LFC Requester:	Eric Chenier

AGENCY BILL ANALYSIS - 2025 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
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SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: 1/29/25
Bill Number: HB186

Check all that apply:
Original *X* Correction __
Amendment __ Substitute __

Sponsor: Rep. Szczepanski
Short Title: State-Administered Health Coverage Plan

Agency Name and Code Number: HCA 630
Person Writing Roy Burt
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY25	**FY26**		
$0.0	$2,000.0	Nonrecurring	General Fund

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY25	**FY26**	**FY27**		
$0.0	$0.0	$0.0	NA	NA

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

FY25	FY26	FY27	FY28	FY29	Recurring or Nonrecurring	Fund Affected
$0.0	$1,000.0	$6,538.9	$1,675,182.2	$3,350,364.5	Recurring	Federal Funds
$0.0	$1,000.0	$2,179.6	$619,935.1	$1,239,870.1	Recurring	General Fund
$0.0	**$2,000.0**	**$8,718.5**	**$2,295,117.3**	**$4,590,234.6**	**Recurring**	**TOTAL HCA IMPACT**

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to: Relates to HB400 from the 2023 legislative session

Duplicates/Relates to Appropriation in the General Appropriation Act: Not known

SECTION III: NARRATIVE

BILL SUMMARY

House Bill 186 (HB186) would enact a new section of the Public Assistance Act for the development of a Medicaid Forward Plan. The Health Care Authority (HCA) would be directed to amend the Medicaid State Plan to provide Medicaid by January 1, 2028, to residents who are under age 65, are not eligible for other full coverage Medicaid, and who have household income that exceeds 133% of the federal poverty level (FPL).

The HCA would be directed to consult with the Medicaid Advisory Committee and Indian Nations and Tribes to promulgate rules that establish an affordability scale for premiums and cost-sharing based on household income for individuals eligible to enroll in the Medicaid Forward Plan, and to offer discounted premiums and cost-sharing. An actuarial analysis is required to set the total amount of premiums to be assessed to Medicaid Forward Plan enrollees.

The HCA and the Superintendent of Insurance (OSI) may seek federal waivers to administer the Medicaid Forward Plan to additional persons to maximize federal dollars to ensure affordability for enrollees.

The HCA and OSI are directed to cooperate with the New Mexico Health Insurance Exchange to establish systems so that individuals may apply for enrollment in and receive an eligibility determination for the Medicaid Forward Plan or a qualified health plan, and to develop consumer outreach programs to assist with enrolling in Medicaid, the Medicaid Forward Plan, and qualified health plans offered through the New Mexico Exchange. The OSI and the New Mexico Health Insurance Exchange may coordinate efforts to make the Medicaid Forward Plan available for direct purchase through the exchange.

FISCAL IMPLICATIONS

Medicaid and the Income Support Division

There is not a sufficient appropriation to cover the programmatic or administrative costs anticipated from implementation of HB186. The total (state and federal) potential cost of this bill in FY28 is likely to be as high as $4,590,234.6 billion with a General Fund share of $1,239,870.1 billion (see tables).

HB186 would appropriate $2 million from the general fund to the HCA for use in fiscal years 2026 and 2027 to hire staff and to contract for consulting or technical assistance for the development of the Medicaid Forward Plan. The HCA assumes a 50% federal match on the $2 million general fund appropriation, which would bring the total to $4 million. The HCA assumes that $2 million would be expended in state fiscal year 2026 and $2 million in state fiscal year 2027.

The Medicaid program and administrative budgets will necessitate recurring general funds starting January 1, 2028, and ongoing, for the payment of coverage for the Medicaid Forward Plan enrollees and associated administrative expenses. These additional expenditure amounts would need to be requested and secured in the HCA FY28 budget request, as the existing appropriation in the bill is insufficient; and **assurance of the general fund share must be submitted with the federal approval request.** The increase in operational expenses regarding capitation premiums and administrative costs are discussed in the Medicaid Forward Report prepared by HCA's

contracted consultant (https://www.hca.nm.gov/medicaid-forward/).

