HOUSE BILL 955
COMPREHENSIVE STUDY

ON HEALTH CARE AND HEALTH CARE COSTS IN NEW MEXICO

Legislative Health and Human Services Committee
Santa Fe, New Mexico
December 2004

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for more information, contact:
The New Mexico Legislative Council Service
411 State Capitol
Santa Fe, New Mexico 87501
(505) 986-4600
www.legis.state.nm.us
202.153454

Table of Contents

Foreword i

Executive Summary iii

Findings 1

State and National Health Care Reform Efforts over the Last Ten to Fifteen Years 1
- Arizona 3
- Maine 5
- Minnesota 6
- Oregon 8
- Tennessee 11
- Texas 12
- Utah 15
- Vermont 17
- Wisconsin 18
- New Mexico 21
- Medicare Federal Health Care Reform Efforts 23
- Military Health Care 25
- Indian Health Service 26
- ERISA 28
- HIPAA 30
- Health Savings Account 32

Public and Private Costs of Providing Health Care to New Mexicans 35
- Overview 35
- Data Collection and Methodology 35
- Study Strengths and Limitations 36
- New Mexico Health Care Costs 36
- Uncompensated Care 40
- Conclusion 41
- Guide to Tables 42
- Contacts 55

Impact Analysis of Health Care Spending on New Mexico's Economy 57
- Overview 57
- The Health Care Industry in New Mexico and the United States 57
- The Effect of Federal Health Care Spending 59
- The Effect of State Health Care Spending 63
- Summary and Conclusion 67

Policy Implications 69

FOREWORD

During the 2003 session, the New Mexico Legislature passed House Government and Urban Affairs Committee Substitute for House Bill 955, which the governor signed into law as Laws 2003, Chapter 380. The legislation required the Legislative Health and Human Services Committee (LHHS), in conjunction with the New Mexico Health Policy Commission (HPC), to

> … conduct a comprehensive study to review or determine the impact of health care expenditures on the health care industry and the state's economy, including compensated and uncompensated costs; the expectations and outcomes of state and national health care reform efforts over the last ten to fifteen years; and the public and private costs of providing health care to all New Mexicans.

The impetus for the study was the recognition that despite 10 to 15 years of state and national health care reform efforts, the cost of health care continued to rise, outpacing regular inflation; more than 40 million Americans were without health care; and more than 20 percent of New Mexicans were uninsured.

In 2002, the Medicaid Reform Committee held 21 full-day meetings that included over 40 testimonies and presentations, more than 100 written and verbal public input comments and over 2,000 pages of written testimony, handouts, reports and graphs.

What became clear was the enormous complexity of the administration and financing of public and private health care. The legislature needed verifiable, objective health care financing information to formulate health care policy. Thus, in 2003, Representative Danice Picraux introduced House Bill 955.

Throughout the 2003 and 2004 interims, LHHS members asked questions of and provided general direction to LHHS staff. Staff from the Legislative Council Service (LCS), LHHS and HPC, as well as outside contractors, researched health care financing, reform efforts and economic impact to produce this report. Lisa Cacari-Stone, Ph.D., and Karen Wells, R.N., conducted the vast majority of health care financing research and writing. Patrick Alarid, formerly with the HPC, provided information on county indigent health care funding. Tony Popp, Ph.D., professor at New Mexico State University, along with faculty and students, provided the economic impact analyses for both in-state and out-of-state funding of health care. Ramona Schmidt, LCS attorney, and Phil Lynch, LCS bill drafter and LHHS staffer, provided other research and analyses of financing and

reform efforts. Sheila C. Hennessy Sievers and Mateo Delgado, third-year law students at the University of New Mexico School of Law, with assistance from Professor Rob Schwartz, provided extensive research and writing on state and national health care reform efforts. Raúl E. Burciaga, LCS assistant director for drafting services, provided general coordination and contracting. Numerous other individuals with the state and federal governments and private organizations provided information, interviews and access to data that was used to prepare this report.

DEDE FELDMAN
Senator, District 13
Chair, Legislative Health and Human Services Committee

EXECUTIVE SUMMARY

The rising costs of health care, federal reform efforts resulting in the devolution of increased decision-making and fiscal responsibility to the states, the growth in the number of uninsured and decreasing state budgets have posed tremendous challenges to state policymakers. Health care expenditure research plays a significant role in monitoring state health care costs and providing information to inform policy. Estimates of health care spending have become increasingly important to private industry and government. National Health Expenditures (1960-2002, CMS)[1] have been regularly monitored by the Centers for Medicare and Medicaid Services, but state-level data has provided the most detailed and relevant information needed to understand how to best direct limited resources. Without evidence, important reform efforts and health policy decisions are vulnerable to competing political agendas, swayed by interest groups and other market forces. In addition, decisions without evidence may have tremendous consequences on the public's health, a state's fiscal viability and the financing and quality of health care delivered. The purpose of this study is to provide state policymakers and the public with evidence of the history of reform efforts, public and private costs of providing health care to New Mexicans and the impact of health care expenditures on the state's economy. Most importantly, this study establishes baseline data that is needed to conduct annual state estimates of health care spending. Detailed measure of health care expenditures at the state level is the basis for monitoring market trends, informing policymakers and educating the public.

BACKGROUND

The Legislative Health and Human Services Committee was charged with completing a health care costs study to determine the amount of public and private money expended on health care in the state, as well as the economic impact and the effect of health care reform efforts. The study was mandated by House Bill 955 from the 2003 regular legislative session (Laws 2003, Chapter 380). The committee was mandated to conduct a comprehensive study, in consultation with the New Mexico Health Policy Commission, to review and determine the:

(1) expectations and outcomes of state and national health care reform efforts over the last 10 to 15 years;
(2) public and private costs of providing health care to all New Mexicans; and

[1] The Office of the Actuary (OACT) in the Centers for Medicare and Medicaid Services (CMS) annually produces 10-year projections of health care spending for categories within the National Health Accounts (NHA). The NHA track health spending by source of funds (e.g., private, Medicare, Medicaid) and by type of service (hospital, physician, pharmaceuticals, etc.). CMS also tracks health care expenditures by state, but this data is not broken down by source of funds except for Medicare and Medicaid. However, this data is only available from 1980 through 1998. CMS is working to update the state data through 2002, but this will not be available until early 2005 (A. Long, Office of the Actuary, National Health Statistics Group, CMS, email correspondence with LCStone, October 5, 2004).

(3) impact of health care expenditures on the health care industry and the state's economy, including compensated and uncompensated care costs.

FINDINGS

The following is a summary of findings for each of the three study aims.

State and National Health Care Reform Efforts Over the Last 10 to 15 Years

- Federal funding for health care is primarily provided through Medicare and Medicaid, with relatively smaller funding for Indian Health Service, Veterans Administration, federal employee plans and other health care programs.

- Federal program expansions in Medicare and Medicaid have provided greater coverage and access as well as increased costs.

- Federal laws and regulations, e.g., ERISA and HIPAA, have both helped and hurt state efforts to provide some health care reforms or expansions.

- States have taken advantage of Medicaid and SCHIP waivers to provide increased coverage, limit benefits and provide more flexible programs for their recipients.

- States have also used waivers to make cutbacks in Medicaid and SCHIP because of state budget deficits.

- New Mexico has implemented many of the health care reform efforts that other states have in both public and private health care programs.

- Health care reform efforts will probably continue to be initiated by state and federal efforts to increase coverage and access while attempting to control the rate at which health care costs increase.

Public and Private Costs of Providing Health Care to New Mexicans

Health care expenditure research plays a significant role in monitoring state health care costs and providing information to inform policy. The scope of work for this study was to determine health care costs in New Mexico for calendar year 2002.

Where it came from

- In calendar year 2002, the cost of providing health care to New Mexicans was $7.8 billion.
- Approximately 75 percent, or $5.8 billion, of the health care expenditure was publicly financed and 25 percent, or $1.9 billion, was privately financed.
- Of the $7.8 billion in health care expenditures in 2002, the federal government paid $4.97 billion, or 64 percent.

- Total state and local spending was approximately $872 million (11 percent). Of the $778 million (10 percent) contributed by state government, $432 million came from the state Medicaid share and $293 million from the Department of Health.
- Counties cover about one percent of health care costs ($94 million).
- Of the $1.9 billion contributed from private sources, 54 percent ($1.1 billion) was paid by fully insured plans and 38 percent ($741 million) was paid by self-insured plans.

Where it went

- In 2002, the largest percentage of spending — 29 percent, or $2.2 billion — went to other health care services, which include ambulatory health care services (except offices of physicians, dentists and other health practitioners), outpatient care centers and medical and diagnostic laboratories.
- The second-largest category was insurance agencies, brokerages and other insurance-related activities at $1.9 billion (25 percent).
- Hospitals comprised 20 percent ($1.5 billion) of the health care spending, followed by home health care services at nine percent ($692 million), offices of physicians, dentists and other health practitioners at 8.4 percent ($653 million), nursing and residential care facilities at 3.9 percent ($303 million), behavioral health at 3.1 percent ($241 million) and prescription drugs at 2.7 percent ($212 million).
- In 2002, uncompensated care costs were reported to be $216 million but were not included as a measurement of health care expenditures for this study.

Previous research efforts demonstrating concern over the rising cost of health care

- 1992-93 the State Health Care Account — $3.9 billion (Goldstein, 1995).
- 1996 New Mexico's personal health care expenditures — $4.6 billion (Reynis, 1998).
- 1999 personal health care expenditures were $6 billion (O'Donnell, 2004).
- 1992-93 to 2002, New Mexico's expenditures doubled to $7.9 billion.

Challenges

- Estimates of health care spending have become increasingly important to private industry and government.
- Despite the policy significance of regularly monitoring health care costs, New Mexico lacks a uniform system of data collection.

Impact Analysis of Federal Health Care Spending on New Mexico's Economy

This part of the report provides insight into the size of the health care industry in New Mexico and the impact of health care spending in the state on the state's economy.

- Through the 1990s, the proportion of total economic activity originating in the health and social services sector increased from 5.25 percent to 5.74 percent for the state of New Mexico.
- In the late 1990s, compensation in health and human services was a larger proportion of total compensation in New Mexico (8.86 percent in 2000) than in the United States (8.67 percent in 2000).
- The percentage of jobs in the health and social services sector has increased from 2001 to 2003 for both New Mexico and the United States and is a larger proportion of jobs in New Mexico (10.4 percent in 2003) than in the United States (10.07 percent in 2003).
- The impact of federal health care spending is substantial. In 2002, federal health-care-related spending in New Mexico totaled $4,967.53 million and represented about 25 percent of all federal spending in the state.
- Due to federal spending on health care, New Mexico's gross state product increased by over $9.7 billion and earnings increased by $7.256 billion, and the number of jobs increased by 269,064.
- For 2002, federal spending on health care was responsible for almost 17 percent of the output of the New Mexico economy, 21.7 percent of all earnings in New Mexico and 27.9 percent of all non-farm jobs in New Mexico.
- Health care expenditures by the state totaled $778 million in 2002.
- The net effect of taxing New Mexico residents and spending the revenues on health care is that the total output of the economy increases by $629.44 million and the amount of earnings increases by $844.64 million, and more than 315,000 new jobs are created.
- Federal and state Medicaid spending for 2002 totaled $1,725 million.
- The spending by state and federal governments on Medicaid results in an increase in total output of over $2.8 billion, an earnings increase of over $2.3 billion and an increase in the number of jobs of 94,288.
- A $1.00 decrease in state spending implies a $3.00 decrease in federal spending.
- Every 10 percent cut in spending ($43 million in state spending and $129 million in federal spending) reduces state output by $285 million and earnings by over $234 million, and the state loses over 9,400 jobs.
- Health care services have been, and will continue to be, an important part of the economy of New Mexico. Any changes in the amount of spending in this sector will have a substantial impact on the size of the state's economy.

FINDINGS

STATE AND NATIONAL HEALTH CARE REFORM EFFORTS OVER THE LAST 10 TO 15 YEARS

Since the enactment of Medicaid in 1965, states have exercised a degree of control over its administration. However, because of its tremendous investment in the form of matching funds, the federal government has maintained oversight by requiring states to submit plans outlining their proposals for providing health care to those eligible. State plans must satisfy criteria established by federal laws and rules promulgated by the Centers for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services (DHHS). Throughout Medicaid's history, states have frequently sought and been granted waivers by CMS to help adapt the program to their particular needs.

Health care reform became part of the national conversation during the presidential campaign of 1992. With the failure of President Clinton's national health care initiatives to progress beyond committee discussions, state-based reform movements to expand health care access and benefits to low-income people gained momentum. These movements were made easier by CMS efforts to streamline the process for obtaining research and demonstration waivers pursuant to Section 1115 of the Social Security Act. The states' ability to obtain significant amounts of federal funding through these waivers allowed them to develop unique health care coverage programs.[2] Also fostering the states' initiatives was the provision for a sufficient duration of these waivers to test the success of new policy approaches, typically five years for health care reform demonstrations.[3]

In 1993 and 1994, six states — Oregon, Hawaii, Kentucky, Rhode Island, Tennessee and Florida — applied for Section 1115 waivers to use savings gained through managed care to expand Medicaid coverage to persons with higher incomes. Florida and Kentucky did not implement their demonstrations as approved, but in other cases coverage was extended to individuals with incomes up to 300 percent of the federal poverty level (FPL).[4]

In addition to Section 1115 waivers, states could apply for Section 1915(b) "freedom of choice" waivers. Both were used by states to control costs by enrolling beneficiaries in managed care programs. By 1998, 35 states had opted for mandatory managed care

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[2] Louise G. Trubek, "Symposium: Barriers to Access to Health Care: Working on the Puzzle: Health Care Coverage for Low-Wage Workers," *12 Health Matrix,* 157, 166.
[3] Clarke Cagey, M.A., "Health Reform, Year Seven: Observations About Medicaid Managed Care," *Health Care Financing Review, Vol. 22, No.1,* 127.
[4] *Ibid*., 129.

enrollment using Section 1915(b) waivers and another 17 used Section 1115 waivers.[5] The percentage of Medicaid beneficiaries enrolled in managed care plans increased dramatically from 9.5 percent in 1991 to 53.6 percent in 1998.[6]

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) impacted the states' administration of Medicaid. This major welfare reform act eliminated the Aid to Families with Dependent Children (AFDC) program and replaced it with the Temporary Assistance for Needy Families (TANF) block grant program. Under AFDC, people who received government income assistance were automatically eligible for health insurance under Medicaid. TANF de-linked, or separated, the income assistance and Medicaid programs. As a result, many former welfare recipients were dropped from Medicaid even if still eligible.[7] Some states created health insurance programs for low-wage workers who were forced off the traditional welfare system and whose income made them ineligible for the traditional Medicaid program.[8]

States gained increased flexibility with the passage of the Balanced Budget Act of 1997 (BBA), which provided a streamlined process of extending health care reform demonstrations for three additional years. It also allowed for a state plan amendment process under Section 1932(a), giving states the authority to mandate enrollment in managed care without seeking a waiver.[9] Unlike a Section 1915(b) waiver, Section 1932(a) has no requirement to demonstrate cost-effectiveness and, unlike a Section 1115 waiver, no requirement to show fiscal neutrality. However, Section 1932(a) does have restrictions on which populations may be enrolled in mandatory managed care, including children with special health care needs, dual eligibles and Native Americans.[10]

BBA also authorized the State Children's Health Insurance Program (SCHIP), under which states were given a more generous federal match than regular Medicaid if they agreed to insure more children. By 2000, all 50 states had SCHIP initiatives in place.[11] Since the inception of SCHIP, the focus of health care expansion in states has shifted toward children and away from adults.[12]

In August 2001, the Bush administration introduced a new Section 1115 waiver authority, the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. This waiver allows states to scale back benefits for optional eligibility groups and use the savings, as well as other funding such as any unspent SCHIP allotment, to extend

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[5] Dayna Bowen Matthew, "The 'New Federalism' Approach to Medicaid: Empirical Evidence That Ceding Inherently Federal Authority to the States Harms Public Health," *90 Ky. L.J.,* 973, 1007.
[6] *Ibid.*
[7] Trubek at 161.
[8] Trubek at 161.
[9] Cagey at 127.
[10] Cagey at 128.
[11] Frank J. Thompson, "Federalism and Health Care Policy: Toward Redefinition?" in *The New Politics of State Health Policy,* ed. Robert B. Hackey and David A. Rochefort (Lawrence, Kansas, 2001), 45.
[12] Cagey at 129.

coverage.[13] New Mexico received a HIFA waiver approval to provide coverage for adults below 200 percent FPL using state, federal, employer and employee funding.

States facing budget deficits in the last few years have used waivers to make cutbacks in both Medicaid and SCHIP. In 2004, many states lowered provider reimbursement, eliminated or cut optional benefits and attempted to reduce the growth of enrollment.[14]

Within this framework of regulations, mandates and waivers, states have created a multitude of health care plans. During the 1990s, it is estimated that state reforms made it possible for one million more individuals to be insured than would have been otherwise.[15] Differences in states' funding abilities, priorities, politics, wealth, abilities to build coalitions and even degrees of unionization played a role in the product. Each state's plan continues to be modified over time as states respond to internal and external pressures, particularly budgetary ones.

Arizona

In 1982, Arizona was the last state to accept federal funding for a Medicaid program. During that year, Arizona obtained its Section 1115 waiver and the Arizona Health Care Cost Containment System (AHCCCS) became the first statewide Medicaid managed care system in the nation. AHCCCS was unique in that it did not rely on a fee-for-service reimbursement system, but paid an upfront capitation payment to public and private health plans.

Initially, AHCCCS covered mostly acute care services. However, in 1988 and 1989, CMS granted extensions that allowed Arizona to implement capitated long-term care programs for elderly, physically disabled and developmentally disabled populations. In 1990, comprehensive behavioral health coverage began.[16] KidsCare, Arizona's children's health insurance program, started in 1998 with 75 percent federal matching funds.[17]

Arizona created a premium sharing program using only state funds in 1998. Low-income individuals with incomes above the Medicaid eligibility mark were able to obtain health insurance with low co-pays and monthly premiums, but the program ended in 2003 when the state was forced to make budget cuts.[18]

In 2001, Arizona applied for and was granted two amendments to its AHCCCS program. The first allowed Arizona to expand eligibility for its Medicaid acute care program to individuals with incomes up to 100 percent FPL. The second, a HIFA waiver, allowed

[13] John Holahan and Mary Beth Pohl, "States as Innovators in Low-Income Health Coverage," *Assessing the New Federalism, An Urban Institute Program to Assess Changing Social Policies* (Washington, D.C., 2002), 7.
[14] Urban Institute, State Budget Crises, http://www.urban.org/ (accessed July 26, 2004).
[15] Cagey at 131.
[16] "Arizona Statewide Health Reform Demonstration," Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/medicaid/1115/azfact.asp.
[17] "Overview of AHCCS," http://www.ahccs.state.az.us/publications/overview/2003/Chapter 1.
[18] *Ibid.*

the state to use SCHIP funds to cover childless adults below 100 percent FPL and parents between 100 and 200 percent FPL. Children were covered up to 200 percent FPL under a separate SCHIP program. The SCHIP funds also covered expenditures under HIFA and, when those funds were exhausted, coverage of childless adults was taken over by regular Medicaid funds as part of the state's Section 1115 waiver.[19]

Arizona did not include an employer-based premium assistance component in its application for the 2001 waiver. However, in negotiations with CMS for the waiver, it agreed to conduct a feasibility study of providing premium assistance to families below 200 percent FPL for the purchase of employer-sponsored insurance (ESI). The study concluded that such a program would not work in Arizona primarily because of the state's high percentage of small employers. Two-thirds of these employers did not offer health insurance, and it was unlikely that they would do so given the economic climate.[20]

Nonetheless, CMS requested that Arizona submit a pilot program for ESI. The state's proposal was to cover 50 people in one rural county and would be dependent on legislative approval and state funding. The employer would pay at least 50 percent of premiums for employee coverage and 30 percent for dependent coverage. Enrollees would pay between $15.00 and $50.00, depending on income and family size. The state would pay the remainder. Families would be required to pay all cost-sharing and there would be no cap on out-of-pocket costs.[21] Budget problems delayed implementation of the pilot program.

During 2002 and 2003, 1.7 million Arizonans under the age of 65, representing 35.7 percent of that age group, had no health insurance for all or part of that two-year period compared with about 33 percent nationally. Eighty-three percent of the uninsured in that age group were members of working families.[22] One factor that may have accounted for the high number of uninsured was the enrollment barrier put into effect in 2003. Children, adults and certain elderly and disabled beneficiaries were required to submit paperwork every six months, rather than permitting 12-month continuous eligibility.[23] Also, in addition to the discontinuance of the premium-sharing program, cost-containment measures such as cuts in provider payments, additional pharmacy controls and higher copays were taken after the beginning of fiscal year 2004.[24]

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[19] Holahan and Pohl at 24.
[20] Vernon Smith, Rekeha Ramesh, Kathleen Gifford, Eileen Ellis, Victoria Wachino and Molly O'Malley, "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," *The Kaiser Commission on Medicaid and the Uninsured*, http://www.kff.org/medicaid/.
[21] *Ibid.*
[22] "The Uninsured: A Closer Look, Arizonans without Health Insurance," Families USA, June 2004, http://www.familiesusa.org.
[23] Leighton Ku and Sashi Nimalendran, "Losing Out: States Are Cutting 1.2 to l.6 Million Low-Income People from Medicaid, SCHIP and Other State Health Insurance Programs," Center on Budget and Policy Priorities, December 2003, http://www.cbpp.org/12-22-03health-states.htm.
[24] Smith et al., "States Respond".

