Mercer

Government Human Services Consulting

Implementation of Medicaid Forward

Impacts on Enrollment, Rates, and Costs

New Mexico Health Care Authority

November 21, 2024

Executive Summary

As directed by the New Mexico legislature in House Bill 400 (2023), this report presents results from a study to estimate the impact of Medicaid Forward. The Medicaid Forward plan would expand Medicaid eligibility so that health care coverage would be available for most New Mexicans under age 65 who are not otherwise eligible for the existing Medicaid program. This report estimates the impact of such a coverage expansion across several topics, including enrollment in health insurance, the uninsured rate, health care providers, access to care, and State costs and revenue.

Informed by broad-based stakeholder input, the study models seven potential program designs, each defined by income eligibility limits and enrollee financial responsibility (i.e., premiums and cost sharing). The body of this report highlights three of those designs, labeled “targeted” for purposes of comparison, and the remaining four designs are provided in the Appendix.

All seven designs result in an increase in Medicaid enrollment and decreases in private insurance enrollment and the uninsured population. From the least expansive design to the most expansive, Medicaid enrollment is estimated to increase between 93,000 and 326,000. The least expansive design caps income eligibility at 200% of the federal poverty level (FPL) with no enrollee financial responsibility. (For 2024, an annual income of 200% of FPL is $30,120 for a one-person household and $62,400 for a household of four.) The most expansive design has no upper income limit on eligibility or enrollee financial responsibility. The number of individuals covered by both employer sponsored insurance and BeWell is estimated to decrease by between 43,000 and 225,000, or between 5% and 26%. The number of uninsured individuals is estimated to decrease by between 50,000 and 101,000, or between 30% and 59%.

All designs attempt to hold providers harmless by estimating the adjustment to total Medicaid reimbursement necessary to maintain provider revenue levels in the New Mexico health care system from all coverage sources. The adjustment is intended to offset decreases in private insurance reimbursement due to the shift from private insurance coverage to Medicaid. The magnitude of the payer mix offset varies by design, with total Medicaid provider payments increasing from 1.2% to 3.6%, above and beyond the $1.7 billion in pending rate actions that are scheduled to be implemented in the Medicaid program over the next 12 months.

The study estimates the change in Medicaid spending by comparing the administrative and service cost of Medicaid Forward to revenues that could be available to fund the program under current law. For all designs, total Medicaid spending is estimated to increase State expenditures between $232 million to $581.7 million before additional potential revenues. The study estimates that as the income eligibility for Medicaid increases, additional private dollars such as “freed up” employer premium contributions for employees that move to Medicaid potentially become available to tax as a source of the State’s Medicaid share. Of the potential program designs modeled, no design could be fully funded with current revenue sources.

The study evaluates existing funding sources that could be repurposed to pay for Medicaid Forward, including State employer contributions to health insurance premium costs and State health insurance premium taxes. The study quantifies private employer contributions, which with legislative action could be a new revenue source to fund the increased Medicaid

spending, as well as enrollee financial responsibility (e.g., premiums and cost sharing) that is not currently applied to New Mexico's Medicaid program.

The study examines federal authority pathways to expand Medicaid eligibility and authorize a managed care delivery system for the Medicaid Forward plan. In addition to long-term sustainability, the examination considers the level of complexity, effort, and cost to develop and operate Medicaid Forward across relevant federal authorities.

The study assumes a stable provider environment but acknowledges that provider access and workforce shortages are challenges in New Mexico as elsewhere. Given the limited enrollee financial responsibility under the proposed Medicaid Forward program, Mercer anticipates additional demand would necessitate an increased supply of providers. This study does not assess the impact of other barriers to provider attraction and retention raised by stakeholders.

There are several important factors that policymakers must weigh in determining how to implement Medicaid Forward. This report is meant to inform that decision-making process.

Contents

Section 1
Introduction

In 2023, New Mexico's legislature passed House Bill 400 (HB 400) directing the New Mexico Health Care Authority (HCA) to conduct a study of a plan that would leverage Medicaid, and associated federal funding, to create a state-administered health care coverage option called Medicaid Forward. This plan would expand Medicaid to New Mexicans who are under age 65, are not otherwise eligible for and enrolled in Medicaid, and have household income that exceeds 133% of FPL.[1,2] The eligibility pathway envisioned by Medicaid Forward was created by the Affordable Care Act (ACA) and gives states the option to set the income eligibility limit, which is not capped by the law.[3] To date, the District of Columbia is the only Medicaid program to cover this eligibility group and it has capped income eligibility at 215% of FPL.[4]

Informed by broad-based stakeholder engagement, the study was conducted by Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, on behalf of HCA. This report provides:

- Analysis of the expected impact of the Medicaid Forward plan on enrollment levels by key health care coverage market segments (e.g., Medicaid and private insurance).
- Analysis of the expected impact of the Medicaid Forward initiative on revenues for health care providers and facilities from all coverage sources.
- Analysis of the costs — in terms of the State's share of Medicaid costs, for both health care services and State administration, and potential enrollee financial responsibility (e.g., premiums and cost sharing) — associated with the Medicaid Forward initiative.
- Analysis of federal authority strategies to implement the Medicaid Forward plan and considerations regarding the sustainability of the strategies.

This study complements a previous study, published in August 2023, conducted by the Urban Institute (UI) on behalf of the New Mexico Office of the Superintendent of Insurance (OSI).[5] The Mercer and UI studies differ in approach, such as designs modeled, data sources and modeling methods, which results in different outcomes.

[1] HB400 as chaptered: State of New Mexico, 56th Legislature, First Session, 2023, Chapter 198, available at https://www.nmlegis.gov/Sessions/23%20Regular/final/HB0400.pdf.

[2] The Affordable Care Act specifies of that childless adults are Medicaid-eligible with "modified adjusted gross income" (MAGI) at or below 133% of FPL. Because of the way MAGI is calculated, the income eligibility threshold is effectively 138% of FPL.

[3] Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act (SSA); 42 CFR 435.218.

[4] District of Columbia State Plan Amendment DC-15-010, available at https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/DC/DC-15-0010.pdf. Note the SPA indicates an income eligibility limit of 210% of FPL but due to the MAGI calculation methodology, the limit is effectively 215% of FPL. To determine Medicaid programs that cover this population, Mercer used Kaiser Family Foundation's (KFF) State Health Facts tool to query all states and "Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level" as of May 2024. The KFF resource is available at https://www.kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/

[5] Matthew Buettgens, Jason Levitis, Jessica Banthin, Urmi Ramchandani, Michael Simpson, Medicaid Forward in New Mexico: Health Coverage, Health Care Spending, and Government Costs, Urban Institute, August 25, 2023, available at https://www.urban.org/research/publication/medicaid-forward-new-mexico.

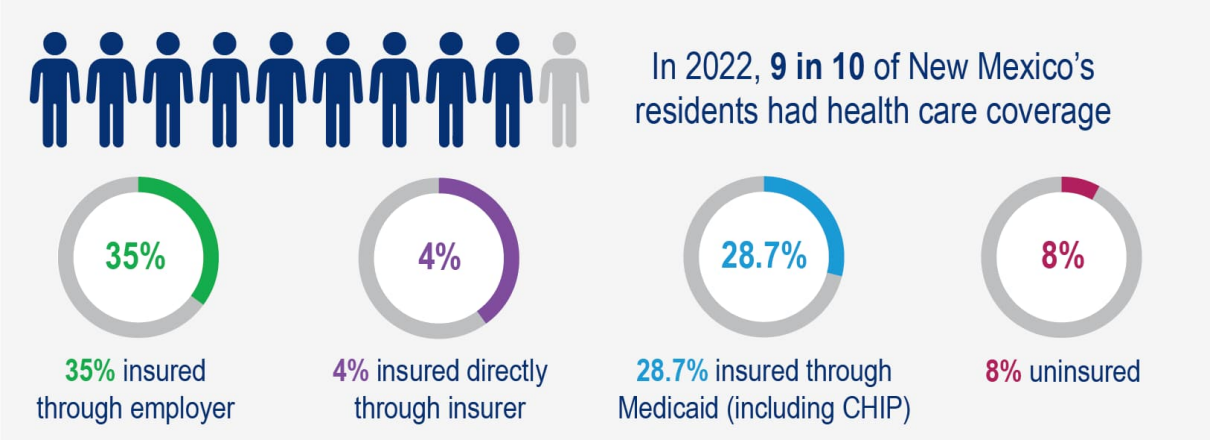
Section 2

Current Coverage Landscape

Medicaid Forward would significantly impact health care coverage in New Mexico, shifting enrollment across coverage sources as well as reducing the rate of uninsured in the state. The following provides a baseline understanding of the current coverage landscape, summarizes the eligible and enrolled populations, benefits, delivery system, and cost and funding sources (where applicable) for each source of health care coverage.

In 2022, 9 in 10 of New Mexico's more than two million residents had health care coverage according to the U.S. Census Bureau American Community Survey (ACS).[6] Among those with coverage, 40% had private health insurance, including 35% with coverage through a job (including private sector employers and federal, State and local governments) and 4% covered by a policy purchased directly from an insurance company or through the State's Health Insurance Marketplace (BeWell).

Approximately 44% were enrolled in at least one public program, with Medicaid (including the Children's Health Insurance Program [CHIP]) representing the largest source of public coverage (28.7%).[7] Approximately 170,000 (8%) were uninsured, including 25,000 Native Americans (13% of all Native Americans).[8]



It should be noted that the ACS figures for the Medicaid program vary from state sources, which reflect the state's enrollment gains during the Coronavirus disease 2019 (COVID-19) Public Health Emergency (PHE) when all states were required to maintain continuous enrollment for Medicaid members. As of February 1, 2022, HCA reported total Medicaid enrollment of over 950,000, or more than half of all New Mexicans.[9,10] Medicaid enrollment fluctuates from month to month. This study uses the State's projected enrollment for the

[6] American Community Survey, 2022, DP03 Selected Economic Characteristics, Health Insurance, U.S. Census Bureau, available at https://data.census.gov/table/ACSDP1Y2022.DP03?q=DP03&t=Health%20Insurance&g=040XX00US35&y=2022.

[7] Id.

[8] U.S. Census Bureau. "Selected Characteristics of Health Insurance Coverage in the United States." American Community Survey, ACS 1-Year Estimates Subject Tables, Table S2701, 2022, available at https://data.census.gov/table/ACSST1Y2022.S2701?t=Health Insurance&g=040XX00US35.

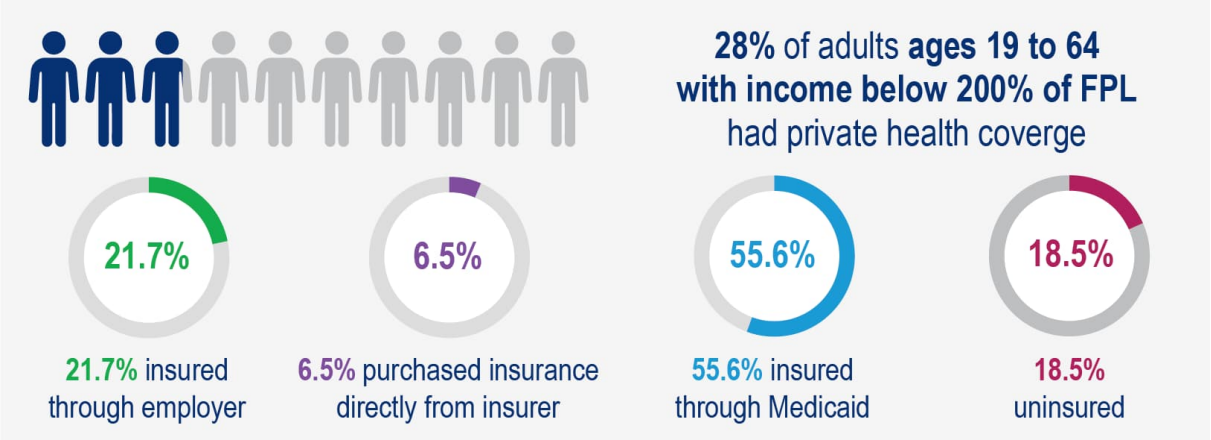
[9] HCA, Medicaid Enrollment Report By Managed Care Organization/Fee-for-Service Thru: 01/01/2022 - 01/31/2022 as of 02/01/22, available at https://www.hca.nm.gov/wp-content/uploads/January-By-Managed-Care-Organization-Fee-for-Service-1.pdf.

[10] HCA, New Mexico Medicaid Alert, available at https://renew.hsd.nm.gov/PHE_Provider_Flyer_08.pdf.

Medicaid managed care program of 687,000 as a baseline for modeling Medicaid Forward designs to align with the anticipated delivery system for most of the individuals eligible for Medicaid Forward.

Among adults ages 19 to 64 (non-elderly adults), the mix of coverage sources is different from that of the state overall.[11] In 2022, non-elderly adults had higher rates of private health insurance (59.5%), including 50.9% through a job, reflecting the group's working age demographic, and 8.6% purchased directly from insurers. These adults had lower rates of public coverage (34.2%). By and large, these adults are too young for Medicare, which covers seniors (age 65 and older) and people under age 65 with long-term disabilities (4.4% had Medicare), or they have income that is too high to qualify for Medicaid (29.8% had Medicaid). The rate of uninsurance for this group of New Mexicans (12.5%) was roughly 50% higher than the uninsured rate for the state overall. The rate of uninsurance among Native Americans in this age group was more than twice the rate for the state overall (18%).[12]

Among non-elderly adults with income below 200% of FPL, 28% had private health coverage, including 21.7% with coverage from a job and 6.5% purchased directly from insurers.[13] The majority were enrolled in Medicaid (55.6%) and 8% were enrolled in other public coverage programs. Nearly one in five (18.5%) were uninsured, more than twice the overall uninsurance rate.



As household income at various levels are referenced throughout this report and are relevant to Medicaid Forward, Table 1 provides a snapshot of the 2024 FPLs and a link to the full poverty guidelines.

[11] American Community Survey, 2022, DP03 Selected Economic Characteristics, Health Insurance, U.S. Census Bureau, available at https://data.census.gov/table/ACSDP1Y2022.DP03?q=DP03&t=Health%20Insurance&g=040XX00US35&y=2022.

[12] U.S. Census Bureau. "Health Insurance Coverage Status by Age (American Indian and Alaska Native Alone)." American Community Survey, ACS 1-Year Estimates Detailed Tables, Table C27001C, 2022, available at https://data.census.gov/table/ACSDT1Y2022.C27001C?t=Health Insurance&g=040XX00US35.

[13] American Community Survey, 2022, DP03 Selected Economic Characteristics, Health Insurance, U.S. Census Bureau, available at https://data.census.gov/table/ACSDP1Y2022.DP03?q=DP03&t=Health%20Insurance&g=040XX00US35&y=2022.

Table 1. 2024 Federal Poverty Guidelines[14]

Household Size	138% FPL	200% FPL	300% FPL	400% FPL
1 person	$20,783	$30,120	$45,180	$60,240
4 people	$43,056	$62,400	$93,600	$124,800

Immigrants

In 2022, an estimated 195,000 people (9.4% of the total State population) were foreign born, and the majority were non-citizens (5.3% of the total State population).[15] Non-citizens are more likely to be uninsured than citizens because they face eligibility restrictions for federally funded options, including Medicaid and Marketplace coverage.[16] Approximately 26% of the State's uninsured are non-citizens.

"Lawfully present" immigrants may qualify for Medicaid subject to certain eligibility restrictions. In general, lawfully present immigrants must have a "qualified" immigration status to be eligible, and many, including most lawful permanent residents or "green card" holders, must wait five years after obtaining qualified status before they may enroll in Medicaid. Individuals with unsatisfactory immigration status are ineligible to enroll in Medicaid, except for payment for treatment of an emergency medical condition when other eligibility requirements, such as income and state residency, are also met.[17,18]

There is a limited coverage pathway under CHIP, known as the "From-Pregnancy-to-the-End-of-Conception" (FCEP) or "unborn child" option, that provides pregnancy-related coverage regardless of the pregnant person's immigration status; however, this coverage terminates at birth of the child and is only an option under Separate CHIP programs.[19] This limited coverage pathway was not explored for purposes of the Medicaid Forward study as it is a CHIP pathway using CHIP allotment funding and is not Medicaid coverage.

Federal law establishes strict limitations on Medicaid coverage for individuals with unsatisfactory immigration status that would apply to Medicaid Forward. Any initiative to provide broader coverage for this population would need to be fully state funded.

Key Sources of Coverage

Medicaid

Medicaid is a joint federal-state program created to be a source of health care coverage for low-income pregnant women and children, parents, and certain aged and disabled

[14] US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "2024 Poverty Guidelines: 48 Contiguous States", available at https://aspe.hhs.gov/sites/default/files/documents/7240229f28375f54435c5b83a3764cd1/detailed-guidelines-2024.pdf.

[15] American Community Survey, 2022, DP03 Selected Economic Characteristics, Health Insurance, U.S. Census Bureau, available at https://data.census.gov/table/ACSDP1Y2022.DP03?q=DP03&t=Health%20Insurance&g=040XX00US35&y=2022.

[16] Healthcare.gov, Immigrants, available at https://www.healthcare.gov/immigrants/lawfully-present-immigrants/.

[17] 8.325.10 NMAC.

[18] However, although individuals covered under Deferred Action for Childhood Arrivals (DACA) are also ineligible for Medicaid, they can now purchase insurance through the Exchange.

[19] Pregnancy, Prenatal Care, and Newborn Coverage Options. Centers for Medicare and Medicaid Services. September 2023, available at https://www.cms.gov/marketplace/technical-assistance-resources/pregnancy-prenatal-care-newborn-coverage-options.pdf.

individuals.[20] States must provide health care coverage for certain mandatory populations and have the option to extend coverage to certain additional populations.

