Potential Impact of Repeal of the Patient Protection and Affordable Care Act on New Mexico

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BURRELL INSTITUTE
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PRESENTATION

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To craft effective health policies, lawmakers and other stakeholders must be informed by unbiased research and analysis. While health policy experts have worked extensively in urban centers and other areas of the nation, there remains a dearth of evidence about health policy in the US-Mexico border region. This Burrell Institute for Health Policy & Research *white paper*: the **Potential Impact of Repeal of the Patient Protection and Affordable Care Act** on New Mexico intents to provide decision-makers with accurate, non-bias, timely information related to this relevant topic in order to facilitate its understanding and analysis and serve as a tool for the decision taking regarding the repeal of the ACA and its potential impact in the Land of Enchantment.

We hope you find this paper useful and accurate. We appreciate any comments and feedback.

I want to take this opportunity to express my gratitude to Mr. Dan Burrell, Dean George Mychaskiw, and President John Hummer for trusting on me to conceptualization, development and starting of the Burrell Institute for Health Policy & Research. Small but steady steps are the beginning of long and lasting journeys.

Sincerely,

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INTRODUCTION AND BACKGROUND

KEY POINTS

Proposals to repeal and replace the Patient Protection and Affordable Care Act of 2010 (ACA) would have a widespread negative impact on New Mexico, leading to:

- **Loss of health coverage for at least 266,000 New Mexicans**[24]
- **Doubling of monthly premiums by 2026**[20]
- 1300+ **preventable deaths yearly**[3]
- **Loss of** $2.3 billion **in federal revenues**[25]
- 32,494 New Mexicans would lose their jobs, a loss of 3.9% of all jobs in the state[25]

The Patient Protection and Affordable Care Act of 2010 ("the ACA"), President Barack Obama's signature health-care law, marked a significant restructuring of health care in the United States. The law expanded health insurance coverage, invested deeply in strengthening the primary health-care system, provided support for providers and insurers to experiment with value-based payment options, developed infrastructure for training health-care providers, and created a national prevention plan.

KEY COMPONENTS OF THE ACA

Since its implementation in 2011, the ACA has expanded health-care coverage to more than 20 million people. Two primary mechanisms were used to achieve this increase in coverage: 1) Medicaid expansion and 2) establishment of federally subsidized health insurance markets for individuals. As originally passed, the law required states to expand Medicaid eligibility to all people with incomes up to 138% of federal poverty level (FPL). Health-care marketplaces were also established, where people earning 139% to 400% of FPL can receive assistance in paying monthly premiums (premium subsidies) and in some cases assistance paying deductibles and co-pays (cost-sharing subsidies). All adults are required to have health coverage or pay a tax penalty.

KEY POINTS

- In 2016, the U.S. uninsured rate reached an all-time low of 8.6%
- The ACA increased the capacity of community health centers, the core of the nation's primary care system
- The National Health Service Corps expanded under the ACA
- The ACA provides funding and technical support for testing new models of value-based health care delivery and payment models
- The ACA provides funding for prevention of disease and injury and public health activities, including emergency preparedness and immunization programs

A growing body of evidence suggests that the law has positively affected health outcomes and reduced disparities in health-care coverage and access across ethnic and socioeconomic classes.[1–3] Gains in health insurance coverage have been most notable among working-age Americans. The uninsured rate in this population fell from January 2010 (20.3%) to March 2016 (11.5%).[4] In mid-2016, the vast majority (84%) of the 10.4 million people enrolled in private insurance plans through the exchanges had incomes less than 400% of the federal poverty level (FPL) and were eligible for premium tax credits. In 2016, the uninsured rate reached an all-time low of 8.6% for all Americans.[5] At the close of the 2017 enrollment period on February 1, 12.2 million people had enrolled in a marketplace plan.[6]

The ACA also emphasizes strengthening the nation's primary care system and workforce, mostly through investment in community health centers. Community health centers are the federally funded centers that form the backbone of the nation's primary care system. The law established a five-year, $11 billion trust fund to develop community health centers' capacity over five years. In addition, $1.5 billion was dedicated to expansion of the National Health Service Corps (NHSC), which is a major recruiting tool for health centers.[7] Increased Medicaid enrollment through the ACA means that community health centers see more insured patients and provide less uncompensated care.

The ACA also established the CMS Center for Medicare and Medicaid Innovation (CMMI) with the purpose of testing new models of high-quality, value-based health-care delivery and payment. CMMI was provided with $10 billion to develop, test, and evaluate demonstration projects from 2011 to 2019 and an additional $10 billion every 10 years starting in 2020.[8,9] CMMI funding has been used to finance demonstration projects in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). CMMI payment and service delivery models and initiatives have reached an estimated 18 million people, as well as more than 207,000 health-care providers.[8] Based on Congressional Budget Office (CBO) estimates, net federal spending on health care will be reduced by about $34 billion from 2017 through 2026 as a result of CMMI's activities. The Center is expected to spend about $12 billion on demonstration projects during this time; those projects are expected to generate about $45 billion in savings.[9]

One area of the ACA has received scant attention from the public, policymakers, journalists, and academics alike: investment in prevention. The law established a National Prevention Council and supported development of the nation's first National Prevention Strategy, which provided a comprehensive roadmap for decreasing chronic disease, acute disease, and injury. Prevention funding supports core public health activities such as

improved immunization programs, reduction of sexually transmitted infections (STIs), surveillance tools, emergency response to growing threats such as Zika and Ebola viruses, and health education. The law also invests in public health workforce development and strengthened the Indian Health Services (IHS). These activities led to development of a new paradigm for integrated clinical and community health, "accountable health communities." Ultimately, the work funded by ACA prevention dollars led to a new concept of public health, Public Health 3.0. The 3.0 framework emphasizes the need for policies and actions that focus on the systems that create the social factors influencing health, including education, transportation, physical environment, workplaces, and other sectors.

