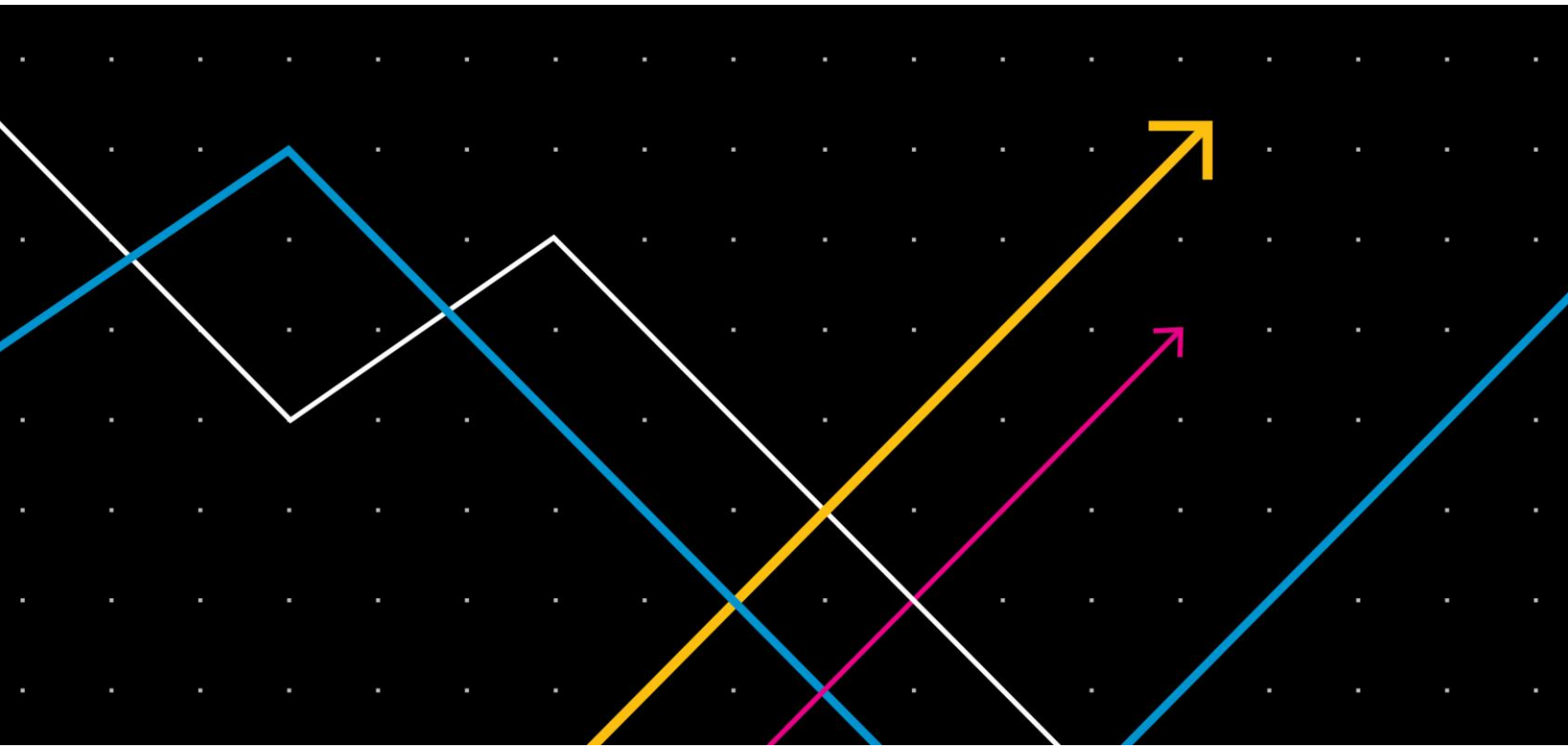

RESEARCH REPORT

Medicaid Forward in New Mexico

Health Coverage, Health Care Spending, and Government Costs

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Authors' Note

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Executive Summary

The Medicaid Forward proposal would extend New Mexico's Medicaid program eligibility to all nonelderly residents.[1] Newly eligible individuals would pay premiums and out-of-pocket costs on a sliding scale, with each family's combined premiums and out-of-pocket spending not to exceed 5 percent of income. Under the proposal, Medicaid spending for most newly eligible individuals would qualify for federal matching funds at New Mexico's standard Federal Medical Assistance Percentage of 73.26 percent. Some individuals would not qualify for federal funding, such as lawfully present immigrants who have resided in the US for less than five years and undocumented individuals. New Mexico's existing state Marketplace subsidies and other programs under the state's Health Care Affordability Fund would no longer be needed because people eligible for subsidies in these programs would instead opt to enroll in Medicaid. Large employers would be required to contribute to Medicaid Forward for workers who enroll in the program. Medicaid provider reimbursements would be raised for Medicaid Forward and existing Medicaid and Children's Health Insurance Program (CHIP) enrollees. We present results for low and high enrollment scenarios and with two levels of Medicaid provider reimbursement rates: 7 percent above current rates and 17 percent above current rates. These increases in provider reimbursements are in addition to the increases in reimbursement for physicians and other services approved by the state legislature in 2023.

We estimate that 710,000 nonelderly New Mexicans would be enrolled in traditional Medicaid and CHIP in 2024 after the unwinding of Medicaid enrollment after the COVID-19 public health emergency is complete.[2] If Medicaid Forward were implemented in 2024, we estimate that between 407,000 and 542,000 New Mexicans would enroll in the new Medicaid Forward option, along with some additional enrollment in traditional Medicaid and CHIP, raising the share of nonelderly New Mexicans in Medicaid from 38.4 percent to between 62 percent and 70.1. There would be between 130,000 and 142,000 fewer uninsured New Mexicans, and the uninsured rate would decline from 13.1 percent to between 6.1 percent and 5.4 percent. The proposal would substantially increase coverage at all income levels and among all racial and ethnic groups. Virtually all uninsured New Mexicans would be eligible for coverage, increasing the importance of efforts to enroll those who are eligible but uninsured.

The number of New Mexicans in employer-sponsored coverage would decline by between 31.9 percent and 50.1 percent as workers and their families opt for Medicaid Forward coverage. Nearly everyone enrolled in the private nongroup market would switch to Medicaid Forward because of the lower premiums and out-of-pocket costs.

The proposal would reduce household spending on health care by between $920 million and $1.2 billion in aggregate, with the largest declines at the lowest incomes. Overall, household spending would fall between 28.3 percent and 37.9 percent, depending on the take-up of Medicaid Forward. Families with incomes up to 138 percent of the federal poverty level (FPL) would see the largest reductions, between 39.6 percent and 49.2 percent, though spending would be notably lower even at incomes above 400 percent of FPL, falling between 22.8 percent and 29.7 percent.

In 2024, assuming that Medicaid is reimbursed at Medicaid plus 17 percent, both large and small employers would see substantial reductions in health care spending for employee premiums on average, though the employer contribution could cause some individual large firms to pay more if they do not offer health coverage to their workers. Depending on take-up of Medicaid Forward, we estimate that employers would pass back to workers between $436 and $874 million in savings on health insurance premium contributions as higher wages or other tax-preferred benefits and still save between $88 and $229 million.

Medicaid Forward would substantially change the utilization and reimbursement of health care. The coverage offered under the proposal has a higher actuarial value than most private plans and comes with very low deductibles and copayments. As a result, enrollees switching to Medicaid Forward from private coverage are estimated to use health care services at a somewhat higher rate. Currently, uninsured New Mexicans who enroll in Medicaid Forward are also estimated to use more health care services, with less care funded out-of-pocket or through uncompensated care.

Physician reimbursement rates under Medicaid Forward would be between 130 percent and 140 percent of Medicare. Provider payment rates for Medicaid Forward are lower than current commercial payment rates typically paid by employer-sponsored private insurance plans. At the same time, provider reimbursement rates would be raised for current Medicaid and CHIP enrollees. Providers who mainly serve privately insured patients under current law would face lower reimbursements for those patients switching to Medicaid Forward, while providers who serve more Medicaid enrollees would see significant reimbursement rate increases. Overall, providers would see a larger volume of utilization because of greater demand for care. Taking all these changes in utilization and reimbursement rates by different groups of people into account, we estimate that total health care spending on acute care for the nonelderly population of New Mexico would increase by between 6 percent to 9.1 percent under Medicaid Forward, depending on take-up and whether Medicaid pays providers 7 percent or 17 percent above current Medicaid rates. We cannot estimate the ultimate consequences of these changes in both utilization and reimbursement rates on providers or what operational decisions they may make in

response. A study on this topic is included in House Bill 400, which passed during the 2023 Legislative Session of the New Mexico Legislature.

In 2024, assuming that Medicaid would be reimbursed at Medicaid plus 17 percent, the federal government would spend between $2.4 billion and $3 billion more in Medicaid under Medicaid Forward, depending on take-up. This increase would be offset in part by a cessation of premium tax credit spending (saving $346 million), lower federal uncompensated care spending (saving $64 million to $65 million), and higher federal income and payroll tax revenues resulting from increased wages (totaling $158 to $294 million). In sum, federal spending would increase by between $1.8 billion and $2.4 billion.

Again, assuming provider reimbursement rates of 17 percent above Medicaid, New Mexico would spend between $57 and $73 million more to cover Medicaid and CHIP enrollees who are currently eligible and between $977 million and $1.3 billion to cover the new Medicaid Forward enrollees. The state would see offsetting savings from the following:

- eliminating its supplemental premium and cost-sharing subsidies and other spending under its affordability fund (saving about $145 million)
- repurposing state-based marketplace (SBM) and high-risk pool assessments to offset the cost of Medicaid Forward ($153 million)
- reducing health spending for state employees and their covered dependents who opt to enroll in Medicaid Forward (saving between $335 million and $379 million)
- reducing uncompensated care funding (saving between $40 million and $41 million)
- collecting more income taxes as wages increase (raising between $23 million and $43 million)
- creating the new Medicaid Forward employer contribution (raising between $247 million and $422 million)
- collecting more in premium tax and premium surcharge revenue as more uninsured individuals enroll in coverage that is subject to these taxes and enrollment shifts away from forms of coverage that are not subject to these taxes, such as self-insured employer plans (raising between $141 million and $198 million)

On net, new state revenue would exceed new spending by between $3 and $51 million. Decreasing reimbursements to 7 percent above Medicaid rates would decrease state costs, increasing this surplus to between $92 and $127 million.

The proposed Medicaid Forward employer contribution has several potential issues. As the proposal specifies, the employer contribution amount does not vary by wage. This has a regressive impact in that the contribution from low-wage employers would represent a larger share of their payroll compared with a high-wage employer of the same size. However, the contribution would be less than the amount spent on health insurance premiums. There is considerable uncertainty about take-up of Medicaid Forward among those workers who currently have employer coverage, particularly in the first years of the program, making it difficult to accurately forecast the amount of contribution revenue that would be collected. There are also legal questions about the employer contribution's compliance with the Employee Retirement Income Security Act of 1974 and federal Medicaid law.

These issues could be addressed by replacing the employer contribution with a payroll tax on employers. We find that state costs for Medicaid Forward could be fully covered by a state payroll tax rate of 0.6888 percent when combined with reimbursements at 7 percent above Medicaid rates and a tax rate of 1.007 percent when combined with reimbursements at 17 percent above Medicaid rates.

TABLE ES 1

Summary of Selected Results for Medicaid Forward Scenarios

Medicaid Forward Take-up **Medicaid Provider Payment Rates**	Low Medicaid + 7%	High Medicaid + 7%	Low Medicaid + 17%	High Medicaid + 17%
Health Coverage (Thousands of People)				
Medicaid Forward enrollment	407	542	407	542
Change in the uninsured	-130	-142	-130	-142
Percent change in the uninsured	-53.8%	-58.7%	-53.8%	-58.7%
Household Health Spending (Percent Change)				
Percent change in household spending	-28.3%	-37.9%	-28.3%	-37.9%
Premiums	-25.6%	-34.6%	-25.6%	-34.6%
Out-of-pocket spending	-31.7%	-42.1%	-31.7%	-42.1%
Employer Spending and Wages (Millions of Dollars)				
Medicaid Forward employer contributions	221	379	247	422
Increased wages	456	908	436	874
Net change in employer spending	-93	-238	-88	-229
Government Spending (Millions of Dollars)				
Net change in the federal deficit	1,525	2,033	1,796	2,376
Change in state health care spending	247	510	361	660
New state revenue	374	603	412	663
Net change in state spending	-127	-92	-51	-3

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Medicaid Forward in New Mexico

Description of the Medicaid Forward Proposal

Under this proposal, all nonelderly New Mexico residents would be eligible for Medicaid, regardless of immigration status or length of US residency. Those who enroll in this new expansion would pay at most five percent of family income in combined premium and out-of-pocket (OOP) costs for all enrolled family members. Those with incomes up to 150 percent of the federal poverty level (FPL) would not pay premiums. Those with incomes up to 200 percent of FPL would pay 0.5 percent of their income in premiums, rising to 1 percent of income up to 250 percent of FPL, 1.5 percent of income up to 300 percent of FPL, 2 percent of income to 350 percent of FPL, and 2.5 percent of income for those with higher income. Given these premiums, each family's OOP costs are capped so premiums plus OOP costs do not exceed 5 percent of income.

State Financing

The costs of the large majority of New Mexicans covered by this expansion of eligibility would be funded according to standard Federal Medical Assistance Percentage (FMAP), with the federal government paying 73.26 percent. New Mexico has one of the highest FMAP rates in the country, making this option more attractive than it would be in other states. The state would entirely fund the costs of covering undocumented immigrants and lawfully present immigrants ineligible for Medicaid because they have been residents for less than five years.

Even with New Mexico's high FMAP, the state share would still reach several hundred million dollars. Several state savings and new state revenues in the proposal are designed to offset the state share of the costs of buy-in enrollees, such as:

- **current state spending no longer needed.** The state estimates that $145 million annually in spending on the Health Care Affordability Fund would no longer be needed under Medicaid Forward. Legislation would likely be needed to discontinue this fund.
- **repurposed assessments**. The State estimates that $153 million in assessments that currently support the SBM and high-risk pool could be repurposed to cover the costs of Medicaid Forward. Legislation would likely be needed to do this.