Maine

Stakeholders debated the course of health care reform in Maine for well over a decade before agreeing on a path designed to provide universal health care coverage by 2009. What distinguished Maine from many other states was its resolve to embark on such a course despite the fact that the state's economic status was far from ideal.

Maine has long espoused the belief that health care coverage should not be limited to children and adult parents of children under 18, but should be for all. To that end, it developed the Maine Health Program in 1989, which used state funds to cover all adults up to 100 percent FPL and children up to 125 percent FPL. When the program reached its peak enrollment of 4,000 enrollees in 1993, it was capped; the program subsequently ran out of money in 1995 and was discontinued. While the children enrolled in this program could be transferred to MaineCare, the state's Medicaid program, the adults lost all coverage.[25]

Maine legislators decided to attack this problem by expanding Medicaid eligibility to cover this group. A bill was introduced in 2000 to expand coverage of Medicaid to childless adults up to 250 percent FPL and parents up to 300 percent FPL. Maine's governor at that time did not approve of the funding source for this bill: a 50-cent increase on the tobacco tax. Compromises were made, reducing the cigarette tax to a six-cent increase and reducing the income eligibility level for childless adults to 100 percent FPL and parents to their original level of 125 percent FPL.[26]

In 2001, the Maine legislature passed the Medicaid expansion and it was sent to CMS as a Section 1115 waiver. The childless adult expansion group received the same benefit package as other Medicaid enrollees with small co-payments for services but no monthly premiums.

Maine proposed to CMS that it be allowed through the waiver to use unspent disproportionate share hospital (DSH) funds as part of its federal matching dollars, and CMS approved.

In 2003, Maine unveiled the Dirigo (Latin for "I lead") Health Reform Initiative. The Dirigo Plan had three major goals: to provide access to quality and affordable coverage for the uninsured and the underinsured; to limit the growth of health care costs; and to improve the quality of care. The plan received bipartisan support and in June 2003, with two-thirds of each body of the legislature voting in favor, the Dirigo Health Reform Act was passed.

Increased access was to be achieved in two ways. First, the plan created a subsidized health insurance product, delivered by private carriers, that covered workers in small

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[25] Tanya Alteras and Sharon Silow-Carroll, "Childless Adult Coverage in Maine," prepared for Economic and Social Research Institute, August 2004, http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm.
[26] *Ibid.*

businesses who work 20 hours a week or more, self-employed individuals and individuals without access to employer coverage and their dependents. Employers paid 60 percent of the cost and employees paid the remainder. Those earning less than 300 percent FPL received state subsidies. Second, MaineCare eligibility was increased to include parents up to 200 percent FPL and childless adults up to 125 percent FPL. MaineCare enrollees with access to ESI were given a premium subsidy option with a MaineCare wraparound.

As part of its plan for cost containment, the state asked insurers, hospitals and providers for a voluntary one-year cap on cost and operating margins. In addition, the Maine Quality Forum was established to aid the state in its goal of quality improvement, specifically to promote quality care initiatives and educate providers and consumers about best medical practices.

While the state needed to find $90 million to fund the Dirigo Health Plan in its first year, it hoped to save $80 million per year thereafter by eliminating the un-reimbursed medical costs arising from bad debt and charity care cases.[27] The $90 million would be paid by employer contributions, individual contributions, $53 million in state general revenue and Medicaid dollars. It was projected that the state revenue portion would be necessary only for the first year of operation.

For 2004, Maine's goal was to provide health care coverage to 41,000 previously uninsured or underinsured individuals. In this first year, the majority of the new enrollees would be employees from small businesses. By 2009, Maine plans to have expanded enrollment to include 189,500 individuals, or all of the state's uninsured population. If this is accomplished, Maine will have achieved universal health care coverage.

Minnesota

As early as 1981, Minnesota sought and was granted a Medicaid waiver to expand the use of home- and community-based programs as alternatives to nursing home care.[28] Minnesota later expanded Medicaid coverage to children of the working poor. The Minnesota Children's Health Plan, enacted in 1987, was an early crucial step to health care reform.[29] Another step taken was the creation of the Health Care Access Commission with a goal to develop and recommend a plan to the legislature for universal health care coverage.[30]

A bipartisan group was credited with negotiating a compromise bill that the governor, who had previously vetoed a health reform package, could endorse. Introduced in 1991,

[27] Jill Rosenthal and Cynthia Pernice, "Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine," for National Academy for State Health Policy, June 2004.
[28] Sharon K. Long and Stephanie J. Kendall, "Recent Changes in Health Policy for Low-Income People in Minnesota," an Urban Institute Report, http://www.urban.org/ur.cfm?ID=310443.
[29] Pamela Paul-Shaheen, "The States and Health Care Reform: The Road Traveled and Lessons Learned from Seven that Took the Lead," *Journal of Health Politics, Policy and Law,* April 1998, 13.
[30] Michael S. Dukakis, "The Governors and Health Policymaking," in *The New Politics of State Health Policy,* ed. Robert Hackey and David Rochefort (Lawrence, Kansas, 2001), 74.

the bill included: limits on health care spending and limits on the ability of insurers to deny coverage to small businesses; purchasing pools; standardized health policy provisions; and health insurance for all families up to 185 percent FPL. It also included sliding scale premiums and a combination of tobacco and provider taxes to fund the program.[31]

One product of this bill was MinnesotaCare, which supplemented the state's Medicaid program. While initially only families up to 185 percent FPL were covered, by 1993 coverage had been extended to families with children in households with income at or below 275 percent FPL.[32] Also by 1993, the benefits provided by this program had expanded to include inpatient hospital benefits.[33]

MinnesotaCare expanded again in 1994 to include childless adults with incomes at or below 125 percent FPL. Expansions in 1996 and again in 1997 raised the eligibility bar to 135 percent and then to 175 percent FPL for this group of beneficiaries.[34] MinnesotaCare began as a fee-for-service program, but by 1997 all enrollees received services through managed care.[35]

With the enactment of SCHIP, Minnesota found itself in a predicament. It was already receiving matching Medicaid funds for children in families earning up to 275 percent FPL. The new law mandated that SCHIP funds be used on new programs and not to supplement existing programs. In order to receive any funds at the higher SCHIP matching rate, Minnesota created a small SCHIP program that covered about 20 children by targeting children under two years of age in families whose incomes were between 275 and 280 percent FPL.[36]

An amendment to its Section 1115 waiver, approved in 2001, allowed Minnesota to use its SCHIP funds to provide benefits for parents or relative caretakers of children enrolled in MinnesotaCare whose families earned between 100 and 200 percent FPL. While this group had already been receiving benefits, the state's effort was now being rewarded at a higher level.[37]

Like many other states, Minnesota faced a budget crisis in 2003. The governor proposed eliminating the General Assistance Medical Care (GAMC), which had been operating

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[31] *Ibid.*, 75.
[32] "History of MinnesotaCare," Minnesota Department of Human Services, http://www.dhs.state.mn.us/main/troups/healthcare/documents.
[33] *Ibid.*
[34] Heather Sacks and Stan Dorn, "Minnesota: A Case Study in Childless Adult Coverage," an Economic and Social Research Institute Report, August 2004, http://www.kff.org/medicaid/loader.dfm?ur.=commonspot/security/getfile.cfm.
[35] "History of MinnesotaCare," Minnesota Department of Human Services, http://www.dhs.state.mn.us/main/tropus/healthcare/documents.
[36] Amy Lutzky, John Holahan and Joshua Wiener, "Health Policy for Low-Income People: Profiles of 13 States," *Assessing the New Federalism, An Urban Institute Program to Assess Changing Social Policies* (Washington, D.C., 2002), 35-36.
[37] *Ibid.*

alongside MinnesotaCare and the state's Medicaid program in providing insurance for childless adults at or below 75 percent FPL who did not qualify for the other programs. The governor suggested shifting those covered by GAMC into MinnesotaCare and reducing the eligibility for that program from 175 to 75 percent FPL, but the legislature resisted. A compromise was reached whereby GAMC was not eliminated but some copays were initiated and spend-down coverage was removed. Coverage of emergency services under GAMC for some 2,000 immigrants and nonresidents was repealed. MinnesotaCare was also hit with some cutbacks in benefits such as weight-loss products and dental services.[38]

While Minnesota has not reached its goal of universal health care coverage, or even its modified goal of a four percent uninsured rate, it has come closer than any other state. According to the U.S. Census Bureau, Minnesota had the lowest three-year (2001- 2003) average percentage of people without health insurance coverage among the 50 states and the District of Columbia.[39] In 2001, Minnesota's uninsured rate was half the national average.[40] While Minnesota currently ranks highest nationally in terms of number of residents insured and provides one of the most comprehensive plans for those residents, it still faces challenges in the future. Presently, the state is considering proposals to change the funding mechanism for MinnesotaCare since projections show sources now being tapped will no longer be sufficient by 2007.[41]

Oregon

A push for increased access to health insurance for uninsured Oregonians began in the late 1980s. Taking health care issues to Oregon residents through town meetings energized a reform movement, spearheaded by a former emergency room doctor who was then the president of the Oregon Senate and later became governor. The policy developed in those meetings became one of the most controversial health care plans in the nation.

Oregon decided to extend health care insurance to all by: 1) providing public insurance for those living in poverty, mandating that persons who worked receive insurance from their employers (a mandate that would eventually run into conflicts with ERISA provisions); and 2) creating a high-risk pool for those formerly denied health insurance because of preexisting conditions.[42] To afford the expansion of Medicaid beneficiaries, Oregon limited the benefits offered. A process was developed that merged cost-benefit

[38] Sacks and Dorn, "Minnesota".
[39] U.S. Census Bureau, "Appendix D: Comparison of State Estimates" *Income, Poverty, and Health Insurance Coverage in the United States: 2003.*
[40] Long and Kendall.
[41] *Ibid.*
[42] Michael Sparer, "Health Policy for Low Income People in Oregon," *Assessing the New Federalism,* a project of the Urban Institute, Sept. 1999, http://www.urban.org.

data and medical outcomes research with public preferences to formulate a priority list of medical care benefits.[43]

The Oregon Health Service Commission (OHSC) was charged with developing a list of health diagnoses and treatments and ranking them. The commission held public hearings and, using the information gathered at these hearings, produced a list of 700 ranked diagnoses and treatments. The commission recommended that Medicaid cover the top 587.[44]

This so-called "rationing" of benefits drew fire from many, particularly those outside the state. Some viewed it as a means of depriving Medicaid enrollees of needed benefits. Oregon's first request for a Section 1115 waiver that would have allowed this scheme was declined by CMS, which cited potential conflicts between Oregon's plan and provisions of the newly enacted Americans with Disabilities Act of 1990 (ADA) as the reason for the rejection. Revisions made to satisfy ADA regulations allowed CMS to approve the Oregon Health Plan (OHP).

The expansion in Medicaid enrollment was not actually financed, as anticipated, by savings created by the rationing of benefits. It is estimated that the prioritization list of benefits generated a savings of only two percent of program costs over its first five years of operation. This can be attributed in part to the fact that the rationing was never fully implemented and partly to the fact that other sources of revenue were tapped. A move to put Medicaid recipients into managed care plans, a 17 percent increase in state general funds allocated to Medicaid and a 10-cent-per-pack cigarette tax were the actual means of paying for Medicaid expansion.[45]

In terms of providing some benefits for more people, Oregon's plan worked. By 2003, more than 1.4 million people had gained access to health care as a result of the OHP Medicaid program.[46] The number of uninsured Oregonians decreased from 18 percent in 1990 to 10.7 percent in 1996, and stood at 12.2 percent in 2000.[47] Studies indicated that populations covered by OHP had improved health outcomes, particularly those outcomes related to prevention. In 2002, 86 percent of those in OHP had a personal doctor or nurse, compared with 77 percent nationally. In the same year, 73 percent of those in OHP reported making no visits to an emergency room, while the figure nationally was 64 percent.[48] On the other hand, during the first six years, close to 11 percent of Medicaid-covered adults reported that OHP had refused to pay for a treatment they needed because the service was "below the line". While one-third of that group was able to get the

[43] Jonathan Oberlander, Lawrence Jacobs and Theodore Marmor, "The Politics of Health Care Rationing: Lessons from Oregon," *The New Politics of State Health Policy,* eds. Hackey and Rochefort (Lawrence, Kansas, 2001), 209.
[44] Sparer, "Health Policy".
[45] *Ibid.*
[46] Office of Oregon Health Policy and Research, "The Oregon Health Plan and its Components," a report to the 72nd Legislature of the State of Oregon, January 2003.
[47] *Ibid.*
[48] *Ibid.*

service through other means, of those who could not, two-thirds reported their health had deteriorated as a result of not receiving treatment.[49]

In terms of "rationing", Medicaid enrollees did not receive an overly restricted package of benefits. While certain treatment requests were denied because they were not on the prioritized list, the federal waiver required Oregon to cover 606 of 745 traditional Medicaid services. In 1998, Oregon's Medicaid beneficiaries had generous coverage of mental health services, dental care, AIDS-related services and organ transplants. Although the federal government refused to contribute to the cost, physician-assisted suicide was also included as a benefit.[50]

In the spring of 2000, community meetings, focus groups and telephone surveys were conducted to gather input about restructuring the health care system. OHP needed change to stay viable. OHP2 was created by the state legislature in order to sustain the OHP program and the Family Health Insurance Assistance Program (FHIAP), which had been put in place in 1997 to offer subsidies to low-income families to assist in purchasing health insurance from employers. OHP2 was also intended to expand coverage to individuals with higher income levels and to leverage private employer-sponsored insurance.

In May 2002, waivers were submitted to CMS seeking approval of OHP2, and approval was granted in October 2002. This plan created OHP Plus and OHP Standard. The first of these provides services for all mandatory Medicaid populations. The second provides a package valued at about 78 percent of the OHP Plus plan for non-TANF parents with incomes below 185 percent FPL and for childless adults below 185 percent FPL. The OHP Standard plan was intended to cover inpatient hospital, outpatient hospital, emergency room, physician services, lab and x-ray, ambulance, prescription drugs, mental health and chemical dependency, durable medical equipment and dental services. Due to budget concerns, however, durable medical equipment, dental, chemical dependency and mental health benefits were removed from the package.[51]

In 2004, Oregon applied to CMS for an amendment to its Section 1115 waiver that would revise the level of funding of condition/treatment pairs on the prioritized list of health care services, expand eligibility, allow for flexibility in designing benefit packages and establish a new health care delivery system. In July, CMS informed the state that some but not all of the requested reductions of covered treatments would be authorized. The state was granted the flexibility to reduce or add services to the OHP Standard package as long as core services mandated under Medicaid were provided. The state's request to expand SCHIP coverage to uninsured children with family incomes up to 200 percent FPL was granted, as was its request to expand FHIAP coverage to families with incomes

[49] Centers for Medicare and Medicaid Services, "Evaluation of the Oregon Medicaid Reform Demonstration," http://www.cms.hhs.gov.
[50] Sparer, "Health Policy".
[51] Office of Oregon Health Policy and Research, "The Oregon Health Plan and its Components," a report to the 72nd Legislature of the State of Oregon, January 2003.

up to 200 percent FPL. Adjustments in optional benefits for OHP Plus beneficiaries were denied. Finally, the state's request to initiate a physician care organization (PCO) program for its health care delivery system was approved.[52]

Tennessee

Before reforming its Medicaid program, Tennessee sought to control the high cost of providing health coverage to state employees by forming a statewide preferred provider organization (PPO) through one insurance carrier. Initiated in a time of runaway inflation, this program was successful in providing comprehensive health benefits for state employees and their families at a cost the state could afford.

Tennessee's next ambitious plan was to expand Medicaid to all Tennesseeans up to 400 percent FPL. Those with incomes up to 100 percent FPL would pay nothing for benefits, those above that level would pay premiums on a sliding scale based on their incomes. In 1994, a Section 1115 waiver was sought to enable Tennessee to move all Medicaid recipients into managed care and expand Medicaid to include the uninsured and the medically uninsurable, a high-risk group who met the state's medical underwriting standards. Since the state was attempting to increase Medicaid coverage by about 50 percent at the same time it was eliminating a provider tax that had generated approximately $500 million, it was difficult to persuade CMS that savings recovered by moving beneficiaries to managed care would be sufficient to keep the program solvent. Nonetheless, Tennessee gained approval for the waiver.

TennCare, as the plan was called, was successful in extending Medicaid coverage to 400,000 previously uninsured individuals. To do this the state pooled all state, federal and local funds dedicated to providing care to low-income populations and required the sliding-scale cost-sharing by those above 100 percent FPL.

In 1995, the year after TennCare's initiation, unanticipated expenses forced the state to freeze enrollment at 1.3 million beneficiaries, and it was open only to Medicaid eligibles and the medically uninsurable.

A study conducted between 1994 and 1997 showed that Tennessee's switch to managed care had helped it gain some predictability in its costs without generating high levels of unmet need or dissatisfaction. The study also found no differences in prenatal care or birth outcomes between Tennessee's managed care and fee-for-service Medicaid. Additionally, rural beneficiaries fared nearly as well as did urban enrollees.

In 1998, Tennessee ranked seventeenth in the nation in per capita personal health care expenditures. At that time, the national average expenditure was $3,759; Tennessee was spending $3,808.

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[52] Donna Schmidt, Centers for Medicare and Medicaid Services, in letter of July 22, 2004 to Lynn Read, Oregon Department of Human Services, regarding results of application for amendment to Section 1115 waiver.

In 2000, the state temporarily froze entry of the medically uninsurable. This was in part because of a fear that insurance companies were failing to cover the chronically ill because they knew this group would be taken care of by TennCare. At this time, providers were dissatisfied due to low capitation rates, and some of the largest plans threatened to withdraw from TennCare. Most of the managed care organizations that provided care under TennCare were losing money.

As with many states, Tennessee faced a recession in 2002. The governor sought to contain Medicaid program costs by restructuring TennCare. He submitted a modified Section 1115 waiver that was approved through June 2007. It was estimated that it would decrease enrollment by 180,000.

Still included in the program were all those who were eligible for Medicaid prior to the initiation of TennCare, uninsured women with breast or cervical cancer, the medically uninsurable regardless of income, those under 200 percent FPL without access to group insurance, Medicaid eligibles who received prescription drugs through TennCare and children up to age 19 with family incomes under 200 percent FPL regardless of group insurance availability. Benefits varied with each of the four categories.

Despite the modifications in TennCare, Tennessee continued to be above average nationally in terms of its coverage. In 2002 and 2003, Tennessee had 5,098,000 residents under the age of 65. Of those, 1,447,000, or 28.4 percent, were uninsured. During the same time period, 42.4 percent of New Mexicans under 65 were uninsured.

By 2004, TennCare's budget had reached $7.1 billion, with Tennessee's contribution to that accounting for about 25 percent of the state budget. Concerned by this, the governor asked a group of stakeholders to fund an independent study to determine the extent of the problem and potential ways to address it. Assuming no new source of revenue, it was predicted that if TennCare was left unchecked, it would consume 91 percent of new state revenues in 2008.

Based on this information, the governor submitted a plan that would cut spending on TennCare by $300 million for FY 2005 and that would amount to a $2.5 billion savings by FY 2008. The plan did not impact enrollment but made changes in coverage for prescription drugs, adjusted benefit levels and established co-pays, evidence-based medicine initiatives and basic case and disease management. This plan will be submitted for federal waiver approval.

Texas

Since 1988, Texas has had one of the worst records in the country for percentage of individuals covered by health insurance.[53] While this can be attributed in part to the fact

[53] Texas Institute for Health Policy Research, "The Health Care Safety Net in Texas Primer," presented at Health Care Policy Forum sponsored by Robert Wood Johnson Foundation and TENET Healthcare Foundation, Dec. 12, 2002, http://www.HealthPolicyInstitute.org.

that it is a large, diverse state with a large low-income population,[54] it may also be a "relic of the state's low-tax, low-service heritage", as the *Wall Street Journal* reported in 2000.[55] Cuts in the FY 2004-2005 budget seem to ensure that Texas will continue to rank fiftieth in health care coverage.