IS THE ACA WORKING?

The ACA is not perfect. 27.2 million Americans remain uninsured, and 43% of them are eligible for coverage through the ACA but have not enrolled.[10] In New Mexico, 228,000 people remained uninsured in 2016. Of the uninsured in New Mexico, an estimated 44% (100,000) are ineligible for financial assistance. Of these, 27,000 do not qualify because of their income, 29,000 because of an offer of employer-sponsored insurance (29,000), and 44,000 because of citizenship status. [11] Those enrolled in individual plans often face limits in provider networks and higher out-of-pocket expenses compared to those enrolled in employer-sponsored plans. While the ACA has reduced disparities in health-care coverage for many Latinos, many remain without access to care.[12] Premiums are higher and network choices more limited for people living in rural areas. Health-care quality has improved, yet medical errors remain a leading cause of death in the United States. Disparities in coverage and access to care have improved but still remain substantial,[1,3,12,13] as do disparities in chronic and acute disease. The rate of premium growth has slowed substantially but continues to grow.[14]

KEY POINTS

- **Despite gains in coverage, 228,000 New Mexicans remained uninsured in 2016**
- **44% of the uninsured in New Mexico are not eligible for financial assistance with premium costs**
- **New Mexicans enrolled in individual plans often encounter limited provider networks and higher out-of-pocket expenses than those in employer-sponsored plans**
- **Premiums are higher and network choices more limited for people living rural areas**
- **The law has extended health care to low- and moderate-income Americans**
- **If the ACA remains intact, national health spending from 2014 to 2019 is expected to be $2.6 trillion less than projected in 2010.**

Despite these problems, the law appears, overall, to be working. It has extended health-care to low and moderate income Americans, fostered entrepreneurship by providing options for health-care coverage in the individual market, and provided alternatives to small business owners. Coverage expansion cost billions of dollars less than expected, partly because of slowing growth in health spending and partly because of the reforms in the ACA. National health spending from 2014 to 2019 is expected to be $2.6 trillion less than projected in 2010.[15]

REPEAL EFFORTS

Despite the early successes of the still nascent law, the 2017 Congress and the Trump administration have begun a series of actions to repeal it. On January 12, the US Senate voted in favor of a "budget blueprint" that cleared the way for legislation called a reconciliation bill, which allows repeal of the law piece by piece with a simple majority of 51 votes, effectively preventing Democrats from filibustering the vote.[16] The House of Representatives approved the measure the following day. On January 20, Donald Trump signed his first executive order after taking office. The order called upon agencies to immediately repeal the law's key provisions "to the maximum extend permissible by law."[17]

No replacement plan has been adopted, although several competing proposals have emerged:

- In 2015, Congress passed and vetoed House Speaker Paul Ryan's **H.R. 3762, the Restoring Americans' Healthcare Freedom Reconciliation Act**, which repealed two key provisions of the law: Medicaid expansion and federal premium tax credits for those purchasing insurance through Health Insurance Marketplaces. In 2016, Congress passed and President Obama vetoed a reconciliation bill similar to one passed in January 2017.
- On January 23, 2017, Senators Senator Bill Cassidy (R-LA), joined by Senator Susan Collins (R-ME), Johnny Isakson (R-GA) and Shelly Moore Capito (R-WV), proposed the **Patient Freedom Act of 2017**, which shifts responsibility to states. The bill provides three options for repealing the consumer mandate: 1) keep core components of the ACA; 2) use subsidized "Roth HSAs" to offer coverage; or 3) reject reform completely.
- Secretary of Health and Human Services Tom Price, long an opponent of the ACA, has introduced his own bill during every Congressional session since 2013, the Empowering Patients First Act. The Act also provides for Health Savings Accounts (HSAs), offers fixed tax credits, which are tied to age but not income, starting at $1200 per year, requires people with pre-existing medical conditions to maintain continuous coverage or else wait 18 months, limits deductions for health insurance expenses for companies, and establishes high-risk pools.
- The American Health Care Act of 2017 (HR 1628) was introduced March 6, 2017 by Diane Black (R-TN).[6] The bill was amended on March 20, March 24, April 6, and April 20. Major changes to the ACA proposed in the AHCA include repeal of the "individual mandate" in 2016, elimination of premium and cost-sharing subsidies by 2020, elimination of essential benefits requirements, provision of age-based tax credits, repeal of the Prevention and Education Fund, and conversion of federal Medicaid funding to a block grant. The plan would require those who go without coverage for more than a month to pay a 30% premium penalty for a full year. The AHCA also encourages use of HSAs and prohibits federal Medicaid funding for Planned Parenthood and other clinics that provide abortion services; tax credits could not be used to purchase private insurance that covers abortions. It also permits states to impose work requirements on able-bodied Medicaid recipients. The April 6 amendment added a "State Patient and State Stability Fund," which would allow states to provide

cost-sharing subsidies and preventive services and establish high-risk pools. The MacArthur Amendment on April 20 strengthened the ability of states to waive essential health benefits, added on community-rating rules, and provided states with default approval for those waivers if not denied by the Department of Health and Human Services within 60 days.