- **state premium taxes and surcharges**. There would be increased state premium taxes and surcharges from covered lives moving from being uninsured or enrolled in self-insured plans (which are not subject to these taxes) to Medicaid Forward. This includes both the 3.003 percent premium tax and the 3.75 percent premium surtax.
- **Medicaid Forward employer contribution**. A contribution to large employers would be assessed for each full-time worker enrolling in Medicaid Forward to offset costs for the state and replace what would otherwise be employer contributions to private health insurance. The contribution amount would be equal to the average state cost of an adult enrolling in Medicaid Forward (see the next section on Employer-Sponsored Insurance).
- **state income taxes**. A share of employer savings on health insurance premium contributions would be passed back to workers as increased wages (See the next section). These would be subject to state income taxes, so state tax revenues would increase.
- **state employees' health care**. The state would save money currently spent on health insurance premium contributions for state employees—including school employees—because Medicaid Forward would attract significant enrollment from state employees because of the proposal's lower premiums and out-of-pocket costs. Because the state would leverage federal funds, state spending per enrollee for state employees and their dependents would decrease. In addition, there would be some wage increases for state employees.
- **uncompensated care**. Reducing the number of uninsured people will reduce the demand for uncompensated care. Part of this decreased demand would be realized as savings to the state.

As an alternative to the employer contribution, a state payroll tax rate of 0.6888 percent for the high take-up scenario with reimbursements at 7 percent above Medicaid rates or a tax rate of 1.007 percent for the high take-up scenario with reimbursements at 17 percent above Medicaid rates could fully offset the state's net cost from Medicaid Forward.

Employer-Sponsored Insurance

Those currently enrolled in employer-sponsored insurance (ESI) would be able to enroll in the new Medicaid category rather than in their employer's plan. If an employer decides to stop offering health insurance as a benefit to its workers, the resulting savings in tax-excluded employer premium contributions would be substantial and must be accounted for in our analysis of the financing flows. We follow common modeling practice in assuming that since employer-provided health insurance is a (tax-

preferred) employee benefit, most of the money saved is eventually returned to workers as higher (taxable) wages.[3] This often translates into an increase in tax revenues.

Generally, we assume the savings would eventually be passed back to workers as higher taxable wages. According to economic theory, in a competitive labor market, employers compete with other employers by offering a combination of wages and benefits that match or slightly exceed what similar employers offer to attract sufficient quality workers to run the business. When an expensive employee benefit such as health insurance is dropped, then the savings in employer contributions would be passed back as wages and/or other tax-preferred benefits to keep total compensation constant (Arnold and Whaley 2020; Gruber 1994; Kim and Koh 2022).[4] In practice, the wage pass-back will likely be less than 100 percent and may take several years to occur. For this report, we assume that about 90 percent of savings would become higher wages, while the remainder would be savings to the employer. If the wage pass-back turned out to be lower, the new state income tax revenue would be slightly lower than we estimate. At the same time, employers who keep more of the savings may report higher profits which are generally subject to taxation.

The proposal would introduce an employer contribution for each worker enrolling in Medicaid Forward. The contribution would apply only to large firms of more than 50 full-time-equivalent employees and would be equal to the state share of covering an average adult per enrolled worker. Collecting contributions for dependents enrolled in Medicaid Forward is not feasible (see the Discussion section on page 38). Employers would not be permitted to deduct this contribution from the salaries of employees choosing to enroll in Medicaid Forward, partly because that could violate the 5 percent cap on Medicaid premiums.

The Nongroup Market

Coverage under the new Medicaid expansion would be so much cheaper to consumers than private nongroup coverage, that only a handful of covered lives would remain. Under federal law, those eligible for Medicaid are not eligible for Marketplace premium tax credits (PTCs) and cost-sharing reductions (CSRs). Thus, virtually no one would qualify for these subsidies under the proposal. It is unclear whether insurers would continue to participate in that market, but we assume there would be insurers for the small number of covered lives who remain. If not, the small number of remaining nongroup enrollees would be able to enroll in Medicaid Forward, almost certainly at a lower cost.

Some of those advocating the proposal have suggested a waiver that allows those eligible for Medicaid to keep PTC and CSR eligibility. While this is potentially feasible under a Section 1332 waiver

under the Affordable Care Act (ACA), such waivers require federal deficit neutrality, and Medicaid Forward would substantially increase federal spending. Moreover, even if the choice were possible, it would have little practical consequence. Even with Marketplace PTCs and CSRs, Marketplace coverage would be substantially more expensive after accounting for premiums and OOP costs than the Medicaid expansion, so few people would choose it.

Provider Reimbursement Rates

We simulated the costs of Medicaid Forward assuming that Medicaid reimbursement rates were raised by 7 percent and by 17 percent. Currently in New Mexico, Medicaid rates for physician services are 93 percent of Medicare rates on average (Zuckerman, Skopec, and Aarons 2021). In 2023, the state legislature approved a substantial increase in physician reimbursements that would raise this to about 123 percent of Medicare rates. Thus, physician reimbursement rates under Medicaid Forward would be between 130 percent and 140 percent of Medicare.

Comparing hospital reimbursement rates between Medicaid and Medicare is much more complicated. Analysis by the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission estimated in 2017 that Medicaid and Medicare reimbursements were roughly equal in New Mexico for 18 inpatient conditions that they examined (MACPAC 2017). However, that ratio may differ for other types of hospital care and among hospitals in the state.

Medicaid Forward would legally be Medicaid, so the Medicaid Drug Rebate Program would apply to all Medicaid Forward enrollees and those enrolled in traditional Medicaid. Thus, prescription drug costs would be at Medicaid levels for the new Medicaid Forward enrollees.

We estimate the impact of Medicaid Forward on health care spending, but we did not estimate changes in the utilization or unit prices of specific health care services. We cannot estimate the financial impact of specific payment rates on providers or what operational decisions they may make in response. House Bill 400 directs the New Mexico Human Services Department to study this topic.

Methods

We produce our estimates using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options (Buettgens and Banthin 2020). The model

simulates household and employer decisions and models the way changes in one insurance market interact with changes in other markets. HIPSM is designed for quick-turnaround analyses of policy proposals. It can be rapidly adapted to analyze various new scenarios—such as novel health insurance offerings and strategies for increasing affordability to state-specific proposals—and can describe the effects of a policy option over several years. Results from HIPSM simulations have been favorably compared with actual policy outcomes and other respected microsimulation models (Glied, Arora, and Solís-Román 2015).

For this work, we updated HIPSM to incorporate data specific to New Mexico provided by the state, including:

- **Medicaid enrollment and costs by major eligibility type, both before the pandemic and in early 2023.** Our estimates represent the middle of 2024 after Medicaid enrollment has stabilized following the end of the continuous coverage requirement, as mandated by the Consolidated Appropriations Act of 2023 (Buettgens and Green 2022). By then, Medicaid enrollment is assumed to have returned to the pre-COVID trend. The costs of Medicaid expansion for adults were particularly important in estimating the cost of Medicaid Forward.
- **Marketplace data from the end of the open enrollment period for 2023, including enrollment, premiums, metal tier selections, and distributions by age and sex**. Enrollment in 2024 will be higher because of the unwinding of the Medicaid continuous coverage requirement, so we adjusted 2023 by our estimates of the impact of this change (Buettgens and Banthin, 2022).
- **state employee health coverage data, including covered lives, worker premium contributions, and state costs.** These were aged to 2024 using projected cost growth and changes to state employment.
- **average ESI premiums in New Mexico from the Medical Expenditure Panel Survey Insurance Component.** The latest available year was 2021, so these were aged to 2024 based on the long-term trend.

Medicaid Forward is a novel proposal, so there is substantial uncertainty about take-up and other behavioral responses. As a sensitivity analysis, we simulated a low and a high take-up scenario focused on three populations: Immigrants not qualifying for FMAP, state employees, and other workers with employer coverage.

Undocumented immigrants may be hesitant to sign up for Medicaid Forward because it requires providing identifying information to the government. Emergency Medicaid is generally available to

undocumented immigrants, but enrollment is low in most states. California and New York, on the other hand, have seen enrollment in emergency Medicaid large enough to cover a substantial share of undocumented immigrants. California is in the process of expanding Medicaid to undocumented immigrants and has so far seen robust enrollment consistent with their previous emergency Medicaid enrollment. Take-up rates in Medicaid Forward could be high but are likely to be lower than current Medicaid rates. We assume that 44 percent of undocumented immigrants would enroll in Medicaid Forward in our low take-up scenario and 64 percent in the high take-up scenario.

Medicaid Forward will become a new option for state employees, but they can still choose traditional coverage options. State savings on state employee health coverage are an important revenue offset in the proposal, so the state is incentivized to encourage as many workers as possible to choose Medicaid Forward. State employees would also have a strong financial incentive to do so. Depending on their income, state employees currently pay between 20 percent and 40 percent of the total premium OOP, which is generally higher than the average share paid by workers nationally.[5] With this in mind, we assume that the large majority of state employees would choose Medicaid Forward in both scenarios, 79 percent with low take-up and 89 percent with high take-up.

In HIPSM, workers can choose between Medicaid Forward and ESI, considering premiums, cost sharing, and the tax advantage of financing premiums through an employer. Also, synthetic firms are constructed to model employer decisions. In the model, employers account for their employees' gains or losses from having a health insurance offer and the perceived offering costs when deciding whether to make an offer. The costs of offering coverage are calculated as the cost of employers' premium contributions plus any assessments or penalties for which the employer is liable, plus a fixed administrative cost, minus any tax incentives because of the tax exclusion of ESI, and minus any employer tax credits under reform, such as small business tax credits under the ACA (Buettgens and Banthin 2020).

The low scenario represents the shift from ESI to Medicaid Forward with standard model parameters, including worker choices and employer offer decisions. However, the ubiquity of Medicaid Forward may change how workers value public versus private health coverage, and employers may favor Medicaid Forward in their benefit decisions in ways not captured by expected utility in the model. We examine this possibility by adding higher levels of ESI crowd-out in our high take-up scenario.

The payroll tax, which was modeled as an alternative approach to the employer contribution, is levied on all employers in New Mexico and applies to all wage and salary income in the state (there is no floor below which, or cap above which, the tax does not apply). Wage and salary income is consistent

with data for New Mexico from the Internal Revenue Service Statistics of Income and is inflated to 2024.[6] The tax rate is set to cover new state spending under Medicaid Forward and would vary depending on assumptions about take-up and provider payment rates for that plan.

Results

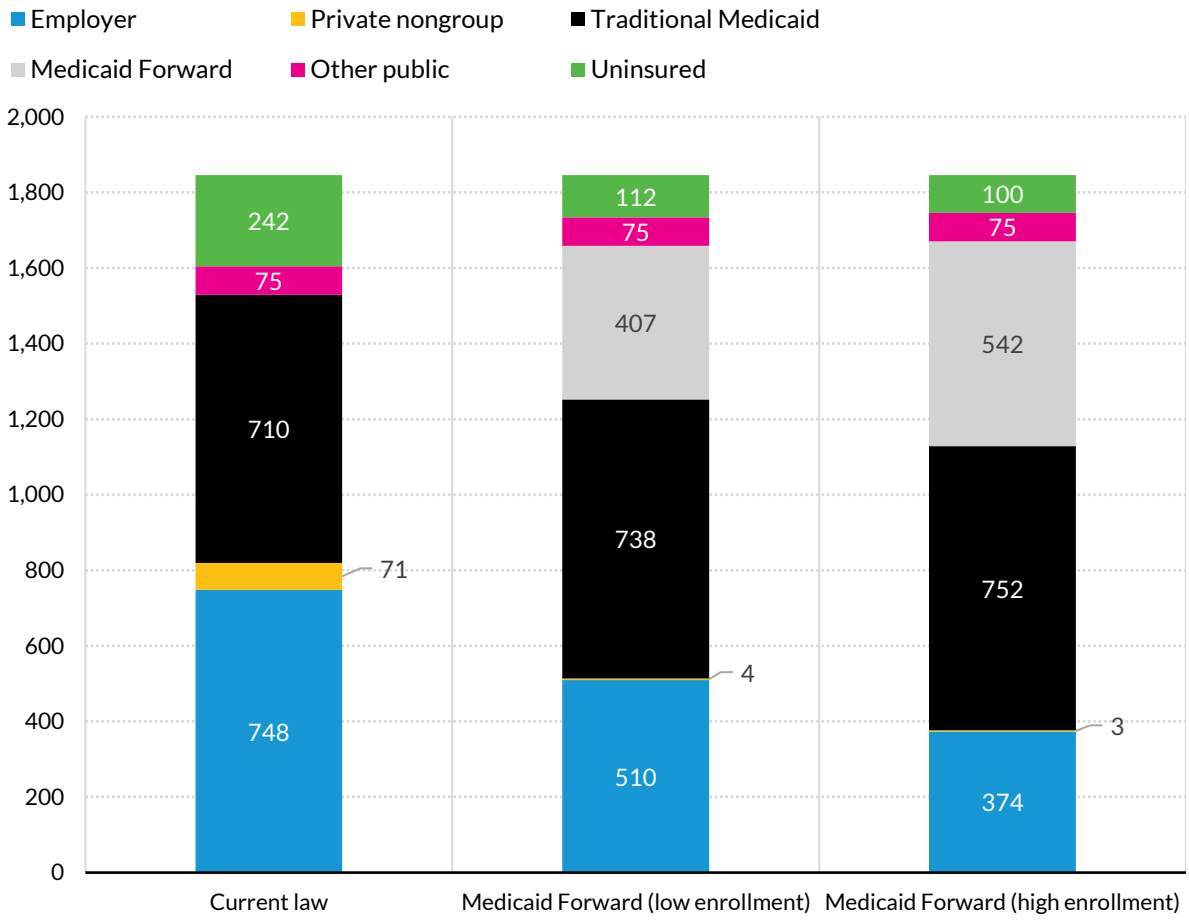
We first examine changes in health coverage in response to this proposal, showing how the number and characteristics of uninsured New Mexicans would change and how many would switch from private health coverage to the new Medicaid expansion. We then examine how the proposal would affect health care spending by households and employers. We estimate the impact on federal and state government spending and on total spending on acute health care services for the nonelderly.

Changes in Health Coverage

We estimate that between 407,000 and 542,000 New Mexicans would enroll in the new Medicaid Forward option if the policy were implemented in 2024, between 22 percent and 29.4 percent of nonelderly New Mexicans (figure 1 and table 1). Thus, between 62 percent and 70.1 percent of nonelderly New Mexicans would be enrolled in Medicaid.

