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# Health Policy for Low-Income People in New Mexico

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**B**y any number of measures, New Mexico faces some of the most daunting challenges among the 50 states in providing adequate health care for its low-income residents. New Mexico boasts a wealth of distinct cultures and traditions, yet economically it is a very poor state. On the basis of a composite of health measures, New Mexico ranked as the fourth-unhealthiest state in the nation.<sup>1</sup> Limited public and private resources as well as impasses between activist and fiscally conservative policymakers have made expansions in health insurance coverage and public health efforts difficult. Nonetheless, New Mexico has recently made insurance more available for children through a Medicaid eligibility expansion and the Children's Health Insurance Program (CHIP). The challenge remains to ensure that eligible children enroll and that managed care plans, with which the state has recently contracted, deliver high-quality care to these enrollees.

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Spaniards and Native Americans gave New Mexico its "mestizo" culture. Anglo-American roots in the state are tied to merchants and cattle barons, among others. New Mexico remains one of the most ethnically and racially diverse states in the country. In 1994-95, 40 percent of residents claimed Hispanic heritage, and about 10 percent classified themselves as Native American. Non-Hispanic whites made up less than half (49 percent) of the population, compared with 73 percent nationwide (table 1).

A "young" state, New Mexico has a smaller proportion of elderly people than the national average and the fourth-highest percentage of persons under age 18. The state's population experienced the eighth-fastest rate of growth in the country from 1990 to 1994, and its growth rate has continued to exceed the national average.

Ranking fifth in land mass, New Mexico contains only 0.7 percent of the United States population. Nearly half of state residents live in nonmetropolitan counties.<sup>2</sup>

## *Economics*

Along with Louisiana and Mississippi, New Mexico has consistently ranked as one of the three poorest states in recent years. As of 1997, nearly one-quarter of the state's population fell under the federal poverty level (FPL), about 10 percentage points lower than the national average. The percentage of New Mexican children below the FPL is even higher, at 30 percent. And the proportion of Native Americans living in poverty is higher still—about half in 1990.<sup>3</sup> Per

## State Characteristics

### *Demographics*

New Mexico, the 47th state, has a historically diverse population. The presence of Native Americans, primarily the Navajos and Pueblos, dates back thousands of years. Spanish explorers and settlers arrived in New Mexico in the 1500s. In the years that followed, the intermarriage of

**Table 1**  
**State Characteristics**

	<u>New Mexico</u>	<u>United States</u>
<b>Sociodemographic</b>		
Population (1994–95) <sup>a</sup> (in thousands)	1,743	260,202
Percent under 18 (1994–95) <sup>a</sup>	32.2%	26.8%
Percent 65+ (1994–95) <sup>a</sup>	10.8%	12.1%
Percent Hispanic (1994–95) <sup>a</sup>	39.8%	10.7%
Percent Non-Hispanic Black (1994–95) <sup>a</sup>	1.1%	12.5%
Percent Non-Hispanic White (1994–95) <sup>a</sup>	48.5%	72.6%
Percent Non-Hispanic Other (1994–95) <sup>a</sup>	10.6%	4.2%
Percent Noncitizen Immigrant (1996) <sup>b</sup>	5.8%	6.4%
Percent Nonmetropolitan (1994–95) <sup>a</sup>	49.3%	21.8%
Population Growth (1995–96) <sup>c</sup>	1.4%	0.9%
<b>Economic</b>		
Per Capita Income (1996) <sup>d</sup>	\$18,803	\$24,426
Percent Change in Per Capita Personal Income (1995–96) <sup>d</sup>	3.2%	4.6%
Percent Change in Personal Income (1995–96) <sup>d</sup>	4.7%	5.6%
Employment Rate (1997) <sup>e, f</sup>	59.6%	63.8%
Unemployment Rate (1997) <sup>f</sup>	6.2%	4.9%
Percent below Poverty (1994) <sup>g</sup>	21.6%	14.3%
Percent Children below Poverty (1994) <sup>g</sup>	29.8%	21.7%
<b>Health</b>		
Vaccination Coverage of Children Ages 19–35		
Months (1996) <sup>h, i</sup>	79.0%	77.0%
Low Birth-Weight Births (<2,500 g) (1995) <sup>j</sup>	7.5%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births)		
(1996) <sup>k</sup>	5.9	7.2
Premature Death Rate (Years Lost per 1,000) (1995) <sup>l</sup>	50.0	46.7
Violent Crimes per 100,000 (1996) <sup>m</sup>	840.6	634.1
AIDS Cases Reported per 100,000 (1996) <sup>n</sup>	12.0	25.2
<b>Political</b>		
Governor's Affiliation (1998) <sup>o</sup>	R	
Party Control of Senate (Upper) (1997) <sup>p</sup>	25D-17R	
Party Control of House (Lower) (1997) <sup>p</sup>	42D-28R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. CPS three-year average, March 1995–March 1997, where 1996 is the center year; edited by the Urban Institute to correct for misreporting of citizenship.

c. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1997* (117th edition). Washington, D.C., 1997. 1995 population as of April 1, 1996 population as of July 1.

d. Bureau of Economic Analysis, U.S. Department of Commerce, January 1998.

e. U.S. Department of Labor, *State and Regional Unemployment, 1997 Annual Averages*. USDL 98-78. Washington, D.C., February 27, 1998.

f. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

g. CPS three-year average (March 1994–March 1996, where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

h. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, "National Immunization Survey, 1996." *Morbidity and Mortality Weekly Report*, vol. 46, no. 29. Hyattsville, MD, July 25, 1997.

i. 4:3:1:3 series: four or more doses of DTP/DT, three or more doses of poliovirus vaccine, one or more doses of any MCV, and three or more doses of *Haemophilus influenzae* type b vaccine.

j. S.J. Ventura, J.A. Martin, S.C. Curtin, and T.J. Mathews. "Advance Report of Final Natality Statistics, 1995." *Monthly Vital Statistics Report*; vol. 45, no. 11, supp. Hyattsville, MD: National Center for Health Statistics, 1997.

k. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for June 1996." *Monthly Vital Statistics Report*; vol. 45, no. 12. Hyattsville, MD: Public Health Service, 1997.

l. Rate was calculated using years of potential life lost from age 65 (National Center for Health Statistics. Multiple Cause of Death Mortality Tapes, 1995) as the numerator and population estimates (U.S. Bureau of the Census. ST-96-1 Estimates of the Population of States: Annual Time Series, July 1, 1990 to July 1, 1996) as the denominator.

m. U.S. Department of Justice, FBI. *Crime in the United States, 1996*. September 28, 1997.

n. Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report, 1996*; vol. 8, no. 2.

o. National Governors' Association. *The Governors, Political Affiliations, and Terms of Office, 1998*. January 15, 1997.

p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update*. D indicates Democrat and R indicates Republican.

capita income is growing but at a slower pace than in the nation overall—3.2 percent from 1995 to 1996, compared with a national average of 4.6 percent.

The state's unemployment rate, although declining, exceeded the national average in 1997—6.2 percent versus 4.9 percent. In 1997, the state ranked 30th in job growth, the largest amount of which occurred in manufacturing. New Mexico currently has a small manufacturing base; the state ranked 45th in the percent of people employed in this sector in 1996.<sup>4</sup> Agriculture, on the other hand, is somewhat more important to the state economy than in the nation as a whole, with cattle and dairy accounting for the majority of what is produced.<sup>5</sup> Following the service sector, the largest employment sector in New Mexico is federal, state, and local governments, employing 25 percent of nonfarm workers in 1997.

### Health Status

New Mexico has made headlines recently for having the largest number of plague and hantavirus cases in the nation. Yet the mortality and morbidity stemming from these viruses pale in comparison to other health problems faced by the state. Many of New Mexicans' health problems are linked to self-destructive behavior: While the state has low death rates for heart disease, cancer, and cerebrovascular disease relative to other states (partly because of its younger population), it ranks among the top four states in death rates for chronic liver disease and cirrhosis, suicide, and accidents/adverse effects, including motor vehicle accidents.<sup>6</sup> The state's premature death rate (potential years of life lost for all causes before the age of 65 per 1,000 population) was higher than the national average in 1995: 50.0 versus 46.7 (table 1).

New Mexico ranked fifth among the states in the percentage of births to teenagers in 1996—17.9 percent of all births compared with 12.9 percent nationally.<sup>7</sup> Nonetheless, the infant mortality rate, at 5.9 deaths per 1,000 live births, was lower than the national rate of 7.2 in 1996, reflecting the better birth outcomes found within the Hispanic population. Another positive health status indicator is New Mexico's immunization rate: At 79 percent in 1996, it slightly exceeded the national average. Moreover, the number of

AIDS cases reported per 100,000 population in New Mexico was less than half the national incidence in 1996.