Analyses by several independent think tanks, including the Kaiser Foundation, Commonwealth Fund, Brookings Institute, Center for American Progress, and CBO, indicate that all plans proposed thus far would have a profoundly negative impact on the US economy, health, health-care coverage, health-care industry, and environment. None of these replacement plans is likely to perform as well as the ACA, which, according to health policy analysts at the Commonwealth Fund, would put one out of 10 Americans at risk of having "no insurance, less affordable insurance, or less valuable insurance."[18]

Analysis of one scenario by the CBO – repeal of the ACA replacement with a modified version of the plan promoted by Speaker Ryan – suggests that 18 million people would lose coverage the first year after implementation.[19] In the following years, elimination of Medicaid expansion and subsidies for insurance purchased through ACA marketplaces would cause 27 million people to lose coverage by 2020; by 2026, 32 million would be uninsured. Premiums for individuals would also skyrocket, increasing by 20-25 percent in 2017 (or the first year after implementation) compared to projections under the ACA. After elimination of marketplace subsidies and Medicaid expansion the following year, premium increases would reach about 50%; by 2026, they would double.[19]

A second CBO analysis estimates the impact of the AHCA as released on March 6, 2017.[20] That preliminary analysis shows that 14 million more people would be uninsured in 2018 than under current law, mostly as a result of repealing the individual mandate. By 2020, as restrictions on Medicaid were enacted and subsidies for private plans reduced, the difference would reach 21 million; by 2026, a total of 52 million Americans would be uninsured, 24 million more than if the current law were left unchanged. Analysts from the Brookings Institute estimated that the amendments would not reduce coverage losses and might lead to even higher numbers of uninsured.[21]

CBO estimates of the AHCA's impact show that premiums for individuals would be expected to increase until 2020 but then decrease, becoming 10% lower than under current law by 2026.[20] However, adults age 50-64 would see substantial increases, as the proposed legislation allows insurers to charge older adults five times more than younger adults, compared to a three-to-one ratio under current law.

Researchers from the Brookings Institute also point out that the 10% decrease would occur only if plans offered fewer benefits and the age distribution of enrollees remained the same; they estimate a net increase in premiums of 13% under the AHCA, in addition to increased cost-sharing for consumers.[22] In addition, Brookings' researchers point out that reductions in subsidies would substantially increase consumers' total costs. The Center for American Progress also projects that total costs for enrollees would

rise substantially, by an average of $3,174 in 2020.[23] Based on their assessment of the original bill, they estimate that enrollees aged 55 to 64 years would see costs increase by $8,329. Those whose income falls below 250 percent of poverty would see an increase of $4,815. CBO's analysis of the AHCA with added provisions for high-risk individuals was not available at the time of this writing.

IMPACT OF ACA REPEAL ON NEW MEXICO

This paper assesses the potential impact of a repeal of the ACA on New Mexico, along with replacement by approaches that have been proposed most frequently. Our findings suggest that repeal of the ACA would have a significant negative impact on New Mexico, which is especially vulnerable to the ACA repeal because of its large rural areas, high proportion of low-income residents, and preponderance of small business owners. At least 266,000 New Mexicans would be in danger of losing access to health care[11], federal, state, and local investment in communities would be reduced[24,25]; and job loss and economic instability would be significant.[24,25] Economic losses would impact all sectors, not just health care;[24] hospitals and other health-care providers would have to severely reduce services or close[25,26]; premiums for health-care coverage would rise for both the individual and employer markets; and there would be notable excess mortality and morbidity from treatable conditions.[1,27] In short, health care would be likely to become less safe, less innovative, less focused on quality and value, and more expensive.

HEALTH-CARE COVERAGE

While the ACA is a comprehensive, multi-level overhaul of the US health-care system, most of the controversy about the law has focused on its creation of an individual health-insurance market for Americans who do not have access to employer coverage. The ACA creates that individual market by two mechanisms: 1) establishing a health-care "exchange," in which individuals can purchase insurance (subsidies are offered up to 400% of federal poverty level); and 2) expanding Medicaid coverage to those making between 100% and 138% of federal poverty level. In the hotly debated King v Burwell case, the US Supreme Court ruled that the penalty was actually a tax; it also gave states the power to decide whether to expand Medicaid coverage. Opponents maintain that the shared tax is unfair. Yet these two provisions were designed to provide an acceptable risk level for insurers to enter the individual market, control skyrocketing premiums, and provide coverage to low-income individuals and families.

KEY POINT

> **Repeal of expanded Medicaid, tax credits and subsidies would lead to a 136% jump in the uninsured rate for New Mexico.[25]**

Repeal of the ACA would lead to significant losses in covered benefits and eligibility. Medicaid, Medicare, and both individual and employer-sponsored private plans would

be affected. Analyses from the Urban Institute[11] and The Economic Policy Institute show that 266,000 New Mexicans[2], including 29,000 children, would lose coverage if the ACA were to be repealed and replaced with a bill similar to the reconciliation bill proposed by House Speaker Paul Ryan in 2016.[25,28] The uninsured rate for New Mexico would jump by 136%.[25]

COVERAGE REQUIREMENTS

In addition to one out of nine New Mexicans becoming uninsured under ACA repeal, benefits, eligibility, and other consumer protections of health-care coverage would be lessened or eliminated under all proposed plans. Proposed changes to the ACA could affect almost all types of health insurance coverage, including that offered in the health-care marketplace, employer-sponsored packages, Medicaid, and Medicare.

