LFC HEARING BRIEF

AGENCY: Human Services Department

DATE: September 27, 2012

PURPOSE OF HEARING: Implementation of Affordable Care Act: Costs and Benefits of Expansion of Medicaid Eligibility

WITNESS: Sidonie Squire, Secretary of the HSD

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EXPECTED OUTCOME: Informational

Medicaid currently provides coverage to 517 thousand New Mexicans including 336 thousand children. There were almost 400 thousand uninsured New Mexicans in 2011, 19.6% of the population.

Currently Medicaid covers groups including:

- Children under age nineteen (19) with family incomes under 185% of the Federal Poverty Level Guidelines (FPL).
- Children under age 19 may be eligible for Medicaid under the Children's Health Insurance Program (CHIP), if family income is between 185-235% of FPL.
- Pregnant women under 185% of FPL.
- Adults (primarily elderly) requiring an institutional level of care.

BACKGROUND INFORMATION

Expansion of Medicaid coverage for adults under the Affordable Care Act (ACA) will be implemented on January 1, 2014. Expansion of eligibility for low-income adults is optional for states, but other mandatory aspects of ACA will impact the state. Costs to the state according to analysis from the Human Services Department (HSD) includes the general fund match to cover newly eligible adults, as well as the cost of enrollment for currently eligible (but non-enrolled) adults and children (commonly called the "woodwork effect"). Additional ACA-related costs include primary care rate increases and insurer fees. A portion or perhaps all of these costs may be offset by revenue increases that New Mexico will receive due to increased premium, gross receipts, and personal income taxes. The benefits of ACA include covering well over 100,000 uninsured adults as well as a reduction in uncompensated care. However, states and the medical community face serious challenges in preparing to implement ACA, in particular in building primary care networks to meet the surge in clients projected beyond 2013.

Medicaid Expansion Under the Affordable Care Act. The major change to Medicaid from ACA is optional coverage for poor adults earning less than 138 percent of the federal poverty level (FPL). The federal government will pay 100 percent of the cost of enrolling the newly eligible population in Medicaid expansion from 2014 to 2016, stepping down to 95 percent in 2017 and then to 90 percent by 2020 and all following years.

The New Mexico Human Services Department (HSD) has developed estimates of the projected costs of increased ACA-related enrollment. Included within those estimates are projected scenarios for low enrollment as well as high enrollment. Cost growth is shown in 3 areas: base program for the current Medicaid enrollees, the woodwork effect of individuals that will sign up who are eligible under regular Medicaid match rates (primarily kids), and newly eligible individuals. The key variables in the HSD's cost projections are the enrollment numbers and the projected premium cost for new enrollees and woodwork enrollees.

Woodwork Effect. There has been much discussion about whether to include woodwork enrollment in the base cost of the Medicaid program or as an additional ACA related cost (HSD's methodology). The enrollment and cost analysis below shows woodwork separately for the base Medicaid program in order to show the additional cost separately. LFC's revenue analysis (starting on page 5) does not include woodwork related revenues or expenditures because they are not Medicaid expansion related costs, these costs will be incurred regardless of the final decision on expansion of Medicaid for low-income adults. HSD has acknowledged as much by submission of an FY14 budget request that includes woodwork effect costs but not expansion of Medicaid for low-income adults.

Potential Enrollment Pool. 2011 Census data shows almost 400 thousand New Mexicans, or 19.6 percent lack insurance, which ranks 46th of all states. Of this group, the HSD estimates that 162,025 adults will be eligible for coverage with incomes at or below 138 percent of the federal poverty level in 2014 (the majority

of the remaining uninsured adults are assumed to receive coverage in the state health exchange). The HSD also assumes that 37,100 individuals currently receiving health insurance through the State Coverage Initiative (SCI) will meet the 138 percent criteria and includes them as part of the newly eligible group. Also, the HSD projects a pool of 25,184 woodwork individuals (mostly kids) who are already Medicaid eligible at the regular match rate (70.4 percent in FY13).

Medicaid Eligibility for Low-Income Adults Under Affordable Care Act

Family Size	138% FPL
One	$15,415
Two	$20,879
Three	$26,344
Four	$31,809

Source: 2012 Federal Poverty Level Table

HSD projects a minimum of 106,519 in ACA-related enrollment in FY14, including 46,810 newly eligible adults (low scenario) and another 37,100 in transfers from the State Coverage Initiative (SCI) insurance program.

HSD projects 84,036 in enrollment growth in the base Medicaid program from 2014 to 2020. Staff argues that “woodwork” enrollment and related costs belong in the base Medicaid cost scenario, not as ACA-related enrollment and costs.