### **Health Care Market**

Like many health care markets in the country, New Mexico's health care environment is characterized by heightened competition, primarily as a result of managed care. Albuquerque, in particular, has been described as one of the leading managed care markets in the nation. As large employers, including the state government, have negotiated more aggressively on price and service, profit margins of HMOs in the state have been shrinking. For example, between 1992 and 1994, four of five HMOs in Albuquerque experienced a drop in their profitability. In response, HMOs in New Mexico have raised their premiums between 4 and 7 percent in 1998 after several years of relatively flat growth.<sup>8</sup>

As of 1996, the largest HMO in the state was Lovelace Health Systems, followed by Presbyterian Healthcare Services. In 1997, Presbyterian purchased FHP New Mexico, making Presbyterian the largest HMO in the state with more than 200,000 members. Approximately 19 percent of the state's insured population was enrolled in an HMO in 1996.<sup>9</sup> This percentage has undoubtedly increased since 1996, in large part because of the enrollment of 200,000 Medicaid recipients in HMOs in 1997–98.

Hospitals in New Mexico are taking steps to strengthen their position in the evolving market. At least 24 non-profit hospitals and health care systems in Texas and New Mexico recently formed VHA Southwest, a cooperative of nonprofit hospitals. The new organization offers financial and managerial resources to support community-controlled hospitals, partly to serve as a buttress against for-profit conversions. In addition, hospitals have entered the managed care market. The state's two major HMOs, Presbyterian and Lovelace, originated from hospitals bearing the same names. Most recently, St. Joseph Healthcare System, an Albuquerque-based chain of four hospitals, developed a risk-bearing provider-sponsored organization to serve Medicare beneficiaries; approval of its federal license was pending as of July 1998.

### **Political Environment**

For the last half of the decade, health policy developments in New Mexico have occurred in a climate of partisan wrangling and tight budgets. Democrats have dominated politics in New Mexico in recent history, and they currently hold a strong majority in both the state senate and house. In the 1996 elections, however, Republicans gained six seats in the legislature. Moreover, in 1994 New Mexico elected a Republican governor, Gary Johnson, on the heels of a Democratic governor, Bruce King. Johnson has made a reputation of wielding his veto power; he vetoed some 200 bills in 1995, more than any other New Mexico governor.<sup>10</sup> For fiscal year 1995–96, Johnson vetoed an estimated 75 to 80 percent of new spending proposed by the legislature for health and social services.<sup>11</sup> As of May 1998, the legislature had overridden only one of his vetoes—a bill to increase home and community-based care for the disabled. Johnson has cut state budget growth to about 5 percent per year, half the level it reached in the last year of his predecessor's term.<sup>12</sup>

Under the King administration, New Mexico gave serious consideration to a universal health insurance program. Two Democratic members of the house introduced legislation for Canadian-style health insurance in January 1993, called New Mexicare. Funding for the program was to include federal and state monies already designated for health care (e.g., Medicaid), individual premiums based on a sliding scale according to income, and a payroll or income tax. Within a month, after public uproar over the new tax and the cross-subsidy for the poor, the New Mexicare plan was tabled in committee. After the failure of New Mexicare, the legislature established a task force, which included nonlegislative members, to study health reform options. The task force eventually turned much of its attention to expanding coverage under Medicaid and private insurance reforms.

### **Health Insurance Coverage**

The legislative attention given to expanding health insurance coverage originates from concerns about the state's high percentage of residents. In 1994–95, New Mexico had one of the

highest uninsurance rates in the country. Approximately one-quarter of the nonelderly population (25.6 percent) in New Mexico had no health insurance, compared with 15.5 percent in the United States (table 2). The disparity primarily lay in the proportion of nonelderly covered by employer-sponsored insurance. Only one-half of New Mexicans had such coverage versus two-thirds nationwide. Although the uninsurance rate for children is lower than that for the general population, the gap between New Mexico's rate and the national rate is striking. In 1994–95, the fraction of uninsured children ages 0–18 was twice as high in New Mexico as the national average (20.9 percent versus 10.4 percent). New Mexico is one of three states (along with Texas and Louisiana) with the highest percentage of uninsured children.<sup>13</sup>

As expected, the prevalence of uninsurance is much higher among the low-income population (those under 200 percent of the FPL) than among the general population. In New Mexico, 37.4 percent of this subset of the population was uninsured in 1994–95, which far surpassed the national average of 25.3 percent. Medicaid covers a similar portion—about one-third—of the low-income population in both New Mexico and the nation. However, because of the state's greater concentration of poverty, Medicaid covers a larger proportion of the entire population in New Mexico than it does in the nation overall (16.0 percent versus 12.2 percent).