FIGURE 1

Health Coverage of Nonelderly New Mexicans in 2024 (Thousands)



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Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

TABLE 1

Health Insurance Coverage Distribution of the Nonelderly (Thousands of People)

	Current law ACA		Medicaid Forward (low enrollment)		Change	Percent change	Medicaid Forward (high enrollment)		Change	Percent change
Insured (minimum essential coverage)	1,604	86.9%	1,734	93.9%	130	8.1%	1,746	94.6%	142	8.8%
Employer	748	40.5%	510	27.6%	-239	-31.9%	374	20.2%	-375	-50.1%
Private Nongroup	71	3.8%	4	0.2%	-67	-94.4%	3	0.2%	-68	-95.7%
Marketplace with PTC	49	2.7%	0	0.0%	-49	-100.0%	0	0.0%	-49	-100.0%
Full-pay Marketplace	5	0.3%	4	0.2%	-1	-13.9%	3	0.2%	-2	-34.4%
OthernNongroup	17	0.9%	0	0.0%	-17	-100.0%	0	0.0%	-17	-100.0%
Medicaid/CHIP	710	38.4%	1,145	62.0%	436	61.4%	1,294	70.1%	585	82.4%
Disabled	68	3.7%	68	3.7%	0	0.1%	69	3.7%	0	0.2%
Medicaid expansion	264	14.3%	281	15.2%	17	6.2%	287	15.6%	23	8.7%
Traditional nondisabled adult	60	3.3%	61	3.3%	1	1.2%	62	3.3%	1	2.0%
Nondisabled Medicaid/CHIP child	317	17.2%	328	17.8%	11	3.6%	335	18.1%	18	5.7%
Medicaid Forward	0	0.0%	407	22.0%	407	100.0%	542	29.4%	542	100.0%
Other public	75	4.1%	75	4.1%	0	0.0%	75	4.1%	0	0.0%
Uninsured	242	13.1%	112	6.1%	-130	-53.8%	100	5.4%	-142	-58.7%
Total	1,846	100.0%	1,846	100.0%	0	0.0%	1,846	100.0%	0	0.0%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Notes: ACA = Affordable Care Act; PTC =premium tax credit; CHIP = Children's Health Insurance Program.

There would be between 130,000 and 142,000 fewer uninsured New Mexicans, a reduction of 53.8 percent to 58.7 percent. New Mexico's uninsured rate would decline from 13.1 percent to between 6.1 percent and 5.4 percent.

We estimate that between 239,000 and 375,000 people who currently have ESI would switch to the new Medicaid Forward option, a reduction of between 31.9 percent and 50.1 percent. The private nongroup market would be reduced from 71,000 to between 3,000 and 4,000 covered lives, almost entirely among those at higher incomes not currently getting subsidized Marketplace coverage.

Uninsurance by Income

Currently, uninsured rates in New Mexico vary strongly by income, with the highest rates among those with incomes just above the Medicaid cut-off (table 2 and figure 2). The Medicaid Forward proposal would substantially increase coverage at all incomes, with the greatest impact on this most-uninsured group.

The proposal would reduce the uninsured rate for people with incomes below 138 percent of FPL by about half—from 11.6 percent to between 5 percent and 6 percent. These people are currently eligible for Medicaid, except for undocumented immigrants and some lawfully present immigrants who have been residents for less than five years. However, not all those currently eligible for Medicaid have enrolled.

The proposal would reduce the uninsured rate most for those with the highest rate of uninsurance—those with incomes between 138 percent and 200 percent of FPL. The uninsured rate in this group would fall from 23.8 percent to between 8.9 percent and 10 percent. People with incomes in this range are generally eligible for Marketplace coverage that is subsidized by both federal and state governments, but enrollment figures after the 2023 open enrollment period showed that take-up is much lower than under Medicaid.

The proposal would similarly reduce the uninsured rate by more than half for those with higher incomes: from 16.5 percent to between 7.3 percent and 7.1 percent for those with incomes between 200 percent and 400 percent of FPL, and from 7.4 percent to between 3 percent and 2.8 percent among those with higher incomes.

TABLE 2

Health Insurance Coverage Distribution of the Nonelderly, by Income Group (Thousands of People)

	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
Below 138% of FPL										
Insured (MEC)	724	88.4%	770	94.0%	46	6.3%	777	95.0%	54	7.4%
Employer	83	10.1%	57	7.0%	-25	-30.7%	45	5.5%	-38	-45.7%
Private nongroup	7	0.8%	1	0.1%	-6	-82.2%	1	0.1%	-6	-90.4%
Marketplace with PTC	6	0.7%		0.0%	-6	-100.0%		0.0%	-6	-100.0%
Full-pay Marketplace		0.0%	1	0.1%	1	265.1%	1	0.1%		98.1%
Other nongroup	1	0.1%		0.0%	-1	-100.0%		0.0%	-1	-100.0%
Medicaid/CHIP	604	73.9%	681	83.2%	77	12.7%	702	85.8%	98	16.1%
Disabled	64	7.8%	64	7.8%		0.0%	64	7.8%		0.0%
Medicaid expansion	264	32.3%	281	34.3%	17	6.2%	287	35.1%	23	8.7%
Traditional nondisabled adult	51	6.2%	51	6.3%	1	1.5%	52	6.3%	1	2.4%
Nondisabled Medicaid/CHIP child	226	27.6%	230	28.1%	4	1.7%	231	28.2%	5	2.0%
Medicaid Forward		0.0%	56	6.8%	56	100.0%	69	8.4%	69	100.0%
Other public	30	3.7%	30	3.7%		0.0%	30	3.7%		0.0%
Uninsured	95	11.6%	49	6.0%	-46	-48.4%	41	5.0%	-54	-56.6%
Total	818	100.0%	818	100.0%		0.0%	818	100.0%		0.0%
Between 138% and 200% of FPL										
Insured (MEC)	150	76.2%	177	90.0%	27	18.2%	179	91.1%	29	19.7%
Employer	69	35.2%	50	25.3%	-20	-28.2%	39	19.9%	-30	-43.6%
Private nongroup	20	10.2%		0.2%	-20	-98.2%		0.1%	-20	-98.5%
Marketplace with PTC	18	9.1%		0.0%	-18	-100.0%		0.0%	-18	-100.0%
Full-pay Marketplace		0.1%		0.2%		36.2%		0.1%		9.0%
Other nongroup	2	1.0%		0.0%	-2	-100.0%		0.0%	-2	-100.0%
Medicaid/CHIP	50	25.4%	117	59.2%	67	133.2%	130	65.8%	80	159.0%
Disabled	2	0.8%	2	0.8%		0.0%	2	0.8%		0.9%
Traditional nondisabled adult	5	2.6%	5	2.6%		0.0%	5	2.6%		0.0%
Nondisabled Medicaid/CHIP child	43	22.0%	47	23.8%	3	8.0%	48	24.4%	5	10.7%
Medicaid for All		0.0%	63	32.1%	63	100.0%	75	38.0%	75	100.0%
Other public	10	5.3%	10	5.3%		0.0%	10	5.3%		0.0%
Uninsured (no MEC)	47	23.8%	20	10.0%	-27	-58.1%	17	8.9%	-29	-62.8%
Total	197	100.0%	197	100.0%		0.0%	197	100.0%		0.0%

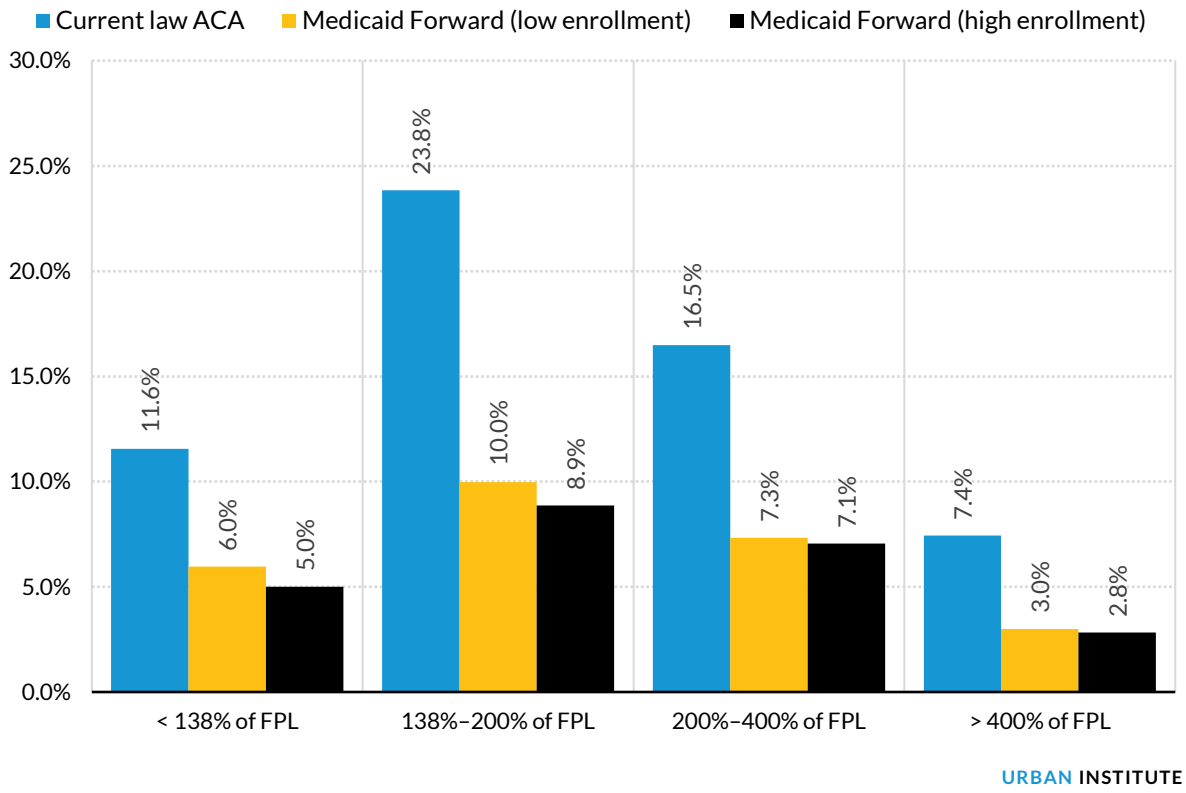
	Current law ACA		Medicaid Forward (low enrollment)		Change	Percent change	Medicaid Forward (high enrollment)		Change	Percent change
Between 200% and 400% of FPL										
Insured (MEC)	355	83.5%	394	92.7%	39	10.9%	395	92.9%	40	11.3%
Employer	266	62.7%	179	42.0%	-88	-33.0%	123	29.0%	-143	-53.8%
Private Nongroup	23	5.4%	2	0.4%	-21	-92.9%	1	0.3%	-22	-94.2%
Marketplace with PTC	17	3.9%		0.0%	-17	-100.0%		0.0%	-17	-100.0%
Full-pay Marketplace	2	0.4%	2	0.4%		4.4%	1	0.3%		-15.5%
Other Nongroup	5	1.2%		0.0%	-5	-100.0%		0.0%	-5	-100.0%
Medicaid/CHIP	47	11.1%	195	45.9%	148	315.4%	252	59.4%	205	436.8%
Disabled	2	0.6%	3	0.6%		2.2%	3	0.6%		4.3%
Traditional nondisabled adult	4	0.9%	4	0.9%		0.0%	4	0.9%		0.0%
Nondisabled Medicaid/CHIP Child	41	9.6%	45	10.5%	4	10.1%	50	11.7%	9	21.9%
Medicaid Forward		0.0%	144	33.9%	144	100.0%	196	46.2%	196	100.0%
Other public	18	4.3%	18	4.3%		0.0%	18	4.3%		0.0%
Uninsured (no MEC)	70	16.5%	31	7.3%	-39	-55.5%	30	7.1%	-40	-57.2%
Total	425	100.0%	425	100.0%		0.0%	425	100.0%		0.0%
Above 400% of FPL										
Insured (MEC)	376	92.6%	394	97.0%	18	4.8%	394	97.2%	19	5.0%
Employer	330	81.3%	224	55.2%	-106	-32.1%	166	41.0%	-164	-49.6%
Private Nongroup	21	5.1%	1	0.2%	-20	-96.4%	1	0.2%	-20	-96.4%
Marketplace with PTC	9	2.1%		0.0%	-9	-100.0%		0.0%	-9	-100.0%
Full-pay Marketplace	2	0.6%	1	0.2%	-2	-69.4%	1	0.2%	-2	-69.4%
Other nongroup	10	2.4%		0.0%	-10	-100.0%		0.0%	-10	-100.0%
Medicaid/CHIP	8	2.0%	152	37.5%	144	1773.4%	211	51.9%	202	2491.7%
Disabled	1	0.2%	1	0.2%		0.0%	1	0.2%		0.0%
Traditional nondisabled adult	1	0.2%	1	0.2%		0.0%	1	0.2%		0.0%
Nondisabled Medicaid/CHIP child	7	1.6%	7	1.6%		0.0%	7	1.6%		0.0%
Medicaid Forward		0.0%	144	35.5%	144	100.0%	202	49.9%	202	100.0%
Other public	17	4.1%	17	4.1%		0.0%	17	4.1%		0.0%
Uninsured (no MEC)	30	7.4%	12	3.0%	-18	-59.7%	11	2.8%	-19	-62.1%
Total	406	100.0%	406	100.0%		0.0%	406	100.0%		0.0%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Notes: ACA = Affordable Care Act; FPL = federal poverty level; PTC = premium tax credit; MEC = minimum essential coverage; CHIP = Children's Health Insurance Program.

FIGURE 2

Uninsured Rates by Income



Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: ACA = Affordable Care Act; FPL = federal poverty level.

Uninsurance by Race and Ethnicity

Currently, American Indians have the highest uninsured rate in New Mexico (21.9 percent; table 3 and figure 3), followed by Hispanics (14.8 percent), non-Hispanic Blacks (12.0 percent), Asians and Pacific Islanders (10.4 percent), and non-Hispanic Whites (7.6 percent).

Under the Medicaid Forward proposal, the numbers of uninsured Hispanics, Asians/Pacific Islanders, and non-Hispanic Whites would all decline by more than 60 percent. The number of uninsured American Indians would be cut in half. Non-Hispanic Blacks would see a smaller but still substantial drop in uninsurance, between 35.4 percent and 35.6 percent. The relative change is smaller for this group because many are currently eligible for Medicaid or CHIP but not enrolled. The Medicaid Forward proposal does not contain explicit provisions to increase enrollment among this group, but additional state initiatives could do so (see the Discussion section on page 38).

