

**The Basic Health Program in New Mexico:
SM54/HM38 Report
for New Mexico's Legislative Finance Committee**
*Prepared by the New Mexico Center on Law and Poverty
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Introduction

The Affordable Care Act (ACA) has the potential to deliver affordable health coverage to more than 300,000 uninsured New Mexicans.¹ First, it gives states the opportunity to extend Medicaid coverage to nearly all adults with incomes below 138% of the Federal Poverty Level (roughly \$15,000 a year for a family of one and \$32,000 for a family of four in 2012.)² Second, it requires the establishment of a Health Insurance Exchange in every state -- an online marketplace that will provide a variety of health coverage options to individuals and small businesses.³ New Mexicans who purchase coverage through the Exchange will have access to federal tax credits and subsidies to help offset the high cost of health insurance premiums, copayments and deductibles.⁴

However, it is likely that many low-income New Mexicans will have trouble affording healthcare coverage even with the assistance of these tax credits and subsidies. Families with incomes between 138% to 200% of the poverty level will earn too much to qualify for Medicaid, and yet they will likely be unable to afford private insurance through an Exchange. In New Mexico, this group includes single adults who earn less than \$22,350 per year and families of three who earn less than \$38,200 and already struggle to pay for the basics – housing, food, transportation, and childcare. Health insurance costs will be out of reach. If New Mexico does not take action to address this affordability problem, studies suggest that high rates of uninsurance and the accompanying health disparities will persist among low-income working families.

This report, prepared in response to Senate Memorial 54 and House Memorial 38, examines the Basic Health Program (BHP), an option for states under the ACA, and its potential to solve this affordability problem for low-income families. Pursuant to the memorials, this report: (1) provides an overview of the BHP and who would be eligible, (2) assesses the affordability of coverage through the Exchange for this population, and considers stakeholder feedback on affordability issues and the BHP as a potential solution, with a particular focus on potential benefits for Native Americans; (3) assesses the feasibility and financial impacts of a BHP in New Mexico; and (4) identifies areas where questions remain, including the potential impact of a BHP on New Mexico's Exchange and areas where federal guidance would be necessary to permit a fully informed state decision on BHP adoption. The conclusion of this report includes recommendations for next steps in New Mexico.

¹ FAMILIES USA, HEALTH COVERAGE IN NEW MEXICO: HOW WILL HEALTH REFORM HELP? at 3 (Mar. 2010).

² ACA § 2001(a).

³ ACA § 1311(b).

⁴ ACA §§ 1401 & 1402.

I. What Is a Basic Health Program (BHP)?

The ACA gives states the option to implement the Basic Health Program (BHP) for low-income individuals who are not eligible for Medicaid and who have incomes up to 200% of the poverty level.⁵ Most of the costs will be paid by the federal government. If a state chooses to make the BHP part of its healthcare system, this group of individuals who have incomes up to 200% of the federal poverty level would not receive tax credits and subsidies to purchase coverage through the Exchange. Instead, the state would receive 95% of the value of those tax credits and subsidies to instead provide healthcare coverage through a BHP.⁶ That money would be placed in a trust, and the state would initiate a competitive bidding process to permit insurance companies to offer “standard health plans” through the BHP.⁷ BHP enrollees would be able to choose among the various health plans and the state would then pay insurers for the coverage they provide.⁸ Any excess funds in the trust would have to be used to reduce costs or improve benefits for BHP enrollees.⁹

BHP enrollees would still pay a portion of premiums and out of pocket costs for coverage through a BHP. However, the ACA requires that the BHP be at least as good as the Exchange in terms of value – enrollees cannot pay more than they would have paid through the Exchange,¹⁰ and the plans must cover at least the Essential Health Benefits that are required of health plans that are offered on the Exchange.¹¹

It is likely that the BHP would provide more affordable coverage than the Exchange. A national analysis by the Urban Institute estimates that the federal funds available to states for the BHP would provide coverage options that could cost as little as \$100 annually for premiums and provide 98% actuarial value, all the while leaving the state with a 23% margin to use in improving benefits or lowering costs even further for BHP enrollees.¹² This is in dramatic contrast to the costs of obtaining coverage on an Exchange, and as a result, Urban projects that 7,400 more New Mexicans would obtain insurance with a BHP than without it.¹³

⁵ ACA § 1331(a)(1).

⁶ ACA § 1331(d)(3)(A)(i). In fact, states may receive *more* than 95% of the value of the credits and subsidies. While the statute makes clear that states would receive 95% of the premium tax credit dollars individuals otherwise would have received to purchase coverage through the Exchange, it is not clear whether states would receive 95% or 100% of the value of cost-sharing subsidies. CMS has not yet resolved this statutory construction problem but is expected to do when it issues Basic Health guidance or regulations.

⁷ ACA § 1331(c)(1).

⁸ ACA § 1331(c)(3).

⁹ ACA § 1331(d)(2).

¹⁰ ACA § 1331(a)(2)(A)(i). The cost-sharing protections in the ACA are actually not quite as strong for the BHP as they are for the Exchange – they appear to require 90% actuarial value (as opposed to 94%) for individuals up to 150% FPL and 80% actuarial value (as opposed to 87%) for individuals up to 200% FPL. ACA § 1331(a)(2)(A)(ii). National advocates believe this was a drafting error and that it can be overridden by the statute’s clear intent that BHP be at least as good a deal for enrollees as Exchange coverage would have been. Because of this problem, however, it is imperative that state-level legislation create clear cost-sharing protections that are at least as good as those in the federal law for the Exchange.

¹¹ ACA § 1331(a)(2)(B).

¹² Stan Dorn, Matthew Buettgens & Caitlin Carroll, *Using the Basic Health Program to Make Coverage More Affordable to Low-Income Households: A Promising Approach for Many States* at 8 [hereinafter BHP: A Promising Approach] (The Urban Institute, Sep. 2011).

¹³ *Id.* at 14.

If the savings that Urban projects nationally could be realized in New Mexico, the benefit to New Mexico families would be substantial. For example, a family of four at 150% of federal poverty would pay a projected 1.2% of annual income for Basic Health coverage using the Urban Institute's numbers, compared to a projected 6.7% of annual income for coverage (premiums plus cost-sharing obligations) through the Exchange. However, because Urban's analysis was conducted at a national and regional level, it is unclear whether these affordability benefits could be fully realized in New Mexico.

II. The Affordability Problem and Why It Matters

To be accessible, health coverage must be affordable. The ACA purports to make coverage affordable in two new ways: by expanding Medicaid eligibility for adults with incomes up to 138% of the poverty level, and by establishing Health Insurance Exchanges and providing tax credits and subsidies to enrollees up to 400% of the poverty level to help with the cost of coverage and care. But these interventions may not translate into affordable coverage in New Mexico. First, the Supreme Court's ruling on the ACA has effectively made the Medicaid Expansion optional for states, calling into question whether individuals with incomes below 138% of the poverty line will have any coverage option at all. And second, for individuals with incomes below 200% of the poverty line, there is a serious question as to whether coverage through the Exchange will be affordable – even with the financial assistance the law provides.