Low- Versus High-Enrollment Scenario. The HSD has provided both low- and high-enrollment scenarios. Total ACA-related enrollment ranges from 126,239 by FY20 in the low scenario to 167,803 in the high scenario, as shown in the table below:

Comparison of ACA-Related Enrollment Scenarios, 2014 and 2020

2014 Enrollment Scenarios	**2014 Low Scenario**	**2014 High Scenario**	**Difference**
Woodwork kids/adults	4,609	11,309	6,700
SCI transfers	37,100	37,100	0
Newly Eligible	64,810	89,114	24,304
Total	**106,519**	**137,523**	**31,004**
2020 Enrollment Scenarios	**2020 Low Scenario**	**2020 High Scenario**	**Difference**
Woodwork kids/adults	9,905	18,707	8,802
SCI transfers	18,051	18,051	0
Newly Eligible	98,283	131,044	32,761
Total	**126,239**	**167,802**	**41,563**

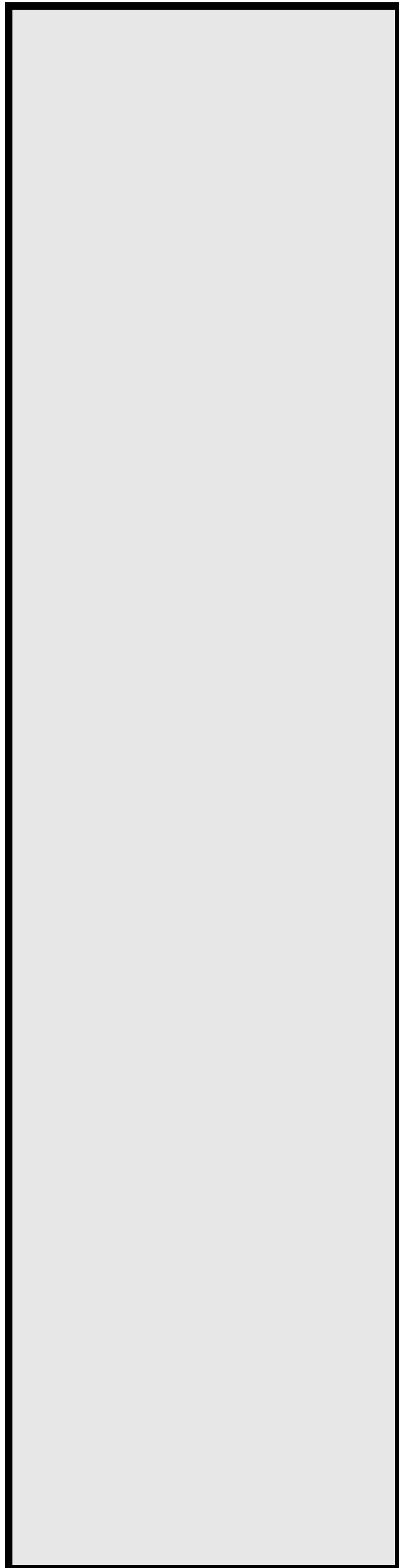
There is a 31,004 difference in enrollment between the low and high scenario in FY14. The accompanying cost difference is $85 million, of which $6 million is general fund.

Base Enrollment. The HSD includes base costs of the current Medicaid program in both the low- and high-enrollment scenarios. This has caused some controversy among advocates, who believe that inclusion of base program costs focuses the discussion on the total costs of the Medicaid program and not the cost of covering the newly eligible. The HSD has countered that it is important to include all costs in order to focus on long-term sustainability of the Medicaid program. The costs and enrollment in the base program are the same in both scenarios.

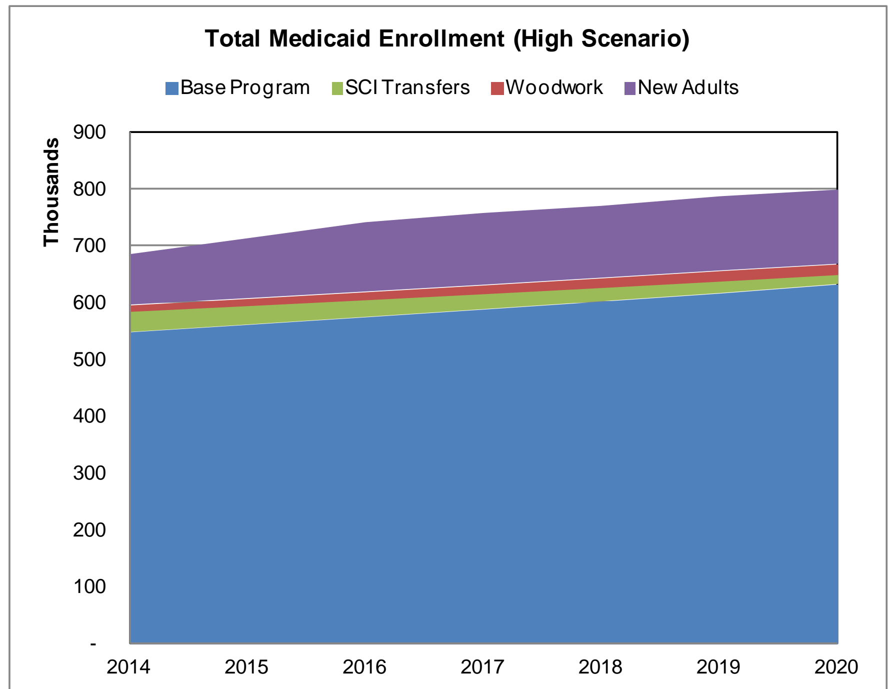
HSD Base Enrollment Growth (Included in Both Scenarios)