The ACA established an "essential benefits" package that applies to all health insurance coverage, including employer-sponsored packages. Under the ACA, evidence-based preventive clinical services, such as mammograms, colonoscopies, and immunizations are provided with no cost-sharing to individuals. The AHCA, as amended April 6, would repeal the essential benefits requirement.

The effectiveness of the preventive services package is demonstrated by the success of birth control, which is considered an evidence-based preventive service. This designation allows women to access it for free. This stipulation appears to have prevented thousands of unplanned pregnancies. In New Mexico, the teen birth rate declined from 53.2 per 1000 women ages 15-19 years in 2010, to 37.8 in 2014. While the birth rate had been decreasing since 1971, the rate of decrease accelerated after ACA implementation. Likewise, a recent report from the Alan Guttmacher Institute suggests that increased access to family planning services, including contraceptives, has contributed to an historic decline in the national abortion rate, which fell to a record 14.1 per 1000 women in 2014.[29]

In addition, repeal of the ACA would jeopardize several very popular – and lifesaving – requirements for health insurance plans sold in both the group and individual markets:

- Adult children are allowed to remain on their parents' policies until age 26, creating a personal safety net during college and early career transitions. Under this provision, 26,000 young adults in New Mexico gained health insurance because they could stay on their parents' health plans until age 26.[14] The AHCA preserves this provision, while other proposals eliminate it. Were it to be eliminated, families would once again have to worry about insuring their children. Many young healthy adults would choose to go without coverage, with a negative effect on risk pools in both employer and individual markets.
- The ACA prohibits insurers from denying someone coverage because he or she has a "pre-existing condition." Repeal of this provision is of serious concern for New Mex-

2 Both the Urban Institute and Economic Policy Institute studies are based on analyses of 2016 enrollment numbers; data released by CMS in February 2017 suggests that more than 300,000 people may be at risk of losing coverage.

icans: Up to 862,000 people in New Mexico, including up to 122,000 children, have pre-existing conditions such as asthma, cancer, or diabetes.[30] Without the protection of the pre-existing conditions clause, they will once again have to worry about being denied coverage or charged higher prices because of their health status or history.

- Under the ACA, health-care insurers can no longer impose lifetime or annual limits on coverage for people. This means that people with chronic diseases can continue to access the care needed to manage their diseases. More than 555,000 New Mexicans[31] have not had to worry about annual limits under the ACA; a repeal of this provision would mean that people with chronic diseases, those undergoing cancer treatment or treatment for other conditions such as hepatitis, would no longer have coverage after they reach the limit.
- The ACA includes the much-debated "individual mandate," which requires that all US residents have some form of health coverage, or else pay a tax penalty. All Republican replacement proposals have called for elimination of the individual mandate. However, insurers and health-systems researchers warn that removing the individual mandate would lead to a "death spiral" – the term used by the insurance industry when an insurance pool is more costly than expected. If insurance is not mandated, it is likely that younger, healthier people will not sign up, resulting in a more expensive "pool" of insured people. Premiums rise, and more healthy people drop out, causing premiums to rise even more. Ultimately, the market "spirals" into bankruptcy.

Republicans have signaled that they consider current benefits packages excessive, and most proposed replacement plans would have less generous benefits, higher co-pays, and reinstate annual or lifetime limits. Both Senator Collins' and Speaker Ryan's plans focus on HSAs, in which individuals must set aside a significant amount of money toward future medical bills. In Collins' plan, uninsured individuals would sign up for high-deductible plans, and several thousand dollars of taxpayer money would be deposited into an HSA for each person. That money would be used to pay premiums, deductibles, and co-pays, until it ran out. While such an approach may be feasible for people who are generally in good health, people with chronic conditions or those with a condition requiring expensive treatments may deplete their accounts quickly.

Replacement plans have not clearly delineated what level of protection would count as coverage. The April 6 update to the AHCA eliminated all essential benefits requirements.[32] Instead, the proposed legislation establishes the "Patient and State Stability Fund," which would provide $15 billion per year to all 50 states from 2018 to 2019 and $10 billion per year from 2020 to 2026. States could use the funds for the following activities:

- Create or enhance state-based high-risk pools
- Provide incentives to help stabilize premiums in the non-group market
- Reduce the costs of providing health insurance coverage in the individual and small group markets for high-cost individuals
- Promote participation in the non-group and small group markets by insurer

- Promote access to preventive services, dental and vision services, or prevention, treatment, or recovery support for individuals with mental health or substance use disorders
- Pay health-care providers
- Reduce patient cost-sharing amounts

States would be required to contribute matching dollars; states that chose not to apply for funding would receive an amount based on incurred claims, the number of uninsured, and insurers' participation in the individual market. The New Mexico Office of the Superintendent of Insurance reports that the actuarial consulting firm Oliver Wyman projects that New Mexico would receive $70.51 million in 2018.[33] Most states would be expected to use the funds to subsidize high-risk pols or create state-based reinsurance programs.[33]

The CBO clearly signaled its concern with the lack of clarity about replacement plans in a strongly worded blog post published December 20, 2016: "If there were no clear definition of what type of insurance product people could use their tax credit to purchase, everyone who received the tax credit would have access to some limited set of health care services, at a minimum, but not everyone would have insurance coverage that offered financial protection against a high-cost or catastrophic medical event; CBO and JCT would not count those people with limited health benefits as having coverage."

