Fiscal Analysis of the Health Security Act Plan: Draft Analysis Plan

Prepared For:

New Mexico Legislative Finance Committee

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I. Introduction

The New Mexico Legislative Finance Committee (LFC) engaged KNG Health Consulting, LLC (KNG Health) and its partners, IHS Markit and Reynis Analytics, to conduct a fiscal analysis of the Health Security Act Plan (HSAP). The key goal of the analysis is to assess, over a 5-year period, the cost of the health reform proposal and whether existing revenue and potential savings from plan implementation would be sufficient to cover the cost of the HSAP. This document presents our policy review of the HSAP, key modeling assumptions, and our analytic approach to simulating the effects of the HSAP.

In our policy review (Section II), we identified features of the HSAP that were required by the legislation, as well as important design features that were not fully specified in the legislation (we refer to these as "non-required features" of the HSAP). For example, the legislation explicitly requires that the HSAP be a premium-based, state-administered insurance plan available to residents living within the state for at least one year. On the other hand, the legislation does not specify how much enrollees would have to pay for coverage.

To model the costs of HSAP, we require explicit assumptions related to those design features that were not fully specified in the legislation. To develop these policy assumptions, we considered the range of different options available to the State. We evaluated the advantages and disadvantages of each option and developed policy assumptions that reflect reasonable options that can proxy for the State's ultimate implementation decisions. To help inform the development of assumptions, we reviewed other health reform proposals (specifically, single payer coverage expansion proposals) at both the state and federal level to see how, if at all, these proposals address in some way the non-required features of the HSAP. For some non-required features, such as whether Medicaid enrollees would be included within HSAP or the level of enrollee costs for plan participants, we elect to model the impact of a variety of different policy scenarios. We review the non-required features and our policy assumptions in Section III. We summarize our proposed modeling scenarios in Section IV.

Once the features of the HSAP are fully specified based on information in the legislation or by our policy assumptions, we would conduct the fiscal analysis to assess the cost and revenue sources for the HSAP. In later sections of this document (beginning with Section V), we describe our methodology for the fiscal analysis. In the fiscal analysis, we will estimate the cost of HSAP to the state of New Mexico as well as assess revenue to fund the plan. First, we describe how we would construct a population file to simulate the effects of the HSAP, with a special focus on the incorporation of New Mexico-specific data resources. Second, we describe how we would simulate the effects of the HSAP on enrollment, utilization, health benefit spending, and enrollee costs. Third, we describe our approach for measuring the downstream economic impacts of the HSAP. Finally, we describe our methodology for calculating the budgetary impact of the HSAP on the state of New Mexico.

The purpose of this draft document is to facilitate public comment on our various methodological decisions. We welcome comments on this analysis plan. Public comments should be sent to Nathan Eckberg, Esq., Legislative Finance Committee, Program Evaluation Team, at Nathan.eckberg@nmlegis.gov by close of business March 6, 2020.

II. Policy Review: Identification of HSAP Non-Required Features

The Health Security Act as introduced during the 2019 New Mexico legislative session as House Bill 295 (HB 295) and Senate Bill 279 (SB 279) specifies several features of the HSAP. These required features need to be part of any option considered under the study. However, other design features are left unspecified, although details are needed to undertake modeling of the potential costs of the HSAP. To better understand the required elements of the HSAP and the underlying intent of the provisions in the legislation, we reviewed the legislative text and public comments received in response to the December 4, 2019 public meeting in Albuquerque and engaged in discussions with LFC staff.

In Table 1, we describe our understanding of the requirements of the HSAP. We also provide notes on the non-required features of the HSAP. There are open questions surrounding benefits (minimum standards are established by the HSAP), premiums, and subsidies; the costs to employers; and plan financing. We would need to develop assumptions on these issues under each modeled option to conduct the fiscal analysis.

Table 1. Required and Non-Required Elements of the Health Security Act Plan

Category	Requirements	Non-Required Features
Overall		
General Approach	A premium-based system to expand health insurance coverage to most New Mexicans, including those currently covered by non-group and fully-insured employer health plans. Under the HSAP, premiums, which are dependent on income levels, and current public expenditures for healthcare are used to finance the system.	

Eligibility – Individuals	• Inclusion Criteria
	  o Individuals residing in New Mexico for 1+ years
	  o Dependents of individuals residing in New Mexico for 1+ years
	• Exclusion Criteria
	  o Federal retiree health plan beneficiaries
	  o Active duty and retired military
	  o Individuals covered by the federal active and retired military health programs
		• The HSAP legislation does not explicitly require Medicare or Medicaid beneficiaries to be enrolled in the plan.