### **Medicaid Eligibility**

Eligibility for New Mexico's Medicaid program is generous and strict at the same time, depending on eligibility category. On the one hand, the income threshold of the state's Aid to Families with Dependent Children (AFDC) program in 1996, which is one basis for determining eligibility for Medicaid, is below the national median (36 percent of the FPL, compared with 39.5 percent). Moreover, the state does not offer an optional medically needy program. Yet New Mexico has been generous in its coverage of children and pregnant women. The state covers pregnant women and infants up to 185 percent of the FPL (133 percent is the mandatory minimum). And, as recommended by the

**Table 2**  
**Health Insurance Coverage**

Health Insurance 1994–1995	New Mexico	United States
<b>Nonelderly Population</b>		
Percent Uninsured <sup>a</sup>	25.6 %	15.5 %
Percent Medicaid <sup>a</sup>	16.0	12.2
Percent Employer-Sponsored <sup>a</sup>	49.9	66.1
Percent Other Health Insurance <sup>a, b</sup>	8.5	6.2
<b>19–64 Population</b>		
Percent Uninsured <sup>a</sup>	28.4	17.9
Percent Medicaid <sup>a</sup>	7.0	7.1
Percent Employer-Sponsored <sup>a</sup>	53.8	67.8
Percent Other Health Insurance <sup>a, b</sup>	10.8	7.2
<b>0–18 Population</b>		
Percent Uninsured <sup>a</sup>	20.9	10.4
Percent Medicaid <sup>a</sup>	31.1	23.1
Percent Employer-Sponsored <sup>a</sup>	43.4	62.5
Percent Other Health Insurance <sup>a, b</sup>	4.6	4.0
<b>&lt;200% of the Federal Poverty Level,</b>		
<b>Nonelderly Population</b>		
Percent Uninsured <sup>a</sup>	37.4	25.3
Percent Medicaid <sup>a</sup>	31.7	34.1
Percent Employer-Sponsored <sup>a</sup>	21.9	33.9
Percent Other Health Insurance <sup>a, b</sup>	9.0	6.7

a. Two-year concatenated March CPS files, 1995 and 1996. These files are edited using the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

task force that emerged from the defeat of New Mexicare, Governor King signed legislation in 1994 to appropriate funds to expand Medicaid eligibility to cover children through age 18 whose family incomes are below 185 percent of the FPL. In 1998, the state also expanded family planning services to all women up to 185 percent of the FPL under a five-year pilot project.

The eligibility expansion for children was heralded as a means of substantially reducing the state's uninsured rate; however, many of those who are eligible have not enrolled in the program. According to one estimate, of the 124,000 uninsured children in the state, 107,000 are eligible for Medicaid but not enrolled.<sup>14</sup> This situation has been blamed on inadequate outreach efforts by the state, including the removal of 20 "outstated" eligibility workers from hospitals, and the reluctance of some people to apply for public assistance. Observers emphasize that the state has

a disincentive to enroll eligible persons because of the impact it would have on the Medicaid budget.<sup>15</sup> An increasing number of eligible persons may fail to enroll in Medicaid, as Temporary Assistance for Needy Families (TANF) rolls shrink and persons become eligible for Medicaid through poverty criteria (which requires an application) rather than being automatically provided a Medicaid card as an AFDC recipient. New Mexico's AFDC/TANF caseload declined by 20 percent from 1994–1997 (a drop from 102,200 to 81,500), somewhat less than the average decline of 23 percent for all states.<sup>16</sup>

Recently, New Mexico has taken steps to increase enrollment of eligible persons in the Medicaid program, including a large outreach effort and a guarantee of 12 months' continuous eligibility. The legislature has also established a contingency fund to cover 40,000 new Medicaid eligibles as they enroll.

### *Other State and Local Programs to Increase Health Care Coverage*

Beyond Medicaid, New Mexico does not administer any large-scale, publicly funded insurance programs for its needy citizens. Nearly all counties (29 of 33), however, support indigent health care programs for their uninsured residents. County indigent funds, supported by local sales taxes, reimburse providers for services provided to indigent patients. Combined, the funds disburse about \$23 million annually; some \$10 million goes to providers, and the balance covers the counties' contribution to the Medicaid program. The state also operates a high-risk insurance pool, which covered 1,124 persons in 1995.<sup>17</sup> In 1994 the state established by statute an insurance purchasing pool, the New Mexico Health Insurance Alliance, for small businesses and self-employed persons. The alliance is a private entity and receives no state funding; the pool had 3,800 persons in 1996.