The Texas legislature has, however, made attempts to deal with this problem in the last 15 years. In 1989, the legislature created the Texas Health Insurance Risk Pool. The pool was actually activated in 1997 and provides uninsurable Texans with access to health insurance for medical conditions that make them ineligible for private insurance coverage.[56]

In 1995, the state legislature passed three health-care-related bills. The first established Medicaid managed care programs. The second eased regulation of small employer benefit plans in order to make health plans more available to small employers. The third established Texas Healthy Kids Corporation, a pilot program providing primary care health insurance coverage for children less than 13 years of age who do not qualify for Medicaid.[57]

The 1997 legislature established the Texas Healthy Kids Corporation as a statewide initiative and created a funding mechanism for it. The same legislature required health benefits plans for college students over age 21 who are still on a parent's policy.[58]

In 1999, the Texas legislature created the Texas Children's Health Insurance Program (CHIP) and passed legislation requiring the state's Health and Human Service Commission to automatically review a child's eligibility for medical assistance when the child's Medicaid benefits were lost due to a family's loss of TANF benefits. The same legislature created a permanent fund for children and public health from tobacco settlement money.[59]

Responding to a concern that many children who qualified for CHIP were not enrolled in the program, the 2001 Texas legislature funded outreach programs and simplified the application process: face-to-face interviews with social services staff were no longer required, asset documentation requirements were reduced and six-month continuous eligibility for children was established.[60]

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[54] Joshua Wiener and Niall Brennan, "Texas," Health Policy for Low-Income People: Profiles of 13 States, Occasional Paper No. 57, The Urban Institute, http://www.urban.org.
[55] Renae Merle, "Task Force on Uninsured Considers Host of Solutions," *Wall Street Journal*, June 14, 2000.
[56] Texas Institute for Health Policy Research, "The Health Care Safety Net in Texas Primer."
[57] *Ibid.*
[58] Texas Institute for Health Policy Research, "The Uninsured in Texas Policy Brief," presented at Health Policy Forum, Austin, Texas, Sept. 29, 2000, http://www.healthpolicyinstitute.org.
[59] *Ibid*.
[60] Laura Hermer and William Winslade, "Access to Health Care in Texas: A Patient-Centered Perspective," *Texas Tech Law Review*, 2004.

The same legislature also passed a bill that would have sought federal Medicaid waivers for the expansion of eligibility for adults. This would have used local funds as the federal match, but the governor vetoed the bill.[61]

Also in 2001, the Texas attorney general issued an opinion stating that undocumented immigrants could not be provided free or discounted preventive care by public hospitals; their only access to free or discounted health service was the emergency room. The state legislature passed a bill in 2003 making it legal for hospitals to provide free or discounted health care to undocumented immigrants. An opinion in July 2004 by the current attorney general termed this type of health care permissive, stating that hospitals may provide government-funded, non-emergency health care to these immigrants but are not required to do so.[62]

During the two-year period following the 2001 legislature, there was dramatic growth in Medicaid and CHIP enrollments and, consequently, in state spending on these programs. When the 2003 legislature began preparing the budget for FY 2004-2005, there was a movement to restore these programs to a more conservative and less generous level.[63] Spurred by a growing state deficit, the legislature voted to cut Medicaid by reducing upper income eligibility limits for pregnant women from 185 percent to 158 percent FPL; eliminating the Medically Needy program for adults with dependent children; eliminating coverage of many optional services for adults, including mental health counseling, podiatric and chiropractic services, eyeglasses and hearing aids; adopting a more stringent verification of declared assets for children; imposing cost sharing at the highest permissible amount under federal law; and implementing a preferred drug list and prior authorization requirements.[64]

The legislature voted to cut CHIP by changing the income test from a net to a gross basis, thereby lowering the upper income limit from 240 to 200 percent FPL; adding an assets test for children in families with incomes over 150 percent FPL; adding a 90-day waiting period before new enrollees receive coverage; eliminating coverage of benefits such as dental, vision, eyeglasses, hearing aids, chiropractic, home health and mental health; reducing coverage of mental health and substance abuse treatment services; reducing provider reimbursement by five percent; and raising premiums and co-payments for enrollees of all income levels.[65]

As a consequence, enrollment in CHIP dropped by more than 149,000 children, or 29 percent, since the beginning of FY 2004. The downward trend was expected to intensify

[61] Wiener and Brennan, "Texas".
[62] "Daily Health Policy Report," Kaisernetwork.org, July 27, 2004, http://www.kaisernetwork.org/daily_reports.
[63] Ian Hill, "State Responses to Budget Crises in 2004: Texas," The Urban Institute, February 2004, http://www.urban.org.
[64] *Ibid*.
[65] *Ibid.*

as new measures went into effect in August 2004.[66] A loss of Medicaid coverage for 18,000 adults is also anticipated.[67]

Despite the fact that these drops in CHIP and Medicaid, together with Texas' low rate of employer-sponsored health insurance, leave approximately one-third of Texans under the age of 65 with no health insurance,[68] most Texas legislators are on record as believing that the budget process was a success and that they have restored reason to a health and human service system that got out of hand during a time of economic strength.[69]

Utah

Utah's *HealthPrint,* drawn up in 1993, contained a master plan to reform health care in that state. Among other things, it called for the formation of the Utah Health Policy Commission, whose task was to develop policy alternatives and make recommendations to the legislature in areas of access, quality and cost. This commission recommended and supported the passage of 34 pieces of legislation between March 1994 and July 2000.[70] However, in 2000 when the legislation forming this commission sunset, the commission was dissolved. Some are concerned that future bills dealing with health care will not be coordinated into a cohesive plan.

Many of the laws the commission endorsed dealt with private insurance. For instance, in 1994, a bill was passed that required individual or group insurance policies to cover unmarried dependants up to the age of 26. In 1995, small employers were guaranteed renewal of coverage and insurers were mandated to charge insurance premiums within set rates. Individuals with health conditions that prohibited them from qualifying for insurance pool criteria could receive certificates that would require individual carriers to cover them with the passage of legislation in 1997.

For those who did not qualify for Medicaid, Medicare or CHIP and who had no other health insurance that covered primary care, Utah created the Primary Care Grants Program (PCGP) in 1996. The grantees in this program were community health centers and other primary care provider organizations. It was first supported through the legislature's mineral lease fund, later by the Medicaid Restricted Account and, most recently, by general appropriation funds.[71]

Utah's CHIP program was implemented in 1998. Utah was one of only 10 states that chose not to expand Medicaid. It created a new state program instead, which was administered by the Department of Health. Using a private grant, it started two pilot

[66]Anne Dunkelberg and Molly O'Malley, "Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts," the Kaiser Commission on Medicaid and the Uninsured, http://www.kff.org/medicaid.
[67] Hill, "State Responses".
[68] "The Uninsured: A Closer Look," Families USA, June 2004, http://www.famliesusa.org.
[69] Hill, "State Responses".
[70] Utah Department of Health, Division of Health Care Financing, "1115 Waiver Request for Primary Care Network of Utah," Nov. 15, 2001, http://health.utah.gov.
[71] Utah Department of Health, Division of Health Care Financing, "1115 Waiver Request for Primary Care Network of Utah," http://www.health.utah.gov.

projects to expand access to CHIP through school- and community-based outreach programs.[72]

In February 2002, Utah's application for a Section 1115 demonstration waiver was approved to expand Medicaid coverage. This waiver established the Utah Primary Care Network (PCN). It was the first such waiver to provide publicly funded primary care coverage with donated hospital and specialty care.[73] It covered United States citizens or legal residents ages 19 through 64 whose incomes fell below 150 percent FPL, who did not have access to health insurance at school or work and who did not qualify for Medicaid. It was a fee-for-service program covering primary care provider visits, some emergency visits, emergency medical transportation, lab services, some prescriptions, dental exams, one eye exam per year and family planning services. It did not cover specialty physician care or inpatient hospital care, but Utah hospitals were willing to donate up to $10 million in inpatient care charges to pre-authorized PCN patients. It also did not cover some of the mandatory Medicaid benefits such as mental health and substance abuse services.[74] Enrollees were charged an annual fee based on a sliding scale. Those receiving general assistance paid $15.00, those with incomes below 50 percent FPL paid $25.00 and all others paid $50.00.

A cap of 19,000 new enrollees was set.[75] In the first year alone, an unanticipated 16,000 individuals enrolled.[76] Enrollment was based on a first-come, first-served basis. Once the cap was met, Utah stopped enrolling new beneficiaries. This cap eliminated the guarantee of coverage and allowed denials or delays of coverage for eligible individuals.[77]

An amendment to the PCN waiver was approved in February 2003. This amendment established the Covered At Work (CAW) program. Through this program, 6,000 Utahans who were not eligible for PCN and who could not afford employer-sponsored insurance could receive a $50.00 per month reimbursement on their share of employer-sponsored health insurance premiums. Through use of employer, employee and state funds, comprehensive health insurance could be extended to one more group.[78]

The Utah Department of Health claims that the percent of the Utah population that was uninsured in 2001 was 8.7 percent. A downturn in the economy raised the percentage

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[72] *Ibid.*
[73] Utah Department of Health, "Health Outcome Evaluation of Utah's Primary Care Network," http://health.utah.gov/had/report/SCIJune04-PCN-RoundTable/files.
[74] "Medicaid HIFA waivers: Lessons for California," presented at roundtable sponsored by the Kaiser Family Foundation and U. Cal. at Berkeley, July 28, 2004.
[75] *Ibid.*
[76] Utah Primary Care Network, "Primary Care Network Annual Report, July 2002-June 2003," http://health.utah.gov/pcn.
[77] "Medicaid HIFA waivers: Lessons for California," presented at roundtable discussion sponsored by the Kaiser Family Foundation and U. Cal. at Berkeley, July 28, 2004.
[78] Utah Primary Care Network, "Primary Care Network Annual Report, July 2002-June 2003," http://health.utah.gov/pcn.

only slightly to 9.1 percent in 2003.[79] A private foundations comparison of states listed Utah's percent of uninsured in 2002 at 14 percent. That figure ranked Utah nineteenth among the states in this category. Accepting even the higher rate as a more accurate assessment, Utah still fared better than its neighbors. New Mexico, Arizona, Colorado, Texas, Nevada, Idaho and Wyoming all had higher rates of uninsured at that time,[80] ranging from 16 percent in Colorado to 25 percent in Texas.[81]

Vermont

Vermont has often been cited as one of the states that has taken the lead in health care reform. By 1995, it had enacted a set of laws that attempted to provide near-universal health care coverage to its residents while curbing health care costs.[82]

One area of particular concern to Vermonters was the provision of health care benefits to children. In 1989, before the federal government had developed the SCHIP program, Vermont introduced *Dr. Dynasaur*. Initially, this program provided Medicaid access to children under the age of six in families earning less than 225 percent FPL. The scope of coverage broadened to include children up to age 18 in 1992. When SCHIP funds became available, Vermont used its share to provide insurance for children in families up to 300 percent FPL. To do this, it created a separate SCHIP program, which shared the name *Dr. Dynasaur* with the Medicaid program. With common applications, identical program cards, the same benefits, the same providers and the same contracted managed care systems, the two programs appeared seamless to the beneficiaries. However, the state's expenditures on its SCHIP beneficiaries received the higher federal match that Congress had allotted for that program.[83]

In April 1995, Vermont's general assembly passed legislation authorizing the Vermont Health Access Plan (VHAP). This plan passed CMS scrutiny in July 1995, and in January 1996, it went into effect as a Section 1115 Medicaid managed care waiver. With this waiver, Vermont was able to extend Medicaid coverage to all adults not otherwise eligible for Medicaid up to 150 percent FPL. With an amendment to this waiver in 1999, Vermont extended this coverage to parents and caretaker relatives up to 185 percent FPL.

VHAP also provided a prescription drug benefit to disabled Vermonters in lower income brackets and individuals age 65 or older who were receiving Medicare or social security disability benefits. In addition to this program, called VHAP-Pharmacy, Vermont introduced another waiver program called VScript and a nonwaiver program called VScript Expanded to cover maintenance drugs for low-income elderly and disabled individuals with incomes over the limit for VHAP-Pharmacy. To complete the prescription drug benefit umbrella and to ensure that no gaps in coverage would occur,

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[79] Utah Department of Health, "Utah's Overall Uninsured Rate Shows Little Change Despite Tough Economic Times," http://health.utah.gov.
[80] Kaiser Family Foundation, "State Health Facts Online," http://www.statehealthfacts.org.
[81] *Ibid.*
[82] Paul-Shaheen at 2.
[83] Holahan and Pohl at 32.

Vermont implemented the Healthy Vermonters Program. Through this program, individuals with no prescription drug insurance could buy drugs discounted to the Medicaid price.[84]

Because of the array of prescription drug benefits Vermont offers to its residents, the state has a vested interest in keeping those drugs affordable. In November 2003, state officials asked the federal Food and Drug Administration (FDA) to approve a pilot program that would allow the state to contract with a Canadian company to mail prescription drugs to Vermont residents. The request was denied in August 2004, and the governor and attorney general subsequently announced that Vermont would sue the FDA.[85]

According to U.S. Census Bureau surveys, Vermont ranked twenty-sixth among the states and the District of Columbia in terms of median household income during the three-year period 2001 to 2003.[86] During that same time period, Vermont ranked forty-fifth among the states and the District of Columbia in terms of individuals without health insurance coverage.[87] While the nation's uninsurance rates were averaging a little over 15 percent and at least one state — Texas — had an uninsurance rate close to 25 percent, Vermont's rate was under 10 percent.[88]

Vermont has demonstrated that a commitment to universal health care coverage for its residents is a more influential factor than per capita income in determining what percent of a state's residents have health care insurance.

Wisconsin

The Wisconsin governor had two reasons for seeking to reform health care. First, having been raised in a small town in a rural part of the state, he understood how difficult it was for farmers and small business owners to obtain health care coverage.[89] Second, in periodic conversations with groups of welfare mothers, it was stressed that in order for his tough new welfare-to-work program to succeed, these mothers needed not only training for real jobs and child care, but also a guarantee of health insurance for themselves and their children when they left welfare to work.[90] He sought to create a plan that would insure low-income individuals with children who did not qualify for Medicaid and provide a safety net for those moving out of Medicaid eligibility.

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[84] Eileen I. Elliott and Paul H. Wallace-Brodeur, "Office of Vermont Health Access Annual Report," December, 2002, http:// www.path.state.vt.us.
[85] Pam Belluck, "Vermont Will Sue U.S. for the Right to Import Drugs," *New York Times*, August 11, 2004.
[86] U.S. Census Bureau, "Appendix D: Comparison of State Estimates," *Income, Poverty, and Health Insurance Coverage in the United States: 2003.*
[87] *Ibid.*
[88] *Ibid.*
[89] Dukakis at 79.
[90] *Ibid.*

Thus, in the mid-1990s the concept of what was to become BadgerCare emerged. In 1995, as part of Wisconsin Works (W-2), the state's welfare reform program, the governor proposed a health care plan to replace Medicaid for low-income working families leaving welfare to enter the work force.[91] The state sought a federal waiver to transform its Medicaid program and implement the proposed health services component of W-2. The proposed plan would have cut enrollees with incomes above 165 percent FPL, which included pregnant women and children under the age of six. Individuals whose employers paid at least 50 percent of the cost of insurance would also have been cut. Those who did qualify would be required to pay premiums and accept services that were less comprehensive than those received under Medicaid.[92] The waiver was denied.

In July 1997, Wisconsin submitted a new waiver proposal for covering low-income parents and children with Medicaid funds. By the fall of 1997, this plan was modified to take advantage of SCHIP. In August 1998, Wisconsin officials learned that the SCHIP waiver had been denied because of the state's inclusion of parents in a program intended to cover children. Finally, in January 1999, after 15 months of negotiations with the former Health Care Financing Administration (now CMS), Wisconsin was granted a regular Medicaid waiver that allowed enrollment of parents who earned below 185 percent FPL.[93]

In April and July 1999, Wisconsin started enrolling beneficiaries in two phases of BadgerCare. After one year, over 66,000 people were enrolled in BadgerCare — 28 percent children and 72 percent adults. The program exceeded its budget authority and the state legislature appropriated additional money for FY 2000-2001.[94] By the end of the program's second year, 90,592 people had enrolled, including 28,665 children and 61,927 adults.[95] In June 2004, a total of 108,634 were enrolled in BadgerCare with 34,957 being children.[96]

The popularity of BadgerCare can be attributed in part to the way the program was marketed. Rather than being promoted as a welfare program, it was introduced as an insurance program. A conscious effort was made to eliminate any stigma that might attach to a public assistance program. Even its name was meant to disassociate it from welfare.[97] Those who qualified for BadgerCare received care under one of the most expansive public health insurance programs in the nation. It included services for physicians, chiropractors, medical social workers, podiatrists, nurse midwives,

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[91] Coimbra Sirica, "The Origins and Implementation of Badger Care: Wisconsin's Experience with the State Children's Health Insurance Program (SCHIP)," a Milbank Report, January 2001, available at http://www.milbank.org/reports/010123 badgercare.html.
[92] *Ibid.*
[93] *Ibid.*
[94] Barbara J. Zabawa, "The 'Access' Problem: How Employee and Employer Issues May Increase BadgerCare Participation by Impeding the Verification Process,"*16 Wis. Women's L.J.* (Fall 2001), 215, 219.
[95] Trubek at 157, 160.
[96] Department of Health & Family Services, "Wisconsin BadgerCare," http://www.dhfs.state.wi.us/badgercare (accessed August 2, 2004).
[97] *Ibid.*, 164.

optometrists and dentists as well as covering prescription drugs, some over-the-counter drugs, hospice care, emergency ambulance transport, personal care and addiction treatment.[98]

With the heightened interest in keeping people off welfare and assisting them into the work force, a bipartisan group made up of state legislators, providers, managed care organizations, faith-based organizations, county government officials and advocacy groups worked with the governor in backing a Health Insurance Premium Payment (HIPP) as a part of BadgerCare.[99] This was an attempt to interweave the private health care coverage, which was offered by employers to low-wage workers and BadgerCare that was to be offered to the uninsured.[100] Under the original waiver obtained in 1999, the state was able to enroll parents and children in families earning up to 185 percent FPL into the HIPP program. Children were covered through the enhanced SCHIP match and adults through the regular Medicaid match. An amendment to the SCHIP waiver received federal approved in January 2001, allowing coverage of adults in HIPP through the enhanced SCHIP match.[101]

Under the amended waiver, to be eligible for the HIPP program, a family must meet the income criterion, must have been uninsured for the six months prior to application and must have an employer who contributes between 40 and 80 percent of the premium. If these requirements are met, the state conducts a cost-effectiveness test to determine if it is less expensive to subsidize the employer plan or to enroll the family in a BadgerCare HMO.

Despite statewide efforts to encourage enrollment in HIPP, the eligibility screening process for HIPP had admitted only 47 families out of 64,128 applicants by October 31, 2001. Another 137 families who had met all requirements were waiting for an open enrollment period before HIPP coverage would be granted.[102] As of February 2003, 104 families were enrolled in HIPP.[103] Although the numbers are low, Wisconsin officials still believe that partnering with the private sector will eventually bring good results.[104]

Since the creation of BadgerCare, Wisconsin has consistently ranked among the top states in the nation for having the least number of residents without health care coverage. In 2002, nine percent of its residents were uninsured while the national average was listed at 15 percent. At that time, 64 percent of Wisconsinites had employer coverage, five percent had individual coverage, nine percent were covered by Medicaid and 13 percent

[98] Zabawa at 219.
[99] Ian Hill and Amy Lutzky, "Premium Assistance Programs Under SCHIP: Not for the Faint of Heart?" an Urban Institute Occasional Paper, (Washington, D.C., 2003) http://www.urban.org.
[100] Trubek at 164.
[101] *Ibid*.
[102] Hill and Lutzky at 17.
[103] Department of Health and Family Service, "State of Wisconsin BadgerCare Waiver," www.cms.hhs.gov/medicaid/1115 (accessed August 2, 2004).
[104] Hill and Lutzky at xi.

were covered by Medicare.[105] These reforms have taken Wisconsin closer to the goal of health coverage for all than has been seen in most states.

New Mexico

New Mexico has initiated many strategies to improve health care coverage for its residents, to address an increasing magnitude of provider issues and to abide by the state's health care policy:

> It is the policy of the state of New Mexico to promote optimal health; to prevent disease, disability and premature death; to improve the quality of life; and to assure that basic health services are available, accessible, acceptable and culturally appropriate, regardless of financial status. This policy shall be realized through the following organized efforts:
> (1) education, motivation and support of the individual in healthy behavior;
> (2) protection and improvement of the physical and social environments;
> (3) promotion of health services for early diagnosis and prevention of disease and disability; and
> (4) provisions of basic treatment services needed by all New Mexicans.[106]

The Comprehensive Health Insurance Pool (CHIP) Act — renamed the New Mexico Medical Insurance Pool (NMMIP) Act to avoid confusion with SCHIP — was designed for people who were denied health insurance or were subject to costly premiums because of their health status. The program is funded by a combination of premiums and insurer assessments. No state general fund money supports NMMIP but insurers do receive a partial premium tax credit.[107]

The Minimum Healthcare Protection Act required a basic health insurance product for individuals and families and groups of less than 20 employees. In 1994, insurers who covered more than 25,000 lives in the state were required to offer such a package but this requirement was dropped when HIPAA was enacted in 1997.[108]

In 1991, the state enacted the Small Group Rate and Renewability Act, applicable to small group health plans only, which provided for the setting of initial rates and subsequent rate increases. It required rating factors to be applied equally to all employers in a class of business and required existing small group coverage to conform to the act and premium limits within five years. Subsequent modifications were made to limit the use of rating factors and pre-existing conditions and exclusions.[109] The New Mexico

[105] Kaiser Family Foundation, "State Health Facts Online," http://www.statehealthfacts.org/cgi-bin (accessed August 2, 2004).
[106] Section 9-7-11.1 D NMSA 1978.
[107] Chapter 59A, Article 54 NMSA 1978.
[108] Chapter 59A, Article 23B NMSA 1978.
[109] Chapter 59A, Article 23C NMSA 1978.