Eligibility – Employers	• All employers may offer coverage through the HSAP. • Employers may offer comprehensive health benefits outside of the HSAP if they elect to self-insure.	• If an employer chooses to drop coverage, there is no specified mechanism to reclaim the employer contribution to premiums.
Enrollment	• Enrollment into the HSAP is voluntary for beneficiaries enrolled in self-insured employer health plans. • Enrollment into the HSAP is required for all other eligible enrollees.	• The legislation does not address retroactive coverage for eligible populations who do not applied for coverage before consuming services.
Benefits and Cost Sharing		
Benefits	The HSAP must cover benefits currently offered by the state employee health plan.	• The HSAP does not limit benefits to those covered by the state employee health plan.
Cost-Sharing Amounts	The HSAP must not apply cost-sharing for preventative services or to any services received by Native American enrollees.	• The legislation does not specify cost-sharing requirements for non-preventative services delivered to non-Native American enrollees.
Cost-Sharing Subsidies	No detail provided.	• A cost sharing subsidy structure is not specified in the HSAP.

Category	Requirements	Non-Required Features
Premiums		
Premium Amounts	• A single per-person premium amount may be applied. • The premium level may be established to fund both benefits spending for HSAP enrollees and HSAP administrative costs. The administrative portion of the premium amount is capped at 5% of total spending after five years.	• Unspecified in the legislation is the obligation of eligible populations who have not applied for coverage to pay premiums and, if so, how such premiums would be collected.
Premium Subsidies	No detail provided.	• The legislation does not specify how premium subsidies should vary by income or if premium subsidies should vary by family size.
Providers		
Provider Participation	Health care providers may not deny care due to non-payment for previous services. New facilities and/or providers must fulfill Certificate of Need requirements prior to participating in the plan.	
Provider Payments	Health facilities are subject to global budgets. Annual HSAP provider rate increases are limited to growth in the medical component of the Consumer Price Index. Supplemental payments may be provided to ensure access in rural and underserved areas.	• The HSAP does not specify how provider rates for non-institutional providers are to be established and to what extent additional payments would be made to underserved and rural communities.

III. Policy Assumptions for HSAP Non-Required Features

In this section, we provide a discussion of policy assumptions related to non-required features of the HSAP. This discussion covers the advantages and disadvantages of various policy options and describes our policy assumptions. Our policy assumptions reflect our efforts to find reasonable options that can proxy for the State's ultimate implementation decisions. However, our assumptions regarding policy direction for non-required elements of the HSAP should not be interpreted as policy recommendations.

This section focuses on the following policy issues that need to be resolved to provide reasonable estimates of the fiscal impact of the HSAP on the state of New Mexico:

1) Treatment of Medicare enrollees;
2) Treatment of New Mexico Medicaid enrollees;
3) Employer contributions to the HSAP;
4) Process for enrollment of eligible populations;
5) Benefits and cost sharing under the HSAP; and
6) Establishment of provider payment rates.

In considering these issues, we conducted an environmental scan to identify state and Federal legislation proposing single-payer or similar models. After identifying the relevant legislation, we reviewed approaches taken by different proposals, with special focus on questions of individual eligibility, treatment of employers, premiums, cost-sharing, out-of-pocket costs, and funding sources.

A. Treatment of Medicare Enrollees

The treatment of Medicare enrollees is not specified by the HSAP legislation. Medicare enrollees could be made ineligible for the HSAP or made ineligible for the HSAP premium subsidies, just as Medicare enrollees are ineligible for Marketplace subsidies. Alternatively, Medicare enrollees could be empowered to opt-out of traditional Medicare in favor of HSAP. The State could also consider requiring Medicare beneficiaries to enroll in HSAP and no longer have access to the traditional Medicare coverage option.

Including Medicare beneficiaries within HSAP would be administratively complex. The State would need to obtain a Federal waiver to make HSAP coverage mandatory for Medicare enrollees. Such a waiver would eliminate Medicare beneficiaries' choice to either enroll in traditional Medicare or select one of the Medicare Advantage (MA) plans offered in the state. We are not aware of any precedent for such a broad Federal waiver.

Prior research from Mathematica suggested that HSAP could potentially be offered as an MA plan, which would allow for voluntary participation in HSAP.[1] However, we are unaware of any precedent or proposals to offer state-administered health plans as MA plans. Doing so would require the State to verify that the HSAP complied with regulatory requirements for MA plans. This could either limit the State's flexibility in designing HSAP or require the State to offer an alternative version of HSAP specific to Medicare enrollees. In addition, the Centers for Medicare & Medicaid Services has an established process for setting premiums for MA plans based on a plan's bid and other information. Thus, even if New Mexico was able to create an MA HSAP, premiums would likely be established separately from the

main HSAP for non-Medicare enrollees, enrollment would be voluntary, and funding would come from current Medicare funding sources.

For purpose of simulating the effect of the HSAP, we will assume that no Medicare beneficiaries enroll in the HSAP during our five-year projection window for the following reasons:

1. Obtaining a Federal waiver to require Medicare beneficiaries to enroll in the HSAP would be complex.
2. While it might be possible for the State to establish an HSAP in Medicare Advantage, this plan will likely be separate from the main HSAP from a revenue and cost perspective.