Medicaid is funded by a combination of federal and state funds. Federal financial participation is based on an individual state's average per capita income relative to the national average. States with lower average per capita income compared to the national average will pay less for Medicaid than states with higher average per capita income. The federal share of a state's Medicaid expenditures is known as the Federal Medical Assistance Percentage (FMAP). For example, in federal fiscal year (FFY) 2025, New Mexico must pay for 28.32% of every dollar for medical services provided to enrollees in traditional Medicaid and the federal government will pay the other 71.68%.[21] Services to adults eligible for Medicaid through the ACA Medicaid expansion are matched at 90%.[22] States must pay for the "state share" of total Medicaid spending to draw down federal funding.

For purposes of this study, Mercer does not account for future changes in New Mexico's FMAP resulting from periods of economic growth or decline. By contrast, the UI study posited that Medicaid Forward would significantly reduce the offering of employer-sponsored insurance and employers would use premium contribution savings to raise employee wages. The increase in wages could in turn increase state per capita income, decrease the state FMAP, and increase required state match.[23] The scope of any potential decrease in New Mexico's FMAP due to Medicaid Forward's impact on per capita income would have to account for the national per capita income. This cannot be modeled at a level of confidence to use an FMAP rate other than New Mexico's current rate of 71.68%.

Eligibility and Enrollment

Household income is a key factor in Medicaid eligibility determinations and income limits vary by eligibility group. For example, New Mexico's income eligibility limit for non-elderly, non-disabled adults is 138% of FPL but it is 305% of FPL for children. In New Mexico, CHIP operates as a Medicaid expansion program rather than as a "Separate CHIP" program. This means that Medicaid laws generally apply, and Medicaid FMAP is available after CHIP allotment funds are expended.[24]

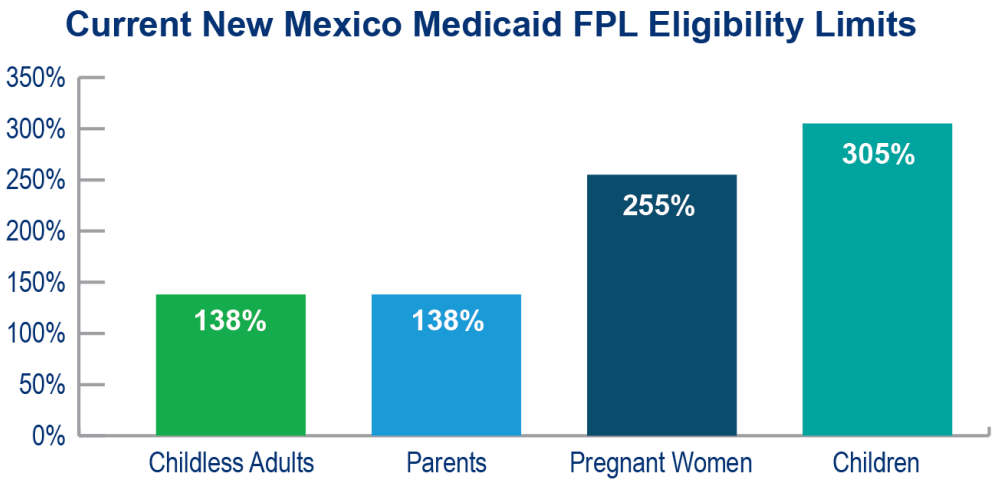
[20] MACPAC. Medicaid 101, available at https://www.macpac.gov/medicaid-101/.

[21] The Department of Health and Human Services issues the FMAP per state for each FFY in the Federal Register and the FFY25 FMAP rates is at Federal Register, November 21, 2023 (Vol. 88, No. 223), pp 81090-81093, available at https://www.govinfo.gov/content/pkg/FR-2023-11-21/pdf/2023-25636.pdf and at Kaiser Family Foundation, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," available at https://www.kff.org/state-category/medicaid-chip/medicaid-spending/.

[22] 42 CFR 433.10(c)(6).

[23] Matthew Buettgens, Jason Levitis, Jessica Banthin, Urmi Ramchandani, Michael Simpson, Medicaid Forward in New Mexico: Health Coverage, Health Care Spending, and Government Costs, Urban Institute, August 25, 2023, available at https://www.urban.org/research/publication/medicaid-forward-new-mexico.

[24] Women, Children, & Family Medicaid Categories, New Mexico Human Services Department, available at https://nmmedicaid.portal.conduent.com/static/PDFs/PE%20Forms/MAD222.pdf; Aged, Blind and Disabled Medicaid Programs, New Mexico Human Services Department, available at https://nmmedicaid.portal.conduent.com/static/PDFs/PE%20Forms/MAD029.pdf; Federal Financing for the State Children's Health Insurance Program (CHIP), Congressional Research Service, Updated May 23, 2018, available at https://crsreports.congress.gov/product/pdf/R/R43949.



Any adult that wants Medicaid coverage, including those applying under Medicaid Forward, must apply and reapply every year. This application must include information about residency and income. A detailed discussion of the eligibility determination process can be found in Sections 5 and 6.

Benefits

In New Mexico, Medicaid has two categories of full benefit coverage, including standard Medicaid coverage and Alternative Benefit Plan (ABP) coverage. Based on HB400's description of the Medicaid Forward population, the managed long-term services and supports (MLTSS) program is excluded from this analysis.

Standard Medicaid coverage is available to children, pregnant women, non-elderly adults, and seniors and people with disabilities and provides comprehensive physical and behavioral health services (mental health and substance use disorder), emergency services, dental and vision services, and non-emergency medical transportation (NEMT), among other services categories.[25] Under federal law, the Medicaid Forward population would not qualify for ABP coverage.[26]

Premiums and Cost Sharing

New Mexico does not currently apply premiums or cost sharing (i.e., copayments, coinsurance, and deductibles) in its Medicaid program. Although attempts were made in the past to apply targeted premiums and cost sharing in New Mexico, there are multiple complexities involved that are discussed in Section 6.

Delivery System

Managed care is the predominant delivery system for New Mexico's Medicaid program, known as Turquoise Care, and covers physical health, behavioral health, and long-term services and supports (LTSS). As of June 2024, 81% of all Medicaid members are enrolled

[25] Eligibility, MACPAC, available at: https://www.macpac.gov/medicaid-101/eligibility/.

[26] Section 1937 of the SSA governs the ABP authority and subparagraph (B) following section 1937(a)(1) limits applicability of the ABP to Medicaid eligibility categories in existence before passage of this section in 2006. The ACA created an exception to this limitation and applied benchmark coverage to the VIII group population at 1902(a)(10)(VIII) of the SSA, but did not do so for optional XX group, at 1902(a)(10)(A)(ii)(XX) of the SSA, that would be the basis for Medicaid Forward's eligibility expansion.

in Managed Care Organizations (MCOs). HCA uses federal section 1115 demonstration authority for its managed care delivery system and this authority permits mandatory enrollment of Native American beneficiaries that are dual eligible (for Medicare and Medicaid) or would be eligible for nursing facility care.[27] HCA pays the MCOs a monthly capitation or per member per month (PMPM) payment for each enrollee and the federal government applies the FMAP to capitation payments.[28]

New Mexico has a relatively small percentage of individuals in a fee-for-service (FFS) delivery system that is administered by HCA. Under FFS, the State contracts directly with "any willing provider" that meets the qualifications to provide services and HCA pays for services rendered according to the reimbursement methodologies in the Medicaid State Plan. As of June 2024, New Mexico covered 59,838 individuals under full benefit FFS, which represents 7% of the total Medicaid enrollment.[29] Under an FFS delivery system, the federal government applies the FMAP to services received by beneficiaries. New Mexico's FFS program serves Native American beneficiaries who did not choose to enroll with an MCO and beneficiaries in limited Medicaid benefit programs, such as the Breast and Cervical Cancer program, coverage limited to family planning services, and emergency medical services for immigrants who do not otherwise qualify for Medicaid.

Private Coverage

Key sources of private health insurance in New Mexico are employer-sponsored insurance and individual market coverage. Employer-sponsored insurance is offered by both governmental and private sector employers. Individual market coverage is available through BeWell and the New Mexico Medical Insurance Pool, as well as health plans that sell coverage directly to individuals. Each source of coverage has its own eligibility and enrollment criteria, benefits, costs, provider networks, provider reimbursement rates, and employer and employee contributions to the cost of funding the plans. Employee premiums are typically structured around household composition.

Employer-Sponsored Insurance

According to ACS, more than a third of New Mexicans (35%)[30] get their health care coverage through an employer, including governmental employers and private sector employers. Employer-sponsored insurance generally includes a choice of medical, dental, and vision plans. Plans offered vary in terms of the specific services covered in each broad benefit category, as well as premiums, deductibles, and out of pocket costs, and employer and employee contributions to the cost of funding the plans.

[27] The same approach to mandatory enrollment for a subset of Native American beneficiaries existed in the 1915(b)/1915(c) CoLTS waiver program and transitioned to the Centennial Care 1115 demonstration. CMS Letter to Julie Weinberg, New Mexico State Medicaid Director, "Approval Letter for Centennial Care Demonstration," July 12, 2013, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-07122013.pdf; CMS, "Turquoise Care Medicaid 1115 Demonstration, Special Term and Condition 5.4 (page 30 of 125)," available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf.

[28] Section 1903(m)(2)(A) of the SSA.

[29] Medicaid Enrollment Report by Managed Care Organization/Fee-for-Service for 06/01/2024-06/30/2024, available at https://www.hca.nm.gov/wp-content/uploads/June-MER-By-Managed-Care-Organization-Fee-for-Service.pdf.

[30] KFF State Health Facts, Health Insurance Coverage of the Total Population, 2022, available at https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/. Estimates based on the 2008-2022 American Community Survey, 1-Year Estimates.

Governmental Employers

Governmental employers are among the largest employers in the State, including the New Mexico State government (31,100), the U.S. federal government (28,900) and local public schools, with Albuquerque being the largest (10,150).[31] Health care coverage offerings across governmental employers are comparable.

New Mexico State Government

The State of New Mexico's Group Benefits Plan (GBP) offers comprehensive medical, dental, and vision coverage to State employees and employees of participating local governments.[32] GBP offers multiple plan choices with varying premiums, deductibles, and out of pocket costs. State and employee premium contributions vary along a three-tier system based on salary.[33] The employer pays 60%, 70%, or 80% of premiums on behalf of employees, whereas employees pay 40%, 30%, or 20% of premiums, with salary breakpoints being greater than $60,000 (60/40), between $50,000 and $60,000 (70/30) and less than $50,000 (80/20), respectively.

In addition, health care benefits through the New Mexico Retiree Health Care Authority (NMRHCA) are available to certain individuals that retired from public service. However, of the 66,000 retirees participating, there are fewer than 11,000 covered lives considered pre-Medicare.[34] As such, Mercer assumes the vast majority of those who participate in NMRHCA coverage would be ineligible to participate in Medicaid Forward as they would be 65 years of age and older. Furthermore, unless the NMRHCA stopped providing health insurance to Medicare and non-Medicare eligible retirees and their dependents,[35] Medicaid Forward would not assume these coverage costs for individuals that would otherwise satisfy the eligibility criteria.

Public Schools

There are two main sources of health care coverage for public school employees in New Mexico. The first, the New Mexico Public Schools Insurance Authority (NMPSIA), serves as a purchasing agency for public school districts, post-secondary educational entities, and charter schools.[36] It covers approximately 47,000 lives. The second, operated by Albuquerque Public Schools (APS), is the purchasing entity for employees of New Mexico's largest school district serving more than a quarter of the state's students.[37]

Both NMPSIA and APS offer comprehensive medical, dental, and vision coverage through multiple health plans with different provider networks and varying levels of cost, including premiums, deductibles, copays, and coinsurance. NMPSIA and APS also use the same

[31] New Mexico Partnership, New Mexico Largest Employers, available at https://nmpartnership.com/incentives-data/new-mexico-largest-employers/.

[32] State of New Mexico Benefits Comparison Guide, available at https://www.mybenefitsnm.com/documents/Benefit_Comparison_Grid_FY24_Final_10-5-23.pdf.

[33] Group Benefits Plan, July 1, 2023–June 30, 2024, State of New Mexico Bi-Weekly Contribution Schedule, available at https://www.mybenefitsnm.com/documents/FY24_Premium_Rates_Schedule_FINAL_JULY2023.pdf.

[34] Annual Meeting of the Board of Directors, NMRHCA, July 2024. Available at https://www.nmrhca.org/wp-content/uploads/2024/07/NMRHCA-2024-Annual-Board-Meeting-Board-Book-Day-2.pdf.

[35] New Mexico Retiree Health Care Authority website, available at https://www.nmrhca.org/.

[36] New Mexico Public Schools Insurance Authority, available at https://nmpsia.com/aboutUs.html.

[37] Albuquerque Public School System website, available at https://www.aps.edu/about-us.

three-tiered system of employee and employer premium contributions as used by the GBP.[38, 39]

Federal Employees Health Benefits

The Federal Employees Health Benefits (FEHB) program provides comprehensive medical, dental, and vision coverage to U.S. Federal government employees.[40] Similar to other employers, FEHB offers multiple plan choices, with varying levels of cost, including premiums, deductibles, copays, and coinsurance.

Private Sector Employers

Private sector employers significantly shape the New Mexico coverage landscape. Among the largest of these are the Sandia National Laboratory (15,100 employees), Walmart (14,725), and Presbyterian Healthcare Services (11,575).[41] Like governmental employers, large private sector employers also offer comprehensive medical, dental, and vision coverage through multiple health plans with different provider networks and varying levels of cost, including premiums, deductibles, copays, and coinsurance. Unlike governmental employers, they generally do not use salary-based tiers for employee premium contributions.

Consideration of the ACA's Employer Shared Responsibility Penalty

The intent of this discussion is to provide a high-level summary of the ACA's Employer Shared Responsibility Penalty; additional information is found in the cited sources and the "Financial Help on BeWell" section of this report. The ACA imposes two types of penalties on large employers (i.e., equal to or greater than 50 employees) that do not offer affordable minimum essential coverage. In 2024, impacted employers are fined $2,970 per employee if the employee's share of self-only coverage is greater than 8.39% of household income. Additionally, a large employer is fined $4,460 for each employee that receives a premium tax credit through the marketplace.[42] If Medicaid Forward significantly decreases enrollment in employer-sponsored insurance and the remaining risk pool results in premiums that exceed the annual affordability measure, or employers decide to stop providing health insurance due to unsustainable costs, the Internal Revenue Service (IRS) penalties would be assessed absent federal approval of a distinct waiver authority.

Section 1332 of the ACA created State Innovation Waiver authority through the U.S. Departments of Health and Human Services and Treasury for states to implement innovative approaches to providing coverage. These approaches must be at least as comprehensive and affordable for a comparable number of state residents under the status quo and cannot increase the federal deficit.[43] State Innovation Waivers are not Medicaid waivers. The State Innovation Waiver authority can be used by states to eliminate the Employer Shared Responsibility Penalties; however, no state has done so, and it is not clear that such a waiver

[38] New Mexico Public Schools Insurance Authority, Monthly Contributions Effective October 1, 2023, available at https://nmpsia.com/pdfs/premium-rates-2023/10.1.23%20Medical%20Rates_3-Tier%20Final.pdf.

[39] Albuquerque Public School System, 2024 Medical Premium Rates, available at https://www.aps.edu/human-resources/benefits/benefit-premium-rates-2024/medical-premium-rates.

[40] The Federal Employees Health Benefits (FEHB) Program. U.S. Office of Personnel Management, available at https://www.opm.gov/healthcare-insurance/healthcare/.

[41] New Mexico Partnership, New Mexico Largest Employers, available at https://nmpartnership.com/incentives-data/new-mexico-largest-employers/.

[42] IRS, Adjustments Under Section 4880H to Calculate the 2024 Employer Shared Responsibility Payments, Rev, Proc 2023-17, available at https://www.irs.gov/pub/irs-drop/rp-23-17.pdf; IRS, Employer shared responsibility provisions, available at https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions; 26 USC § 4980H(a) and (b) .

[43] 42 USC § 18052; 45 CFR 155.1308(f)(4)(1)-(iii).

request would satisfy the requirement to not increase the federal deficit (e.g., elimination of the IRS employer penalties and increase in federal premium subsidies on the marketplace).[44]

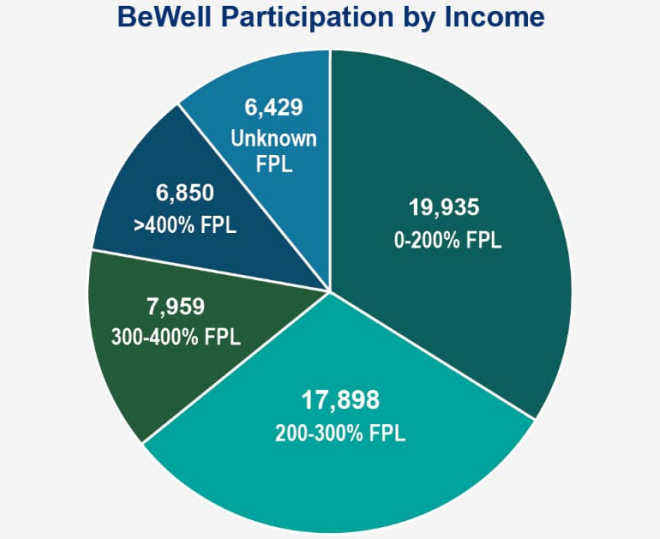
Individual Market Coverage

New Mexico Marketplace (BeWell)

Eligibility and Enrollment

The ACA requires each state and the District of Columbia to have a health insurance marketplace and the marketplace may be administered by the state, known as a state-based exchange (SBE), or the federal government, known as a federally facilitated exchange (FFE).[45] In New Mexico, BeWell is the SBE; it is not an insurance company but rather a virtual marketplace for the purchase of private health care coverage through qualified health plans. Most individuals can purchase a health care plan through BeWell, though costs are dependent on a host of factors including access to other minimal essential coverage.[46] As of July 2024, 59,071 individuals have health care coverage through BeWell.[47]

While it is possible to purchase unsubsidized coverage on the marketplace, most coverage is subsidized through state and federal resources to provide affordable health care coverage.[48] The availability of financial help results in enrollment that is disproportionately low-income. Specifically, 77.5% of people enrolled in coverage through BeWell have incomes below 400% of FPL.[49]



[44] 42 USC § 18052 and paragraph (a)(2)(D) of this section indicates the waiver can apply to Sections 36B, 4980H, and 5000A of title 26 that creates the Employer Shared Responsibility provisions; KFF, "Tracking Section 1332 State Innovation Waivers", available at https://www.kff.org/affordable-care-act/fact-sheet/tracking-section-1332-state-innovation-waivers/. In 2018, Ohio commissioned an actuarial study to evaluate the impacts of such a waiver and did not pursue it, see Oliver Wyman. Impact of Eliminating the Employer Mandate in the State of Ohio, 2018, available at https://dam.assets.ohio.gov/image/upload/insurance.ohio.gov/Consumer/Documents/Employer%20Mandate%20Actuarial%20Analysis%20-%20Final%20Report.pdf.

