

# Updated Estimates of the New Mexico Uninsured and Health Care Reform Options to Expand Marketplace Coverage and Improve Affordability

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## Executive Summary

In this brief, we present new research estimating New Mexico's nonelderly uninsured population in 2020, as well as new analyses of seven reform options intended to increase health coverage and improve affordability. We produced these estimates using the Urban Institute's Health Insurance Policy Simulation Model, updated for 2020 to reflect both the projected impact of the COVID-19 recession and recent and detailed data on state-level enrollment in public health insurance programs.

***The number of uninsured New Mexicans and their eligibility for subsidized insurance.*** We estimate that 214,000 nonelderly New Mexicans will be uninsured in an average month over the last three quarters of 2020, the COVID-19 recession period this year (table 1). This is an increase relative to our previous estimate of 187,000 uninsured New Mexicans in 2019. Our new estimates of the uninsured reflect lower nongroup enrollment during the 2020 open enrollment period and the impact of job losses due to the COVID-19 pandemic. So far, recession-related income losses have made more New Mexicans eligible for Medicaid, the Children's Health Insurance Program (CHIP), or Marketplace premium tax credits, and some New Mexicans have lost health coverage provided through their jobs. Medicaid and Marketplace enrollment have increased in recent months, but not enough to prevent the increased number of uninsured New Mexicans.

Over the last three quarters of 2020, 57,000 uninsured New Mexicans, or 27 percent of the state's uninsured population, will be eligible for Medicaid or CHIP but not enrolled. Participation in Medicaid and CHIP is already very high in the state; only 6 percent of New Mexico residents eligible for Medicaid or CHIP are uninsured. However, further outreach and enrollment assistance efforts could further reduce uninsurance.

An additional 56,000 uninsured New Mexicans, or 26 percent of the state's uninsured population, would be eligible for premium tax credits in the state's nongroup (sometimes called individually purchased) insurance Marketplace but not enrolled. Greater outreach and enrollment assistance could also help increase Marketplace coverage, but improving affordability would likely have a greater impact on reducing uninsurance for New Mexicans.

About 100,000 uninsured people, or 47 percent the state's total, are ineligible for any subsidized health insurance coverage. These residents either have incomes too high to qualify for Medicaid or premium tax credits, are ineligible for such coverage because of immigration status, or are disqualified for premium tax credits because they or a family member have been offered employment-related coverage deemed affordable to them under current law.

***The cost and coverage implications of seven health reform options.*** The seven policy alternatives we analyze would each improve affordability for some residents and thus increase enrollment in health insurance coverage. Each would lower household premium contributions, and some would also lower out-of-pocket costs paid by households when they use medical care.

The first three health reform proposals we analyze would supplement the federal premium tax credits for individual purchasers of Marketplace coverage with enhanced state premium tax credits. These additional state-funded tax credits would lower premiums paid by eligible households beyond the reductions already provided under the Affordable Care Act. We consider three options of increasing levels of state credits that vary with income. For example, a family of two adults with income of \$30,170 in 2020 (175 percent of the federal poverty level, or FPL) would receive additional premium assistance of about \$242 per year under the most modest enhancement proposal and of about \$1,150 per year under the most generous proposal.

Depending on the level of enhanced tax credits, we estimate the number of uninsured people over the last three quarters of 2020 would drop by between 11,000 and 18,000. This is a substantial share of the estimated 56,000 uninsured New Mexicans eligible for premium tax credits. Not only would enrollment increase in New Mexico's nongroup insurance market, but total nongroup premiums (before subtracting premium tax credits) would fall by between 9.0 percent and 13.9 percent, because the health insurance risk pool improves as additional healthy people enroll in coverage. The enhanced tax credits would cost the state between \$14 million and \$52 million per year, depending on the option.

The next three reform options would reduce the out-of-pocket costs (sometimes called cost-sharing requirements) many people face when using medical care, in addition to reducing people's annual premium contributions for Marketplace coverage. The approach would lower deductibles, coinsurance, copayments, and maximum out-of-pocket payments, increasing the value of the coverage purchased by eligible people. These additional cost-sharing subsidies would increase the value of Marketplace coverage to at least the gold level (80 percent actuarial value) for New Mexico Marketplace enrollees with incomes up to 400 percent of FPL who qualify for premium tax credits. People with very low incomes would remain eligible for plans with an even higher value.

The next three options we estimate add state-funded cost-sharing subsidies to the three levels of enhanced premium tax credits described above. The cost-sharing subsidies would be provided in addition to similar subsidies already provided by the federal government under current law. We find that enhancing cost-sharing subsidies would increase enrollment substantially, regardless of the level of enhanced premium tax credits to which they are added. With the new cost-sharing and premium

subsidies in place, between 20,000 and 23,000 fewer New Mexicans would be uninsured. The state would spend between \$26 million and \$68 million per year to enhance both subsidies, depending on the level of premium tax credits chosen.

The last option we analyze is a Basic Health Program (BHP) for New Mexico. BHPs are provided for under the Affordable Care Act, but only New York and Minnesota have them in place. Under this option, New Mexico could contract with a limited number of insurers to provide coverage with very low premiums and cost-sharing requirements for those with incomes up to 200 percent of FPL who qualify for premium tax credits. The coverage would have lower premiums and cost-sharing requirements than those currently offered to Marketplace enrollees in this income group. We find a BHP would reduce the number of uninsured people by 12,000. This is a smaller increase in coverage than we estimate would be achieved through some of the other options studied, because federal law limits BHPs to only covering people with incomes at or below 200 percent of FPL. BHPs are separate from a state's nongroup insurance market, so unlike the other options, the BHP approach would shrink the size of the state's private nongroup insurance market. We estimate that adding a BHP in New Mexico would have little effect on private nongroup insurance premiums. It would cost the state an estimated \$90 million per year, making it the most expensive of the options presented here.

**Conclusion.** We estimate that the COVID-19 recession has increased the number of uninsured New Mexicans relative to a year ago. As recent increases in Medicaid, CHIP, and Marketplace coverage indicate, Medicaid expansion and Marketplace coverage have protected many New Mexicans from becoming uninsured in the face of large numbers of job losses. However, these programs have not been able to hold coverage constant under these unprecedented circumstances. Our estimates indicate several reform options could reduce the number of uninsured residents and improve affordability of existing coverage for many more.

## Introduction

In this brief, we provide new estimates of New Mexico's uninsured population in 2020, updating previous estimates of the uninsured in 2019.<sup>1</sup> We also describe new analyses of seven reform options intended to increase health coverage and improve affordability. These new estimates account for recent changes that have affected insurance markets and coverage levels. First, the 2020 open enrollment period for insurance purchased in the private nongroup (sometimes called individually purchased) insurance markets in New Mexico closed with lower enrollment in the Affordable Care Act (ACA) Marketplace than it did in 2019. Second, job losses related to the COVID-19 pandemic have caused some New Mexicans to lose health coverage sponsored by their former employers. In addition, losses of income resulting from the recession have made some New Mexicans newly eligible for Medicaid, the Children's Health Insurance Program (CHIP), or federal subsidies for insurance bought through the Marketplaces.

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<sup>1</sup> Jessica Banthin, Matthew Buettgens, Linda J. Blumberg, Robin Wang, and Clare Wang Pan, *The Uninsured in New Mexico* (Washington, DC: Urban Institute, 2019).

Recent New Mexico administrative data show a notable increase in Medicaid enrollment and a modest increase in Marketplace enrollment since February of this year. Higher enrollment in these subsidized programs aligns with our forecasted increase in the number of people eligible for such programs because of lost income. The future of the pandemic and the associated economic downturn in New Mexico remain highly uncertain, so our estimates of insurance coverage and the implications of additional reforms should be considered preliminary. However, our estimates, produced using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), incorporate the latest available data on employment impacts and enrollment changes.

We begin by projecting the number and characteristics of uninsured New Mexicans in 2020. Our estimates should be considered averages over the last three quarters of 2020, the COVID-19 recession period. We also show how many of the state's uninsured residents are eligible for financial assistance obtaining health insurance coverage through Medicaid, CHIP, or Marketplace plans.

We then provide the results of our analysis of seven policy options intended to increase health insurance coverage in New Mexico and improve affordability of coverage purchased through the Marketplaces. The first three approaches would introduce a state program that supplements the federal premium tax credits for Marketplace coverage available under current law. We simulate the cost and coverage effects of three levels of supplementary premium tax credits to show the impact of greater state investment in health coverage and affordability. The next three alternatives add enhanced cost-sharing subsidies, in addition to those provided by the federal government, to the three enhanced state premium tax credit options. These options would reduce eligible households' out-of-pocket costs for medical care and annual premium contributions. The final reform would put in place a Basic Health Program (BHP). A state option provided for in the ACA, a BHP would allow the state to contract with managed-care organizations to provide lower-premium and lower-cost-sharing coverage to residents with incomes up to 200 percent of the federal poverty level (FPL) currently eligible for federal Marketplace premium tax credits and cost-sharing subsidies.

## Methods Overview

We estimate implications of the seven reform options using the Urban Institute's Health Insurance Policy Simulation Model, a detailed microsimulation model of the US health insurance system. HIPSM estimates the coverage effects of proposed health insurance reforms as well as reforms' implications for spending by households, employers, and the government. The model estimates the implications of reforms for different populations (e.g., by socioeconomic characteristics, health status), and it is designed to produce quick-turnaround analyses that inform current policy debates. HIPSM can be rapidly adapted to analyze a range of new scenarios—from 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.

Experts in the field have favorably compared results from HIPSM simulations with actual policy outcomes and results from other respected microsimulation models.<sup>2</sup> Findings from the model were cited in the majority opinion in the Supreme Court case *King v. Burwell* and in the government's brief and many amicus briefs submitted to the court in that case. Findings from HIPSM have been broadly cited in top-tier media, including the *New York Times*, *Washington Post*, *Wall Street Journal*, *Vox*, CNN, and *Los Angeles Times*. Results from HIPSM have also been displayed on the floor of the US Senate during debates and are widely distributed among legislative staff.

HIPSM is based on two years of data from the American Community Survey, which provides a large, representative sample of New Mexico families. The model has been updated to reflect the most recent available data on New Mexico's Medicaid and Marketplace enrollment, as well as population projections from the University of New Mexico's Geospatial and Population Studies and the Urban Institute's Mapping America's Futures program. We provide additional details on our methods in the appendix at the end of this brief.