> Policy Assumption #1: We will assume no Medicare beneficiaries enroll in the HSAP during the five-year projection window.

B. Treatment of Medicaid Enrollees

Including Medicaid beneficiaries within HSAP has advantages and disadvantages. Unlike Medicare, Medicaid is already administered by the State. Therefore, combining Medicaid with HSAP would likely reduce administrative complexity for both the State government and the rest of the state's healthcare system. Nevertheless, New Mexico would need to obtain a Federal waiver to include its Medicaid program in the HSAP. As in the case of offering the HSAP as an MA plan, the State would need to verify that the HSAP complied with regulatory requirements for Medicaid plans, including cost-sharing requirements, premium costs for beneficiaries, and minimum benefits. Requirements related to out-of-pocket costs could likely be achieved through premium subsidies and cost-sharing reductions. For the most part, benefits could likely also be aligned or addressed through the HSAP design (except, perhaps, for long-term services and support).

Because of administrative savings and other benefits of including Medicaid in the HSAP, we will simulate the effects of HSAP where Medicaid enrollees are enrolled in the HSAP. However, in recognition that obtaining a Federal waiver for Medicaid is uncertain, we will also model a scenario where Medicaid enrollees are not eligible for the HSAP.

> Policy Assumption #2: We will model a scenario where current Medicaid enrollees are eligible for the HSAP and a scenario where Medicaid enrollees are ineligible for the HSAP.

C. Employer Contributions to HSAP

Currently, NM businesses pay some healthcare costs by subsidizing premiums for workers and dependents enrolled in their company health plans. As populations shift from employer-based coverage into HSAP, this financial support would disappear. This would help employers by reducing the benefits share of their labor costs. These savings could translate to higher profits or be passed on as wages to employees. However, if employers are no longer directly contributing towards paying for the healthcare

expenses of their employees, that cost is likely to be transferred to the State or workers themselves. This would result in either a more negative fiscal impact of the HSAP or potentially unaffordable enrollee costs.

Health reform proposals are often designed to have employers continue to pay into the healthcare system, even if they are no longer directly offering coverage. One solution would be to require employers whose workers shift from employer coverage into HSAP coverage to pay some of the cost of the HSAP plan but exempt employers who continue providing coverage to their workers. For example, Maine's H.2987 Bill required employers to pay a 7.5% payroll tax but exempted self-insured employers. Under Medicare for America (H.R. 2452), some employers would pay a penalty if they did not offer coverage or if their workers opted for public coverage. If the State tried to implement these policies, they may be challenged as violating the Employment Retirement Income Security Act (ERISA), which prohibits most state regulation of self-insured health plans.

A second option would be to impose a dedicated payroll tax on employers. Such a tax would likely be compliant with ERISA and could maintain employer contributions within the HSAP. Some employers may be indifferent or even prefer paying a defined payroll tax, as opposed to having to offer a company health plan. However, employers who previously were not offering coverage or who continue to offer self-insured employer health plans, would likely be made worse-off by the tax. An employer payroll tax could have broader negative impacts on the local economy. It might also interfere with policymaker's intention to frame the HSAP as a "premium-based system" rather than a "tax-based system."

Policy Assumption #3: We will assume that the state would adopt a dedicated payroll tax to cover any HSAP costs in excess of revenue to support the program.

D. Process for Enrollment of Eligible Populations

The creation of a public coverage program will not necessarily result in universal coverage. For example, approximately 30% of uninsured NM residents are already eligible for Medicaid and 23% are eligible for subsidies on the New Mexico Health Insurance Exchange, or Marketplace, but are not enrolled.[2] These residents could obtain coverage at little or no cost but have elected not to enroll in the program. The state may attempt to automatically enroll all eligible persons. However, this requires an administrative mechanism to verify eligibility (i.e., the one-year residency requirement) and collect premiums when applicable. In our review of state universal coverage legislative proposals, we did not identify any proposals that described an automatic enrollment process.

The state has not yet implemented verifying eligibility and enforcing premium payment on a continuous basis. One solution would be for the State to adopt retroactive eligibility, in which providers can be paid for services by enrolling eligible patients after care has already been received. Retroactive eligibility is currently used by New Mexico's Medicaid program. The State would likely need to collect unpaid premiums through end-of-year tax returns. The State would need to decide whether non-enrolled individuals who had de facto coverage through retroactive eligibility would be required to pay a premium amount when filing their taxes. If so, some individuals may perceive the premiums as taxes. If not, individuals may choose not to enroll in HSAP until they need care.

> Policy Assumption #4: We will assume that the State achieves universal coverage among eligible populations through retroactive eligibility and that all individuals would be required to pay subsidized premiums (collected through tax filings, if necessary) regardless of whether they enroll in the HSAP.

E. Covered Benefits and Cost Sharing under the HSAP

The legislation specifies that benefits must be at least as expansive as those offered to New Mexico state government workers. The legislation does not specify whether more expansive benefits should be offered. The legislation does allow for the possibility of the benefits package being expanded over time.