	2014	2020	Change
Base Medicaid Enrollment	547,635	631,671	84,036

Increased enrollment of 84,036 in the base program (approximately 2.6 percent per year from FY14 to FY20) plays a large role in cost growth of the HSD out-year scenarios. Additional scrutiny of projected enrollment growth is warranted: actual enrollment growth in the past two fiscal years was 2 percent in FY11 and less than 2.5 percent in FY12. In fact, growth in children’s enrollment was a meager 1.3 percent in the past 2 years.



Total enrollment growth for the high scenario is shown on the following chart, which shows projected enrollment growing from 685,158 in FY14 to 799,474 in FY20.

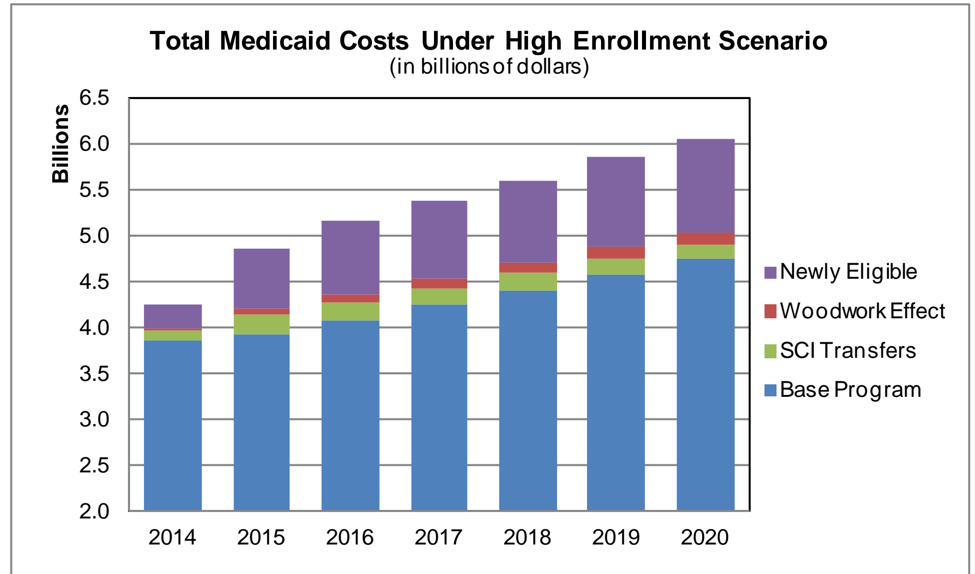


Cost Growth Per Client. Both scenarios use the same costs per person and assume about 5 percent annual growth in medical costs per client from FY14 to FY20. The HSD used data from the current SCI program to model the costs of new adult enrollees. The average cost for a newly eligible adult is $5,788 per year in FY14, increasing to $7,731 by 2020. The FY14 cost compares favorably with current annual costs for SCI clients (about $6,200 in FY12). The cost for woodwork effect children is $3,199 in FY14, increasing to $4,317 by FY20. The FY14 cost compares favorably to the current physical health average cost of $3,156 in FY12.