INCREASED COST-SHARING

The ACA provides help with deductibles and limits out-of-pocket expenses, including co-pays and deductibles, for qualified enrollees. The AHCA, like other proposed replacement plans, eliminates the ACA's cost-sharing reductions in 2020. Without these protections, consumers' net costs would increase substantially and they would be at greater financial risk.

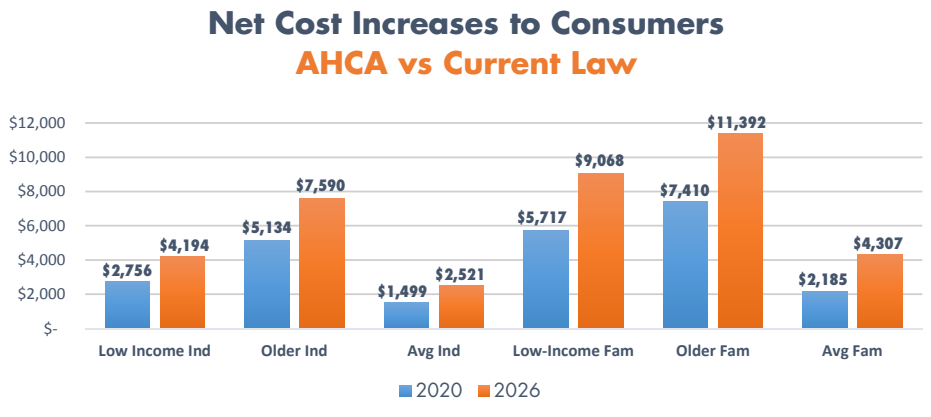

Figure 1: Net Cost Increases to Consumers, American Health Care Act vs Current Law. Source: https://www.americanprogress.org/issues/healthcare/reports/2017/03/16/428418/impact-house-aca-repeal-bill-enrollees-costs/

Analysis by the Center for American Progress suggests New Mexicans would pay more for health care under any of the proposed replacement schemes. In an analysis of AHCA legislation as first drafted, Cutler, Bertko, and Spiro[23] estimate that individual New Mexicans who earn less than 250% of the poverty standard ("low income") would see a net increase in costs of $2,756 annually by 2020, while New Mexico families in this income bracket would pay an additional $5,717 per year. By 2026, the net increase for low-income individuals would be $4,194 and $9,068 for families. Older individuals would pay an additional $5,143 for health care over current law in 2020, and that figure would increase to $7590 by 2026; older families would pay $7410 annually in 2020 and $11,392 in 2026. These estimates are depicted in Figure 1.

HEALTH INSURANCE EXCHANGE

Through the health insurance exchanges established by the ACA, New Mexicans can purchase health insurance as individuals. The ACA also provides support for small businesses to provide coverage for their employees through the "SHOP" marketplace. Subsidies are provided on a sliding fee scale.

KEY POINT

> **Elimination of the individual mandate and individualized tax credits would lead to destabilization of health insurance markets, with a probable "death spiral" in the individual insurance market.**

Nearly 55,000 New Mexicans have purchased health insurance on the exchange, representing slightly more than 35% of those eligible for coverage.[34] Of those, 38,838 live in the state's sole metropolitan area, Albuquerque; the remaining 16,025 reside in non-metropolitan areas of the state. The second lowest-cost Silver Plan is one of the most popular and is often used as the "benchmark" plan. In 2016, a 40-year-old nonsmoking male living in Albuquerque and making $30,000 a month paid a $186 monthly premium but would not have received a subsidy because the premium was so low; in 2017, the monthly premium is $258, and the same individual will receive $51 in tax credits. The net monthly premium would be $251.[35] If, as predicted by the CBO,[19] premiums increase by 25% in 2018 under a repeal scenario, the same individual would pay $322.50 per month. By 2026, his monthly premiums would be $516. These more expensive plans would likely offer fewer benefits.

In addition, the ACA established four levels of health coverage, allowing consumers to choose the actuarial value of their plans. Plans cover 60%, 70%, 80%, or 90% of expected costs. The AHCA drops this requirement and shifts responsibility to set plan standards for actuarial value to the states.[32] This requirement would increasing New Mexico's costs for staff and actuarial resources needed to evaluate, develop, and implement potential state-based actuarial value structures.[33]

Repeal of the ACA could lead to extreme disruption in the individual market. If employer and individual mandates were eliminated, the repercussions would resonate with providers, patients, insurers, and employers. Many individuals would stop paying premiums, leading insurers to incur substantial losses.[11] If the individual mandate is eliminated but tax credits and cost-sharing reductions left in place, most insurers would stop participating in marketplaces in 2018.

The AHCA eliminates the individual mandate; instead, people who go without coverage for two or more months would be required to pay a 30% higher premium for the following year of coverage. While the framers of the legislation intended this provision to replace the individual mandate, which served to broaden the risk pool, the net effect would likely be the opposite. In this scenario, younger, healthier people would be more likely to forego coverage, while those who would be willing to pay the extra premium would be more likely to have significant medical expenses. Thus, the risk pool would likely become skewed with sicker people, and insurance companies would be forced to raise premiums even more than predicted.