Section 18 of the legislation calls for the appointment of an advisory "long-term care committee" one year after the implementation date of the HSAP to determine if and how long-term care benefits should be included in the plan. Medicaid covers long-term care (LTC) benefits and accounts for more than half of total LTC services (after excluding short-term stays in skilled nursing facilities and home health).[3] We assume that LTC benefits will not be included in the HSAP within the 5-year projection window. While we allow for Medicaid enrollees to be included in the HSAP in some scenarios, we assume that LTC benefits would be provided to this population outside of the HSAP.

> Policy Assumption #5: We will assume that, during the five-year projection window, HSAP benefits would be identical to those benefits currently offered to state workers. Currently eligible Medicaid beneficiaries enrolling in HSAP would also have coverage for Medicaid mandatory benefits not currently offered to state workers (e.g. long-term care).

The legislation requires the plan to be financed by enrollee premiums. Total premiums would need to cover benefit spending for plan enrollees and administrative overhead. We interpret the legislation as requiring a complete community rating, where all individuals are assigned the same premium amount. As many plan enrollees would not be able to afford the full premium costs, the HSAP would need to have

income-based premium subsidies. The state's Federal Medicaid waiver would likely not allow the State to charge most Medicaid-eligible HSAP enrollees any premium amount. Higher premium subsidies will reduce revenue to fund the plan but will improve the affordability of coverage for low-income families.

The legislation provides little detail on enrollee cost-sharing (e.g. deductibles, coinsurance, and copayments). The HSAP could have cost-sharing levels comparable to typical Marketplace plans, typical employer plans, or have no cost-sharing at all. The State may consider subsidies for low-income enrollees, like the Marketplace cost-sharing reduction plans. The state's Federal Medicaid waiver would likely not allow the State to charge most Medicaid-eligible HSAP enrollees any cost-sharing. Lower levels of cost-sharing would have a fiscal impact on the policy, both by reducing enrollee contributions and by inducing additional demand for services. Higher levels of cost-sharing may be burdensome for enrollees and lead patients to delay or forego high-value medical services.

In our review of state and federal regulations, we observed significant variation in proposed premium and cost-sharing levels. Most proposals had little or no enrollee costs at all.

> Policy Assumption #6: We will model the fiscal impact of the HSAP under a variety of premium subsidy and cost-sharing policy scenarios (as described in the Section IV).

F. Establishment of Provider Payment Rates

While the legislation stipulates that facilities would be subject to global budgets under HSAP, limited detail is offered for how global budgets would be established or how non-facility providers would be paid.[4] If payment rates are set too low, enrollees may struggle to find providers. There is already significant concern regarding the availability of physician specialty care, particularly in rural areas in New Mexico. A key assumption in the underlying proposal for a single payer system is that provider administrative costs will be significantly reduced and, thereby, allow provider payment rates to be reduced without inducing negative supply responses. Reductions in provider administrative costs are viewed as one key source of savings under a single payer system or similar health reform efforts.

> Policy Assumption #7: We will assume that HSAP payment rates are established to initially equal payment rates prior to implementation of HSAP. Over the subsequent five years, payment rates will be decreased to the extent administrative savings are expected to be realized.

IV. Policy Scenarios to Model

Table 2 summarizes our proposed policy assumptions for modeling the impact of the HSAP. (Policy details that will not influence our modeled estimates are excluded from the table.) The table only includes policy assumptions that will apply under all modeled scenarios. Additional policy assumptions that will vary by scenario are provided later in this section.

Table 2. Health Security Plan Policy Assumptions

Policy Category	Policy Assumptions
Implementation Date	January 1, 2021
Benefits package	Comprehensive medical, pharmacy, and dental coverage based on benefits packages available to state employees. No long-term care benefits in the HSAP. Medicaid enrollees maintain eligibility for long-term care benefits, but these are provided outside of the HSAP.
Eligibility requirement	Must reside in New Mexico for at least 1 year Must not be eligible for Medicare
Enrollment mechanisms	Automatic enrollment (except for ineligible and self-insured employer enrollees) Voluntary enrollment (except for ineligible)
Populations exempt from automatic enrollment	Self-insured employer coverage enrollees
Premiums	Aggregate premiums will be determined based on total benefit spending for plan enrollees, inflated by a Medicare-based administrative loading factor. This amount will be divided by the number of enrollees to determine the premium for each enrolled plan member.
Hospital Payment Rates	Hospitals would be paid using global budgets. Each hospital's budget would be established based on the hospital's revenue in 2018. We would adjust projected hospital spending to account for expected volume reductions based on what is observed in the literature. We would also apply productivity savings from an assumption of reduced administrative burdens. These productivity adjustments would be based on an analysis of baseline New Mexico hospital administrative costs. Prices would also be adjusted for medical inflation.
Payment Rates to Other Providers	Payment rates would be established such that total payments for the provider category were comparable to what the provider was paid prior to the implementation of the Health Security Plan. Payment rates would be decreased over a 5-year period to account for an assumption of administrative savings based on literature. Prices would also be adjusted for medical inflation.