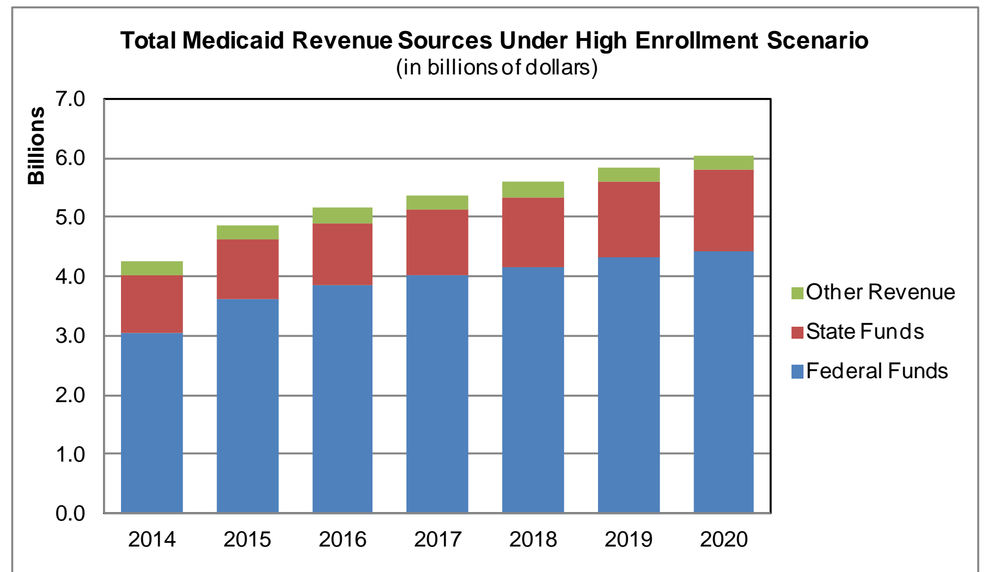
HSD assumes woodwork effect adults are over the age of 65 and projects costs that are similar to those currently enrolled in the coordination of long-term services (CoLTS) program. The CoLTS population is significantly more costly than the children, parents and SCI clients. The average annual cost for a CoLTS client was $21.4 thousand in FY12; the HSD is projecting a cost of $24 thousand per client in FY14, which reflects their expectation that these enrollees will be sicker than average. Finally, the average cost for 547 thousand clients projected to already be in the base program is $7,052 in FY14, projected to increase to $7,527 by FY20.

Overall Cost of Medicaid Expansion and Base Program. HSD's FY14 appropriation request did not include the cost of Medicaid expansion for additional adults, but did include ACA-related costs of approximately $22.3 million including woodwork effect enrollment. Total Medicaid spending is projected to increase from $3.77 billion in FY13 to $4.06 billion in FY14, an increase of about

$288 million ($60 million of the increase is general fund). Under the high enrollment scenario, total Medicaid costs are projected to increase from $4.2 billion in FY14 to $6.1 billion in FY20. The chart below shows the cost by year allocated to the base Medicaid program, woodwork enrollment, and newly eligible enrollment. Note that it does not include administration-related costs for expanding enrollment (50% federal match).



Total revenue sources by year are shown on the next table. The federal share of the total Medicaid program is projected at 70.4 percent for FY13; it increases to 72 percent in FY14 for the first half year of ACA implementation and is 75 percent in FY15. It ends up at 73 percent in FY20 after the federal share for newly eligible enrollees drops to 90 percent.



Federal Match for Newly Eligible in Medicaid		
	ACA Match	HSD Projected Match
FY14	100%	97.5%
FY15	100%	97.5%
FY16	100%	97.5%
FY17	95%	95.2%
FY18	94%	92.4%
FY19	93%	91.5%
FY20	90%	88.3%

Source: HSD, LFC files.

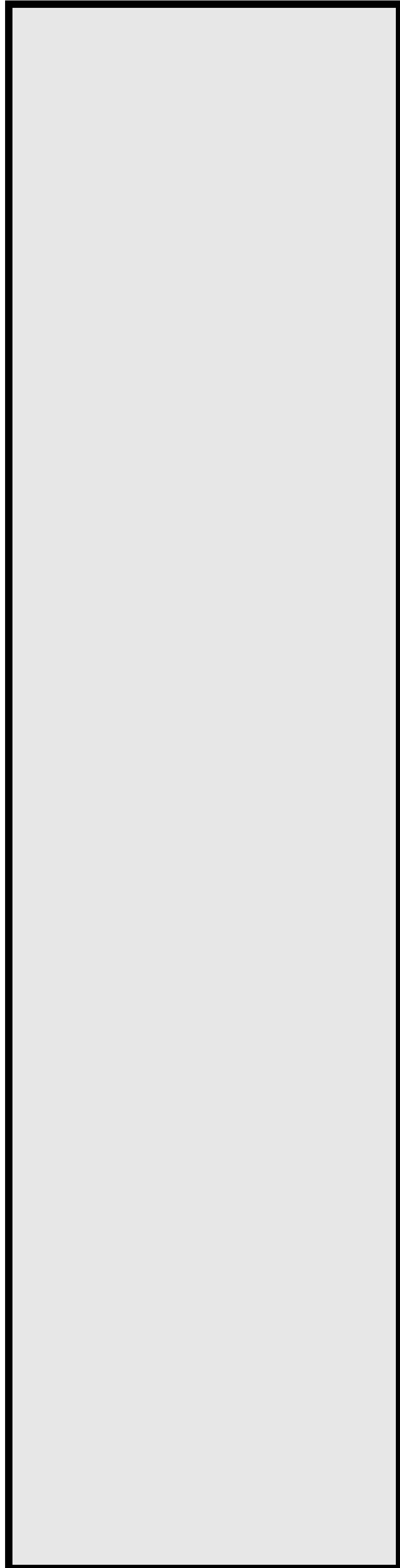
Impact on General Fund. This is one of the most debated areas of the HSD ACA projections. First, the HSD has focused on the total increase in general fund for the entire program; advocates prefer focusing on the cost of expansion for newly eligible adults, not woodwork or regular enrollment growth which is funded at a lower match rate. Second, as shown on the sidebar table, the HSD does not assume full 100 percent federal coverage for newly eligible the first three years; they assume a lower federal match for about 8 percent of the newly eligible adults which they project will have kids and be moved into a "parents" category of eligibility. As a result, HSD is including $42.2 million in general fund costs for newly eligible during FY14-FY16. This methodology has been questioned by advocates and further research is warranted. And finally, as discussed earlier, HSD is including woodwork effect in their cost estimates; LFC analysis below does not include woodwork effect enrollment as part of expansion.

