U.S. Census Bureau, 2017 American Community Survey 1-Year Estimates, available at <https://www.census.gov/programs-surveys/acs/technical-documentation/table-and-geography-changes/2017/1-year.html>.

⁴ Human Services Department, Medicaid Enrollment Report by Managed Care Organization, September 2018, available at <http://www.hsd.state.nm.us/LookingForInformation/medicaid-eligibility.aspx>.

⁵ Stakeholder Advisory Committee Presentation, July 2018.

⁶ Kaiser Family Foundation, Explaining Health Care Reform: Questions About Health Insurance Subsidies, November 8, 2017, available at <https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>.

⁷ Kaiser Family Foundation, Marketplace Average Benchmark Premiums 2014-2019, available at <https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/>; Kaiser Family Foundation, Marketplace Average Premiums and Average Advanced Premium Tax Credit, 2018, available at <https://www.kff.org/health-reform/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁸ BeWellNM, Stakeholder Advisory Committee Meeting, July 16, 2018.

⁹ Associated Press, Rate Decreases Coming to New Mexico Health Exchange, September 5, 2018, available at <https://www.abqjournal.com/1217117/rate-decreases-coming-to-new-mexico-health-exchange.html>.

¹⁰ Senate Memorial 3, available at <http://www.sos.state.nm.us/uploads/files/SM3-2018.pdf>.

¹¹ Manatt analysis of HIX Compare 2018 Data Files, available at <https://hixcompare.org/individual-markets.html>.

¹² Federal guidance states that “[u]nder the deficit neutrality requirement, the projected Federal spending net of Federal revenues under the State Innovation Waiver must be equal to or lower than projected Federal spending net of Federal revenues in the absence of the waiver. The estimated effect on Federal revenue includes all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including user fees), that would result from the proposed waiver. Estimated effects would include, for example, changes in: the premium tax credit and health coverage tax credit, individual shared responsibility payments, employer shared responsibility payments, the excise tax on high-cost employer-sponsored plans, the credit for small businesses offering health insurance, and changes in income and payroll taxes resulting from changes in tax exclusions for employer-sponsored insurance and in deductions for medical expenses.” U.S. Department of Health and Human Services. (December 16, 2015). Department of the Treasury; Waivers for State Innovation. 80 Fed. Reg. 78,131 (codified at 31 CFR 33 and 45 CFR 155). <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>.

¹³ Risk adjustment offsets an insurer’s cost of providing health insurance to higher-risk individuals, including those with chronic conditions, by compensating insurers that enroll a greater-than-average number of high-risk individuals with payments from insurers that enroll an overall healthier population.

¹⁴ Note that under federal BHP authority, states cannot fund the administration of the BHP through federal funding (i.e., the 95% of federal subsidies that would have otherwise been provided to BHP enrollees); they must self-fund the administrative costs of the program.

¹⁵ Kaiser Family Foundation, The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks, and Considerations for States, March 2012, available at <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8283.pdf>.

¹⁶ When the federal administration stopped making cost-sharing reduction (CSR) payments, plans increased premiums for silver plans (called “silver loading”), which had the net effect of making the federal government cover CSR payments through higher premium tax credit amounts.

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