### *Private Insurance Reforms*

In its attempts to increase health insurance coverage, the state has focused attention on reforming the small-group and individual insurance markets. Before the passage of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, which instituted several changes in these insurance markets, New Mexico had undertaken its own reforms. As early as 1984, New Mexico passed a law requiring that persons obtaining health insurance through a group be allowed to convert to nongroup coverage. In compliance with HIPAA, this group-to-individual portability is now available through the state's high-risk pool or the New Mexico Health Insurance Alliance. Insurance reforms enacted by the state in 1991 required that insurers renew small-group policies except in cases of fraud, nonpayment, and so on—known as "guaranteed renewability." In 1994, the state passed legislation to limit pre-existing condition exclusions to six months after the person enrolls in the plan; the limit applies to conditions treated or diagnosed up to six months before enrollment. Exclusion periods elapsed under a previous policy must be credited under a new policy. These 1994 provisions applied to both the

small-group and individual markets. Throughout the 1990s, New Mexico has also passed legislation to improve the affordability of small-group policies, including rate bands and community rating provisions.

With the passage of HIPAA, the state had to make some adjustments to its insurance laws. The most important changes were to establish guaranteed renewability in the individual market and guaranteed issue of health insurance products to small groups, regardless of past claims experience or group health status.

In addition to enacting laws to improve the availability of private insurance, New Mexico has sought to improve insurance practices, especially among HMOs. The state Corporation Commission, which regulates insurance as well as other services in the state, has issued numerous rules, including a 48-hour minimum maternity stay, direct access to obstetricians/gynecologists, and coverage of adult check-ups and well-child care. A patient protection act, which would have instituted grievance procedures and gag rule protections,

was vetoed by Governor Johnson in April 1997 because of his concern that premiums would rise. However, in 1998, the governor signed patient protection legislation, which was largely a formality since the Corporation Commission had implemented most of the reforms through the regulatory process.

## Medicaid Expenditures and Enrollment

New Mexico operates a \$1 billion Medicaid program. With a 73 percent federal matching rate, the state spends one dollar for every three spent by the federal government on the program. Whether measured by state general-fund expenditures or combined state and federal dollars, in 1995 Medicaid was the third-largest program in the state budget, after K–12 education and higher education. From 1990 to 1995, Medicaid was the second-fastest-growing program, trailing AFDC.<sup>18</sup>

New Mexico's Medicaid program has experienced a string of budget overruns in the past few years. Most recently, in November 1996, the Medicaid

budget was \$40 million short of projected expenditures for state fiscal year (SFY) 1996–97. At the same time, the state had a \$13 million shortfall it was attempting to cover from the previous fiscal year (SFY 1995–96).<sup>19</sup> (The state blamed excess spending in SFY 1995–96 on higher-than-expected home and community-based care expenditures.<sup>20</sup>) As of March 1997, the state had increased the projected shortfall for SFY 1996–97 to \$65 million.<sup>21</sup> These shortfalls have been covered by supplemental appropriations by the legislature, as required to balance the state's budget.

Throughout the 1990s, growth in New Mexico's Medicaid program has outstripped the national average. Even as spending growth fell to about 6 percent per year nationwide from 1994 to 1996, expenditures rose at an average annual rate of 16 percent in New Mexico (table 3). In particular, spending on children and the disabled rose dramatically from 1994 to 1996, by 25 percent and 20 percent per year, respectively. In 1996, spending per disabled enrollee (\$8,559) and child enrollee (\$1,193) both slightly exceeded the national aver-

**Table 3**  
**Medicaid Expenditures**  
**by Eligibility Group and Type of Service,**  
**New Mexico and United States**  
(Expenditures in Millions)

