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Economic and Fiscal Impacts of the Proposed Medicaid Expansion in New Mexico

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Economic and Fiscal Impacts of the Proposed Medicaid Expansion in New Mexico

This brief analyzes the economic and fiscal impacts of the "Medicaid Expansion" in New Mexico. Under the Patient Protection and Affordable Care Act (ACA) as enacted on March 23, 2010, states were required to extend Medicaid coverage to low-income adults under 65 years old with incomes up to 133% percent of the poverty level (138% after income disregards). However, the Supreme Court held that the federal government cannot withhold current Medicaid funding should a state decide to opt out of the Medicaid Expansion. At this time, New Mexico has not decided whether to implement the Medicaid Expansion.

This brief examines:

1. The additional flow of federal Medicaid dollars to the State of New Mexico expected under both Low and High uptake scenarios (high and low enrollment projections) for the Medicaid Expansion based on projections by the NM Health and Human Services Department (HSD) in May 2012.

2. The net impacts of the Medicaid Expansion on State expenditures.

3. The economic impacts on New Mexico of the Medicaid Expansion (including new job creation).

4. The anticipated impacts of the Medicaid Expansion on the State General Fund.

Under ACA, the Federal government will pick up 100% of the costs of extending Medicaid coverage to newly eligible adults at or below 138% of poverty for the first three years: calendar years 2014, 2015 and 2016. In calendar year 2017 the federal match will fall to 95%. This decline continues with 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. The federal government will also charge the state a 1.9% insurance fee on the additional costs for the care of those adults newly enrolled in Medicaid. Moreover, some of those adults newly eligible for Medicaid are currently provided with health insurance under the NM State Coverage Insurance (SCI) program: a limited health insurance program for adults. The SCI program is funded in part by federal Medicaid which the state receives both for low income childless adults and for low income parents under two separate Medicaid waivers. With ACA, SCI will cease to exist: those above 138% of poverty will be covered through the Exchange; those with incomes at or below 138% of poverty will be eligible to obtain coverage at the more favorable federal match from the Medicaid Expansion. The State will lose the federal matching dollars that currently flow under the SCI waivers. In addition, under ACA the state will receive

reduced federal matching funds for the state Medicaid Disproportion Share Hospitals (DSH) program.[1]

Total state expenditures that are expected to result from the Medicaid Expansion are calculated by subtracting available federal Medicaid funding from the total program costs. For the implementation period FY14 through FY20, the State match totals $199 million under the low uptake scenario and $258 million under the high uptake scenario. HSD is estimating that the State costs of administering the Medicaid Expansion will be $2.8 million per year. However, the state is expected to save money with the elimination of the State Coverage Insurance (SCI) program. Nearly all adults in SCI are expected to receive coverage through the Medicaid Expansion.[2] We estimate that after accounting for these savings, the state may spend up to $42 million on Medicaid Expansion over state fiscal years 2014 to 2020 assuming the higher level of participation by enrollees and could save more than $17 million assuming a lower level of participation. Note that these estimates for State expenditures do not take into account of new revenues generated. (See Fiscal Impact below.) It also should be noted that these numbers do not reflect the impact on State expenditures of the "Woodwork Effect" under which those currently eligible for Medicaid but not enrolled come out of the woodwork as implementation of the ACA proceeds. This effect may be expected with or without the Medicaid expansion. While this effect may be a consideration in discussing the impacts of the ACA on State expenditures, our focus is specifically on the effects of Medicaid Expansion.

The economic impact of Medicaid Expansion includes economic activity, which encompasses new jobs, supported directly and indirectly by the additional *federal* expenditures for Medicaid. (Additional spending by the State of New Mexico on Medicaid does not result in net new economic activity, since the money could have been spent elsewhere or returned to taxpayers.) We estimate that the expansion of Medicaid under ACA will generate from $4.8 billion to $8.6 billion of economic activity in New Mexico between FY14 and FY20 and create 6,000 to almost 8,500 new jobs by FY20 depending on Medicaid enrollment levels.

Fiscal impacts will focus on the State's General Fund. In addition to the new expenditures mentioned above, the Medicaid Expansion and the associated additional

[1] This program provides federal assistance with a state match to hospitals that serve a disproportionate number of low income patients. NM is a low DSH state, meaning that it currently receives less than $20 million from the federal government for this program. Under ACA and in anticipation of the reduction in uncompensated care, the federal DSH allotments to states will be reduced by $18.1 billion over seven years. Including the State match, which is estimated to be 31.21% in FY 14, HSD anticipates the total DSH payments to NM hospitals will decrease from $30.1 million in FY14 to $17.3 million in 2020. This analysis is based on testimony by Brent Earnest, Deputy Secretary, HSD, to the Legislative Health and Human Services Committee on Aug. 13, 2012.