Affordability as a Barrier to Healthcare Access and Economic Stability

Research has confirmed that affordability is a serious barrier to obtaining health coverage. One study concluded that where health insurance premiums consumed 5% of family income, only 18% of individuals enrolled in coverage; where premiums consumed 3% of family income, only 35% of individuals enrolled in coverage.¹⁴ By comparison, if premiums are 1% of family income, over half of individuals enrolled in coverage.¹⁵

Under the ACA, tax credits are calculated based on the assumption that individuals with incomes between 138% and 200% of the poverty level will contribute between 3% and 6.3% of household income to pay for health coverage. Thus, there are serious questions whether the federal financial assistance will be enough to ensure that families at this income level will be able to afford and obtain health insurance. In a survey of 1,718 individuals without access to employer-sponsored insurance, the Congressional Budget Office concluded that price sensitivity had a great impact on insurance uptake for lower-income families.¹⁶ In Washington state, which has a state program similar in structure to the federal BHP, studies have shown that as monthly premiums increased from \$10 to \$50, enrollment in the program fell by half.¹⁷

For those who remain without coverage or who are “underinsured” (where insurance does not cover the full costs of their medical needs), the rising costs of healthcare have taken a heavy financial toll. In families with household incomes of less than \$36,000 (placing them under 186% of the poverty level), 46% reported having medical debt in 2005.¹⁸ Roughly half of personal

¹⁴ Ku, L., & Coughlin, T., *Slide-Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 4, 471-80 (1999).

¹⁵ *Id.*

¹⁶ Auerbach, D., & Ohri, S., *The Price Sensitivity of Demand for Nongroup Health Insurance* (Congressional Budget Office Background Paper, 2005), available at <http://www.cbo.gov/ftpdocs/66xx/doc6620/08-24-HealthInsurance.pdf>.

¹⁷ Madden, C., et al., *Voluntary Public Health Insurance for Low-Income Families: The Decision to Enroll*, 20 JOURNAL OF HEALTH POLITICS, POLICY AND LAW 4, 955-72.

¹⁸ Michelle Melendez, *Medical Debt Collections Policies of Safety Net Provider Systems in Bernalillo County, NM* [hereafter Medical Debt] (unpublished article, University of New Mexico School of Public Administration, Nov. 2011) (citing R. Seifert, *Home Sick: How Medical Debt Undermines Housing Security*, The Access Project (2005)). Families that are low-income (between 100% and 200% of the poverty level) are actually more likely to have medical debt than families that live in poverty.

bankruptcies nationally are medical,¹⁹ and 29% of Americans in 2010 reported problems paying medical bills – up from 23% in 2005²⁰. Forty percent of people using consumer credit counseling said a medical problem had contributed to their debt problem by leaving them with a large bill they could not afford to pay and/or limiting their ability to work.²¹ Medical debt leads to bankruptcy, poor credit ratings, stress, and anxiety.²² By contrast, the recent Oregon “Medicaid Experiment” showed that people with health coverage have less trouble paying their medical bills, are less likely to be in medical debt, and report less anxiety and stress.²³

Affordability of Health Coverage in New Mexico under the ACA

In New Mexico today, a family must earn significantly more than the Federal Poverty Level (FPL) before it can cover essential expenses like food, housing, transportation, and childcare. As shown in Table I below, even with the support of programs like SNAP (food stamps) and LIHEAP (heating assistance), a family of four in Albuquerque does not have enough income to pay for



basic necessities excluding healthcare until it reaches about 200% of the poverty level – and even then, the monthly surplus is very small. Families with incomes below this level will struggle to pay even a portion of their insurance premiums, and yet they would be required to make significant out-of-pocket contributions in order to access health coverage through the Exchange.

I. Insurance Premiums

The ACA provides federal tax credits to help offset the costs of insurance on the Exchange for families that have incomes below 400% of the federal poverty level. These tax credits are calculated based on the cost of the health plan and the income of the family – for example,

¹⁹ *Id.* (citing Himmelstein et al., *Discounting the Debtors Will Not Make Medical Bankruptcy Disappear*, HEALTH AFFAIRS W84 (Feb. 2006)).

²⁰ *Id.* (citing Schoen et al., *Affordable Care Act Reforms Could Reduce the Number of Uninsured U.S. Adults by 70 Percent*, 30 HEALTH AFFAIRS 1762-71 (Sept. 2011)).

²¹ *Id.* (citing Gurewich et al., *Medical Debt and Consumer Credit Counseling Services*, 15 J. HEALTH CARE FOR THE POOR AND UNDERSERVED 336-46 (2004)).

²² *Id.* (citing Schoen et al., *supra* note 19).

²³ Finkelstein et al., *The Oregon Health Insurance Experiment: Evidence from the First Year*, NBER Working Paper No. 17190 (Jul. 2011), finding that the group with Medicaid had substantively and significantly higher healthcare utilization and better self-reported physical and mental health than the control group. Self-reported health correlates strongly with measurable health outcomes. See, e.g., Idler & Benyamini, *Self-Rated Health and Mortality: a Review of Twenty-Seven Community Studies*, 38 J. HEALTH SOC. BEHAV. 21-37 (Mar. 1997).

families under 150% of the poverty level have their costs capped so that they pay no more than 4% of their annual income on health insurance, whereas families closer to 400% of the poverty level may have to pay up to 9.5% of their income. The tax credits pay the remainder of the premium costs.

Table I: Monthly Income and Expected Contribution to Premiums in the Exchange, Family of 4 in Albuquerque, Income 150-250% FPL

Income as a % of FPL	Monthly Income	Support from Public Programs	Basic Family Budget ²⁴	Surplus/ Deficit Each Month	Expected Premium in Exchange <i>With federal financial help</i>
150% FPL	\$2,881	\$469 ²⁵	\$3,514	(\$164)	\$115
200% FPL	\$3,841	\$0	\$3,514	\$327	\$387
250% FPL	\$4,802	\$0	\$3,514	\$1,288	\$639

Under the ACA, a family of four with an income at 150% FPL – just under \$35,000 per year – will be expected to contribute \$115 per month toward health insurance premiums through the Exchange after factoring in federal tax credits. But in New Mexico, that family is already \$164 dollars short of what it needs each month. Even at 200% FPL, a family of four is expected to pay \$387 a month toward health insurance premiums through the Exchange – more than erasing any surplus they might have put toward savings. Without an affordability solution, research about low-income families and price sensitivity suggests that there will be very low insurance uptake through the Exchange for families with incomes below 200% FPL.

Because families with incomes below 200% FPL would struggle to pay their expected premium contribution, they are likely to use their tax credits to purchase a lower-premium plan with higher “cost-sharing” in the form of deductibles and co-pays. The size of a tax credit in the Exchange is calculated based on the cost of a “Silver” plan (a plan with 70-80% actuarial value), but individuals can use the tax credit to buy a “Bronze” plan instead (a plan with 60-70% actuarial value). Because the actuarial value is lower, the premium will be cheaper and the tax credit is likely to cover all of the premium cost. Enrollees would not have to pay any portion of premiums, but the amount of other out-of-pocket costs would be much higher.

After the Supreme Court’s July decision on the healthcare law, some New Mexico policymakers have been questioning the wisdom of implementing the Medicaid Expansion in New Mexico, which means that families with incomes below 138% FPL may also be required to purchase coverage through the Exchange. As shown in Table 2 below, without the Medicaid

²⁴ <http://www.epi.org/resources/budget/> (last visited August 22, 2012).

²⁵ According to current New Mexico Human Services Department guidelines, a family of four at 150% of the poverty level is likely to qualify for \$460 per month in SNAP (food stamps) and would receive \$112 per year help offset heating or cooling costs.