## Updated Estimates of the Uninsured in New Mexico and Their Characteristics

We estimate that 214,000 nonelderly New Mexicans will be uninsured in an average month of the last three quarters of 2020 (table 1). This exceeds our estimate of 187,000 uninsured New Mexicans in 2019 for two reasons. First, our new estimates reflect data showing the 2020 open enrollment period ended with lower nongroup Marketplace enrollment than did the 2019 open enrollment period. Second, we have updated our model to reflect projected coverage changes associated with COVID-19-related job losses. Recession-related income losses are projected to make more New Mexicans eligible for Medicaid, CHIP, or Marketplace premium tax credits (some with cost-sharing subsidies as well), and some New Mexicans will lose health coverage provided through their jobs or a family member's job. Medicaid and Marketplace enrollment have increased in recent months, but not enough to prevent an increase in the number of uninsured New Mexicans.

Of the estimated 214,000 New Mexicans who will be uninsured over the last three quarters of 2020, 57,000, or 27 percent, will be eligible for Medicaid or CHIP but not enrolled (figure 1). This is a similar number to 2019 but a smaller share; we estimated that 56,000 uninsured New Mexicans, or 30 percent of the state's total, were eligible for these programs (data not shown). Participation in Medicaid and CHIP is already very high in the state; only 6 percent of New Mexico residents eligible for Medicaid or CHIP are uninsured (figure 2). However, if further outreach and enrollment assistance efforts can reach the remainder, uninsurance will decrease further.

An additional 56,000 uninsured New Mexicans, or 26 percent of the total, will be eligible for premium tax credits in the Marketplace but not enrolled in the last three quarters of 2020 (figure 1). This is a higher number of uninsured people and greater share of the uninsured population relative to our 2019 estimates (43,000 people, or 23 percent). We estimate that 37 percent of those eligible for

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<sup>2</sup> Sherry A. Glied, Anupama Arora, Claudia Solís-Román, "The CBO's Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?" (New York: Commonwealth Fund, 2015).

premium tax credits will be uninsured (figure 2). This is several times higher than the uninsurance rate for those eligible for Medicaid and CHIP for several reasons, including the higher household cost associated with subsidized Marketplace coverage, lower awareness of eligibility, and greater complexity in enrolling in and choosing a Marketplace plan. Greater outreach and enrollment assistance could help increase Marketplace coverage, but improving affordability would likely have a greater impact, and this is the focus of the seven policy options described in the next section.

Though just over half of New Mexico's uninsured population is eligible for Medicaid, CHIP, or Marketplace tax credits, the remainder (about 100,000 uninsured people, or 47 percent the total) are ineligible for assistance affording health coverage. This share is roughly the same as that in 2019. These uninsured people either have incomes too high to qualify for financial assistance (17 percent of the uninsured), are ineligible because of immigration status (20 percent), or are disqualified for premium tax credits because they or a family member have been offered coverage deemed affordable under the ACA (10 percent).

In table 1, we present detailed characteristics of New Mexico's uninsured population in 2020. The uninsured in 2020 and 2019 generally have similar characteristics, though recent job losses have increased the share of uninsured people in higher-income groups in 2020.

TABLE 1

## Characteristics of Uninsured Nonelderly New Mexicans, by Eligibility Type under Current Law, Last Three Quarters of 2020

|   | Total                     |               |                       | Eligible for Medicaid/CHIP |               |                       | Eligible for Marketplace<br>Premium Tax Credits |               |                       | Ineligible for Public<br>Program |               |                       |
|---|---------------------------|---------------|-----------------------|----------------------------|---------------|-----------------------|---|---------------|-----------------------|----------------------------------|---------------|-----------------------|
|   | Number<br>of<br>uninsured | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured  | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured                       | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured        | % of<br>total | Unins.<br>rate<br>(%) |
| <b>Total</b>  | <b>214,000</b>            | <b>100.0</b>  | <b>11.9</b>           | <b>57,000</b>              | <b>100.0</b>  | <b>6.0</b>            | <b>56,000</b>                                   | <b>100.0</b>  | <b>37.2</b>           | <b>100,000</b>                   | <b>100.0</b>  | <b>14.5</b>           |
| <b>Race/ethnicity</b>                                   |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| American Indian/Alaska Native                           | 37,000                    | 17.3          | 15.5                  | 19,000                     | 32.6          | 11.3                  | 10,000  | 17.6          | 45.9                  | 8,000                            | 8.4           | 20.3                  |
| Asian and Pacific Islander                              | 3,000                     | 1.5           | 10.7                  | —                          | —             | —                     | 1,000   | 2.1           | 60.3                  | 2,000                            | 1.8           | 11.4                  |
| Non-Hispanic Black                                      | 4,000                     | 1.8           | 10.3                  | —                          | —             | —                     | 1,000   | 2.0           | 44.0                  | 2,000                            | 2.2           | 15.5                  |
| Hispanic  | 121,000                   | 56.3          | 13.1                  | 30,000                     | 51.6          | 5.8                   | 27,000  | 48.4          | 38.8                  | 64,000                           | 63.5          | 20.8                  |
| Non-Hispanic white                                      | 48,000                    | 22.5          | 7.7                   | 8,000                      | 14.3          | 3.4                   | 17,000  | 29.7          | 31.0                  | 23,000                           | 23.4          | 7.6                   |
| Other   | 1,000                     | 0.6           | 6.3                   | —                          | —             | —                     | —   | —             | —                     | —                                | —             | —                     |
| <b>Sex</b>  |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| Male  | 126,000                   | 58.8          | 13.1                  | 30,000                     | 52.4          | 6.6                   | 39,000  | 70.0          | 48.4                  | 56,000                           | 56.3          | 15.5                  |
| Female  | 88,000                    | 41.2          | 9.7                   | 27,000                     | 47.6          | 5.5                   | 17,000  | 30.0          | 24.2                  | 44,000                           | 43.7          | 13.3                  |
| <b>Age group</b>  |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| 0–18  | 30,000                    | 14.1          | 5.6                   | 16,000                     | 27.6          | 4.1                   | 2,000   | 4.1           | 18.8                  | 12,000                           | 12.0          | 8.3                   |
| 19–34   | 82,000                    | 38.4          | 18.0                  | 21,000                     | 36.2          | 8.4                   | 28,000  | 50.0          | 53.2                  | 33,000                           | 33.2          | 20.9                  |
| 35–54   | 79,000                    | 36.9          | 15.3                  | 15,000                     | 27.0          | 7.5                   | 21,000  | 38.0          | 40.6                  | 42,000                           | 41.9          | 16.2                  |
| 55–64   | 23,000                    | 10.6          | 8.1                   | 5,000                      | 9.3           | 4.6                   | 4,000   | 7.8           | 13.2                  | 13,000                           | 12.9          | 10.0                  |
| <b>Citizenship status –<br/>Individuals ages 19–64</b>  |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| Citizen   | 148,000                   | 69.1          | 8.9                   | 39,000                     | 68.7          | 4.4                   | 55,000  | 97.2          | 37.2                  | 54,000                           | 53.6          | 8.7                   |
| Noncitizen  | 66,000                    | 30.9          | 52.7                  | 18,000                     | 31.3          | 38.4                  | 2,000   | 2.8           | 36.9                  | 47,000                           | 46.4          | 62.7                  |
| <b>English proficiency –<br/>Individuals ages 19–64</b> |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| <i>Subtotal</i>   | <i>184,000</i>            | <i>100.0</i>  | <i>14.7</i>           | <i>42,000</i>              | <i>100.0</i>  | <i>7.3</i>            | <i>54,000</i>                                   | <i>100.0</i>  | <i>38.8</i>           | <i>88,000</i>                    | <i>100.0</i>  | <i>16.1</i>           |
| Speak very well or better                               | 138,000                   | 75.0          | 14.7                  | 28,000                     | 68.6          | 7.3                   | 51,000  | 93.7          | 38.8                  | 59,000                           | 66.5          | 16.1                  |
| Do not speak very well or less proficient               | 46,000                    | 25.0          | 36.0                  | 13,000                     | 31.4          | 21.0                  | 3,000   | 6.3           | 37.2                  | 30,000                           | 33.5          | 52.4                  |

|  | Total                     |               |                       | Eligible for Medicaid/CHIP |               |                       | Eligible for Marketplace<br>Premium Tax Credits |               |                       | Ineligible for Public<br>Program |               |                       |
|--|---------------------------|---------------|-----------------------|----------------------------|---------------|-----------------------|---|---------------|-----------------------|----------------------------------|---------------|-----------------------|
|  | Number<br>of<br>uninsured | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured  | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured                       | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured        | % of<br>total | Unins.<br>rate<br>(%) |
| <b>Education –<br/>Individuals ages 19–64</b>                |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| <i>Subtotal</i>  | 184,000                   | 100.0         | 14.7                  | 42,000                     | 100.0         | 7.3                   | 54,000  | 100.0         | 38.8                  | 88,000                           | 100.0         | 16.1                  |
| Less than high school  | 31,000                    | 17.1          | 14.7                  | 10,000                     | 24.7          | 7.3                   | 5,000   | 8.4           | 38.8                  | 17,000                           | 18.8          | 16.1                  |
| High school  | 66,000                    | 35.7          | 31.0                  | 17,000                     | 40.4          | 15.1                  | 20,000  | 36.4          | 62.7                  | 29,000                           | 33.1          | 63.7                  |
| Some college   | 56,000                    | 30.6          | 18.0                  | 12,000                     | 27.8          | 8.3                   | 19,000  | 36.0          | 44.2                  | 25,000                           | 28.6          | 25.0                  |
| College graduate   | 31,000                    | 16.7          | 13.6                  | 3,000                      | 7.2           | 5.7                   | 10,000  | 19.2          | 38.8                  | 17,000                           | 19.6          | 15.6                  |
| <b>Citizenship status –<br/>Family</b>                       |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| All citizens   | 140,000                   | 65.5          | 9.0                   | 36,000                     | 63.3          | 4.4                   | 52,000  | 92.5          | 36.7                  | 52,000                           | 51.5          | 8.6                   |
| One or more<br>noncitizen                                    | 74,000                    | 34.5          | 31.1                  | 21,000                     | 36.7          | 15.7                  | 4,000   | 7.5           | 43.6                  | 49,000                           | 48.5          | 51.7                  |
| <b>Self-reported health<br/>status</b>                       |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| Better than fair/poor  | 185,000                   | 86.4          | 12.1                  | 46,000                     | 80.3          | 6.0                   | 51,000  | 90.2          | 38.1                  | 88,000                           | 87.7          | 14.0                  |
| Fair/poor  | 29,000                    | 13.6          | 11.2                  | 11,000                     | 19.7          | 6.4                   | 6,000   | 9.8           | 30.5                  | 12,000                           | 12.3          | 18.8                  |
| <b>Geography</b>   |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| Albuquerque  | 66,000                    | 30.9          | 11.6                  | 15,000                     | 26.9          | 5.6                   | 17,000  | 30.1          | 36.6                  | 34,000                           | 33.6          | 13.6                  |
| Northwest NM   | 20,000                    | 9.4           | 15.5                  | 11,000                     | 19.5          | 11.8                  | 4,000   | 7.8           | 40.1                  | 5,000                            | 4.6           | 19.2                  |
| Farmington,<br>Bloomfield, and Aztec<br>cities               | 10,000                    | 4.5           | 11.3                  | 2,000                      | 4.0           | 5.2                   | 2,000   | 4.3           | 39.8                  | 5,000                            | 4.9           | 14.0                  |
| North Central NM   | 11,000                    | 5.2           | 10.5                  | 3,000                      | 4.7           | 4.7                   | 3,000   | 5.8           | 29.3                  | 5,000                            | 5.1           | 13.8                  |
| Eastern Plains NM  | 10,000                    | 4.5           | 11.3                  | 4,000                      | 6.2           | 6.0                   | 3,000   | 4.7           | 30.4                  | 3,000                            | 3.4           | 12.7                  |
| Santa Fe County  | 17,000                    | 8.1           | 14.3                  | 4,000                      | 6.7           | 7.3                   | 4,000   | 6.4           | 30.5                  | 10,000                           | 9.8           | 17.4                  |
| Sandoval County  | 11,000                    | 5.2           | 9.5                   | 3,000                      | 5.6           | 5.8                   | 3,000   | 5.9           | 37.4                  | 5,000                            | 4.7           | 8.6                   |
| Valencia, Bernalillo<br>East Mountains, and<br>Isleta Pueblo | 9,000                     | 4.1           | 10.5                  | 2,000                      | 3.9           | 5.3                   | 3,000   | 5.1           | 41.9                  | 4,000                            | 3.6           | 10.7                  |
| Southwest NM   | 8,000                     | 3.7           | 9.7                   | 2,000                      | 3.4           | 3.6                   | 2,000   | 4.4           | 34.3                  | 4,000                            | 3.6           | 16.4                  |
| Doña Ana County  | 22,000                    | 10.4          | 12.0                  | 5,000                      | 9.1           | 4.8                   | 6,000   | 10.0          | 38.0                  | 11,000                           | 11.4          | 18.0                  |
| Central Southwest NM   | 16,000                    | 7.4           | 12.7                  | 3,000                      | 5.6           | 4.5                   | 6,000   | 10.4          | 54.1                  | 7,000                            | 6.8           | 15.7                  |
| Far Southeast NM   | 14,000                    | 6.6           | 13.5                  | 3,000                      | 4.5           | 5.5                   | 3,000   | 5.2           | 36.7                  | 9,000                            | 8.7           | 17.2                  |