In addition, the AHCA replaces a key component of the ACA – tax credits in the form of individualized premium subsidies – with flat tax credits.[32] Under the ACA, subsidies were calculated based on income, the cost of insurance in a given geographic region, and age. This creates a dynamic interplay between cost and need, effectively providing customized support for each enrollee. The AHCA proposed an age-related tax credit, with annual credit amounts starting at $2,000 up to age 29 years and capped at $4,000 for those 60 years or older. However, insurers would be allowed to charge older persons up to five times as much.

EMPLOYER-SPONSORED COVERAGE

In 2016, about 42% (884,000) of New Mexicans were covered through employer-sponsored plans.[36] Monthly premiums for employer-sponsored plans grew 4.3% per year from 2010 to 2015, about half as fast as during the previous decade (8.5% per year).[37] Estimates from the US Department of Health and Human Services suggest that if premiums had continued to increase at pre-ACA rates, they would be $5,100 higher today.[37,38] The ACA imposed standards for all plans, requiring that insurers spend at least 80 cents of every dollar directly on health care or care improvements, as opposed to administrative costs such as salaries or marketing; any difference must be refunded to consumers. As a result of this stipulation, New Mexicans covered under employer-sponsored plans received nearly $1.8 million in insurance refunds between 2012 and 2016.[30]

KEY POINT

> **Low-wage small employers would no longer receive tax credits beginning January 1, 2020.**

The AHCA eliminates the ACA's requirement that large employers offer their employees coverage that meets certain standards. Wellness incentives are not changed. The ACA provides tax credits for low-wage employers with up to 25 employees, up to half of the employer's premium contribution; those, too, are eliminated in the AHCA legislation beginning January 1, 2020. Starting in 2018, small businesses would be prohibited from using tax credits to purchase plans that cover abortions, except under Hyde limitations.

The net impact of the changes proposed in the AHCA: consumers would pay more for less, while insurers would be allowed to charge more for administrative costs.

With repeal of the employer mandate, the CBO estimates that employer-sponsored coverage will decrease by 1.8% by 2018 and 4.5% by 2026. In New Mexico, approximately 9,880 people would be likely to lose coverage by 2018, while 34,200 would lose coverage by 2026[33] These numbers do not take into account projected job losses.

MEDICAID/CHIP

New Mexico is one of 32 states that expanded Medicaid eligibility under the ACA. Medicaid is a state-federal sponsored program that provides health-care coverage for children, pregnant women and low-income adults. The ACA expanded eligibility to children and adults living in families with 138% of poverty and provided five additional years of funding for the Children's Health Insurance Program (CHIP), which covers children in families with incomes too high to qualify for Medicaid. Federal funding for the program was increased.[4] Congress extended CHIP funding for an additional two years in 2015; funding is continued through September 30, 2017.

KEY POINTS

- **Repeal of Medicaid expansion would leave nearly 10 percent of New Mexicans without health coverage.[14]**
- **Block grants or per capita funding for Medicaid would lead to severe reductions in services for all Medicaid enrollees, including children, pregnant women, and people with disabilities**
- **The decrease in federal matching funds proposed in the AHCA would increase state general fund obligations by up to $140 million annually.[40]**

The ACA allowed states to use their CHIP allotments to expand Medicaid, fund a separate CHIP program, or develop a combination of the two. All but nine of the states that expanded Medicaid through the ACA use all or part of their CHIP allotment to fund the program. During 2014, 2015, and 2016, the federal government provided a 100% match for the cost of expanding Medicaid coverage to those at or below 138% of FPL. That percentage is set to drop to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and after. The state pays a 1.9% insurance fee to the federal government on additional costs for the care of newly enrolled adults.[39]

According to analysis from Kaiser Foundation researchers,[14] Medicaid spending in New Mexico in 2015 was $4.9 billion, with 80% spent in managed care. While most beneficiaries are children and adults, a disproportionate share of funding went to the elderly and people with disabilities. Federal funding for Medicaid is guaranteed with no cap, so it is responsive to program needs. Currently, the federal share (FMAP) is 71.1%, which means that for every dollar New Mexico invests in Medicaid, the federal government matches $2.46. Medicaid comprises 61% of all federal funds received by New Mexico. In expansion dollars alone, New Mexico received $2.1 billion from federal sources from January 2014 through September 2015.

The AHCA sunsets the enhanced match for Medicaid expansion as of January 2020, except for "grandfathered enrollees" (those who qualify for traditional Medicaid without the expansion). On March 22, 2017, the Associated Press reported the results of an analysis by Jenny Felmley, Senior Fiscal Analyst at the New Mexico Legislative Finance Committee. Felmley's analysis showed the decrease in federal matching funds

would impact the state budget dramatically starting in 2020. Per-person costs to the state would increase from $457 annually to $1,227 for new enrollees and people who leave Medicaid and then return. State general fund obligations would be expected to increase by up to $140 million annually.[40]

The ACA also decreased administrative burden for determining eligibility for Medicaid, CHIP, and exchange subsidies, partly by establishing a new standard called the Modified Adjusted Gross Income (MAGI) standard and eliminating the asset test. This made enrollment and renewal simpler for people participating in Medicaid, CHIP, and marketplace health plans, significantly reducing administrative burden and expense. Repealing this requirement would increase administrative costs for the state and pose a barrier to potential Medicaid enrollees.