A. Enrollee Cost Assumptions under Different Policy Scenarios

We will vary our enrollee cost policy assumptions under different modeled scenarios. Enrollee costs can influence the cost of the plan to the state, utilization levels among enrolled populations, and participation rates among populations for which enrollment is voluntary. Detailed assumptions on enrollee cost parameters under each scenario are provided in Table 3. The least generous subsidies would be based on a modified version of the current ACA Marketplace subsidy structure. Next, we assume similar benefit generosity to what would typically be offered in employer-based coverage (though low-income enrollees would still receive additional subsidies). In the next option, we would assume enrollee costs would be comparable to what was proposed in the Medicare for America Act.[5] In the last option, we would assume no enrollee cost-sharing and similar premium levels to Medicare for America.

Table 3. Enrollee Cost Assumptions across Scenarios

	Cost-Sharing	Premiums
ACA Marketplaces	Actuarial Values (AV): <138% FPL: 100% AV 138% - 150% FPL: 94% AV 151% - 200% FPL: 87% AV >200% FPL: 70% AV	Premium subsidies would be set so that families must pay no more than a fixed percentage of their income on plan premiums. This would range from 3.09% for families with incomes at 138% FPL to 9.78% for families with incomes above 400% FPL. Families with incomes below 138% FPL would have no premium obligations.
Employer Plan	Actuarial Values (AV): <138% FPL: 100% AV >138% FPL: 83% AV	Premium subsidies would be set so that families must pay no more than a fixed percentage of their income on plan premiums. This would range from 3.09% for families with incomes at 138% FPL to 9.78% for families with incomes above 400% FPL. The minimum subsidy would equal 75% of the full premium cost. Families with incomes below 138% FPL would have no premium obligations.
Medicare for America	Actuarial Values (AV): <200% FPL: 100% AV >200% FPL: 90% AV	Premium subsidies would be set so that families must pay no more than a fixed percentage of their income on plan premiums. This would range from 0% for families with incomes at 200% FPL to 8% for families with incomes above 600% FPL. Families with incomes below 200% FPL would have no premium obligations.
No Cost-Sharing	Actuarial Values (AV): 100% AV	Same as Medicare for America

B. Included Populations under Different Policy Scenarios

We will model both a scenario in which Medicaid enrollees are included within HSAP and a scenario in which current Medicaid enrollees remain in a separate insurance program. The inclusion of Medicaid enrollees has implications for provider payment rates, enrollee benefits, and public administration burdens. Between our four cost-sharing options and our two Medicaid inclusion options, we will model

eight distinct HSAP policy scenarios. These policy scenarios are shown in Table 4. We will not include Medicare-covered populations in any of the modeled scenarios.

Table 4. Scenarios to Model

	Less Generous	Cost-Sharing Scenario		More Generous
Medicaid Enrollees	ACA Marketplaces	Employer Plan	Medicare for America	No Cost-Sharing
Include in HSAP	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Exclude from HSAP	Scenario 5	Scenario 6	Scenario 7	Scenario 8

V. Building Population File

We will develop a comprehensive analytic file that includes information on New Mexican residents and employers. The resident file will include demographic information, chronic conditions, utilization rates, and spending patterns. The employer file includes data on firms offering coverage and characteristics of offered health plans.

We begin with our KNG Health Reform Model (KNG-HRM) analytic file, which is based in the American Community Survey (ACS) and includes broad information for a large nationally representative sample.[6,7] Our sample is then limited to NM individuals and employers. Finally, we calibrate the file with additional NM-specific data sources to account for the unique features of the State. Table 5 describes the data resources we would use to calibrate our analytic file.