|                               | Total                     |               |                       | Eligible for Medicaid/CHIP |               |                       | Eligible for Marketplace<br>Premium Tax Credits |               |                       | Ineligible for Public<br>Program |               |                       |
|-------------------------------|---------------------------|---------------|-----------------------|----------------------------|---------------|-----------------------|---|---------------|-----------------------|----------------------------------|---------------|-----------------------|
|                               | Number<br>of<br>uninsured | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured  | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured                       | % of<br>total | Unins.<br>rate<br>(%) | Number<br>of<br>uninsured        | % of<br>total | Unins.<br>rate<br>(%) |
| <b>MAGI ratio<sup>b</sup></b> |                           |               |                       |                            |               |                       |   |               |                       |                                  |               |                       |
| <= 138% of FPL                | 75,000                    | 34.8          | 9.2                   | 51,000                     | 89.1          | 6.5                   | —   | —             | —                     | 23,000                           | 23.1          | 77.6                  |
| 138–200% of FPL               | 37,000                    | 17.5          | 18.9                  | 4,000                      | 6.2           | 4.0                   | 15,000  | 26.0          | 34.2                  | 19,000                           | 19.1          | 28.9                  |
| 200–400% of FPL               | 71,000                    | 33.0          | 17.5                  | 3,000                      | 4.7           | 3.7                   | 41,000  | 73.4          | 40.0                  | 26,000                           | 26.4          | 11.7                  |
| > 400% of FPL                 | 31,000                    | 14.7          | 8.2                   | —                          | —             | —                     | —   | —             | —                     | 31,000                           | 31.4          | 8.5                   |

**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

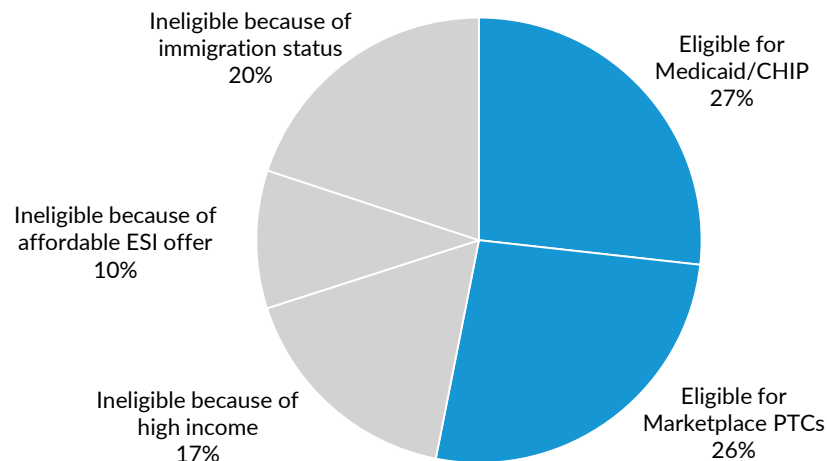
**Notes:** CHIP is Children’s Health Insurance Program. Unins. rate is uninsurance rate. MAGI is modified adjusted gross income. FPL is federal poverty level. Dashes indicate data were suppressed for being smaller than 1,000, or no record exists.

<sup>a</sup> Our research indicates many indigenous New Mexicans prefer to be called American Indians, but we recognize this population constitutes diverse communities and identities.

<sup>b</sup> The upper end of income ranges is not inclusive. For example, \$10,000–25,000 includes incomes greater than or equal to \$10,000 but less than \$25,000.

FIGURE 1

**Eligibility for Assistance among the 214,000 New Mexicans Projected to Be Uninsured over the Last Three Quarters of 2020**



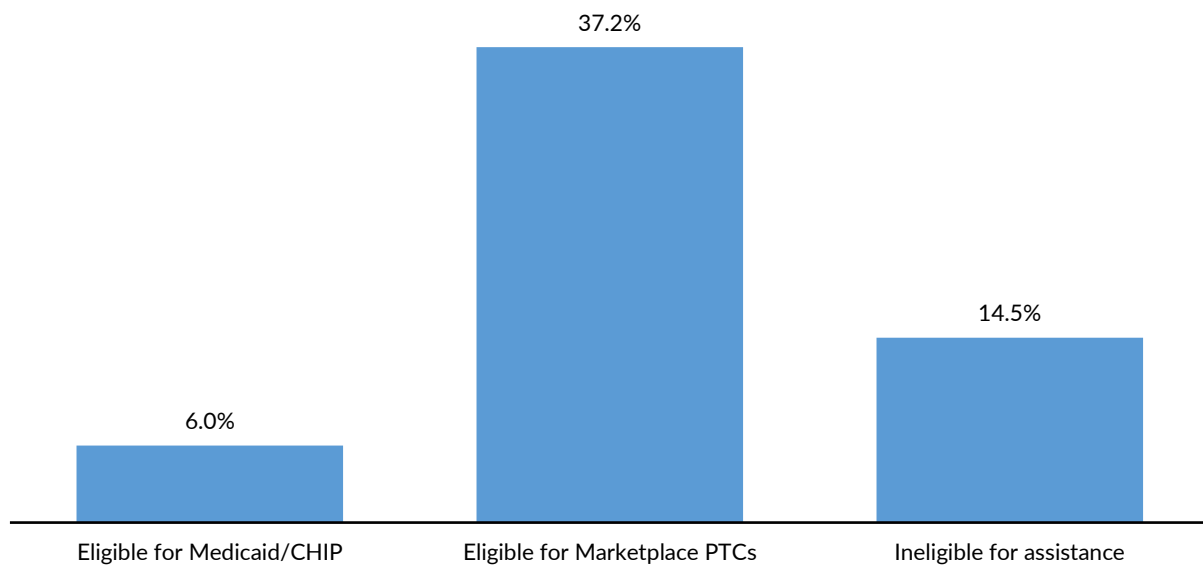
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**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

**Notes:** CHIP is Children's Health Insurance Program. PTCs are premium tax credits. ESI is employer-sponsored insurance.

FIGURE 2

**Uninsurance Rates of Nonelderly New Mexicans, by Eligibility Type, Last Three Quarters of 2020**



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**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

**Notes:** CHIP is Children's Health Insurance Program. PTCs are premium tax credits.

## Enhancing Marketplace Premium Tax Credits

We begin by analyzing three health reform options, what we call enhanced premium assistance 1–3, that provide additional state premium tax credits to people purchasing health insurance coverage in the Marketplace. These state premium tax credits would enhance the existing Marketplace premium tax credits paid for by the federal government.

The ACA provides premium tax credits on a sliding scale, such that people with lower incomes can obtain Marketplace coverage for smaller premium contributions than can people with higher incomes. Premium tax credits limit the percentage of family income enrollees must contribute to the cost of “benchmark” coverage, or the second lowest-priced silver-level<sup>3</sup> plan available to the enrollee.<sup>4</sup> For example, a person or family with income at 150 percent of FPL would pay a maximum 4.12 percent of their income toward premiums for the benchmark plan. If the state provides additional premium tax credits, the percentage-of-income caps established by the ACA will be reduced, making coverage more affordable because people pay a lower percentage of their annual income on health insurance premiums.

To show how increased state spending could improve household affordability and enrollment, we simulate three alternative supplemental state tax credit schedules of increasing generosity (enhanced premium assistance 1–3). We describe the three tax credit schedules in table 2, which shows the maximum percentage of family income payable toward benchmark coverage at various income levels. In each family income group, the percentage-of-income cap increases linearly as income increases.