Expansion, affordability of coverage in the Exchange is an even bigger problem for these families. Under the ACA, families with incomes below 100% FPL are ineligible for any financial assistance to help pay premiums through the Exchange and would have to pay full price to get coverage.²⁶ And families with incomes between 100% and 138% FPL are already hundreds of dollars short of what they need to pay for basic necessities and would likely be unable to afford the cost of health insurance premiums even with financial assistance.

Table 2: Monthly Income and Expected Contribution for Coverage in the Exchange, Family of 4 in Albuquerque, Income Below 138% FPL

Income as a % of FPL	Monthly Income	Support from Public Programs	Basic Family Budget ²⁷	Surplus/ Deficit Each Month	Expected Premium in Exchange <i>With federal financial help</i>
90% FPL	\$1,729	\$1,446 ²⁸	\$3,514	(\$339)	FULL COST
115% FPL	\$2,209	\$630 ²⁹	\$3,514	(\$675)	\$44

2. Co-pays and Other Cost Sharing

Premiums make up only a portion of the costs of healthcare coverage. Most health plans also require individuals to pay other out-of-pocket costs, known as “cost sharing”, such as deductibles and co-pays each time a person visits the doctor. Fortunately, the ACA also provides financial help with cost-sharing in the form of federal subsidies that effectively cap the amount that families must pay. These caps are tied to the maximum allowable out-of-pocket expenditures in a pretax Health Savings Account (HSA), an account individuals and families can use to pay medical expenses. The HSA contribution limits are currently \$6,050 per year for an individual and \$12,100 per year for a family. Health plans that are offered through the Exchange must ensure that cost-sharing does not exceed these limits.³⁰

Low-income individuals and families qualify for subsidies that will further limit non-premium out-of-pocket costs. For individuals and families with incomes up to 200% of federal poverty,

²⁶ ACA §§ 1401-1402 authorize federal tax credits and subsidies for individuals with incomes from 100% to 400% of the poverty level to purchase coverage through a Health Insurance Exchange. This financial assistance effectively caps the cost of premiums and other cost-sharing such as co-pays and deductibles.

²⁷ <http://www.epi.org/resources/budget/> (last visited August 22, 2012).

²⁸ According to current New Mexico Human Services Department guidelines, a family of four at 90% of the poverty level is likely to qualify for \$437 per month in SNAP (food stamps) and would receive \$128 per year help offset heating or cooling costs. This calculation assumes that 100% of the child care costs from the Basic Family Budget (\$998) would be covered by child care assistance.

²⁹ According to current New Mexico Human Services Department guidelines, a family of four at 115% of the poverty level is likely to qualify for \$621 per month in SNAP (food stamps) and would receive \$112 per year help offset heating or cooling costs.

non-premium out-of-pocket costs are capped at one-third the HSA contribution limit.³¹ Currently, this limit is \$2,017 for an individual and \$4,033 for a family. Once an individual or family below 200% of the federal poverty level reaches these limits, federal subsidies then pay the remainder of any non-premium out-of-pocket costs.

However, these caps do not solve the affordability problem. As shown in Table 3, families with incomes between 100% and 200% of the federal poverty level would have to spend between 15% and 20% of their household income on premiums, copayments and deductibles before statutory protections would prevent additional out-of-pocket costs. These families are likely to be those with high health needs, meaning those most in need of care are at risk of being unable to access that care.

As mentioned earlier in this report, families with incomes below 200% FPL are at particular risk of being “underinsured.” Because families at this income level would struggle to pay their expected premium contribution, they are likely to purchase lower-premium plans with higher “cost-sharing” in the form of deductibles and co-pays.

There would be serious healthcare access implications to this decision. This is because the cost-sharing protections in the ACA – the provisions that lower deductibles and copayments – only apply if an individual purchases “Silver” level coverage. If, for example, the family of 4 with income at 150% FPL in Table 1 paid \$115 a month for “Silver” coverage, protections in the ACA would convert their plan to one with 94% actuarial value.³² But if they cannot afford the \$115 a month and instead get the cheaper (or free) “Bronze” coverage, they lose those cost-sharing protections, and will be covered under a plan with less than 70% actuarial value. This means that even though more people may obtain insurance, copays and deductibles are likely to be cost-prohibitive and prevent individuals from accessing care. As a result, New Mexico taxpayers and providers will continue to shoulder the burden of those unpaid copayments and deductibles in the form of uncompensated care costs.

³¹ ACA § 1402(c)(1)(i).

³² ACA § 1402(c)(2)(A).

Table 3: Estimated Maximum Expenditures for Health Coverage in the Exchange, Family of Four Purchasing Silver Level Coverage

Federal Poverty Level	Annual Household Income	Annual Premium Payment in Dollars	Max. Annual Out of Pocket Costs ³³	Maximum Allowable Costs for Coverage	
				In Dollars	As % of Household Income
100%	\$23,050	\$461	\$4,033	\$4,494	19.5%
150%	\$34,575	\$1,383	\$4,033	\$5,416	15.7%
200%	\$46,100	\$2,904	\$4,033	\$6,937	15.0%

Concerns about Affordability for New Mexicans

New Mexicans consistently identify affordability as one of their chief concerns about healthcare. In July of 2010, the State of New Mexico received \$1 million in federal funds to facilitate the planning of the New Mexico Health Insurance Exchange (Exchange). The New Mexico Human Services Department and the New Mexico Office on Health Care Reform published reports from various stakeholders which collected, analyzed, and reported information about access to healthcare and health insurance plans. In particular, the reports provide insight into the affordability concerns of different New Mexican populations. The reports focused on key stakeholder groups, including consumers of healthcare and health insurance plans; young adults; the marginally employed; women; off- and on-reservation Tribal members; monolingual Spanish speakers; individuals with substance abuse and behavioral health issues; individuals living with a disability; members of the lesbian, gay, bisexual, and transgender (LGBT) community; and uninsured individuals.

Across these disparate stakeholder groups, participants consistently reported that the current cost of health insurance prevents them from obtaining health coverage. The general consumer report found that the greatest barrier to getting or keeping health insurance coverage is cost.³⁴ For individuals living with a disability, higher cost for coverage because of the disability was a constant barrier to insurance coverage.³⁵ Individuals with substance abuse and behavioral health

³³ Indexed to Health Savings Account Limit for 2012 and Reduced by 2/3.

³⁴ NEW MEXICO OFFICE OF HEALTH CARE REFORM, FINAL REPORT: NM HEALTH INSURANCE EXCHANGE CONSUMER FEEDBACK MEETINGS at 13 (Jun. 2011), available at <http://www.hsd.state.nm.us/pdf/hcr/General%20Consumer%20Final%20Report%20June%202011.pdf>.