TABLE 3

Health Insurance Coverage Distribution of the Nonelderly, by Race/Ethnicity (thousands of people)

	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
White, non-Hispanic										
Insured (MEC)	567	92.4%	598	97.3%	30	5.4%	598	97.4%	31	5.4%
Employer	320	52.1%	227	36.9%	-94	-29.2%	170	27.6%	-151	-47.1%
Private nongroup	39	6.3%	2	0.3%	-37	-95.5%	1	0.2%	-37	-96.1%
Marketplace with PTC	24	3.9%	0	0.0%	-24	-100.0%	0	0.0%	-24	-100.0%
Full-pay Marketplace	3	0.5%	2	0.3%	-2	-47.2%	1	0.2%	-2	-54.6%
Other nongroup	11	1.9%	0	0.0%	-11	-100.0%	0	0.0%	-11	-100.0%
Medicaid/CHIP	171	27.9%	333	54.1%	161	94.0%	390	63.5%	219	127.6%
Disabled	21	3.4%	21	3.4%		0.0%	21	3.4%		0.2%
Medicaid Expansion	79	12.8%	82	13.3%	3	4.3%	84	13.6%	5	6.4%
Traditional nondisabled adult	14	2.3%	14	2.3%		0.0%	14	2.3%		1.0%
Nondisabled Medicaid/CHIP child	58	9.4%	59	9.6%	1	2.1%	61	9.9%	3	5.5%
Medicaid Forward	0	0.0%	157	25.5%	157	100.0%	210	34.2%	210	100.0%
Other public	37	6.0%	37	6.0%		0.0%	37	6.0%		0.0%
Uninsured	47	7.6%	16	2.7%	-30	-65.0%	16	2.6%	-31	-65.5%
Total	614	100.0%	614	100.0%		0.0%	614	100.0%		0.0%
Hispanic										
Insured (MEC)	775	85.2%	845	92.9%	70	9.0%	856	94.2%	81	10.5%
Employer	328	36.1%	218	24.0%	-110	-33.5%	154	16.9%	-174	-53.1%
Private nongroup	24	2.6%	1	0.1%	-23	-96.2%	1	0.1%	-23	-97.4%
Marketplace with PTC	18	2.0%	0	0.0%	-18	-100.0%	0	0.0%	-18	-100.0%
Full-Pay Marketplace	1	0.1%	1	0.1%		-8.1%	1	0.1%		-38.0%
Other nongroup	5	0.5%	0	0.0%	-5	-100.0%	0	0.0%	-5	-100.0%
Medicaid/CHIP	395	43.4%	598	65.8%	203	51.4%	674	74.1%	279	70.7%
Disabled	34	3.8%	34	3.8%		0.1%	34	3.8%		0.1%
Medicaid expansion	133	14.6%	140	15.4%	7	5.6%	143	15.8%	10	7.9%
Traditional nondisabled adult	34	3.7%	34	3.8%		0.7%	34	3.8%		1.4%
Nondisabled Medicaid/CHIP child	194	21.3%	199	21.9%	5	2.5%	202	22.2%	8	4.3%
Medicaid for All	0	0.0%	190	21.0%	190	100.0%	260	28.6%	260	100.0%
Other public	28	3.1%	28	3.1%		0.0%	28	3.1%		0.0%
Uninsured (no MEC)	134	14.8%	64	7.1%	-70	-52.1%	53	5.8%	-81	-60.4%
Total	909	100.0%	909	100.0%		0.0%	909	100.0%		0.0%

	Current law ACA		Medicaid Forward (low enrollment)		Change	Percent change	Medicaid Forward (high enrollment)		Change	Percent change
Black, non-Hispanic										
Insured (MEC)	33	88.0%	34	92.2%	2	4.8%	34	92.3%	2	4.9%
Employer	15	39.5%	9	25.6%	-5	-35.2%	8	21.2%	-7	-46.2%
Private nongroup	1	1.5%	0	0.2%		-85.5%	0	0.2%		-85.5%
Marketplace with PTC	0	0.9%	0	0.0%		-100.0%	0	0.0%		-100.0%
Full-Pay Marketplace	0	0.0%	0	0.2%		100.0%	0	0.2%		100.0%
Other nongroup	0	0.6%	0	0.0%		-100.0%	0	0.0%		-100.0%
Medicaid/CHIP	15	40.9%	22	60.3%	7	47.6%	24	64.7%	9	58.2%
Disabled	2	5.9%	2	5.9%		0.0%	2	5.9%		0.0%
Medicaid expansion	7	19.4%	7	20.1%		4.0%	8	20.8%	1	7.5%
Traditional nondisabled adult	1	1.7%	1	1.7%		0.0%	1	1.7%		0.0%
Nondisabled Medicaid/CHIP child	5	13.9%	5	13.9%		0.0%	5	13.9%		0.0%
Medicaid Forward	0	0.0%	7	18.7%	7	100.0%	8	22.3%	8	100.0%
Other public	2	6.1%	2	6.1%		0.0%	2	6.1%		0.0%
Uninsured (no MEC)	4	12.0%	3	7.8%	-2	-35.4%	3	7.7%	-2	-35.6%
Total	37	100.0%	37	100.0%		0.0%	37	100.0%		0.0%
Asian/Pacific Islander										
Insured (MEC)	27	89.6%	29	95.7%	2	6.9%	29	96.3%	2	7.5%
Employer	16	52.0%	9	31.4%	-6	-39.6%	7	22.5%	-9	-56.7%
Private nongroup	1	4.2%	1	2.5%	-1	-42.0%	0	1.1%	-1	-73.5%
Marketplace with PTC	1	1.8%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Full-pay Marketplace	0	0.4%	1	2.5%	1	546.9%	0	1.1%		195.9%
Other nongroup	1	2.1%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Medicaid/CHIP	8	28.0%	17	56.5%	9	102.0%	20	67.3%	12	140.5%
Disabled	1	2.3%	1	2.3%		0.0%	1	2.3%		0.0%
Medicaid expansion	5	15.9%	5	17.5%		9.8%	5	17.5%		9.8%
Traditional nondisabled adult	1	1.9%	1	1.9%		0.0%	1	1.9%		0.0%
Nondisabled Medicaid/CHIP child	2	7.8%	3	8.5%		9.2%	3	9.4%		20.3%
Medicaid Forward	0	0.0%	8	26.3%	8	100.0%	11	36.2%	11	100.0%
Other public	2	5.4%	2	5.4%		0.0%	2	5.4%		0.0%
Uninsured (no MEC)	3	10.4%	1	4.3%	-2	-59.2%	1	3.7%	-2	-64.5%
Total	30	100.0%	30	100.0%		0.0%	30	100.0%		0.0%

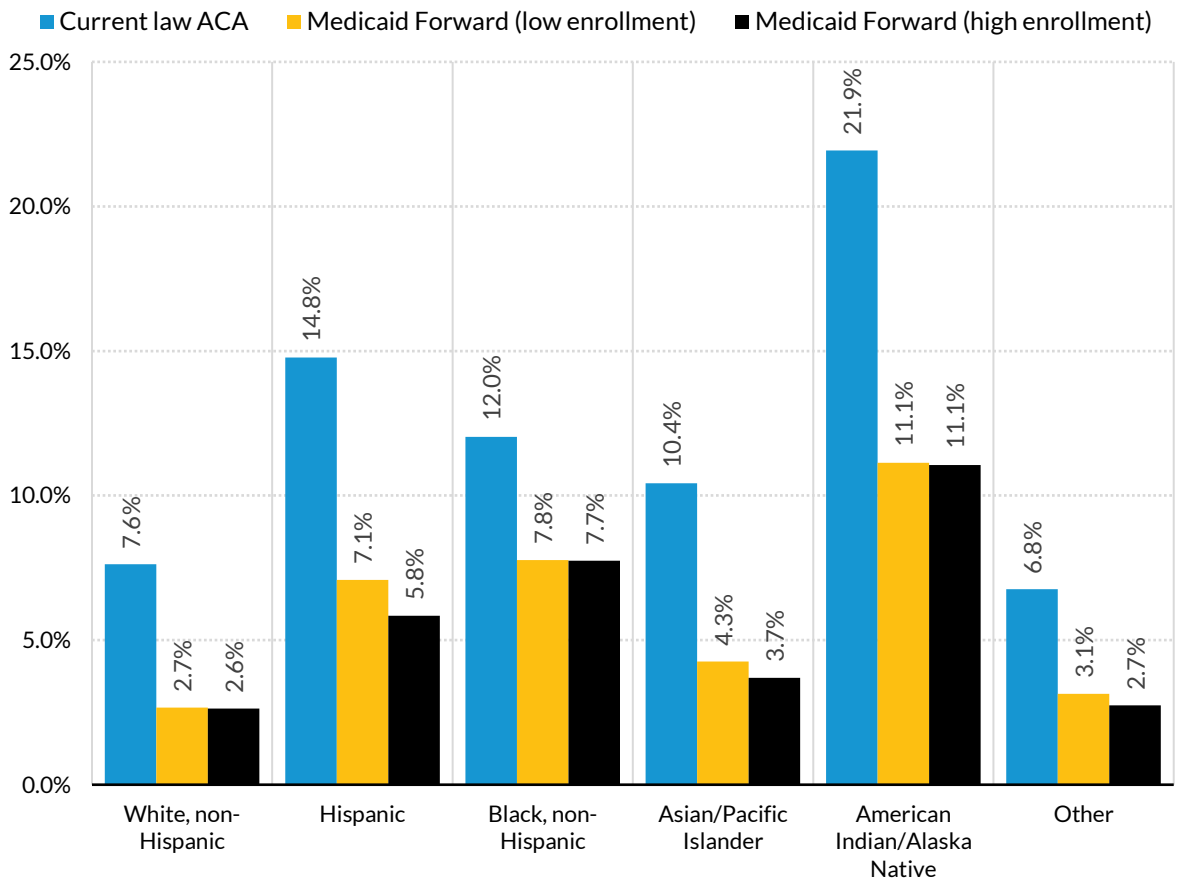
	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
American Indian/Alaska Native										
Insured (MEC)	184	78.1%	209	88.9%	25	13.8%	209	88.9%	26	13.9%
Employer	60	25.5%	39	16.7%	-21	-34.3%	31	13.0%	-29	-48.9%
Private nongroup	6	2.5%	0	0.2%	-5	-93.6%	0	0.2%	-5	-93.6%
Marketplace with PTC	5	2.3%	0	0.0%	-5	-100.0%	0	0.0%	-5	-100.0%
Full-pay Marketplace	0	0.0%	0	0.2%		829.8%	0	0.2%		829.8%
Other nongroup	0	0.2%	0	0.0%		-100.0%	0	0.0%		-100.0%
Medicaid/CHIP	112	47.7%	163	69.5%	51	45.8%	172	73.3%	60	53.8%
Disabled	10	4.3%	10	4.3%		0.2%	10	4.3%		0.4%
Medicaid expansion	38	16.1%	43	18.2%	5	12.7%	44	18.8%	6	16.4%
Traditional nondisabled adult	11	4.6%	11	4.8%	1	4.8%	11	4.8%	1	5.4%
Nondisabled Medicaid/CHIP child	53	22.7%	58	24.8%	5	9.5%	59	25.3%	6	11.5%
Medicaid Forward	0	0.0%	41	17.4%	41	100.0%	47	20.1%	47	100.0%
Other public	6	2.4%	6	2.4%		0.0%	6	2.4%		0.0%
Uninsured (no MEC)	52	21.9%	26	11.1%	-25	-49.2%	26	11.1%	-26	-49.6%
Total	235	100.0%	235	100.0%		0.0%	235	100.0%		0.0%
Other										
Insured (MEC)	19	93.2%	19	96.9%	1	3.9%	20	97.3%	1	4.3%
Employer	10	47.8%	7	32.5%	-3	-32.1%	5	24.4%	-5	-49.0%
Private nongroup	1	2.7%	0	0.6%		-77.0%	0	0.6%		-77.0%
Marketplace with PTC	0	0.9%	0	0.0%		-100.0%	0	0.0%		-100.0%
Full-pay Marketplace	0	0.8%	0	0.6%		-24.0%	0	0.6%		-24.0%
Other nongroup	0	1.0%	0	0.0%		-100.0%	0	0.0%		-100.0%
Medicaid/CHIP	8	38.3%	12	59.3%	4	55.0%	14	67.8%	6	77.1%
Disabled	1	2.6%	1	2.6%		0.0%	1	2.6%		0.0%
Medicaid expansion	3	14.2%	3	14.4%		1.1%	3	15.5%		8.8%
Traditional nondisabled adult	0	1.1%	0	1.1%		0.0%	0	1.1%		0.0%
Nondisabled Medicaid/CHIP child	4	20.3%	4	20.5%		0.8%	4	20.5%		0.8%
Medicaid Forward	0	0.0%	4	20.7%	4	100.0%	6	28.1%	6	100.0%
Other public	1	4.4%	1	4.4%		0.0%	1	4.4%		0.0%
Uninsured (no MEC)	1	6.8%	1	3.1%	-1	-53.5%	1	2.7%	-1	-59.4%
Total	20	100.0%	20	100.0%		0.0%	20	100.0%		0.0%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Notes: ACA = Affordable Care Act; FPL = federal poverty level; PTC = premium tax credit; MEC = minimum essential coverage; CHIP = Children's Health Insurance Program.

FIGURE 3

Uninsured Rates by Race/Ethnicity



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Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: ACA = Affordable Care Act.

Uninsurance by Region

Table 4 and figure 4 show health coverage in 12 substate regions with and without Medicaid Forward. Under current law, uninsured rates vary from 21.2 percent in the Northwest to 10.1 percent in the Southwest. Under Medicaid Forward with high enrollment, the uninsured rate would fall to 10.3 percent in the Northwest and 4.3 percent in the Southwest. While all regions would see substantial declines in uninsurance under Medicaid Forward, four regions would see declines of more than 60 percent: Albuquerque; Valencia, Bernalillo East Mountain, and Isleta Pueblo; Doña Ana; and the far Southeast.