	New Mexico				United States			
	Expenditures	Average Annual Growth			Expenditures	Average Annual Growth		
	1996	1990–92	1992–94	1994–96	1996	1990–92	1992–94	1994–96
<b>Total</b>	<b>\$936.8</b>	<b>30.6%</b>	<b>14.4%</b>	<b>16.4%</b>	<b>\$160,968.6</b>	<b>27.1%</b>	<b>9.4%</b>	<b>6.2%</b>
<b>Benefits</b>								
Benefits by Service	886.8	30.0	15.1	16.2	140,290.1	18.8	11.2	7.7
Acute Care	613.7	32.8	18.3	16.3	84,666.5	22.3	13.5	9.0
Long-Term Care	273.1	25.2	8.8	16.0	55,623.6	14.6	8.1	5.9
Benefits by Group	886.8	30.0	15.1	16.2	140,290.1	18.8	11.2	7.7
Elderly	143.0	17.6	10.7	6.5	42,418.5	16.7	8.3	6.2
Acute Care	37.1	14.0	16.5	7.3	11,229.3	18.9	12.4	11.0
Long-Term Care	105.9	18.7	8.9	6.3	31,189.2	16.0	7.1	4.6
Blind and Disabled	381.7	20.5	22.5	20.3	56,601.3	17.6	13.8	10.5
Acute Care	233.4	20.9	29.3	17.0	33,880.1	22.9	16.7	12.3
Long-Term Care	148.3	20.0	12.5	25.9	22,721.2	11.9	10.2	7.8
Adults	105.1	21.3	17.7	1.3	16,956.6	21.4	9.2	4.8
Children	257.0	73.3	7.1	25.0	24,313.8	23.8	12.8	6.5
<b>Disproportionate Share Hospital Administration</b>	<b>11.9</b>	<b>243.4</b>	<b>-18.3</b>	<b>22.5</b>	<b>15,102.6</b>	<b>263.4</b>	<b>-2.1</b>	<b>-5.7</b>
	38.1	16.3	14.7	19.9	5,575.9	9.8	13.1	7.1

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

ages for these two groups (table 4). Moreover, child and disabled enrollees accounted for a much larger share (72 percent) of spending on benefits in the program compared with the national average (58 percent). Consistent with the state's relatively youthful population, only 30 percent of Medicaid spending on benefits was for long-term care (70 percent for acute care), versus national averages of 40 percent and 60 percent, respectively.

In 1996, approximately 340,000 New Mexicans were enrolled in Medicaid for at least part of the year. Enrollment trends show once more that the disabled and children are the driving force behind program growth in the state. Between 1994 and 1996, adult enrollment fell by 4 percent annually, and elderly enrollment grew by only 3 percent. In contrast, the number of disabled enrollees grew by an average of 6 percent per year, and the number of children grew by 13 percent (table 4). Nationwide, child enrollment in Medicaid fell slightly as a result of shrinking AFDC rolls; however, in New Mexico this trend was offset by the state's eligibility expansion for children in 1994.

New Mexico's disproportionate

share hospital (DSH) program is small compared to many states. It constituted only 1.3 percent of the state's Medicaid budget in 1996 versus 9.4 percent nationwide. The program has grown significantly, however, from \$1 million in 1990 to \$12 million in 1996 (table 3).

## Current State Health Policy Issues

### Medicaid Managed Care

On July 1, 1997, New Mexico began implementation of its mandatory HMO program for most Medicaid recipients. Before this, the state had operated a primary care case management program, referred to as a primary care network. Operating under a 1915(b) freedom-of-choice waiver, the primary care network was implemented in 1991 and was phased in until it was available statewide. Both AFDC/AFDC-related and Supplemental Security Income (SSI) populations participated in the primary care network.

Although the state legislature endorsed a managed care system for the Medicaid population in 1994, it was not until 1996 that the state began the

process of converting the primary care network into a "privatized" system run by HMOs. Prompted by program growth in excess of 20 percent in the preceding year, Governor Johnson pushed for speedy implementation of the managed care reforms, with the expectation that HMOs could achieve 10 to 25 percent savings and better service. Requests for proposals from HMOs were solicited in October 1996, and implementation was to begin April 1, 1997. Some legislators expressed concern that the administration was moving ahead too rapidly, without due preparation, and critics questioned how the projected savings would be achieved.<sup>22</sup> Health care providers lobbied the state to exempt rural and mental health patients from HMO enrollment. Still others questioned the state's decision to offer statewide contracts as opposed to regional contracts, since the latter would allow provider-sponsored networks and smaller managed care organizations the chance to participate.<sup>23</sup>

By late 1996, legislators were discussing a package of proposals to delay the movement to managed care by a year. Moreover, the Health Care Financing Administration (HCFA) called the

**Table 4**  
**Medicaid Enrollment**  
**and Expenditures per Enrollee:**  
**Contributions to Total Expenditure Growth**