³⁵ NEW MEXICO OFFICE OF HEALTH CARE REFORM, CONSUMER INPUT AND ANALYSIS: INDIVIDUALS LIVING WITH A DISABILITY at 9 (Jun. 2011), available at <http://www.hsd.state.nm.us/pdf/hcr/DRNM%20Final%20Report%20Complete.pdf>.

issues listed affordability as the main reason they did not currently have insurance.³⁶ The report on sex and gender found that of the 76% of respondents who were insured or had Medicaid or Medicare coverage, 43% stated they had to forgo or severely limit necessities such as food, rent, or transportation in order to pay for health care.³⁷ 84% of these same respondents agreed with the statement “I can’t afford it (health insurance).”³⁸

All stakeholders surveyed listed affordability of coverage in the Exchange as a concern. Three quarters of all monolingual Spanish speakers said cost was the most important factor when choosing a health insurance plan.³⁹ The young adult and marginally employed groups had high levels of agreement that reasonable costs would encourage participation in New Mexico’s Exchange.⁴⁰ Over half of uninsured individuals stated the cost of the plan/premiums (40%), cost of the deductibles (7%), or the co-pays for doctor’s visits (6%) would be the single most important factor when comparing plans.⁴¹ Finally, the LGBT report found that affordability concerns are not limited to those who must purchase coverage in the individual market. While the loss of a job or marginal employment can make purchasing health insurance cost-prohibitive, employed participants also said they were unable to afford employer-sponsored health insurance benefits.⁴²

Concerns about Affordability for Native Americans

Under the ACA, Native Americans benefit from some additional affordability protections. Native Americans with incomes below 300% FPL are exempt from all cost-sharing (other than premiums) if they purchase plans through the Exchange,⁴³ and a Native American receiving items or services furnished through Indian Health Providers is exempt from cost-sharing regardless of income.⁴⁴ But Native Americans still must pay premiums at the same rate as all other Exchange enrollees. Particularly because Native Americans are exempt from the

³⁶ NEW MEXICO OFFICE OF HEALTH CARE REFORM, A REPORT TO THE NEW MEXICO OFFICE OF HEALTH CARE REFORM at 2 (Sep. 2011), *available at* <http://www.hsd.state.nm.us/pdf/hcr/Behavioral%20Health%20Final%20Report%20September%2011.%202011.pdf>.

³⁷ NEW MEXICO OFFICE OF HEALTH CARE REFORM, HEALTH INSURANCE EXCHANGE STAKEHOLDER INPUT: SEX AND GENDER IMPLICATIONS at 4 (Jun. 2011), *available at* <http://www.hsd.state.nm.us/pdf/hcr/Sex-Gender%20Final%20Report%20June%202011.pdf>.

³⁸ *Id.* at 5.

³⁹ NEW MEXICO OFFICE OF HEALTH CARE REFORM, HEALTH INSURANCE EXCHANGE SURVEY FOR SPANISH-ONLY SPEAKERS at 3 (Jul. 2011), *available at* <http://www.hsd.state.nm.us/pdf/hcr/Spanish%20Speaking%20Final%20report%20July%202011.pdf>.

⁴⁰ NEW MEXICO OFFICE OF HEALTH CARE REFORM, YOUNG ADULTS AND marginally EMPLOYED FINAL REPORT at 16 and 28 (Jun. 2011) *available at* <http://www.hsd.state.nm.us/pdf/hcr/Young%20Adults%20and%20Marginally%20Employed%20Final%20Report%20June%202011.pdf>

⁴¹ NEW MEXICO OFFICE OF HEALTH CARE REFORM, NEW MEXICO OFFICE OF HEALTHCARE REFORM UNINSURED ADULT HOUSEHOLD SURVEY at 5 (May 2011), *available at* <http://www.hsd.state.nm.us/pdf/hcr/Uninsured%20Survey%20Final%20Report%20June%202011.pdf>

⁴² NEW MEXICO OFFICE OF HEALTH CARE REFORM, TOWARDS AN LGBT-INCLUSIVE APPROACH TO HEALTH CARE REFORM IMPLEMENTATION: RECOMMENDATIONS FOR ESTABLISHING A NEW MEXICO HEALTH INSURANCE EXCHANGE at 17 (Jul. 2011), *available at* <http://www.hsd.state.nm.us/pdf/hcr/LGBT%20Final%20Report%20June%202011.pdf>.

⁴³ ACA § 1402(d)(1).

⁴⁴ ACA § 1402(d)(2).

individual mandate under the ACA to obtain coverage,⁴⁵ there is a real risk that Native Americans will not enroll in coverage through the Exchange because it is unaffordable. Over half of off-reservation Tribal members and 61% of on-reservation Tribal members rated cost as the most important factor when purchasing health insurance.⁴⁶

Why Is Health Coverage Important?

If affordability acts as a barrier to obtaining health coverage, New Mexicans will continue to suffer significant health consequences: less timely care, less medical care overall, and patients enter the health system in poorer health and have worse health outcomes. Medical research clearly shows that *health coverage* translates into dramatically increased access to *healthcare*.

Compared to the insured, the uninsured postpone or forgo receiving medical care for both chronic and serious conditions. One study found that 28% of uninsured people postponed seeking care for a serious condition compared to 5% of insured people.⁴⁷ Additionally, 20% of uninsured people failed to receive needed care for a serious medical conditions compared to 3% of insured people.⁴⁸ Because of this delayed treatment, once they do enter into the health care system, the uninsured suffer from much more serious conditions and diseases than those who have health insurance. For example, uninsured cancer patients are much more likely to be diagnosed at an advanced disease stage and successful treatment becomes more difficult.⁴⁹ This finding has been replicated across a variety of medical conditions.⁵⁰

Even after entering the health care system, uninsured people get only half as much care as the insured (measured in dollars spent on health care services and taking into account free care received) when adjusted for age, income, health status and other factors.⁵¹ Uninsured adults receive fewer preventive screening services such as mammograms, clinical breast exams, pap

⁴⁵ ACA § 1501(b) (amending Subtitle D of the Internal Revenue Code of 1986 at § 5000a(e)(3) to exempt members of Indian Tribes from the individual mandate.)

⁴⁶ NEW MEXICO OFFICE OF HEALTH CARE REFORM, HEALTH COVERAGE NEEDS AND EXPECTATIONS OF OFF-RESERVATION TRIBAL MEMBERS: RECOMMENDATIONS FOR ESTABLISHING A NEW MEXICO HEALTH INSURANCE EXCHANGE at 17 (Jul. 2011), available at <http://www.hsd.state.nm.us/pdf/hcr/Off%20Reservation%20Tribal%20Input%20Final%20Report%20September%202011.pdf>; NEW MEXICO OFFICE OF HEALTH CARE REFORM, TRIBAL INPUT ON ESTABLISHMENT OF HEALTH INSURANCE EXCHANGES IN NEW MEXICO at 11 (Aug. 2011), available at <http://www.hsd.state.nm.us/pdf/hcr/On%20Reservation%20Tribal%20Input%20Final%20Report%20August%202011.pdf>.

⁴⁷ Jack Hadley, *Consequences of the Lack of Health Insurance on Health and Earnings* [hereinafter *Consequences*], at 3 (Missouri Foundation for Health/Urban Institute, 2006).

⁴⁸ *Id.*

⁴⁹ *Id.* at 5-6 (finding that 31.9% of uninsured melanoma patients were diagnosed at a late stage compared to a maximum of 15.6% of commercially insured melanoma patients and 42.6% of uninsured breast cancer patients were diagnosed at a late stage compared to 32% for commercially insured women).

⁵⁰ See, e.g., *id.* at 5 (finding that for people starting dialysis, 62% of uninsured people had low hematocrit levels, a primary indicator of suboptimal kidney function, compared to 49% of people who had private insurance); *id.* at 6 (finding that uninsured patients were 50% more likely to have an abnormal report after having undergone a colonoscopy or endoscopy); *id.* at 7-8 (finding that for appendicitis, 34.3% of uninsured adult patients experienced a ruptured appendix compared to 28.1% of privately insured patients).