[45] 42 USC § 18031; Overview of Health Insurance Exchanges, Congressional Research Service, Updated March 17, 2023, available at https://sgp.fas.org/crs/misc/R44065.pdf.

[46] See the "Financial Help on BeWell" discussion within this section.

[47] Enrollment Dashboards. BeWell, available at https://bewellnm.com/transparency/dashboards/.

[48] Id.

[49] Id.

As of 2024, plans offered through BeWell are from the following insurers: Ambetter from Western Sky Community Care, Blue Cross and Blue Shield of New Mexico, Presbyterian Health Plan, Molina Healthcare and United Healthcare.[50] Each plan offers its own specific benefits within each broad essential health benefit category.

Benefits

Federal law requires that all plans offered through BeWell include at least 10 categories of services known as Essential Health Benefits: including emergency services, hospitalization, pregnancy, maternity and newborn care, and several others.[51]

Costs

Health plans offered through BeWell are available in three levels: Gold, Silver, and Bronze.[52]

Gold Level plans have the highest monthly premium and cover the most out-of-pocket costs. Gold Level plans cover about 80% of costs, while the enrollee pays 20%.

Silver Level plans have lower monthly premiums than Gold plans, but they cover fewer out-of-pocket costs. Silver Level plans cover 70% of costs, while enrollees pay 30%.

Bronze Level plans have the lowest monthly premium and consequently, the highest out-of-pocket costs when enrollees use health services. Bronze Level plans cover 60% of costs, while enrollees pay 40%.

Financial Help on BeWell

Financial help available through BeWell comes in two forms, one federal and one state funded. The federal government provides premium tax credits and cost sharing reductions. In addition to the federal help, funding from the State of New Mexico further lowers or eliminates enrollee premium payments.

Federal premium tax credits[53] reduce enrollees' monthly payments for health care coverage. To qualify for a premium tax credit, a person must: be enrolled in a BeWell plan, have income above 138% of FPL[54], not have access to affordable coverage through an employer, and not be eligible for coverage through Medicaid or Medicare.[55] U.S. citizenship or proof of legal residency is also required. Lawfully present immigrants whose household income is below 100% of FPL can also be eligible for tax subsidies through the Marketplace if they meet all other eligibility criteria.[56]

"Affordable" coverage guidelines are established by the IRS and vary from year to year. The employee's share of premium for the employer's lowest cost plan cannot be greater than a

[50] Is Obamacare the same as BeWell. BeWell, available at https://bewellnm.com/how-to/obamacare-bewell/.

[51] What Marketplace health insurance Plans Cover, Health Benefits & Coverage, Healthcare.gov, available at: https://www.healthcare.gov/coverage/what-marketplace-plans-cover/.

[52] Your Guide to Bronze, Silver, and Gold Health Insurance Coverage. BeWell, available at https://bewellnm.com/how-to/plan-categories/.

[53] The Affordable Care Act 101, Kaiser Family Foundation, Published May 28, 2024, available at https://www.kff.org/health-policy-101-the-affordable-care-act/?entry=table-of-contents-how-much-do-people-pay-for-marketplace-plans-and-how-are-subsidies-calculated.

[54] Nationally, the lower income limit for Premium Tax Subsidies is the upper income limit for Medicaid eligibility. In New Mexico and other states that have expanded Medicaid to all adults under 138% of FPL, the lower limit of eligibility for the Premium Tax Subsidy is 138% of FPL. In ACA non-expansion states, this limit is 100% of FPL.

[55] 26 US Code 5000A(f).

[56] 45 CFR 155.305(f)(2)).

certain percentage of an individual's household income.[57] For 2024, the maximum percentage of household income for the employee's share of self-only plan premium is 8.39%.[58] If the employee's share of premium does not exceed this percentage, the individual would not receive federal premium tax credits through BeWell if the individual would otherwise qualify. The determination does not consider the cost of self-plus spouse coverage or family coverage.

Premium tax credits can be applied to BeWell plans at any level of coverage. The premium tax credit works by limiting the amount an individual must contribute toward the premium. This contribution is set on an income-based sliding scale. In 2024, for individuals with income up to 150% of FPL, the required contribution is zero, while at an income of 400% of FPL or above, the required contribution is 8.5% of household income.[59] Premium tax credits were expanded under the Inflation Reduction Act of 2022; however, these enhanced premium tax credits will end after 2025 absent Congressional action. According to one analysis, these enhanced premium tax credits resulted in an estimated 44% decrease in premium payments for those receiving the credits.[60]

The cost-sharing reduction (CSR) [61] reduces enrollees' out-of-pocket costs in the form of deductibles, copayments, and coinsurance when they use covered health care services. Individuals who are eligible to receive a premium tax credit and have household incomes between 100% to 250% of FPL are also eligible for CSRs. CSRs are determined on an income-based sliding scale but are only available for individuals that select a Silver Level plan.

With funding from the State of New Mexico[62], Turquoise Plans available through BeWell offer the most savings on the Marketplace. Anyone who is otherwise eligible for Marketplace coverage with an income between 100% and 300% of FPL will qualify for a Turquoise Plan. Turquoise Plans are available in Gold and Silver Levels. This additional State assistance is funded through the Health Care Affordability Fund (HCAF) created in 2021. The HCAF uses revenue from a surtax on health insurance premiums to fund cost reductions for Turquoise Plans.

There are two important points for policymakers to consider regarding the potential impact of Medicaid Forward on BeWell, regardless of the income level for Medicaid eligibility. First, it is important to note that an individual must only be eligible for Medicaid — not covered by Medicaid — to be ineligible for the federal premium tax credit and, by extension, the State-funded subsidies for the Turquoise Plans. If Medicaid Forward is implemented, any New Mexican that becomes *eligible* for Medicaid will thereby become *ineligible* for financial help through BeWell for both the federal and State-subsidized plans.

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[57] Questions and Answers on Employer Shared Responsibility Providers until the Affordable Care Act, Affordability and Minimum Value No. 39, Internal Revenue Service, available at https://www.irs.gov/affordable-care-act/employers/questions-and-answers-on-employer-shared-responsibility-provisions-under-the-affordable-care-act#Affordability.

[58] Internal Revenue Service, Examination of Returns and Claims for Refund, Credit, or Abatement; Determination of Correct Tax Liability, Rev, Proc 2023-29, available at https://www.irs.gov/pub/irs-drop/rp-23-29.pdf.

[59] Health Insurance Premium Tax Credit and Cost-Sharing Reductions, Congressional Research Service, Updated February 14, 2024. Available at https://crsreports.congress.gov/product/pdf/R/R44425.

[60] Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire?, Ortaliza, Cord, McGough, Lo, and Cox. Kaiser Family Foundation, Published June 26, 2024. Available at https://www.kff.org/private-insurance/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/.

[61] The Affordable Care Act 101, Kaiser Family Foundation, Published May 28, 2024, available at https://www.kff.org/health-policy-101-the-affordable-care-act/?entry=table-of-contents-how-much-do-people-pay-for-marketplace-plans-and-how-are-subsidies-calculated.

[62] BeWell New Mexico's Health Insurance Marketplace, "Understanding the Plans Offered on the BeWell Marketplace", available at https://bewellnm.com/answers/plans/.

To illustrate the impact using July 2024 figures, 77.5% of individuals enrolled in a BeWell plan have an income below 400% of FPL, thus resulting in 45,792 individuals who would become ineligible for financial help through BeWell if Medicaid Forward is implemented up to 400% of FPL. Such a change could impact BeWell's long-term viability.

Second, as mentioned earlier, each state must provide access to a marketplace. And as addressed above, BeWell enrollment could decline significantly with the implementation of Medicaid Forward. The State Innovation Waiver authority discussed in the context of the Employer Shared Responsibility Penalty appears to allow for a waiver of the requirement for each state to provide access to a marketplace[63]; however, the same approval criteria would apply and to date, no state has requested such authority.[64] For example, it is unlikely that Medicaid Forward, as an alternative to BeWell, would cost the federal government less than federal BeWell subsidies.

New Mexico Medical Insurance Pool

Eligibility and Enrollment

The New Mexico Medical Insurance Pool[65] (NMMIP) provides access to health insurance coverage for State residents who are denied health insurance and considered uninsurable. Examples of eligible individuals include those rejected for comprehensive health care coverage, have coverage that is limited due to a health condition, or have reached the coverage limit of their current health insurance plan.

As of December 2023, less than 4,500 people were enrolled in NMMIP.

Benefits

All NMMIP plans provide access to Essential Health Benefits.

Costs

Costs for enrollees in NMMIP plans, including premiums, deductibles, copayments or coinsurance, and out-of-pocket limits, vary by plan. Plans are defined by deductible tier, including $500, $1,000, $2,000, and $5,000. Premium amounts are based on deductible tier, income, and county.

The State-funded Low-Income Premium Program (LIPP) included nearly 78% of NMMIP policyholders and offers premium discounts on a sliding-scale basis on income:

- 25% premium reduction for 300% to 399% of FPL.
- 50% premium reduction for 200% to 299% of FPL.
- 75% premium reduction for 0% to 199% of FPL.

[63] The State Innovation Waiver authority (aka 1332 waivers) is codified at 42 USC § 18052 and paragraph (a)(2)(B) of this section indicates the waiver can apply to 42 USC § 18031 that is the requirement for states to establish an Exchange.

[64] KFF, "Tracking Section 1332 State Innovation Waivers", available at https://www.kff.org/affordable-care-act/fact-sheet/tracking-section-1332-state-innovation-waivers/.

[65] New Mexico Medical Insurance Pool website, available at https://nmmip.org/eligibility-and-coverage/benefits-and-eligibility/.

Funding

Funding for NMMIP comes from premium revenues and assessments levied on health and life insurers in the state. The NMMIP assessment for health and life insurers is based on their share of direct written premium in the state, excluding self-insured plans. These carriers also receive a premium tax credit equal to approximately 52% of the assessment paid. The assessments provide the overwhelming majority of NMMIP's funding.

Section 3
Stakeholder Engagement

Mercer engaged in a robust stakeholder engagement process as a part of the Medicaid Forward study. Through the stakeholder engagement process, Mercer received feedback from a variety of perspectives. Stakeholders included State agencies, purchasing entities, advocacy organizations, MCOs, and provider and employer associations. A list of engagements can be found in Appendix A. In addition, Mercer held meetings with the Native American Technical Advisory Committee and the Medicaid Advisory Committee, as well as a public meeting.

Below is a summary of the stakeholder feedback heard throughout the engagement process in response to the Medicaid Forward proposal, organized by theme. It does not attempt to respond to stakeholder comments.

Provider Access

Multiple stakeholders raised concerns about access to health care services if Medicaid Forward was implemented. Stakeholders said that access to providers in New Mexico, both through commercial insurance and Medicaid, is already strained, and that a Medicaid expansion could exacerbate the issue. Individuals voiced concern over providers leaving the state. In particular, stakeholders said that the number of primary care doctors, OBGYNs, and psychiatrists is decreasing, and that wait times to access primary care doctors and specialists are lengthy.[66] Workforce challenges generated since the PHE were also brought up consistently.

While some stakeholders said that health care coverage does not equate to health care access, other stakeholders stated that the coverage landscape today is not equal. Some stakeholders commented that Medicaid Forward could potentially bring providers to the State and positively impact the economy.

Reimbursement

Medicaid provider reimbursement rates were a consistent theme heard across stakeholder engagements. Many stakeholders expressed concern regarding rates being too low to keep providers in the Medicaid program and in the state in general. Many stakeholders stated that Medicaid rates would need to increase if Medicaid Forward were implemented. Some expressed that raising select Medicaid rates to 150% of Medicare is not enough to sustain providers and practices, particularly for facilities. Some suggested that provider rates for the *current* Medicaid population needed to increase to 200% to 250% of Medicare.[67]

Rural Provider Access

Stakeholders almost universally voiced concern that provider access is further limited in the rural regions of New Mexico, particularly access to specialists, and the impact on rural areas

[66] A discussion of provider access issues is included later in this report.

[67] Although this was a suggested rate increase from certain stakeholders, in its modeling, Mercer assumed a hold harmless approach to reimbursement to take into account the shift of individuals to Medicaid from other markets.

must be considered if implementing Medicaid Forward. Southwest New Mexico was identified as a region that struggles with access to health care, with higher wait times and individuals traveling to nearby states for care.

Non-Reimbursement Impacts on Provider Access

Several stakeholders said that provider access is impacted by a variety of factors that are not related to reimbursement rates. Stakeholders encouraged the examination of other factors that are impacting providers, such as ways to reduce and streamline required administrative measures and data collection, and other drivers of provider burnout, stressing a desire for providers to be able to "survive."

Certain stakeholders specifically stated that there is a psychological toll on providers that cannot help individuals in need access affordable health care. Such stakeholders attribute providers leaving the state, in some part, to the inability of those providers to adequately care for individuals due to financial barriers.

Premiums and Cost Sharing

Some stakeholders expressed support for enrollee financial responsibility — premiums and cost sharing — as a feature of Medicaid Forward for individuals with higher incomes. Others said that premiums and cost sharing should not apply, consistent with how Medicaid operates in New Mexico today. Some supported the idea of enrollee financial responsibility on an income-based sliding scale, with one respondent specifically mentioning 200% of FPL as an appropriate starting point. Stakeholders asked if there would be consequences for non-payment of premiums or cost-sharing for services. In general, there was concern that if there were no consequences for non-payment, then it would not be worthwhile to include enrollee financial responsibility in Medicaid Forward. Additionally, some stakeholders raised the impact of cost-sharing on providers' GRT obligations.

Benefits and Delivery System

Some stakeholders were encouraged by the offerings of Medicaid, compared to commercial health insurance, especially when it comes to behavioral health. Certain stakeholders specifically pointed to a larger suite of behavioral health benefits in Medicaid as being broadly beneficial to potential enrollees. There was support for Medicaid-like coverage plans as the model for benefits and coverage options for Medicaid Forward, due to the comprehensive coverage and innovative policy opportunities.

There was overall support for managed care as a delivery system, again, with the understanding that Native American beneficiaries would continue to have the ability to opt in to FFS.

Impact of Medicaid Forward

Tax Impacts

Tax-related impacts described by stakeholders include the potential for increased taxes overall to fund the program, such as an increase in income tax taken in by the State. Additionally, some stakeholders mentioned the potential big lift and stand-up cost to implement a payroll tax to fund the program. This is also explored in the UI study.

Employers and Employees

Stakeholders explained that if Medicaid Forward were to be implemented, there would still be individuals who would want employer-sponsored coverage and inquired if the Medicaid Forward plan would effectively limit employer offerings or make employer offerings less robust. Concerns were expressed about what Medicaid Forward would do to coverage offered by employers, and how those would continue to operate if offered only for a small population. Additionally, certain stakeholders voiced concerns that Medicaid Forward could drive businesses away from New Mexico and dissuade new businesses from coming in.

There was concern with Medicaid Forward potentially undermining the role of the private sector. As described by one stakeholder, employees trust their employers to provide their insurance coverage. This stakeholder explained that the Medicaid Forward option could impact this relationship between employers and employees. The same stakeholder acknowledged that employers could potentially save money if employees were to opt-in to Medicaid Forward and therefore direct funds elsewhere, such as employee salaries. One stakeholder stated that collective bargaining agreements would have to be updated based on the implementation of Medicaid Forward.

Eligible Populations

There was distinct disagreement among stakeholders as to the populations that should be included in Medicaid Forward. The disagreement is best described as being split into three categories based on those who want (1) a focus on the uninsured; (2) a focus on those with the most financial need; and (3) to “go big” and open Medicaid to as many New Mexicans as possible. Stakeholders also asked if Medicaid Forward would apply to individuals with unsatisfactory immigration status.

Native Americans

Considerations for Native Americans were raised by virtually all parties. There was support for the assurance that Native American beneficiaries without a nursing facility level of care need would continue to retain the ability to remain in FFS, as they are today. In short, all stakeholders support relying on Medicaid Forward to increase coverage while maintaining the protections and flexibilities currently available to Native Americans under Medicaid. Stakeholders asked about the potential impact to the Indian Health Service, Tribal health services, and Urban Indian Health Programs (I/T/Us) and emphasized the Medicaid Forward plan would not replace the federal government’s responsibility related to health care.

Other Suggestions, Concerns, and Support

Other suggestions raised by stakeholders include the idea of applying a stricter definition of state residency for Medicaid Forward eligibility[68], the necessity of risk adjustment, and provisions to keep employers from removing employer-sponsored insurance with the expectation that employees join a Medicaid Forward plan.

[68] State residency is an existing requirement for Medicaid eligibility.

Concerns raised about the potential of Medicaid Forward include political feasibility; affordability and long-term viability for the State; distrust of a sweeping, government-run program; and the perceived stigma of Medicaid coverage.