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

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

	No income Limit with Enrollee Financial Responsibility	No income Limit without Enrollee Financial Responsibility
Increase in Member months	3,484,980	3,913,104
Increase in Members	290,415	326,092
Net Medicaid Program Cost	$3,724,051,480	$4,590,234,561
Federal Matching Funds	$2,729,181,382	$3,350,364,450
State Share of Net Capitation Costs and Administrative Expenses	$994,870,097	$1,239,870,111

There is significant uncertainty regarding the overall costs of implementing Medicaid Forward and potential impacts to the remainder of New Mexico's health insurance market.

The study estimates a significant increase in operational expenses from enrolling between 290,415 to 326,092 new members to the Medicaid program. The coverage of these new members could increase programmatic state costs between $994 million to $1,240 billion. The lower estimate above reflects members assuming financial responsibility while the higher estimate assumes no financial responsibility. These estimates are for the first year of implementation only and assume that the Centers for Medicare and Medicaid Services (CMS) would approve the state's expansion request and provide federal matching participation funds at 71.68%.

The estimate includes between $88 million and $92 million in funding for the administrative costs

of implementing Medicaid Forward. The additional administrative expenses include items such as: additional state staff (and associated costs for equipment and facilities) to process the higher Medicaid application volume in compliance with federal timeliness requirements and additional contract costs, such as for technical assistance with federal approvals or changes to IT systems that support Medicaid eligibility and enrollment and provider payments. Examples of administrative costs includ:

- $4 million in eligibility system changes and $4.7 million for changes to the claims payment, third-party liability, and customer portal systems, and programming for federally-required customer notices.

- Increased Medicaid enrollment will mean additional calls to the HCA Consolidated Customer Service Center (CCSC), necessitating more call staff at a cost of $100,000 per month. Additional design and development changes to CCSC systems would cost $1,500,000.00. Applying the standard cost allocation model would result in a 25% state fund to 75% federal fund split, or $375,000.00 state funds to $1,125,000.00 federal funds.

- The HCA Income Support Division (ISD) would be processing a significant volume of additional applications and renewals for Medicaid Forward Plan enrollees. Additional ISD staff (120 FTE) will be needed due to increased workload.

It should be also noted that these costs assume the HCA's base budget does not decrease, however ISD staff are critical to the implementation of Medicaid Forward and the FY26 LFC recommendation underfunds the ISD baseline budget significantly. ISD is narrowly meeting timeliness standards today and would be unable to remain timely with current HCA demands without a sufficient investment in FTE to accommodate the increased workload. Increasing the pool of potential HCA customers would adversely affect timeliness, hindering the HCA's ability to meet federal requirements and risking substantial federal financial penalties.

State Health Benefits

Data throughout this analysis is based on the November 2024 Mercer Government Human Services Consulting "Implementation of Medicaid Forward" report. Medicaid Forward could shift individuals from State Health Benefits (SHB) to Medicaid, reducing SHB claim expenditures; however, any reduction is not possible to quantify because the bill is not clear about what would happen to SHB funding or the structure of the SHB program if Medicaid Forward were to be implemented. The impact of Medicaid Forward on SHB would depend on eligibility criteria established for the program and the premium and cost-sharing structure.

Because the bill provides flexibility related to these program elements, SHB's analysis is based on assumptions used in Mercer's November 2024 analysis of Medicaid Forward that sets the maximum FPL at 400% FPL and includes a member responsibility arrangement as follows:

- No member financial responsibility under 200% FPL
- 2% of household income between 200-300% FPL
- 3.5% of household income between 300-400% FPL

SHB Plan Costs

According to Mercer's November 2024 study, 30,551, or 60.15%, of SHB enrollees would shift from SHB to Medicaid Forward under these program parameters. While the study did not break out the specific percentage reduction in state costs, the total level of SHB/NMPSIA/APS savings due to this enrollment shift would be $310,839.7. With 112,503 current enrollees in these insurance options, the average savings to the state per enrollee equals $2,762.95. If 30,551 SHB members switched to Medicaid Forward, the state would save $84,410.9. FY28 savings are half as much ($42,205.5) due to the program changes occurring halfway through the fiscal year.