**TABLE 2**

**Percentage-of-Income Caps for Premium Tax Credits under Current Law and Enhanced Premium Assistance for Nongroup Insurance, by Family Income Relative to the Federal Poverty Level, 2020**  
Percent

|                  | Current law<br>(ACA) | Enhanced premium<br>assistance 1 | Enhanced premium<br>assistance 2 | Enhanced premium<br>assistance 3 |
|------------------|----------------------|----------------------------------|----------------------------------|----------------------------------|
| 100%–138% of FPL | 2.06–2.06            | 0.0–0.0                          | 0.0–0.0                          | 0.0–0.0                          |
| 139%–150% of FPL | 3.09–4.12            | 1.5–3.5                          | 0.0–2.0                          | 0.0–0.0                          |
| 150%–200% of FPL | 4.12–6.49            | 3.5–5.5                          | 2.0–4.0                          | 0.0–3.0                          |
| 200%–250% of FPL | 6.49–8.29            | 5.5–7.0                          | 4.0–6.0                          | 3.0–4.0                          |
| 250%–300% of FPL | 8.29–9.78            | 7.0–8.5                          | 6.0–8.5                          | 4.0–8.5                          |
| 301%–400% of FPL | 9.78–9.78            | 8.5–8.5                          | 8.5–8.5                          | 8.5–8.5                          |

**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

**Notes:** ACA is Affordable Care Act. FPL is federal poverty level.

<sup>3</sup> Silver-level coverage has an actuarial value of 70 percent, meaning that, on average, silver plans reimburse providers for 70 percent of the medical costs enrollees incur. Enrollees with incomes below 250 percent of FPL who purchase silver-level coverage with their premium tax credits are also eligible for cost-sharing subsidies that lower their deductibles, coinsurance, copayments, and out-of-pocket maximums.

<sup>4</sup> Consumers choosing a plan with a higher premium than the benchmark plan must pay the full premium difference. Those choosing a plan with a lower premium than the benchmark plan pay less than their applicable percentage-of-income cap.

Table 3 shows how each enhanced premium tax credit schedule would affect illustrative households' premium contributions for benchmark coverage in the Marketplace. A family of two adults with income of \$30,170 in 2020 (175 percent of FPL) pays no more than \$1,593 annually for benchmark insurance coverage under current law. Under enhanced premium assistance 1, this family would pay no more than \$1,351, a savings of \$242 per year relative to current law. The more generous enhanced premium assistance 2 schedule would lower the same family's maximum premium to \$899, a savings of \$694 relative to current law. The still more generous enhanced premium assistance 3 schedule would lower the family's maximum premium to \$443 per year, a savings of \$1,150 relative to current law. Each schedule would provide savings to all individuals and families currently eligible for premium tax credits. All three schedules would lower premiums for a two-adult family with income of \$64,650 (375 percent of FPL) by \$828.

**TABLE 3**

**Annual Premiums for Benchmark Coverage Paid by a Family of Two Adults under Current Law and Enhanced Premium Assistance for Nongroup Insurance, by Family Income Relative to the Federal Poverty Level, 2020**

*In dollars*

|             | Annual family income | Current law | Enhanced premium assistance 1 | Enhanced premium assistance 2 | Enhanced premium assistance 3 |
|-------------|----------------------|-------------|-------------------------------|-------------------------------|-------------------------------|
| 175% of FPL | 30,170               | 1,593       | 1,351                         | 899                           | 443                           |
| 225% of FPL | 38,790               | 2,859       | 2,418                         | 1,932                         | 1,354                         |
| 275% of FPL | 47,410               | 4,276       | 3,667                         | 3,425                         | 2,941                         |
| 325% of FPL | 56,030               | 5,480       | 4,763                         | 4,763                         | 4,763                         |
| 375% of FPL | 64,650               | 6,323       | 5,495                         | 5,495                         | 5,495                         |

**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

**Notes:** FPL is federal poverty level. ACA is Affordable Care Act.

Each enhanced premium tax credit schedule would improve health coverage affordability for households of all sizes, increasing the number of people choosing to enroll in health insurance coverage. The reforms would reduce the number of uninsured people by between 11,000 and 18,000, depending on the generosity of subsidies (table 4). Though the estimated declines in the uninsured population may not seem large compared with the total number of uninsured New Mexicans, they represent a substantial share of the 56,000 uninsured people eligible for premium tax credits in the state—the group directly affected by these policies. Enrollment in the nongroup insurance market would increase by between 12,000 and 20,000 people.<sup>5</sup> In addition to previously uninsured people

<sup>5</sup> As a technical note, the Marketplace with PTC category in tables 4 and 5 counts those eligible for nonzero premium tax credits. Under current law, some people with higher incomes are categorically eligible for tax credits, but their premiums are lower than the applicable percentage-of-income cap, so their tax credit is \$0. We count them as full-pay nongroup enrollees. With enhanced tax credits, these people become eligible for nonzero tax credits. That is why the full-pay nongroup categories are slightly lower than under current law: new enrollment among those ineligible for tax credits is offset by those gaining nonzero PTCs.

who newly enroll, we project a small number of people currently covered through employer plans switch to Marketplace coverage because of enhancements to the premium tax credits.

**TABLE 4**

**Estimated Average Health Coverage and Costs for Nonelderly New Mexicans under Enhanced Premium Assistance for Nongroup Insurance, Last Three Quarters of 2020**

|   | Current law  | Enhanced premium assistance<br>1 | Enhanced premium assistance<br>2 | Enhanced premium assistance<br>3 |
|---|--------------|----------------------------------|----------------------------------|----------------------------------|
| <b>Coverage status (number of people)</b>             |              |                                  |                                  |                                  |
| <i>Insured (minimum essential coverage)</i>           | 1,582,000    | 1,593,000                        | 1,596,000                        | 1,599,000                        |
| Employer  | 690,000      | 688,000                          | 688,000                          | 688,000                          |
| Private nongroup                                      | 67,000       | 79,000                           | 83,000                           | 87,000                           |
| Marketplace with PTC                                  | 35,000       | 48,000                           | 52,000                           | 56,000                           |
| Full-pay Marketplace                                  | 10,000       | 9,000                            | 9,000                            | 9,000                            |
| Other nongroup  | 22,000       | 22,000                           | 22,000                           | 22,000                           |
| Medicaid/CHIP   | 751,000      | 751,000                          | 751,000                          | 751,000                          |
| Other public  | 74,000       | 74,000                           | 74,000                           | 74,000                           |
| <i>Uninsured (no minimum essential coverage)</i>      | 214,000      | 203,000                          | 200,000                          | 197,000                          |
| <i>Total</i>  | 1,796,000    | 1,796,000                        | 1,796,000                        | 1,796,000                        |
| <b>Household health spending (\$ millions)</b>        |              |                                  |                                  |                                  |
| Premiums  | 1,202        | 1,191                            | 1,177                            | 1,162                            |
| Other   | 1,185        | 1,187                            | 1,187                            | 1,189                            |
| <i>Total</i>  | 2,388        | 2,378                            | 2,365                            | 2,351                            |
| <b>Federal government spending (\$ millions)</b>      |              |                                  |                                  |                                  |
| Marketplace PTC                                       | 152          | 159                              | 158                              | 159                              |
| <b>State government spending (\$ millions)</b>        |              |                                  |                                  |                                  |
| Marketplace PTC                                       | 0            | 14                               | 31                               | 52                               |
| <b>Silver premium for a 40-year-old (\$ annually)</b> | <b>4,141</b> | <b>3,769</b>                     | <b>3,658</b>                     | <b>3,565</b>                     |

**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

**Notes:** PTC is premium tax credit. CHIP is Children's Health Insurance Program. FPL is federal poverty level. Coverage results are rounded to the nearest thousands.

Each tax credit enhancement schedule would also reduce total health care spending by New Mexico households, with the savings ranging from \$10 million to \$37 million (table 5). These savings occur not only because of the enhanced tax credits but because the policies reduce total nongroup market premiums by between 9.0 percent and 13.9 percent, even before applying premium tax credits. As households' premiums fall because of the enhanced tax credits, healthier people who have remained uninsured view coverage more favorably and newly enroll. And as healthier people enroll in insurance, the average medical needs of those insured through these plans decline. Lower average medical costs for enrollees translate into lower premiums. The new enrollees would have lower health risk on average than existing enrollees, and because premiums are a function of the average costs associated with a whole group of enrollees, premiums would decrease across the market. Thus, both new enrollees and those already participating in the nongroup market would benefit, including people eligible for premium tax credits and those paying the full premium themselves.

Depending on the generosity of the subsidies, we estimate that these enhanced premium tax credits would cost New Mexico between \$14 million and \$52 million per year. Higher tax credits improve affordability more for people already paying for coverage, and they lower unsubsidized nongroup premiums further than do the smaller tax credits because they attract larger numbers of healthier new enrollees. Therefore, improved affordability for people already enrolled in nongroup insurance coverage also varies in magnitude across these approaches.

**TABLE 5**

**Estimated Average Changes to Health Coverage and Costs for Nonelderly New Mexicans under Enhanced Premium Assistance for Nongroup Insurance, Last Three Quarters of 2020**

|   | ENHANCED PREMIUM ASSISTANCE 1 |      | ENHANCED PREMIUM ASSISTANCE 2 |       | ENHANCED PREMIUM ASSISTANCE 3 |       |
|---|-------------------------------|------|-------------------------------|-------|-------------------------------|-------|
|   | Change from Current Law       |      | Change from Current Law       |       | Change from Current Law       |       |
|   | #                             | %    | #                             | %     | #                             | %     |
| <b>Coverage status (number of people)</b>             |                               |      |                               |       |                               |       |
| <i>Insured (minimum essential coverage)</i>           | 11,000                        | 0.7  | 14,000                        | 0.9   | 18,000                        | 1.1   |
| Employer  | -1,000                        | -0.2 | -2,000                        | -0.2  | -2,000                        | -0.3  |
| Private nongroup                                      | 12,000                        | 18.6 | 16,000                        | 24.0  | 20,000                        | 29.3  |
| Marketplace with PTC                                  | 13,000                        | 36.3 | 17,000                        | 47.0  | 21,000                        | 57.9  |
| Full-pay Marketplace                                  | 0                             | -2.3 | 0                             | -3.4  | -1,000                        | -6.4  |
| Other nongroup  | 0                             | -0.9 | 0                             | -1.2  | 0                             | -1.4  |
| Medicaid/CHIP   | 0                             | —    | 0                             | —     | 0                             | —     |
| Other public  | 0                             | —    | 0                             | —     | 0                             | —     |
| <i>Uninsured (no minimum essential coverage)</i>      | -11,000                       | -5.2 | -14,000                       | -6.7  | -18,000                       | -8.3  |
| <i>Total</i>  | 0                             | —    | 0                             | —     | 0                             | —     |
| <b>Household health spending (\$ millions)</b>        |                               |      |                               |       |                               |       |
| Premiums  | -11                           | -0.9 | -25                           | -2.1  | -40                           | -3.4  |
| Other   | 1                             | 0.1  | 2                             | 0.2   | 3                             | 0.3   |
| <i>Total</i>  | -10                           | -0.4 | -23                           | -1.0  | -37                           | -1.6  |
| <b>Federal government spending (\$ millions)</b>      |                               |      |                               |       |                               |       |
| Marketplace PTC                                       | 7                             | 4.8  | 7                             | 4.4   | 7                             | 4.9   |
| <b>State government spending (\$ millions)</b>        |                               |      |                               |       |                               |       |
| Marketplace PTC                                       | 14                            | NA   | 31                            | NA    | 52                            | NA    |
| <b>Silver premium for a 40-year-old (\$ annually)</b> |                               |      |                               |       |                               |       |
|   | -372                          | -9.0 | -483                          | -11.7 | -576                          | -13.9 |

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: PTC is premium tax credit. CHIP is Children's Health Insurance Program. FPL is federal poverty level. NA is not applicable. Dashes indicate data were suppressed for being smaller than 1,000, or no record exists. Coverage results are rounded to the nearest thousands.