[2] HSD estimates that 94% of current SCI enrollees would be eligible for coverage under the Medicaid Expansion. See HSD chart, *Medicaid Under Healthcare Reform By State Fiscal Year with Different Up Take Rates* (May 2012), page 2 with "Low Uptake Scenario", footnote 5.

economic activity will generate new revenues from existing taxes and fees that will accrue to the State General Fund. New Mexico levies insurance premium taxes on managed care organizations and gross receipts taxes on some healthcare providers that serve Medicaid enrollees. The state can also expect additional revenues from income taxes and gross receipts taxes as new jobs and income are generated by the federal funds. Gains may also be expected through the phasing out of the state's high risk pool which currently serves adults who may transfer to Medicaid. When the anticipated savings and the additional revenues from existing taxes and fees are all taken into account, the Medicaid Expansion is estimated to result in net gains for the State between $478 million to $523 million over fiscal years 2014 to 2020. Assuming no change in the rules, we further note the likelihood that the State will continue to see net gains after the year 2020.

1. Medicaid Expansion

The estimates used as a basis for this analysis are the Low Uptake and High Uptake projections of new enrollees and associated Medicaid costs that were developed by the NM Human Services Department (HSD) Medical Assistance Division, in May 2012. BBER was provided with the underlying population estimates for different groups within the anticipated new Medicaid population as well as their per person costs under different scenarios regarding uptake. Estimates of the federal share (the federal government's contribution to paying these costs) are based on the annual percentages given in the ACA for Medicaid Expansion as well as the likely applicable Federal match (FMAP) for different programs as provided by HSD.

The analysis assumes that all those who enroll in Medicaid under the Medicaid Expansion will have their care coordinated by a Managed Care Organization (MCO). HSD is in the process of reforming the State's Medicaid program and is proceeding with the Centennial Care under which all Medicaid recipients will receive health care services, will access needed prescription drugs and durable medical equipment, and will have their care coordinated by a MCO under contract to the State. Fee-for-service Medicaid will no longer exist. MCOs will receive a capitated payment for each patient who is enrolled, which means that the MCO will receive a fixed sum for each participating adult to provide a "medical home", to cover the adult's health care expenses over a stipulated period of time, and to process payments to health care providers . We assume that each MCO will take 15% off the top to cover administration, premium taxes, etc. This is the maximum allowed under the ACA but it is in line with current charges by MCOs in Salud.

New Mexico has long been under-served in terms of health care providers and health care facilities. ACA includes funding and provisions aimed at developing the health care infrastructure of states and at increasing the supply of health professionals. BBER is aware of investments in new facilities made possible by ACA, for example a new health

center that First Choice is building in Los Lunas. Nevertheless, as was true even in Massachusetts with its very low rate of uninsured, demand is likely to exceed available supply and patients may have difficulty accessing the care they need. BBER assumes that some of this demand may initially be met by sending patients out-of-state, but only if other states are willing to accept what NM will pay. More typically and until the supply of providers catches up with demand, patients will face long waits; many may simply go without some of the care they need as they in all likelihood did prior to being covered by Medicaid. Even when care is provided and payments are made, the broader "multiplier" impacts on the economy will not be immediate as the increases in demand will take time to ripple through the economy. As a way of capturing these lags, we assume that only 70% of the payments estimated by HSD for FY 14 will actually go to NM providers, followed by 85% in FY 15, 97% in FY 17, 99% in FY 18 and 100% thereafter.

Low Uptake Scenario

Under the Low Uptake Scenario, 101,910 adults (51% of the roughly 200,000 presently ineligible but likely to meet the program qualifications when implemented in 2014) will take up health insurance coverage under Medicaid beginning in January 2014. Those newly enrolled in Medicaid include about 65,000 newly eligible and about 37,000 in SCI. By FY 20, the number of adults in the program is forecasted to be 116,334. The essential details of the scenario are laid out in Table 1.1. Note that while the federal share is estimated to total almost $4.9 billion over the 7-year period from FY 2014 to FY 2020, the net new federal dollars flowing to the state under this scenario are estimated to total $3.9 billion.[3] The difference is due to the 1.9% insurance administration fee mandated by ACA, the loss in federal Medicaid for those receiving insurance under SCI who now qualify for Medicaid under the Medicaid Expansion, and the reductions in the federal contributions for the DSH program. It should be noted that there is a further loss to the state under ACA that is not included in the above analysis, namely reductions in Medicare payments that were negotiated with providers. These reductions are estimated to result in reduced payments to hospitals of $751 million over 10 years and will occur whether or not the State participates in the Medicaid expansion.[4]