SHB Member Costs

While Mercer's study did not examine how much Medicaid Forward enrollees would save compared to current arrangements, the study examined the difference in costs under specific household scenarios, as shown in the table below.

Comparison of Medicaid Forward Costs to State Health Benefits Plan

Potential Enrollee	Annual Income	State Employee Maximum Annual Health Care Costs	Medicaid Forward Maximum Health Care Costs (5% Limit)	Member Cost Difference
200% FPL Individual	$30,120	$6,544.66	$1,506	($5,038.66)
200% FPL Family of 4	$62,400	$19,556.76	$3,120	($16,436.76)
400% FPL Individual	$60,240	$8,089.32	$3,012	($5,077.32)
400% FPL Family of 4	$124,800	$24,113.52	$6,240	($17,873.52)
600% FPL Individual	$90,360	$8,089.32	$4,518	($3,571.32)
600% FPL Family of 4	$187,200	$24,113.52	$9,360	($14,753.52)

Source: Mercer November 2024 Report

The study estimated the total enrollee responsibility amount would equal $130,723.9 across 158,830 Medicaid Forward enrollees, for an average of $823 in premium and out-of-pocket costs per enrollee per year. Mercer's study estimates 30,551 SHB enrollees will switch to Medicaid Forward, meaning the total enrollee financial responsibility for those who switch would equal $25,143.5.

Under the FY26 Executive and LFC Budget Recommendations, state and local government employees enrolled in a State of NM health plan would pay $138,269.0 in premiums (assuming state employees pay 45% of premiums and local employees pay 20% of premiums) and $105,162.2 in out-of-pocket costs (assuming the average actuarial value for SHB plans is 82%), for a combined $243,431.2. SHB's enrollment census is higher than Mercer's projections, so if the amount above

is spread across 59,000 SHB enrollees, it equals $4,125.95 per enrollee per year. Among the 30,551 SHB enrollees who are expected to switch to Medicaid Forward, the total current SHB enrollee financial responsibility is projected to be $126,052.0.

This means that member premiums and cost sharing would be reduced by $100,908.5 (Current $126,052.0 minus $25,143.5 under Medicaid Forward). FY28 savings are half as much due to the program changes occurring halfway through the fiscal year.

Health Care Affordability Fund

Data throughout this analysis is based on the November 2024 Mercer Government Human Services Consulting "Implementation of Medicaid Forward" report.

Marketplace Affordability Program (MAP)

Per the Mercer analysis, enrollment in the BeWell Marketplace would decrease by 69.5% (enrollment decrease from 56,091 to 17,374) if Medicaid Forward eligibility was limited to 400% FPL and 88.9% (enrollment decrease from 56,901 to 6,302) if there is no income limit. Due to the reduction in Marketplace enrollment, state subsidy costs will decrease by 75.2% if Medicaid Forward eligibility was limited to 400% FPL and 93.3% if there was no income limit. Based on a June 2024 Wakely analysis that assumed 57,950 enrollees for FY28 with the expiration of the enhanced Federal Premium Tax Credit (and its resulting 75.2% decrease in subsidy costs), that would save $60,460.8 in HCAF funding; with a 93.3% decrease in subsidy costs, that would save $75,495.6 in HCAF funding.

Due to BeWell's record enrollment of 70,373 as of January 2025, HCA requested Wakely provide updated data on costs. Based on newly available data, HCA would expect an enrollment of 71,050 in FY28. In FY28, assuming an expiration of the enhanced Federal Premium Tax Credit, a 75.2% decrease in subsidy costs would save $67,755.2 in HCAF funds; a 93.9% decrease in subsidy costs would save $84,603.9 in HCAF funds. FY28 savings are half as much due to the program changes occurring halfway through the fiscal year. The percentage decrease in enrollment is different than the decrease in subsidy costs as different consumers are eligible for different levels of coverage. The "Estimated Additional Operating Budget Impact" data is based on income limits at 400% FPL and the June 2024 Wakely data.