## Enhancing Both Premium Tax Credits and Cost-Sharing Reductions

Lowering premiums is not the only way to make Marketplace coverage more affordable; a health reform can also increase the share of health care spending covered by an insurance plan, thus reducing the amount families pay out of pocket when they access care. Policies such as cost-sharing subsidies that decrease deductibles, copayments, coinsurance, and out-of-pocket spending maximums while holding premiums constant make coverage more valuable to enrollees, thereby increasing the likelihood that they will enroll in the insurance and improving their financial access to care once they are enrolled.

The ACA currently provides cost-sharing subsidies to some Marketplace enrollees, but this assistance is limited to people eligible for premium tax credits with incomes below 250 percent of FPL. The subsidies increase the generosity of the benefits, measured by the actuarial value, provided to enrollees with low incomes who purchase silver-level coverage. Standard silver-level coverage has an actuarial value of 70 percent, meaning that, on average, insurers cover 70 percent of the medical costs for covered benefits incurred by enrollees, and enrollees pay the other 30 percent directly through deductibles, copayments, and coinsurance. The ACA's cost-sharing subsidies increase the actuarial value of standard silver coverage to 94 percent for enrollees with incomes up to 150 percent of FPL, to 87 percent for enrollees with incomes between 150 and 200 percent of FPL, and to 73 percent for enrollees with incomes between 200 and 250 percent of FPL. Enrollees with incomes above 250 percent of FPL are currently ineligible for any cost-sharing assistance.

The next three state health reform options we analyze, what we call enhanced premium and cost-sharing assistance 1–3, would supplement each of the enhanced premium tax credit schedules in the first three reform options with additional cost-sharing subsidies (in addition to those provided by the federal government under the ACA). These reform options would increase cost-sharing subsidies and expand eligibility for such subsidies (table 6). First, the proposed schedule would increase the actuarial value of coverage for all eligible enrollees with incomes below 200 percent of FPL, from 87 percent to 94 percent. Second, it would increase the actuarial value of coverage from 73 percent to 87 percent for enrollees with incomes between 200 and 250 percent of FPL. Third, it would increase the actuarial value of coverage from 70 percent to 80 percent for enrollees with incomes between 250 and 400 percent of FPL. The state could achieve this result most cost effectively by using an 80 percent actuarial value (gold) plan as the benchmark for its enhanced premium tax credits for eligible enrollees with incomes above 200 percent of FPL.<sup>6</sup>

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<sup>6</sup> The state can implement increased cost-sharing subsidies in several ways, and one strategy is less costly for the state than others: using a gold plan (80 percent actuarial value) as the benchmark plan for all enrollees with incomes above 200 percent of FPL. The state would pay to boost benefits for those with incomes between 200 and 250 percent FPL but would pay nothing to boost benefits for those with incomes between 250 and 400 percent of FPL. This strategy is less expensive because gold premiums in New Mexico are similar to or lower than silver premiums, like in most states. Silver and gold premiums are similar even though gold plans provide more generous benefits (80 percent versus 70 percent actuarial value), because the federal government stopped paying directly for the ACA's cost-sharing reductions; instead, insurers have added those costs to Marketplace silver premiums, increasing them to a level similar to and sometimes higher than gold premiums.

TABLE 6

**Actuarial Value of Coverage Provided through Silver-Level Plan for Eligible Enrollees under Current Law and Enhanced Premium and Cost-Sharing Assistance for Nongroup Insurance, by Family Income Relative to the Federal Poverty Level, 2020**

*Percent*

| Income range     | Current law | Enhanced premium and cost-sharing assistance |
|------------------|-------------|--|
| 0%–150% of FPL   | 94          | 94   |
| 151%–200% of FPL | 87          | 94   |
| 201%–250% of FPL | 73          | 87   |
| 251%–300% of FPL | 70          | 80   |
| 300%–400% of FPL | 70          | 80   |

**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

**Note:** FPL is federal poverty level.

We have estimated the average annual savings in out-of-pocket medical costs for illustrative families of two adults at different incomes. These are average savings that would accrue if the state provided the enhanced cost-sharing subsidies delineated above. Because the ACA already provides some out-of-pocket subsidies for the lowest-income families eligible for premium tax credits, the additional savings provided under this proposal increase in size as incomes rise. We estimate that average annual savings are more than \$700 for a couple with income below 200 percent of FPL, approximately \$1,200 for a couple with income between 200 and 250 percent of FPL, \$1,370 for a couple with income between 250 and 300 percent of FPL, and \$2,080 for a couple with income between 300 and 400 percent of FPL (data not shown).

We find that enhanced cost-sharing subsidies consistent with this proposed schedule would increase enrollment in Marketplace insurance plans substantially, regardless of the level of enhanced premium tax credits to which they are applied. Lowering out-of-pocket health spending would remove much of the difference in health coverage gains between the three enhanced premium tax credit proposals. The number of uninsured people would decrease by between 20,000 and 23,000 (table 7).

Enhancing both premium tax credits and cost-sharing subsidies would lead to substantial savings in household health care spending. New Mexicans would spend between \$6 million and \$40 million less in premiums and between \$30 million and \$32 million less in out-of-pocket health care costs, depending on the level of enhanced premium tax credits (table 8). The nongroup market would benefit more from both increased enrollment and somewhat greater reductions in total premiums (the premium before subtracting tax credits) than it would from enhancing premium tax credits alone (premiums would be 15.3 percent to 18.5 percent lower). However, the cost to the state to finance both enhanced premium tax credits and cost-sharing subsidies would also be notably higher than enhancing premium tax credits alone, ranging from \$26 million to \$68 million per year.



TABLE 7

**Estimated Average Health Coverage and Costs for Nonelderly New Mexicans under Enhanced Premium and Cost-Sharing Assistance for Nongroup Insurance, Last Three Quarters of 2020**

|   | Current law  | Enhanced premium and cost-sharing assistance 1 | Enhanced premium and cost-sharing assistance 2 | Enhanced premium and cost-sharing assistance 3 |
|---|--------------|--|--|--|
| <b>Coverage status (number of people)</b>             |              |  |  |  |
| <i>Insured (minimum essential coverage)</i>           | 1,582,000    | 1,602,000                                      | 1,603,000                                      | 1,605,000                                      |
| Employer  | 690,000      | 686,000  | 686,000  | 685,000  |
| Private nongroup                                      | 67,000       | 90,000   | 92,000   | 94,000   |
| Marketplace with PTC                                  | 35,000       | 59,000   | 61,000   | 64,000   |
| Full-pay Marketplace                                  | 10,000       | 9,000  | 9,000  | 9,000  |
| Other nongroup  | 22,000       | 22,000   | 22,000   | 22,000   |
| Medicaid/CHIP   | 751,000      | 751,000  | 751,000  | 751,000  |
| Other public  | 74,000       | 74,000   | 74,000   | 74,000   |
| <i>Uninsured (no minimum essential coverage)</i>      | 214,000      | 194,000  | 193,000  | 191,000  |
| <i>Total</i>  | 1,796,000    | 1,796,000                                      | 1,796,000                                      | 1,796,000                                      |
| <b>Household health spending (\$ millions)</b>        |              |  |  |  |
| Premiums  | 1,202        | 1,196  | 1,180  | 1,163  |
| Other   | 1,185        | 1,156  | 1,156  | 1,154  |
| <i>Total</i>  | 2,388        | 2,352  | 2,336  | 2,316  |
| <b>Federal government spending (\$ millions)</b>      |              |  |  |  |
| Marketplace PTC                                       | 152          | 191  | 191  | 189  |
| <b>State government spending (\$ millions)</b>        |              |  |  |  |
| Marketplace PTC                                       | 0            | 18   | 37   | 59   |
| Marketplace CSR                                       | 0            | 9  | 9  | 9  |
| <i>Total</i>  | 0            | 26   | 45   | 68   |
| <b>Silver premium for a 40-year-old (\$ annually)</b> | <b>4,141</b> | <b>3,507</b>                                   | <b>3,443</b>                                   | <b>3,374</b>                                   |

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: PTC is premium tax credit. CHIP is Children's Health Insurance Program. CSR is cost-sharing reduction. EP+CSA = enhanced premiums and cost-sharing assistance. FPL is federal poverty level. Coverage results are rounded to the nearest thousands.

TABLE 8

**Estimated Average Changes to Coverage and Costs for Nonelderly New Mexicans under Enhanced Premium and Cost-Sharing Assistance for Nongroup Insurance, Last Three Quarters of 2020**

|   | ENHANCED PREMIUM<br>AND COST-SHARING<br>ASSISTANCE 1 |       | ENHANCED PREMIUM<br>AND COST-SHARING<br>ASSISTANCE 2 |       | ENHANCED PREMIUM<br>AND COST-SHARING<br>ASSISTANCE 3 |       |
|---|--|-------|--|-------|--|-------|
|   | Change from Current<br>Law                           |       | Change from Current<br>Law                           |       | Change from Current<br>Law                           |       |
|   | #  | %     | #  | %     | #  | %     |
| <b>Coverage status (number of people)</b>             |  |       |  |       |  |       |
| <i>Insured (minimum essential coverage)</i>           | 20,000   | 1.3   | 22,000   | 1.4   | 23,000   | 1.5   |
| Employer  | -3,000   | -0.5  | -4,000   | -0.5  | -4,000   | -0.6  |
| Private nongroup                                      | 24,000   | 35.2  | 26,000   | 38.2  | 27,000   | 41.0  |
| Marketplace with PTC                                  | 24,000   | 66.7  | 26,000   | 73.2  | 28,000   | 79.8  |
| Full-pay Marketplace                                  | 0  | -1.8  | 0  | -1.9  | -1,000   | -6.4  |
| Other nongroup  | 0  | 0.3   | 0  | -1.0  | 0  | -1.2  |
| Medicaid/CHIP   | 0  | —     | 0  | —     | 0  | —     |
| Other public  | 0  | —     | 0  | —     | 0  | —     |
| <i>Uninsured (no minimum essential coverage)</i>      | -20,000  | -9.4  | -22,000  | -10.2 | -23,000  | -10.8 |
| <i>Total</i>  | 0  | 0.0   | 0  | 0.0   | 0  | 0.0   |
| <b>Household health spending (\$ millions)</b>        |  |       |  |       |  |       |
| Premiums  | -6   | -0.5  | -22  | -1.8  | -40  | -3.3  |
| Other   | -30  | -2.5  | -30  | -2.5  | -32  | -2.7  |
| <i>Total</i>  | -36  | -1.5  | -52  | -2.2  | -71  | -3.0  |
| <b>Federal government spending (\$ millions)</b>      |  |       |  |       |  |       |
| Marketplace PTC                                       | 40   | 26.1  | 39   | 26.0  | 38   | 24.9  |
| <b>State government spending (\$ millions)</b>        |  |       |  |       |  |       |
| Marketplace PTC                                       | 18   | NA    | 37   | NA    | 59   | NA    |
| Marketplace CSR                                       | 9  | NA    | 9  | NA    | 9  | NA    |
| <i>Total</i>  | 26   | NA    | 45   | NA    | 68   | NA    |
| <b>Silver premium for a 40-year-old (\$ annually)</b> | -634   | -15.3 | -698   | -16.9 | -767   | -18.5 |

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: PTC is premium tax credit. CHIP is Children's Health Insurance Program. FPL is federal poverty level. NA is not applicable. Dashes indicate data were suppressed for being smaller than 1,000, or no record exists. Coverage results are rounded to the nearest thousands.