Benefits of Medicaid Expansion to State Revenues. There are benefits to the Medicaid expansion under ACA. The state will generate additional revenues from personal income taxes, gross receipt taxes, and premium taxes. Also, the state will benefit from reduced enrollment in the New Mexico Medical Insurance Pool (NMMIP). Using the high-enrollment scenario provided by the HSD, LFC economists estimated the potential revenues that the state will collect as a result of Medicaid expansion. The high-enrollment scenario was chosen because it assumes that the eligibles enroll quickly and that there are few or no capacity constraints to healthcare services. This analysis does not cover the potential costs and benefits of other ACA impacts, such as the woodwork effect, and the exchange. Note that this is a very high-level cost-benefit analysis that did not undergo the consensus scrutiny that revenue estimates undergo. The underlying benefit and cost assumptions may change due to ACA uncertainty in implementation, changes in take-up assumptions, and rate changes. Revenue estimates are likely to differ from the numbers presented in this analysis.

The Bureau of Business and Economic Research (BBER) used the HSD high-enrollment scenario to estimate that personal income could increase 0.6 percent by FY20 due to the additional dollars and employment impacts from the Medicaid expansion. Wages and salaries could increase 1 percent by FY20 due to the Medicaid expansion. BBER assumed that the employment multiplier[1] from the Medicaid expansion is about 1.85. For every $100 million dollars spent on Medicaid, 1,195 total jobs are created - 646 direct jobs, and 550 indirect/induced jobs. Total employment could increase almost 1 percent each year.

Personal Income Taxes. LFC economists used the personal income impact from BBER to roughly estimate the total revenue impact on personal income taxes. PIT liabilities could increase about 0.4 percent in FY14 and 0.6 percent in FY20. The state could collect an additional $2.6 million in FY14, and $8.3 million in FY20 when fully implemented.

[1] An employment multiplier is one of the measures used to determine the impact a particular industry will have upon a municipality when it arrives or departs. In its simplest terms, the employment multiplier measures the amount of direct, indirect and induced jobs created (or lost) in the area. Direct jobs are related to the specific industry, while indirect jobs are those that support the industry. Induced jobs are those that are a result of direct/indirect employee's spending money in the community. Generally, industries with a higher multiplier are more desirable.



Gross Receipts Taxes. Section 7-9-93 NMSA 1978 states clearly that health care service provided for Medicare patients or for Medicaid patients are not exempt from the GRT. BBER estimate of the impact on wages and salaries was used to estimate the revenue impact on the gross receipts taxes. The state could collect an additional $6.6 million in FY14, and $12.5 million in FY20 when fully implemented. There is some confusion in the healthcare community whether the GRT is due from providers who work for an HMO or MCO. According to the TRD, the GRT is due from all providers who service Medicaid patients.

Premium Taxes. Under the premium tax statute, health and life insurers pay 4 percent tax on gross premiums received from their insured in lieu of paying other taxes. The additional health insurance premiums from the Medicaid expansion include the newly eligible adults who are not currently in the Medicaid program or in SCI. Premiums from the additional children and adults enrolled due to the woodwork effect are not included. Also, premiums received from the existing SCI program, at the current federal match rate, are not included. Additional premium taxes could generate $9.8 million additional revenues in FY14 and $38.7 million in FY20 when fully implemented.

New Mexico Medical Insurance Premiums. All health and life insurers operating within NM are subject to paying an assessment fee to subsidize premiums paid into the New Mexico Medical Insurance Pool (NMMIP). The NMMIP is the state's high risk pool. Under the ACA, most of the individuals in this program will move to the exchange. The NMMIP reduction is about $33.9 million per year starting in FY15.