[3] The Federal matching rate (FMAP) for newly eligible adults with income up to 138% of the Federal Poverty Level is 100% for calendar years 2014, 2015 and 2016, 95% for 2017, 94% for 2018, 93% for 2019 and 90% for 2020 and after. However, HSD's analysis projects a lower federal match in every year on the assumption that 8% of newly eligible adults will become parents over the forecast period, which will "result in them being re-categorized as Parents, a category of eligibility available as of December 2009. [JUL Medicaid]. Therefore, the federal share for these adults is assumed to be reversed to the regular FMAP rate of 69.07%." BBER's estimates do not make this assumption. BBER talked with Dr. Deborah Challet, a health care expert with Mathematica. She indicated that no one working on these issues in Washington is making this type of assumption.

[4] Materials provided by Jeff Dye, Executive Director, New Mexico Hospital Association.

State expenditures under the Low Uptake Scenario include the State share under the Medicaid Expansion: zero in fiscal years 2014, 2015 and 2016; 2.5% in FY17 (half a year at zero, half a year at 5%); 5.5% in FY18; 6.5% in FY19, and 8.5% in FY20 when half the

Table 1.1. Medicaid Expansion: NM Medicaid Population and Costs Under the Low Uptake Scenario

	FY 2014 Jan - June	FY 2015	FY 2020	Totals FY 2014 -20
Newly Enrolled Medicaid Population				
Newly Eligible	64,810	73,279	98,283	
Presently in SCI	37,100	34,148	18,051	
Enrolled Under Low Uptake	101,910	107,427	116,334	
Percent of All Eligible Adults	*51.2%*	*54.5%*	*64.0%*	
Cost Per Person	$ 5,788	$ 6,191	$ 7,768	
Costs in Millions of Dollars				
Total Costs	$ 294.9	$ 665.1	$ 903.7	$ 5,077.2
Federal Share	$ 294.9	$ 665.1	$ 826.9	$ 4,878.1
Percent of Total	*100.0%*	*100.0%*	*91.5%*	*96.1%*
Minus: 1.9% Insurance Fee [a]	$ (5.6)	$ (12.6)	$ (17.2)	$ (96.5)
Minus: Federal Share SCI [b]	$ (74.2)	$ (146.0)	$ (96.9)	$ (826.4)
Minus: Federal Share DSH [c]	$ -	$ -	$ (8.9)	$ (24.9)
Net Federal Share	$ 215.2	$ 506.4	$ 704.0	$ 3,930.3
State Share	$ -	$ -	$ 76.8	$ 199.1
Plus: Additional Admin Costs	$ 2.8	$ 3.0	$ 3.9	$ 23.1
Minus: State Share SCI [d]	(21.5)	(42.3)	(28.0)	(239.3)
New State Share	$ (18.7)	$ (39.3)	$ 52.7	$ (17.1)

Notes:

a. The annual cost per person includes a 1.9% federal tax called the insurer fee.
b. Calculated at 69.07% per HSD.
c. 68.79% of estimated DSH reductions per HSD.
d. Calculated to average roughly 20% per HSD.

UNM BBER Calculations from NM HSD Medical Assistance Division data, May 2012

year will be at 7% and half at 10%. The State also expects to spend $2.8 million per year on administering the program. According to the LFC, "The Congressional Budget Office is estimating that administrative costs will increase an average of 5.5% over the implementation period."[5] This increase is built into the figures in the table.

[5] NM Legislative Finance Committee, *Hearing Brief, Implementation of ACA: Costs and Benefits of Expansion of Medicaid Eligibilit*y, September 27, 2012, p. 7.

The elimination of the SCI program will result in savings to the State, which generally makes up the difference between total costs and what is contributed by the federal government as well as through a sliding scale of premium payments from program participants.[6] The savings included here are on those adults currently in SCI who are at or below 138% of poverty and who are assumed to be covered under the Medicaid Expansion. Savings to the State on the SCI program could be as much as $239 million over the FY 2014-20 period. With sizeable savings on the SCI program, the state actually comes out ahead with an estimated $17.1 million net reduction in Medicaid spending over the 7-year implementation period even before taking into account any of the additional revenues likely to accrue to the State General Fund.