TABLE 4

Health Insurance Coverage Distribution of the Nonelderly, by Region (Thousands of People)

	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
Albuquerque										
Insured (MEC)	514	87.8%	554	94.7%	40	7.8%	558	95.4%	44	8.6%
Employer	260	44.4%	186	31.8%	-74	-28.3%	137	23.5%	-123	-47.2%
Private nongroup	23	4.0%	2	0.4%	-21	-90.4%	2	0.3%	-22	-92.8%
Marketplace with PTC	14	2.4%	0	0.0%	-14	-100.0%	0	0.0%	-14	-100.0%
Full-pay Marketplace	2	0.3%	2	0.4%		12.6%	2	0.3%		-15.6%
Other nongroup	7	1.2%	0	0.0%	-7	-100.0%	0	0.0%	-7	-100.0%
Medicaid/CHIP	208	35.5%	343	58.6%	135	64.9%	396	67.7%	188	90.7%
Disabled	18	3.1%	18	3.1%		0.0%	18	3.1%		0.0%
Medicaid expansion	81	13.8%	85	14.6%	4	5.5%	88	15.0%	7	8.4%
Traditional nondisabled adult	17	2.9%	17	2.9%		1.0%	17	2.9%		1.2%
Nondisabled Medicaid/CHIP child	92	15.7%	95	16.2%	3	2.7%	97	16.6%	5	5.3%
Medicaid for All	0	0.0%	128	21.8%	128	100.0%	177	30.2%	177	100.0%
Other public	23	3.9%	23	3.9%		0.0%	23	3.9%		0.0%
Uninsured (no MEC)	71	12.2%	31	5.3%	-40	-56.3%	27	4.6%	-44	-61.9%
Total	585	100.0%	585	100.0%		0.0%	585	100.0%		0.0%
Northwest										
Insured (MEC)	105	78.8%	120	89.7%	15	13.8%	120	89.7%	15	13.8%
Employer	30	22.7%	19	14.6%	-11	-35.8%	14	10.6%	-16	-53.5%
Private nongroup	4	2.7%	0	0.3%	-3	-90.2%	0	0.1%	-3	-94.4%
Marketplace with PTC	3	2.5%	0	0.0%	-3	-100.0%	0	0.0%	-3	-100.0%
Full-pay Marketplace	0	0.1%	0	0.3%		124.8%	0	0.1%		27.7%
Other nongroup	0	0.1%	0	0.0%		-100.0%	0	0.0%		-100.0%
Medicaid/CHIP	67	50.5%	96	71.9%	29	42.4%	102	76.0%	34	50.6%
Disabled	6	4.3%	6	4.3%		0.4%	6	4.3%		0.4%
Medicaid expansion	23	17.3%	26	19.1%	3	10.9%	26	19.6%	3	13.8%
Traditional nondisabled adult	7	5.2%	7	5.4%		3.6%	7	5.5%		4.6%
Nondisabled Medicaid/CHIP child	32	23.7%	34	25.2%	2	6.5%	35	26.0%	3	9.8%
Medicaid for All	0	0.0%	24	17.8%	24	100.0%	27	20.6%	27	100.0%
Other public	4	2.9%	4	2.9%		0.0%	4	2.9%		0.0%
Uninsured (no MEC)	28	21.2%	14	10.3%	-15	-51.3%	14	10.3%	-15	-51.3%
Total	134	100.0%	134	100.0%		0.0%	134	100.0%		0.0%

	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
Farmington, Bloomfield, and Aztec cities										
Insured (MEC)	76	87.3%	81	92.7%	5	6.2%	81	92.7%	5	6.3%
Employer	41	46.8%	29	32.6%	-12	-30.3%	21	23.8%	-20	-49.2%
Private nongroup	4	4.5%	0	0.0%	-4	-100.0%	0	0.0%	-4	-100.0%
Marketplace with PTC	2	2.8%	0	0.0%	-2	-100.0%	0	0.0%	-2	-100.0%
Full-pay Marketplace	0	0.5%	0	0.0%		-100.0%	0	0.0%		-100.0%
Other Nongroup	1	1.1%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Medicaid/CHIP	29	33.6%	50	57.6%	21	71.6%	58	66.5%	29	98.2%
Disabled	2	2.2%	2	2.2%		0.0%	2	2.2%		0.0%
Medicaid expansion	11	12.3%	12	13.5%	1	9.5%	12	13.8%	1	11.5%
Traditional nondisabled adult	3	3.9%	3	3.9%		0.0%	3	3.9%		0.0%
Nondisabled Medicaid/CHIP child	13	15.1%	14	15.6%		3.5%	14	16.0%	1	5.8%
Medicaid Forward	0	0.0%	20	22.4%	20	100.0%	27	30.7%	27	100.0%
Other public	2	2.4%	2	2.4%		0.0%	2	2.4%		0.0%
Uninsured (no MEC)	11	12.7%	6	7.3%	-5	-42.4%	6	7.3%	-5	-43.0%
Total	88	100.0%	88	100.0%		0.0%	88	100.0%		0.0%
North Central										
Insured (MEC)	95	88.3%	103	95.4%	8	8.0%	103	95.8%	8	8.5%
Employer	45	41.5%	27	25.1%	-18	-39.6%	20	18.2%	-25	-56.0%
Private nongroup	6	5.2%	0	0.2%	-5	-96.8%	0	0.1%	-6	-97.6%
Marketplace with PTC	5	4.4%	0	0.0%	-5	-100.0%	0	0.0%	-5	-100.0%
Full-Pay Marketplace	0	0.0%	0	0.2%		332.0%	0	0.1%		228.6%
Other nongroup	1	0.8%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Medicaid/CHIP	40	37.5%	71	66.1%	31	76.2%	79	73.3%	39	95.5%
Disabled	5	5.0%	5	5.0%		0.0%	5	5.0%		0.0%
Medicaid expansion	15	13.9%	15	14.3%		3.1%	16	14.7%	1	6.0%
Traditional nondisabled adult	4	3.4%	4	3.5%		3.0%	4	3.5%		3.0%
Nondisabled Medicaid/CHIP child	16	15.2%	17	16.1%	1	6.0%	18	16.6%	1	9.1%
Medicaid Forward	0	0.0%	29	27.1%	29	100.0%	36	33.5%	36	100.0%
Other public	4	4.1%	4	4.1%		0.0%	4	4.1%		0.0%
Uninsured (no MEC)	13	11.7%	5	4.6%	-8	-60.6%	5	4.2%	-8	-63.9%
Total	108	100.0%	108	100.0%		0.0%	108	100.0%		0.0%
	95	88.3%	103	95.4%	8	8.0%				

	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
Eastern Plains										
Insured (MEC)	77	87.9%	82	93.8%	5	6.8%	83	94.9%	6	8.0%
Employer	27	30.6%	19	21.8%	-8	-28.7%	15	17.5%	-11	-42.7%
Private nongroup	4	4.2%	0	0.1%	-4	-97.0%	0	0.1%	-4	-97.0%
Marketplace with PTC	3	3.4%	0	0.0%	-3	-100.0%	0	0.0%	-3	-100.0%
Full-pay Marketplace	0	0.1%	0	0.1%		-10.4%	0	0.1%		-10.4%
Other nongroup	1	0.7%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Medicaid/CHIP	38	43.3%	54	62.1%	16	43.5%	59	67.5%	21	55.9%
Disabled	5	5.6%	5	5.7%		0.8%	5	5.7%		0.9%
Medicaid expansion	13	14.4%	13	14.6%		1.6%	13	14.7%		2.3%
Traditional nondisabled adult	4	4.4%	4	4.4%		0.0%	4	4.4%		0.0%
Nondisabled Medicaid/CHIP child	16	18.9%	17	19.1%		0.7%	17	19.3%		2.2%
Medicaid Forward	0	0.0%	16	18.4%	16	100.0%	20	23.4%	20	100.0%
Other public	8	9.8%	8	9.8%		0.0%	8	9.8%		0.0%
Uninsured (no MEC)	11	12.1%	5	6.2%	-5	-49.1%	4	5.1%	-6	-58.1%
Total	87	100.0%	87	100.0%		0.0%	87	100.0%		0.0%
Santa Fe County										
Insured (MEC)	105	84.5%	115	92.4%	10	9.3%	116	93.5%	11	10.6%
Employer	54	43.7%	32	26.0%	-22	-40.5%	25	19.9%	-30	-54.4%
Private nongroup	8	6.8%	0	0.1%	-8	-98.1%	0	0.1%	-8	-98.1%
Marketplace with PTC	6	4.8%	0	0.0%	-6	-100.0%	0	0.0%	-6	-100.0%
Full-pay Marketplace	0	0.3%	0	0.1%		-57.1%	0	0.1%		-57.1%
Other nongroup	2	1.7%	0	0.0%	-2	-100.0%	0	0.0%	-2	-100.0%
Medicaid/CHIP	38	30.8%	78	63.0%	40	104.5%	87	70.2%	49	127.8%
Disabled	5	4.3%	5	4.3%		0.0%	5	4.4%		0.3%
Medicaid expansion	14	11.6%	15	12.2%	1	5.7%	15	12.4%	1	7.1%
Traditional nondisabled adult	2	1.9%	2	1.9%		0.0%	2	2.0%		0.7%
Nondisabled Medicaid/CHIP child	16	13.0%	17	13.4%	1	3.5%	17	13.5%	1	4.6%
Medicaid Forward	0	0.0%	39	31.1%	39	100.0%	47	37.9%	47	100.0%
Other public	4	3.3%	4	3.3%		0.0%	4	3.3%		0.0%
Uninsured (no MEC)	19	15.5%	9	7.6%	-10	-50.8%	8	6.5%	-11	-57.9%
Total	124	100.0%	124	100.0%		0.0%	124	100.0%		0.0%

	Current law ACA		Medicaid Forward (low enrollment	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
Sandoval County										
Insured (MEC)	108	88.6%	115	94.7%	7	6.8%	116	94.9%	8	7.0%
Employer	62	51.0%	46	38.0%	-16	-25.5%	35	28.4%	-28	-44.2%
Private nongroup	4	3.4%	0	0.0%	-4	-98.6%	0	0.0%	-4	-98.6%
Marketplace with PTC	2	1.7%	0	0.0%	-2	-100.0%	0	0.0%	-2	-100.0%
Full-pay Marketplace	0	0.3%	0	0.0%		-84.4%	0	0.0%		-84.4%
Other nongroup	2	1.4%	0	0.0%	-2	-100.0%	0	0.0%	-2	-100.0%
Medicaid/CHIP	37	30.5%	64	52.8%	27	73.1%	76	62.6%	39	105.3%
Disabled	2	1.8%	2	1.8%		0.0%	2	1.8%		0.0%
Medicaid expansion	15	12.3%	17	13.8%	2	12.1%	17	14.1%	2	15.0%
Traditional nondisabled adult	4	3.0%	4	3.1%		1.7%	4	3.2%		4.2%
Nondisabled Medicaid/CHIP child	16	13.4%	17	14.3%	1	6.7%	18	14.9%	2	11.6%
Medicaid Forward	0	0.0%	24	19.9%	24	100.0%	35	28.6%	35	100.0%
Other public	5	3.8%	5	3.8%		0.0%	5	3.8%		0.0%
Uninsured (no MEC)	14	11.4%	7	5.3%	-7	-52.9%	6	5.1%	-8	-54.9%
Total	122	100.0%	122	100.0%		0.0%	122	100.0%		0.0%
Valencia, Bernalillo East Mountains and Isleta Pueblo										
Insured (MEC)	76	89.1%	81	95.0%	5	6.6%	82	95.9%	6	7.6%
Employer	38	45.0%	25	29.2%	-13	-35.2%	20	23.1%	-19	-48.7%
Private nongroup	2	2.3%	0	0.2%	-2	-92.6%	0	0.2%	-2	-92.6%
Marketplace with PTC	1	1.7%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Full-pay Marketplace	0	0.1%	0	0.2%		46.2%	0	0.2%		46.2%
Other nongroup	0	0.5%	0	0.0%		-100.0%	0	0.0%		-100.0%
Medicaid/CHIP	31	36.9%	52	60.7%	20	64.5%	58	67.7%	26	83.5%
Disabled	4	5.2%	4	5.2%		0.0%	4	5.2%		0.0%
Medicaid expansion	10	11.4%	10	11.9%		4.2%	10	12.1%	1	6.4%
Traditional nondisabled adult	3	3.9%	3	3.9%		0.0%	3	3.9%		0.0%
Nondisabled Medicaid/CHIP child	14	16.3%	15	17.1%	1	4.7%	15	17.3%	1	6.0%
Medicaid Forward	0	0.0%	19	22.6%	19	100.0%	25	29.1%	25	100.0%
Other public	4	5.0%	4	5.0%		0.0%	4	5.0%		0.0%
Uninsured (no MEC)	9	10.9%	4	5.0%	-5	-53.9%	3	4.1%	-6	-62.1%
Total	85	100.0%	85	100.0%		0.0%	85	100.0%		0.0%

	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
Southwest										
Insured (MEC)	76	89.9%	81	95.4%	5	6.2%	81	95.7%	5	6.5%
Employer	27	31.8%	18	20.8%	-9	-34.6%	13	15.5%	-14	-51.3%
Private nongroup	3	3.4%	0	0.3%	-3	-89.8%	0	0.2%	-3	-93.1%
Marketplace with PTC	2	2.7%	0	0.0%	-2	-100.0%	0	0.0%	-2	-100.0%
Full-pay Marketplace	0	0.2%	0	0.3%		79.8%	0	0.2%		22.5%
Other nongroup	0	0.5%	0	0.0%		-100.0%	0	0.0%		-100.0%
Medicaid/CHIP	43	50.8%	60	70.4%	17	38.6%	65	76.1%	21	49.8%
Disabled	5	6.3%	5	6.3%		0.0%	5	6.3%		0.0%
Medicaid expansion	18	21.6%	19	22.7%	1	5.2%	20	23.2%	1	7.5%
Traditional nondisabled adult	2	2.5%	2	2.5%		0.0%	2	2.7%		6.3%
Nondisabled Medicaid/CHIP child	17	20.3%	18	20.8%		2.3%	18	21.1%	1	4.1%
Medicaid Forward	0	0.0%	15	18.0%	15	100.0%	19	22.7%	19	100.0%
Other public	3	3.8%	3	3.8%		0.0%	3	3.8%		0.0%
Uninsured (no MEC)	9	10.1%	4	4.6%	-5	-54.9%	4	4.3%	-5	-57.4%
Total	85	100.0%	85	100.0%		0.0%	85	100.0%		0.0%
Doña Ana County										
Insured (MEC)	166	86.9%	181	94.8%	15	9.1%	183	95.7%	17	10.2%
Employer	70	36.4%	46	24.1%	-24	-33.9%	31	16.0%	-39	-56.1%
Private nongroup	5	2.5%	0	0.1%	-5	-96.1%	0	0.0%	-5	-98.2%
Marketplace with PTC	4	2.0%	0	0.0%	-4	-100.0%	0	0.0%	-4	-100.0%
Full-pay Marketplace	0	0.1%	0	0.1%		-32.6%	0	0.0%		-69.3%
Other nongroup	1	0.3%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Medicaid/CHIP	87	45.3%	130	67.9%	43	50.0%	147	77.0%	61	70.1%
Disabled	7	3.6%	7	3.6%		0.0%	7	3.6%		0.0%
Medicaid expansion	34	17.9%	36	18.9%	2	5.8%	37	19.4%	3	8.3%
Traditional nondisabled adult	6	3.2%	6	3.2%		0.9%	6	3.2%		0.9%
Nondisabled Medicaid/CHIP child	39	20.6%	40	20.9%	1	1.6%	40	21.0%	1	2.3%
Medicaid Forward	0	0.0%	41	21.2%	41	100.0%	57	29.8%	57	100.0%
Other public	5	2.7%	5	2.7%		0.0%	5	2.7%		0.0%
Uninsured (no MEC)	25	13.1%	10	5.2%	-15	-60.4%	8	4.3%	-17	-67.6%
Total	191	100.0%	191	100.0%		0.0%	191	100.0%		0.0%