Multiple stakeholders expressed that coordination across entities will be necessary if implementing Medicaid Forward, including State entities and State purchasers. There was concern that Medicaid Forward, if implemented, could pull individuals away from BeWell in significant numbers, as well as other private insurance.

Section 4

Medicaid Forward Design Options and Impacts

Overview

To inform State decision making on Medical Forward program design, the study models multiple design options under a multi-payer environment. For each option presented, Mercer analyzes the potential impact of Medicaid Forward as follows:

1. Estimate the number of individuals who are currently uninsured or covered through private insurance and will choose to enroll in Medicaid coverage.
2. Based on the expected changes in coverage source, estimate the adjustment to Medicaid provider reimbursement levels to maintain the current provider revenue in the entire New Mexico health care system, meaning revenue from all coverage sources.
3. Estimate the change in the total cost of the Medicaid program, as well as the net impact of Medicaid Forward on the State's share of those costs. This analysis includes the impact of federal matching funds and the recognition of additional revenue from existing State revenue sources, such as health insurance premium tax collections and Medicaid pharmacy rebates.

Data

The analysis relies on a multitude of data sources, including information submitted by State entities in response to data requests and publicly available data.

Medicaid program costs for traditional and ACA Medicaid expansion populations are sourced from New Mexico's Turquoise Care Medicaid managed care capitation rates effective July 2024–December 2024 for the physical and behavioral health programs, which are the most current rates available at the time of this report. The analysis leverages other supporting information from the capitation rate development process (e.g., enrollment projections developed by HCA, rating trends, assumptions for state assessments and taxes).

Mercer submitted data requests to BeWell, the State's General Services Division (GSD)[69], APS, and NMPSIA. All four entities responded to these data requests. The data request gathered demographic information (e.g., subscriber counts, covered lives, and member months) and financial data (e.g., gross premiums and member out-of-pocket costs). To the extent possible, the analysis relies on the data collected directly from these State entities. Where necessary, national data such as the Medical Expenditure Panel Survey, American Community Survey, National Association of Insurance Commissioners (NAIC) filings, and regional sources such as information published by the New Mexico Partnership, supplemented the analysis.

[69] At the time of the data request, GSD administered public employee benefits. However, in July 2024, oversight of public employee benefits shifted to HCA.

Lastly, other publicly available industry information was considered, such as PricewaterhouseCoopers Health Research Institute medical trend information and studies on the uninsured population completed by the UI on behalf of HCA.

Methodology

To illustrate the potential impact of Medicaid Forward implementation across a range of program design options, Mercer evaluated the impact of expanding Medicaid coverage from its current limit of 138% of FPL to four distinct income eligibility limits (200% of FPL, 300% of FPL, 400% of FPL, and no income limit), both with and without enrollee financial responsibility, for a total of seven designs. (See Table 1. 2024 Federal Poverty Guidelines for the dollar value of each FPL limit.)

Mercer limited the designs to align with the goals and expectations of the Medicaid Forward plan and further identified a subset of targeted designs that reflect potential implementation scenarios. These targeted designs are explored further in this section, with additional detail available in the Appendix.

Table 2. List of Modeled Designs Considered

Design	Income Eligibility	Enrollee Financial Responsibility	Design Determination
1	>138%–200% FPL	No	Targeted Design
2	>138%–300% FPL	Yes	Included in Appendix
3	>138%–300% FPL	No	Included in Appendix
4	>138%–400% FPL	Yes	Targeted Design
5	>138%–400% FPL	No	Included in Appendix
6	>138% FPL (no upper limit)	Yes	Targeted Design
7	>138% FPL (no upper limit)	No	Included in Appendix

There is no assumed enrollee financial responsibility for individuals up to 200% of FPL in the designs modeled.[70] In designs that apply enrollee financial responsibility, individuals between 200% and 300% of FPL are assumed to have an enrollee financial responsibility of no more than 2% of household income; individuals between 300% and 400% of FPL are assumed to have an enrollee financial responsibility of no more than 3.5% of household income; and individuals above 400% of FPL are assumed to have an enrollee financial responsibility of no more than 5% of household income, the maximum allowed under federal law absent special, time-limited federal authority.[71]

[70] Although there was an initial decision to examine the impact of expanding Medicaid to individuals under 200% of FPL with enrollee financial responsibility, the authors determined that HCA's administrative costs to meet federal requirements for tracking and suspension of such payments would likely exceed the potential reduction in state Medicaid costs. As such, that design was removed from consideration.

[71] This limited federal authority is addressed in the report's discussion of Medicaid's premium and cost sharing regulations.

Enrollment Shift Impacts Across Markets

For each design, the first step in the analysis is to estimate the number of enrollees currently enrolled in private coverage who would be eligible to enroll in Medicaid Forward, as well as the proportion of eligible individuals that would choose to enroll in Medicaid. For purposes of this analysis, private insurance includes employer-sponsored insurance, both public and private sectors, including public school and state employees; coverage available through BeWell; and insurance purchased directly from health insurers. Estimates of currently uninsured individuals who would be eligible for traditional Medicaid, ACA Medicaid expansion, or Medicaid Forward were developed in each design.

In all designs, the benefit package assumed for Medicaid Forward mirrors the State Plan physical and behavioral health services available to non-elderly, non-disabled individuals. The benefits are assumed to be at least as generous, if not more so, than the benefits offered under private plans. As such, the primary factors that are expected to motivate individuals currently enrolled in private coverage to choose Medicaid Forward are the number of New Mexicans with private coverage who reside in a household that falls within the expanded Medicaid Forward eligibility income limit and the affordability of Medicaid Forward coverage relative to private coverage alternatives.

The modeling relies on the data collected directly from BeWell, GSD, the NMPSIA, and APS to estimate potential Medicaid Forward transitions for those subsets of the private market segment. Enrollment for the FEHB program was sourced from total federal employees in the State published by the NM Partnership. Data for individuals enrolled in employer-sponsored insurance from private employers was estimated based on data obtained from the U.S. Census Bureau Medical Expenditure Panel Survey Insurance Component (MEPS-IC) and estimates of New Mexico's uninsured population were developed from the ACS for calendar year (CY) 2022. Individuals who are ineligible for full federal matching funds due to their immigration status are excluded from the estimates of uninsured individuals for purposes of this analysis, as possible.

In general, Mercer assumes eligible individuals become increasingly likely to choose Medicaid Forward over private insurance when 5% of their household income for premiums and cost sharing — the current federal limit — is less than their share of premiums and cost sharing for private market alternatives.

A summary of the projected change in coverage by source among Medicaid Forward eligible individuals for the targeted designs is provided in Tables 3a, 3b, and 3c.

Table 3a. Enrollment Shift Analysis — >138%–200% FPL without Enrollee Responsibility

	Baseline	>138%–200% FPL without Enrollee Financial Responsibility	
Market Segment/Subpopulation	Enrollment	Enrollment	% Change
Medicaid	687,000	780,488	13.6%
BeWell (Exchange)	56,901	43,207	-24.1%
Private and Federal Employer Sponsored Insurance	691,625	676,886	-2.1%
State and Local Employer Sponsored Insurance	112,503	97,770	-13.1%

	Baseline	>138%–200% FPL without Enrollee Financial Responsibility	
Market Segment/Subpopulation	Enrollment	Enrollment	% Change
Uninsured	170,000	119,680	-29.6%
Grand Total	**1,718,029**	**1,718,031**	**0.0%**
Insured Total	**1,548,029**	**1,598,351**	**3.3%**

Table 3b. Enrollment Shift Analysis — >138%–400% FPL with Enrollee Responsibility

	Baseline	>138%–400% FPL with Enrollee Financial Responsibility	
Market Segment/Subpopulation	Enrollment	Enrollment	% Change
Medicaid	687,000	899,295	30.9%
BeWell (Exchange)	56,901	17,374	-69.5%
Private and Federal Employer Sponsored Insurance	691,625	645,564	-6.7%
State and Local Employer Sponsored Insurance	112,503	55,301	-50.8%
Uninsured	170,000	100,496	-40.9%
Grand Total	**1,718,029**	**1,718,030**	**0.0%**
Insured Total	**1,548,029**	**1,617,534**	**4.5%**

Table 3c. Enrollment Shift Analysis — No Income Limit with Enrollee Responsibility

	Baseline	No Income Limit with Enrollee Financial Responsibility	
Market Segment/Subpopulation	Enrollment	Enrollment	% Change
Medicaid	687,000	977,415	42.3%
BeWell (Exchange)	56,901	6,302	-88.9%
Private and Federal Employer Sponsored Insurance	691,625	603,802	-12.7%
State and Local Employer Sponsored Insurance	112,503	42,279	-62.4%
Uninsured	170,000	88,230	-48.1%
Grand Total	**1,718,029**	**1,718,029**	**0.0%**
Insured Total	**1,548,029**	**1,629,798**	**5.3%**

Provider Reimbursement Analysis

Having established the estimated changes in coverage source for each design, Mercer then examines the impact of the changes in coverage mix on the aggregate reimbursement levels for key providers, most notably hospitals and physicians, and the system in aggregate.

Due to the availability and reliability of Medicaid data and information, Mercer utilizes projected New Mexico Turquoise Care MCO capitation rates effective July 2024–December 2024, for the traditional Medicaid (disabled and non-disabled) and ACA Medicaid expansion

populations under age 65 to estimate baseline Medicaid reimbursement for key providers and in the aggregate. These baseline expenditures are adjusted to reflect the anticipated impact of two key pending rate actions not yet incorporated into the capitation rates: fee increases provided for in the General Appropriations Act (House Bill 2) of 2024 and anticipated state directed payments[72] provided for in the Healthcare Delivery and Access Act of 2024 (HDAA) (Senate Bill 17). The fee increases in House Bill 2 of 2024 expand upon prior legislative action in House Bill 2 of 2023 that increased reimbursement rates for most professional and institutional services in the Medicaid program. Increases resulting from HDAA are targeted to inpatient and outpatient hospital services.

As Table 4 demonstrates, the impact of these rate actions on Medicaid reimbursement, measured as a percentage of the Average Commercial Rate (ACR), is expected to be significant.[73] The ACR is an important reference point for Medicaid provider reimbursement levels. The ACR is used by the Centers for Medicare & Medicaid Services (CMS) as the limit for Medicaid reimbursement when the state directs how MCOs pay for inpatient and outpatient hospital services, professional services at an academic medical center, and nursing facility services. When the state dictates how MCOs pay for covered services for specific providers, that is referred to as a "state directed payment" that usually requires CMS's prior approval before implementation.[74]

Table 4. Estimate of Pending Rate Actions

	Pending Medicaid Rate Actions		
Provider Class	**Comparison to ACR Prior to 2024**	**Estimated Impact**	**Comparison to ACR Beginning in 2025**
Hospital Expenditures	53.1%	$1,493,169,061	95.1%
Physician Expenditures	72.0%	$166,066,390	90.0%

These pending provider rate increases have a material impact on the results of this analysis, as they represent a significant investment in closing the gap in reimbursement levels between Medicaid and private insurance that will happen prior to the implementation of Medicaid Forward. Please note that the results of the provider reimbursement analysis are very sensitive to this adjustment. In developing this adjustment, Mercer relied on the most currently available information regarding these pending rate actions, but they have yet to be finalized as of the publication of this report. If actual implementation of one or both rate actions differs from what is assumed, the results of this analysis would need to be revised accordingly.

The baseline estimates of private payer expenditures were developed based on the baseline Medicaid expenditures and the relationship between Medicaid and private insurance spending levels, by major service category, based on data from the Peterson-KFF Health System Tracker, National Health Spending Explorer for CY2022. This source was developed

[72] State Directed Payments are payment programs within Medicaid managed care. Generally, a state may not direct a Medicaid MCO to pay a provider a particular amount. State Directed Payments are an exception to this general rule that a Medicaid program may use if it wants to ensure that a particular provider class receives a certain level of payment for providing health care services. Many types of State Directed Payments require prior written approval from CMS before the state can implement the provider reimbursement increases through the MCOs. The requirements for State Directed Payments are specified at 42 CFR 438.6(c).

[73] Average Commercial Rate means the average rate paid for services by the highest claiming third-party payers for specific services as measured by claims value. 42 CFR 438.6(a).

[74] 42 CFR 438.6(c).

by the Kaiser Family Foundation using data from CMS's National Health Expenditure Accounts that provides information on U.S. health spending by private companies.[75]

Table 5. Estimates of Medicaid and Private Insurance Spending Levels

	Medicaid		Private		Total	
Adjusted Baseline	**Revenue**	**% ACR**	**Revenue**	**% ACR**	**Revenue**	**% ACR**
Hospital Expenditures	$3,008.3	95.1%	$1,244.9	100.0%	$4,253.2	96.5%
Physician Expenditures	$830.3	90.0%	$1,583.4	100.0%	$2,413.7	96.6%
Pharmacy Expenditures	$394.5	105.0%	$1,078.7	100.0%	$1,473.2	101.3%
All Other Expenditures	$1,484.8	63.0%	$4,319.7	100.0%	$5,804.5	90.5%
Total Medical Expenditures	**$5,717.9**	**86.7%**	**$8,226.7**	**100.0%**	**$13,944.6**	**94.5%**

Estimated revenue shown in millions.

A key feature of this analysis is that Mercer estimates the adjustment to Medicaid reimbursement levels in each design that would be necessary to maintain a consistent level of provider revenues as exists in New Mexico's health care system today.

In the opinion of several stakeholders interviewed by Mercer, the total amount of health care spending in the State must at least be maintained, if not increased, to sustain the current provider workforce under Medicaid Forward. However, estimating the size or structure of any such additional investments in individual provider reimbursement levels is beyond the scope of this report. As such, Mercer's modeling maintains at least current system-wide reimbursement levels in all designs.

Fiscal Impact Analysis

The final step in analyzing each design is to estimate the change in the total cost of the Medicaid program, as well as the total change in State revenue, so that there can be an estimate of the net impact of Medicaid Forward on the State budget.

Total program costs are inclusive of increases in traditional Medicaid and ACA Medicaid expansion capitation rates due to changes in Medicaid reimbursement levels, and additional premium costs for new traditional Medicaid, ACA Medicaid expansion, and Medicaid Forward enrollees. For the uninsured market, Mercer assumes a small portion of the transitioning population would be eligible for traditional Medicaid or ACA Medicaid expansion.

State revenue changes include consideration of the availability of additional federal matching funds, enrollee financial responsibility (where applicable), increased premium tax revenue, the redirection of State health coverage expenditures for State and local government employees (including public school employees) and BeWell subsidies to Medicaid Forward, and increases in Medicaid Drug Rebate Program revenue due to increased Medicaid enrollment.

The difference in total Medicaid cost and State revenue represents the additional State share that New Mexico would be required to fund Medicaid Forward.

[75] National Health Spending Explorer on the Peterson-KFF Health System Tracker, available at https://www.kff.org/interactive/health-spending-explorer/.

Comparison with Urban Institute Analysis

As previously stated, UI modeled potential impacts of Medicaid Forward in 2023. There are differences between the UI report and this report in terms of data sources and assumptions. Mercer, as New Mexico Medicaid's actuary of record, used up to date, in house Medicaid enrollment and cost data. Mercer also received enrollment and cost information directly from many important sources and employers in New Mexico.

Additionally, Mercer included key assumptions in its modeling that differ from the UI report. First, Mercer included new provider rate increases in HB2 (2024) and HB2 (2023). Second, Mercer included the potential impact of the HDAA on hospital rates. These rate increases represent a significant increase in the overall spending in New Mexico's Medicaid program. Third, Mercer assumed that Medicaid provider reimbursement would be raised to address changes in coverage mix in the event Medicaid Forward is implemented (i.e., a lower proportion of private insurance utilization at reimbursement levels that exceed Medicaid) to ensure no change in total health care spending. Fourth, Mercer included a variety of income-based eligibility limits to assess incremental costs at each FPL threshold. Fifth, Mercer did not assume any new taxes or fees to cover the cost of expanded Medicaid eligibility.

Results

This section includes a discussion and summary of the results of each component of the analysis across the designs defined at the beginning of this section.

Enrollment Shift Analysis

Across the modeled designs, Mercer estimates significant enrollment shifts to Medicaid from private insurance and uninsured market segments.

Table 6. Estimate of Increase in Medicaid Enrollment Across Modeled Designs

Design	Increase in Medicaid Enrollment (Covered Lives)	Increase in Medicaid Enrollment (%)
>138%–200% FPL, w/o enr. resp.	93,488	13.6%
>138%–300% FPL, w/ enr. resp.	159,538	23.2%
>138%–300% FPL, w/o enr. resp.	176,549	25.7%
>138%–400% FPL, w/ enr. resp.	212,295	30.9%
>138%–400% FPL, w/o enr. resp.	235,475	34.3%
No Limit FPL, w/ enr. resp.	290,415	42.3%
No Limit FPL, w/o enr. resp.	326,092	47.5%

The enrollment shift analysis generally assumes that as income eligibility limits increase, more individuals in private and uninsured market segments would elect coverage through the Medicaid Forward program. Under Medicaid Forward, Mercer estimates that the program could result in an increased Medicaid enrollment of up to 48% and corresponding reductions in BeWell enrollment of up to 89%, employer-sponsored insurance of up to 22% and in the number of uninsured individuals of up to 59%. Mercer anticipates that some people will remain uninsured, including individuals ineligible for Medicaid based on immigration status.

In general, the enrollment shifts will be sensitive to program design elements such as enrollee financial responsibility (e.g., premiums, cost sharing) and benefit package design. As discussed earlier, the Medicaid benefit package is more generous than benefit packages offered through other health coverage sources.

Detailed results are provided in the Appendix for each individual design by market segment.