⁵¹ Randall R. Bovbjerg and Jack Hadley, *Why Health Insurance is Important* [hereafter *Why Health Insurance is Important*] at 1 (Urban Institute, November 2007).

tests, and colorectal screenings and are less likely to be screened for a serious illness.⁵² Even when compared to those whose insurance does not cover preventative screenings, the insured are more likely to receive these services than the uninsured because they have and communicate with a regular medical provider.⁵³ Uninsured trauma victims are less likely to be admitted to a hospital, receive fewer services when admitted, and are more likely to die than are insured trauma victims.⁵⁴ And in California, sick uninsured newborns had shorter hospital stays (by 1.8-5.9 days) and received less care (measured by hospital charges) than privately insured newborns.⁵⁵ In addition to receiving less care, the uninsured are at a greater risk for substandard hospital care. One study found that 40.3% of adverse events among the uninsured were due to negligence compared to 20.3% of privately insured.⁵⁶

This lack of access translates into dramatically poorer health outcomes. The Institute of Medicine estimates lack of insurance causes 18,000 unnecessary deaths per year.⁵⁷ In New Mexico, over 375 people die each year due to being uninsured.⁵⁸ The risk of death for the uninsured with certain chronic conditions is 25% or higher than those with insurance.⁵⁹ In Massachusetts hospital trauma cases, uninsured patients are twice as likely to die as the insured.⁶⁰ For pediatric trauma cases, 4.2% of uninsured children died compared with 2.1% of children with commercial insurance.⁶¹ These results persist even in studies that account for “reverse causation” (the fact that low health status may cause uninsured status).⁶²

The negative effects of uninsurance reach far beyond the uninsured. Children are up to three times more likely to see a doctor if their parents see a doctor, and whether a parent sees a doctor correlates directly with whether that parent has coverage.⁶³ Coverage retention is significantly improved when children are covered in the same program as their parents, as opposed to vouchers for private coverage or separate adult programs.⁶⁴ And benefits extend beyond the family, as well; research suggests that in communities with high levels of uninsured people, even those with insurance are more likely to have difficulties accessing needed healthcare and are less satisfied with the care they do receive.⁶⁵

⁵² *Consequences*, *supra* note 47, at 4; INSTITUTE OF MEDICINE AMERICA’S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE, [hereinafter UNINSURED CRISIS] at 4 (2009); INSTITUTE OF MEDICINE COMMITTEE ON HEALTH INSURANCE STATUS AND ITS CONSEQUENCES, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE [hereafter TOO LITTLE, TOO LATE] at 3 (2002); *Why Health Insurance is Important*, *supra* note 52, at 1.

⁵³ TOO LITTLE, TOO LATE, *supra* note 52, at 3; *Why Health Insurance is Important*, *supra* note 15, at 1

⁵⁴ TOO LITTLE, TOO LATE, *supra* note 52, at 5.

⁵⁵ *Consequences*, *supra* note 47, at 9-10.

⁵⁶ *Consequences*, *supra* note 47, at 10.

⁵⁷ *Why Health Insurance is Important*, *supra* note 51, at 1.

⁵⁸ Wilper et al., *Health Insurance Mortality in U.S. Adults*, 99 AM. J. PUB. HEALTH 2289-95 (2009).

⁵⁹ *Id.*

⁶⁰ *Consequences*, *supra* note 47, at 11.

⁶¹ *Id.*

⁶² *Why Health Insurance is Important*, *supra* note 51, at 1.

⁶³ Jeanne M. Lambrew. *Health Insurance: A Family Affair*, at 1 (The Common Wealth Fund, May 2001).

⁶⁴ Benjamin Sommers, *Why Millions of Children Eligible for Medicaid and SCHIP are Uninsured: Poor Retention Versus Poor Takeup*. (Health Affairs, July 26, 2007).

⁶⁵ UNINSURED CRISIS, *supra* note 52, at 4.

III. How Would a BHP Work in New Mexico?

The BHP has the potential to address the affordability problem, making health coverage – and therefore healthcare – more accessible for low-income New Mexicans. It could dramatically lower enrollees’ premium and cost-sharing obligations, mitigate the negative impact of “churn” as individuals’ incomes fluctuate between Medicaid and Exchange eligibility levels, reduce uncompensated care costs, and benefit the already insured and small businesses in the state. But many questions remain about the likely cost to New Mexico of implementing a BHP.

Who Would Qualify for a New Mexico BHP?

Under federal law, to qualify for the Basic Health Program, individuals must:

- Have income at or below 200% of the Federal Poverty Level;⁶⁶
- Be ineligible for Medicaid;⁶⁷
- Be younger than 65;⁶⁸
- Be U.S. citizens or lawfully residing immigrants;⁶⁹ and
- Have no access to employer-sponsored insurance that meets the minimum requirements of the ACA.⁷⁰

In New Mexico, approximately 63,500 people would be eligible for BHP coverage under these guidelines.⁷¹ Three major groups would qualify:

- Uninsured adults with incomes 139-200% FPL, including citizens and lawfully residing immigrants (approximately 50,000 New Mexicans)⁷²;
- Uninsured and lawfully residing immigrant adults with incomes below 139% FPL but who are ineligible for Medicaid because they are in a five-year waiting period that applies to certain lawful permanent residents (approximately 6,500 New Mexicans)⁷³;
- Adults with health coverage through the State Coverage Insurance (SCI) program and with incomes 139-200% FPL (approximately 2,000 New Mexicans)⁷⁴.

How many of these eligible individuals would enroll would vary based on required premium and out-of-pocket cost-sharing contributions. Modeling a \$100 premium and 98% actuarial value (about 1.2% of household income), the Urban Institute projects that 42,000 New Mexicans

⁶⁶ ACA § 1331(e)(1)(B).

⁶⁷ ACA § 1331(e)(1)(A).

⁶⁸ ACA § 1331(e)(1)(D).

⁶⁹ ACA § 1331(e)(1)(B).

⁷⁰ ACA § 1331(e)(1)(C).

⁷¹ This eligibility estimate is roughly in line with Urban Institute’s assessment that 65,000 New Mexicans would qualify for BHP coverage. BHP: A Promising Approach, *supra* note 12.

⁷² www.statehealthfacts.org (subtract uninsured with incomes below 139% FPL from uninsured with incomes below 200% FPL).

⁷³ New Mexico Center on Law and Poverty estimates in collaboration with the Georgetown Center for Children & Families.

⁷⁴ Based on state data showing that in 2010 approximately 5% of SCI enrollees had incomes 139-200% FPL without disregards; extrapolated to HSD SCI enrollment projections for 2014.

would enroll in BHP coverage.⁷⁵ Modeling maximum premium and cost-sharing contributions (meaning that coverage would be no more affordable than it is in the Exchange, about 6.7% of household income), The Hilltop Institute projects that 45,000 New Mexicans would enroll in BHP coverage⁷⁶. Given price sensitivity and impact on insurance uptake at these income levels, it is extremely unlikely that either of these estimates – each projecting an uptake rate of about 2/3 – is reliable. New Mexico would need a state-specific analysis that focuses primarily on the BHP in order to obtain realistic enrollment and cost projections. The limitations of the Urban and Hilltop studies are discussed more fully below.

How Much Federal Funding Would Be Available for a BHP in New Mexico?

It is unclear how much federal funding would be available for a New Mexico BHP. State-specific actuarial analysis with a focus on the BHP would be required to accurately predict the amount of BHP funds.