The total revenues the state could potentially collect under the HSD high-enrollment scenario are shown in the table below. As mentioned earlier the ACA takes effect on January 1, 2014. The additional revenues are $19 million in FY14, and $93.4 million in FY20 when fully implemented.

Revenues from Medicaid Expansion
(Includes Induced Effects, general fund in millions of dollars)

	FY14	FY15	FY16	FY17	FY18	FY19	FY20
PIT Increase	2.6	6.1	7.7	8.4	8.6	8.5	8.3
GRT Increase	6.6	9.3	11.0	11.7	12.0	12.3	12.5
Premium Tax	9.8	24.9	30.2	32.6	34.1	36.9	38.7
NMMIP Reduction		33.9	33.9	33.9	33.9	33.9	33.9
Total Revenues	19.0	74.2	82.8	86.6	88.5	91.6	93.4

Sources: BBER, LFC Files

Cost of Affordable Care Act on State Expenditures. The additional expenditures from the Medicaid expansion are presented in the table below. Coverage of newly eligible adults from the Medicaid expansion is an additional cost to the HSD. In FY14 this cost is $6.4 million, rising to $118.8 million in FY20. The SCI population is newly eligible under ACA but the entire costs, $16 million by FY20, have not been included in this analysis because HSD is currently incurring the cost of the SCI program. There will be a higher federal match for the

SCI population due to ACA. The reduced general fund need or cost savings to the state is $22.2 million in FY14 and $7.9 million in FY20. According to the HSD, administrative costs will be about $2.8 million per year. The Congressional Budget Office estimates that administrative costs for the states will increase an average of 5.5 percent over the implementation period.

The total additional costs to the state of the Medicaid expansion are presented in the table below. In FY14 the state gains $13.1 million. There is an expenditure reduction to the state in the first three years of implementation of the Medicaid expansion. When fully implemented in FY20 the additional expenditures are $113.7 million.

Expenditures on Medicaid Expansion
(General fund in millions of dollars)

	FY14	FY15	FY16	FY17	FY18	FY19	FY20
Newly Eligible Adults	6.4	16.2	19.6	41.0	67.6	82.1	118.8
SCI Add. match	(22.2)	(42.0)	(38.1)	(29.7)	(20.8)	(15.4)	(7.9)
Admin. Costs	2.8	2.8	2.8	2.8	2.8	2.8	2.8
Total Expenditures*	(13.1)	(23.0)	(15.7)	14.1	49.6	69.5	113.7

* Negatives are reductions in expenditures — Sources: HSD, LFC Files

ACA Impact: Gain/(Loss) to the State (dollars in millions)	
FY14	**32.0**
FY15	**97.1**
FY16	**98.5**
FY17	**72.5**
FY18	**38.9**
FY19	**22.1**
FY20	**(20.3)**

General Fund Revenue and Costs of the Medicaid Expansion. If the state does choose to expand Medicaid, the revenues outweigh the expenditures in the first six years as the match is phased down. When the program is fully implemented in FY20 the state may incur additional costs. The benefits minus the costs are presented in the table below. Under this high-level scenario the state will gain $32 million in FY14 but will begin to pay an additional $20.3 million in FY20. Six years after implementation, when the state has to pay 10 percent of the costs in FY20, the direct costs start to outweigh the revenues.

Revenues and Expenditures from Medicaid Expansion
(General fund in millions of dollars)

	FY14	FY15	FY16	FY17	FY18	FY19	FY20
Total Revenues	19.0	74.2	82.8	86.6	88.5	91.6	93.4
Total Expenditures	(13.1)	(23.0)	(15.7)	14.1	49.6	69.5	113.7
State Gain/(Loss) *	32.0	97.1	98.5	72.5	38.9	22.1	(20.3)

* Revenues minus expenditures — Sources: BBER, HSD, LFC Files

ACA Impact on Other Healthcare Programs. The ACA will have an impact on other healthcare programs including the county indigent fund, the sole community hospital program, and disproportionate share hospitals. The impact on these programs will require more analysis than has been provided in this brief.

County Indigent Fund. Fewer individuals will require county support through indigent care programs, because more individuals will have health insurance or be eligible for Medicaid under the ACA. The impact will vary depending on coverage rates by counties. This level of GRT support for indigent care programs

may not be needed in the future. However, there will still be a need for programs, such as ambulance services and for undocumented immigrants (who are not eligible for health insurance), that are not covered under the ACA.

Sole Community Provider Hospital Program. The need for the sole community provider hospital program should diminish from current levels as more people gain access to health insurance under the ACA.