## A Basic Health Program

The seventh and final reform option makes health coverage more affordable for some New Mexico households by establishing a BHP. As explained earlier, the ACA provides states with the BHP option to offer coverage with lower premiums and out-of-pocket requirements to people with incomes up to 200 percent of FPL, who would otherwise be eligible for Marketplace premium tax credits. Under this approach, the state would contract with private insurers to provide coverage at least as affordable to households as is Marketplace coverage, and the federal government would give the state 95 percent of the premium tax credits BHP enrollees would have gotten under current law. If costs exceed federal payments, the state is responsible for the difference.

BHP enrollees are not included in the Marketplace. This has both potential benefits and drawbacks. Potential benefits of the separation between BHP and the nongroup market include the following:

- The state can improve affordability by setting both premiums and cost sharing at levels below federal premium tax credits and cost-sharing reductions in the Marketplace.
- The state has more flexibility to define what benefits to cover for the BHP population (though they cannot be of lower value than those provided in the Marketplace).
- The state can potentially lower its costs by negotiating lower provider payment rates than those used by insurers in the Marketplace.
- Unlike those receiving Marketplace premium tax credits, BHP enrollees do not have to reconcile tax credits with the IRS—or potentially repay credits if their annual income ends up higher than originally expected—every year at tax time.

Potential drawbacks include the following:

- BHP cannot make coverage more affordable for those with incomes above 200 percent of FPL.
- The federal government spends less under BHP than if such enrollees were in the Marketplace, adding financial pressure to the state to reduce its costs by having insurers negotiate lower provider reimbursement levels.
- The Marketplace loses a substantial number of enrollees, making participation less attractive to insurers.
- BHP sets up a counterintuitive relationship with the nongroup market. Higher nongroup premiums increase federal BHP payments, lowering state costs. Lower nongroup premiums have the opposite effect. Thus, BHP is more financially attractive in states that have relatively high nongroup premiums than in other states, like New Mexico, that have relatively low premiums relative to the national average.

We simulated a possible BHP approach for New Mexico using parameters provided by state officials. The program would not charge premiums for those with incomes up to 150 percent of FPL and would charge a \$20 monthly premium for those with incomes between 150 percent and 200 percent of FPL, similar to the premiums charged in BHPs in New York and Minnesota. The actuarial value of the BHP coverage we simulated for enrollees with incomes up to 150 percent of FPL is 94 percent, and the actuarial value for enrollees with incomes between 150 and 200 percent of FPL is 90 percent. BHP would cover the same services as Marketplace plans. We assume the same medical loss ratio for the BHP and Marketplace plans, 85 percent. Medical loss ratio rules set the minimum share of

a premium collected by an insurer that must be devoted to paying (1) claims for medical services and (2) for programs to enhance the quality of care provided (as opposed to the share of premiums used to cover administrative expenses, including insurer profit).

Based on information provided by state officials, we assume Marketplace insurers currently typically reimburse providers at 135 percent of Medicare rates, and that the state would be able to negotiate with a select group of insurers to offer a BHP that reimburses providers at lower rates: Medicaid rates for the small number of BHP enrollees with incomes up to 138 percent of FPL and 105 percent of Medicare rates for those with incomes between 138 and 200 percent of FPL. Based on data from the Henry J. Kaiser Family Foundation, we assume overall Medicaid provider reimbursement is about 89 percent of Medicare's reimbursement rates in New Mexico.<sup>7</sup>

Using these assumptions, we find that a New Mexico BHP would reduce the number of uninsured people by 12,000 (table 9). This is a slightly larger impact than the least generous enhanced premium tax credit option but a smaller effect than those of all other options we analyzed. A BHP is more narrowly targeted than the other options presented; it only affects those with incomes up to 200 percent of FPL, therefore reaching fewer people.

A BHP would reduce household spending on premiums by \$17 million and out-of-pocket costs by \$9 million. These are smaller aggregate savings than would be achieved by the enhanced cost-sharing reduction scenarios because the benefits are concentrated among fewer people with lower incomes; this is the population already eligible for the largest federal premium and tax credit subsidies under the ACA.

A BHP would draw 15,000 people out of the total nongroup market (including both Marketplace and off-Marketplace enrollees), reducing its size from 67,000 to 52,000 people. Total nongroup premiums (before applying premium tax credits) would decline by 1.5 percent, a far smaller reduction than any of the other health reform options considered. Also, providers would get lower reimbursement for the 15,000 people who were formerly in the Marketplace and newly enroll in BHP.

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<sup>7</sup> "Medicaid-to-Medicare Fee Index," Henry J. Kaiser Family Foundation, accessed August 19, 2020, <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>. This difference in provider reimbursements can be difficult to measure because of factors like Medicaid supplemental payments. However, most BHP enrollees would have incomes above 138 percent of FPL, so uncertainty about the ratio of Medicaid to Medicare provider reimbursements will have a very modest impact on state BHP spending.

TABLE 9

**Estimated Average Health Coverage and Costs for Nonelderly New Mexicans under a Basic Health Program, Last Three Quarters of 2020**

|  |             |                      | Change from Current Law |       |
|--|-------------|----------------------|-------------------------|-------|
|  | Current law | Basic Health Program | #                       | %     |
| Coverage status (number of people)             |             |                      |                         |       |
| Insured (minimum essential coverage)           | 1,582,000   | 1,594,000            | 12,000                  | 0.8   |
| Employer                                       | 690,000     | 688,000              | -2,000                  | -0.3  |
| Private nongroup                               | 67,000      | 81,000               | 14,000                  | 21.4  |
| Basic Health Program                           | 0           | 30,000               | 30,000                  | NA    |
| Marketplace with PTC                           | 35,000      | 20,000               | -15,000                 | -43.4 |
| Full-pay Marketplace                           | 10,000      | 10,000               | 0                       | 0.8   |
| Other nongroup                                 | 22,000      | 22,000               | 0                       | 0.1   |
| Medicaid/CHIP                                  | 751,000     | 751,000              | 0                       | —     |
| Other public                                   | 74,000      | 74,000               | 0                       | —     |
| Uninsured (no minimum essential coverage)      | 214,000     | 202,000              | -12,000                 | -5.7  |
| Total  | 1,796,000   | 1,796,000            | 0                       | —     |
| Household health spending (\$ millions)        |             |                      |                         |       |
| Premiums                                       | 1,202       | 1,185                | -17                     | -1.4  |
| Other  | 1,185       | 1,176                | -9                      | -0.8  |
| Total  | 2,388       | 2,361                | -27                     | -1.1  |
| Federal government spending (\$ millions)      |             |                      |                         |       |
| Marketplace PTC and Basic Health Program       | 152         | 144                  | -7                      | -4.7  |
| State government spending (\$ millions)        |             |                      |                         |       |
| Basic Health Program                           | 0           | 90                   | 90                      | NA    |
| Silver premium for a 40-year-old (\$ annually) | 4,141       | 4,079                | -62                     | -1.5  |

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: PTC is premium tax credit. CHIP is Children's Health Insurance Program. FPL is federal poverty level. NA is not applicable. Dashes indicate data were suppressed for being smaller than 1,000, or no record exists. Coverage results are rounded to the nearest thousands.

We estimate that a BHP would cost the state \$90 million, \$22 million more than the cost of the most generous enhanced premium tax credits and cost-sharing subsidies option. The benefits of the program are, by design, concentrated among a more narrowly defined low-income population than are the benefits in the other reform options. Also, because federal BHP payments are computed based on premiums in the nongroup Marketplace, the modest 1.5 percent reduction in presubsidy nongroup premiums lowers the federal funding contribution for a state's BHP.

These cost estimates assume New Mexico can negotiate BHP premiums with insurers that reflect substantially lower provider reimbursements than Marketplace plans in New Mexico currently pay. Offering a BHP with higher provider reimbursement could substantially increase its cost to the state.

## Reinsurance

In addition to the seven reform options presented here, we also analyze the implications of a state waiver to establish a reinsurance program for the nongroup market at two different levels of state funding (\$10 million and \$25 million). We find that reinsurance would not significantly increase the number of people with health insurance beyond what the enhanced premium tax credit approaches described above would achieve. Though these two reinsurance proposals would reduce total (presubsidy) premiums by 2 and 6 percentage points beyond the reductions achieved from only enhancing the subsidies, they result in 1,000 or fewer new enrollees than does enhancing premium tax credits alone (data not shown).

Several states, such as Colorado, have also shown that some low-income people eligible for tax credits would face higher premiums because of a reinsurance program.<sup>8</sup> Because the level of premium tax credits available to each enrollee is based on the benchmark (second lowest silver) premium available to them, lower premiums resulting from reinsurance also lower the dollar value of premium tax credits. Consequently, some enrollees with lower incomes who could have used their premium tax credit to obtain, for example, a bronze plan with a \$0 premium, could face a higher premium contribution for the same coverage with a reinsurance program in place. In the same way, the lower dollar value of premium tax credits resulting from implementing a reinsurance program would make gold or silver coverage with higher premiums than the benchmark plan less affordable for consumers with modest incomes. In July 2020, a bill was introduced into the Colorado legislature that would make several changes to the state's reinsurance program, including provisions intended to correct this problem.<sup>9</sup> However, doing so will likely increase state costs.<sup>10</sup>

## Discussion

We estimate that about 214,000 New Mexico residents will be uninsured in an average month during the last three quarters of 2020. Just over half of these New Mexicans (114,000, or 53 percent of the uninsured population) are eligible for financial assistance for health insurance coverage. Of these,

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<sup>8</sup> David Anderson, Andrew Sprung, and Coleman Drake, "ACA Marketplace Plan Affordability Is Likely to Decrease for Subsidized Enrollees in 2020," *Health Affairs Blog*, November 22, 2019, <https://www.healthaffairs.org/doi/10.1377/hblog20191118.253219/full/>; Aree Bly and Freddy Quiram, *Colorado Individual Exchange Renewals: Consumer Impact Analysis* (Atlanta: Wakely Consulting, 2019).