Provider Revenue Analysis

The following table demonstrates the estimated required increase in provider Medicaid revenues that would be necessary to maintain the baseline, system-wide expenditure levels. As noted previously, these would be investments above and beyond the Medicaid reimbursement increases prescribed in HB2 (2024) and HDAA.

Table 7. Provider Revenue Analysis

Design	Estimated Medicaid Revenue Increase Needed
>138%–200% FPL, without enrollee financial responsibility	+ 1.2%
>138%–300% FPL, with enrollee financial responsibility	+ 2.1%
>138%–300% FPL, without enrollee financial responsibility	+ 2.2%
>138%–400% FPL, with enrollee financial responsibility	+ 2.7%
>138%–400% FPL, without enrollee financial responsibility	+ 2.8%
No Limit FPL, with enrollee financial responsibility	+ 3.4%
No Limit FPL, without enrollee financial responsibility	+ 3.6%

In general, as more individuals move from the private market to Medicaid Forward, the gap between Medicaid and private payer reimbursement needs to be further narrowed to preserve baseline provider revenues in the aggregate. Please note that, depending on how increases in provider reimbursement levels are operationalized, it is also likely that such actions would influence the cost of New Mexico's MLTSS program. Estimation of these impacts are beyond the scope of this report.

Administrative Costs Analysis

To ensure that Medicaid Forward is successful, the administrative capacity of HCA must be adequately resourced. In this context, administration includes multiple costs, such as State employee salaries, contractors, information technology (e.g., the Medicaid eligibility and enrollment system enhancements and the incremental replacement of the existing Medicaid Management Information System (MMIS)). Like payments for Medicaid services, the state's costs to administer the Medicaid program are matched by the federal government. However, the federal match rates for administrative costs can be 50%, 75%, or 90% depending on the type of cost.[76]

For purposes of this analysis, Mercer reviewed Medicaid administrative costs by comparing New Mexico's per member per year cost to other states and the national average using FFY2019 data compiled by the Medicaid and CHIP Payment and Access Commission

[76] 42 CFR 433.15.

(MACPAC).[77,78] Mercer relies on the FFY2019 data as it is the last year of complete data prior to the COVID-19 PHE. According to this analysis, New Mexico spends $247.57 per member per year for administration of the Medicaid program.

However, the above figures do not account for the management of enrollee financial responsibility, which is likely to require considerable administrative effort and expense. To estimate this cost, Mercer reviewed administrative costs for the Medicaid programs in Indiana, Montana, and Wisconsin. In FFY2019, these states charged premiums and disenrolled individuals for non-payment of premiums.[79] The average per member per year administration cost for these states is $312.71.

Using the average administrative costs for states that have implemented enrollee financial responsibility and applying adjustments for trend, Mercer developed a baseline administrative cost for Medicaid Forward. Mercer considered an additional differential in administrative costs for designs where enrollee financial responsibility is anticipated for additional conservatism. This baseline amount is adjusted upwards for the increasing share of Medicaid Forward enrollees as a proportion of total Medicaid managed care enrollees (non-LTSS) reflected in designs with higher income limits, thus increasing administrative expenses as Medicaid Forward enrollment increases in the designs.

It is important to note that the scale of the eligibility expansion and enrollee financial responsibility payments contemplated by Medicaid Forward is entirely new in the context of Medicaid, and consequently extremely difficult to estimate. Table 8 below shows the administrative cost estimates for the targeted designs using the approach described above. Although the match rates for each type of administrative cost depends on the nature of the specific administrative activity, the state share of the estimated administrative costs is calculated at 50% to show the upper bound of impact.

Table 8. Comparison of Potential Administration Costs Under Medicaid Forward

	>138%–200% FPL, w/o Enr. Resp.	>138%–400% FPL, w/ Enr. Resp.	No Limit FPL, w/ Enr. Resp.
Estimated Total Administrative Costs	$21,854,539	$61,547,312	$88,163,046
Estimated State Share	$10,927,270	$30,773,656	$44,081,523

Outside of these ongoing expenses, there might be the need for one-time expenses, such as potentially significant modifications to the MMIS. The MMIS manages Medicaid business functions, such as eligibility, claims processing, provider enrollment, and other administrative activities.[80] New Mexico is in the process of replacing its existing MMIS. The project is now estimated to cost $418 million and be completed in 2027.[81]

[77] MACStats: Medicaid and CHIP Data Book, December 2020.

[78] MACStats: Medicaid and CHIP Data Book, December 2021.

[79] Understanding the Impact of Medicaid Premiums & Cost Sharing: Updated Evidence from the Literature and Section 1115 Waivers. KFF, September 9, 2021. Available at https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

[80] E-Bulletin: The Medicaid Management Information System Snapshot. Centers for Medicare & Medicaid Services. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ebulletins-medicaidmanage-infosystem.pdf.

[81] Id.

Fiscal Impact Analysis

The analysis of the difference in total program cost and State revenue under the targeted Medicaid Forward designs forecasts potential increases in new State expenditures between $232.0 million to $581.7 million.

Summarized results for the targeted designs are presented in Tables 9a and 9b. Table 9a describes estimated changes in State Medicaid costs. Table 9b describes estimated potential revenues from both existing and theoretical tax sources. These particular designs reflect the broad impacts to costs and revenues that can occur as income eligibility limits and enrollee financial responsibility assumptions are adjusted. Further detail is provided in the Appendix.

For purposes of Table 9a, "New State Costs with Medicaid Forward" is an estimate of how much each targeted design would cost the State before accounting for (subtracting) potential additional revenue from existing sources, such as the premium tax. It includes State spending on Medicaid, health care coverage for public employees, and subsidies for BeWell and NMMIP funded by the HCAF.

Table 9a. Estimation of Cost Impact of Certain Medicaid Forward Designs

		>138%–200% FPL, w/o Enr. Resp.	>138%–400% FPL, w/ Enr. Resp.	No Limit FPL, w/ Enr. Resp.
		Enrollment (Member Months)	Enrollment (Member Months)	Enrollment (Member Months)
Medicaid Managed Care Enrollment (Non-LTSS)		8,244,000	8,244,000	8,244,000
Projected Medicaid Managed Care Enrollment (Non-LTSS) with Medicaid Forward		9,365,856	10,791,540	11,728,980
		Medicaid Costs	Medicaid Costs	Medicaid Costs
State Costs (Medicaid* and Public Employee)	(A)	$2.1 billion	$2.1 billion	$2.1 billion
Projected State Costs (Medicaid* and Public Employee) with Medicaid Forward	(B)	$2.3 billion	$2.5 billion	$2.7 billion
Enrollee Financial Responsibility Amount Reflected in Projected State Costs (B)	(C)	$0	$130.7 million	$348.2 million
New State Costs with Medicaid Forward	**(B)-(A)**	**$232.0 million**	**$407.0 million**	**$581.7 million**

***Medicaid represents costs related to the Medicaid managed care program for non-LTSS populations.

For purposes of Table 9b, the following terms are described below:

"Additional State Revenues with Medicaid Forward" is an estimate of potential additional state revenue from existing sources such as premium tax.

"Potential Private Employer Funding" is a revenue estimate assuming the State creates a mechanism to capture the savings in employers' share of health insurance premiums as employees switch from employer-based coverage to Medicaid.

Table 9b. Estimation of Revenue Impact of Certain Medicaid Forward Designs

	>138%–200% FPL, w/o Enr. Resp.	>138%–400% FPL, w/ Enr. Resp.	No Limit FPL, w/ Enr. Resp.
	Potential Revenues	Potential Revenues	Potential Revenues
Additional State Revenues with Medicaid Forward	$70.9 million	$160.2 million	$214.1 million
Potential Private Employer Funding	$71.1 million	$218.7 million	$413.4 million

As is clear from Tables 9a and 9b, each targeted Medicaid Forward model increases State costs beyond current revenue streams. New Mexico could see an increase in State revenue through existing sources such as the premium tax. However, New Mexico would still need to create a new revenue stream to cover the costs of every Medicaid Forward design. Modeling suggests that only certain designs could result in employer savings large enough to cover the cost of the coverage expansion. Again, no current mechanism exists for the State to capture such funding.

A discussion of the limitations and caveats related to the modeling contained in this report is provided in the Limitations and Disclosures section.

Section 5

Additional Potential Impacts

The projected enrollment shifts and costs resulting from Medicaid Forward, as set forth in Section 4, only provide part of the picture. There are several additional impacts described in this section for policymakers to consider, including:

- Affordability as a Driver of Medicaid Forward Enrollment
- Provider Capacity and Access to Care
- Impact on State Administrative Capabilities
- Impact of Political and Financial Instability
- Impacts to the Over 65 Population
- Impacts to Other Markets
- Medicaid Forward and Individuals with Unsatisfactory Immigration Status

Affordability as a Driver of Medicaid Forward Enrollment

Enrollee costs vary considerably across private coverage sources, including BeWell, state and local government employee plans and private employer-sponsored insurance. However, the federal limit on Medicaid enrollee financial responsibility makes Medicaid Forward less costly to enrollees than private coverage options (i.e., premiums and cost sharing cannot exceed 5% of household income).

Consider the following comparison of enrollee financial responsibility for Medicaid Forward to that of plans available to State employees or through BeWell. Table 10 features the least costly options available to State employees and through BeWell's Turquoise or Clear Cost plans. For purposes of Table 10, "maximum health care costs" is equal to the annual enrollee premium and the out-of-pocket maximum.

Table 10. Comparison of Medicaid Forward Costs to Selected Coverage Options

Potential Enrollee	Annual Income	Medicaid 5% Limit	State Employee Maximum Health Care Costs	BeWell Maximum Health Care Costs
200% FPL Individual	$30,120	$1,506	$6,544.66	$2,400.00
200% FPL Family of 4	$62,400	$3,120	$19,556.76	$4,800.00
400% FPL Individual	$60,240	$3,012	$8,089.32	$9,567.92
400% FPL Family of 4	$124,800	$6,240	$24,113.52	$17,856.40
600% FPL Individual	$90,360	$4,518	$8,089.32	$9,699.92
600% FPL Family of 4	$187,200	$9,360	$24,113.52	$23,160.40

For individuals enrolled in plans available to State employees or through BeWell, State subsidies reduce premium costs on an income-based sliding scale. State employees pay between 20% and 40% of premiums, however, cost sharing still applies. A State employee at 200% of FPL could expect to pay $1,545 per year on premiums for the least costly option. The most such an individual could pay in Medicaid for both premiums and cost sharing is $1,506. For private sector employees, whose coverage costs are not similarly subsidized, the potential savings from Medicaid enrollment are greater. In fact, for Medicaid Forward to be more costly than these alternatives, an enrollee's household income would have to top $480,000, well above the estimated $423,000 threshold for the top 1% of earners in New Mexico, as of 2021.[82] In other words, there are very few, if any, New Mexicans who would be discouraged from a shift from private coverage to Medicaid Forward on the basis of cost alone.

Provider Capacity and Access to Care

Access to care is a key factor in evaluating the feasibility of Medicaid Forward. Many stakeholders believe that there are significant issues with provider capacity and accessibility in New Mexico at present, spanning primary care, behavioral health, and specialty care, and they expressed concern that Medicaid Forward could worsen the situation. This section addresses the current state of provider access in New Mexico generally and in Medicaid specifically and discusses potential adverse impacts to access to care if Medicaid Forward were implemented.

By design, Medicaid provides comprehensive benefits to low-income individuals and families with considerable limitations on financial contributions through premiums and cost-sharing that is unmatched by other coverage options. Today, New Mexico's Medicaid program does not require premiums or cost sharing of any kind. The modeling of coverage shifts by income band in part assumes that lower cost thresholds for both coverage (i.e., premiums) and receipt of health care services (i.e., cost-sharing) would result in higher utilization of medical care. This assumption was also posited in the UI report.[83]

There are different methodologies by which one could measure the adequacy of provider access. Common quantitative measures include provider counts, provider-to-enrollee ratios, time and distance standards, and wait times to appointments.

Federal Measures of Provider Access

At the federal level, the Health Resources and Services Administration (HRSA) designates health professional shortage areas (HPSAs) of various kinds.[84] For example, to be designated as a primary care HPSA, the area must have fewer than one provider per 3,500 people, or one provider per 3,000 people in unusually high needs areas.[85] Nationally, approximately 75 million people live in primary care HPSAs and 122 million live in mental health HPSAs.[86]

[82] Internal Revenue Service. Adjusted Gross Income (AGI) percentile data by state, 2021. Available at https://www.irs.gov/statistics/soi-tax-stats-adjusted-gross-income-agi-percentile-data-by-state.

[83] Medicaid Forward in New Mexico, p. vii. Urban Institute. October 2023.

[84] 42 U.S.C. 254e.

[85] "Unusually high needs" areas in the context of primary care mean those that 1) have more than 100 births per year per 1,000 women aged 15 to 44, 2) have more than 20 infant death per 1,000 live births, or 3) more than 20% of the population have incomes below the poverty level.

[86] Health Resources & Services Administration, Health Workforce Shortage Areas. Available at https://data.hrsa.gov/topics/health-workforce/shortage-areas.

Thirty-two of thirty-three New Mexico counties, or portions of those counties, qualify as primary care, dental health, and mental health HPSAs. However, the degree of the shortage varies widely depending on the area. For example, according to HRSA, both Harding County and Lea County are Geographic HPSAs as it relates to primary care, but the degree of the shortage is different. According to these analyses, Harding County is short 0.19 FTEs for primary care while Lea County is short 7.17 FTEs. While both counties are classified as primary care HPSAs, the extent of the shortage in one county is much higher than the other. Since the start of the decade, sixteen counties were newly designated as primary care Geographic HPSAs or contain areas or populations newly designated as primary care HPSAs.[87]

Provider Counts

Provider counts are another method to compare provider access across geographic areas. The provider counts and benchmarks in this report do not delineate between commercial and Medicaid beneficiaries. In October 2023, the New Mexico Health Care Workforce Committee released a report discussing provider access in the State.[88] According to the Committee, New Mexico is below national benchmarks for multiple types of providers, with significant differences across regions of the state. The Committee found that, based on data from 2021, the State would need an additional 334 primary care providers (PCPs) across the State to meet a national benchmark of 8.5 PCPs per 10,000 people.[89,90] According to HRSA, in 2021, New Mexico had 80.6 PCPs per 100,000 people, ranking it thirty-first among all states and the District of Columbia.[91,92]

One of the starkest findings of the Committee was the need for registered nurses (RNs) and clinical nurse specialists (CNSs). As of 2022, there were 16,181 RNs and CNSs practicing in the State. The Committee found that an additional 5,704 RNs and CNSs would be needed statewide to meet a national benchmark of 92 per 10,000.[93] According to HRSA methodologies, New Mexico is projected to have 83% to 86% of the necessary supply of RNs through 2036.[94] That is slightly greater than the national supply deficit projection of 9% to 10% over the same period.[95]

Time and Distance Standards

A third way of measuring provider access is how long it takes to see a provider and how far one must travel to get there. Federal regulations require each state to develop quantitative network adequacy standards for Medicaid MCOs.[96] When developing those standards, states must consider a variety of elements including enrollment, utilization, and the geographic

[87] Id.

[88] New Mexico Health Care Workforce Committee. 2023 Annual Report.

[89] This calculation of needed additional providers assumes no redistribution of the current workforce within the State. For example, according to this analysis, while New Mexico would need 334 additional PCPs without redistribution, it would only need an additional 149 PCPs if a portion of the current workforce were redistributed. This difference in the calculation highlights the uneven distribution of providers within the State.

[90] For purposes of the Committee report, "PCPs" are all physicians who specialize in family practice, general practice, general pediatrics, general internal medicine, geriatrics, and adolescent medicine.

[91] State of Primary Care Workforce 2023, National Center for Health Workforce Analysis, HRSA. Nov 2023.

[92] For purposes of HRSA, "PCPs" are all physicians who specialize in Family medicine, general internal medicine, geriatrics, and pediatrics.

[93] New Mexico Health Care Workforce Committee. 2023 Annual Report, p 56.

[94] Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections.

[95] Department of Health and Human Services, Health Resources and Services Administration, Nurse Workforce Projections, 2021-2036.

[96] 42 CFR 438.68(b).

distribution of both providers and beneficiaries.[97] New Mexico adopted quantitative network adequacy standards in State regulations.[98] For example, there are specific requirements for PCP availability.[99,100] MCOs must have at least one PCP per 2,000 members and not more than 2,000 members can be assigned to a PCP unless HCA approves an exception. Additionally, depending on the county in which a member resides, there are maximum travel distances standards. Ninety percent (90%) of members in urban, rural, and frontier counties must be within 30, 45, and 60 miles, respectively from a PCP. Lastly, members should be able to access routine primary care appointments within 30 days of request.[101]

Specialty and behavioral health access requirements in Medicaid managed care are slightly different. For such providers, 90% of members in urban, rural, and frontier counties must be within 30, 60, and 90 miles, respectively.[102] In addition, members should be able to access non-urgent behavioral health appointments within 14 calendar days of a request.[103]

Access for Medicaid managed care members must be monitored by the State's external quality review organization (EQRO).[104] An EQRO is an organization selected through the State's competitive procurement process to analyze the quality, timeliness, and access to health care services for Medicaid beneficiaries. All States with Medicaid managed care programs are required to contract with an EQRO to conduct annual mandatory (and optional) compliance reviews in accordance with CMS protocols for each MCO, culminating in a technical report.[105] The annual cost of an EQRO contract may be $1.0 million or more, depending on the scope of review areas and number of MCOs. The cost of these federally required contracts is matched at 75% FMAP.[106] As of 2022, New Mexico's Medicaid MCOs met distance standards for many key provider types, including primary care, obstetrics and gynecology, and pediatrics.[107] However, the EQRO noted several distance standard deficiencies relating to behavioral health. The EQRO also conducted a secret shopper survey to determine timeliness of appointments. That survey of PCPs and OB/GYNs for routine and non-urgent symptomatic appointments showed that only 18% of calls resulted in timely appointments.