High Uptake Scenario

Table 1.2 provides similar details for the High Uptake Scenario, which assumes an initial uptake by 89,114 of the newly eligible (not SCI) versus the 64,810 enrolled under the Low Uptake Scenario. Under this scenario, the total costs of the Medicaid expansion would be $6.65 billion with the federal government picking up $6.4 billion. After making appropriate adjustments as outlined above, the net new federal dollars from the Medicaid Expansion total $5.4 billion for the FY 2014 to 2020 period.

The Medicaid expansion would in this case be a net cost to the State of $41.6 million over the 7 years before taking into account the additional General Fund revenues. The amount would be higher – as much as $239.3 million -- in the absence of savings on the SCI program.

Note that the tables capture only the essential information available from HSD about the two scenarios. Neither of the tables captures the potential additional revenues, which are discussed in Section 3 of this report.

[6] Per a memorandum of understanding, UNM pays both the State share and the premiums for those enrolled through them. Estimating what the State share for SCI would be in 2014 and beyond is complicated. Per a spreadsheet analysis provided by HSD staff, we assume 20%.

Table 1.2. Medicaid Expansion: NM Medicaid Population and Costs Under the High Uptake Scenario

	FY 2014 Jan - June	FY 2015	FY 2020	Totals FY 2014 -20
Newly Enrolled Medicaid Population				
Newly Eligible	89,114	105,847	131,044	
Presently in SCI	37,100	34,148	18,051	
Enrolled Under High Uptake	126,214	139,995	149,095	
Percent of All Eligible Adults	*63.4%*	*71.1%*	*82.0%*	
Cost Per Person	$ 5,788	$ 6,191	$ 7,768	
Costs in Millions of Dollars				
Total Costs	$ 365.3	$ 866.7	$ 1,158.2	$ 6,648.5
Federal Share	$ 365.3	$ 866.7	$ 1,059.7	$ 6,390.7
Percent of Total	*100.0%*	*100.0%*	*91.5%*	*96.1%*
Minus: 1.9% Insurance Fee [a]	$ (6.9)	$ (16.5)	$ (22.0)	$ (126.3)
Minus: Federal Share SCI [b]	$ (74.2)	$ (146.0)	$ (96.9)	$ (826.4)
Minus: Federal Share DSH [c]	$ -	$ -	$ (8.9)	$ (24.9)
Net Federal Share	$ 284.2	$ 704.2	$ 932.0	$ 5,413.1
State Share	$ -	$ -	$ 98.4	$ 257.8
Plus: Additional Admin Costs	$ 2.8	$ 3.0	$ 3.9	$ 23.1
Minus: State Share SCI [c]	$ (21.5)	$ (42.3)	$ (28.0)	$ (239.3)
Net State Share	$ (18.7)	$ (39.3)	$ 74.3	$ 41.6

Notes:

a. The annual cost per person includes a 1.9% federal tax called the insurer fee.

b. Calculated at 69.07% per HSD.

c. 68.79% of estimated DSH reductions per HSD.

d. Calculated at 20% per HSD.

UNM BBER Calculations from NM HSD Medical Assistance Division data, May 2012

2. Economic Impacts

This section reports the results of an economic impact analysis conducted by BBER staff. Economic impacts on the state's economy result when out-of-state funds are used to purchase goods and services within New Mexico and thereby stimulate an overall expansion of production, employment and labor income. In modeling the Medicaid

Expansion, BBER was careful to consider only the net additional federal funding that would flow into New Mexico under the Medicaid Expansion.

In the previous section, figures were presented on the net flow of federal dollars into New Mexico from the Medicaid Expansion for newly eligible adults under both the Low and the High Uptake Scenarios. As noted above, under the State's new Centennial Care plan, all the dollars from the Medicaid Expansion will be funneled through the Managed Care Organizations (MCO's). The dollars should flow depending upon the uptake by those eligible. Access to needed services, however, is likely to depend upon the availability of local health care providers and facilities. NM is underserved in terms of physicians (particularly primary care physicians), and it is unlikely that the pipeline for new primary care physicians or even for mid-level providers – advance practice nurses, such as nurse practitioners, physician assistants, etc. – will be cranked up in time to meet the demands in New Mexico and, simultaneously, in the rest of the country.