	New Mexico				United States			
	1996	Average Annual Growth			1996	Average Annual Growth		
		1990-92	1992-94	1994-96		1990-92	1992-94	1994-96
<b>Elderly</b>								
Total expenditures on benefits (millions)	\$886.8	17.6%	10.7%	6.5%	\$42,418.5	16.7%	8.3%	6.2%
Enrollment (thousands)	20.5	7.5%	4.4%	2.5%	4,103.2	5.1%	4.0%	0.3%
Expenditures per enrollee	\$6,971	9.3%	6.0%	4.0%	\$10,338	11.0%	4.2%	5.8%
<b>Blind and Disabled</b>								
Total expenditures on benefits (millions)	\$381.7	20.5%	22.5%	20.3%	\$56,601.3	17.6%	13.8%	10.5%
Enrollment (thousands)	44.6	12.6%	11.6%	6.2%	6,698.2	9.8%	10.8%	5.8%
Expenditures per enrollee	\$8,559	7.1%	9.8%	13.2%	\$8,450	7.1%	2.7%	4.4%
<b>Adults</b>								
Total expenditures on benefits (millions)	\$105.1	21.3%	17.7%	1.3%	\$16,956.6	21.4%	9.2%	4.8%
Enrollment (thousands)	59.4	21.8%	10.9%	-3.5%	9,225.0	11.4%	6.8%	-1.5%
Expenditures per enrollee	\$1,771	-0.3%	6.1%	5.1%	\$1,838	8.9%	2.2%	6.3%
<b>Children</b>								
Total expenditures on benefits (millions)	\$257.0	73.3%	7.1%	25.0%	\$24,313.8	23.8%	12.8%	6.5%
Enrollment (thousands)	215.4	29.5%	10.4%	12.7%	21,270.5	13.1%	6.6%	-0.1%
Expenditures per enrollee	\$1,193	33.8%	-3.0%	10.9%	\$1,143	9.5%	5.8%	6.7%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Note: Expenditures exclude disproportionate share hospital payments and administrative costs.

state's plans "overly ambitious" and requested additional information before it would approve the necessary 1915(b) waiver.<sup>24</sup> In response to the concerns of legislators and HCFA, in March 1997 the Johnson administration announced it would spread enrollment over the period July 1997 to May 1998, rather than over the proposed 90-day period beginning in July.<sup>25</sup> In March 1997, through a competitive bidding process, three HMOs—Presbyterian Health Plan, Lovelace Health Systems, and Cimarron HMO—were awarded contracts to provide care to 200,000 of the state's 250,000 Medicaid beneficiaries,<sup>26</sup> under the state's managed care program SALUD! Federal approval of the 1915(b) waiver request followed soon after.

Phase 1 of enrollment began in the urban areas. The fourth and final phase was completed June 1, 1998, achieving statewide HMO enrollment of all TANF, TANF-related, and SSI recipients. Dually eligible beneficiaries and institutionalized populations are excluded from managed care; and Native Americans, about 30,000 of whom are eligible for Medicaid, may opt out and remain in the fee-for-service system. As of July 1998, a contingent of tribal representatives was proceeding with plans to establish an HMO to serve Medicaid-eligible Native Americans in the state.

### Children's Health Insurance Program

On March 6, 1998, Governor Johnson signed a bill to expand the Medicaid eligibility ceiling for children ages 0–18 from 185 percent to 235 percent of the FPL using Children's Health Insurance Program funds. Under CHIP, New Mexico is eligible for about \$58 million in federal funds for fiscal year 1998. Its federal matching rate for CHIP is 81 percent. Thus, to draw upon the full federal allotment, the state would need to contribute approximately \$14 million.

Even with the substantial eligibility expansion to 235 percent of the FPL, New Mexico will not be able to spend its full CHIP allotment. Because the state had already expanded Medicaid eligibility to 185 percent of the FPL and the majority of uninsured children fall below this threshold, the state must cover them under Medicaid at the lower federal matching rate. Thus, New Mex-

ico is essentially penalized for its earlier efforts to expand coverage. The state estimates that 5,500 children will qualify for Medicaid coverage under CHIP, at a cost of about \$3 million annually to the state. Because the state will use only a fraction of its CHIP allotment, it has proposed to the federal government to use the remaining CHIP monies for special services, including home visits for newborns and developmental disability services, for all children under 235 percent of the FPL. This proposal has not yet received federal approval. The New Mexico legislature has appropriated revenues from existing sources to finance the state's share of CHIP funding; the governor vetoed a bill to increase the state cigarette tax to support the CHIP expansion.