Disproportionate Share Hospital. Disproportionate share hospitals will no longer be funded under the ACA. The revenue impact to the state is unclear.

Policy Benefits of Medicaid Expansion. A little over a year is left before full implementation of the Affordable Care Act on January 1, 2014. Nationally, policymakers are still weighing the costs and benefits of expanding Medicaid coverage for adults; as of August over 30 states (including New Mexico) remain undecided, 7 states have declined to participate, and 12 have agreed to participate. Regardless, states are working to implement other aspects of ACA that are not discretionary and are working on health insurance exchange development.

Benefits of Medicaid Coverage on Health of Uninsured Adults. A number of recent studies are shedding light on the potential benefits of expanding Medicaid coverage for low-income adults. A July study from the New England Journal of Medicine found that Medicaid expansions were associated with a 6.1 percent decline in deaths. The decline in mortality was greatest among nonwhites and people living in poorer counties. A National Bureau of Economic Research study of 10,000 Oregon Medicaid recipients found that having Medicaid significantly increased the chances people will perceive their health as being good to excellent, while decreasing the likelihood they'll have to borrow money or skip paying other bills because of medical expenses. The study found that people with Medicaid were 70 percent more likely to have a regular medical office or clinic for their basic care, and 55 percent more likely to have a personal doctor and more likely to get preventive care, such as mammograms and cholesterol screening.

There is $42 million in general fund support for non-Medicaid behavioral health services in the FY14 budget; HSD is researching potential cost savings in this area because newly covered adults would be able to receive Medicaid coverage for these services

Impact of Medicaid Expansion on Substance Abuse Treatment. The federal government reported dependence on or abuse of alcohol or illicit drugs among persons aged 12 or older was 8.9 percent nationwide in 2009; New Mexico's rate was 10.34 percent, in the bottom five of all states. New Mexico also ranked in the bottom quartile of states for access to treatment for drug use. Applying the addiction percentage to HSD's high enrollment estimate of 149,095 newly eligible adults, an estimated 15,416 individuals could be in need of substance abuse treatment and could benefit from Medicaid expansion. In addition to helping those with addictions, a 2009 federal study noted that each dollar invested in substance abuse treatment generated $12 in savings in medical and crimal justice system costs.

Reduction in Uncompensated Care. Providing Medicaid coverage for over 100,000 additional adults will help to reduce the amount of uncompensated care provided by medical practitioners and hospitals and is expected to help slow the growth in health insurance premiums for the privately insured. How much uncompensated care exists is subjective. The Kaiser Commission on Medicaid

and the Uninsured reported an estimate of uncompensated care from provider data sources of $57.4 billion for 2008, compromising $35.0 billion in uncompensated care from hospitals, $14.6 billion from community-based providers, and $7.8 billion from office-based physicians. Figures for New Mexico from advocates have ranged from $335 million to $384 million for uncompensated (and undercompensated care). A 2011 Families First Study projects that under health reform, previously insured families will pay an average of $622 less in premiums in 2019.

Challenges to Implementation. Both government and the private sector are on a tight schedule to prepare for ACA implementation on January 1, 2014. A number of items that will effect successful implementation of expansion of Medicaid for uninsured adults include:

HSD's Enrollment Systems Are Being Modified. Key to this effort is a $75 million effort to modernize the income support enrollment system (ASPEN) used to enroll clients into Medicaid. Other modifications are being made to the Medicaid information management system (OMNICAID). These modifications are currently on schedule to be implemented by January 1, 2014, but much remains to be completed in the next 15 months, including staff training and roll-out to ISD offices.

Impact of Centennial Care. HSD has submitted a waiver request to the federal government to make a number of changes to how the current Medicaid program is operated; of note HSD has issued a new request-for-proposals (RFP) for new contract awards for managed care companies to provide services as of January 1, 2014. HSD plans to move away from separate providers for physical health, behavioral health and long-term services for the elderly; bidders are expected to provide all of these services.

Health Exchange Development. HSD is also a key player in development of New Mexico's health insurance exchange by January 1, 2014. The exchange is to be a focal point for uninsured New Mexicans to seek advice and compare insurance alternatives in order to meet the medical insurance coverage requirements of ACA. The exchange is important to Medicaid expansion because it may be the first place a potential client goes for advice. A task force assisted by Leavitt Partners has been meeting to develop an implementation plan, but few details have thus far been released.

Adequacy of Provider Networks. New Mexico has struggled to maintain an adequate primary care network. Of 33 counties, 32 are designated as health professional shortage areas or medically underserved. As a result, there has been much concern over the ability of health providers to absorb the increase of insured seeking services, particularly in rural areas. While ACA has already provided capital infusions to expand primary care clinic infrastructure in New Mexico, recruitment of medical professionals remains a key challenge. Offsetting New Mexico's disadvantages to some extent is that the state already has much experience with Medicaid managed care due to Medicaid covering more than 30% of the population; a recent report from the Robert Wood Johnson Foundation stated that many providers felt the state had adequate capacity to aborb enrollment growth in 2014.