The economic impacts on New Mexico of the flow of federal dollars under the Medicaid Expansion will depend critically on how much of the anticipated additional demand for health care services can actually be met by providers working out of facilities in New Mexico. Many New Mexicans in Southeast New Mexico currently meet their health care needs by journeying to Lubbock, Texas, or some other major medical center. Under what conditions would Medicaid pay for care provided by out-of-state providers, and is out-of-state care likely to be a realistic option for those newly covered under Medicaid? There could be transportation issues and program participants might also encounter difficulties in taking time off from work, arranging childcare, etc. Historically, states have strictly limited the amount they will pay to out-of-state providers to care for their Medicaid patients.[7]

In modeling the economic impacts of the Medicaid expansion, BBER has made use of the IMPLAN Pro 3 Model and proprietary databases on New Mexico. IMPLAN is a regional economic model that is widely used in economic impact analysis. As previously stated, we assume that the MCOs take 15% off of the top to cover administrative expenses, including taxes, coordination of care, payment processing, etc., and have modeled the 15% by using an IMPLAN sector that captures production information for accident and health insurance companies. For working age adults, we have identified three major IMPLAN health care sectors that are likely to provide services: (1) hospitals, (2) offices of physicians and other health care providers, and (3) a category that includes outpatient care centers, medical and diagnostic laboratories and other ambulatory health care services. Adults obviously will also need access to prescription drugs, and they may occasionally need access to medical equipment. Such needs may be met by mail order; they may be met locally but the impacts on the local economy are likely to be relatively small. We take off 10% of the Medicaid dollars to cover the amounts likely to be paid

[7] Conversation with Ava Lovell, UNM HSC.

for prescription drugs and for medical equipment and assume that 90% of adult needs will require the medical services enumerated above.[8]

We assume that there may be some delays in the supply side response, both in developing the capacity to provide needed medical services and in the overall economy's response to an increase in activity in the healthcare services sector. Thus in FY14, we assume that only 70% of the flow of dollars for the above service categories actually results in payments to NM health care providers. We assume the supply side response increases to 85% in FY15, to 97% in year FY16 and to 100% in FY17.[9] Otherwise, our modeling of economic impacts generally makes the assumption that newly eligible enrollees will be able to get the care they need in New Mexico and that the payments for these services will support additional activity around the state.

Medicaid Expansion: Low Uptake Scenario

Table 2.1 presents the results of our analysis of economic impacts for the Low Uptake Scenario. As above, figures are presented for FY14, FY15, FY20, and for the period FY14-20. Under each year, the first entry, "Direct Health Care", reflects the activity directly supported by the MCO payments: (1) the total payments received by the offices of providers, by health care centers, labs, etc., and by hospitals (here captured under "output" but available to pay wages and salaries and to purchase supplies and other goods and services); (2) the additional employment of health care workers to provide services to the Medicaid patients; and (3) the earnings of these workers in the health care sector. The second entry. "Direct Administration" refers to the administrative expenses incurred by MCOs in coordinating care for Medicaid recipients, in processing payments, and in performing the insurance functions of maintaining adequate reserves, etc. Once again, the total going to administration covers wages and salaries and other operating expenses of the MCOs. The second and third columns indicate the number of direct employees and their labor income.

Indirect impacts are the multiplier impacts: the additional employees added and their earnings, the additional goods and services purchased as businesses throughout New Mexico gear up to meet the additional demand for supplies and services both from health care providers and insurance companies and from their newly hired workers who take their earnings out into the market place and purchase various goods and services.

Total Impacts refer to the total amount of new activity supported directly (in health services and in administration) and indirectly throughout the NM economy as employees spend their earnings and as goods and services are purchased to be used in

[8] Major hospitals like Presbyterian are integrated healthcare service providers, offering the range of health care services that may be needed by the newly eligible adults.

[9] These percentages are consistent with prior experience using BBER's forecasting model to estimate economic impacts.

providing health care services to patients. We start out in the first column with the net federal dollars coming into the state under the Medicaid expansion. These dollars go directly to the MCOs and to those who provide medical care to the newly eligible Medicaid recipients, but effects will ripple through the economy. The total impact for any one year is then the total amount of additional economic activity supported – directly and indirectly through the multiplier effect. Thus in FY15, $329 million for direct patient services and $47 million for administration (together, the net federal funds) end up generating $622 million in additional economic activity as those new health care and MCO workers spend their incomes on NM goods and services and as doctors offices, hospitals, etc. purchase goods and services, stimulating an overall expansion of demand.