Health Insurance Alliance was created to provide small employers with increased access to voluntary health insurance coverage.[110]

In the General Appropriation Act of 1994, $2.379 million was appropriated to expand Medicaid eligibility to children under 19 years of age in households with family income equal to or less than 185 percent FPL. In 1998, Medicaid eligibility was expanded to children up to 19 years of age in households with family income equal to or less than 185 percent FPL and enacted into law as a recurring expense under the Public Assistance Act.[111] The legislature further revised Medicaid by requiring a statewide managed care system for Medicaid recipients by July 1, 1995, although the program did not go into effect until July 1, 1997.

The Health Insurance Portability Act amended the New Mexico Insurance Code to ensure state compliance with HIPAA, including limitations upon the inclusion in both group and individual policies of restrictions in coverage and waiting periods pertaining to preexisting conditions; inclusion of children over the age of 18 who are full-time students; changes in adjusted community rating requirements for premium determination; prohibition of discrimination based on health status in determining premium contributions for group plans and in determining eligibility for enrollment; guaranteed renewability of coverage for employers in a group market with exceptions; required coverage of employers in a small group market (under certain conditions); and opening up the Health Insurance Alliance Act to provide individual health insurance coverage.[112] The act was amended in 2000 to ensure that a health insurance plan does not impose treatment limitations or financial requirements on the provision of mental health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.[113]

After the federal government introduced SCHIP, New Mexico enacted the Child Health Act to expand the Medicaid program to children in households with income equal to or less than 235 percent FPL.[114] Because of the prior statutory expansion to 185 percent FPL, the enhanced SCHIP match was limited to children in households with incomes between 185 and 235 percent FPL, although some federal match adjustments were made.

The Health Care Purchasing Act provides for consolidated purchasing of health care benefits for state employees, public school employees and public retirees. In 2001, it was amended to permit counties and municipalities to voluntarily buy into the consolidated purchasing.[115]

In summary, significant efforts were made during the 1990s to reduce the number of uninsured persons, particularly children. During the strong economic periods of that

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[110] Chapter 59A, Article 56 NMSA 1978.
[111] Section 27-2B-15 NMSA 1978.
[112] Chapter 59A, Article 23E NMSA 1978.
[113] Section 59A-23E-18 NMSA 1978.
[114] Chapter 27, Article 12 NMSA 1978.
[115] Chapter 13, Article 7 NMSA 1978.

decade, it was largely feasible. Over the last four to five years, however, the number of uninsured has continued to grow. Tight state and federal budgets have made it increasingly difficult to provide public financing to cover more persons.

Medicare Federal Health Care Reform Efforts

Medicare, Title XVII of the Social Security Act, was enacted in 1965 as one of the Great Society programs. The Medicare system was originally administered by the Social Security Administration; in 1977 management was transferred to the Health Care Financing Administration (HCFA), since renamed the Centers for Medicare and Medicaid Services (CMS). Medicare is a federally funded system of health and hospital insurance for U.S. citizens age 65 or older, or for younger people receiving Social Security benefits due to disability, and for persons needing dialysis or kidney transplants for the treatment of end-stage renal disease.[116]

Medicare consists of two parts: hospital insurance or Part A; and supplementary medical insurance or Part B. A new, third part of Medicare, sometimes known as Part C, is the Medicare+Choice program, which was established by the Balanced Budget Act (BBA) of 1997 and which expanded beneficiaries' options for participation in private-sector health care plans. The goal of this program was to allow Medicare to take advantage of the savings that managed care was giving to the private industry. When Medicare began in 1966, approximately 19 million people enrolled. In 2003, over 41 million people were enrolled in Part A or Part B, and five million of them have chosen to participate in a Medicare+Choice plan.[117] The enrollment in Part B requires a voluntary premium paid for by the beneficiary. Medicare+Choice (Part C) is an expanded set of options for the delivery of health care under Medicare. While all Medicare beneficiaries can receive their benefits through the original fee-for-service program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare+Choice plan instead. Organizations that seek to contract as Medicare+Choice plans must meet specific organizational, financial and other requirements. Most Medicare managed care plans offer additional coverage beyond what the traditional fee-for-service Medicare plan offers.

Medigap, also known as Medicare Supplemental Insurance, provides supplemental health insurance coverage for Medicare beneficiaries. Medigap is encouraged for individuals in the original Medicare program because Medicare often covers less than the total cost of the beneficiary's health care.[118]

The most important reform of the 1980s featured the Prospective Payment System (PPS) for hospitals, in which the patient's age, sex, discharge status, diagnoses and treatment determined how much Medicare would compensate a hospital rather than a percentage of

[116] Medicare Law: An Overview, Legal Information Institute, http://www.law.cornell.edu/topics/medicare.html.
[117] Medicare: a Brief Summary, Centers for Medicare and Medicaid Services, 2002, http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default3.asp.
[118] Supplemental/Medigap Coverage, MedicareMD, http://www.medicare.com/supplemental_coverage.asp.

charges. This helped reduce health care spending, but savings have been reduced over time as providers have shifted to other settings such as outpatient hospital services.[119] Payments for skilled nursing care, home health care, inpatient rehabilitation and long-term hospital care are made under separate prospective payment systems or other payment mechanisms.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) was an attempt to help seniors pay for their prescription drug costs. In 2002, one in three Americans with Medicare had no prescription drug coverage, yet the typical American over the age of 65 takes an average of six prescription drugs.[120] The growing concern over this caused Congress to institute a Medicare drug discount card, intended to give people with Medicare a 10 to 15 percent discount on some of their drug coverage.[121] In addition, Medicare will now pay for all medically reasonable and necessary outpatient therapy without the caps; however, the moratorium on caps will expire on January 2, 2006. In addition, the government will help people afford the Part B premium. The cost of the Part B premium increases in January 2005 and new screening tests for people at high risk for diabetes will be covered. In November 2005, Medicare drug coverage will begin. The most troubling portion of the bill, however, contains a provision that requires Medicare to compete with private plans in six geographic areas as a demonstration project in January 2010.[122] This bill was hailed as the "the most significant improvement to senior health care in 40 years".[123]

The MMA is seen by many as a short-term solution to the current problems in Medicare. The coverage has a doughnut hole in which the majority of beneficiaries will see little benefit from the new drug coverage that begins in 2005. This bill does not allow the government to negotiate with pharmaceutical companies for cheaper drug prices as the Veterans Administration does. There is a cap in the amount of spending that the government will give to Medicare; once reached, the federal government can enter a crisis provision that allows it to cut benefits in order to reduce the cost of Medicare.[124] This could lead to a reduction in benefits in the near future. This bill is not designed to grow with the needs of Medicare, which may mean that it will not be as successful as intended.

The aging of the population has caused a recent concern over the ability of Medicare to provide for all those who are soon to be eligible. There has been an attempt to find

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[119] The Basics: Medicare Reform, Century Foundation, 2001, http://www.medicarewatch.org/Basics/MedicareBasic.pdf.
[120] Help Paying for Prescription Drugs, Medicare Rights Care, http://www.medicarerights.org/rxframeset.html.
[121] Medicare Prescription Drug Discount Cards, Medicare Rights Center-FAQ, http://www.medicarerights.org/maincontentrxcards_faq.html.
[122] Benefits under the New Medicare Law, Medicare Rights Center, http://www.medicarerights.org/newlawframeset.html.
[123] Medicare Modernization Act, Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/medicarereform/.
[124] How Beneficiaries Will Fare Under the New Medicare Drug Bill, Marilyn Moon, American Institutes for Research, June 2004, http://www.cmwf.org/programs/medfutur/moon_medicarerxdrug_ib_730.pdf.

savings within the plan that will allow Medicare to cope with the large upsurge in enrollees beginning in 2010 with the entrance of the baby boom generation into Medicare. Roughly one-third of Medicare spending goes to individuals who live less than one year after covered treatment begins. Costs are high because patients are usually the most ill shortly before they die, but many recover and it is not easy to tell which patients will recover before the investment in treatment is made.[125] Increased cost-sharing may result in less coverage, as some would be forced to forgo medical treatment due to the out-of-pocket expense.

Medicare only covers items that are reasonable and medically necessary for the diagnosis and treatment of injury or to improve the functioning of a malformed body member. In 1989, the federal government tried to use a cost-effective analysis to determine if a new treatment or device was worth including in the coverage. The proposed regulation proved very controversial and some claimed it would lead to rationing. To this day, the de facto Medicare policy is that Medicare will pay for most new medical technology that confers some positive health benefit, even if it is hugely expensive, to gain marginal health effects. CMS still does not want, or cannot afford politically, to have the program seen as an agent of cost-containment rather than a vehicle to improve care.[126] With the advancement of medical technology and the increasing elderly population, Medicare will continue to grow in size and expense.

Military Health Care

The military health system has two main components. The first component is responsible for the health care of currently serving active duty soldiers while TRICARE and Veterans Affairs (VA) provide care for veterans, spouses, survivors and dependents.

The VA was established on March 15, 1989, succeeding the Veterans Administration. It is responsible for providing federal benefits to veterans and their families. Headed by the secretary of veterans affairs, VA is the second largest of the 15 cabinet departments and operates nationwide programs for health care, financial assistance and burial benefits.

The most visible of all VA benefits and services is health care. From 54 hospitals in 1930, VA's health care system has grown to 158 hospitals, with at least one in each of the 48 contiguous states, Puerto Rico and the District of Columbia. VA operates 854 ambulatory care and community-based outpatient clinics, 132 nursing homes, 42 residential rehabilitation treatment programs and 88 comprehensive home-care programs. VA health care facilities provide a broad spectrum of medical, surgical and rehabilitative care. A unique feature of the VA health system is that it negotiates directly with pharmaceutical companies in order to get lower prices for its beneficiaries and to help

[125] The Basics: Medicare Reform, Century Foundation, 2001, http://www.medicarewatch.org/Basics/MedicareBasic.pdf.
[126] Peter J. Neumann, Sc.D., "Medicare, Cost-Effectiveness Analysis and New Medical Technology," *Harvard Health Policy Review*, Volume 5 Number 1 (Spring 2004), http://www.hcs.harvard.edu/~epihc/currentissue.

control costs of the program. More than 4.8 million people received care in VA health care facilities in 2003.

VA manages the largest medical education and health professions training program in the United States. VA facilities are affiliated with 107 medical schools, 55 dental schools and more than 1,200 other schools across the country. Each year, about 81,000 health professionals are trained in VA medical centers. More than half of the physicians practicing in the United States had some of their professional education in the VA health care system.

TRICARE is the Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families. TRICARE consists of TRICARE Prime, a managed care option; TRICARE Extra, a preferred provider option; and TRICARE Standard, a fee-for-service option. TRICARE for Life is also available for Medicare-eligible beneficiaries age 65 and over.[127] This program provides comprehensive health benefits to its enrollees, and includes vision, dental and pharmaceutical coverage.

From 1966 until the present, if active duty personnel or their families needed medical attention they went to the hospital on the base. If they lived too far from the base or if care was not available there, they went to a civilian hospital, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) picked up most of the bill after the deductible was met.[128] Beginning in March 1995, Congress began to initiate the TRICARE program with this region as a pilot.[129] The new program offers beneficiaries three choices, hence the "tri" in TRICARE. TRICARE Prime boasts, on average, the lowest out-of-pocket cost, but gives patients a limited choice in doctors and medical professionals they see. TRICARE Standard is just the reverse — it is potentially the most expensive for patients but allows the greatest liberty in choosing a civilian doctor. TRICARE Extra is somewhere in the middle. Treatment in military facilities is still free, regardless of the program chosen.

Indian Health Service

American Indians and Alaska Natives have a unique historical and legal relationship with the federal government, which acts as a trustee for the Indian tribes.[130] The federal government provides a health care system through the Indian Health Service (IHS), an agency within the Department of Health and Human Services (DHHS). This unique

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[127] TRICARE: The Basics, TRICARE Management Activity, June 11, 2003, http://www.tricare.osd.mil/Factsheets/viewfactsheet.cfm?id=127.

[128] TRICARE Explained, Tech. Sgt. Pat McKenna, Airman, July 1996, http://www.af.mil/news/airman/0796/tricare.htm.

[129] Defense Department Announces Uniform Costs for New "TRICARE PRIME" Health Benefit Plan, News Releases, TRICARE, Feb. 2, 1995, No. 95-3/P3. http://www.tricare.osd.mil/news/1995/newsreleases9534.html.

[130] U.S. Congress, Office of Technology Assessment, Indian Health Care, OTA-H-290 (Washington, DC: U.S. Government Printing Office, April 1986) http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk2/1986/8609/8609.PDF.

historical and legal relationship, established in 1787, is based on Article I, Section 8 of the U.S. Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states.[131]

The IHS's annual appropriation is approximately $3.5 billion. The IHS strives for maximum tribal involvement in meeting the needs of its service population, who live mainly on reservations and in rural communities in 35 states, mostly in the western United States and Alaska.[132]

Preventive measures involving environmental, educational and outreach activities are combined with therapeutic measures into a single national health system. Within these broad categories are special initiatives in traditional medicine, elder care, women's health, children and adolescents, injury prevention, domestic violence and child abuse, health care financing, state health care, sanitation facilities and oral health. Most IHS funds are appropriated for American Indians who live on or near reservations. Congress also has authorized programs that provide some access to care for American Indians who live in urban areas.[133]

IHS services are provided directly through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers annually. The federal system consists of 36 hospitals, 61 health centers, 49 health stations and five residential treatment centers. In addition, 34 urban Indian health projects provide a variety of health and referral services.

Through Public Land 93-638 self-determination contracts, American Indian tribes and Alaska Native corporations administer 13 hospitals, 158 health centers, 28 residential treatment centers, 76 health stations and 170 Alaska village clinics.

To better provide for the differing needs of each tribe, Congress determined that it would be necessary for each tribe to be able to make their own decisions with regard to how federal programs are designed to meet their needs. This led to the passage of the Indian Self-Determination and Education Assistance Act in 1975 to allow tribal management of programs that previously had been managed on their behalf by the Department of the Interior (DOI) and the Department of Health, Education and Welfare (now DHHS). Specifically, tribes are authorized to assume management of programs in the Bureau of Indian Affairs (BIA) and IHS through contractual agreements with the two agencies.

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[131] The Indian Health Service, U.S. Department of Health and Human Services, Indian Health Service, April 8, 2004, http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp.
[132] IHS Fact Sheet, U.S. Department of Health and Human Services, Indian Health Service, March 29, 2004, http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/ThisFacts.asp.
[133] Health Care Delivery, HIS Fact Sheet, U.S. Department of Health and Human Services, Indian Health Services, March 29, 2004, http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/ThisFacts.asp.

Amendments in 1992 to the Indian Health Care Improvement Act extended self-governance demonstration projects to the IHS and its programs. The Tribal Self-Governance Act Amendments of 2000 (P.L.06-260) confirmed the success of the self-governance demonstration in the IHS, thus making tribal self-governance permanent within the IHS.[134]

As the Indian population and its distribution have changed, a need developed to provide health care service to Native Americans living outside of reservations. Urban Indian health programs provide limited services to more than 150,000 Indians.[135] The National Council of Urban Indian Health was founded in 1998 to meet the unique health care needs of the urban Indian population through education, training and advocacy. There are 36 urban Indian health organizations operating at 41 sites located in cities throughout the United States. Primary care clinics and outreach programs provide culturally acceptable, accessible, affordable and accountable health services to an underserved off-reservation urban Indian population. The 36 programs engage in a variety of activities, ranging from the provision of outreach and referral services to the delivery of comprehensive ambulatory health care. The urban Indian health programs operate independently through grants and contracts from IHS. Most urban Indian programs obtain supplemental resources from private and other local government sources.[136]

Of all the racial and ethnic groups in the United States, Native Americans have long been among the most disadvantaged, in terms of their health and their ability to get medical care.[137] Despite the great strides that IHS made in providing treatment for Native Americans, it still has not been able to provide access to health care that is equivalent of the mainstream population.

ERISA

The federal Employee Retirement Income Security Act of 1974 (ERISA) impacts state insurance laws directly and can render certain health care plans immune to state regulation. Due to recent developments within the law, there have been numerous requests for Congress to change this law to make it less complex.

Throughout the 1960s, stories of widespread mismanagement of employee pension funds were common among workers. The problems increased until the 1970s, when it became clear that Congress needed to get involved. Congressional emphasis on the need for comprehensive pension plan reform grew throughout the decade, eventually resulting in ERISA.[138] ERISA sets minimum standards for most voluntarily established pension and

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[134] Introduction, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 2002, Transmittal Letter, http://aspe.os.dhhs.gov/search/selfgovernance/Report/feasibility.htm.
[135] Indian Health Service, an Agency Profile, Indian Health Service, http://info.ihs.gov/IHSProfile.pdf.
[136] About, NCUIH, National Council of Urban Indian Health, http://www.ncuih.org/about_ncuih.htm.
[137] New Challenges for States: Indian Health Care, Mary Guiden and Susan Johnson, State Legislatures Magazine, June 2000, http://www.ncsl.org/programs/pubs/600ind.htm#care.
[138] *Rush Prudential HMO, Inc. v. Moran*: 21 Or Bust! Does ERISA Preemption Give HMOs the Power…, Stephanie Reinhart, Akron Tax Journal, 19 Akron Tax J. (2004), 99.

health plans in private industry to provide protection for individuals in these plans.[139] ERISA applies to two separate classes of employee benefit plans: welfare benefit plans and pension plans. Welfare benefit plans include health care plans for workers. The plans regulated by original focus of ERISA were the pension plans since insurance plans were primarily regulated by the states.

Congress sought to extend ERISA's protection to more workers by encouraging employers to offer the plans. Among the methods chosen to encourage employers was the explicit preemption of state law. ERISA's express preemption provision provides that Titles I and III of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan". Congress reasoned that preemption would allow multistate employers to offer a single plan to all its workers without the cost and inconvenience of complying with contradictory state insurance regulations. This convenience would, in turn, benefit workers. Employers who might otherwise have forgone offering any plan might be willing to offer coverage, provided that they did not have to comply with the varied administrative requirements, and especially insurance regulations, of various separate state jurisdictions.[140]

The limitation of states' ability to regulate employer-based insurance has three parts:
a) All state laws relating to employer benefit plans, including health plans, are preempted under ERISA. b) The Savings Clause preserves state insurance regulation, allowing states to continue to regulate insurance companies and the business of insurance. Thus, although a state is not allowed to tell an employer what insurance the employer must buy, it can tell insurance companies what they are allowed to sell, how to sell it and to whom. C) The Deemer Clause says that states may not treat self-insured or self-funded employer plans as if they were insurance, since the employer, rather than the insurer, carries the risk.