If New Mexico were to implement a BHP, the estimated 58,500 New Mexicans who would be BHP-eligible would no longer be permitted to enroll in plans through the Exchange.⁷⁷ Instead, they would be able to choose among “standard health plans” offered by insurers who contract with the state. In order to fund these contracts, the state would receive a substantial portion of the federal funding that would have subsidized the BHP-eligible individual’s purchase of coverage through the Exchange. Specifically, the state gets 95% of the value of the tax credits and cost-sharing subsidies an individual would have received in the Exchange.⁷⁸ So in order to calculate the federal financing available for a BHP, it is important to understand how tax credits and subsidies will be calculated in the Exchange.

Calculating the Value of Tax Credits and Subsidies in the Exchange

There are two major costs that people must pay for healthcare when they have insurance. The first is the premium – the flat dollar amount the enrollee pays each month to have coverage. The second is cost-sharing, usually seen in the form of copayments and deductibles. After 2014, when people purchase coverage through the Exchange, they will get help with both types of costs.

PREMIUM TAX CREDITS

First, Exchange enrollees will get help paying premiums through premium tax credits. These credits are “advanceable” – they are available throughout the year through the Exchange and enrollees don’t have to wait until the end of the year to get them. The amount of tax credit an individual receives is based on income. An individual is expected to contribute a certain percentage of his income to health insurance costs. This percentage of income is determined

⁷⁵ Stan Dorn, Urban Institute, Basic Health Program: A Webinar for New Mexico at slide 25 [hereinafter Dorn Webinar] (presentation to the Legislative Health and Human Services Committee, Nov. 2011).

⁷⁶ Hilltop Institute, New Mexico Health Care Reform Fiscal Model: Detailed Analysis and Methodology at 29 (Mar. 2012).

⁷⁷ ACA §1331(e)(2).

⁷⁸ ACA § 1331(d)(3)(A)(i). In fact, the state could receive an even higher percentage. See note 6, *supra*.

based on a sliding scale that requires a larger contribution for higher-income people. An individual with income below the poverty level has an expected contribution of 2% of income toward premiums and the tax credit will pay the rest. An individual with income at 200% of the poverty level has an expected contribution of 6.3% of income and the tax credit will pay the rest. The tax credit is then calculated based on the cost of a “Silver Plan” (a plan with 70% actuarial value) in the Exchange.

Table 4: Sample Premium Tax Credit Calculations

	Annual Income	Expected Monthly Contribution	Size of Tax Credit (Per Month) if Silver Plan Costs \$350
Donna (single mother, 1 child)	\$15,130 (100% FPL)	\$25 (2% of income)	$\$350 - \$25 = \mathbf{\$275}$
Jacob & Emilia (married, 2 children)	\$34,575 (150% FPL)	\$115 (4% of income)	$\$700 - \$115 = \mathbf{\$585}$
Abby (single, no children)	\$22,340 (200% FPL)	\$117 (6.3% of income)	$\$350 - \$117 = \mathbf{\$233}$

COST-SHARING SUBSIDIES

Exchange enrollees will also get help with their out-of-pocket costs through cost-sharing subsidies. Cost-sharing refers to the money people with health insurance have to pay in addition to their monthly premium when they use healthcare services. Typically, an enrollee must pay a flat dollar contribution (a copay) or a percentage of the cost of a service (coinsurance) up to an annual cap whenever she uses her health plan. So, for example, she might pay \$25 toward the cost of each prescription or 20% of the cost of a visit to the emergency room – until she hits the annual out-of-pocket maximum, when the plan will begin to pay 100% of the costs. The amount of cost-sharing in a given plan is reflected in the plan’s actuarial value. This is the percentage of total healthcare costs that a health plan will cover.⁷⁹ So for example, if a plan has an actuarial value of 85%, it generally covers 85% of covered health costs and the enrollee must pay the remaining 15% of costs out of pocket. Plans with high actuarial value generally have higher monthly premiums than plans with low actuarial value.

Cost-sharing subsidies will help with these out-of-pocket costs in two ways. First, they will cap the total copayments and deductibles a person can be required to pay. For example, in the chart above, Abby would pay a maximum of \$3,025 per year in cost-sharing before subsidies would pay the rest. Second, the subsidies will lower cost-sharing for people at certain income levels by increasing the plan’s actuarial value. So for example, even though Jacob and Emilia are paying for a plan with 70% actuarial value, subsidies will convert the plan into one with 94% actuarial value. That means lower copays for prescriptions and less in required out-of-pocket costs for visits to the hospital.

⁷⁹ Actuarial value is averaged across all enrollees in a health plan. This means that while, on average, if your plan has an AV of 85% you are responsible for 15% of the costs out of pocket, actual cost-sharing (copayments and deductibles) might be higher or lower depending on the healthcare services you need in a given year.

Applying Tax Credit and Subsidy Values to Calculate BHP Financing

Since tax credits and subsidies will be based on costs associated with plans on the Exchange, calculating available federal financing for the BHP requires projecting those plan costs. In its national BHP analysis, Urban Institute projected these costs for the Mountain Region (a group of about ten states) and concluded that 95% of the value of tax credits and subsidies would be \$5,418 per BHP enrollee across the region.⁸⁰ However, Urban did not conduct New Mexico-specific analysis on this point and cautioned that the value of the tax credits and subsidies in New Mexico could be quite different.⁸¹ By contrast, The Hilltop Institute estimated that 95% of the value of tax credits and subsidies for the BHP-eligible in New Mexico would be \$4,316 per enrollee,⁸² dramatically less than Urban's Mountain Region projections. But while Hilltop's analysis was state-specific, there are reasons to doubt its accuracy as well: the BHP analysis was a small subpoint of a larger healthcare reform implementation and analysis, and the available financing estimate was based on state employee health plan costs – a large group with considerable bargaining power that is likely to have the ability to negotiate better rates than will be able available in the Exchange. In order to accurately assess likely available federal financing for a BHP, New Mexico needs a state-specific actuarial analysis that more accurately estimates the costs of Exchange plans.

How Much Would a BHP Cost in New Mexico?

As with federal financing, it is unclear how much a BHP would cost in New Mexico. In theory, health plans that are offered through the BHP should be less expensive than plans offered on the Exchange because the state contracts with health plans on the BHP and has more bargaining power than individuals would have on an Exchange. However, state-specific actuarial analysis that focuses on the BHP is required to obtain a reliable projection of BHP per-member costs.

Urban Institute and Hilltop Institute both addressed this question in their analyses, but again, their projections suffer from serious limitations. Urban's model assumes extremely low cost-sharing: \$100 annual premiums and 98% actuarial value. Based on some studies suggesting that the BHP population will be younger and healthier than the Exchange population generally, Urban projected this level of BHP coverage would cost \$4,426 per enrollee each year.⁸³ But again, this projection is of limited value to New Mexico because it is a *regional* projection that aggregates ten states.

By contrast, the Hilltop Institute projected a total cost in New Mexico of \$5,570 per enrollee each year.⁸⁴ But this estimate is likely inflated as it is based on an assumption that BHP per-enrollee costs will be similar to State Coverage Insurance (SCI) enrollee costs because the costs are negotiated by the state. However, because of the absence of an individual mandate

⁸⁰ Dorn Webinar, *supra* note 75, at slide 23.

⁸¹ *Id.*

⁸² Hilltop Institute, New Mexico Health Care Reform Fiscal Model: Detailed Analysis and Methodology [hereinafter Hilltop Institute] at 29 (Mar. 2012).

⁸³ Dorn Webinar, *supra* note 75, at slide 23.