Table 2.1. New Mexico Economic Activity Supported by the Medicaid Expansion
Low Uptake Scenario
Employment and Millions of Dollars of Labor Income and Output

		Output	Employment		Labor Income
FY 2014					
Direct Health Care	$	115.2	826	$	55.1
Direct Administration	$	13.4	50	$	1.5
Indirect Economic Impact	$	84.5	772	$	26.1
Total Economic Impact	**$**	**213.1**	**1,648**	**$**	**82.7**
FY 2015					
Direct Health Care	$	329.3	2,433	$	157.6
Direct Administration	$	46.7	227	$	10.3
Indirect Economic Impact	$	246.0	1,424	$	68.1
Total Economic Impact	**$**	**621.9**	**4,084**	**$**	**236.0**
FY 2020					
Direct Health Care	$	437.0	2,853	$	199.5
Direct Administration	$	71.0	305	$	15.7
Indirect Economic Impact	$	221.4	2,843	$	83.2
Total Economic Impact	**$**	**729.5**	**6,001**	**$**	**298.4**
Total FY 2014-20					
Direct Health Care	$	2,513.9	2,853	$	1,373.0
Direct Administration	$	406.1	305	$	90.0
Indirect Economic Impact	$	1,905.3	2,843	$	645.4
Total Economic Impact	**$**	**4,825.3**	**6,001**	**$**	**2,108.4**

UNM BBER calculations

The second and third columns of data for FY 2015 provide the details on what is happening to employment and earnings. That $329 million in direct patient care

involves 2,433 health care workers, who according to the third column have earnings of $158 million. In addition, the $47 million for administration employs 227 involved in coordinating care, processing payments, etc., and these workers have earnings of $10 million. As all these workers go out and spend their earnings in grocery stores, restaurants, and other NM businesses they stimulate additional demand. To provide the goods and services demanded by the health care providers and expanding businesses, other firms may have to increase employment; they may have to purchase various types of supplies and services. The additional demands stemming both from employees and from the direct purchases of health care providers and insurance companies may be expected to work their way through the economy, stimulating further rounds of expansion. Through this process the Medicaid expansion in FY 2015 is expected to support total revenues of $622 million and a gain in employment of 4,084 with additional labor income of $236 million.

The cumulative effects of the Medicaid expansion at the end of the first seven fiscal years are summarized in the final block of rows on the bottom. Under this low participation scenario, the cumulative value of the additional activity supported by the Medicaid expansion is in excess of $4.8 billion. The total gains to employment by FY20 are 6,000 and over the 7 years these employees will have cumulative earnings of over $2.1 billion.

In the previous section, it was estimated that under the Low Uptake Scenario the Medicaid Expansion from FY14 to FY20 will pay for itself without the need either to raise State taxes or to cut State spending in other areas. The fact that the program pays for itself means that the State should get the full benefits of the Medicaid Expansion in terms of economic impacts and the economic activity supported both directly and indirectly by the federal dollars flowing to New Mexico for the Medicaid Expanison. As the next section on General Fund impacts will show, the State actually comes out a net winner.

Medicaid Expansion: High Uptake Scenario

Table 2.2 presents the estimates for the High Uptake Scenario. The methodology and underlying assumptions are basically the same, but the numbers are larger. In this case, the total employment supported directly and indirectly increases from just under 2,200 in FY14 to almost 8,500 in FY20, with the total gain in labor income – wages and salaries, benefits, and self-employment income – increasing from $115 million in FY14 to over $620 million in FY20.

Table 2.2. New Mexico Economic Activity Supported by the Medicaid Expansion
High Uptake Scenario
Employment and Millions of Dollars of Labor Income and Output

		Output	Employment		Labor Income
FY 2014					
Direct Health Care	$	152.2	1,090	$	72.8
Direct Administration	$	38.7	138	$	4.3
Indirect Economic Impact	$	123.1	954	$	38.6
Total Economic Impact	$	313.9	2,183	$	115.7
FY 2015					
Direct Health Care	$	545.9	3,747	$	261.2
Direct Administration	$	98.3	328	$	21.8
Indirect Economic Impact	$	419.3	2,634	$	329.0
Total Economic Impact	**$**	**1,063.5**	**6,710**	**$**	**612.0**
FY 2020					
Direct Health Care	$	833.4	4,052	$	380.4
Direct Administration	$	119.3	406	$	26.4
Indirect Economic Impact	$	438.3	4,003	$	214.4
Total Economic Impact	**$**	**1,391.0**	**8,461**	**$**	**621.2**
Total FY 2014-20					
Direct Health Care	$	4,499.4	4,052	$	2,053.7
Direct Administration	$	718.9	406	$	159.3
Indirect Economic Impact	$	3,405.7	4,003	$	1,148.9
Total Economic Impact	**$**	**8,623.9**	**8,461**	**$**	**3,361.9**