The EQRO is not the only entity to conduct a secret shopper survey. Turquoise Care MCOs also conduct these surveys, and one was conducted by the New Mexico Legislative Finance Committee (LFC) in 2022. It found that Medicaid beneficiaries faced significant challenges with access to primary care and behavioral health providers.[108] Only 13% of calls led to an appointment, with behavioral health calls only resulting in an appointment one in ten times. According to the survey, 34% of PCP appointments and 9% of behavioral health appointments were greater than 30 days from the date of request.

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[97] 42 CFR 438.68(c).

[98] 8.308.2.9 NMAC through 8.308.2.18 NMAC.

[99] 8.308.2.11(B) NMAC.

[100] For purposes of these standards, "primary care" includes care for both adults and children.

[101] 8.308.2.12(B) NMAC.

[102] 8.308.2.11(D) NMAC.

[103] 8.308.2.12(E) NMAC.

[104] 42 CFR 438.350.

[105] Section 1932(c)(2) of the SSA.

[106] Section 1903(a)(3)(C)(ii) of the SSA.

[107] IPRO. Centennial Care 2.0 New Mexico State Medicaid Managed Care 2023 Validation of Network Adequacy.

[108] Program Evaluation: Medicaid Network Adequacy, Access, and Utilization. Report #22-06. New Mexico Legislative Finance Committee, Program Evaluation Unit. December 2022, available at https://www.nmlegis.gov/Entity/LFC/Documents/Program_Evaluation_Reports/A-1-1%20Draft_%20Medicaid%20Adequacy%20and%20Access%20v16.pdf.

Upcoming Changes to Federal Network Adequacy and Access Standards

When considering the design of the Medicaid Forward plan, the State should also consider the upcoming changes in federal Medicaid network adequacy requirements. Beginning in 2028, Medicaid MCO provider networks will be held to the following wait time standards for routine appointments: no more than 10 business days for behavioral health and substance abuse appointments and 15 business days for PCP and OB/GYN appointments.[109] An MCO will be considered compliant with these standards if an independent secret shopper survey shows at least 90% of appointment requests result in timely appointments.

Table 11. Comparison of Maximum Appointment Time Requirements

Type of Appointment	2024 Medicaid	2028 Medicaid
Routine, Asymptomatic Primary Care Wait Time (adult and pediatric)	30 Calendar Days	15 Business Days
Non-Urgent Mental Health and Substance Use Disorder Wait Time (adult and pediatric)	7 Calendar Days after initial assessment	10 Business Days
Routine OB/GYN Wait Time	Routine prenatal varies by trimester (14 Calendar Days, 7 Calendar Days, and 3 Business Days)	15 Business Days

In addition, recent changes to federal regulation will impact the type and frequency of network-related reporting to CMS and increase the level of scrutiny applied to MCO requests for exceptions to network adequacy standards. The compliance dates provided below are specific to New Mexico's Turquoise Care program and would apply to the Medicaid Forward managed care delivery system.

- As of January 1, 2027, HCA will need to submit an annual network certification to CMS that documents assurances of an adequate provider network, incorporates findings from the secret shopper surveys, and is posted on HCA's website. CMS will consider this annual network certification in the managed care contract approval process.[110]
- As of January 1, 2027, if an MCO requests an exception to a network adequacy standard, HCA will need to evaluate the adequacy of provider rates in the determination of whether to grant the exception.[111]
- As of January 1, 2029, HCA must submit a network adequacy remedy plan to CMS within 90 days of identifying an access issue. The remedy plan must have a path to completion

[109] 42 CFR 438.68(e).
[110] 42 CFR 438.207(d).
[111] 42 CFR 438.68(d)(1)(iii).

within 12 months and include measurable goals. CMS can defer federal financial participation (FFP) if the access issue is not resolved.[112]

Not all New Mexico providers accept Medicaid. While it is possible that some of these providers will accept Medicaid after the implementation of Medicaid Forward, it is also possible that some will remain private pay only. Wait times for both Medicaid and private pay patients could increase as a result of Medicaid Forward.[113] In addition, a sizable increase in the number of individuals with low or no cost health care coverage could increase demand for health care services, compounding the State's health care workforce shortages.

Impact on State Administrative Capabilities

With expanded Medicaid eligibility comes the need to scale State administrative capacity. It is reasonable to assume that if Medicaid Forward is implemented, HCA will require additional funding for State staffing and private contracts, including high-cost technology vendors. It is important for policymakers to be aware that there are numerous federal performance requirements that require State operations to scale up as Medicaid enrollment grows, such as standards for timely applications and renewal processing and the eligibility workforce required to meet these requirements.

Application Processing

Under federal law, a Medicaid agency is required to determine Medicaid and CHIP eligibility for those whose eligibility is based on Modified Adjusted Gross Income (MAGI) within 45 days of a submitted application.[114] Application review is a complex process. Timely and accurate performance is essential as states face the potential of corrective action plans and expensive financial penalties.[115]

Even if Medicaid Forward is implemented with no income eligibility limits, review of applicant income would still be necessary as federal matching funds vary by category (e.g., ACA Medicaid expansion version traditional Medicaid eligibility categories). To properly claim federal matching funds, individuals must be categorized correctly. Improper classification can result in findings of improper payments, requiring the state to return the federal share of those payments to the federal government, often years after the fact.

State Procurements

Medicaid Forward could necessitate additional state procurements, including information technology systems and Medicaid MCOs. For example, additional Medicaid MCOs may be needed to take on the increased enrollment. MCO procurements are resource intensive with long lead times, from development and issuance of the request for proposal to contract awards, readiness reviews and the start of health plan operations. The timeline is frequently extended by protests from unsuccessful bidders. It is not uncommon for states to have to

[112] 42 CFR 438.207(f); Federal Register, May 10, 2024 (Vol. 89, No. 92), p 41002,41034, available at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf.

[113] A literature review found mixed evidence on the issue of provider capacity after ACA Medicaid expansion. The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020. Madeline Guth, Rachel Garfield, Robin Rudowitz, Kaiser Family Foundation. March 2020, available at https://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf.

[114] 42 CFR 435.912 and 42 CFR 457.340.

[115] CMS, "CMCS Informational Bulletin: Guidelines for Achieving Compliance with Medicaid and CHIP Eligibility Renewal Timeliness Requirements Following the Medicaid and CHIP Unwinding Period," August 29, 2024, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib08292024.pdf.

repeat a procurement as a result of a successful protest, further extending the implementation timeline.

Information technology systems are central to Medicaid program operations. The largest of these are eligibility and payment systems, with price tags often in the hundreds of millions of dollars. These are complex procurements with protracted design, development, and implementation timelines.

Whether system changes are needed to accommodate a new program at the State's option or to satisfy new federal requirements, they are a key consideration in assessing the level of time, effort and funding needed for success.

Impact of Political and Financial Instability

A concern expressed by multiple stakeholders was instability, both political and financial. Political instability referred to changes in state or federal policy and budget priorities that could shift support away from Medicaid Forward to other government functions. Examples of political instability could be the unwillingness of a future CMS administration to renew an 1115 demonstration waiver for a particular program design granted by a previous administration, or Congress changes how Medicaid is federally funded or eliminates optional eligibility groups.[116]

An example of financial instability could be a downturn in state general fund revenues or a decrease in the state's FMAP, either of which could necessitate Medicaid budget cuts. For example, New Mexico's current FMAP is 71.68%, meaning that the federal government pays for nearly 72 cents of each dollar of Medicaid service costs. The FMAP is a rolling average that changes from year to year as state per capita income fluctuates. In 2019, when the New Mexico FMAP was 72.26%, fewer state general funds were required for each dollar spent. In 2014, by contrast, the New Mexico FMAP was 69.20%, and more state general funds were required for each dollar spent, as compared to either 2019 or 2025. As shown in Table 12 below, the impact of these changes in the FMAP could have a material impact on the State budget.

Table 12. Impact of FMAP Changes

	New State Managed Care Costs with Medicaid Forward		
	>138%–200% FPL, w/o enr. resp.	>138%–400% FPL, w/ enr. resp.	No Limit FPL, w/ enr. resp.
Current FMAP — 71.68%	$210.1 million	$345.4 million	$493.5 million
FFY2014 FMAP — 69.2%	$235.6 million	$404.7 million	$573.0 million
FFY2019 FMAP — 72.26%	$204.2 million	$331.6 million	$474.9 million

As is evident in Table 12, if the FMAP were akin to the FMAP from FFY2014 and New Mexico were to remove the income eligibility cap for Medicaid, the state costs would increase by almost $80 million.

[116] Over the past few decades, there have been several attempts to change Medicaid from a federal matching program to a block grant or per capita cap. These alternatives would allocate a specific amount of federal funding to states to administer the Medicaid program. E.g., Is Medicaid Too Big to Block Grant? Drew Altman. KFF. Mar 26, 2024, available at https://www.kff.org/from-drew-altman/is-medicaid-too-big-to-block-grant/.

Impacts to the Over 65 Population

Medicaid Forward eligibility is limited to those below the age of 65. However, individuals over the age of 65 could be indirectly impacted. According to the ACS, there are 400,122 individuals in New Mexico ages 65 and older, or just under 20% of the state's population.[117] Of this population, 137,407 rely exclusively on Medicare as a source of coverage. However, 119,567 New Mexicans 65 and older use either private insurance alone or some combination of private insurance and Medicare.[118] Thus, almost 6% of the population is 65 or older and currently uses some form of private insurance.

Medicaid Forward could result in major changes in the mix of the State's population across coverage sources. If younger, healthier people choose to move to Medicaid, the private market could be left with an older, sicker population, resulting in higher costs borne by enrollees. It is also possible that the private market pool could become so small that staying in New Mexico could become financially unsustainable for health plans, resulting in some carriers leaving the state, less competition and higher enrollee costs.

Impacts to Other Markets

The modeled designs anticipate a considerable transition of individuals to Medicaid Forward from other coverage sources, specifically private coverage sources such as employer-sponsored coverage. As stated previously, 35% of New Mexicans are covered through an employer. As of 2022, New Mexico had the lowest rate of employer-sponsored insurance (ESI) of any state in the nation.[119] Since there are no other states with a smaller proportion of their population covered through employer plans to use as a reference point, it is difficult to determine how much New Mexico's ESI coverage rate could decline without destabilizing the employer-sponsored insurance market. This is a concern that was also raised by multiple stakeholders.

To reliably evaluate the potential impact of Medicaid Forward on New Mexico's ESI market, Mercer recommends HCA consider a further study that includes the collection and analysis of data from commercial employer plans and estimates the changes in the risk profiles of individuals who remain in employer plans as compared to those who are more likely to elect Medicaid Forward. Such a study should also allow for significant stakeholder input with commercial employers so that HCA can obtain a better understanding of the factors that would influence a private employer's business decisions in a Medicaid Forward environment. If feasible, it would also be ideal to include individuals who are currently enrolled in employer plans to gain insight into the psychological factors that inform an individual's health care coverage decision-making process, in addition to economic considerations.

Medicaid Forward and Individuals with Unsatisfactory Immigration Status

Section 2 of the report discussed the limited opportunities to provide health care coverage to individuals with unsatisfactory immigration status using federal match (i.e., Medicaid). This

[117] American Community Survey, 2022, B27010 Types of Health Insurance Coverage by Age, U.S. Census Bureau, available at https://data.census.gov/table/ACSDT1Y2022.B27010?q=new%20mexico%20&t=Age%20and%20Sex:Health%20Insurance.

[118] Id.

[119] Health Insurance Coverage of the Total Population. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Employer%22,%22sort%22:%22asc%22%7D.

report, however, does not assume the inclusion of individuals with unsatisfactory immigration status within the Medicaid Forward plan because federal Medicaid matching funds would not be available. There are mechanisms a state may implement to provide state-only funded coverage for this population. As of June 2024, twelve states and the District of Columbia provide tailored, state-funded coverage to children and six states and the District of Columbia offer coverage to adults regardless of immigration status. These health care coverage programs have taken the following forms: Medicaid-look alike programs with narrower benefits and eligibility criteria, or allowing individuals to access qualified health plans on the Marketplace with or without state-funded subsidies.[120]

[120] State Health Coverage for Immigrants and Implications for Health Coverage and Care. Akash Pillai, Drishti Pillai, and Samantha Artiga, Kaiser Family Foundation. May 2024, available at https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/.

Section 6
Federal Authority Pathways

Regardless of the final design of the Medicaid Forward plan, HCA would need CMS's approval to expand eligibility and provide services through a managed care delivery system. This section describes the federal authority pathways for these two foundational program elements and requirements for premiums and cost sharing.

Eligibility

Federal law defines Medicaid's mandatory and optional eligibility groups. Each state documents covered populations and eligibility criteria in the State Plan, subject to CMS's approval. The ACA created an optional eligibility group for individuals under age 65, that are not otherwise eligible for and enrolled in Medicaid and have household income that exceeds 133% of FPL, which is consistent with the target population in HB 400.[121] For purposes of this discussion, this optional eligibility group is referred to as the "XX Group". As with other populations where age or disability is not a criterion for Medicaid eligibility, household income is calculated using the MAGI methodology. This eligibility pathway is unique in that there is no maximum income limit, meaning a state may establish an infinite income standard, and a state may phase-in coverage over time, e.g., based on geography, income, or permissible populations in section 1905(a) of the SSA (e.g., pregnant women under a specific age, populations subject to MAGI).[122] As of this report's writing, only the District of Columbia covers this optional eligibility group and only up to 215% of FPL.[123]

Federal law does not require states to conduct public notice for eligibility State Plan Amendments (SPAs)[124] and the State Plan tribal consultation policy must be followed whenever a proposed change to the Medicaid program has a direct impact on Indian health programs and Urban Indian organizations.[125] However, state law or HCA's discretion may result in a public notice process and tribal consultation.

Per Section 1915(f) of the SSA[126], CMS must approve, disapprove, or request additional information (known as an RAI) within 90 calendar days of submission, or the SPA is deemed approved. The 90-calendar day timeframe can be stopped once through CMS's provision of an RAI, which starts a new 90-day clock. Once an eligibility SPA is approved, it remains in effect until the state submits a subsequent amendment request. While the XX Group is an optional Medicaid eligibility group, the scope of CMS's questions for a SPA with an unlimited income level, or at a considerable multiple of the FPL, is difficult to anticipate.

To provide a comprehensive discussion of federal pathways to expand Medicaid eligibility, HCA could request expenditure authority through the Turquoise Care 1115 demonstration.

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[121] Section 1902(a)(10)(A)(ii)(XX) of the SSA; 42 CFR 435.218.

[122] CMS, "Implementation Guide: Medicaid State Plan Eligibility, Eligibility Groups – Options for Coverage Individuals Above 133% FPF under Age 65", *available at* https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-individuals-above-133-fpl-under-age65.pdf; Section 1905(a) of the Social Security Act, *available* at https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

[123] See *supra* note 4.

[124] Federal law requires public notice for changes in provider reimbursement methodologies, see 42 CFR 447.205.

[125] New Mexico's Medicaid Tribal Consultation Policy was revised in SPA 16-0003.

[126] Section 1915(f) of the Social Security Act, 42 CFR 430.20; CMS, "State Plan Amendment Submission and Process for State Medicaid Agencies" (February 2024), available at https://www.medicaid.gov/stateresource-center/downloads/spa-and-1915-waiver-processing/training-slides.pdf.

However, CMS would likely direct HCA to State Plan authority due to a federal policy position that 1115 demonstration authority is used only when necessary. Furthermore, CMS can impose additional requirements through terms and conditions and CMS is not held to approval timeframes that apply to eligibility SPAs.

Delivery System

FFS is Medicaid's default delivery system and is governed by the State Plan. A waiver of the "freedom of choice" requirement at Section 1902(a)(23) of the SSA, which requires beneficiaries to freely choose among qualified providers, permits states to use a managed care delivery system and limit provider networks.[127] There are four federal authorities a state may pursue for a managed care delivery system: State Plan (1932[a] authority), a waiver authority (1915[b], 1115 demonstration), or contracting authority (1915[a]). These federal pathways differ in several ways and the primary distinguishing factors across these authorities are provided in Table 14, followed by a more detailed discussion for each authority.

Table 14. Summary of Managed Care Authorities

Federal Authority	1932(a)	1115 Demonstration	1915(b)	1915(a)
Enrollment	Mandatory enrollment permissible, except for dual eligibles, Native Americans, and children with special health care needs	Mandatory or voluntary for any population*	Mandatory or voluntary for any population*	Voluntary only, state may require an opt-in or opt-out process
Financial Test	No	Yes	Yes	No
Selective Contracting	Yes	Yes	Yes	No
CMS Approval Clock	Yes	No	Yes	No
Approval Period	No expiration	5 years	2 years	Annually
Ongoing Monitoring and Reporting	No	Yes	Yes	No

*While the managed care authority allows for mandatory enrollment in an MCO, CMS has generally instituted a policy that enrollment is voluntary.

1932(a) State Plan Authority

Section 1932(a) of the SSA can be used to operate a managed care program through a SPA[128] and the state may selectively contract with MCOs through a competitive procurement. Eligibility groups, other than dual eligibles, Native Americans, and children with special health care needs, may be enrolled on a mandatory basis.

[127] Additional waivers of the Social Security Act often used for managed care delivery systems available across all authorities in this section are statewideness (1902(a)(1) of the SSA), which permits a state to use managed care in designated geographic areas and comparability of benefits (1902(a)(10)(B) of the SSA), which means the amount, duration, and scope of covered services may differ from FFS.

[128] The template for 1932(a) authority, which becomes Attachment 3.1-F of the State Plan upon approval, is available at https://www.medicaid.gov/sites/default/files/2020-02/1932a-state-plan-preprint.pdf.

The same public comment and tribal consultation considerations and CMS approval process described for the eligibility SPA applies here. Distinguishing characteristics of this authority when compared to the other delivery system authorities are no financial test, no expiration date, and no ongoing federal reporting requirements.