⁸⁴ Hilltop Institute, *supra* note 82, at 29.

when SCI enrollment was open and the fact that the SCI program has been frozen and losing membership by attrition over the past several years, the SCI population is likely to be less healthy and more expensive than the BHP population as a whole. It may be that the better comparison group is very low-income parents in the state's JUL Medicaid program. The differences between SCI costs and JUL Medicaid costs are dramatic: JUL enrollees cost \$4,257 per year in 2011 compared to SCI enrollees who cost \$7,200 per year in the same year.

New Mexico needs a state-specific actuarial analysis that focuses on the BHP to obtain a reliable projection of likely BHP costs. Without an independent analysis that predicts enrollment, federal financing, and per-member costs of BHP coverage (modeled at a variety of cost-sharing levels), state policymakers will not have the information they need to make an informed decision about BHP implementation. Among other things, this analysis could determine (1) how much more affordable would BHP coverage be than Exchange coverage; (2) whether available federal funds would fully cover the costs of BHP coverage and administration; and (3) whether a state general fund appropriation would be necessary to supplement federal funds for a BHP.

Additional Benefits of BHP Implementation

A BHP could be a good investment for the state even if federal funds are inadequate to cover program costs and it requires a general fund appropriation. First, as outlined in Section II of this report, it is clear that affordability is likely to be a barrier to Exchange enrollment for individuals with incomes below 200% FPL. Low take-up of insurance in the Exchange and continued high rates of uninsurance hurt everyone in New Mexico – particularly those who are the victims of persistent health disparities that flow from unequal access to care. Second, New Mexico providers currently shoulder the burden of hundreds of millions of dollars in uncompensated care costs – and that burden would be reduced if a BHP were to ensure that more people get coverage. Third, studies show that income fluctuations at this income level are likely to make continuity of coverage a serious concern, and a BHP has the potential to lessen that problem. Fourth, securing coverage for more than 50,000 New Mexicans through the BHP would likely improve access to healthcare and health outcomes, not just for individuals but for entire communities. And finally, local businesses would realize benefits from expanded healthcare coverage.

Reductions in Uncompensated Care

People who are uninsured pay about 37% of their healthcare costs out of pocket.⁸⁵ Government programs and charities pay another 26%.⁸⁶ The remaining portion – 37% – is called “uncompensated care.” According to the New Mexico Hospital Association, hospitals in the state had \$362 million in uncompensated care costs on 2011. And while hospitals are the primary source of uncompensated care in the state, they are not the only source. The American Medical Society's Socioeconomic Monitoring System found that 68% of physicians nationally provide some uncompensated care, spending an average of 7.2 hours each week

⁸⁵ FAMILIES USA, COSTLY COVERAGE: PREMIUMS OUTPACE PAYCHECKS IN NEW MEXICO at 7 (Sep. 2009).

⁸⁶ *Id.*

delivering it.⁸⁷ Ensuring access to affordable healthcare coverage for more than 50,000 people would reduce these uncompensated care costs, easing the burden on New Mexico’s providers.

Minimizing the Negative Impacts of “Churn” and Ensuring Continuity of Coverage

One concern for states in ACA implementation is the management of transitions as individuals’ incomes fluctuate in ways that move them from Medicaid eligibility to Exchange eligibility or vice versa. These transitions from one source of insurance coverage to another are known as “churn,” and it is not a new problem – but its scope will increase greatly as more low-income people gain access to coverage under the ACA.⁸⁸ Experts estimate that nearly one third of the people who qualify for Exchange subsidies or Medicaid will change eligibility status each year.⁸⁹ The BHP mitigates this problem because people whose incomes rise above 138% FPL would be placed into state-contracted plans rather than private plans in the Exchange. The state can structure its BHP system and contracts to align well with the Medicaid system to smooth these transitions. And because incomes are more volatile at 138% of poverty, moving the “churn” point to 200% FPL would reduce churning by 16% because people at higher income levels are more likely to have coverage available through their employers.⁹⁰

Improving Health of Communities

As mentioned in Section II, affordable coverage translates into improved healthcare and health outcomes. Studies also show that creating a culture of coverage in a community improves health not just for the newly insured, but for the community as a whole. Lowering the rate of uninsurance in a community helps people who have private coverage in that community. A recent study found that a 10% increase in uninsured people in a community reduced the probability that people with insurance in that same community would have a usual source of care by 6.2% and increased the probability they would have difficulty with, delay, or not receive needed care by 7.7%.⁹¹ This same increase in the rate of uninsurance decreases the probability the insured in the same community will be “somewhat” or “very” satisfied with their care by 1.9% and increases the probability of a very low index of satisfaction by 3.6%.⁹²

Benefits for Local Businesses

New Mexico’s small businesses would also realize the benefits of a BHP. Employers bear the cost of the uninsured through lost productivity, turnover, and absenteeism. A 2001 survey found that 16% of people without insurance reported missing work during the year due to a dental problem, compared to 8% with insurance.⁹³ In fact, the National Bureau of Economic

⁸⁷ Jack Hadley & John Holahan, *How Much Medical Care Do the Uninsured Use, and Who Pays for It?*, W3 HEALTH AFFAIRS 66, 71 (Feb. 2003).

⁸⁸ Matthew Buetggens et al., *Churning Under the ACA and State Policy Options for Mitigation* (Robert Wood Johnson Foundation Timely Analysis of Immediate Health Policy Issues, Jun. 2012).

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ Carole Roan Gresenz & José J. Escarce, *Spillover Effects of Community Uninsurance on Working-Age Adults and Seniors*, 49 MEDICAL CARE e14, e17 (Sep. 2011) [hereinafter *Spillover Effects*].

⁹² *Id.* at e17.

⁹³ Commonwealth Fund 2001 Health Insurance Survey.

Research has found that increased expenditures on health might be justified purely on the grounds of productivity impact. That study found that a one-year improvement in a country's life expectancy translates into 4% growth in Gross Domestic Product (GDP).⁹⁴

⁹⁴ Bloom et al., *The Effect of Health on Economic Growth: Theory and Evidence* (National Bureau of Economic Research, Nov. 2001).

IV. What Information Would New Mexico Need to Make a Decision About BHP Implementation?

Despite the clear potential benefits of a BHP, New Mexico policymakers still need the answers to several key questions before a fully informed decision can be made about whether or not a BHP is the right affordability solution for New Mexico.

Areas Where Federal Guidance Is Required

Several significant uncertainties remain that make it difficult to accurately assess the benefits and drawbacks of a BHP. Like many other states, New Mexico requires guidance from the federal government before a full analysis of the BHP in the state can be completed.

Most significantly, the federal government must issue guidance setting out its BHP financing methodology and rules. First, for states to determine if the Basic Health Plan is affordable, what benefits they will be able to offer and to what extent the BHP might enable them to reduce individuals' premium and cost-sharing obligations, they need to know how the federal government will calculate its payments to support the program.⁹⁵ This requires defining the process by which the federal government will calculate the federal BHP payments to the states, as well as how it will reconcile over and under-payments to the states based on the covered individuals' reported income in the year following BHP enrollment.⁹⁶

States also need to know whether any portion of the federal BHP allocation may be utilized to support the state's administrative costs.⁹⁷ While it is likely that federal payments will apply to both the costs of coverage and administration, there is a possibility that the state could be left with shouldering the costs of administering the BHP.

Finally, federal guidance is needed to determine whether Exchange establishment grant funds may be used for BHP planning and implementation activities. Several BHP state analyses have proceeded using funds from Exchange grants, but absent federal guidance, it is impossible to know whether this will actually be permitted.