UNM BBER calculations

3. General Fund Impacts of Medicaid Expansion

Low Uptake Scenario

The General Fund impacts include additional costs incurred, primarily the additional State match that will be required beginning in 2017. As noted earlier, under ACA, the federal government will pick up 100% of the expansion in calendar 2014, 2015 and 2016, followed by 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and beyond. Any state match will be offset at least in part by reduced payments for SCI, since that program will disappear and most of the people currently enrolled will qualify as newly eligible under the Medicaid expansion or will move into one of the health care exchanges.[10] In addition, State outlays for the Medicaid Expansion will be generally more than offset by the additional revenues that will accrue to the State's General Fund. These additional revenues include those from the following sources:

- **Insurance Premium Taxes.** The premium tax will be collected from the MCOs on the capitation payments received for the care of New Mexican residents who have enrolled. The tax on health care premiums is 4%. Since the SCI program is an insurance program and subject to the premium tax, new premium taxes will only be received for those newly eligible that were not in the SCI program. [11]

- **New Mexico Medical Insurance Premiums**. The State currently has a high risk pool, the New Mexico Medical Insurance Pool (NMMIP), that is funded by a fee on all health and life insurance companies operating within the State. Under ACA, most of those in the program will move to the exchange, at a savings to the state of $33.9 million per year according to the LFC, which recognizes this reduction as General Fund revenue in their September 27, 2012, *Hearing Brief on the ACA*.

- **Gross Receipts Taxes** on health care providers not exempt from the tax. Tax exempt entities include non-profit hospitals, like Presbyterian, government hospitals run by the Veterans Administration, by the Indian Health Service, and by UNM; Federally Qualified Health Centers, like First Choice, and other non-profit clinics around the state; and for-profit entities like Lovelace that pay insurance premium taxes are exempt from gross receipts tax for those patients covered by their health plan which is subject to the premium tax. Gross receipts tax revenues on health care providers include only the care for those newly eligible and not those currently under SCI.

  Gross Receipts Taxes on activity is supported indirectly as providers of health services gear up to provide the newly eligible Medicaid patients with health care services by hiring additional staff and purchasing various goods and services in New

[10] According to HSD, about 6% of adults currently in SCI are above 138% of poverty.
[11] UNM accounts for about 25% of the total but they contract with Molina to manage the program and process payments. Molina is subject to and pays the premium tax on the UNM SCI program.

Mexico. Gross receipts taxes will be due on many of the transactions thus stimulated as the impacts ripple across the economy.[12]

- **Personal Income Taxes** on those employees supported directly and indirectly by Medicaid Expansion.

Table 3.1 reports BBER's analysis of the General Fund impacts of Medicaid Expansion for the Low Uptake Scenario. Additional revenues from taxes and fees already in place are expected to bring $461 million in additional revenues into the State General Fund between FY14 and FY20. Over the same period, cost savings to the State General Fund from the SCI program are expected to total $239 million. Under the Low Uptake Scenario, the State General Fund has a net gain in each of the first seven fiscal years of the Medicaid Expansion, with an estimated cumulative gain through FY20 of $478 million. This is true even though not all the likely gross receipts tax revenues are included in the analysis.

[12] Because BBER estimates for gross receipts taxes from health care providers in the High Uptake Scenario exceed the LFC estimates for the same scenario no attempt has been made to estimate the additional revenues that might be generated from the induced and indirect spending supported by the Medicaid expansion.

Table 3.1. General Fund Impacts of the Medicaid Expansion, Low Uptake Scenario
All Figures in Millions of Dollars

	FY 2014	FY 2015	FY 2020	FY 2014 - 20
New Revenues				
Premium Tax -- 4% a	$ 7.5	$ 18.1	$ 30.5	$ 155.2
NMMIP Reduction b	$ -	$ 33.9	$ 33.9	$ 203.3
Gross Receipts Tax				
Direct Only c	$ 2.3	$ 6.8	$ 13.5	$ 66.0
Supported				
Personal Income Tax d	$ 1.9	$ 4.4	$ 6.0	$ 36.1
	$ 11.7	$ 63.2	$ 83.9	$ 460.6
Cost Savings				
State Savings SCI (20%)	$ 21.5	$ 42.3	$ 28.0	$ 239.3
State DSH e	$ -	$ -	$ -	$ -
	$ 21.5	$ 42.3	$ 28.0	$ 239.3
Additional Costs				
Administrative Costs	$ (2.8)	$ (3.0)	$ (3.9)	$ (23.1)
State Share on Newly Eligible	$ -	$ -	$ (76.8)	$ (199.1)
	$ (2.8)	$ (3.0)	$ (80.7)	$ (222.3)
State Gain (Loss)	**$ 30.4**	**$ 102.6**	**$ 31.3**	**$ 477.7**

a. On newly eligible only since premium tax is paid on all current SCI.