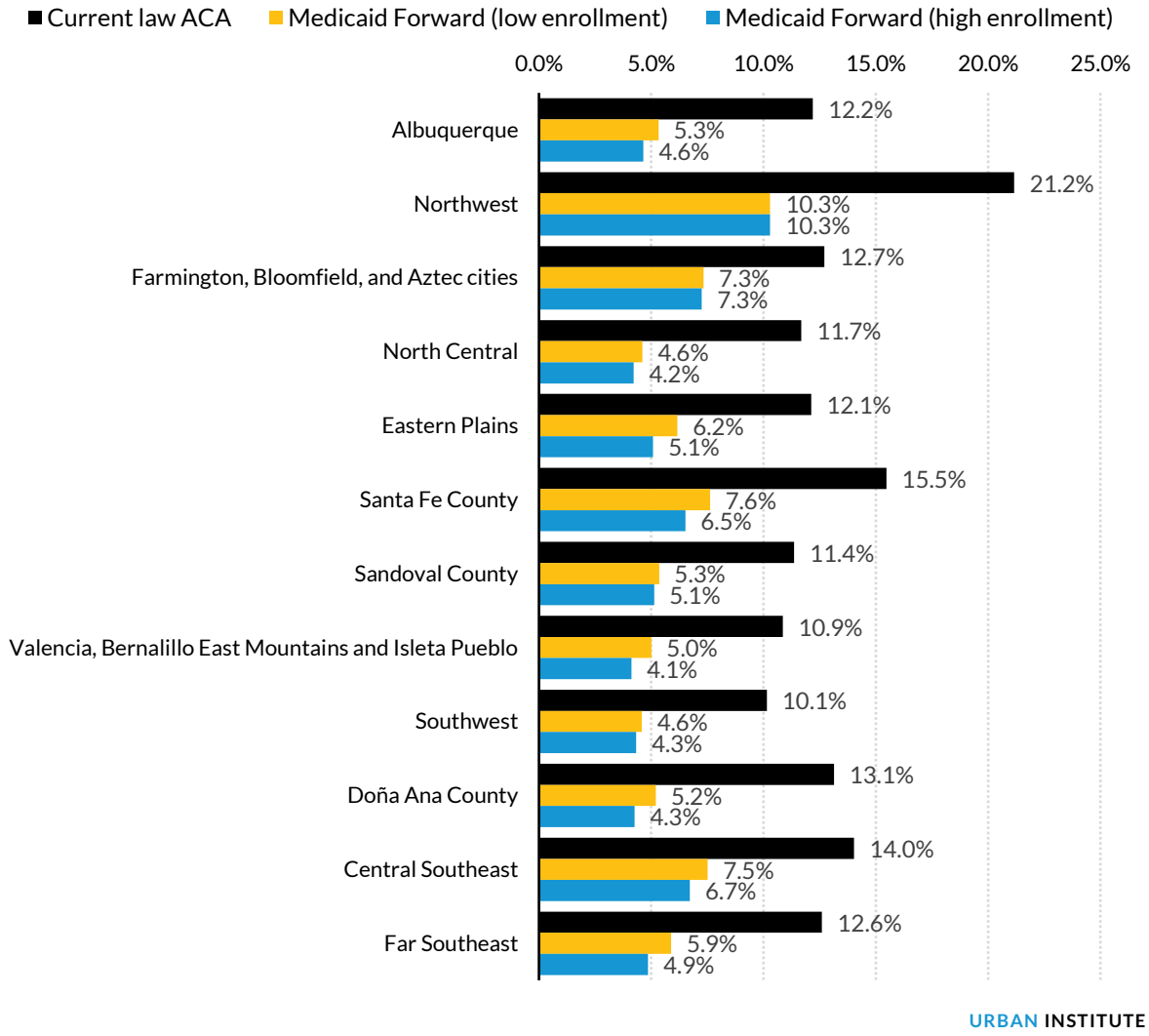
	Current law ACA		Medicaid Forward (low enrollment)	Change		Percent change	Medicaid Forward (high enrollment)	Change		Percent change
Central Southeast										
Insured (MEC)	111	86.0%	119	92.5%	8	7.6%	120	93.3%	9	8.5%
Employer	42	32.9%	27	20.8%	-16	-36.7%	17	13.1%	-25	-60.0%
Private nongroup	4	3.2%	0	0.1%	-4	-95.9%	0	0.1%	-4	-95.9%
Marketplace with PTC	3	2.4%	0	0.0%	-3	-100.0%	0	0.0%	-3	-100.0%
Full-pay Marketplace	0	0.2%	0	0.1%		-34.2%	0	0.1%		-34.2%
Other nongroup	1	0.6%	0	0.0%	-1	-100.0%	0	0.0%	-1	-100.0%
Medicaid/CHIP	54	42.3%	82	64.0%	28	51.1%	93	72.4%	39	71.1%
Disabled	5	4.1%	5	4.1%		0.0%	5	4.2%		0.8%
Medicaid expansion	19	14.7%	20	15.6%	1	6.3%	20	15.9%	2	8.0%
Traditional nondisabled adult	5	4.2%	5	4.2%		1.8%	6	4.3%		4.1%
Nondisabled Medicaid/CHIP child	25	19.3%	27	20.6%	2	6.6%	27	20.9%	2	8.3%
Medicaid Forward	0	0.0%	25	19.4%	25	100.0%	35	27.1%	35	100.0%
Other public	10	7.6%	10	7.6%		0.0%	10	7.6%		0.0%
Uninsured (no MEC)	18	14.0%	10	7.5%	-8	-46.5%	9	6.7%	-9	-52.1%
Total	129	100.0%	129	100.0%		0.0%	129	100.0%		0.0%
Far Southeast										
Insured (MEC)	95	87.4%	102	94.1%	7	7.7%	103	95.1%	8	8.9%
Employer	52	47.9%	35	32.5%	-17	-32.2%	27	24.6%	-25	-48.7%
Private nongroup	5	4.3%	0	0.1%	-5	-97.6%	0	0.1%	-5	-97.6%
Marketplace with PTC	3	2.3%	0	0.0%	-3	-100.0%	0	0.0%	-3	-100.0%
Full-pay Marketplace	0	0.3%	0	0.1%		-67.8%	0	0.1%		-67.8%
Other nongroup	2	1.7%	0	0.0%	-2	-100.0%	0	0.0%	-2	-100.0%
Medicaid/CHIP	36	33.0%	64	59.4%	29	79.8%	74	68.3%	38	106.9%
Disabled	3	2.6%	3	2.6%		0.0%	3	2.6%		0.0%
Medicaid expansion	11	10.4%	12	11.1%	1	6.2%	12	11.4%	1	9.3%
Traditional nondisabled adult	3	2.3%	3	2.3%		0.0%	3	2.3%		0.0%
Nondisabled Medicaid/CHIP child	19	17.6%	19	17.8%		1.2%	20	18.0%		2.3%
Medicaid Forward	0	0.0%	28	25.5%	28	100.0%	37	33.9%	37	100.0%
Other public	2	2.1%	2	2.1%		0.0%	2	2.1%		0.0%
Uninsured (no MEC)	14	12.6%	6	5.9%	-7	-53.3%	5	4.9%	-8	-61.5%
Total	108	100.0%	108	100.0%		0.0%	108	100.0%		0.0%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Notes: ACA = Affordable Care Act; FPL = federal poverty level; PTC = premium tax credit; MEC = minimum essential coverage; CHIP = Children's Health Insurance Program.

FIGURE 4

Uninsured Rates by Region



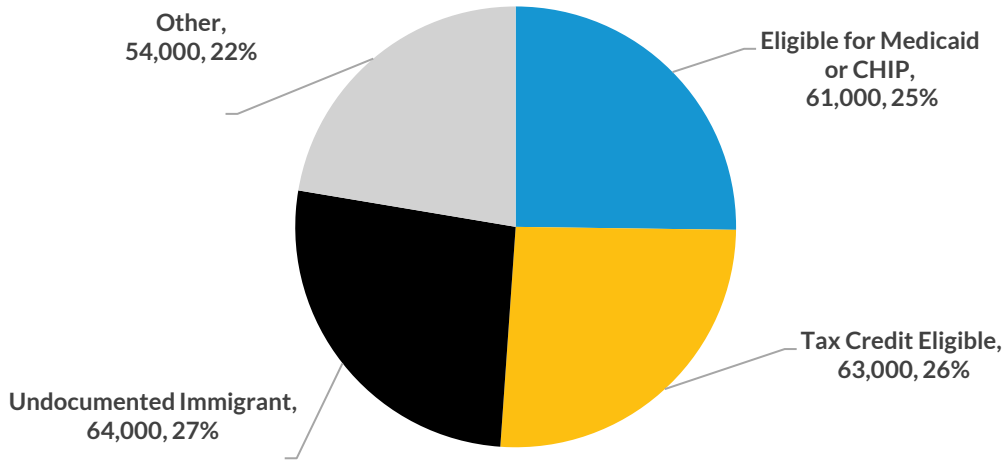
Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: ACA = Affordable Care Act.

Eligibility for Assistance among the Uninsured

Of the 242,000 nonelderly New Mexicans estimated to be uninsured in 2024 under current law, 25 percent are eligible for Medicaid or CHIP but not enrolled (figure 5). Another 26 percent are eligible for Marketplace PTCs, but not enrolled. About 27 percent of the uninsured are undocumented immigrants who are ineligible for all three programs. The remaining 22 percent are also ineligible for assistance, nearly all because they have an offer of employer coverage that is deemed affordable under the ACA.

FIGURE 5

Eligibility of Uninsured New Mexicans Under Current Law



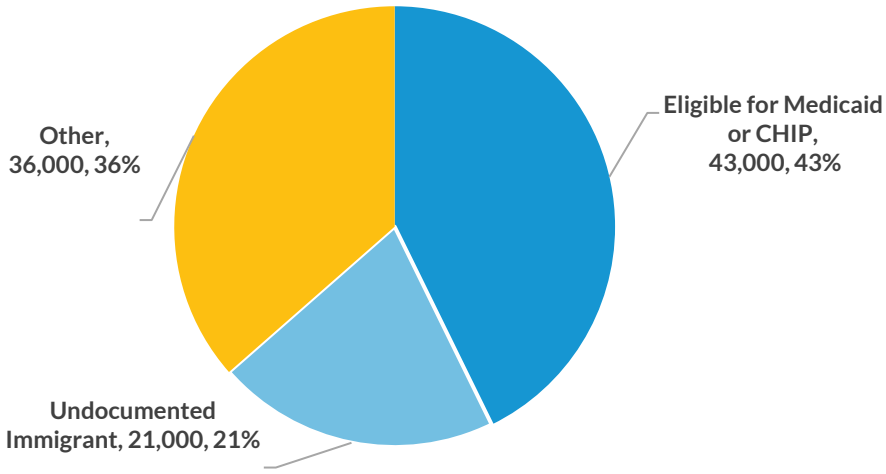
URBAN INSTITUTE

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: CHIP = Children's Health Insurance Program.

Under Medicaid Forward, not only would there be 142,000 fewer uninsured New Mexicans (with high take-up), but all of them would be eligible for Medicaid or CHIP. About 43 percent would be eligible for traditional Medicaid or CHIP (figure 6), 21 percent would be uninsured undocumented immigrants eligible for Medicaid Forward but not enrolled, and 36 percent would be lawfully present New Mexicans eligible but not enrolled.

FIGURE 6

Eligibility of Uninsured New Mexicans, Medicaid Forward



URBAN INSTITUTE

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: CHIP = Children's Health Insurance Program.

The key to increasing health coverage beyond what we estimate will be increasing enrollment among those eligible for assistance, particularly those currently eligible for Medicaid or CHIP but not enrolled. The proposal does not directly change the coverage for which these people are eligible, so there is no new financial incentive. We estimate that more would enroll, particularly as family members newly enroll in the new Medicaid expansion. However, the proposal does not contain provisions specifically designed to increase enrollment among those already eligible for Medicaid (See the Discussion section on page 38).

Table 5 shows some additional characteristics of the uninsured with and without Medicaid Forward.

TABLE 5

Characteristics of the Uninsured (Thousands of People)

Characteristics	Uninsured under Current Law			Uninsured under Medicaid Forward (High Enrollment)		
	Number of uninsured	Percent of total	Uninsured rate	Number of uninsured	Percent of total	Uninsured rate
Race and Ethnicity						
White, non-Hispanic	47	19.4%	7.6%	16	16.2%	2.6%
Hispanic	134	55.6%	14.8%	53	53.2%	5.8%
Black, non-Hispanic	4	1.8%	12.0%	3	2.9%	7.7%
Asian and Pacific Islander	3	1.3%	10.4%	1	1.1%	3.7%
American Indian/Alaska Native	52	21.3%	21.9%	26	26.0%	11.1%
Other	1	0.6%	6.8%	1	0.6%	2.7%
Age group						
0 –18	41	17.1%	7.5%	25	25.2%	4.5%
19–34	88	36.2%	18.4%	39	39.1%	8.2%
35–54	87	35.9%	16.2%	27	27.5%	5.1%
55–64	26	10.8%	9.3%	8	8.2%	2.9%
Sex						
Male	136	56.2%	14.7%	61	61.6%	6.6%
Female	106	43.8%	11.5%	38	38.4%	4.2%
English proficiency—individual (age 19–64)						
Subtotal	200		15.5%	75	0	5.8%
Speak very well or better	150	74.9%	12.9%	58	77.9%	5.0%
Not very well or less proficient	50	25.1%	38.4%	16	22.1%	12.6%
Education—individual (age 19–64)						
Subtotal	200		15.5%			
Less than high school	34	16.8%	32.5%	13	17.6%	12.6%
High school	74	37.0%	19.8%	28	37.7%	7.5%
Some college	62	31.2%	14.6%	22	29.5%	5.1%
College graduate	30	15.0%	7.8%	11	15.2%	2.9%
Citizenship status—individual						
Citizen	172	71.2%	10.0%	77	77.1%	4.5%
Non-citizen—Undocumented	64	26.5%	77.7%	21	20.8%	25.1%
Non-citizen—Documented	5	2.2%	11.5%	2	2.1%	4.4%
Citizenship status—family						
All citizen	165	68.4%	10.3%	74	74.3%	4.6%
Has undocumented immigrant	67	27.8%	43.1%	21	21.5%	13.8%
No undocumented, has legal immigrant	9	3.9%	10.6%	4	4.2%	4.8%
Working status—family						
No worker in family	43	17.9%	12.7%	19	19.0%	5.6%
Only part-time worker in family	15	6.3%	11.7%	6	6.5%	4.9%
One full-time worker in family	145	60.2%	14.9%	59	58.9%	6.0%
>1 full-time worker in family	38	15.6%	9.4%	16	15.5%	3.9%
Total	242	100.0%	13.1%	100	100.0%	5.4%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Household Health Care Spending

We estimate the change in household spending on health care by income under Medicaid Forward under low and high enrollment scenarios. With low enrollment, households spend 28.3 percent less on acute health care for the nonelderly in total, a reduction of $920 million (table 6). Spending on premiums declines by 25.6 percent, while OOP health care spending declines by 32.7 percent.