In the largely rural state of New Mexico, both Medicaid expansion and simplified enrollment procedures have dramatically increased coverage rates and access to care. Medicaid enrollment increased by 68.19% in New Mexico, compared to a 30.07% jump in Medicaid enrollment nationwide.[14] Approximately 266,700 adults were enrolled under expanded Medicaid as of March 1, 2017.[41] Analysts attribute the increase both to expansion of eligibility and increased enrollment due to increased awareness and streamlined enrollment processes (the "woodwork effect").

Repeal of the ACA would eliminate eligibility for the expansion population (i.e. individuals and families with incomes up to 138% of FPL), taking health coverage from nearly 10 % of New Mexicans.[14] In addition, ACA repeal would significantly change the traditional Medicaid program, although it is not clear exactly what changes would occur.[28,42] Because Medicaid is a federal-state partnership, New Mexico does have some control over those changes, but in all of the scenarios proposed thus far, federal funding for the program would be drastically cut.

In addition, several federal proposals propose a reversion to asset-based eligibility, establish cost-sharing requirements, and link work requirements to eligibility. These strategies are likely to lead to increased administrative time and effort attempting to collect payment, require providers to deliver more uncompensated care, and create another barrier to accessing care for low-income New Mexicans.

The AHCA allows states to impose work requirements on Medicaid recipients. Work requirements are modeled on those in the Temporary Aid to Needy Families (TANF) program, despite ample evidence that those requirements are not effective at helping move people to employment.[43] Yet, according to the Kaiser Family Foundation, nearly 8 out of 10 Medicaid adults, including both parents and those covered by the expansion, live in working families.[44] Most are employed by small firms; almost all work in jobs where wages are below the cost of living. Conversely, researchers from the Kaiser

Family Foundation found that most adult Medicaid enrollees who were not working faced serious impediments to their ability to work. As of January 2017, New Mexico had the highest unemployment rate in the nation (6.7%), creating another obstacle to fulfilling a work requirement: lack of jobs, especially in rural areas of the state.

Current ACA replacement proposals, including the AHCA, suggest shifting away from the current dynamic federal-state partnership Medicaid structure to either a "per capita cap" or "block grant" structure in which each state receives a specified amount of funding based on a calculated formula.[42,45,46] The AHCA only allows block grants for traditional Medicaid recipients, including children, pregnant women, and extremely low-income parents.

Either a per capital or block grant approach to Medicaid would deeply cut federal funding and limit the state's ability to cover residents who would remain eligible – mostly children, extremely low-income pregnant women and parents, and low-income people with severe disabilities or chronic disease. New Mexico would have few options except severely curtailing eligibility, establishing a waiting list, or sharply reducing covered services and benefits. Analysis from the Kaiser Commission[46] suggests that if Medicaid were converted to a block grant program, an additional 14 to 20 million people would lose coverage nationwide. Because of the high percentage of low income residents in New Mexico – 41% of residents earn less than 200% of federal poverty rate and 20.7% live below the poverty line[14] – New Mexico would be one of the states most affected.

MENTAL HEALTH PARITY

In addition to broadening eligibility and providing tax subsidies to those who participate in the exchanges, the ACA strengthened the Mental Health Parity and Addiction Act of 2008 (MHPAA) by requiring all plans sold on the Marketplace to cover essential health benefits including mental health care and substance abuse treatment. As a result, about 403,000 New Mexicans gained expanded mental health and substance use disorder benefits and/or federal parity protections – and would stand to lose them if the law were repealed, DHHS reported under President Obama (data has since been removed from the Health.gov website).

KEY POINT

> **About 403,000 New Mexicans would lose expanded mental health and substance use disorder benefits and/or federal parity protections**

The AHCA repeals this requirement and would lead to loss of coverage for mental health services and substance abuse treatment – which the ACA defines as required benefits – even for those who remain insured. It could also make it more difficult to enforce the MHPAA and the 21st Century Cures Act, the latter of which was signed by President Barack Obama in December, 2016. The Cures Act includes stricter enforcement of parity requirements and tasks the federal Department of Health and Human Services with helping health plans comply.

Reductions in coverage would also impact access to mental health services. Nationally, Medicaid is the single largest payer for behavioral health services and provides the most comprehensive benefits. The program is essential for those with severe mental illness, partly because it offers them an array of both clinical and community-based services and supports.

MEDICARE

Medicare, the federal health-care program for seniors and the disabled, would also be dramatically affected by ACA repeal. The ACA contains several provisions that strengthen Medicare, all of which would be eliminated if the law were to be repealed:

KEY POINT

- **Privatization of Medicare would dramatically increase costs to seniors**
- **Delaying Medicare eligibility to age 67 would leave many seniors uninsured yet yield little in the way of savings**

- It has reduced the "donut hole" –the gap in coverage many seniors face in paying for prescription drugs – and is on track to eliminate it altogether by 2020. In 2016, seniors received a 60% discount on covered brand-name prescription drugs. As a result of this provision, 23,642 New Mexico seniors saved $24 million on drugs in 2015, an average of $1,006 per beneficiary.
- It provides evidence-based preventive services, often with no co-pay or deductible. These include colonoscopies, mammograms, and a free yearly "Wellness visit."
- It supports care coordination, providing additional resources for a team of health-care providers to support seniors.
- The ACA extended the life of the Medicare Trust fund at least 12 years to 2029 by targeting waste, fraud, abuse, and unnecessary costs.