The preemption of state laws has caused many problems for plan beneficiaries when they try to assert their rights to their benefits. ERISA provides that a civil action may be brought (1) by a participant or beneficiary--... (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.[141]

This provision is relatively straightforward. If a participant or beneficiary believes that benefits promised under the terms of the plan are not provided, the participant or beneficiary can bring suit seeking provision of those benefits. A participant or beneficiary can also bring suit generically to enforce the rights under the plan, or to clarify any rights to future benefits. Any dispute over the precise terms of the plan is resolved by a court under a de novo review standard, unless the terms of the plan give the

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[139] Employee Retirement Income Security Act, U.S. Department of Labor, http://www.dol.gov/dol/topic/health-plans/erisa.htm.
[140] Form, Function, and Managed Care Torts: Achieving Fairness and Equity In ERISA Jurisprudence, Peter D. Jacobson, Scott, D. Pomfret, Houston Law Review, 35 Hou. L. Rev. 985 (1998).
[141] 29 U.S.C. Section 1132(a)(1)(B).

administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.[142]

This gives ERISA plans a great deal of liability protection from their beneficiaries. States have tried to make inroads into this protection through the passage of independent medical reviews of plan medical decision laws. The U.S. Supreme Court allowed the independent medical review of ERISA plan denials.[143] ERISA does not preempt the practice of medicine, one form of which is medical decision-making for what is medically necessary or not; nor does ERISA, by its history, language or wording, preempt decisions that involve, in whole or in part, medical decision-making of the variety that health maintenance organizations (HMOs) make in determining whether a particular treatment is medically necessary.[144] If a claim is not administrative in nature, it is not preempted; also, if it does not involve benefits or a party acting as a plan administrator or fiduciary, then it is not preempted. Causes of action against a doctor or other medical care provider to the plan are not preempted.[145]

Not all state attempts to make plans liable have been effective. Most recently in *Aetna v. Davila*, the U.S. Supreme Court found the Texas Health Care Liability Act to be preempted by ERISA because it attempted to place liability on an HMO for refusal to cover certain medical services in violation of an HMO's duty "to exercise ordinary care". This finding was due to the fact that the law attempted to legislate an administrative decision of an ERISA plan. If an individual brings suit complaining of a denial of coverage for medical care when the individual is entitled to such coverage only because of the terms of an ERISA-regulated employee benefit plan, and where no state or federal legal duty independent of ERISA or the plan terms are violated, then the suit falls within the scope of ERISA.[146]

ERISA's state law interaction has been and will remain a very complex and controversial issue well into the future unless Congress decides to significantly amend this legislation.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was a result of an almost decade-long health care reform effort. There are two major parts to this reform: insurance portability and privacy standards. HIPAA covers both group and

[142] *Aetna Health Inc., fka Aetna U.S. Healthcare, Inc. and Aetna U.S. Healthcare of North Texas, Inc. v. Juan Davila*, *Cigna Healthcare of Texas; Inc. dba Cigna Corporation, v. Ruby R. Calad, et al.* 124 S.Ct. 2488 (2004).
[143] *Rush Prudential HMO, Inc. v.Debra C. Moran*, 536 U.S. 355 (2002).
[144] HMOs, Accountability, and the Death of ERISA Preemption, Miles J. Zaremski, J.D., Journal of Legal Medicine, 23 J. LegalMed., 547 (2002).
[145] Patients Rights and Accountability: Can There Exist Rights Without Remedies in an American Legal and Legislative Framework?, Miles J. Zaremski, Medicine and Law, 22 Med. & L., 429 (2003).
[146] *Metropolitan Life Insurance Company, v. Arthur Taylor*, 481 U.S. 58 (1987).

individual policies. HIPAA also established federal medical privacy requirements. This is the regulatory floor. More stringent state laws continue to apply.[147]

HIPAA's portability portion was intended to provide important new protections for an estimated 25 million Americans who move from one job to another, are self-employed or have pre-existing medical conditions.[148] HIPAA is designed to improve the stability of insurance markets and reduce risk segmentation. Despite making coverage more available for certain groups, HIPAA has not had much effect on the total number of people covered. Unlike state insurance reforms, HIPAA does not address premium rates. The departments of Labor, Health and Human Services and the Treasury jointly administer HIPAA.[149]

The protections of the portability section include limits on the use of pre-existing condition exclusions, and exclusions based on conditions the plan covers; prohibition against denying coverage or charging extra for coverage based on the insured or the insured's family member's past or present poor health; guarantees for certain small business employers or individuals who lose job-related coverage to purchase health insurance; and some guarantees that employers or individuals who purchase health insurance can renew coverage regardless of any health conditions of individuals covered under the insurance policy.[150]

For the privacy provision of HIPAA, Congress set a three-year deadline for enacting national patient medical privacy protection standards. If Congress failed to meet its self-imposed deadline, the law required the DHHS to create health information privacy protections through regulation based on specific parameters outlined in the law.

In 2000, medical information was to be restricted to only those who had a need to know. Furthermore, those individuals or entities would only have access to the minimum amount of information necessary in order to carry out the purpose for which the medical information was required.

In 2001, the new administration ordered a review of the previous administration's regulations, including the final privacy regulations. The goal was to protect privacy while reducing the federal regulatory burden on covered entities and business associates and to ensure that the nation's health care distribution and payment systems would continue to run smoothly to ensure that patients would not experience disruptions in their care. Proposed amendments to the final rule took effect on August 14, 2003.

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[147] HIPAA Privacy Requirements Compliance Guide, National Association of Health Underwriters, http://www.nahu.org/publications/HIPAA_Guide/1_Introduction.doc.
[148] Summary of Bill from HCFA, HIPAA, from HCFA, August 21, 1996, http://www.netreach.net/%7Ewmanning/hr3103.htm.
[149] Frequently Asked Questions… Insurance and Managed Care, National Conference of State Legislatures Forum for State Health Policy Leadership, January 2001.
[150] What is HIPAA?, HIPAA Insurance Reform, Centers for Medicare and Medicaid Services, August 2002, http://www.cms.hhs.gov/hipaa/hipaa1/content/more.asp#QA.

Since being signed into law, HIPAA has been amended with the addition of the Women's Health and Cancer Rights Act of 1998 (WHCRA), Mental Health Parity Act of 1996 (MHPA) and Newborn's and Mothers' Health Protection Act of 1996 (NMHPA). Each of these acts provide additional protection to specific groups.

The WHCRA is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy, and is applicable to group and individual health plans. WHCRA does not require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.[151]

MHPA is a federal law that may prevent group health plans from placing annual or lifetime dollar limits on mental health benefits that are lower or less favorable than annual or lifetime dollar limits for medical and surgical benefits offered under the plan. Although the law requires parity with regard to dollar limits, MHPA does not require group health plans and their insurers to include mental health coverage in their benefits package. The law's requirements apply only to group health plans and their health insurance issuers that include mental health benefits in their benefits packages.[152]

The NMHPA affects the amount of time the mother and her newborn child are covered for a hospital stay following childbirth. The law applies to those enrolled in group as well as individual health plans.[153]

Health Savings Account

The increasing cost of health care has led to reforms in how the health care market is structured, how services are delivered and even how payment for services and equipment is determined. However, none of these reforms has had the long-term effect of keeping health care costs at a rate of inflation that is consistent with other markets. This is due to the peculiarities of the health care market.

One aspect of the market that greatly contributes to this abnormality is the manner in which services are paid for within the market. People spend lots of money on health care because almost 80 percent of the money they spend is coming from a third-party payer. The tax system and the way it gives incentive to spend money on health care is considered by some to be problematic because it encourages people to spend on health care when they would not otherwise.[154] More than a decade ago, a study discovered that

[151] The Women's Health and Cancer Act, Centers for Medicare and Medicaid Services, January 2003, http://www.cms.hhs.gov/hipaa/hipaa1/content/whcra.asp.
[152] The Mental Health Parity Act, Centers for Medicare and Medicaid Services, August 2002, http://www.cms.hhs.gov/hipaa/hipaa1/content/mhpa.asp.
[153] The Newborn's and Mother's Health Protection Act, Centers for Medicare and Medicaid, August 2002, http://www.cms.hhs.gov/hipaa/hipaa1/content/nmhpa.asp.
[154] For Patient Power: The Patient's Handbook, Jane M. Orient and Kathryn Serkes, Association of American Physicians and Surgeons, May 1996, http://www.aapsonline.org/patients/handbk.htm.

when people are spending their own money on health care, they spend 30 percent less with no adverse effects on their health.[155]

This spending has caused a huge increase in costs within the market. In the mid-1990s, managed care helped lower costs, but not as much currently. The transition to managed care has largely been completed. After rising rapidly for many years, increase in health insurance premiums slowed dramatically during the 1990s as Americans moved in to managed care programs. These large, one-time savings have all been exhausted.[156]

This caused Congress to search for a new method of combating rising health care costs. In 1996, Medical Savings Accounts (MSA) were created through HIPAA and given a term of three years to determine their effectiveness at controlling health care costs. The MSA was designed to provide an incentive for the health care consumer to conserve health care spending. Eligible individuals were permitted to establish MSAs under a pilot project that began on January 1, 1997. An MSA is a trust or custodial account established to pay medical expenses in conjunction with a high-deductible health plan. To be eligible for an MSA, an individual must be either employed by a small employer that establishes a high-deductible health plan or a self-employed person covered by a high-deductible health plan. The MSA account is established in the name of the individual. Expenditures from an MSA are self-administered.[157]

Under HIPAA, contributions to an MSA may be made either by the individual or the individual's employer, but not both in the same year, and are deductible or excludable from the individual's gross income. Expenditures from an MSA are excludable from gross income if used for qualified medical expenses.

This program demonstrated that MSAs help to fight overutilzation of health care.[158] With this knowledge, Congress passed a Health Savings Account (HSA) as part of the Medicare bill, allowing people to save tax-free money for future medical expenses.[159] The new HSAs help pay unreimbursed medical expenses effective January 1, 2004 on a tax-preferred basis. The new law was signed December 8, 2003.

HSAs provide consumers with an excellent way to obtain affordable health insurance and a way to save on overall medical expenses, as well as future medical expenses. The ability of baby boomers to begin saving now for their health expenses during retirement

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[155] Medical Savings Accounts: The Private Sector Already Has Them, National Center for Policy Analysis, April 1994, Brief Analysis 105, http://www.ncpa.org/ba/ba105.html.
[156] Issue Brief: Why do Health Insurance Premiums Rise, Health Insurance Association of America, September 2002, http://membership.hiaa.org/pdfs/healthinsurancepremiums.pdf.
[157] Issues: Medical Savings Accounts, National Association of Underwriters, http://www.nahu.org/government/issues/MSAs/index.htm.
[158] Real Patient Protection: Expanding Medical Savings Accounts, Merril Matthews, Jr. and Jack Strayer, National Center for Public Policy, July 16, 1998, Brief Analysis No. 275, http://www.ncpa.org/ba/ba211.html.
[159] Interview with Megan Hauck, Harvard Health Care Policy Review, same as above, conducted by Katherine Mr. Cembrola. Harvard Health Policy Review. Spring 2004, Volume 5 Number 1. http://www.hcs.harvard.edu/~epihc/currentissue.

should also save Medicare money in the future and help ensure Medicare's financial vitality into the future.[160]

The key to HSAs is that they allow the consumer to keep any remaining money in their account. Arguably, HSAs make the health care consumer more cost-conscious and less likely to obtain frivolous medical care.

Although HSAs are relatively new, some health insurance industry experts contend the accounts could become the dominant form of health care financing in the next 5 to 10 years. Analysts project that more than 40 million HSAs will be established over the next decade.[161]

Not everyone is as enthusiastic about the HSAs and their impact on health care costs for the average consumer. These accounts would represent a $6.7 billion tax subsidy over the next decade, according to official estimates, and possibly much more if utilization turns out to be higher than expected. The big winners would be high-income people who are healthier than average. The losers include Medicare beneficiaries, whose drug benefits had to be trimmed to make room for this tax incentive, and people of working age with lower incomes or costly chronic health conditions.[162]

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[160] Issues: Health Savings Accounts, National Association of Underwriters, http://www.nahu.org/government/issues/MSAs/HSAs-HSSAs/index.htm.
[161] HSAs Will Dominate Health Care Financing, Stephen Parezo, Health Care News Vol. 4 No. 6-June 2004, printed by the Heartland Institute, http://www.heartland.org/pdf/HCNJun04.pdf.
[162] HSAs Won't Cure Medicare's Ills, Leonard E. Burman, Linda J. Blumberg, Urban Institute, November 2003, http://www.urban.org/UploadedPDF/1000578_HSAs_wont_cure_Medicaids_ills.pdf.

PUBLIC AND PRIVATE COSTS OF PROVIDING HEALTH CARE TO NEW MEXICANS

Overview

In 2002, the estimated cost of providing health care to New Mexicans was $7.8 billion. Approximately 75 percent of health care expenditures were publicly financed ($5.8 billion). The following provides a description of the data collection and methodology, study strengths and limitations and cost of health care for calendar year 2002.

Data Collection and Methodology

The scope of work for this study was to determine health care costs in New Mexico for calendar year 2002. Data was collected from a variety of payer sources (both public and private). The methodology used to measure health care costs in New Mexico borrows from previous efforts to estimate health care expenditures for New Mexico and for other states.[163] Two questions are answered in the estimation of the dollars spent on health care in New Mexico: Where did the money come from and where did it go?

- ***Where it came from:*** Data is based on the sources of health care payments, both public (federal, state, tribal and county) and private (insurance and out-of-pocket payments).
- ***Where it went:*** Data is grouped by common categories of services (hospital care, physicians, dentists, drugs, medical supplies, nursing home care, research, public health, home care and other personal care) to determine what payments are spent on.

Data was collected from July through November 2004 by a team of six researchers consisting of staff from the New Mexico Legislative Council Service (LCS), two LCS policy consultants and a staff member from the New Mexico Health Policy Commission (HPC). An interview guide was developed and used in order to obtain data from a variety of sources. Over 100 key informants from national, tribal, state, county and local entities were contacted in person or via phone, email and mail and were asked to provide data on health care expenditures following the guide.

The data collected was based on availability of existing data from multiple sources (federal, tribal, state, local and private industry). When data was not readily available,

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[163] Reynis, Lee (1998). New Mexico Personal Health Expenditures Calendar 1996. New Mexicans for Health Security Campaign, UNM Bureau of Business and Economic Research.
O'Donnell, K. (2004). Government Financed Healthcare in New Mexico.
Goldstein, G. (1995). NM State Health Expenditure (SHE) Account for Period July 1, 1992-June 30, 1993 (1995). New Mexico Health Care Initiative & NM HPC, funded by Robert Wood Johnson Foundation and NM State Legislature.
Blewitt, L., Sonier, J., Gustafson, B.C., Leitz, S.D. (1999). SHEA Minnesota's Perspective.
2000-2001 State Health Expenditure Report. Milbank Memorial Fund, National Association of State Budget Officers, Reforming States Group.

the research team relied on public access data and reports via credible sources on the Internet. The health care cost data was compiled into spreadsheets, aggregated into public and private categories, cross-checked and validated and analyzed into the estimations of health care costs. Finally, special tracking efforts were used to ensure that expenditures were not "double-counted" across data sources (i.e., Medicaid figures were used from the New Mexico Human Services Department but omitted from the IHS and county-level data).

Study Strengths and Limitations

This study reflects a comprehensive and collaborative effort to measure health care expenditures using valid and credible research methods. This and previous studies provide a baseline for regularly monitoring state health care costs and providing information to inform policy.

The study defines health care as "… the care, services or supplies related to the health of an individual. Health care includes but is not limited to preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, and counseling, service, assessment or procedure with respect to the physical or mental condition or functional status of an individual or that affects the structure or function of the body. It also includes the sale or dispensing of a drug, device, equipment or other item in accordance with a prescription".

Environmental health (air and water) and indirect costs such as facilities and maintenance are not included in the definition of health care for purposes of this study.

The challenge in collecting health expenditure data in New Mexico is common to other states' experiences[164] in that:

- most organizations do not tend to track data on either covered lives or expenditures;
- there is no uniform system of data collection;
- there is no uniform set of definitions;
- there are no uniform methodologies for estimating expenditures;
- there is no historical database; and
- there are no comparison bases.

New Mexico Health Care Costs

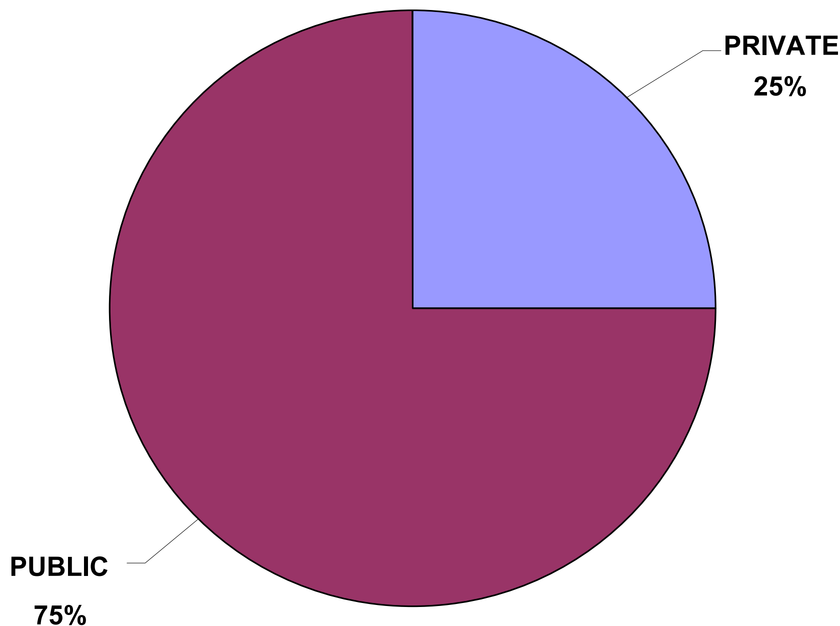
Where It Came From

Figure 1 and TABLE A display expenditures for health care services by payer source for calendar year 2002. The estimated cost of providing health care to New Mexicans was $7.8 billion. Approximately 75 percent, or $5.8 billion, of the health care expenditure

[164] Goldstein, G. (1995). New Mexico State Health Expenditure (SHE) Account for Period July 1, 1992, through June 30, 1993.

was publicly financed and 25 percent, or $1.9 billion, was privately financed (Figure 1). This estimate is consistent with the 2004 study "Government Financed Healthcare in New Mexico"[165], which also found that in 1999, three-fourths of New Mexico's $6 billion health care expenditure was publicly financed. Compared to another estimate made in 1996[166], the portion that government contributed to New Mexico's health care spending was 51 percent. This represents a 7.8 percent annual growth rate in government-financed health care.

Figure 1. New Mexico Health Care Spending in 2002
Where it came from



Of the $7.8 billion in health care expenditures in 2002, the federal government paid $4.97 billion or 64 percent (TABLE A). Total state and local spending was approximately $872 million, or 11 percent. Of the $778 million (10 percent) contributed by state government, $432 million came from the state Medicaid share and $293 million from the Department of Health. Counties covered about one percent of health care costs, or $94 million. Of the $1.9 billion contributed from private sources, 54 percent ($1.1 billion) was paid by fully insured plans and 38 percent ($741 million) was paid by self-insured plans.

[165] O'Donnell, K. (2004). Government Financed Healthcare in New Mexico.
[166] Reynis, Lee (1998). New Mexico Personal Health Expenditures Calendar 1996. New Mexicans for Health Security Campaign, UNM Bureau of Business and Economic Research.

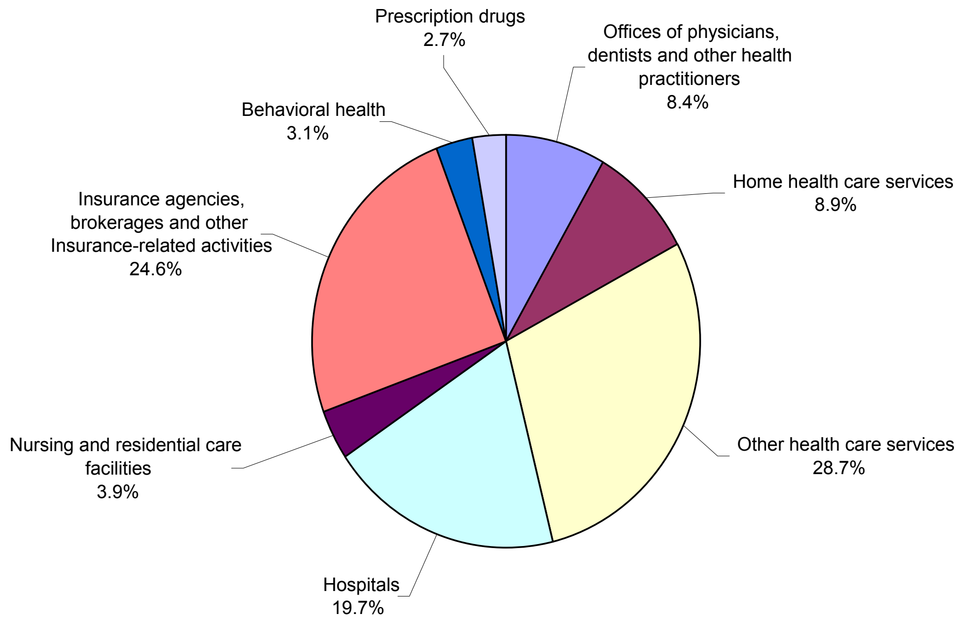
TABLE A: NEW MEXICO HEALTH CARE EXPENDITURES BY PAYER SOURCE, CALENDAR YEAR 2002

	FEDERAL	STATE	COUNTY	PRIVATE	TOTAL
PRIVATE					
Insurance					
Self-Insured Plans				$740,824,000	$740,824,000
Fully Insured Plans				$1,056,918,000	$1,056,918,000
Workers' Compensation				$88,506,000	$88,506,000
Other Private					
Out-of-Pocket				$41,641,000	$41,641,000
PhRMA*				$13,400,000	$13,400,000
UNM Prescription Drug Clinical Trials				$3,382,534	$3,382,534
PUBLIC					
Federal					
Medicare	$2,992,000,000				$2,992,000,000
Medicaid	$1,294,793,013	$429,994,672			$1,724,787,685
Veterans Administration	$194,090,768				$194,090,768
Indian Health Service - Albuquerque & Navajo	$228,280,988				$228,280,988
Military Claims (TRICARE) & Facilities	$140,528,874				$140,528,874
Grants					
University of New Mexico	$3,444,891	$3,229,456			$6,674,347
Federally Qualified Health Centers	$25,395,276				$25,395,276
State					
Department of Health	$83,722,000	$292,735,000			$376,457,000
Aging & Long-Term Services Dept	$2,799,849	$9,286,943			$12,086,792
Children, Youth & Families Dept	$1,493,022	$16,493,804			$17,986,826
Dept of Vocational Rehabilitation	$996,338	$281,017			$1,277,355
Public Education Dept (School Health)		$5,253,600			$5,253,600
Corrections Dept		$20,908,490			$20,908,490
County					
County Indigent Fund			$23,367,862		$23,367,862
Jail Inmate Health Expenditures			$3,988,462		$3,988,462
Other Health Expenditures			$66,698,318		$66,698,318
TOTAL	**$4,967,545,019**	**$778,182,982**	**$94,054,642**	**$1,944,671,534**	**$7,784,454,177**

Where It Went

Figure 2 and TABLE B display estimates of the distribution of health care spending in New Mexico by category of service. The categories were created based on Standard Industry Classification codes related to health expenditures by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce[167] (see Guide to TABLE B). Figure 1 shows that in 2002, the largest percentage of spending — 29 percent, or $2.2 billion — went to other health care services, which include ambulatory health care services (except offices of physicians, dentists and other health practitioners), outpatient care centers, medical and diagnostic laboratories, and other services that were not uniformly categorized by the New Mexico County Indigent Fund and Corrections Department. The second-largest category covered insurance agencies, brokerages and other insurance-related activities at 25 percent ($1.9 billion). Included in this category is the full amount expended to pay insurance claims for 2002. Hospitals accounted for 20 percent ($1.5 billion) of the health care spending, followed by home health care services at 9 percent ($692 million), offices of physicians, dentists and other health practitioners at 8.4 percent ($653 million), nursing and residential care facilities at 3.9 percent ($303 million), behavioral health at 3.1 percent ($241 million) and prescription drugs at 2.7 percent ($212 million).