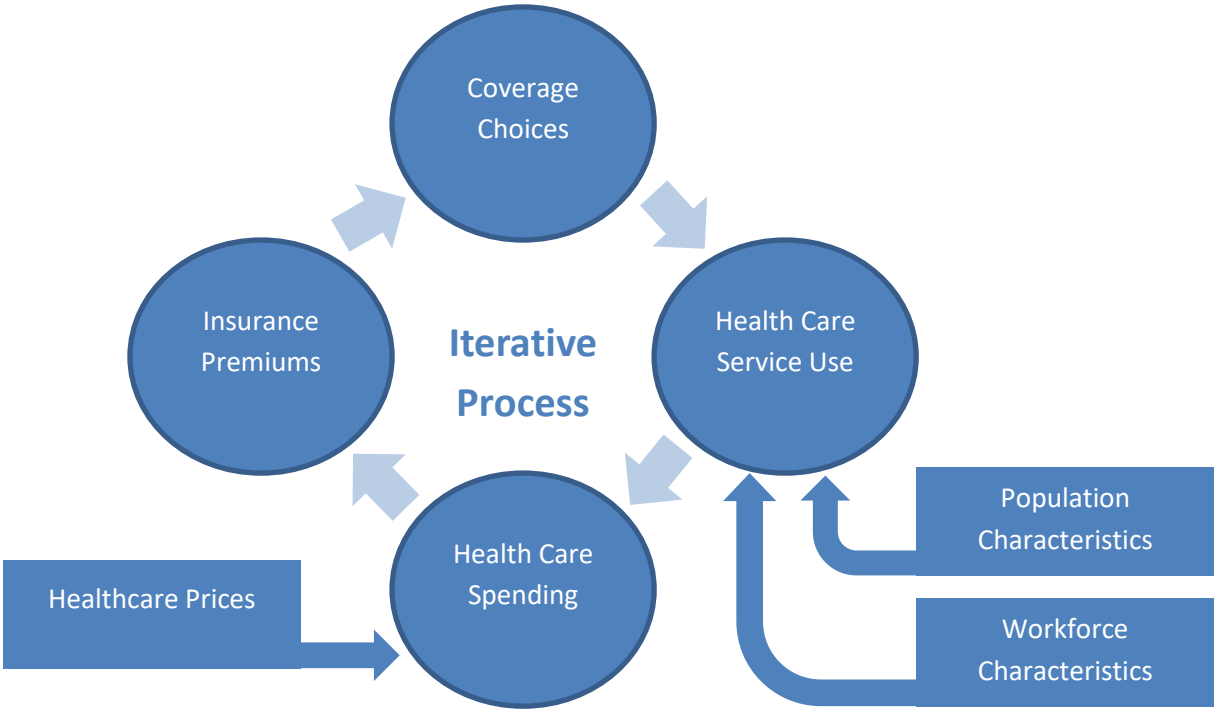
Table 5. NM-specific Data Resources used in Analysis

Population	Enrollment	Utilization & Spending
Medicare	CMS Medicare Geographic Variation Public Use File[8]	
Medicaid	New Mexico's Indicator-Based Information System[9]	Managed Care Expenditure Reports (NM HSD Data)[10] & CMS-64 Expenditure Reports[11]
State Employee Coverage	IBAC Cost and Utilization Trends Report[12]	
Other Employer	American Community Survey (ACS)[13]	HCCI Annual Report[14] & Medical Expenditure Panel Survey Insurance Component[15] & Insurance Public Filings[16]
Non-Group	CMS Medical Loss Ratio Public Use File[17]	
Uninsured	ACS	New Mexico Hospital Inpatient Database[18] & New Mexico Emergency Room encounter data[19]

VI. Simulating Health Reform Proposals

We will use the KNG-Health Reform Model (KNG-HRM) to simulate the impact of the HSAP on coverage, spending, and utilization. This involves implementing an iterative process where premium levels influence enrollment and enrollment levels influence premiums. This process is illustrated in Figure 1.

Figure 1. High-level schematic of the KNG-HRM



C. Enrollment

We will simulate individual enrollment decisions using a series of decision rules. These decision rules are summarized in Table 6. We would assume people who have resided in NM for less than one year would not enroll in HSAP, because they would be ineligible. The following populations would enroll in HSAP, as doing so would be mandatory:

- Uninsured populations;
- Non-group enrollees;
- Fully-insured employer enrollees; and
- Medicaid enrollees (under some scenarios).

For individuals covered by self-insured employer plans, enrollment would be voluntary. We would assume a portion of this population would choose to enroll in HSAP based on the cost of coverage and their income (see Table 7). Implementing HSAP could lead self-insured employers to stop offering insurance coverage if doing so would result in significant savings. We will define the savings from dropping coverage as the difference in costs between a scenario where the firm offers coverage and a scenario where the firm drops coverage. If these savings exceed a minimum savings threshold (i.e. 5% of annual payroll), we

will assume the firm drops coverage. The cost components considered in our savings calculation are defined in Table 7. If a firm drops coverage, we will assume all enrollees move into HSAP.

Table 6. Assumptions Guiding Individual Enrollment Decisions

Group	Policy	Identification	Enrollment Assumption
Residents living in NM for less than one year	Ineligible for HSAP	Residency in the prior year can be directly observed in the ACS (our model's base dataset).	• Will not enroll in HSAP. • Will maintain existing coverage unless that coverage becomes unavailable or unaffordable.
Medicare enrollees	Ineligible for HSAP	Medicare coverage can be directly observed in the ACS and will be calibrated to NM-specific Medicare enrollment administrative data.	• Will not enroll in HSAP. • Will maintain existing Medicare coverage.

Self-Insured Employer Plan Enrollees	May voluntarily enroll in HSAP.	Employer self-insurance is an imputed variable in the KNG-HRM and will be calibrated to self-insurance rates in New Mexico observed in the Medical Expenditure Panel Survey Insurance Component.	• If income is under 138% FPL, will enroll in HSAP.
			• If income is above 138% FPL
			  ○ If employee premium meets the ACA-based affordability standard, will maintain employer coverage.
			  ○ Otherwise, will enroll in HSAP.