The bill is not clear about what role the Exchange would play if Medicaid Forward were to be implemented. **Substantial reductions in Exchange and State Employee Health plan enrollment would destabilize those health plans and would likely render them financially insolvent.**

Small Business Health Insurance Premium Relief Initiative

According to Mercer's analysis, enrollment in private insurers offered by private employers would decrease by 9.4% if Medicaid Forward eligibility was limited to 400% FPL and 17.9% if there is no income limit. Based on Wakely data from June 2024, the Initiative would be expected to cover 37,500 employees in Coverage Year 2027. With a 10% premium reduction that small businesses receive under the Initiative, the HCA would expect to pay $42,300.0 in FY28 for this coverage.

With a 9.4% decrease in enrollees, that would save $3,976.2 in HCAF funds; with a 17.9% decrease, that would save $7,571.7 in HCAF funds. FY28 savings are half as much due to the program changes occurring halfway through the fiscal year. The "Estimated Additional Operating Budget Impact" data is based on income limits at 400% FPL.

Total HCAF Impact

With $67,755.2 in lower MAP spending and $3,976.2 in lower small business initiative spending, HCAF program spending would be $71,731.4 lower with the implementation of Medicaid Forward.

SIGNIFICANT ISSUES

Medicaid and Income Support Division

HB186 does not provide funding for anticipated MAD, ASPEN, MMIS, and call center and ISD staffing changes necessary to implement the Medicaid Forward Plan; or for the ongoing programmatic costs of coverage. The bill is not clear about what impacts would occur on the existing health insurance market in New Mexico.

Medicaid provider reimbursement is generally lower than reimbursement through commercial coverage. The bill does not contemplate what level Medicaid reimbursement would need to be set at to offset any reduction to provider payments resulting from the movement to Medicaid Forward. It is likely that Medicaid reimbursement rates would need to be increased under the proposed structure.

Health Care Affordability Fund

Consumers within the income range for Medicaid Forward are expected to transfer from private coverage to Medicaid Forward due to the anticipated cost savings. Per federal requirements, Medicaid Forward premiums and cost-sharing cannot exceed 5% of household income without an 1115 waiver. However, plans for consumers at 400% of the Federal Poverty Level and above on BeWell, the New Mexico Health Insurance Marketplace, currently have a maximum consumer contribution rate of 8.5% of household income (see table below with examples from Mercer's study).

Comparison of Medicaid Forward Costs to BeWell Costs

Potential Enrollee	Annual Income	BeWell Maximum Health Care Costs	Medicaid Forward Maximum Health Care Costs (5% Limit)	Member Cost Difference
200% FPL Individual	$30,120	$2,400.00	$1,506	($894.00)
200% FPL Family of 4	$62,400	$4,800.00	$3,120	($1,680.00)
400% FPL Individual	$60,240	$9,567.92	$3,012	($6,555.92)

400% FPL Family of 4	$124,800	$17,856.40	$6,240	($11,616.40)
600% FPL Individual	$90,360	$9,699.92	$4,518	($5,181.92)
600% FPL Family of 4	$187,200	$23,160.40	$9,360	($13,800.40)

Source: Mercer November 2024 Report

Under HB 186, financial assistance will be offered, "at a minimum, to households with incomes below four hundred percent of the federal poverty level." Based on July 2024 BeWell data, that means that 77.5% (45,792 individuals) of enrollees in BeWell would be eligible to receive financial assistance through enrollment in Medicaid Forward. Per the Affordable Care Act, to qualify for the PTC, an individual cannot be eligible for Medicaid. If these consumers become eligible for Medicaid, they will no longer be eligible for the PTC under the Affordable Care Act. Further, if they are not eligible for the PTC, they are not eligible for additional state subsidies, including premium and out-of-pocket assistance provided by the Marketplace Affordability Program under the Health Care Affordability Fund (HCAF). Though BeWell's core enrollment would be likely to decline significantly, HB 186 may include a substantial role for BeWell's platform to be used to enroll consumers in Medicaid Forward, thus maintaining their platform and staff.