Figure 2. New Mexico Health Care Spending in 2002: Where it Went



[167] A detailed description of the Standard Classification codes (Health Care and Social Assistance) used by BEA is available at http://www.bea.doc.gov/bea/regional/rims/appb.cfm.

TABLE B: NEW MEXICO HEALTH CARE EXPENDITURES BY CATEGORY OF SERVICE AND FUNDING SOURCE CALENDAR YEAR 2002

Categories of Service	Federal	State	County	Private	Total
Offices of physicians, dentists and other health practitioners	$580,972,577	$58,749,732	-	$13,488,000	$653,210,309
Home health care services	$490,272,347	$199,318,404	-	$2,282,000	$691,872,751
Other health care services	$1,923,798,086	$211,997,038	$94,054,642	$4,577,000	$2,234,426,766
Hospitals	$1,434,474,368	$95,077,577	-	$3,329,000	$1,532,880,945
Nursing and residential care facilities	$254,125,000	$48,687,000	-	-	$302,812,000
Insurance agencies, brokerages and other insurance-related activities	$20,530,000	$9,839,000	-	$1,886,248,000	$1,916,617,000
Behavioral health	$120,057,838	$120,480,065	-	-	$240,537,903
Prescription drugs	$143,314,803	$34,034,166	-	$34,747,534	$212,096,503
TOTAL	**$4,967,545,019**	**$778,182,982**	**$94,054,642**	**$1,944,671,534**	**$7,784,454,177**

Uncompensated care

Uncompensated care was not included in the measurement of health care expenditures because it is a measure of hospital care provided by which ***no payment*** was received from the patient or the insurer.[168] The data described in TABLE A includes measures of payments for health care. However, in a state with a high proportion of uninsured residents, it is important to note that in 2002, the uncompensated care costs reported by the New Mexico Hospital and Health Systems Association was $209 million and $6.6 million for private practice dentists (TABLE C).

TABLE C: ESTIMATED UNCOMPENSATED CARE COSTS, 2002

New Mexico Hospital and Health Systems Association	$209,000,000
New Mexico Dentists	$ 6,640,000
TOTAL	**$215,640,000**

[168] American Hospital Association, February 2003. Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer. It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided.

Conclusion

In 2002, the estimated cost of providing health care to New Mexicans was $7.8 billion. Approximately 75 percent of health care expenditures were publicly financed ($5.8 billion). This estimate is consistent with the 2004 study "Government Financed Healthcare in New Mexico"[169], which also found that in 1999, three-fourths of New Mexico's $6 billion health care expenditure was publicly financed.

Of the $7.8 billion in health care expenditures in 2002, the federal government paid $4.97 billion, or 64 percent. Total state and local spending was approximately $872 million (11 percent). Of the $1.9 billion contributed from private sources, 54 percent ($1.1 billion) was paid by fully insured plans and 38 percent ($741 million) was paid by self-insured plans. In 2002, the largest percentage of spending — 29 percent, or $2.2 billion — went to other health care services, which include ambulatory health care services (except offices of physicians, dentists and other health practitioners), outpatient care centers, medical and diagnostic laboratories and other services that were not uniformly categorized by the New Mexico County Indigent Fund and Corrections Department. The second-largest category covered insurance agencies, brokerages and other insurance-related activities at $1.9 billion, or 25 percent. Hospitals accounted for 20 percent, or $1.5 billion, of the health care spending.

Health care expenditure research plays a significant role in monitoring state health care costs and providing information to inform policy. Estimates of health care spending have become increasingly important to private industry and government. Yet, despite the policy significance of regularly monitoring health care costs, New Mexico lacks a uniform system of data collection. Previous efforts by the Robert Wood Johnson Foundation and the New Mexico State Legislature (1995), the Bureau of Business and Economic Research of the University of New Mexico (1998) and the McCune Foundation and New Mexico Voices for Children (2004) demonstrate concern over the rising cost of health care.[170] In 1992 and 1993, the State Health Care Account was $3.9 billion (Goldstein, 1995). New Mexico's Personal Health Expenditures (Reynis, 1998) were $4.6 billion in 1996. A study to determine the extent to which New Mexico's health care is paid for by government (O'Donnell, 2004) found that personal health care expenditures were $6 billion. In the decade from 1992 to 2002, New Mexico's expenditures doubled to $7.8 billion.

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[169] O'Donnell, K. (2004). Government Financed Healthcare in New Mexico.
[170] Reynis, Lee (1998). New Mexico Personal Health Expenditures Calendar 1996. New Mexicans for Health Security Campaign, UNM Bureau of Business and Economic Research.
O'Donnell, K. (2004). Government Financed Healthcare in New Mexico.
Goldstein, G. (1995). NM State Health Expenditure (SHE) Account for Period July 1, 1992-June 30, 1993 (1995). New Mexico Health Care Initiative & NM HPC, funded by Robert Wood Johnson Foundation and NM State Legislature.

Guide to Tables

There are various methodologies used at the national and state levels to measure and/or project health care spending.[171] The methodology used in the HB 955 study tracked health care spending by source of funds (e.g., private, Medicaid, Medicare) and by type of service (hospital, physician, prescription drugs, etc.). The data is based on what was readily available and reported from federal, state, local and private organizations from July through October 2004. This study did not collect and analyze tax data from health-care-related expenditures. Following is a guide to TABLES A, B and C of the study, including definitions of each payer source, the methods used to collect and estimate health care cost and a description of health care costs by category of service. Also included is a list of organizations and contacts that contributed to the study and provided data. This is provided as a baseline and resource for further health care expenditure studies in New Mexico.

TABLE A
Sources and Methods for Health Care Expenditures by Payer Source (Public and Private) — Calendar Year 2002

I. Private Insurance

TABLE A shows the cost of insurance in New Mexico. It is divided into three categories: self-insured plans, fully insured plans and workers' compensation. The amount reflected represents the amount of direct losses paid as a result of claims rather than the premium cost to employers and employees. Though employers and employees do incur costs when they purchase health insurance, a decision was made to use claims losses as the most accurate representation of actual amounts paid for the provision of health care services. It is worth noting that the cost of claims is less than the amount paid for health insurance premiums. The difference between the two represents the administrative costs and profits of the insurance companies and is not reflected in this study.

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[171] National and State Health Expenditures. The Office of the Actuary (OACT) in the Centers for Medicare and Medicaid Services (CMS). http://www.cms.hhs.gov/statistics/nhe/#download.
Reynis, Lee (1998). New Mexico Personal Health Expenditures Calendar 1996. New Mexicans for Health Security Campaign, UNM Bureau of Business and Economic Research.
O'Donnell, K. (2004). Government Financed Healthcare in New Mexico.
Goldstein, G. (1995). NM State Health Expenditure (SHE) Account for Period July 1, 1992-June 30, 1993 (1995). New Mexico Health Care Initiative & NM HPC, funded by Robert Wood Johnson Foundation and NM State Legislature.
Blewitt, L., Sonier, J., Gustafson, B.C., Leitz, S.D. (1999). SHEA Minnesota’s Perspective.
2000-2001 State Health Expenditure Report. Milbank Memorial Fund, National Association of State Budget Officers, Reforming States Group.
Basu, J., Lazenby, H.C., and Levit, K.R. (Winter 1995). Medicare Spending by State: The Border-Crossing Adjustment. Health Care Financing Review, 17, (2), 219-241.
Florida Health Care Expenditures 1992-1999. State Center for Health Statistics, June 2001, State of Florida, Agency for Health Care Administration. www.FloridaHealthStat.com.

Fully insured policies are those that are sold by licensed insurance companies and managed care organizations in New Mexico to private individuals and employers. The insurance companies carry the entire risk of losses. Self-insured policies are those in which an employer carries the risk for losses and generally utilizes a third-party administrator to carry out administrative functions.

Private insurance data regarding the cost of claims for fully insured policies was extrapolated from an annual survey conducted by the National Association of Insurance Commissioners (NAIC) and obtained from the Insurance Division of the New Mexico Public Regulation Commission. State law requires the annual reporting of this data to the NAIC. Health insurance is sold in New Mexico through property and casualty companies, through life and accidental health insurance companies and by managed care organizations. Workers' compensation data is reported in the NAIC data. Workers' compensation losses are reflected separately.

Information regarding self-insured policies is protected by the federal ERISA law, and hence not included in the NAIC data. The Agency for Healthcare Research and Quality (AHRQ) conducts an annual household survey as part of the Medical Expenditure Panel Survey (MEPS). This survey includes information on employees who are covered by self-insured plans. For the purposes of this study, data was extrapolated from the HPC study "Employment-Based Health Insurance in New Mexico" regarding the number of employees with health insurance (both self-insured and fully insured). The MEPS survey allowed the researchers for the HB 955 study to identify the number of employees in the state in self-insured plans by size of employee group. When combined with the HPC data, it was possible to determine the number of employees in both self-insured and fully insured plans. Using the NAIC data, researchers were able to convert total claims loss data into a figure that represents an individual cost of claims in New Mexico; this was then applied to the number of people in self-insured plans to identify the cost of insurance claims for people in self-insured plans. The HPC data is from the year 2000; it was not adjusted to reflect projected increases in employment status or increased take-up rates for 2002. Individuals without health insurance who self-insure their costs of health care are reflected in the out-of-pocket section of the table.

II. Out-of-Pocket Expenses

The amount of money spent out of pocket by individuals is extremely difficult to ascertain since no formal data is routinely collected in this regard. The AHRQ MEPS household survey, however, does capture this information in several key categories. This data reflects out-of-pocket expense as a percentage of total expenses in each category and may be refined to regional estimates. The region that includes New Mexico also includes Montana, Idaho, Wyoming, Colorado, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska and Hawaii. The out-of-pocket expense for New Mexico was calculated by creating a ratio between the estimated percentage of uninsured in New Mexico for the year, the estimated percentage of uninsured in the region for the same

year and the estimated out-of-pocket expense for the region. The figure was then adjusted by the consumer price index for the year to adjust the MEPS 2001 data to 2002. The estimated percentage of uninsured in New Mexico was obtained from the HPC publication *Quick Facts, 2003*.

III. Federal Expenditures

Medicare

Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age and people with permanent kidney failure. In 2004, Medicare covered more than 41 million Americans — 35 million seniors and 6 million non-elderly people with disabilities. Medicare has covered eligible elderly beneficiaries without regard to income or medical history since it was established in 1965, and coverage for disabled people under the age of 65 was added in 1972. Medicare consists of four parts[172]:

- Part A — the Hospital Insurance Program covers inpatient hospital, skilled nursing facility, hospice and home health care. Part A is financed by a 1.45 percent payroll tax paid by employees and employers. People over 65 who do not get Part A automatically may purchase Part A coverage.
- Part B — Supplementary Medical Insurance accounts for over one-third of Medicare benefits spending in 2004. Medicare Part B pays for doctors' services, outpatient hospital care, lab tests, medical supplies and home health. Part B is financed by beneficiary premiums (25 percent) and general revenues (75 percent).
- Part C — refers to managed care plans that provide Part A and B benefits to enrollees. Formerly called "Medicare+Choice", Part C has been renamed "Medicare Advantage".
- Part D — refers to the new outpatient prescription drug benefit that will be implemented in 2006, enacted under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Part D will be financed through beneficiary premiums (25.5 percent) and general revenues (74.5 percent).

The data for the HB 955 study is drawn from the Centers for Medicaid and Medicare Services (CMS) State Health Expenditure Accounts (SHEA).[173] The structure of the SHEA parallels that of the National Health Expenditure accounts for health services, which clusters spending according to the establishment providing those services: dental; drugs and other medical non-durables; home health care; hospital care; nursing home care; other professional services; personal health care; physician services; and vision products and other medical durables. As part of the SHEA, CMS has health expenditures by state that are not broken by source of funds *except* for Medicare and Medicaid. As of October 2004, CMS had data available from 1980 through 1998. CMS is working on an update showing 1980 through 2002, but this will not be available until 2005. Therefore,

[172] Medicare at a Glance: Fact Sheet (March 2004). The Henry J. Kaiser Family Foundation. www.kff.org.
[173] National and State Health Expenditures. The Office of the Actuary (OACT) in the Centers for Medicare and Medicaid Services (CMS). http://www.cms.hhs.gov/statistics/nhe/#download.

the 2002 New Mexico state estimates were determined by calculating the percent (straight-line) growth rates from existing data from 1994 to 1998 and projecting for 1999 through 2002.

Medicaid

Medicaid is a joint federal-state program designed to provide health care for low-income persons. Medicaid was created in 1965 as Title XIX of the Social Security Act, at the same time Medicare was created, which is Title XVIII. In 2004, Medicaid enrollment nationwide is projected to be about 50 million while enrollment in Medicare is projected at over 41 million. Part of the recent growth in Medicaid has been the establishment in 1997 of the State Children's Health Insurance Program (SCHIP), or Title XXI, the largest expansion of Medicaid since its inception.[174] The federal government matches state Medicaid spending with the federal share of Medicaid spending, ranging from 50 percent to 77 percent depending on state per capita income. In 2002, the federal government financed 57 percent of the $250 billion in total national Medicaid spending.[175]

Medicaid growth in New Mexico has been similar to that nationwide. In 1991, total state and federal expenditures in Medicaid were approximately $341 million, of which the state contributed about $88 million, or 25 percent. Twelve years later, the state contribution alone is expected to exceed $380 million, or 25 percent of a program that has grown to about $1.9 billion. It is expected to exceed $2 billion in fiscal year 2004, requiring a state contribution of over $400 million. Medicaid enrollment tripled during the 12-year period, growing from about 129,400 in 1991 to a projected 400,000 by the end of fiscal year 2003[176] (Medicaid Reform Committee, Findings and Recommendations, Legislative Council Service, 2002).

Data is from the state of New Mexico, Human Services Department (HSD), Medical Assistance Programs-Title XIX & XXI Projections with Actual Expenditures for State Fiscal Years (SFY) 2002 and 2003. Expenditures in fee-for-service Medicaid are reported by 36 categories of services that parallel the 2082 Reports, which are generated monthly to CMS. For most of the categories of service, the federal share and composite Federal Medical Assistance Percentage (FMAP) is reported. SFY 2002 and 2003 were averaged to calculate the calendar year 2002. The Medicaid Managed Care and SCHIP were broken down by categories of services for behavioral and physical health for calendar year 2002 (HSD Medical Assistance Division).

Indian Health Service

The Indian Health Service (IHS), an agency within the federal Department of Health and Human Services (DHHS), is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of

[174] New Mexico Medicaid Reform Committee: Findings and Recommendations (December 2002). Legislative Council Service.

[175] The Medicaid Program at a Glance: Medicaid Facts (January 2004). The Henry J. Kaiser Family Foundation.

[176] New Mexico Medicaid Reform Committee: Findings and Recommendations (December 2002). Legislative Council Service.

federally recognized tribes grew out of the special government-to-government relationship between the federal government and American Indian tribes. This relationship, established in 1787, is based on Article I, Section 8 of the U.S. Constitution and has been given form and substance by numerous treaties, laws, Supreme Court decisions and executive orders. The IHS is the principal federal health care provider and health advocate for American Indian people and its goal is to raise their health status to the highest possible level. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 557 federally recognized tribes in 35 states.[177]

IHS services are provided directly and through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers annually. The federal system consists of 36 hospitals, 61 health centers, 49 health stations and five residential treatment centers. In addition, 34 urban Indian health projects provide a variety of health and referral services. Unlike privately insured people or recipients of Medicare or Medicaid, Indians who utilize IHS are not assured access to a defined package of health care services. The level of services provided by the IHS varies by location and by year depending on available funding.[178]

There are two IHS administrative units serving tribes in the New Mexico area: Albuquerque and Navajo area offices. Each office compiles its health-related cost data differently. Both IHS area offices submitted a "Recurring Base Distribution Summary" for federal FY 2002. The spreadsheet summaries had similar but not identical categories of services: hospitals and clinics; Indian Health Care Improvement Fund allocations; emergency medical services; dental; mental health; alcohol and substance abuse; health education; community health representative program; urban health; contract and special costs; and public health nursing. Indirect costs were not included. Medicaid expenditures were omitted to avoid double-counting the IHS and HSD Medicaid data. In both the Navajo and Albuquerque area offices, figures represent allowance summaries (revenues); however, in both areas, expenditures are close to 100 percent of allowances. In order to calculate New Mexico-based expenditures, data from Ysleta del Sur Service Unit (Texas) and Southern Colorado Ute and Ute Mountain Ute (Colorado) was omitted from the Albuquerque area distribution summary. The Navajo Area IHS Office of the Area Director reported that its service units serve approximately 95 percent New Mexico residents (Crownpoint 99 percent; Gallup 80 to 90 percent; and Shiprock 90+ percent). Thus, it is difficult to calculate health expenditures for New Mexico residents only in the Navajo Area.

Veterans Health Administration

The Veterans Health Administration (VHA) provides a broad spectrum of medical, surgical and rehabilitative care to veterans. Veteran status is established by active duty service in the military naval or air service, and a discharge or release from active military

[177] Introduction to the Indian Health Services (2004). http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp
[178] Indian Health Services Fact Sheet (2004). http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp

service under other than dishonorable conditions. In October 1996, Congress passed Public Law 104-262, the Veterans' Health Care Eligibility Reform Act of 1996. This legislation paved the way for the creation of a Medical Benefits Package — a standard enhanced health benefits plan available to all enrolled veterans. Like other standard health care plans, the Medical Benefits Package emphasizes preventive and primary care, offering a full range of outpatient and inpatient services.[179]

The VHA collects health care expenditure data based on enrollment costs. The health care data is broken down by bed section into two categories: inpatient (medical surgical) and outpatient (captured in visits). Data was compiled and submitted from the VHA to the New Mexico Legislative Council Service for federal fiscal years 1999 through 2003.

Military — TRICARE

TRICARE is the U.S. Department of Defense's (DOD) worldwide health care program for active duty and retired uniformed services members and their families. The DOD submitted data for calendar year 2002 that includes:

- purchased care claims for medical care of dependents of active duty military personnel and their dependents and retired military personnel and their dependents living in New Mexico; and
- direct care costs of medical/dental treatment facilities for New Mexico (Kirtland, Holloman, Cannon and White Sands).

IV. Grants

Grants are provided to New Mexico for the provision of health care in three ways that are captured in this study. Other grants may have been awarded in 2002 that would meet the definition of health care used in this study; however, the researchers were unable to accurately quantify the amounts or purposes and so have excluded them. The three avenues that are included are grants awarded to the University of New Mexico Health Sciences Center (UNMHSC), federal grant money awarded to federally qualified health centers and prescription drugs that are donated to New Mexicans through patient assistance programs offered by prescription drug manufacturers.

Information regarding UNMHSC was found on its web site, assisted by the controller. Grants reflected in this study are primarily those that are identified as service grants (coded "s" in the report of awards) and that, by subjective determination, adhere to the definition of health care. Grants that are funded by other sources reported in this study were eliminated to avoid double counting. Grants were further delineated by whether the funding sources were in-state or out-of-state and are thus reported in TABLE A. All awards provided for the purpose of clinical trials are included, as the nature of clinical trial studies involves the provision of experimental drugs to patients, which fits the definition of health care. Clinical trials are shown separately on TABLE A.

[179] Veterans Health Administration (2004). http://www1.va.gov/health_benefits/

Federally qualified health centers apply for and receive substantial funding from the federal Bureau of Primary Health. The New Mexico Primary Care Association provided the amount reported in this study.

Most pharmaceutical manufacturing companies provide free prescription drugs to individuals who meet qualifications such as income, age and other characteristics, and who make application to the individual manufacturer. Qualifications vary by manufacturer. The data included in this report was provided by the regional Pharmaceutical Research and Manufacturers of America (PhRMA) and is based on national estimates. It should be noted that several individual manufacturers cooperated in this study, but the data received from them had significant differences in reporting and was not consistently available for the time period requested; a decision was made to use the estimate provided by PhRMA. Additionally, the information provided by the regional PhRMA was deemed to be more inclusive.