Medicaid enrollees	• Depending on the scenario, Medicaid enrollees will either be ineligible for HSAP or automatically enrolled in HSAP.	Medicaid coverage can be directly observed in the ACS and will be calibrated to NM-specific Medicaid administrative data.	• If ineligible, will not enroll in HSAP. • If eligible, will enroll in HSAP.
All other New Mexico residents	• Automatically enrolled in HSAP.		• Will enroll in HSAP.

Table 7. Self-Insured Employer Decisions to Offer Coverage: Cost Components Considered

Cost Component	If the employer maintains coverage…	If the employer drops coverage…
Premiums for workers and dependents, net of subsidy	The sum of: • The employee's and employer's share of ESI premiums for those taking-up ESI coverage, reduced by the enrolling family's marginal tax rate; and • HSAP premiums for those opting out of ESI coverage, reduced by the income-based HSAP subsidy.	HSAP premiums for all workers and dependents, reduced by the income-based HSAP subsidy.
Out of Pocket Costs	Out of pocket health costs of the workers and dependents either participating in the ESI plan or receiving coverage through HSAP.	Out of pocket health costs for workers and dependents receiving coverage through HSAP.
Other Costs	The internal HR administrative burden of offering coverage.	None.

D. Utilization and Health Benefit Spending

HSAP will influence health utilization and spending through several mechanisms:

1) Price reductions to reclaim administrative savings
2) Utilization changes due to coverage gains
3) Utilization changes due to cost-sharing reductions
4) Utilization changes due to global budgets

Price Reductions to Reclaim Administrative Savings. In the KNG-HRM, we estimate state-specific Commercial-, Medicaid-, and Uninsured-to-Medicare price ratios for hospitalizations, outpatient visits, physician visits, and prescription drugs. By applying prices to utilization rates, we can forecast health spending. Under the HSAP, prices might fall due to savings in provider-side administrative costs. For example, some research suggests that U.S. hospital administrative costs are much higher than in other countries that either have single-payer systems or more tightly regulated multi-payer systems.[20] To assess potential administrative savings, we will first estimate baseline provider-side administrative costs in New Mexico. For this, we will use three primary sources:

- Medicare cost reports which provide administrative cost data for New Mexico hospitals
- The American Community Survey (ACS) which provides wage data for administrative workers employed in various New Mexico healthcare settings
- Published literature which provides estimates for administrative costs not captured in the above resources

Once we have an estimate of administrative costs, we will adjust them downward based on international comparisons of administration spending rates and other sources of information. This could result in

administrative spending reductions between 0% and 60% for affected populations.[21] We will assume that any administrative savings will phase-in over time.

Utilization Increases due to Coverage Gains. As individuals gain coverage and gain better access to care, their utilization is likely to increase, although some utilization – particularly in the long-term, may be offset by reductions in other types of services. Using a randomized controlled trial approach, the Oregon Health Insurance Experiment studied the effect of expanding Medicaid on several key outcomes, including health care use and patient outcomes, during the first two years of the program.[22] To randomized enrollees, the state drew names by lottery for its Medicaid program for low-income and uninsured adults. An evaluation of the Oregon Health Insurance Experiment found that previously uninsured people gaining Medicaid coverage increased inpatient utilization by 30%, emergency room utilization by 68%, physician visits by 50%, and prescription drug usage by 15%.[23]

We would use the results from the Oregon Health Insurance Experiment to adjust utilization for New Mexicans gaining coverage under the HSAP.

Utilization Increases due to Cost-Sharing Reductions. Lower cost-sharing is likely to induce additional utilization. For example, the RAND Health Insurance Experiment found that a 10% decrease in cost-sharing was associated with a 2% increase in utilization.[24] We would use this empirical relationship to adjust utilization for changes in coverage generosity.

Utilization Decrease due to Global Budgets. Global budgets de-link hospital revenue with volume, which encourages more efficient operation. For example, researchers have found that global budgets in Maryland resulted in inpatient admission declines of 4.0% for commercial beneficiaries.[25] We would assume global budgeting could have similar impacts in New Mexico.

E. Premiums and Out of Pocket Costs

In the KNG-HRM, premiums are driven by enrollment, health spending, benefit generosity, and administrative costs. We will calculate premiums for HSAP enrollees and self-insured employer-based coverage enrollees. In both cases, the calculation of premiums will follow four steps. First, we will calculate total benefit spending for the risk pool. Second, we will partition benefit spending into out-of-pocket costs and plan liability based on the plan's cost-sharing parameters. Third, we will inflate plan liability by an administrative loading factor. Fourth, we will allocate premiums to families on a per-enrollee basis. Additional detail on our methods for calculating premiums is available in the KNG-HRM online technical appendix.[26]

We would assume that HSAP would have similar administrative costs to Medicare, which is significantly less than private insurance. For example, in 2018, about 13.2% of private health insurance spending went towards administration, compared to 7% of Medicare spending.[27] We would also assume that both HSAP and employers would practice community rating. While HSAP would use a single rating pool, self-insured employer plans would each be pooled separately. Premium levels would affect enrollment decisions, which would require premiums to be recalculated. This process would be repeated until enrollment and premiums stabilize.