## Conclusions

New Mexico's long-standing problems of poverty and a high uninsurance rate present formidable barriers to improving access to health care for its population. Nonetheless, the state has not shied away from instituting private insurance reforms and expansions in Medicaid eligibility, including the CHIP expansion. Some of New Mexico's efforts to expand Medicaid have fallen short of their objective because of low participation rates among eligible state residents. There is some concern that aggressive enrollment strategies now under way, if successful, may strain the state budget. However, with the ambitious movement of most recipients into HMOs, it is anticipated that the Medicaid budget will be more predictable and contained than it was under the fee-for-service system.

## Notes

1. "Health Rankings—MN Tops, LA Carries Bottom," *American Health Line*, 11/22/96. Primary source: 1996 Reliastar health rankings.
2. Statistics not found in table 1 are from [www.nmsu.edu/~bho/bho/demograp.html](http://www.nmsu.edu/~bho/bho/demograp.html); [www.edd.state.nm.us/ECONOMIC/RESEARCH/research.htm](http://www.edd.state.nm.us/ECONOMIC/RESEARCH/research.htm); and [www.census.gov/statab/www/states/nm.txt](http://www.census.gov/statab/www/states/nm.txt).
3. [www.nmsu.edu/~bho/bho/demograp.html](http://www.nmsu.edu/~bho/bho/demograp.html).
4. [www.census.gov/statab/www/states/nm.txt](http://www.census.gov/statab/www/states/nm.txt).
5. U.S. Bureau of the Census and [nmdaweb.nmsu.edu/MD/Agfact95.htm](http://nmdaweb.nmsu.edu/MD/Agfact95.htm).

6. *Gale State Rankings Reporter*, Gary Alampi, editor, Gale Research, Inc., Detroit, MI, 1994. Primary source: U.S. National Center for Health Statistics, *Monthly Vital Statistics Report*.

7. [www.nmsu.edu/~bho/bho/demograp.html](http://www.nmsu.edu/~bho/bho/demograp.html).

8. "New Mexico HMOs: Raising Rates," *American Health Line*, August 24, 1998.

9. American Association of Retired Persons, *Reforming the Health Care System: State Profiles 1997*, The Public Policy Institute, AARP, 1997. Primary source: Interstudy.

10. [www.abqjournal.com/news/legis/2legis1-31.htm](http://www.abqjournal.com/news/legis/2legis1-31.htm).

11. "New Mexico: Governor Vetoes Funding for Preventive Health," *American Health Line*, 3/29/95.

12. [164.64.43.1/pubaccess/1-2098/SOSCOPY.htm](http://164.64.43.1/pubaccess/1-2098/SOSCOPY.htm).

13. "Children's Health—One in Three Lack Insurance," *American Health Line*, 3/27/98.

14. [www.abqjournal.com/news/xgr98/3legis2-13.htm](http://www.abqjournal.com/news/xgr98/3legis2-13.htm).

15. "N.M. Kids Miss Out on Care," *Albuquerque Journal*, 11/3/97.

16. The Urban Institute, 1998. Based on ACF-3637, Statistical Report on Recipients under Public Assistance.

17. American Association of Retired Persons, *Reforming the Health Care System, State Profiles 1996*, Washington, D.C.: AARP, 1996.

18. National Association of State Budget Officers, *1992 State Expenditure Report* (April 1993) and *1996 State Expenditure Report* (April 1997).

19. "Officials Debate Impact of Managed Care Reforms," *American Health Line*, 11/19/96.

20. "Waiver Program Causes Medicaid Budget Shortfall," *American Health Line*, 6/18/96.

21. [www.abqjournal.com/news/legis/1legis2-4.htm](http://www.abqjournal.com/news/legis/1legis2-4.htm).

22. "New Mexico Moves Forward with Medicaid Managed Care," *American Health Line*, 8/16/97; "Proposed Managed Care Savings Questioned," *American Health Line*, 8/21/96.

23. "Officials Launch Plan to Convert Medicaid to Managed Care by Early 1997," *Health Care Policy Report*, vol. 4, The Bureau of National Affairs, 9/9/96.

24. "Feds Put Medicaid Managed Care on Hold," *American Health Line*, 2/21/97.

25. "New Mexico Delays Medicaid Privatization Plan," *American Health Line*, 3/3/97.

26. This number is lower than the enrollment total reported earlier because it reflects average monthly caseload as opposed to those "ever on" in a given year.



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