Section 1115 Demonstration Authority

Section 1115 demonstration authority is the current and long-standing managed care authority for New Mexico's Medicaid program.[129] This authority is statutorily defined as an "experimental, pilot, or demonstration project likely to promote the objectives of the Medicaid program." As 1115 demonstration authority modifies the bounds of federal Medicaid laws by waiving statutory requirements or authorizing new federal Medicaid expenditures, CMS is not held to an approval timeframe like other authorities. In addition, states are held to unique requirements, such as extensive public notice and comment processes, a CMS negotiation period of uncertain duration, federal expenditure limits in a budget neutrality model, independent evaluation requirements, and routine reporting throughout the approval period. Typically, the 1115 demonstration must be renewed every five years, subject to the uncertainty of changing federal administrations and priorities.[130]

Section 1115 demonstrations must have an evaluation plan that results in an evaluation report; the evaluation plan must include evaluation questions and hypotheses that translate goals into quantifiable targets, a research methodology consistent with standards of scientific and academic rigor, identification of an independent evaluator, and an evaluation budget.[131] To illustrate the financial impact to the State, the projected Centennial Care 2.0 evaluation budget for 2019–2023 was $1.6 million. This figure accounted for State staff and consultant resources that are considered Medicaid administrative costs matched at 50% FFP. CMS would likely require specific evaluation measures for Medicaid Forward, which would increase evaluation budget.[132]

Budget neutrality is the financial test applied through CMS policy to limit federal expenditures to what the federal government would have spent if the authority was not in place.[133] These calculations establish limits on the amount of federal funding available over the life of demonstration expenses, putting the state at financial risk for overspending the limit. Differences in the assumptions underlying cost projections and actual experience (e.g., enrollment and service utilization) can make or break a state budget.

Section 1915(b) Authority

The 1915(b) waiver permits contracting with managed care plans that cover limited benefits in addition to MCOs and using savings to cover additional services. The request is submitted

[129] New Mexico transitioned the Salud! 1915(b) and CoLTS 1915(b)/(c) waivers to 1115 authority in the Centennial Care program, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/Centennial-Care/nm-centennial-care-appvl-ltr-07122013.pdf.

[130] To illustrate the complex nature of 1115 demonstrations, CMS approved New Mexico's 1115 demonstration request for Turquoise Care on July 25, 2024, approximately 19 months after submission. Centers for Medicaid & Medicaid Service, CMS approved New Mexico's 1115 demonstration request for Turquoise Care on July 25, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-extn-aprvl-07252024.pdf

[131] 1115 Demonstration State Medicaid Evaluation Resources, CMS, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html.

[132] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nm-centennial-care-dmnstrtn-aprvl-04232024.pdf, pages 258/260.

[133] For CMS's description of budget neutrality, see SMD #18-09, "Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects", available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf. Additionally, CMS has communicated more recent changes to budget neutrality policy in approval documents for specific types of 1115 demonstrations.

through a specific waiver template and waiver submissions must be submitted to CMS at least 90 days prior to the effective date of the waiver. CMS does have up to two 90-day clocks to approve the waiver.[134]

The 1915(b) waiver must include cost-effectiveness projections for federal expenditures for the two-year waiver period, which may require actuarial support.[135] States are expected to monitor the cost of services provided under the waiver to ensure that actual costs remain equal to or less than the projected costs included in the approved waiver. In addition, 1915(b) waivers require an independent assessment for the first two waiver renewals of how the waiver impacted access to care, quality of care, and cost effectiveness.

Section 1915(a) Contracting Authority

Section 1915(a) of the SSA is referred to as a "contracting authority" because the pathway for approval is the state's managed care contract and rate certification, submitted to CMS annually, rather than the State Plan or a distinct waiver template. This authority only authorizes voluntary enrollment in the managed care delivery system, meaning individuals can remain in FFS or return to FFS.[136] Another key distinction is that the state cannot selectively contract the number of managed care plans that participate in the program. Under this authority, States can conduct a procurement for managed care plans following state procurement rules, but any vendor that meets the qualifications must be offered a contract. This means that a state cannot selectively contract with a limited number of plans under this pathway. The number of MCO contracts is an important consideration, given states' experience with how many plans are necessary for success of the managed care model (e.g., the number of contracts that provide meaningful choice for enrollees, financial viability for MCOs, and state administrative costs). Currently, HCA contracts with four MCOs for the Turquoise Care program.

Premiums and Cost Sharing

Under federal law, it is permissible to apply premiums and cost sharing to members of certain Medicaid-eligible populations and income levels; the description of permissible premiums and cost sharing in this section is limited to the requirements that would apply to the Medicaid Forward population (i.e., income greater than 138% of FPL with potentially no limit). Application of premiums and cost-sharing requires CMS approval through the SPA process, which requires public notice.[137]

Premiums are typically a monthly financial obligation to keep health coverage and is only permissible for Medicaid beneficiaries with income greater than 150% of FPL; based on 2024 FPL standards, 150% of FPL is an annual income of $22,590 for an individual and $46,800 for a four-person household.[138] Native American beneficiaries who are eligible for or have received services from an Indian Health Care Provider (IHCP) are exempt for Medicaid premiums regardless of income level.[139] Federal law allows, but does not require, the state to

[134] 42 CFR 431.55.

[135] The 1915(b) waiver approval period is generally 2 years unless dual eligible individuals are covered under the authority. As the Medicaid Forward plan does not contemplate this population, this authority should be evaluated in terms of a 2-year approval period.

[136] Section 1915(a) of the SSA.

[137] Id.

[138] US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "2024 Poverty Guidelines: 48 Contiguous States", available at https://aspe.hhs.gov/sites/default/files/documents/7240229f28375f54435c5b83a3764cd1/detailed-guidelines-2024.pdf.

[139] 42 CFR 447.56(a)(1)(x).

disenroll individuals that would be in the Medicaid Forward plan for non-payment of premiums for 60 consecutive days or more.[140]

Cost sharing is limited to certain services and permissible amounts of cost sharing vary by income level. These limitations are summarized in Table 13. Native American beneficiaries are exempt from any cost-sharing obligations for any Medicaid service from any Medicaid provider if the individual ever received a service or referral from an IHCP.[141] States may allow providers to deny a service if a Medicaid beneficiary does not pay an otherwise permissible cost sharing amount; however, providers may waive or reduce cost sharing amounts on a case-by-case basis.[142]

Table 13. Maximum Cost Sharing for the Medicaid Forward Population

	Income 100%–150% FPL	Income > 150% FPL
Outpatient Services[143]	10% of the cost the Medicaid agency pays for the services	20% of the cost the Medicaid agency pays for the services
Inpatient Hospital Stay[144]	10% of the cost the Medicaid agency pays for the entire stay	10% of the cost the Medicaid agency pays for the entire stay
Prescription Drugs[145]	Preferred Drug: $4 Non-Preferred Drug: $8	Preferred Drug: $4 Non-Preferred Drug: 20% of the cost the agency pays
Non-Emergent Use of Emergency Department[146]	$8	No Limit (subject to 5% aggregate cap)
Excluded Services Regardless of Income	Emergency services, family planning services and supplies, preventive services for children under age 18, tobacco cessation services for pregnant women[147]	

All permissible premiums and cost sharing incurred by all individuals in a Medicaid household are limited to an aggregate cap of 5% of family income applied either on a quarterly or monthly basis. This aggregate cap is calculated based on both premiums and cost sharing. The state must have a system to track imposed premiums and cost sharing at the individual beneficiary level if the applied premiums and cost sharing amounts could reach that cap. This process cannot rely on information provided by Medicaid beneficiaries.[148]

A state can request permission from CMS under section 1115 demonstration authority to modify these requirements; however, there are several conditions that the state must meet and the authority can only be in place for two years per federal law. Pursuant to section 1916(f) of the SSA[149], a state's request to exceed premium and cost sharing limits must show

[140] 42 CFR 447.55(b).

[141] Id.

[142] 42 CFR 447.52(e),

[143] 42 CFR 447.52(b)(1).

[144] Id.

[145] 42 CFR 447.53(b).

[146] Before a hospital can provide non-emergency services in an emergency department, several activities must be completed including, an appropriate medical screening and referral to an alternative provider. 42 CFR 447.54.

[147] 42 CFR 447.56(a)(1)(x).

[148] 42 CFR 447.56(f).

[149] Section 1916(f) of the SSA.

the proposal (1) will test a unique and previously untested use of copayments; (2) is limited to two years; (3) will reasonably provide equivalent risks and benefits to impacted beneficiaries; (4) is based on hypotheses that will be tested with control group(s); and (5) is voluntary.

General Considerations for Delivery System Authority

Regardless of the managed care delivery system authority pursued for the Medicaid Forward plan — except for 1915(a) contracting authority that requires the state to contract with any qualified and willing MCO — HCA will need to evaluate whether the State's procurement laws would apply. Furthermore, the managed care contract and rate certification will need to account for any impacts of the Medicaid Forward plan.

In addition, federal law requires the state to conduct a readiness review and submit documented findings to CMS when a new population is added to an existing Medicaid managed care program or a new managed care program is implemented. The readiness review must start at least three months before the programmatic change and CMS will consider the state's findings when reviewing the managed care contract for approval. The readiness review process may include both a desk review of MCO policies and procedures, staffing plans, and provider network adequacy documentation, and onsite reviews to interview key staff across critical operational functions.[150] Many states use contractor support to conduct readiness reviews, and the entire process typically takes no less than four months.

In the event Medicaid Forward's managed care delivery system is authorized outside the 1115 demonstration and ultimate program design element(s) deviate from federal law, a concurrent 1115 and other managed care authority would be needed.

[150] 42 CFR 438.66(d).

Section 7

Conclusion

Medicaid Forward is an ambitious plan that could fundamentally alter New Mexico's health care coverage landscape. Only the District of Columbia has used this optional eligibility group and expanded Medicaid to 215% of FPL. No state has expanded Medicaid to nearly all its residents.

Historically, Medicaid is the source of health care coverage for lower income groups. While there is experience to reference in developing reliable estimates for traditional Medicaid expansions, the absence of real-world experience for broad-based Medicaid coverage creates considerable uncertainty in estimating Medicaid Forward's likely impacts.

Based on the assumptions included in the analysis, this study finds that:

1. The individual's cost of coverage under Medicaid Forward would be lower than that of other coverage options for virtually any eligible New Mexican, driving a shift from private coverage sources to Medicaid. The degree of that shift will depend on the income limit chosen (if any) and the preferences of individual New Mexicans.

2. Medicaid Forward would significantly increase total Medicaid costs, including health care service costs and State costs to administer the program. A considerable amount of State funding would be needed to pay for Medicaid Forward. The total amount of funding needed would exceed existing State revenue sources.

While stakeholders agree that improving access to affordable health care coverage is a priority, they are decidedly mixed at how to achieve that goal and specifically how far Medicaid eligibility should extend.

The modeling in this report demonstrates the ability to cover the cost of additional health care coverage increases as the income eligibility limit increases or is removed completely. However, this is dependent on the State generating sufficient revenue through a mix of additional, or increased, taxes.

In addition to potential provider access strains and the need to increase Medicaid reimbursement, the magnitude of Medicaid expansion and resulting enrollment shifts from employer-sponsored and Exchange coverage to Medicaid could eliminate or significantly reduce individual choice. Because there will always be individuals who either do not want Medicaid coverage or would not qualify for such coverage, Mercer anticipates the continued need for a private market of some sort. If implemented, Medicaid Forward would result in a larger proportion of the State's budget dedicated to health care costs that are also subject to federal Medicaid laws.

As with all most aspects of the health care system, there are pros, cons, and tradeoffs. This study is intended to help stakeholders weigh the pros and cons and to inform decision-making on the most appropriate path forward for New Mexico.

The following chart summarizes findings across major data points in Mercer's analysis for ease of reference.

Impacts	Targeted Design: >138%–200% FPL without Enrollee Financial Responsibility	Targeted Design: >138%–400% FPL with Enrollee Financial Responsibility	Targeted Design: No Income Limit with Enrollee Financial Responsibility
	• Income limit: 200% FPL • Enrollee financial responsibility as % of household income: None	• Income limit: 400% FPL • Enrollee financial responsibility as % of household income: — <200% FPL, 0% — 200%–300% FPL, 2% — 300%–400% FPL, 3.5%	• Income limit: None • Enrollee financial responsibility as % of household income: — <200% FPL, 0% — 200%–300% FPL, 2% — 300%–400% FPL, 3.5% — >400% FPL, 5%
Affordability for Eligible Individuals and Families Medicaid cost (premiums and cost sharing) capped at 5% of household income vs. the least costly current coverage options reduce premiums to 20% but cost sharing remains	Household income 200% FPL	Household income 400% FPL	Household income 600% FPL
Reduction in Uninsured Rate	50,000 (30%)	70,000 (41%)	82,000 (48%)
Reduction in Private Insurance Enrollment	43,000 (5%)	143,000 (17%)	209,000 (24%)
Increase in Medicaid Enrollment	93,000 (14%)	212,000 (31%)	290,000 (42%) people

	Targeted Design: >138%–200% FPL without Enrollee Financial Responsibility	Targeted Design: >138%–400% FPL with Enrollee Financial Responsibility	Targeted Design: No Income Limit with Enrollee Financial Responsibility
Payer Mix Adjustment Increases needed to Medicaid provider payments to offset loss of private insurance payments	1.2%	2.7%	3.4%
Enrollee Responsibility Total payment due from enrollees (premiums and cost sharing)	$0	$130.7 million	$348.2 million
State Administration Additional state staffing, contracts, IT system changes	$21.9 million	$61.5 million	$88.2 million
State Cost Additional state cost for increased Medicaid enrollment, net of existing state revenue sources	$161.1 million	$246.9 million	$367.6 million

Section 8
Limitations and Disclosures

This report was prepared on behalf of HCA to assist in the evaluation of proposed Medicaid Forward program designs as required under HB 400 (2023). It includes estimates of changes in Medicaid enrollment, expenses and revenues as summarized in Tables 6, 9a and 9b and Appendices B and C. In developing these projections, Mercer has used and relied upon enrollment, eligibility, claim, reimbursement level, benefit design and financial data and information supplied by the HCA, BeWell, GSD, APS, and NMPSIA, as well as third party vendors under contract with the State of New Mexico. These agencies and vendors are solely responsible for the validity and completeness of this supplied data and information. Mercer reviewed the summarized data and information for internal consistency and reasonableness but did not audit it. In our opinion, the data used in developing these projections are appropriate for the intended purpose. However, if the data and information are incomplete/inaccurate, the values shown in this report may differ significantly from values that would be obtained with accurate and complete information; this may require a later revision to this report.

Where detailed data was not available to support an element of this analysis, Mercer relied on publicly available data and studies to facilitate modeling where possible. These publicly available sources are documented throughout this report where they were relied upon.

Furthermore, there are several potential impacts of this initiative that may be relevant to HCA's decision-making pertaining to Medicaid Forward program designs but were not modeled in this report because they are beyond the scope of HB400 (2023). These factors include but are not limited to impacts on Medicaid costs for individuals who are over age 65, qualify for MLTSS, or are ineligible for Medicaid based on immigration status (including emergency Medicaid services for non-citizens in the five-year bar period), and impacts on State employee retiree benefits administered through the NMRHCA.

Because modeling all aspects of a situation or scenario is not possible or practical, Mercer may use summary information, estimates, or simplifications of calculations to facilitate the modeling of future events in an efficient and cost-effective manner. Mercer may also exclude factors or data that are immaterial in our judgment. Use of such simplifying techniques does not, in our judgment, affect the reasonableness of the results.

Estimates of theoretical future expenses and revenues developed by Mercer are actuarial projections of future contingent events. All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely and potentially wide, range of variability from the estimate.

This report is prepared on behalf of HCA and is intended to be relied upon by HCA for the purpose of recommending a Medicaid Forward plan program design. It should be read in its entirety. The projections in this report have been prepared under the direction of F. Ronald Ogborne III, FSA, CERA, MAAA, who is a member of the American Academy of Actuaries and meets its US Qualification Standard for issuing the statements of actuarial opinion herein.

To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

HCA understands that Mercer is not engaged in the practice of law, or in providing advice on taxation matters. This report, which may include commenting on legal or taxation issues or regulations, does not constitute and is not a substitute for legal or taxation advice. Accordingly, Mercer recommends that HCA secures the advice of competent legal and taxation counsel with respect to any legal or taxation matters related to this report or otherwise.

This report assumes the reader is familiar with New Mexico's Medicaid program and Medicaid eligibility rules. It has been prepared exclusively for HCA and should not be relied upon by third parties. Other readers should seek the advice of actuaries or other qualified professionals competent in the area of actuarial projections to understand the technical nature of these results. Mercer is not responsible for and expressly disclaims liability for, any reliance on this report by third parties.

HCA agrees to notify Mercer within 30 days of receipt of this report if it disagrees with anything contained in this report or is aware of any information or data that would affect the results of this report that has not been communicated or provided to Mercer or incorporated herein. The report will be deemed final and acceptable to HCA if nothing is received by Mercer within such 30-day period.