While households at all income levels spend notably less under Medicaid Forward, the largest percentage declines are at the lowest incomes. Those with incomes below 138 percent of FPL would see a 39.6 percent decrease, while those with incomes between 138 percent and 200 percent of FPL would see a 34.8 percent decrease. Those with the highest incomes would see a 22.8 percent decrease.

TABLE 6

Total Household Spending on Acute Care for the Nonelderly by Income Group, Low Enrollment (Millions of Dollars)

	Income < 138% of FPL	138% ≤ Income < 200% of FPL	200% ≤ Income < 400% of FPL	Income >= 400% of FPL	Total, All Incomes
Current Law					
Premiums	148	157	595	948	1,849
Other health care spending	188	121	453	647	1,409
Subtotal, household	337	278	1,048	1,595	3,258
Medicaid Forward (Low Enrollment)					
Premiums	113	111	415	737	1,375
Other health care spending	91	70	306	495	962
Subtotal, household	203	181	721	1,231	2,337
Change from Current Law					
Premiums	-35	-46	-180	-212	-473
Other health care spending	-98	-51	-147	-152	-447
Subtotal, household	-133	-97	-327	-364	-920
Percent Change					
Premiums	-23.9%	-29.3%	-30.3%	-22.3%	-25.6%
Other health care spending	-51.9%	-42.0%	-32.4%	-23.5%	-31.7%
Subtotal, household	-39.6%	-34.8%	-31.2%	-22.8%	-28.3%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: FPL = federal poverty level.

Under a scenario with higher Medicaid Forward enrollment, even more people would save on health care, so the total savings would be larger, nearly $1.2 billion or a reduction of 37.9 percent for all

incomes (table 7). Those with the lowest incomes would see their total health care spending cut nearly in half.

TABLE 7

Total Household Spending on Acute Care for the Nonelderly by Income Group, High Enrollment (Millions of Dollars)

	Income < 138% of FPL	138% ≤ Income < 200% of FPL	200% ≤ Income < 400% of FPL	Income >= 400% of FPL	Total, All Incomes
Current Law					
Premiums	148	157	595	948	1,849
Other health care spending	188	121	453	647	1,409
Subtotal, household	337	278	1,048	1,595	3,258
Medicaid Forward (High Enrollment)					
Premiums	95	92	336	685	1,209
Other health care spending	75	57	248	436	816
Subtotal, household	171	149	584	1,121	2,025
Change from Current Law					
Premiums	-53	-65	-259	-264	-640
Other health care spending	-113	-65	-205	-211	-593
Subtotal, household	-166	-129	-464	-474	-1,233
Percent Change					
Premiums	-35.6%	-41.2%	-43.5%	-27.8%	-34.6%
Other health care spending	-60.0%	-53.4%	-45.3%	-32.6%	-42.1%
Subtotal, household	-49.2%	-46.5%	-44.3%	-29.7%	-37.9%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: FPL = federal poverty level.

Employer Spending

As explained in the Methods section above, there is substantial uncertainty in predicting how many people currently covered by ESI would switch to Medicaid Forward. We look at the total and average spending per worker for large and small firms. Under the low enrollment scenario with Medicaid reimbursed at 17 percent above current rates, large firms would spend $498 million less) and small firms $273 less in total premium contributions (table 8). We assume that about 90 percent of the net savings to employers, after deducting Medicaid Forward contributions, would be passed back to workers as higher wages, $230 million in large firms and $206 million in small firms. Large firms would

be assessed $247 million in contributions for workers taking Medicaid Forward, while small firms would not pay anything. On net, large employers would save $20 million in total, while small employers would save $67 million. Lower Medicaid reimbursement rates would have little effect on these estimates, except for the size of employer contributions. As we noted earlier, not all large individual firms would spend less. In particular, a small number of large firms that do not currently provide health coverage would be subject to this contribution.[7]

TABLE 8

Total Employer Spending Impact with Employer Contributions, Except for State Employees (Millions of Dollars)

Millions of Dollars	Medicaid +7%		Medicaid +17%	
	Medicaid Forward (low enrollment)	Medicaid Forward (high enrollment)	Medicaid Forward (low enrollment)	Medicaid Forward (high enrollment)
Large firms (50 or more workers)				
Premium contributions	-498	-1,214	-498	-1,214
Wage increases	250	671	230	637
Medicaid Forward employer contributions	221	379	247	422
Total spending change	**-26**	**-163**	**-20**	**-154**
Small firms (up to 50 workers)				
Premium contributions	-273	-312	-273	-312
Wage increases	206	237	206	237
Medicaid Forward employer contributions				
Total spending change	**-67**	**-75**	**-67**	**-75**

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

If we look at these results in terms of spending on the average worker, a large firm would pay $255 less per worker in employer contributions (table 9). They would pass back $118 in increased wages per worker and pay $127 in employer contributions per worker. Thus, a large firm would save $10 per worker on average. If the wage pass-back were smaller than estimated, the firm would save more.

TABLE 9

Average Employer Spending Impact per Worker with Employer Contributions, Except for State Employees

Millions of Dollars	Medicaid +7%		Medicaid +17%	
	Medicaid Forward (low enrollment)	Medicaid Forward (high enrollment)	Medicaid Forward (low enrollment)	Medicaid Forward (high enrollment)
Large firms (50 or more workers)				
Premium contributions	-255	-623	-255	-623
Wage increases	128	344	118	327
Medicaid Forward employer contributions	114	194	127	217
Total spending change	**-13**	**-84**	**-10**	**-79**
Small firms (Up to 50 workers)				
Premium contributions	-1,162	-1,326	-1,162	-1,326
Wage increases	876	1,008	876	1,008
Medicaid Forward employer contributions	0	0	0	0
Total spending change	**-286**	**-318**	**-286**	**-318**

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

With higher take-up, premium savings are substantially higher, as are employer contributions and wage increases. Again, both large and small firms see savings in total, $163 million (average $84 per worker) for large firms and $75 million (average $318 per worker) for small firms.

A state payroll tax on employers could be an alternative to the employer contribution. A payroll tax rate of 1.007 percent of wages for the high take-up scenario with reimbursements at 17 percent above Medicaid rates would result in large firms spending $1.2 billion less and small firms spending $312 million less in total premium contributions (table 10). Alternatively, small firms could be exempt from the payroll tax, as they are from the employer contribution, in which case a slightly higher rate would be required.[8] We assume that $637 million in large firms and $237 million in small firms would be passed back to workers as higher wages. Large firms would pay $331 million in payroll taxes and small firms will pay $90 million in payroll taxes. On net, large employers would save $245 million total, while small employers' costs would increase by $15 million.

TABLE 10

Employer Spending Impact with Payroll Taxes Instead of Employer Contributions, Except for State Employees (Millions of Dollars)

Millions of Dollars	Medicaid +7%	Medicaid +17%
	Medicaid Forward (high enrollment)	Medicaid Forward (high enrollment)
Large firms (50 or more workers)		
Premium contributions	-1,214	-1,214
Wage increases	671	637
Medicaid Forward employer contributions	227	331
Total spending change	**-316**	**-245**
Small firms (up to 50 workers)		
Premium contributions	-312	-312
Wage increases	237	237
Medicaid Forward employer contributions	62	90
Total spending change	**-13**	**15**

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: *Payroll tax rate is 0.6888 percent for the high take-up Medicaid +7 percent scenario. Payroll tax rate is 1.007 percent for the high take-up Medicaid +17 percent scenario.

A tax rate of 0.6888 percent for the high take-up scenario with reimbursements at Medicaid plus 7 percent would result in $316 million net savings for large employers and $13 million net savings for small employers.

Most economists believe that the incidence of a payroll tax would eventually fall on the worker. This could reduce the wage pass-back to workers somewhat.

Total Health Care Spending

We estimate that under Medicaid Forward, total health care spending on acute care for the nonelderly would increase by 6 percent to 9.1 percent, depending on take-up and Medicaid reimbursement rates (table 11). Those currently enrolled in employer coverage who switch to Medicaid Forward would see total health care spending decline by about 0.9 percent or 9.5 percent, depending on take-up and Medicaid reimbursement rates. Medicaid rates would be lower than commercial ESI rates. However, Medicaid Forward would have a higher actuarial value than most employer plans, resulting in a higher volume of health care services demanded by patients, partially offsetting the impact of lower rates on total spending. The situation is similar for those moving from nongroup coverage to Medicaid Forward, but provider reimbursements tend to be lower in that market, and the difference in actuarial value would be much higher (in many cases, going from 60 percent to over 95 percent actuarial value). As a result, total health spending for this group would increase under either reimbursement rate policy.

TABLE 11

Spending on Acute Care for the Nonelderly (Thousands of People, Millions of Dollars)

Coverage Type	Number of People	Current Law	Medicaid Forward	Difference	Percent Difference
Low Enrollment, Medicaid +7%					
ESI to Medicaid or Medicaid Forward	240	1,740	1,575	-165	-9.5%
Nongroup to Medicaid or Medicaid Forward	67	474	575	101	21.3%
Uninsured to Medicaid or Medicaid Forward	128	194	984	790	407.1%
Medicaid before and after	710	5,437	5,437	0	0.0%
Others	701	4,327	4,353	26	0.6%
Total	1,846	12,173	12,924	751	6.2%
High Enrollment, Medicaid +7%					
ESI to Medicaid or Medicaid Forward	377	2,742	2,482	-260	-9.5%
Nongroup to Medicaid or Medicaid Forward	67	474	578	104	22.0%
Uninsured to Medicaid or Medicaid Forward	141	199	1,069	869	436.4%
Medicaid before and after	710	5,437	5,437	0	0.0%
Others	552	3,320	3,334	15	0.4%
Total	1,846	12,172	12,901	728	6.0%
Low Enrollment, Medicaid +17%					
ESI to Medicaid or Medicaid Forward	240	1,740	1,723	-17	-1.0%
Nongroup to Medicaid or Medicaid Forward	67	474	633	159	33.5%
Uninsured to Medicaid or Medicaid Forward	129	194	1,068	875	451.3%
Medicaid before and after	710	5,437	5,437	0	0.0%
Others	700	4,328	4,354	26	0.6%
Total	1,846	12,173	13,215	1,042	8.6%
High Enrollment, Medicaid +17%					
ESI to Medicaid or Medicaid Forward	377	2,742	2,718	-24	-0.9%
Nongroup to Medicaid or Medicaid Forward	67	474	637	163	34.3%
Uninsured to Medicaid or Medicaid Forward	141	199	1,160	960	482.1%
Medicaid before and after	710	5,437	5,437	0	0.0%
Others	552	3,320	3,334	15	0.4%
Total	1,846	12,172	13,286	1,114	9.1%

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Notes: ESI = employer-sponsored insurance.

Currently, uninsured New Mexicans would see enormous increases in health care spending on their behalf when they gain Medicaid Forward coverage. They would receive substantially more health care, and providers would be reimbursed at significantly higher-than-Medicare rates, including the increases passed by the state legislature in 2023, rather than incurring uncompensated care.

Those currently enrolled in Medicaid and CHIP would have their health care reimbursed at higher rates. Their utilization would not change noticeably under Medicaid Forward, so total health care spending would match the increase in reimbursements. Finally, the total health care spending of those who do not enroll in Medicaid Forward would not change much.

Federal Government Spending

Depending on enrollment, the federal government would spend between $2.4 billion and $3.1 billion more in Medicaid under the proposal in 2024, assuming New Mexico Medicaid would reimburse at 17 percent above Medicaid rates (table 12). Federal spending on Marketplace PTCs would cease, saving $346 million. With fewer uninsured people, federal spending on uncompensated care would decline by $64 million to $65 million, mainly because of lower Medicare Disproportionate Share Hospital payments. In sum, federal spending would increase between $1.9 billion and $2.7 billion.

TABLE 12

Change to Federal Deficit, All Incomes (Millions of Dollars)

Millions of Dollars	Medicaid +7%		Medicaid +17%	
	Medicaid Forward (Low enrollment)	Medicaid Forward (High enrollment)	Medicaid Forward (Low enrollment)	Medicaid Forward (High enrollment)
Changes in spending				
*Medicaid**	2,099	2,749	2,364	3,081
ACA subsidies	-346	-346	-346	-346
Uncompensated care	-64	-65	-64	-65
Total spending change	*1,689*	*2,337*	*1,954*	*2,670*
Changes in revenue				
Income and payroll effect of ESI change	163	304	158	294
Change in federal deficit	*1,525*	*2,033*	*1,796*	*2,376*

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Notes: ESI = employer-sponsored insurance. * Includes additional spending on elderly and limited-benefit Medicaid enrollees because of higher Medicaid payment rates. Spending on Specified Low-Income Medicare Beneficiaries and Qualifying Individuals does not change because those costs are based on Medicare premiums. Federal costs for uncompensated care are paid by several agencies, including the Department of Health and Human Services, Veterans Affairs and Indian Health Service. These agencies have activities beyond the direct provision of care; we assume their funding will not shrink in proportion to the reduction in uncompensated care provided. Savings shown are mainly from lower Medicare Disproportionate Share Hospital spending.

As wages rise in response to lower employer health care spending, we estimate that the federal government would collect between $158 and $294 million in additional federal income and payroll taxes, depending on enrollment. Thus, federal spending net of revenues would increase by between $1.8 billion and $2.4 billion.

If Medicaid were reimbursed at 7 percent above Medicaid rates, federal Medicaid spending would increase by between $1.7 and $2.3 billion, depending on enrollment. Considering other offsets and new revenue, the federal deficit would increase by between $1.5 and $2 billion.

New Mexico Government Spending

We examine total state government spending under Medicaid Forward in detail for each of the two payment rate levels we simulated. We also examine state government spending under a state payroll tax scenario for additional revenue.

Medicaid Forward at Medicaid Plus 17 Percent Rates

Although the coverage available to those currently eligible for Medicaid and CHIP would not directly change under the proposal, more of them would choose to enroll, particularly if other family members newly enroll in the new Medicaid expansion. As a result, we estimate that the state would spend between $57 and $73 million more to cover these new enrollees and higher provider reimbursements for existing enrollees (table 13),[9] depending on enrollment. The largest new cost to the state would be the state share of the new Medicaid Forward enrollees, between $977 million and $1.3 billion. This includes between $185 and $276 million to cover immigrants ineligible for FMAP.