<sup>9</sup> Marianne Goodland, "Senate Committee Approves Rewrite of State Reinsurance Program, but Not without Dissent," *Colorado Politics*, June 4, 2020, [https://www.coloradopolitics.com/legislature/senate-committee-approves-rewrite-of-state-reinsurance-program-but-not-without-dissent/article\\_cbfbc3e-a5e4-11ea-a1b5-ff481735ff46.html](https://www.coloradopolitics.com/legislature/senate-committee-approves-rewrite-of-state-reinsurance-program-but-not-without-dissent/article_cbfbc3e-a5e4-11ea-a1b5-ff481735ff46.html).

<sup>10</sup> We acknowledge that several models for financing and operating state reinsurance programs exist among states with approved reinsurance innovation waivers, and that these models' implications and applicability for New Mexico may differ. For more information about existing reinsurance models' overall budgetary impacts and a discussion of reinsurance models not incorporating predetermined high-cost conditions, see "State Relief and Empowerment Waivers: State-Based Reinsurance Programs" (Washington, DC: Centers for Medicare & Medicaid Services, 2020).

57,000 are eligible for Medicaid or CHIP and could be reached by additional outreach and enrollment assistance.

In addition, 56,000 uninsured New Mexicans are eligible for Marketplace premium tax credits for the purchase of nongroup insurance coverage but are not enrolled. Lowering premiums and the out-of-pocket medical costs individuals and families face when using care would increase the number of people who enroll in coverage and therefore reduce uninsurance in the state. We find that each of the seven health reform proposals we analyze would improve household health care affordability and increase enrollment in health coverage.

Enhanced subsidies provide value to consumers beyond increasing the number of people with coverage. Enhancing premium and cost-sharing subsidies substantially reduces health care costs for New Mexicans already enrolled in coverage in the nongroup market. In other words, these subsidies significantly improve health care affordability for many residents with modest incomes. The state may also consider investing more not only in increasing coverage but in reducing household financial burdens and increasing access to necessary care. The greater the generosity of the subsidies provided, the greater the improvements in household affordability, but the greater the cost to the state government, too.

Some stakeholders may want to target benefits to New Mexicans with lower incomes. A BHP is necessarily more targeted to those with lower incomes, because federal law limits eligibility for such programs to people with incomes below 200 percent of FPL. However, if such restricted eligibility is preferred, enhanced tax credits and cost-sharing subsidies can also be limited to this same income group and at a lower cost to the state than a BHP.

Another consideration for evaluating state policy options is how each approach affects the strength of New Mexico's nongroup insurance market, as measured by enrollment and premiums. Larger numbers of enrollees in the market tend to attract and retain more insurer participation, which could lead to greater competition and lower premiums over time.<sup>11</sup> Greater insurer participation provides consumers with more choices, and lower premiums make coverage more affordable to consumers, particularly those ineligible for financial assistance with premiums. They are also indicators of a balanced insurance risk pool that can attract enrollees with lower expected health care costs. All options except a BHP unequivocally improve both enrollment and total (presubsidy) premiums, and higher spending on premium tax credits improves both measures. A BHP would reduce the size of the nongroup market by nearly a quarter while reducing premiums slightly.

Implementing any of these reforms will require more effort and cost than the direct subsidy costs we estimate here. All would also require New Mexico to transition to a state-based Marketplace, as the state plans to do for the 2022 plan year. In addition, the reforms would require changes to the standard Marketplace eligibility determination and enrollment processes. Enhancing cost-sharing reductions would require that the state reimburse insurers in a way similar to how the federal

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<sup>11</sup> John Holahan, Erik Wengle, and Linda J. Blumberg, "[What Characterizes the Marketplaces with One or Two Insurers? An Update](#)" (Washington, DC: Urban Institute, 2019).

government formerly funded ACA cost-sharing subsidies.<sup>12</sup> A BHP would require additional state infrastructure, such as annual negotiation of the BHP and establishment of a BHP trust fund.

We estimate that more New Mexico residents are uninsured than was the case in 2019. As recent increases in enrollment show, Medicaid expansion and the Marketplace have protected many New Mexicans from becoming uninsured during the COVID-19 recession. We also find that various policy options could further reduce uninsurance in New Mexico via investments in improved household health care affordability.

## Methodological Appendix

We produced estimates for this report using the Health Insurance Policy Simulation Model, a detailed microsimulation model of the health insurance system designed to estimate the cost and coverage effects of proposed health care policy options. The model includes the US population below age 65 and is based on two years of data from the American Community Survey, which provides a representative sample of families constituting more than 6 million individuals. The sample is reweighted to reflect more recent information on income and demographics and aged to future years using recent American Community Survey data and projections from the University of New Mexico's Geospatial and Population Studies and the Urban Institute's Mapping America's Futures program. We regularly update the model to reflect the latest published Medicaid and Marketplace enrollment and costs in each state. In this analysis, we incorporate the latest available Medicaid and Marketplace enrollment data from New Mexico.

### *Incorporating New Mexico Enrollment Data*

As noted, the standard HIPSM model incorporates publicly available data on Medicaid and Marketplace enrollment in each state. For this analysis, we customized the model based on detailed enrollment information provided by New Mexico and based on estimates of the number of uninsured New Mexicans in the latest available census surveys. Specifically, we customized HIPSM for New Mexico based on the following:

- Medicaid and CHIP enrollment by detailed eligibility type for the nonelderly, including people with disabilities, Medicaid expansion adults, parents and caretaker adults, and nondisabled children, focusing on those eligible for full benefits, rather than waivers that only cover certain services
- per capita costs of Medicaid/CHIP enrollees by the previously mentioned eligibility types
- Medicaid enrollment among American Indians<sup>13</sup>
- Marketplace enrollees by receipt of premium tax credits and cost-sharing reductions
- the distribution of Marketplace enrollees by age and sex

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<sup>12</sup> Beginning in plan year 2020, the Trump administration halted direct reimbursement to insurers for cost-sharing subsidies. Insurers now build these costs into the premiums they charge, and they are indirectly reimbursed for providing these subsidies to consumers.

<sup>13</sup> Our research indicates many indigenous New Mexicans prefer to be called American Indians, but we recognize this population constitutes diverse communities and identities.



## *The Impact of the COVID-19 Pandemic*

HIPSM is designed to incorporate timely, real-world data when they are available. Here, we incorporate the latest detailed information on employment losses by industry, state, and demographic characteristics collected from multiple sources and released by the US Department of Labor.<sup>14</sup> Thus, recent data on actual employment losses are the foundation for our estimates of changes in insurance coverage due to the COVID-19 recession.

Simulating the effects of the COVID-19 recession on insurance coverage involves three broad steps. The first is incorporating reported employment losses into our microsimulation model. We model total employment losses to capture both people exiting the labor force and those who are unemployed (i.e., not working but actively seeking work). We use those data to impose employment losses from monthly US Bureau of Labor Statistics (BLS) employment situation reports on the individuals in our data, selecting people by their reported industry, occupation, educational attainment, sex, race/ethnicity, and full-/part-time work status. We also match our distribution of employment losses by state to that from BLS state employment and unemployment reports. We control our estimates of total employment losses to projections from the Congressional Budget Office, finding that, on average, 22.4 million workers across the US will be unemployed or will have left the labor force during the last three quarters of 2020.<sup>15</sup> Of those national job losses, we compute the proportion of New Mexico job losses based on BLS state employment and unemployment reports.

In the second step, we calculate the losses of income and employment-based coverage that follow the loss of employment. We assume workers who lose their jobs also lose the income associated with it, but many workers will apply for and receive unemployment insurance (UI). We apply New Mexico and federal rules in calculating UI payments, because states vary considerably in their rules and in the number of weeks unemployed workers can collect UI benefits. We also apply recent federal rules affecting UI payments: The Coronavirus Aid, Relief, and Economic Security, or CARES, Act extended UI by 13 weeks beyond existing state limits and increased such weekly payments by \$600 through July 31, 2020. It also expanded eligibility for UI to self-employed workers, such as rideshare drivers.

We follow federal rules on how various UI payments are counted toward eligibility for Medicaid and Marketplace subsidies. We rely on the underlying data in our model to estimate how many workers who lose their jobs also lose access to employer-sponsored insurance. Not all newly unemployed workers will lose their employer coverage immediately: Some employers are continuing to pay premiums on behalf of their furloughed employees. Some employers are using loans from the Paycheck Protection Program to pay health insurance premiums, but that money may run out before the economy recovers. And some businesses will return to full capacity, but others will not. Our

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<sup>14</sup> We use the following data sources from the Bureau of Labor Statistics: the Current Employment Statistics program, which produces estimates of employment, hours, and earnings nationally and for states and metropolitan areas; employment situations for March through May; and state employment and unemployment (monthly) reports. We also use the unemployment insurance weekly claims report from US Department of Labor.

<sup>15</sup> Congressional Budget Office, *Interim Economic Projections for 2020 and 2021* (Washington, DC: Congressional Budget Office, 2020).

projections assume all unemployed workers who remain out of work eventually lose their employer coverage from their previous jobs. We assume those losing jobs permanently will lose their employer-based coverage, but on average over the last three quarters of 2020, about one-quarter will remain covered. Many workers who lose their jobs have access to employer-sponsored coverage through a family member. Based on past observed behavior and preferences incorporated in our model, we estimate that a high share of people with this option take it up when it is available. We simulate this in our model, accounting for differences in premiums and plan generosity between the family member's offer and the coverage lost.

In the final step, after accounting for changes in income and for losses of offers of employer coverage, we recalculate each person's eligibility for subsidized health insurance coverage and their choice of available coverage. Our model estimates people's enrollment responses to the new set of insurance choices they face, including employer-sponsored insurance (if available), Medicaid, CHIP, BHP (in one simulation only), and nongroup insurance coverage (including Marketplace plans), as well as uninsurance. Our model is based on evidence drawn from vast literature on insurance choices, observed preferences, and take-up elasticities. We also incorporate the latest Medicaid and Marketplace enrollment data available from the state government.