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Future of Medicaid Funding Given Federal Solvency. States have expressed concern that future federal funding for Medicaid expansion may not actually materialize, particularly if the federal government elects to address the federal budget deficit. According to the Federal Funds Information for States, the ACA Medicaid provisions result in approximately $642 billion in additional federal spending from FY2012-2022, according to CBO. To date, Congress has introduced several federal deficit reduction proposals including modifying federal matching rates for Medicaid, converting Medicaid to a block grant, and reducing states' ability to draw down federal Medicaid dollars. None of these proposals have passed, but the potential uncertainty of the future status of federal Medicaid funding remains a concern for states.

Healthcare Tax Policy Issues. There are almost twenty tax expenditures related to healthcare, and an estimated $290 million annually in foregone revenue can be attributed to these healthcare tax expenditures. These expenditures are typically intended to reinforce health policy goals such as increasing access to healthcare services, recruiting and retaining healthcare professionals, or encouraging health-related companies to do business in New Mexico. In December 2011 the LFC study "The Impact of Financing Healthcare through Tax Code Policy and Local Counties" reviewed some of these healthcare tax expenditures. With the possible expansion of Medicaid under ACA, many of these tax credits will require further review. Under ACA, access to healthcare services should increase, therefore potentially eliminating the need for some of these credits. Some of the tax credits that could be impacted by ACA are addressed below.

Insurance Premium Tax. As mentioned earlier, health and life insurers pay the 4 percent premium tax in lieu of paying other taxes. While there is not a clearly defined purpose to this tax expenditure, it is implied that the pre-emption from other taxes makes NM a more attractive business environment in which insurers can operate. Foregone revenue associated with this tax expenditure was $84 million in FY2010. It is possible that insurance companies will respond to the requirements in the ACA by raising premiums. The number of insured will increase under the ACA. These impacts would increase the premium tax paid to the state by insurers.

Hospital GRT Tax Credit. Currently New Mexico law allows a GRT tax credit to for-profit hospitals. About half of NM hospitals are for-profit that do not pay the GRT. Foregone revenue associated with this tax expenditure is about $14 million per year. As premium rates increase in the future the potential loss from this tax credit could increase.

NMMIP Assessment Tax Deduction. All health and life insurers operating within the state are subject to paying an assessment fee to subsidize premiums paid into the NMMIP. Associated with the NMMIP assessment is a premium tax deduction administered by the Insurance Division of the PRC. Insurers subject to the NMMIP assessment are able to deduct 50 percent, and in some cases 75 percent, of total assessment paid of their premium tax obligation. As mentioned earlier most of this population will move to the exchange under ACA and generate about $33.9 million in revenue.

Medical Service Provider GRT Tax Deduction. This deduction applies to providers who receive payments from any organized plan network, including HMO and PPO plans. Therefore, virtually all non-Medicaid medical services are exempt from GRT. Total general fund impact for foregone GRT revenue is $52 million per year. There is a corresponding hold harmless distribution that was created to offset local option GRT revenue losses resulting from the Medical Service Provider GRT tax deduction. Total general fund impact for foregone GRT revenue plus hold harmless payouts to municipalities under the medical GRT repeal totaled $82 million in FY11. The Legislature could work to phase out the hold harmless provision of the medical service providers deduction for GRT and redistribute these funds to federally-matchable healthcare programs as the need for local financing of healthcare diminishes.

Near-Term Outlook for Medicaid Expansion. Governor Martinez has not made a decision on expansion of Medicaid for adults but the department continues to be actively engaged with the federal government on key policy issues related to implementation. On September 10th HSD sent the federal Health and Human Services Department a letter (attached) outlining questions relating to the ACA, including: 1) could the state expand eligibility for poor adults to a lesser level than 138 percent of poverty; 2) could the state phase-in enrollment; 3) could the state pay premiums for people who receive coverage through the exchange and still receive federal matching funds; 4) how long will the federal government guarantee the favorable ACA match; and 5) if the federal match is reduced, could states respond by adjusting client eligibility.

There has been recent speculation about a new approach for states: only expand Medicaid eligibility to those making under 100 percent of FPL and steer those earning between 100 percent and 135 percent (or 138 percent in the case of New Mexico) to the health insurance exchange. This group would be eligible for federal subsidy of their health insurance cost and the state would avoid the cost of covering these individuals in the out-years. It is unclear at this point if the federal government is willing to deviate from expansion up to 135 percent FPL in order to nudge some states into entering the program.

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