Appendix A

List of Stakeholders Meetings

Medicaid Forward Stakeholder Interactions
Albuquerque Public Schools
BeWell
Blue Cross Blue Shield of New Mexico
Molina Healthcare of New Mexico
Native American Technical Advisory Committee (NATAC)
New Mexico Alliance of Health Councils (NMAHC)
New Mexico Alliance for School-Based Health Care (NMASBHC)
New Mexico Behavioral Health Providers Association (NMBHPA)
New Mexico Chamber of Commerce
New Mexico Health Care Association (NMHCA)
New Mexico Hospital Association (NMHA – NMHSC)
New Mexico Medicaid Medical Advisory Committee (MAC)
New Mexico Medical Insurance Pool (NMMIP)
New Mexico Medical Society (NMMS)
New Mexico Office of the Superintendent of Insurance (OSI)
New Mexico Primary Care Association (NMPCA)
New Mexico Taxation and Revenue Department
New Mexico Tribal Behavioral Providers
New Mexico Together for Health Care
Presbyterian Healthcare Services
United Healthcare Community Plan of New Mexico

Appendix B

Enrollment Shift Analysis

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Table 1. Estimated Enrollment Shift < 200% FPL w/o Enrollee Responsibility

	Baseline	<200% FPL w/o Enrollee Financial Responsibility	
Market Segment/Subpopulation	**Enrollment**	**Enrollment**	**% Change**
Medicaid	***687,000***	***780,488***	***13.6%***
Traditional/Non-Disabled	400,000	418,870	4.7%
Traditional/Disabled	26,000	26,000	0.0%
Medicaid Expansion	261,000	273,580	4.8%
Medicaid Forward	0	62,038	N/A
BeWell (Exchange)	***56,901***	***43,207***	***-24.1%***
Gold	24,120	22,311	-7.5%
Silver	421	356	-15.4%
Turquoise 1	6,177	1,235	-80.0%
Turquoise 2	8,046	1,408	-82.5%
Turquoise 3	15,892	15,892	0.0%
Turquoise 4	0	0	N/A
Bronze	373	306	-18.0%
Expanded Bronze	1,872	1,699	-9.2%
Employer Sponsored Insurance	***804,128***	***774,656***	***-3.7%***
FEHB	44,937	44,263	-1.5%
State & Local Gov't Employees	50,855	46,734	-8.1%
State Agency Employees	30,746	28,133	-8.5%
Local Public Body Employees	20,109	18,601	-7.5%
Public School Employees	61,648	51,036	-17.2%
Albuquerque Public Schools	14,682	11,819	-19.5%
NM Public Schools Ins. Authority	46,966	39,217	-16.5%
Commercial	646,688	632,623	-2.2%
Large Employers	323,344	318,494	-1.5%
Mid-size Employers	64,669	63,214	-2.2%
Small Employers/Other	258,675	250,915	-3.0%
Uninsured	***170,000***	***119,680***	***-29.6%***
FFP Eligible	125,800	75,480	-40.0%
FFP Ineligible	44,200	44,200	0.0%
Grand Total	***1,718,029***	***1,718,031***	***0.0%***
Insured Total	***1,548,029***	***1,598,351***	***3.3%***

Table 2. Estimated Enrollment Shift < 300% FPL with and w/o Enrollee Responsibility

	Baseline	<300% FPL w/ Enrollee Financial Responsibility		<300% FPL w/o Enrollee Financial Responsibility	
Market Segment/Subpopulation	**Enrollment**	**Enrollment**	**% Change**	**Enrollment**	**% Change**
Medicaid	***687,000***	***846,538***	***23.2%***	***863,549***	***25.7%***
Traditional/Non-Disabled	400,000	428,305	7.1%	428,305	7.1%
Traditional/Disabled	26,000	26,000	0.0%	26,000	0.0%
Medicaid Expansion	261,000	279,870	7.2%	279,870	7.2%
Medicaid Forward	0	112,363	N/A	129,374	N/A
BeWell (Exchange)	***56,901***	***23,421***	***-58.8%***	***23,421***	***-58.8%***
Gold	24,120	16,884	-30.0%	16,884	-30.0%
Silver	421	193	-54.2%	193	-54.2%
Turquoise 1	6,177	1,235	-80.0%	1,235	-80.0%
Turquoise 2	8,046	1,408	-82.5%	1,408	-82.5%
Turquoise 3	15,892	2,384	-85.0%	2,384	-85.0%
Turquoise 4	0	0	N/A	0	N/A
Bronze	373	138	-63.0%	138	-63.0%
Expanded Bronze	1,872	1,179	-37.0%	1,179	-37.0%
Employer Sponsored Insurance	***804,128***	***739,397***	***-8.0%***	***736,540***	***-8.4%***
FEHB	44,937	43,639	-2.9%	43,589	-3.0%
State & Local Gov't Employees	50,855	29,577	-41.8%	28,186	-44.6%
State Agency Employees	30,746	17,254	-43.9%	16,372	-46.8%
Local Public Body Employees	20,109	12,323	-38.7%	11,814	-41.3%
Public School Employees	61,648	46,569	-24.5%	46,207	-25.0%
Albuquerque Public Schools	14,682	10,936	-25.5%	10,865	-26.0%
NM Public Schools Ins. Authority	46,966	35,633	-24.1%	35,342	-24.7%
Commercial	646,688	619,612	-4.2%	618,558	-4.3%
Large Employers	323,344	314,007	-2.9%	313,644	-3.0%
Mid-size Employers	64,669	61,868	-4.3%	61,759	-4.5%
Small Employers/Other	258,675	243,737	-5.8%	243,155	-6.0%
Uninsured	***170,000***	***108,673***	***-36.1%***	***94,520***	***-44.4%***
FFP Eligible	125,800	64,473	-48.7%	50,320	-60.0%
FFP Ineligible	44,200	44,200	0.0%	44,200	0.0%
Grand Total	***1,718,029***	***1,718,029***	***0.0%***	***1,718,030***	***0.0%***
Insured Total	***1,548,029***	***1,609,356***	***4.0%***	***1,623,510***	***4.9%***

Table 3. Estimated Enrollment Shift < 400% FPL with and w/o Enrollee Responsibility

	Baseline	<400% FPL w/ Enrollee Financial Responsibility		<400% FPL w/o Enrollee Financial Responsibility	
Market Segment/Subpopulation	**Enrollment**	**Enrollment**	**% Change**	**Enrollment**	**% Change**
Medicaid	***687,000***	***899,295***	***30.9%***	***922,475***	***34.3%***
Traditional/Non-Disabled	400,000	432,079	8.0%	432,079	8.0%
Traditional/Disabled	26,000	26,000	0.0%	26,000	0.0%
Medicaid Expansion	261,000	282,386	8.2%	282,386	8.2%
Medicaid Forward	0	158,830	N/A	182,010	N/A
BeWell (Exchange)	***56,901***	***17,374***	***-69.5%***	***17,374***	***-69.5%***
Gold	24,120	11,457	-52.5%	11,457	-52.5%
Silver	421	193	-54.2%	193	-54.2%
Turquoise 1	6,177	1,235	-80.0%	1,235	-80.0%
Turquoise 2	8,046	1,408	-82.5%	1,408	-82.5%
Turquoise 3	15,892	2,384	-85.0%	2,384	-85.0%
Turquoise 4	0	0	N/A	0	N/A
Bronze	373	37	-90.1%	37	-90.1%
Expanded Bronze	1,872	660	-64.7%	660	-64.7%
Employer Sponsored Insurance	***804,128***	***700,865***	***-12.8%***	***693,725***	***-13.7%***
FEHB	44,937	42,831	-4.7%	42,690	-5.0%
State & Local Gov't Employees	50,855	20,304	-60.1%	17,883	-64.8%
State Agency Employees	30,746	11,374	-63.0%	9,839	-68.0%
Local Public Body Employees	20,109	8,930	-55.6%	8,044	-60.0%
Public School Employees	61,648	34,997	-43.2%	33,348	-45.9%
Albuquerque Public Schools	14,682	7,501	-48.9%	7,047	-52.0%
NM Public Schools Ins. Authority	46,966	27,496	-41.5%	26,301	-44.0%
Commercial	646,688	602,733	-6.8%	599,804	-7.2%
Large Employers	323,344	308,187	-4.7%	307,177	-5.0%
Mid-size Employers	64,669	60,122	-7.0%	59,819	-7.5%
Small Employers/Other	258,675	234,424	-9.4%	232,808	-10.0%
Uninsured	***170,000***	***100,496***	***-40.9%***	***84,456***	***-50.3%***
FFP Eligible	125,800	56,296	-55.2%	40,256	-68.0%
FFP Ineligible	44,200	44,200	0.0%	44,200	0.0%
Grand Total	***1,718,029***	***1,718,030***	***0.0%***	***1,718,030***	***0.0%***
Insured Total	***1,548,029***	***1,617,534***	***4.5%***	***1,633,574***	***5.5%***

Table 4. Estimated Enrollment Shift > 400% FPL with and w/o Enrollee Responsibility

	Baseline	No Limit w/ Enrollee Financial Responsibility		No Limit w/o Enrollee Financial Responsibility	
Market Segment/Subpopulation	Enrollment	Enrollment	% Change	Enrollment	% Change
Medicaid	***687,000***	***977,415***	***42.3%***	***1,013,092***	***47.5%***
Traditional/Non-Disabled	400,000	437,740	9.4%	437,740	9.4%
Traditional/Disabled	26,000	26,000	0.0%	26,000	0.0%
Medicaid Expansion	261,000	286,160	9.6%	286,160	9.6%
Medicaid Forward	0	227,515	N/A	263,192	N/A
BeWell (Exchange)	***56,901***	***6,302***	***-88.9%***	***6,302***	***-88.9%***
Gold	24,120	6,030	-75.0%	6,030	-75.0%
Silver	421	95	-77.4%	95	-77.4%
Turquoise 1	6,177	0	-100.0%	0	-100.0%
Turquoise 2	8,046	0	-100.0%	0	-100.0%
Turquoise 3	15,892	0	-100.0%	0	-100.0%
Turquoise 4	0	0	N/A	0	N/A
Bronze	373	37	-90.1%	37	-90.1%
Expanded Bronze	1,872	140	-92.5%	140	-92.5%
Employer Sponsored Insurance	***804,128***	***646,081***	***-19.7%***	***629,275***	***-21.7%***
FEHB	44,937	40,921	-8.9%	40,443	-10.0%
State & Local Gov't Employees	50,855	13,297	-73.9%	9,639	-81.0%
State Agency Employees	30,746	6,931	-77.5%	4,612	-85.0%
Local Public Body Employees	20,109	6,366	-68.3%	5,027	-75.0%
Public School Employees	61,648	28,982	-53.0%	26,274	-57.4%
Albuquerque Public Schools	14,682	5,878	-60.0%	5,139	-65.0%
NM Public Schools Ins. Authority	46,966	23,104	-50.8%	21,135	-55.0%
Commercial	646,688	562,881	-13.0%	552,919	-14.5%
Large Employers	323,344	294,445	-8.9%	291,010	-10.0%
Mid-size Employers	64,669	55,999	-13.4%	54,969	-15.0%
Small Employers/Other	258,675	212,437	-17.9%	206,940	-20.0%
Uninsured	***170,000***	***88,230***	***-48.1%***	***69,360***	***-59.2%***
FFP Eligible	125,800	44,030	-65.0%	25,160	-80.0%
FFP Ineligible	44,200	44,200	0.0%	44,200	0.0%
Grand Total	***1,718,029***	***1,718,029***	***0.0%***	***1,718,029***	***0.0%***
Insured Total	***1,548,029***	***1,629,798***	***5.3%***	***1,648,669***	***6.5%***

Appendix C
Fiscal Impact Analysis

Notes:

1. "Net Medicaid Program Cost" is calculated as "Medicaid Capitation Costs" less "Enrollee Financial Responsibility", less "Medicaid Drug Rebate Program Revenue", plus "Additional State Administrative Expenses".
2. "State Share of Net Capitation Costs and Administrative Expenses" is calculated as "Net Medicaid Program Costs" less "Federal Matching Funds".
3. "Additional State Costs" calculated as the sum of "State Share of Net Capitation Costs and Administrative Expenses", "BeWell State Subsidies", and "GSD/Public School Employer Contributions".
4. "Premium Tax Revenue" is an estimate of potential additional state revenue from existing sources such as premium tax.
5. "Potential Private Employer Funding" is a revenue estimate assuming the State creates a mechanism to capture the savings in employers' share of health insurance premiums as employees switch from employer-based coverage to Medicaid.

Table 1. Estimated Fiscal Impact < 200% FPL w/o Enrollee Responsibility

	<200% FPL w/o Enrollee Financial Responsibility	
	Expenditure Chg.	**% Change**
Medicaid Enrollment	1,121,856	13.6%
Medicaid Capitation Costs (+)	$1,256,002,026	17.0%
Enrollee Financial Responsibility (-)	$0	N/A
Medicaid Drug Rebate Program Revenue (-)	$32,040,560	19.5%
Additional State Administrative Expenses (+)	$21,854,539	N/A
Net Medicaid Program Cost	**$1,245,816,005**	
Federal Matching Funds (-)	$924,436,102	16.0%
State Share of Net Capitation Costs and Administrative Expenses	**$321,379,903**	
BeWell State Subsidies (+)	($9,300,357)	-27.5%
GSD/Public School Employer Contributions (+)	($80,082,552)	-13.0%
Additional State Costs	**$231,996,994**	
Premium Tax Revenue	$70,863,284	9.5%
Additional State Costs less Premium Tax Revenue	*$161,133,710*	*N/A*
Potential Private Employer Funding	$71,075,608	-2.2%

Table 2. Estimated Fiscal Impact < 300% FPL with and w/o Enrollee Responsibility

	<300% FPL w/ Enrollee Financial Responsibility		<300% FPL w/o Enrollee Financial Responsibility	
	Expenditure Chg.	% Change	Expenditure Chg.	% Change
Medicaid Enrollment	1,914,456	23.2%	2,118,588	25.7%
Medicaid Capitation Costs (+)	$2,186,537,493	29.7%	$2,434,792,585	33.0%
Enrollee Financial Responsibility (-)	$44,999,280	N/A	$0	N/A
Medicaid Drug Rebate Program Revenue (-)	$55,962,457	34.1%	$62,870,067	38.3%
Additional State Administrative Expenses (+)	$43,541,148	N/A	$45,575,440	N/A
Net Medicaid Program Cost	**$2,129,116,905**		**$2,417,497,959**	
Federal Matching Funds (-)	$1,572,698,219	27.2%	$1,779,619,665	30.8%
State Share of Net Capitation Costs and Administrative Expenses	**$556,418,686**	**39.0%**	**$637,878,294**	**44.8%**
BeWell State Subsidies (+)	($23,287,706)	-68.8%	($23,290,030)	-68.8%
GSD/Public School Employer Contributions (+)	($197,780,378)	-32.2%	($207,329,739)	-33.7%
Additional State Costs	**$335,350,602**		**$407,258,525**	
Premium Tax Revenue	$118,497,267	16.0%	$134,780,962	18.1%
Additional State Costs less Premium Tax Revenue	*$216,853,335*	*N/A*	*$272,477,563*	*N/A*
Potential Private Employer Funding	$135,674,822	-4.1%	$141,271,936	-4.3%

Table 3. Estimated Fiscal Impact < 400% FPL with and w/o Enrollee Responsibility

	<400% FPL w/ Enrollee Financial Responsibility		<400% FPL w/o Enrollee Financial Responsibility	
	Expenditure Chg.	% Change	Expenditure Chg.	% Change
Medicaid Enrollment	2,547,540	30.9%	2,825,700	34.3%
Medicaid Capitation Costs (+)	$2,953,829,195	40.1%	$3,294,277,285	44.7%
Enrollee Financial Responsibility (-)	$130,723,925	N/A	$0	N/A
Medicaid Drug Rebate Program Revenue (-)	$76,207,418	46.4%	$85,616,171	52.1%
Additional State Administrative Expenses (+)	$61,547,312	N/A	$64,117,874	N/A
Net Medicaid Program Cost	**$2,808,445,164**		**$3,272,778,988**	
Federal Matching Funds (-)	$2,065,152,195	35.7%	$2,398,302,026	41.5%
State Share of Net Capitation Costs and Administrative Expenses	**$743,292,969**	**52.2%**	**$874,476,962**	**61.4%**
BeWell State Subsidies (+)	($25,449,099)	-75.2%	($25,451,354)	-75.2%
GSD/Public School Employer Contributions (+)	($310,839,664)	-50.6%	($332,944,262)	-54.2%
Additional State Costs	**$407,004,206**		**$516,081,346**	
Premium Tax Revenue	$160,153,284	21.6%	$181,845,814	24.5%
Additional State Costs less Premium Tax Revenue	*$246,850,922*	*N/A*	*$334,235,533*	*N/A*
Potential Private Employer Funding	$218,738,874	-6.6%	$233,532,710	-7.1%

Table 4. Estimated Fiscal Impact No Income Limit with and w/o Enrollee Responsibility

	No Limit w/ Enrollee Financial Responsibility		No Limit w/o Enrollee Financial Responsibility	
	Expenditure Chg.	% Change	Expenditure Chg.	% Change
Medicaid Enrollment	3,484,980	42.3%	3,913,104	47.5%
Medicaid Capitation Costs (+)	$4,090,240,348	55.5%	$4,618,113,330	62.7%
Enrollee Financial Responsibility (-)	$348,224,210	N/A	$0	N/A
Medicaid Drug Rebate Program Revenue (-)	$106,127,705	64.6%	$120,595,167	73.4%
Additional State Administrative Expenses (+)	$88,163,046	N/A	$92,716,398	N/A
Net Medicaid Program Cost	**$3,724,051,480**		**$4,590,234,561**	
Federal Matching Funds (-)	$2,729,181,382	47.2%	$3,350,364,450	58.0%
State Share of Net Capitation Costs and Administrative Expenses	**$994,870,097**	**69.8%**	**$1,239,870,111**	**87.0%**
BeWell State Subsidies (+)	($31,593,581)	-93.3%	($31,594,365)	-93.3%
GSD/Public School Employer Contributions (+)	($381,597,606)	-62.1%	($416,168,445)	-67.7%
Additional State Costs	**$581,678,910**		**$792,107,301**	
Premium Tax Revenue	$214,092,414	28.8%	$245,391,786	33.0%
Additional State Costs less Premium Tax Revenue	*$367,586,497*	*N/A*	*$546,715,515*	*N/A*
Potential Private Employer Funding	$413,396,896	-12.5%	$462,415,363	-14.0%

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