### *Limitations*

Our projections of the COVID-19 recession's effects on insurance coverage are based on the best presently available data. Given uncertainty about the recession's eventual effects, however, we face several uncertainties when estimating insurance coverage. First, data on the number of people who lost employer coverage when they lost their jobs are not yet available; we estimate this change based on the known characteristics of the people losing employment. Second, the distribution of job losses due to the pandemic continues evolving. Third, tremendous uncertainty surrounds the pandemic itself, how seriously it will continue to affect people and how their behavior will change, when widespread testing or a vaccine will be available, and how fast the economy may recover as a result. Unanticipated shifts in any of these factors will change our estimates. Also, if additional legislation is passed by Congress and signed into law, outcomes will vary from our estimates.

## Supplementary Tables

TABLE A.1

Estimates of Premium Payments by Existing Nongroup Households and the Number of Uninsured Nonelderly New Mexicans under Enhanced Premium Assistance Reforms and Enhanced Premium and Cost-Sharing Assistance Reforms, Last Three Quarters of 2020

|  | Current law | Enhanced premium assistance 1 | Enhanced premium assistance 2 | Enhanced premium assistance 3 | Enhanced premium and cost-sharing assistance 1 | Enhanced premium and cost-sharing assistance 2 | Enhanced premium and cost-sharing assistance 3 |
|--|-------------|-------------------------------|-------------------------------|-------------------------------|--|--|--|
| <b>Premium payments after federal and state assistance, by family income relative to FPL (\$ millions)<sup>a</sup></b> |             |                               |                               |                               |  |  |  |
| < 138% of FPL  | 1           | 0                             | 0                             | 0                             | 1  | 0  | 0  |
| 138–150% of FPL  | 4           | 3                             | 2                             | 1                             | 4  | 3  | 2  |
| 150–200% of FPL  | 23          | 19                            | 15                            | 10                            | 23   | 19   | 15   |
| 200–250% of FPL  | 15          | 12                            | 10                            | 8                             | 15   | 12   | 10   |
| 250–300% of FPL  | 24          | 20                            | 19                            | 17                            | 24   | 20   | 19   |
| 300–400% of FPL  | 41          | 36                            | 35                            | 35                            | 41   | 35   | 77   |
| <b>Number of uninsured people</b>  |             |                               |                               |                               |  |  |  |
| <i>Select races/ethnicities</i>  |             |                               |                               |                               |  |  |  |
| American Indian  | 37,000      | 34,000                        | 33,000                        | 33,000                        | 37,000   | 33,000   | 32,000   |
| Hispanic   | 121,000     | 115,000                       | 114,000                       | 111,000                       | 121,000  | 111,000  | 110,000  |
| <i>By family income relative to FPL<sup>a</sup></i>  |             |                               |                               |                               |  |  |  |
| Under 100% of FPL  | 58,000      | 58,000                        | 58,000                        | 58,000                        | 58,000   | 58,000   | 58,000   |
| 100–150% of FPL  | 18,000      | 16,000                        | 16,000                        | 16,000                        | 18,000   | 16,000   | 16,000   |
| 150–200% of FPL  | 34,000      | 27,000                        | 27,000                        | 25,000                        | 34,000   | 26,000   | 25,000   |
| 200–300% of FPL  | 49,000      | 46,000                        | 43,000                        | 41,000                        | 49,000   | 39,000   | 38,000   |
| 300–400% of FPL  | 24,000      | 24,000                        | 24,000                        | 24,000                        | 24,000   | 23,000   | 23,000   |

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: FPL is federal poverty level. Coverage results are rounded to the nearest thousands.

<sup>a</sup> The upper end of income ranges is not inclusive. For example, \$10,000–25,000 includes incomes greater than or equal to \$10,000 but less than \$25,000.

TABLE A.2

Estimated Changes to Total Premium Payments by Existing Nongroup Households and the Number of Uninsured Nonelderly New Mexicans under Enhanced Premium Assistance Reforms and Enhanced Premium and Cost-Sharing Assistance Reforms, Last Three Quarters of 2020

|  | ENHANCED<br>PREMIUM<br>ASSISTANCE 1 |       | ENHANCED<br>PREMIUM<br>ASSISTANCE 2 |       | ENHANCED<br>PREMIUM<br>ASSISTANCE 3 |       | ENHANCED<br>PREMIUM AND<br>COST-SHARING<br>ASSISTANCE 1 |       | ENHANCED<br>PREMIUM AND<br>COST-SHARING<br>ASSISTANCE 2 |       | ENHANCED<br>PREMIUM AND<br>COST-SHARING<br>ASSISTANCE 3 |       |
|--|-------------------------------------|-------|-------------------------------------|-------|-------------------------------------|-------|---|-------|---|-------|---|-------|
|  | Change from<br>Current Law          |       | Change from<br>Current Law          |       | Change from<br>Current Law          |       | Change from<br>Current Law                              |       | Change from<br>Current Law                              |       | Change from<br>Current Law                              |       |
|  | #                                   | %     | #                                   | %     | #                                   | %     | #   | %     | #   | %     | #   | %     |
| <b>Premium payments after federal and state assistance, by family income relative to FPL (\$ millions)<sup>a</sup></b> |                                     |       |                                     |       |                                     |       |   |       |   |       |   |       |
| < 138% of FPL  | 0                                   | -23.7 | 0                                   | -25.9 | 0                                   | -28.1 | 0   | -25.4 | 0   | -26.3 | 0   | -27.8 |
| 138–150% of FPL  | -1                                  | -27.1 | -2                                  | -59.9 | -3                                  | -81.8 | -1  | -27.5 | -2  | -60.0 | -3  | -81.8 |
| 150–200% of FPL  | -3                                  | -14.6 | -8                                  | -34.4 | -12                                 | -54.9 | -3  | -15.3 | -8  | -34.6 | -12   | -54.8 |
| 200–250% of FPL  | -4                                  | -23.8 | -5                                  | -34.4 | -7                                  | -45.8 | -4  | -23.9 | -5  | -34.3 | -7  | -45.7 |
| 250–300% of FPL  | -4                                  | -17.2 | -5                                  | -21.9 | -8                                  | -31.2 | -4  | -17.5 | -5  | -21.9 | -8  | -31.1 |
| 300–400% of FPL  | -6                                  | -13.8 | -6                                  | -14.9 | -6                                  | -15.6 | -6  | -14.5 | 35  | 85.3  | -6  | -15.3 |
| <b>Number of uninsured people</b>  |                                     |       |                                     |       |                                     |       |   |       |   |       |   |       |
| <i>By select races/ethnicities</i>   |                                     |       |                                     |       |                                     |       |   |       |   |       |   |       |
| American Indian  | -3,000                              | -8.4  | -4,000                              | -10.0 | -4,000                              | -11.1 | -4,000  | -11.8 | -5,000  | -13.1 | -5,000  | -13.8 |
| Hispanic   | -6,000                              | -4.6  | -7,000                              | -5.7  | -9,000                              | -7.6  | -9,000  | -7.9  | -11,000   | -8.8  | -11,000   | -9.4  |
| <i>By family income relative to FPL<sup>a</sup></i>  |                                     |       |                                     |       |                                     |       |   |       |   |       |   |       |
| Under 100% of FPL  | 0                                   | 0.0   | 0                                   | 0.0   | 0                                   | 0.0   | 0   |       | 0   |       | 0   |       |
| 100–150% of FPL  | -1,000                              | -8.0  | -1,000                              | -8.0  | -1,000                              | -8.0  | -1,000  | -8.0  | -1,000  | -8.0  | -1,000  | -8.0  |
| 150–200% of FPL  | -7,000                              | -19.4 | -7,000                              | -20.9 | -9,000                              | -25.6 | -8,000  | -22.8 | -9,000  | -26.6 | -9,000  | -27.4 |
| 200–300% of FPL  | -3,000                              | -6.9  | -6,000                              | -12.5 | -8,000                              | -16.0 | -10,000   | -20.9 | -11,000   | -21.7 | -12,000   | -23.9 |
| 300–400% of FPL  | 0                                   | -0.7  | 0                                   | -0.7  | 0                                   | -0.7  | -1,000  | -4.4  | -1,000  | -4.4  | -1,000  | -4.4  |

Source: Urban Institute Health Insurance Policy Simulation Model, 2020.

Notes: FPL is federal poverty level. Coverage results are rounded to the nearest thousands.

<sup>a</sup> The upper end of income ranges is not inclusive. For example, \$10,000–25,000 includes incomes greater than or equal to \$10,000 but less than \$25,000.

TABLE A.3

**Estimates of Premium Payments by Existing Nongroup Households and the Number of Uninsured Nonelderly New Mexicans under a Basic Health Program, Last Three Quarters of 2020**

|  | Current law | Basic Health Program | Change from Current Law |       |
|--|-------------|----------------------|-------------------------|-------|
|  |             |                      | #                       | %     |
| Premium payments after federal and state assistance, by family income relative to FPL (\$ millions) <sup>a</sup> |             |                      |                         |       |
| < 138% of FPL  | 1           | 0                    | 0                       | -19.1 |
| 138–150% of FPL  | 4           | 1                    | -3                      | -79.2 |
| 150–200% of FPL  | 23          | 11                   | -12                     | -52.9 |
| 200–250% of FPL  | 15          | 13                   | -2                      | -12.6 |
| 250–300% of FPL  | 24          | 23                   | -2                      | -6.5  |
| 300–400% of FPL  | 41          | 40                   | -1                      | -3.0  |
| Number of uninsured people   |             |                      |                         |       |
| By select races/ethnicities  |             |                      |                         |       |
| American Indian  | 37,000      | 34,000               | -3,000                  | -9.1  |
| Hispanic   | 121,000     | 114,000              | -7,000                  | -5.5  |
| By family income relative to FPL <sup>a</sup>  |             |                      |                         |       |
| Under 100% of FPL  | 58,000      | 58,000               | 0                       | -0.1  |
| 100–150% of FPL  | 18,000      | 16,000               | -1,000                  | -8.3  |
| 150–200% of FPL  | 34,000      | 25,000               | -9,000                  | -27.8 |
| 200–300% of FPL  | 49,000      | 47,000               | -2,000                  | -4.1  |
| 300–400% of FPL  | 24,000      | 24,000               | 0                       | 1.2   |

**Source:** Urban Institute Health Insurance Policy Simulation Model, 2020.

**Notes:** FPL is federal poverty level. Coverage results are rounded to the nearest thousands.

<sup>a</sup> The upper end of income ranges is not inclusive. For example, \$10,000–25,000 includes incomes greater than or equal to \$10,000 but less than \$25,000.

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*Robin Wang is a research analyst in the Health Policy Center, where he helps develop Urban's Health Insurance Policy Simulation Model.*

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