Those who would enroll in coverage through BeWell for Medicaid Forward would be enrolling in a different benefits package than is currently offered in the form of Qualified Health Plans (QHPs) through BeWell. Per Mercer's "Implementation of Medicaid Forward" report, Medicaid Forward coverage is likely to be the standard Medicaid coverage that provides comprehensive physical and behavioral health services (mental health and substance use disorder), emergency services, dental and vision services, and non-emergency medical transportation services, as well as other services. Some of these benefits are not currently covered by QHPs. Additionally, stakeholder feedback provided in the Mercer report noted that there is a larger suite of behavioral health benefits in Medicaid coverage and the opportunity for more policy innovation.

Additionally, the Small Business Health Insurance Premium Relief Initiative may also be impacted by Medicaid Forward. If employees choose to enroll in Medicaid Forward over small group employer-sponsored coverage, the HCAF cost to support the Initiative's 10% premium discount may greatly decrease. Funding needs for most HCAF programs would likely diminish with the implementation of Medicaid Forward.

PERFORMANCE IMPLICATIONS

Medicaid is regulated by a complex set of laws and regulations. All of these laws and regulations would apply to the Medicaid Forward plan. These include provider payment methodologies and upper payment limits; customer-facing operations regarding eligibility, enrollment, recertification, and notices; protections and tracking of all out-of-pocket costs for customers; benefit package requirements; financial requirements; federal audits; beneficiary engagement rules; and provider network requirements. It is unlikely that New Mexico could meet the federal provider network

requirements for all New Mexicans in the Medicaid Forward plan with the state's current workforce shortages.

Failure to meet these complex and rigorous requirements results in financial penalties and funding withholds that are not contemplated in this analysis but which will present a risk to the state.

The bill does not clarify what would happen to the remainder of New Mexico's insurance market upon implementation of Medicaid Forward; however, these considerations are critically important to ensure that risk is appropriately managed and to prevent substantial destabilization. Under federal rules, Medicaid cannot utilize many of the other tools that are used to stabilize and predict risk, such as defined open enrollment periods and lock-out penalties for premium non-payment. Without these tools, and without clarifying the impact to the New Mexico's private insurance market, the Medicaid Forward bill presents some risk and uncertainty to the state that the HCA is unable to predict.

ADMINISTRATIVE IMPLICATIONS

Implementation of HB186 has numerous administrative implications. The HCA would be required to submit a Medicaid State Plan Amendment (SPA) for coverage of individuals with income exceeding 133% of the FPL. Implementation of premium and cost sharing requirements may require both a SPA and a federal Medicaid waiver; as well as rigorous tracking requirements that the agency does not do today. There are anticipated system changes which require state and vendor resources to implement. Promulgation of policy changes and the development of consumer outreach materials. Additional staffing would be needed for the HCA Consolidated Customer Service Center and ISD.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

None known

TECHNICAL ISSUES

None known

OTHER SUBSTANTIVE ISSUES

Cautionary Note on Medicaid Policy Changes in New Mexico

Given the transition to a new federal administration, significant policy changes at the federal level may impact New Mexico's Medicaid program. The new administration has previously advocated approaches such as block grants or per capita caps, which, if implemented, could alter the structure of federal Medicaid funding and increase fiscal uncertainty for the state.

Given New Mexico's high reliance on Medicaid, with over 40% of the population enrolled in the program, policymakers should consider the following key risks:

1. **Fiscal Impacts**: Changes to federal funding formulas could lead to budget shortfalls, potentially requiring the state to adjust eligibility criteria, reduce benefits, or increase state funding to maintain coverage levels.
2. **Beneficiary Impact**: Any changes in eligibility requirements, benefit packages, or funding

formulas could result in reduced coverage or services for vulnerable populations.

3. **Health Equity Concerns**: New Mexico's Medicaid expansion under the Affordable Care Act has been critical in reducing the uninsured rate, particularly in rural and tribal communities. Policy shifts that reduce federal support may reverse these gains.
4. **Administrative Challenges**: Greater flexibility in program design may result in additional administrative complexity and costs for the state Health Care Authority (HCA) in managing program changes and compliance.
5. **Uncertain Timelines**: The timing of federal legislative or regulatory changes remains unclear, complicating state-level planning for future Medicaid policy adjustments.

ALTERNATIVES

None suggested

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

Status quo

AMENDMENTS

None.