V. State Expenditures

Many state agencies provide health care services directly to New Mexicans. The largest state expenditure for health care was the state portion of funding for the Medicaid program; however the Department of Health, the former State Agency on Aging (now the Aging and Long-Term Services Department), the Children, Youth and Families Department, the Vocational Rehabilitation Division of the Public Education Department (Office of School Health) and the Corrections Department all incurred health care costs and are also included in this study. All state agencies were asked to provide data about health care costs covering the period FY 1999 to FY 2003. More specifically, each was asked to identify the source of funding (state general fund, federal funds, grants, other), the source of information about the data they provided (annual budget documents, actual expenditures), the type of expenditures incurred (inpatient care, behavioral health, pharmacy, etc.) and how often the data is collected. Agencies of state government were all extremely cooperative and were responsive to the importance of the research being conducted. All state agencies reflected in TABLE A cooperated in the production of this study by providing data.

Not all state agencies were able to provide data in the format requested, and adjustments to the data were made to compensate for that limitation. For example, in some cases, data was not available for the years requested. Because fiscal years of other reporting sources varied, the calendar year of 2002 was used for this study, thus necessitating an adjustment of state fiscal year data. This was done by averaging FY 2002 and FY 2003. Additional adjustments were made from the data submitted to ensure inclusion only of data that met the definition of health care, as well as to consolidate data into like categories.

Aging and Long-Term Services Department (formerly the State Agency on Aging)
This department is dedicated to promoting the independence and dignity of elders and people with disabilities. Its mission is to achieve the highest quality of life for older persons, people with disabilities and their families by enhancing autonomy, health,

economic well-being, community involvement and personal responsibility. Services provided that qualify as provision of health care are largely focused on home- and community-based care and supportive services. The data provided by this department was based on actual expenditures during fiscal years 1999 to 2003 and reflected federal and state sources of funding. Definitions were provided for the services for which health care expenditures were reported.

Department of Health

The Department of Health operates, or contracts for, statewide programs for health improvement; primary and emergency medical care; treatment for sexual assault and AIDS victims; substance abuse prevention; treatment of alcoholism, drug abuse, drug dependency, mental health disorders and illnesses; forensic evaluations; and long-term services for the developmentally and mentally disabled. The department operates a scientific laboratory and is responsible for licensure and oversight of health care facilities in the entire state. Virtually all of the expenditures within the department qualify as health care costs for the provision of health care to New Mexicans. The data provided was arranged by payer source, as well as by divisions within the department. Data was obtained from budget documents.

Vocational Rehabilitation Division

The purpose of the Vocational Rehabilitation Division of the Public Education Department is to help people with disabilities to achieve a suitable employment outcome. Its program is supported by approximately 22 percent state and 78 percent federal funds. A small portion of its budget is used to purchase medical and psychological diagnostics and some restoration services. Not included in the data is approximately $4 million of federal money that is received in discretionary funds, but for which there is no record of how it is used. The data for fiscal years 2002 and 2003 reflects detailed categories of expenditures; however, the categories varied slightly from year to year. Additionally, no further breakdown was available beyond the estimate of percentage of state and federal funding. For TABLE A, after averaging the two fiscal years, the federal/state percentage breakdown was applied to the data. For the categories of spending, like expenditures were grouped and then averaged. The data is based on annual reports required by the federal funding source.

Children, Youth and Families Department

The vision of the Children, Youth and Families Department is to partner with communities to strengthen families in New Mexico to be productive and self-sufficient. Its wide range of services addresses prevention, early intervention, child care, domestic violence, behavioral health and juvenile justice services. The services it provides that are relevant to this study include behavioral health services for children, behavioral health and crisis services to victims of domestic violence and health care services to children in the juvenile justice system. Children's behavioral health services and domestic violence services were reported for fiscal years 2001 to 2004 and represent actual expenditures for those years. Services provided were described. Health care expenditures and services for the juvenile justice system were provided only for FY 2004, and this is the year that was included for the purpose of this study. The data was not adjusted since types of services

provided have changed dramatically each year in the juvenile justice system, and it was determined that the calendar year of 2002 would not be representative of any predictable trend in care.

Public Education Department, School Health Unit
Health care services are provided in most, if not all, public primary and secondary schools in New Mexico. The School Health Unit of the Public Education Department provides primarily consultative assistance to individual schools; hence, much of its funding is not reflected in this study. The unit provided the number of school nurses employed in the schools and an average salary for those nurses during 2002. Approximately 40 percent of the salaries are paid for out of the general fund, so this amount was counted for in the study. Additionally, the unit receives a federal entitlement grant to provide for safe and drug-free schools. The money is used for drug prevention activities and may be used for administration of those programs as well. It was not possible to separate out an amount dedicated to administration; however, it was determined that this amount was insignificant compared to the overall grant, and so the entire allocation was included as a cost of health care in New Mexico. No attempt was made to identify dollars spent by each school in New Mexico, so it can be assumed that the data relative to school health is understated.

Colleges and institutions of higher learning were contacted regarding health care services provided to students. They are included in this study, but not separately identified as such. Most college-level health care is provided by health insurance policies; those expenditures are reported with the private insurance data. Some colleges operate health centers for students; however, all reported that they charge for those services and, therefore, these expenditures are included in the out-of-pocket expenditures for this study.

Corrections Department
Medical and psychiatric services are provided to inmates through private health services contracts. Data was provided on the total contract medical services expenditures for fiscal years 1999 to 2002 and on expenditures for HIV services provided through a contract with the Department of Health, all of which are funded by the state general fund. The HIV expenditures were not included with other Corrections Department expenditures to avoid double counting. A breakdown of expenditures into categories of service was not possible as reporting was inconsistent during 2002.

VI. County

Under the Indigent Hospital and County Health Care Act (CIF Act) and the County Local Option Gross Receipts Taxes Act, counties are given great latitude to determine how revenues for the County Indigent Fund program are to be generated and collected (NMHPC, 2001). Under the CIF Act, participating counties are required to appoint a county indigent and county health care board to, among other duties, administer CIF claims (NMHPC, 2001). In 1997, the CIF Act was amended to expand the allowable

uses of county indigent funds to include all health services and health planning (NMHPC, 1997).

The CIF Act also states that "the individual county of this state is the responsible agency for ambulance transportation or the hospital care or the provision of health care to indigent patients domiciled in that county for at least three months". It should be noted that Bernalillo County uses a mill levy approach to fund indigent care. Funds for services and capital improvement are collected from gross receipts tax, mill levy, general appropriation and bonds. There is relative flexibility in how counties appropriate these funds:

- *State statute specifies and limits the types of services that can be paid for with county indigent funds.*
- Counties are given leeway in determining which of the services they want to include as provided services, such as hospital, ambulance, substance abuse, mental health care, nursing home care, home health and hospice, primary care clinics/community health centers, planning and health outreach, dental and physician and other services.
- *Counties determine the qualifying criteria for indigent services. This includes identifying income requirements, county residency requirements and immigrant qualifications.*

For purposes of the HB 955 study, the HPC, which produces the Annual County Indigent Fund Reports, submitted data for the CIF state fiscal years (SFYs) 2002 and 2003. County expenditures were averaged for SFY 2002 and SFY 2003 in order to determine calendar year 2002. Not all counties report financial data to the HPC. SFY 2002 includes financial data compiled from 27 reporting counties, and SFY 2003 includes data compiled from 29 counties. Since counties collect and report categories of services differently, it is impossible to break down the total expenditures by service types. County-supported Medicaid is included in the HSD data and was excluded from the county expenditures to avoid double counting. Administration, health care facility construction and health care capital outlays were omitted from the "other county funding expenditures" category.

A special survey was administered by the HPC to determine other health care expenditures for county jail inmates from SFY 2001 to SFY 2003. Twenty-two counties submitted expenditures for health services delivered to jail inmates (inpatient and outpatient). These figures did *not* include administrative costs.

TABLE B
Summary Description of New Mexico Health Care Expenditures by Category of Service — Calendar Year 2002

Categories of services are collected and reported by federal, state and county organizations and by the insurance industry in multiple methods. For purposes of the HB 955 study, the following categories were created based on the Standard Industry

Classification codes related to health expenditures by the Bureau of Economic Analysis (BEA), U.S. Department of Commerce.[180]

- Offices of physicians, dentists and other health care practitioners
- Home health care services
- Other health care services
- Hospitals
- Nursing and residential care facilities
- Agencies, brokerages and other insurance-related activities

The behavioral health services and prescription drugs categories were not in the BEA classification code but are included in TABLE B, New Mexico Health Care Expenditures by Category of Service and Funding Source, Calendar Year 2002.

I. Offices of Physicians, Dentists and Other Health Practitioners

This industry comprises establishments of health practitioners having the degree of M.D. (doctor of medicine) or D.O. (doctor of osteopathy) primarily engaged in the independent practice of general or specialized medicine (e.g., anesthesiology, oncology, ophthalmology, psychiatry) or surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.

Offices of dentists comprise establishments of health practitioners having the degree of D.M.D. (doctor of dental medicine), D.D.S. (doctor of dental surgery) or D.D.Sc. (doctor of dental science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic or emergency care, or specialize in a single field of dentistry.

Offices of other health practitioners comprise establishments of independent health practitioners (except physicians and dentists).

II. Home Health Care Services

This industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupational and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy.

[180] A detailed description of the Standard Industry Classification codes (Health Care and Social Assistance) used by BEA is available at http://www.bea.doc.gov/bea/regional/rims/appb.cfm.

III. Other Health Care Services

This category of service also includes ambulatory health care. Industries in the ambulatory health care services subsector provide health care services directly or indirectly to ambulatory patients and do not usually provide inpatient services. Health practitioners in this subsector provide outpatient services, with the facilities and equipment not usually being the most significant part of the production process.

Other ambulatory health care services
This industry group comprises establishments primarily engaged in providing ambulatory health care services (except offices of physicians, dentists and other health practitioners; outpatient care centers; medical laboratories and diagnostic imaging centers; and home health care providers). Outpatient care centers include family planning centers and other outpatient care centers.

Medical and diagnostic laboratories
This industry comprises establishments known as medical and diagnostic laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis and diagnostic imaging, generally to the medical profession or to the patient on referral from a health practitioner.

Other
This category includes related services that could not be categorized by service, including corrections/prisons (from the Corrections Department) and the County Indigent Fund, which does not track data by categories of services.

IV. Hospitals

Industries in the Hospitals subsector provide medical, diagnostic and treatment services that include physician, nursing and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Establishments in the Hospitals subsector provide inpatient health services, many of which can only be provided using the specialized facilities and equipment that form a significant and integral part of the production process.

V. Nursing and Residential Care Facilities

Industries in the Nursing and Residential Care Facilities subsector provide residential care combined with either nursing, supervisory or other types of care as required by the residents. In this subsector, the facilities are a significant part of the production process and the care provided is a mix of health and social services with the health services being primarily some level of nursing services.

VI. Insurance Agencies, Brokerages and Other Insurance-Related Activities

This industry group comprises establishments primarily engaged in: 1) acting as agents (i.e., brokers) in selling annuities and insurance policies; or 2) providing other employee benefits and insurance-related services, such as claims adjustment and third-party administration.

VII. Prescription Drugs

This category includes spending for prescription drugs and spending for nonprescription (over-the-counter) medicines and sundries. It includes pharmacy costs paid for by public and private sources, including prescription drugs provided in outpatient settings and for the Medicaid population, both fee for service and managed care. It also includes clinical trials conducted through UNMHSC, free drugs provided as part of manufacturer patient assistance programs and out-of-pocket expenditures.

VIII. Behavioral Health

This category includes mental health and substance abuse services, including inpatient (psychiatric and residential treatment centers) and outpatient (mental health restoration, counseling, psychosocial therapies, crisis-intervention, etc.). This also includes children's behavioral health services and domestic violence services.

TABLE C
Uncompensated Care Costs

Uncompensated care is an overall measure of hospital care provided for which no payment was received from the patient or insurer.[181] It is the sum of a hospital's "bad debt" and the charity care it provides. Charity care is care for which hospitals never expected to be reimbursed. A hospital incurs bad debt when it cannot obtain reimbursement for care provided. The amounts in TABLE C include:

- annual dollars of cost and are expressed in millions; and
- hospital and hospital units, but may include hospital-based primary care, physician or home health costs.

In addition:

- 1997 through 2001 figures are based on various NMHHSA data sets, projections and estimates;
- 2002 figures are based on reports gathered by the HPC;
- 2003 figures are based on cost report data and financial statement data gathered from NMHHSA membership via survey and data request; and
- 2002 and 2003 figures are comprised of charity care and bad debt write-offs converted to cost.

[181] American Hospital Association Definition (February 2003).

Costs are derived from charges multiplied by a Medicare cost report cost-to-charge ratio. Actual definitions of what qualifies as charity care or bad debt write-offs differ from member to member. There is no standard definition of what qualifies as charity care. Seven members of the 2003 data set were based on the 2002 data updated by the Medicare Market Basket Increase of 3.3 percent. Also included is the net Medicare margin for NMHHSA members for 2003. This amount has not been tabulated for the earlier years. (Report prepared by New Mexico Hospitals and Health Systems Association, October 2004. 2002 estimate of charity care provided by private practice dentist. Based on 2002 Survey of Current Issues in Dentistry conducted by Survey Center of ADA.)

Contacts

Staff

Lisa Cacari Stone, Health Policy Research Consultant to the New Mexico Legislative Council Service, Lcacaristo@aol.com
Karen Wells, Medical Legal Consultant to the New Mexico Legislative Council Service, Kwells5555@msn.com
Raul Burciaga, New Mexico Legislative Council Service, Raul.Burciaga@state.nm.us
Phil Lynch, New Mexico Legislative Council Service, Phil.Lynch@state.nm.us
Ramona Schmidt, New Mexico Legislative Council Service, Ramona.Schmidt@state.nm.us
Anthony Popp, Department of Economics and International Business, New Mexico State University, apopp@nmsu.edu

Federal

David Wright and Julia Lothrop, Centers for Medicare & Medicaid Services, Regional Office, Dallas, TX
Anna Long and Cathy Cowan, Office of the Actuary, National Health Statistics Group, Centers for Medicare & Medicaid Services, Baltimore, MD
Ronald Gresch, Actuary Office, U.S. Office of Personnel Management
Cynthia Speight, TRICARE Management Activity, Department of Defense, Falls Church, VA
Jay Barden, Veterans Health Administration
Deborah Nunez, Benefits, Sandia National Laboratories
Chris Binns, Health Care Benefits, Los Alamos National Laboratory
Robert J. Reese, Commanding General, White Sands Missile Range
Ronald Wood and Patricia Olson, Office, Navajo Area Indian Health Services, U.S. Department of Health and Human Services
Sandra Winfrey, Rhonda Boal and John Tafoya, Office of the Director, Albuquerque Area Indian Health Services, U.S. Department of Health and Human Services

State

Patrick Alarid, New Mexico Health Policy Commission
Secretary Pamela Hyde, Carolyn Ingram, Pao Her, Jason Sanchez and Matthew Onstott, New Mexico Human Services Department, Medical Assistance Division

Secretary-Designee Deborah Armstrong, Aging and Long-Term Services Department
Sandra Haug, Administrative Services Division
Albino Martinez, Department of Health
Sherry Garcia, Division of Vocational Rehabilitation, Public Education Department
Diana Gonzales and Donna Elliot, Children, Youth and Families Department
Frank Pullara, Medical Director, Corrections Department
Kristine Meurer, Public Education Department, Office of School Health
Michael Batte, Insurance Division of the New Mexico Public Regulation Commission

<u>Other</u>
Brian Leugs, Pharmaceutical Research and Manufacturers of America (PhRMA)
UNMHSC was found on its web site, assisted by Judy Cartnell, Controller.
Jeff Dye and Dan Weaks, New Mexico Hospitals and Health Systems Association
Bill Fulginiti, New Mexico Municipal League
Randy Marshall, New Mexico Medical Society
David Roddy and Scott Brandstetter, New Mexico Primary Care Association
Greater Albuquerque Medical Association
New Mexico Association of Naturopathic Physicians
New Mexico Chiropractor Association
New Mexico Dental Association
New Mexico School of Natural Therapeutics
Oriental Medicine Association of New Mexico
Con Alma Health Foundation
Robert Wood Johnson Foundation
Kaiser Family Foundation
McKune Foundation
Stephen Chreist, MERCER, Human Resource Consulting
Keven Kargcin, Bureau of Business and Economic Research, University of New Mexico
Scott Leizt and Julie Sonier, Health Economics Program, Minnesota Department of Health
James Branscome, Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services
Janet Peacock, New Mexico Legislative Council Service
Kelly O'Donnell, New Mexico Voices for Children
Leighton Ku, Center for Budget and Policy Priorities, Washington, D.C.
Chuck Milligan, Center for Health Policy, University of Maryland
Kala Ladenheim, National Conference of State Legislatures

Impact Analysis of Health Care Spending On New Mexico's Economy

Overview

This section of the HB 955 study provides an analysis of the impact on the New Mexico economy of health care spending both by the state and the federal government. It provides an indication of the size of the health care industry in New Mexico and the United States, calculates the impact of health care spending originating from outside the state on the state economy, estimates the impact of state health care spending on the state economy and estimates the impact of Medicaid spending on the state economy.

The Health Care Industry in New Mexico and the United States

Health care services have been, and will continue to be, an important part of the economy of New Mexico. TABLES D through F provide some insight into the size of the health care industry in New Mexico and the United States. The health and social services sector is used as an indication of the size of the overall health care industry, though this sector is only a part of the overall health care industry; it does not include professional and technical health care services, health and personal care stores and the health care insurance industry. The size of the health care industry is larger than what is indicated in the tables.

TABLE D provides information on the amount of gross state product (GSP) the health and social services sector generated in New Mexico and in the United States for the years 1990 through 2001. Through the 1990s, the proportion of total economic activity originating in the health and social services sector increased from 5.25 percent to 5.74 percent for the state of New Mexico. The proportion of United States gross domestic product (GDP) resulting from the health and social services sector also increased during this time period. The health and social services sector, in terms of gross state product (GSP), was relatively smaller in New Mexico than in the rest of the country.

TABLE D
Gross State Product – New Mexico and the United States
(millions of $)

New Mexico					United States			
Year	Total	Health and Social Services	HSS as % of Total		Year	Total	Health and Social Services	HSS as % of total
1990	27,175	1,423	5.24		1990	5,706,658	344,443	6.04
1991	30,862	1,585	5.13		1991	5,895,430	378,883	6.43
1992	32,858	1,747	5.32		1992	6,209,096	415,125	6.69
1993	37,110	1,888	5.09		1993	6,513,026	435,503	6.69

1994	41,772	1,982	4.74		1994	6,930,791	458,122	6.61
1995	42,170	2,183	5.18		1995	7,309,516	480,478	6.57
1996	44,114	2,395	5.43		1996	7,715,901	508,788	6.59
1997	47,829	2,507	5.24		1997	8,224,960	524,739	6.38
1998	48,488	2,689	5.54		1998	8,750,174	548,702	6.27
1999	49,221	2,722	5.53		1999	9,251,541	577,259	6.24
2000	52,592	2,906	5.52		2000	9,891,187	616,126	6.23
2001	55,426	3,180	5.74		2001	10,137,190	664,468	6.55

Source: Bureau of Economic Analysis

TABLE E shows that the level of compensation received by those in the health and social services industry grew continuously during the 1990s in both New Mexico and in the United States. Until the late 1990s, the growth in compensation in these areas was larger than the growth in compensation for all sectors, resulting in health and human services compensation becoming a larger proportion of total compensation. In the late 1990s, compensation in the health and human services sector was a larger proportion of total compensation in New Mexico than in the United States.

TABLE E
Compensation of Employees – New Mexico and the United States
(millions of $)

New Mexico					United States			
Year	**Total**	**Health and Social Services**	**HSS as % of Total**		**Year**	**Total**	**Health and Social Services**	**HSS as % of total**
1990	15,206	1,073	7.06		1990	3,331,299	272,175	8.17
1991	16,179	1,179	7.40		1991	3,433,348	299,230	8.72
1992	17,246	1,339	7.76		1992	3,629,317	330,077	9.09
1993	18,519	1,448	7.82		1993	3,801,314	347,357	9.14
1994	19,892	1,529	7.69		1994	4,005,317	366,290	9.15
1995	21,155	1,704	8.08		1995	4,192,638	387,948	9.25
1996	21,805	1,886	8.65		1996	4,385,299	413,511	9.43
1997	22,740	1,972	8.67		1997	4,641,180	428,973	9.24
1998	23,868	2,163	9.06		1998	4,979,492	448,420	9.01
1999	24,623	2,188	8.89		1999	5,299,392	467,837	8.83
2000	26,252	2,327	8.86		2000	5,713,724	495,532	8.67

Source: Bureau of Economic Analysis

TABLE F provides the total number of non-farm, full-time and part-time jobs and the number of full-time and part-time jobs in the health and social services sector in New Mexico and the United States for the years 2001 through 2003. The percentage of jobs in the health and social services sector increased over that time period for both New Mexico and the United States and was a larger proportion of jobs in New Mexico than in the United States.