TABLE 13

State Budget Impact, All Incomes (Millions of Dollars)

Millions of Dollars	Medicaid +7%		Medicaid +17%	
	Medicaid Forward (Low enrollment)	Medicaid Forward (High enrollment)	Medicaid Forward (Low enrollment)	Medicaid Forward (High enrollment)
Changes in spending				
*Traditional Medicaid**	40	55	57	73
Medicaid Forward	880	1,173	977	1,305
Medicaid Forward, FMAP	711	923	792	1,030
Medicaid Forward, no FMAP	170	251	185	276
Health Care Affordability Fund	-145	-145	-145	-145
Repurposed SBM and high-risk pool assessments	-153	-153	-153	-153
State employee health care	-335	-379	-335	-379
Uncompensated care	-40	-41	-40	-41
Total spending change	**247**	**510**	**361**	**660**
Changes in revenue				
State income tax	24	45	23	43
Medicaid Forward employer contribution	221	379	247	422
Premium tax	57	80	63	88
Premium surcharge	71	100	78	110
Total new revenue	**374**	**603**	**412**	**663**
Change in state spending	**-127**	**-92**	**-51**	**-3**

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.
Notes: SBM = state-based Marketplace; FMAP = Federal Medical Assistance Percentage. * Includes additional spending on elderly and limited-benefit Medicaid enrollees because of higher Medicaid payment rates. Spending on Specified Low-Income Medicare Beneficiaries and Qualifying Individuals does not change because those costs are based on Medicare premiums.

Several types of savings would partially offset this new spending. The amount spent on New Mexico's Health Care Affordability Fund would no longer be needed, as this fund focuses on programs that would be replaced by Medicaid Forward, leading to savings of about $145 million. The state will also repurpose SBM and high-risk pool assessments, about $153 million, to reduce the cost of Medicaid Forward. We estimate that the state could save between $335 million and $379 million on health insurance premiums for state employees and their covered dependents. The large drop in the number of uninsured people will lead to less demand for uncompensated care. State and local funding of uncompensated care is complex, but we estimate there could be between $40 million and $41 million in realized savings. That leads to a net change in state spending of between $361 million and $660 million.

The proposal also introduces new sources of revenue. The state would collect between $23 million and $43 million more in income taxes as employers pass back part of their savings on health insurance premium contributions as increased wages. Employers may choose to use part of the savings on other

tax-preferred benefits instead of wages. This could reduce the amount of state income tax slightly. The new Medicaid Forward employer contribution would collect between $247 million and $422 million. There would be between $141 million and $198 million more in additional premium tax and premium surcharge revenue because of increased enrollment in coverage that is subject to these taxes. This totals between $412 and $663 million in new revenue to the state. On net, the state would save between $3 and $51 million by implementing Medicaid Forward.

Medicaid Forward at Medicaid Plus 7 percent

If provider payment rates were decreased to 7 percent above Medicaid rates, the costs of providing Medicaid Forward would be lower, between $247 million to $510 million for low and high enrollment. However, offsetting revenue would be somewhat lower, between $374 million and $603 million for low and high enrollment. On net, the state will save between $127 million for low enrollment and $92 million for high enrollment by implementing Medicaid Forward.

Medicaid Forward at Medicare Plus 7 Percent with State Payroll Tax

If the Medicaid Forward employer contribution is replaced by a state payroll tax rate of 1.007 percent for the high take-up scenario with reimbursements at 17 percent above Medicaid rates and a tax rate of 0.6888 percent for the high take-up scenario with reimbursements at Medicaid plus 7 percent, the state will save $2 million on net (table 14).

TABLE 14

Summary of Selected Results for Medicaid Forward Scenarios

Millions of Dollars	Medicaid +7%	Medicaid +17%
	Medicaid Forward (High enrollment)	Medicaid Forward (High enrollment)
Changes in spending		
*Traditional Medicaid**	55	73
Medicaid Forward	1,173	1,305
Medicaid Forward, FMAP	923	1,030
Medicaid Forward, no FMAP	251	276
Health Care Affordability Fund	-145	-145
Discontinued SBM and high-risk pool assessments	-153	-153
State employee health care	-379	-379
Uncompensated care	-41	-41
Total spending change	**510**	**660**
Changes in revenue		
State income tax	45	43
*Payroll taxes**	288	421
Premium tax	80	88
Premium surcharge	100	110
Total new revenue	**512**	**662**
Change in state spending	**-2**	**-2**

Source: The Urban Institute. Health Insurance Policy Simulation Model (HIPSM), 2023.

Notes: SBM = state-based Marketplace; FMAP = Federal Medical Assistance Percentage. * Includes additional spending on elderly and limited-benefit Medicaid enrollees because of higher Medicaid payment rates. Spending on Specified Low-Income Medicare Beneficiaries and Qualifying Individuals does not change because those costs are based on Medicare premiums..*Payroll tax rate is 0.6888% for the high take-up Medicaid +7 percent scenario. Payroll tax rate is 1.007 percent for the high take-up Medicaid +17% scenario.

Discussion

We conclude with a discussion of several issues.

Health Coverage and the Remaining Uninsured

We find that Medicaid Forward would reduce the number of uninsured New Mexicans by between 130,000 and 142,000 people. All the remaining uninsured would be eligible for traditional Medicaid or Medicaid Forward. By contrast, nearly half of uninsured New Mexicans under current law are not eligible for Medicaid or Marketplace PTCs. Thus, take-up in traditional Medicaid, CHIP, and Medicaid Forward will be the key to increasing health coverage further.

New Mexico recently adopted a facilitated enrollment program that may prove helpful in closing this enrollment gap. Beginning with the 2022 tax year, residents can check a box on the state income tax return to permit the tax agency to share information with the state Medicaid agency and Marketplace to perform outreach to encourage enrollment.[10]

Medicaid Forward could be particularly beneficial for tribal health providers, who would be reimbursed at rates significantly higher than current Medicaid and, in most cases, higher than Medicare. However, based on state enrollment reports and our estimated population eligible for Medicaid, we estimate that current Medicaid take-up among American Indians is lower than for other New Mexicans. New Mexico also provides generous supplemental subsidies for American Indians with incomes up to 400 percent FPL in the Marketplace, though take-up rates could be much higher. Outreach and assistance efforts in those communities will be important for the success of Medicaid Forward.

Employer Contribution and Additional Revenue

We find that the savings and revenue offsets specified in the proposal would more than fully cover state costs. However, there are several important issues regarding the Medicaid Forward employer contribution.

1. It is impossible to know in advance how many workers would enroll in the new Medicaid expansion, so the amount of revenue it would raise would also be uncertain, making it difficult for the state to budget the policy, particularly in the first years. Employers would cover the average cost of each worker moving to Medicaid Forward, so this uncertainty would not necessarily affect the net balance of state costs minus revenue.
2. Assessing employers for a contribution for the dependents of workers who enroll in Medicaid Forward is not feasible. While ESI currently covers many dependents, it is impossible to know whether dependents would have enrolled in the employer's plan without Medicaid Forward. In families with multiple workers, often only one of them takes employer coverage. However, it is impossible to determine whether a worker would have enrolled without Medicaid Forward, so if both workers in a two-worker family enroll in Medicaid Forward, then both employers would be liable for the contribution.
3. If the contribution were limited to workers offered ESI, firms could easily avoid it by not offering ESI or making some types of employees ineligible for ESI. Thus, the contribution should apply to all workers enrolled in Medicaid Forward.

4. The amount of the employer contribution does not vary by wage and thus would fall disproportionately on low-wage employers in a regressive manner, though large, low-wage employers offering health coverage would spend less on health insurance premiums and may spend less on net.
5. It is not clear if the employer contribution is permissible under federal law. For example, if the employer contribution were considered a premium payment, it could fall afoul of the cap on Medicaid premiums, as discussed above. If the arrangement were considered a form of employer-sponsored coverage, it could violate the Employee Retirement Income Security Act of 1974, which preempts state authority over employer-provided health plans (McCuskey 2023).

As we have shown, replacing the Medicaid Forward employer contribution with a payroll tax on employers is an alternative approach that would also cover state Medicaid Forward costs. The tax would make it easier to predict revenue in advance, avoid legal issues, and vary with wages rather than being basically the same for a low-wage and a high-wage worker. We assume small firms would be exempt from the employer contribution but not from a payroll tax, though a payroll tax could also readily exempt small firms. Regardless, it seems unlikely that a payroll tax of 1 percent would cause noticeable changes in employment.

Health Care Supply Constraints

We do not assume limits on the utilization of care because of supply constraints. That is, provider capacity expands to meet the increased demand for services under Medicaid Forward. An analysis of regions with large coverage gains under the ACA showed providers responded to increased demand by expanding staff, including hiring more advanced-practice clinicians (such as nurse practitioners) and care coordinators, opening new or expanding existing health care sites, and/or extending their office hours (Wishner and Burton 2017). This does not necessarily mean there would be no supply constraints under Medicaid Forward, particularly in certain localities or during the first years. Supply constraints could mean increased waiting times for particular providers or services and unmet demand, which would translate into lower state and federal costs than those presented here.

Notes

[1] New Mexico Legislature, State-Administered Health Coverage Plan of 2023, HR 400, 56th Legislature, State of New Mexico.

[2] For more about coverage changes during this period, see Buettgens and Green 2022.

[3] See CBO (Congressional Budget Office), "Options for Reducing the Deficit, 2023 to 2032 – Volume 1: Larger Reductions, Reduce Tax Subsidies for Employment-Based Health Insurance," accessed August 16, 2023, https://www.cbo.gov/budget-options/58627.

[4] The economics literature includes many studies that offer evidence of the trade-off between wages and health insurance benefits. For example, one recent study finds that a $579 increase in costs of hospital care among the privately insured led to a $638 reduction in wages (Arnold and Whaley, 2020). A widely cited study found that mandated maternity benefits, which raised the cost to employers of insuring women of childbearing age, resulted in reduced wages for that group (Gruber, 1994). A third study found that the Affordable Care Act requirement that private insurance policies cover dependents up to age 26 resulted in reduced annual wages for parents of about $2,600 (Kim and Koh, 2022). These studies find evidence that an increase in health care costs results in a decrease in wages. Whether the effect is symmetric and occurs when health care costs fall and within what timeframe is uncertain.

[5] For example, see page 2 of *Tracking Federal Stimulus Funds, Before the Legislative Finance Committee*, (2021) (prepared by Eric Chenier, Analyst, LF, and Catherine Dry, Program Evaluator, LFC).

[6] IRS (Internal Revenue Service), "SOI Tax Stats - Individual Income Tax State Data," accessed August 17, 2023, https://www.irs.gov/statistics/soi-tax-stats-individual-income-tax-state-data.

[7] In addition to the reduction in employers' health insurance premium contributions, Medicaid Forward would generally eliminate employer mandate penalties in the state, since liability is triggered by employees receiving PTC. Since New Mexico employers currently pay only very little in employer mandate penalties, accounting for them would not significantly change our results, and we ignore them in this analysis.

[8] Structuring a small employer exemption would be somewhat easier with a payroll tax than the employer contribution. A payroll tax could simply exempt a fixed amount of payroll for each employer, whereas a small employer exemption from the employer contribution would require rules for measuring employer size and would likely result in a "cliff," where adding one employee would trigger substantial liability.

[9] This includes additional spending on limited-benefit and elderly Medicaid beneficiaries, except for Spending on Specified Low-Income Medicare Beneficiaries and Qualifying Individuals, which are subsidies of Medicare premiums. These costs were estimated outside HIPSM, which focuses on the nonelderly.

[10] See 2022 PIT-1 New Mexico Personal Income Tax Return, accessed August 16, 2023.

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About the Authors

Matthew Buettgens is a senior fellow in the Health Policy Center at the Urban Institute, where he is the mathematician leading the development of Urban's Health Insurance Policy Simulation Model (HIPSM). The model is currently being used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington, as well as to the federal government. His recent work includes several research papers analyzing various aspects of national health insurance reform, both nationally and state-by-state. Research topics have included the costs and coverage implications of Medicaid expansion for both federal and state governments; small firm self-insurance under the Affordable Care Act and its effect on the fully insured market; state-by-state analysis of changes in health insurance coverage and the remaining uninsured; the effect of reform on employers; the affordability of coverage under health insurance exchanges; and the implications of age rating for the affordability of coverage.

Buettgens was previously a major developer of the Health Insurance Reform Simulation Model—the predecessor to HIPSM—used in the design of the 2006 Roadmap to Universal Health Insurance Coverage in Massachusetts.

Jason Levitis is a senior fellow in the Health Policy Center and a nonresident senior fellow at Yale Law School's Solomon Center for Health Law and Policy. He researches health insurance policy and provides technical assistance to state health officials. Levitis's research focuses on federal and state policies affecting private health coverage, the Affordable Care Act (ACA), and the intersection of health care and tax law. He has worked extensively on federal and state financing and regulation of private health coverage, health insurance subsidies, Section 1332 waivers, and interactions with federal tax law. He is deeply versed in operational issues and approaches to minimizing consumers' administrative burdens. Levitis provides technical assistance to states through State Health and Value Strategies, a Robert Wood Johnson Foundation project. He helps state Marketplaces, insurance regulators, and Medicaid agencies navigate the federal health landscape and develop and implement options to meet their policy goals.

Levitis served at the US Treasury Department from 2009 to 2017. He represented the Treasury on the interagency team that helped craft the ACA and later led the Treasury's ACA implementation as counselor to the assistant secretary for tax policy. He also cochaired the interagency working group that established the Section 1332 waiver program. Levitis earned a BA in mathematics from Wesleyan

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Jessica Banthin is a senior fellow in the Health Policy Center, where she studies the effects of health insurance reform policies on coverage, costs, and households' financial burdens. Before joining the Urban Institute, she served more than 25 years in the federal government, most recently as deputy director for health at the Congressional Budget Office. During her eight-year term at the Congressional Budget Office, Banthin directed the production of numerous major cost estimates of legislative proposals to modify the Affordable Care Act.

Banthin has also conducted significant research on a wide range of topics, such as the burdens of health care premiums and out-of-pocket costs on families, prescription drug spending, and employer and nongroup market premiums. She has special expertise in designing microsimulation models for analyzing health insurance coverage and an extensive background in designing and using household and employer survey data. Banthin served on the President's Task Force on National Health Care Reform in 1993 and participated in an interagency work group on improving the measurement of income and poverty in 1998, leading to the Census Bureau's Supplemental Poverty Measure. Banthin earned her AB cum laude from Harvard University and her PhD in economics from the University of Maryland, College Park. Jessica Banthin has served on the advisory board for the Cancer Policy Institute since 2020.

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