b. BBER is following the LFC in estimating 80% of high risk pool supported by this fee will enter an exchange with savings to the General Fund.

c. Direct only. BBER direct estimates for the high uptake scenario used by the LFC exceed LFC estimates for direct and indirect except for first year, when LFC estimates $6.6 million. BBER assumes capacity limitations at start-up.

d. BBER defers to LFC expertise in estimating personal income taxes. Figures for low uptake scenario are scaled down using premium tax estimates for the two scenarios.

e. BBER assume State continues to contribute to DSH program.

UNM BBER Calculations

High Uptake Scenario

BBER's analysis of the General Fund impacts of Medicaid Expansion for the High Uptake Scenario is given in Table 3.2. As might be expected, the overall net gain to the state over the seven fiscal years is somewhat higher -- $523 million versus $478 million.

Table 3.2. General Fund Impacts of the Medicaid Expansion, High Uptake Scenario
All Figures in Millions of Dollars

High Uptake Scenario	Revenues in $ Millions			
	FY 2014	**FY 2015**	**FY 2020**	**FY 2014 - 20**
New Revenues				
Premium Tax -- 4% a	$ 10.3	$ 26.2	$ 40.7	$ 218.6
NMMIP Reduction b	$ -	$ 33.9	$ 33.9	$ 203.3
Gross Receipts Tax				
Direct Only c	$ 3.2	$ 9.8	$ 18.0	$ 92.9
Supported				
Personal Income Tax d	$ 2.6	$ 6.1	$ 8.3	$ 50.2
	$ 16.1	$ 76.0	$ 100.9	$ 565.0
Cost Savings				
State Savings SCI (20%)	$ 21.5	$ 42.3	$ 28.0	$ 239.3
State DSH e	$ -	$ -	$ -	$ -
	$ 21.5	$ 42.3	$ 28.0	$ 239.3
Additional Costs				
State Administrative Costs	$ (2.8)	$ (3.0)	$ (3.9)	$ (23.1)
State Share on Newly Eligible	$ -		$ (98.4)	$ (257.8)
	$ (2.8)	$ (3.0)	$ (102.3)	$ (280.9)
State Gain (Loss)	**$ 34.8**	**$ 115.4**	**$ 26.6**	**$ 523.4**

a. On newly eligible only since premium tax is paid on all current SCI.

b. BBER is following the LFC in estimating 80% of high risk pool supported by this fee will enter an exchange with savings to the General Fund.

c. BBER direct estimates exceed LFC estimates for direct and indirect except for first year, when LFC estimates $6.6 million. BBER assumes capacity limitations at start-up.

d. BBER defers to LFC expertise in estimating personal income taxes.

e. BBER assume State continues to contribute to DSH program at same level.

UNM BBER Calculations

The additional revenues total $565 million versus $461 million. On the other hand, the State's cost share is higher in dollar terms -- $281 million over seven fiscal years versus $222 million. As is true in the Low Uptake Scenario, the net gain to the General Fund is forecast to be positive in every year.

The gain dips to $26.6 million in FY20 when the state experiences its first half a year with a federal match at 90%. BBER analyzed the impact in FY20 had the federal match been 90% for the full year. On a full year basis at 10%, the State share would have been $115.8 million, or $17.3 million higher in FY20. The revenues would have been but marginally affected. The net federal share would have been down by the same $17.3 million, but only a fraction of that would have been reflected in lower tax revenues. Premium tax payments do not depend on the net but the gross flow of Medicaid through the MCOs, so revenues from this source would not be affected. Personal income taxes would be lower but the marginal rate is only 4.9%. Due to the numerous gross receipts tax deductions applicable to medical providers, only some providers receiving payment from Medicaid would be paying the tax and the state rate is only 5.125%. To conclude, the net gain to the General Fund would still be positive but closer to $9 million, without including gross receipts tax on the indirect economic impacts. Moving forward, the State should break even, assuming no changes in the rules.

To help ensure this result, State administrative expenses should be held down at or below the $2.8 million HSD said would be needed per year. Contracting with in-state versus out-of-state MCOs is likely to create more jobs and economic activity in New Mexico, so that the full revenue benefits as well as economic impacts can be felt.