In addition to financing questions, New Mexico and other states would benefit from clear federal guidance about risk-sharing in the Exchange and the BHP. In small states like New Mexico, the Exchange will be most viable and costs for health coverage will be lower if the BHP and Exchange risk pools could be combined. Federal guidance is required to determine whether this type of risk pooling is allowed and what method is recommended for risk adjustment between insurance carriers.

⁹⁵ January Angeles, *State Considerations on Adopting Health Reform's "Basic Health" Option: Federal Guidance Needed for States to Fully Assess Option* [hereinafter *State Considerations*] at 8 (Center for Budget and Policy Priorities, 2012); Fredrick Blavin et al., *The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State* at 15, (Urban Institute Health Policy Center, March 2012).

⁹⁶ MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, ANALYSIS OF THE BASIC HEALTH PROGRAM, at 2 (January 2012).

⁹⁷ *Id.*; *State Considerations*, *supra* note 95, at 10.

Federal guidance is also required to evaluate the BHP's ability to mitigate negative effects from churn – people switching between coverage options including Medicaid, the Exchange, and BHPs as their incomes fluctuate. The BHP could –dramatically reduce churning if it were permitted to adopt 12 month “continuous eligibility” guidelines, like the Medicaid program. Continuous eligibility would allow individuals to remain on the BHP for 12 months regardless of fluctuations to their income – a benefit that's especially important for temporary, seasonal or contract workers so that they do not suffer interruptions to their health coverage and access to care.

In June 2012, Washington state took the initiative on these matters by submitting a BHP proposal to the federal Department of Health and Human Services.⁹⁸ This proposal puts forth a recommended resolution for many of the open questions described above. In its proposal, for example, Washington recommends that:

- Consistent with the Medical Loss Ratio rules in the state's Medicaid/CHIP program, BHP federal funds be allowed to be used for administrative costs;⁹⁹
- Continuous eligibility be considered for BHP as well as for Medicaid to mitigate the consequences of churn when incomes fluctuate and family structures change;¹⁰⁰
- Statutory ambiguity about cost-sharing requirements be resolved by establishing a single required actuarial value of 92% for all BHP enrollees;¹⁰¹ and
- The reconciliation/adjustment process hold the state harmless for the first three years of BHP operations – until enough data can be collected to ensure reasonable predictability/stability in the calculation of federal BHP financing.¹⁰²

⁹⁸ Letter to Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services, from Doug Porter, Director, State of Washington Health Care Authority (June 18, 2012).

⁹⁹ WASHINGTON STATE PROPOSAL FOR A FEDERAL BASIC HEALTH OPTION at 4-5 (Washington State Health Care Authority, June 18, 2012).

¹⁰⁰ *Id.* at 7.

¹⁰¹ *Id.* at 10-11.

¹⁰² *Id.* at 16.

V. Conclusion & Recommendations for Next Steps

Immediate action on the BHP: If New Mexico were to determine that a BHP is in the best interests of the state, it could consider an application to HHS similar to Washington state's that affirmatively resolves some of the questions outlined above, rather than waiting for HHS to issue federal guidance.

Further study of the affordability problem: If the Legislature determines that further study of affordability and the BHP is warranted, the Legislature could establish a workgroup or subcommittee dedicated to further investigation of this problem with a goal of establishing recommendations for legislative action in the 2014 or 2015 Legislative Session. Some tasks that the workgroup or subcommittee could undertake include:

Obtaining in-depth, state-specific actuarial analysis of the BHP in New Mexico. Using the analyses done for California,¹⁰³ Connecticut,¹⁰⁴ Massachusetts,¹⁰⁵ Minnesota,¹⁰⁶ New Hampshire,¹⁰⁷ New York,¹⁰⁸ North Carolina,¹⁰⁹ and Washington¹¹⁰ as models, New Mexico could contract with an independent actuarial firm to calculate likely costs to the state, costs to enrollees, and scope of BHP benefits package given available federal financing in New Mexico.

Researching and evaluating alternatives to the BHP. It may be that there are other solutions to the affordability problem that are a better fit for New Mexico than the BHP. Some possible options include:

Exchange Premium Assistance Program: New Mexico could explore the viability of a state-based Exchange premium assistance program to supplement the federal financial assistance individuals receive when they enroll in plans through the Exchange. This program could pay all or a portion of the premiums owed to encourage enrollment and discourage underinsurance through the selection of a low-premium, high deductible plan. Vermont, for example, already has a premium assistance programs in place.¹¹¹ And New Mexico previously had premium assistance programs in place for children and pregnant women who were not income eligible for Medicaid.¹¹²

¹⁰³ State of California Financial Feasibility of a Basic Health Program (Mercer, Jun. 28, 2011) (analysis by Mercer).

¹⁰⁴ Sustinet Health Partnership, Report to the Connecticut General Assembly (Jan. 2011) (analysis by Sustinet Health Partnership).

¹⁰⁵ Jeremy Palmer, Healthcare Reform and the Basic Health Program Option (Apr. 2011) (analysis by Milliman).

¹⁰⁶ Jonathan Gruber and Bela Gorman, Coverage and Financial Impacts of Market Reforms and a Basic Health Plan (BHP) in Minnesota (Nov. 18, 2011) (analysis by MIT and Gorman Actuarial).

¹⁰⁷ Endowment for Health/Health Strategies of New Hampshire, Analysis of the Basic Health Program Options for New Hampshire (Feb. 9, 2012) (analysis by Mercer and Manatt Health Solutions).

¹⁰⁸ Elisabeth Benjamin and Arianne Slagle, Covering More New Yorkers While Easing the State's Budget Burden (Community Service Society and NYS Health Foundation, Jun. 2011) (analysis by Manatt Health Solutions).

¹⁰⁹ Milliman, North Carolina Health Benefit Exchange Study (Mar. 31, 2011) (analysis by Milliman).

¹¹⁰ Milliman, The Federal Basic Health Program: An Analysis of Options for Washington State (Dec. 2011) (analysis by Milliman).

¹¹¹ <http://www.greenmountaincare.org/> (describing the state's Catamount Care Program).

¹¹² See NMAC 8.171 and 8.172.

Bridge Option: Another option worth investigation is Tennessee’s Bridge Option, which would put in place a single plan for families that would otherwise be “split” between different plans because some household members are enrolled in Medicaid and others have private insurance.¹¹³ There is currently limited information available about the “Bridge Option” but it merits further investigation.

Medicaid Expansion up to 200% FPL: Finally, states continue to have the option to expand eligibility for adults beyond those whose incomes fall below 138% of the federal poverty level (FPL). New Mexico could decide to simply expand Medicaid eligibility up to 200% FPL. This would be paid jointly by federal and state funds, where the state would receive its regular rate of federal matching funds for Medicaid.

All of these options should be explored and compared to the BHP to identify the best course of action for New Mexico.

Data collection on affordability of Exchange coverage: If New Mexico does not decide to implement a BHP beginning in January 2014, the state should ensure that data is collected through the Exchange to inform a decision on a BHP or other affordability solutions in the future. The state should monitor Exchange enrollment levels in the BHP income range and should track which plans these families choose. The state should also collect data on whether families that choose Bronze coverage are more likely to experience financial hardships including medical debt or delay medical care due to high copayments and deductibles. The Legislature should consider whether to incorporate this data collection and reporting in any Exchange or other healthcare reform legislation.

¹¹³ Tennessee Insurance Exchange Planning Initiative, Bridge Option: One Family, One Card Across Time (Nov. 2011).