The levels of GSP and compensation and the number of jobs in the health care industry are a result of the spending by a variety of groups. State, federal and local governments, as well as individuals, are the buyers of health care services. Because of the existence of spending by the federal government, the health care industry in New Mexico is larger than it would otherwise be and, therefore, so is the size of the overall New Mexico economy. The overall impact of federal spending on health care services goes beyond the industry itself.

TABLE F Total Full-Time and Part-Time Employment (# of jobs) New Mexico and the United States								
New Mexico					**United States**			
Year	**Total Non-Farm**	**Health and Social Services**	**HSS as % of Total**		**Year**	**Total Non-farm**	**Health and Social Services**	**HSS as % of total**
2001	953,476	89,598	9.40		2001	163,903,700	15,605,400	9.52
2002	965,316	96,325	9.98		2002	163,407,000	16,075,000	9.82
2003	981,466	102,024	10.40		2003	163,956,400	26,503,300	10.07

Source: Bureau of Economic Analysis

The purpose of this section of the study is to estimate the impact of federal spending on health care services on the economy of New Mexico.

The Effect of Federal Health Care Spending

Methodology - Impact Analysis

There are numerous ways to calculate the impact of spending originating from outside a state on the state's economy. One of the more accepted methodologies is to use an input-output matrix of the state economy that describes the connections between the different industries within the state. The effect of new spending in one industry, originating from outside the state, can then be traced as it generates spending in other industries. Because of these multiple stages of spending, the total income generated is a multiple of the original spending. An output multiplier is a summary number that aids in the calculation of the overall effect of a change in spending that originates from outside the state.

The basic premise underlying the multiplier process is the truism that one individual's spending is another person's income. An initial injection of funds into an economy will stimulate the recipient to spend. The spending will become income for another. The second person will spend some of that income, which will become a third person's income, and so on. Of course, not all of the initial injection of funds stays in the local economy. Some will be saved, some will be paid in taxes and some will be spent on goods and services outside the local area.

For example, a local businessperson sells an item for $1.00 to a customer that resides out of state. The local area has just received an injection equivalent to $1.00 in gross receipts. From that $1.00, the businessperson will have to pay wages, taxes and the cost of the item sold; what is left over is profit. Suppose that the cost of the item to the business is $.40, business taxes are $.10 and the wages and profits that become the owner's income total $.50. Of the $.40 in the cost of the item, $.25 represents expenditures from outside the local area and $.15 represents expenditures in the local area. Of the $.50 in wages and profits retained by the owner as personal income, suppose that $.15 goes to personal taxes, $.05 is saved and $.05 is spent on items outside the local area. The following calculation summarizes the example to this point — the column on the left indicates the distribution of the initial $1.00 of gross receipts, and the column on the right shows how the individual spends the income.

Business Expenditures		Personal Expenditures	
$ .10	business taxes	$.15	personal taxes
.25	out-of-area cost	.05	savings
.15	local cost	.05	out-of-area spending
.50	wages and profits	.25	local spending
$1.00	total initial gross receipts	$.50	total wages and profits

From this information, the total amount of the initial $1.00 that is re-spent in the local community can be calculated. It is the amount the local business re-spends ($.15) and what the owner re-spends locally from his personal income ($.25), for a total of $.40, and this amount becomes gross receipts for other businesses in the area.

The total increase in gross receipts so far is $1.40 — the initial $1.00 spent by the out-of-state customer plus the $.40 re-spent within the local economy. The process continues and the next addition to gross receipts that results from the spending of the $.40 can be calculated. If the same cost and spending distributions are assumed, $.16 of the $.40 is re-spent in the economy in this third round. In the fourth round, $.064 would be spent. The amount re-spent becomes smaller and smaller in each round until it is too small to count. The total amount of gross receipts generated can be calculated and is equal to $1.65. The following table summarizes the multiplier process.

$1.00	initial spending
.40	second round
.16	third round
.064	fourth round
.0256	fifth round
$1.65	**Total Spending**

One dollar of new spending will recycle through the economy, generating total spending of $1.65. Thus, the multiplier for this hypothetical area is 1.65.

In the real world, the size of a community's multiplier is a function of the local economy's propensity to import from outside the area, the propensity of individuals to save and the amount of taxes paid. The larger and more diverse the economic base, the larger the multiplier will likely be as individuals will not need to go outside the area to buy desired goods and services. The estimates of the multiplier for the economy of the United States range from as low as 2.0 to as high as 4.0. Individual states will have multipliers lower than this, which usually range between 2.0 and 2.5. The smaller the economic unit analyzed, the smaller the multiplier, simply because the area is smaller and the economy is unlikely to be very diverse. Small bedroom communities near large cities will have multipliers very close to one.

New Mexico State Level Multipliers

For the current study, multipliers for the state of New Mexico were obtained from the U.S. Department of Commerce Bureau of Economic Analysis (BEA). The BEA has developed United States multipliers based on an input-output table reflecting the structure of 500 United States industries. This information in conjunction with state wage and salary data has allowed the BEA to estimate multipliers at the state level. The multipliers are calculated based on four-digit Standard Industrial Classification codes.[182]

The multipliers used for this study are based on the industry classification relating to health care expenditures. In addition to an output multiplier, earnings and employment multipliers are provided by the BEA. The multipliers used in this part of the report are listed in TABLE G. An earnings multiplier indicates the proportion of total output that represents earnings to someone in the state. An employment multiplier indicates the number of jobs that are generated in the economy for every $1 million in total output generated by the new spending.

The multipliers are interpreted in the following manner. The output multiplier for hospitals indicates that for $1.00 of expenditure made at a hospital, output for the state increases by $1.9631. The earnings multiplier indicates that $.7286 of each $1.00 of total output represents earnings to local households.[183] The employment multiplier indicates that for every $1 million of output gain, 25.0144 jobs are created in the state economy.[184]

TABLE G
BEA Multipliers

Expenditure Classifications	**Multipliers**		
	Output	**Earnings**	**Employment**
Offices of physicians, dentists and other health practitioners	1.9132	.8034	24.0465
Home health care services	1.9084	.8092	40.5944
Other health care services*	2.0001	.7236	25.7272

[182] A detailed description of the methodology used by the BEA in developing local multipliers is available at www.bea.doc.gov/rims.htm.
[183] Household earnings include wages and salaries paid to employees and proprietor incomes.
[184] Employment is a measure of the number of persons on the payroll of businesses. Most agricultural employment is excluded.

Hospitals	1.9631	.7286	25.0144
Nursing and residential care facilities	2.0446	.8278	39.8989
Insurance agencies, brokerages and other insurance-related activities	1.6408	.5198	19.1500
Prescription drugs (retail trade)	1.8124	.5746	28.3656

**Other health care services include behavioral health.*
Source: BEA RIMS Multipliers.

Health-Related Expenditures by the Federal Government
As noted elsewhere in this report, health-related expenditures by federal government entities made in the state of New Mexico were tabulated. The data included Medicare, Medicaid, Indian Health Service and Veterans Administration expenditures; expenditures made on behalf of federal employees and military personnel; expenditures by the national laboratories; and federal grants received by various state agencies from the federal government. Federal government health-related expenditures in the state of New Mexico totaled $4,967.53 million in 2002.

The federal expenditures were allocated to the appropriate categories as shown in TABLE H. The only difference between this allocation and that shown previously in this report is that behavioral health expenditures were allocated to the "other health care services" sector and prescription drugs are allocated to the "retail trade" sector.

TABLE H
Breakdown of Federal Health-Related Expenditures
(Calendar Year 2002)

Category	Amount (millions of $)
Offices of physicians, dentists and other health practitioners	580.97
Home health care services	490.27
Other health care services*	2,043.86
Hospitals	1,434.47
Nursing and residential care facilities	254.12
Agencies, brokerages and other insurance-related activities	20.53
Prescription drugs	143.31
Total Expenditures	**4,967.53**

**Other health care services include behavioral health.*

The Impact of Federal Health-Related Spending
The output, earnings and employment multipliers are applied to the amounts of expenditures listed in TABLE G to determine the overall effect on the state economy of

federal health-related expenditures. TABLE I provides the estimates of the impact on the state economy of each of the categories and the total impact of all spending.

TABLE I **Impact of Federal Health-Related Spending** **(Calendar Year 2002)**			
Expenditure Classifications	**Effects**		
	Output (millions of $)	**Earnings (millions of $)**	**Employment (# of jobs)**
Offices of physicians, dentists and other health practitioners	1,111.51	892.99	26,727.97
Home health care services	935.63	757.11	37,981.39
Other health care services*	4,087.92	2,958.02	105,170.80
Hospitals	2,816.01	2,051.74	70,440.75
Nursing and residential care facilities	519.57	430.10	20,730.42
Agencies, brokerages and other insurance-related activities	33.68	17.51	645.08
Prescription drugs	259.74	149.24	7,367.54
Total Impacts	**9,764.07**	**7,256.71**	**269,063.95**

**Other health care services include behavioral health.*
Source: Calculations by A. Popp, Dept. of Economics and International Business, NMSU, December 2004.

The impact of federal health care spending is substantial. Federal health-care-related spending in New Mexico totaled $4,967.53 million and represented about 25 percent of all federal spending in the state. Because of federal spending on health care, New Mexico's gross state product increased by over $9.7 billion, earnings for New Mexicans increased by $7.277 billion and the number of jobs in the state economy increased by 269,064. For 2002, New Mexico's gross state product is estimated to be about $56.5 billion. This indicates that federal spending on health care is responsible for over 17 percent of the New Mexico economy. Total earnings for New Mexico in 2002 were $33.274 billion. This means that federal health care spending is responsible for 21.7 percent of all earnings in New Mexico. Jobs in New Mexico in 2002 totaled 989,478 and non-farm jobs totaled 965,316. Federal spending on health care is responsible for 27.9 percent of all non-farm jobs in New Mexico.

The Effect of State Health Care Spending

In addition to the federal spending, the state of New Mexico, as indicated earlier, spends over $778 million directly on health care. This is an underestimate of total state spending. The state indirectly spends more because of tax revenues it does not receive. Businesses expense health care expenditures and, therefore, pay taxes on a smaller amount of profits. The forgone revenue is equivalent to a tax expenditure. Total tax receipts forgone are not estimated in this report and are not included in the amount of total state spending on health care.

The impact of state spending on the state economy is more difficult to estimate. The $778 million are not expenditures originating from outside the state, but represent tax revenues received from individuals from within and from outside the state. If these individuals did not have to pay these taxes, they would spend these funds in a different fashion than the state does. The following analysis assumes that all of the $778 million comes from residents of the state and, therefore, represents a decrease in their household incomes.

One other assumption is made for this section of the report: much of the federal spending on health care requires matching funds from the state. If the state did not provide matching funds, the federal expenditures would decrease (the effects of Medicaid spending if the state decreases the amount of matching funds are described below). For the following analysis, it is assumed that if the state decreased funding, no decrease in federal spending would occur.

The Effect of Taxation and Spending

Calculating the effect of state government spending on health care requires taking into account the effect of health care expenditures on the state budget. In calculating the effect of federal spending on health care, the implicit assumption is that changes in federal spending have an insignificant effect on the tax liability of New Mexico residents; however, this assumption is not viable when looking at state spending. Specifically, the New Mexico constitution requires that the state budget not operate in deficit. Accordingly, increased spending on health care necessitates increased taxes, but increased taxation reduces disposable income and, hence, reduces spending by households.

The BEA provides a multiplier for households that would represent the impact of increased (or decreased) household spending on the state economy. The output multiplier is 1.147, the earnings multiplier is .3327 and the employment multiplier is 14.9081. The $778 million represents the decrease in household spending power due to tax revenues received by the state. TABLE J provides a summary of the impact of this decrease in spending power. Because the state receives taxes of $778 million, gross state output would decrease by $892 million, earnings would decrease by almost $297 million and the state would lose 13,298 jobs.

TABLE J
Effect of a Decrease in Household Incomes
Due to Tax Revenues of $778 Million

	Output	Earnings	Employment
BEA Multipliers	1.1470	.3327	14.9081
Effects	**-$892.36 million**	**-$296.89 million**	**-13,298 jobs**

Source: Calculations by A. Popp, Department of Economics and International Business, NMSU, December 2004.

The effects in TABLE J would occur if the state taxed $778 million from residents and then did not spend the revenues. The state does spend these revenues on health care. The allocation of the $778 million to specific spending categories is presented in TABLE K.

TABLE K Breakdown of State Health-Related Expenditures (Calendar Year 2002)	
Category	**Amount (millions of $)**
Offices of physicians, dentists and other health practitioners	58.75
Home health care services	199.32
Other health care services*	332.48
Hospitals	95.08
Nursing and residential care facilities	48.69
Agencies, brokerages and other insurance-related activities	9.84
Prescription drugs	34.03
Total Expenditures	**778.19**

**Other health care services include behavioral health.*

The overall effects of these spending amounts are estimated in the same way as for federal expenditures. The spending in each category is multiplied by the appropriate multipliers and then summed to get the overall effect. These calculations are presented in TABLE L. Because of state expenditures on health care, total gross state output is increased by $1.5 billion, earnings are increased by $1.14 billion and the number of jobs is increased by 328,370.

TABLE L Impact of State Health-Related Spending (Calendar Year 2002)			
Expenditure Classifications	**Effects**		
	Output (millions of $)	**Earnings (millions of $)**	**Employment (# of jobs)**
Offices of physicians, dentists and other health practitioners	112.40	90.30	6,603.5
Home health care services	380.38	307.80	75,817.8
Other health care services*	664.99	481.19	221,097.0
Hospitals	186.65	135.99	17,746.8
Nursing and residential care facilities	99.55	82.41	4,847.2
Agencies, brokerages and other insurance-related activities	16.14	8.39	158.9
Prescription drugs	61.67	35.44	2,098.8
Total Impacts	**1,521.78**	**1,141.52**	**328,370.0**

**Other health care services include behavioral health.*
Source: Calculations by A. Popp, Dept. of Economics and International Business, NMSU, December 2004.

The net effect of taxing New Mexico residents and spending the revenues on health care is reported in TABLE M. The total output of the economy increases by $629.44 million,

the amount of earnings increases by $844.64 million and more than 315,000 new jobs are created.

TABLE M Net Effects of Taxing and Spending by the State			
Policy	**Effects**		
	Output (millions of $)	**Earnings (millions of $)**	**Employment (# of jobs)**
Taxation	-892.36	-296.89	-13,298
Spending	+1,521.80	+1,141.53	+328,370
Net Effect	**+629.44**	**+844.64**	**+315,072**

Source: Calculations by A. Popp, Dept. of Economics and International Business, NMSU, December 2004.

Medicaid Spending and Matching State Funding

The Medicaid program requires that the state provide matching funds. Federal and state Medicaid spending for 2002 is provided in TABLE N. The federal match is determined by a number of factors and is not the same for every category of spending nor is it the same for all states. The average matching percentage implied by TABLE N is 25 percent. For every $1.00 spent by the state on this program, the federal government provides an additional $3.00 of funding.

TABLE N Medicaid Expenditures (millions of $)			
Categories of Spending	**Federal Expenditures**	**State Expenditures**	**Total Expenditures**
Offices of physicians, dentists and other health practitioners	154.166	52.550	206.716
Home health care services	281.378	98.887	380.265
Other health care services*	305.176	91.758	396.934
Hospitals	296.169	94.670	390.839
Nursing and residential care facilities	139.125	48.687	187.812
Agencies, brokerages and other insurance-related activities	20.530	9.839	30.369
Prescription drugs	98.252	33.604	131.855
Total Expenditures	**1,294.793**	**429.995**	**1,724.788**

**Other health care services include behavioral health.*

The total effect of this spending is estimated using the same techniques applied in the previous sections of this report. The appropriate multipliers are applied to each of the categories of spending to derive the total effects on gross state product, earnings and

employment. For state expenditures, the total effects are adjusted for the decrease in spending by households from which the revenues are derived.

The result of this analysis is provided in TABLE O. The spending by state and federal governments results in an increase in total output of over $2.8 billion, an earnings increase of over $2.3 billion and an increase in the number of jobs of 94,288.

TABLE O
Impact of Medicaid Spending
(Calendar Year 2002)

Governmental Unit	**Effects**		
	Output (millions of $)	**Earnings (millions of $)**	**Employment (# of jobs)**
Federal	2,519.937	1,892.08	76,183.65
State	342.015	463.39	18,104.59
Total Impact	**2,861.952**	**2,355.47**	**94,288.24**

Source: Calculations by A. Popp, Dept. of Economics and International Business, NMSU, December 2004.

Given TABLE O, an analysis can be done of what would happen if the state decided to cut spending on Medicaid. TABLE P provides estimates of decreases in spending by the state of 10, 20 and 30 percent. It is assumed that for every $1.00 decrease in state spending, federal spending is decreased by $3.00. Every 10 percent cut in spending ($43 million in state spending and $129 million in federal spending) reduces state output by $285 million and earnings by over $234 million, and the state loses over 9,400 jobs.

TABLE P
Impact of Medicaid Spending Cuts by the State

Cut in Spending			**Impact**		
Percent Decrease	**Decrease in State Funding (millions of $)**	**Decrease in Federal Funding (millions of $)**	**Output (millions of $)**	**Earnings (millions of $)**	**Employment (# of jobs)**
10	43	129	-285.182	-234.867	-9,411.6
20	86	258	-570.364	-370.716	-18,823.2
30	129	387	-855.546	-704.601	-28,234.8

Source: Calculations by A. Popp, Dept. of Economics and International Business, NMSU, December 2004.

Summary and Conclusion

This part of the report has provided insight into the size of the health care industry in New Mexico and the impact of health care spending in the state on the state's economy.

The health and social services sector is used as an indicator of the size of the health care industry in New Mexico. This sector is only a part of the overall health care industry; it does not include professional and technical health care services, health and personal care stores and the health care insurance industry. Therefore, the use of this sector provides an underestimate of the actual size of the health care industry in New Mexico.

Through the 1990s, the proportion of total economic activity originating in the health and social services sector increased from 5.25 percent to 5.74 percent for the state of New Mexico. The level of compensation received by those in the health and social services industry grew faster than compensation in other sectors, resulting in health and human services compensation becoming a larger proportion of total compensation. In the late 1990s, compensation in health and human services was a larger proportion of total compensation in New Mexico (8.86 percent in 2000) than in the United States (8.67 percent in 2000). The percentage of jobs in the health and social services sector has increased from 2001 to 2003 for both New Mexico and the United States and is a larger proportion of jobs in New Mexico (10.4 percent in 2003) than in the United States (10.07 percent in 2003).

The impact of federal health care spending is substantial. In 2002, federal health-care-related spending in New Mexico totaled $4,967.53 million and represented about 25 percent of all federal spending in the state. Due to federal spending on health care, New Mexico's gross state product increased by over $9.7 billion and earnings increased by $7.256 billion, and the number of jobs increased by 269,064. For 2002, federal spending on health care was responsible for almost 17 percent of the output of the New Mexico economy, 21.7 percent of all earnings in New Mexico and 27.9 percent of all non-farm jobs in New Mexico.

The impact of state health care spending on the state is the net effect of the positive spending effect by the state government and the negative effect of taxing the residents of the state. Health care expenditures by the state totaled $778 million in 2002. The net effect of taxing New Mexico residents and spending the revenues on health care is that the total output of the economy increases by $629.44 million and the amount of earnings increases by $844.64 million, and more than 315,000 new jobs are created.

The Medicaid program requires that the state provide matching funds. Federal and state Medicaid spending for 2002 totaled $1,725 million. The average matching percentage implied by TABLE 11 is 25 percent. For every $1.00 spent by the state on this program, the federal government provides an additional $3.00 of funding. The spending by state and federal governments on Medicaid results in an increase in total output of over $2.8 billion, an earnings increase of over $2.3 billion and an increase in the number of jobs of 94,288.

The implications of state decreases in spending on Medicaid are provided in TABLE P. A $1.00 decrease in state spending implies a $3.00 decrease in federal spending. Every 10 percent cut in spending ($43 million in state spending and $129 million in federal spending) reduces state output by $285 million and earnings by over $234 million, and the state loses over 9,400 jobs.

Health care services have been, and will continue to be, an important part of the economy of New Mexico. Any changes in the amount of spending in this sector will have a substantial impact on the size of the state's economy.

POLICY IMPLICATIONS

This report indicates that about $8 billion was spent on health care in New Mexico in 2002. Such an expenditure has a significant impact on the state budget, other public bodies, private for-profit and nonprofit organizations and every resident of New Mexico.

The complexity of health care delivery, administration and financing requires an ongoing evaluation of how administrative and fiscal policy decisions are made at all levels. An increase or decrease in health care funding or a change in delivery or administration has a ripple effect on the health care system, regardless of whether the catalyst was publicly or privately initiated.

It is important, therefore, to develop a process whereby the state can assess the financing of health care based on verifiable, objective information. Financing health care is not as simple as obtaining a greater federal match or providing insurance coverage to more New Mexicans. Health care financing has a substantial impact on health care indicators, general employment, economic development, rural access and numerous other areas.

This report has provided a baseline of data and information on which the state must continue to study the financing of health care. A biennial health care financing study would provide the legislative and executive branches, as well as the public and private health care industry, with information to assist in the development of administrative and fiscal policy for the delivery and financing of health care.