F. Accounting for Supply Constraints

Health care reform has the potential to increase patient access to health care services, encourage receipt of prevention services, and re-direct care to appropriate providers and care delivery settings. This raises the question of whether New Mexico has enough capacity to meet patient demand for services. Projections of physician supply (by specialty and setting) and nurses (by training, specialty for APRNs, and setting) will be generated using IHS Markit's models of health workforce supply (Healthcare Worker Supply Model, or HWSM) and healthcare demand and the resulting demand for healthcare workers (Healthcare Demand Microsimulation Model, or HDMM). These models use a microsimulation approach, meaning providers are the unit of observation. The models have been validated through modeling efforts for the federal government, state governments, and hospitals and health systems, as well as resulting in academic journal publications. New-Mexico-specific parameters regarding baseline provider supply from state licensure data will be used to predict supply.[28] The supply of providers will be compared to estimates of demand for providers under HSAP to assess the adequacy of supply by occupation and specialty, and by geographic region. We will assume that service use does not exceed the maximum amount of volume that could be served by NM's current clinical workforce.

VII. Downstream Economic Impacts

The healthcare industry, however it is financed, is an important part of the New Mexico economy. Personal healthcare expenditures in New Mexico were estimated to be $13.5 billion in 2018.[29] This represents about 13% of the state's gross domestic product.

The spending increases from the HSAP will result in additions to this output and income as the demand for, and provision of, healthcare services increases, from more intense utilization of existing resources and the addition of capital investment in the state. (Note that not all the increases will represent in-state sales and directly contribute to increased economic output – for instance, prescription drugs imported from out-of-state are a notable exception). We will calculate the in-state economic contribution of spending under the HSAP using the IMPLAN model of the New Mexico economy, which explicitly models the degree to which service inputs are provided from businesses in the state. (The IMPLAN model is an input-output model where the production of goods or services depends upon the purchase of a set of specific inputs, that is, labor and required materials. The quantitative requirements are modeled by the detailed input-output production matrix estimated by the University of New Mexico Bureau of Business and Economic Research.)

This IMPLAN analysis will generate direct and indirect impacts of the new spending on related state sectors – for example, an increase in physician office visits generate an indirect demand for office space, medical support staff, etc. Moreover, the sales and income earned in these related sectors further generate demand for other goods and services in the state. These demands result in revenue and output of goods and services in healthcare and other industries. Our IHS Markit state economic model will project these induced effects for New Mexico.

The economic impact of these changes will be further analyzed through their influence on three sets of economic actors:

1. Government
2. Business
3. Households

The IHS Markit econometric model of the New Mexico economy consists of a series of simultaneous equations, with demand and spending in each sector of the economy a function of household (consumer) income and spending, business (investment or purchases of inputs), and government spending. That spending, in turn, creates the demand for labor in each sector which, together with demographics and local labor supply, generates employment and wage and salary income.

The state government must maintain an annual budget balance. Therefore, any increased spending must be balanced by increased tax revenues. We will calculate any required rate increases under various finance plans in order to analyze their impact on business and/or household taxpayers. These rates and tax cost changes will have further implications for consumer spending and business activity. These impacts are estimated by the economic model. Of course, as the HSAP decreases business and household health insurance premiums, it may hold them harmless on net.

Any net changes in business costs or household disposable income will have further impacts on economic demand and activity across all sectors, which are captured in our model equations. The full direct, indirect, and induced impacts on households and businesses in each sector will be reported as changes relative to the baseline from the date of plan implementation to 5 years beyond.

VIII. Budgetary Analysis

We will develop a state budget model to estimate the fiscal impact of HSAP on the State of New Mexico. The purpose of the budgetary analysis is to assess whether the cost of HSAP can be financed with existing funds and, if not, the shortfall of funds and estimates of a state payroll tax necessary to close the shortfall. Our initial model will have five key factors:

1) Total administrative and benefit spending for plan enrollees;
2) The amount HSAP enrollees would contribute to premiums;
3) Repurposed Federal Marketplace and Medicaid spending;
4) The state's share of Medicaid spending; and
5) The net impact on state income tax revenues.

The first, second, third, and fourth factors would be an output of our health reform analysis. The fifth factor would be an output from our downstream economic impact analysis. We will work with the Legislative Finance Committee (LFC) staff to identify other elements of the state budget that would likely be affected by HSAP. We would also verify that baseline state spending projections generated by our models are consistent with budget projections released by the LFC.

Endnotes

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