Republicans, including Paul Ryan and incoming HHS Secretary Tom Price, have advocated two major changes to Medicare: 1) privatization and 2) increasing the age of eligibility to 67. Privatization would take the form of providing vouchers to seniors to purchase available plans. While billed as "choice," this approach would result in dramatically increased costs, rendering care unaffordable for many seniors living on fixed incomes – especially as costs of care increase. Analysis by the Center for American Progress shows that under Ryan's 2012 Medicare privatization plan, a person who turns 65 in 2023 would pay an extra $59,500 in Medicare costs over his lifetime, compared to the current system. In addition, vouchers become less valuable as time passes. An individual who turns 65 in 2050 would pay an extra $331,200 over their lifetimes.[15]

Raising the age for Medicare eligibility from 65 to 67 years would reduce access to care for seniors while yielding little, if any, net savings.[47] While restricting eligibility would decrease the number of Medicare enrollees, those ages 65-69 years account for only 15% of Medicare spending and comprise 24% of the total Medicare population.[48,49] Delaying Medicare eligibility to age 67 in the absence of Medicaid expansion and health exchange subsidies would leave many seniors uninsured and less likely to access preventive care yet yield little in the way of savings. Uninsured seniors who did need to access care emergently or urgently would contribute to the uncompensated care burden for hospitals and other providers.[15]

NATIVE AMERICAN POPULATIONS

Repeal of the ACA also jeopardizes health-care for more than 2 million tribal members. The Indian Health Care Improvement Act (IHCIA), first passed in 1976, serves to formalize treaties that obligate the federal government to provide free health care to tribal members. It established and funded the Indian Health Services (IHS); however, appropriations expired in 2000. These treaties go back more than a century. The ACA permanently reauthorized the IHCIA when it became law in 2010, adding several changes including:

KEY POINT

- **More than 2 million tribal members could lose crucial health-care services**

- Enhancing the authorities of the IHS Director
- Providing authorization for hospice, assisted living, long-term, and home- and community-based care
- Allowing tribally operated health care facilities to recover costs from third parties
- Updating current law regarding collection of reimbursements from Medicare, Medicaid, and CHIP (Children's Health Insurance Program) by Indian health facilities
- Allowing tribes and tribal organizations to purchase health benefits coverage for IHS beneficiaries
- Authorizing IHS to enter into arrangements with the Departments of Veterans Affairs and Defense to share medical facilities and services
- Allowing a tribe or tribal organization carrying out a program under the Indian Self-Determination and Education Assistance Act and an urban Indian organization carrying out a program under Title V of IHCIA to purchase coverage for its employees from the Federal Employees Health Benefits Program
- Authorizing the establishment of a Community Health Representative program for urban Indian organizations to train and employ Indians to provide health care services
- Directs the IHS to establish comprehensive behavioral health, prevention, and treatment programs for Indians

These amendments responded to the unique needs of the Native American population. For instance, the updated IHCIA allows physicians to practice across state lands while on tribal lands, which may encompass two or more state boundaries, such as the Four Corners area of New Mexico, Utah, Colorado, and Arizona. The 2010 amendments supported the financially strapped system by allowing it to bill third-party payers including Medicare.

Wholesale repeal of the ACA would also embody repeal of the IHCIA, jeopardizing health care access for Native American and Alaska Native populations. New Mexico would be critically affected, as Native Americans comprise nine percent of the state's population. There are 23 tribes, pueblos, and nations in the state, all of which would lose crucial services if the ACA is repealed and with it, the IHCIA.

HEALTH-CARE FINANCING AND INNOVATIONS

The ACA has had a significant impact on the way that health care is paid for and delivered. The framers of the law sought a system that delivers care that is not only affordable but accountable, and new delivery models that shift both responsibility and rewards. For instance, Accountable Care Organizations (ACOs) offer a model in which providers, payers, and patients share risk; Patient-Centered Medical Homes (PCMHs) provide primary care with wraparound services, including non-clinical social supports. Value-based and bundled payment models are being tested as ways to pay for quality rather than volume. The models share a focus on lowering costs, improving quality, and putting the patient's and family's needs at the center.

KEY POINT

> **Federal support for testing innovate, value-based health-care payment models would be reduced or eliminated**

The CMS Innovation Center (CMMI) was developed to test the different models. To date, 55 models are being tested in New Mexico, with pilots being carried out at primary care, specialty care, and surgical centers and at acute care hospitals. In 2015, New Mexico received a State Innovation Model Design grant from CMMI, which was used to bring together stakeholders across geographic regions and sectors to develop a State Health Innovation Plan, with a vision of integrated clinical care and community supports.

HEALTH-CARE DELIVERY

The framers of the ACA sought not only to make health care less expensive and more accessible, but to make it better and accessible to all. The goal is to develop the infrastructure to deliver high-value care that meets the Institute for Healthcare Improvement's (IHI's) "triple aim" of high-quality, patient-centered, cost-effective care.50

KEY POINT

> **Incentives to improve health-care quality would be eliminated**

In addition, the ACA ties payment incentives to health-care quality. Hospitals are rewarded for eliminating preventable patient harms and avoidable readmissions. Between 2010 and 2015, hospital readmissions for New Mexico Medicare beneficiaries decreased by 3%. New Mexico Medicare beneficiaries avoided an unnecessary return to the hospital in 2015 a total of 118 times.

MORBIDITY AND MORTALITY

Through the ACA, New Mexico has expanded health coverage to more of its residents than ever before. National studies have found that, by the end of 2015, the ACA has increased coverage, has reduced cost-related barriers to care and has been linked to increased use of preventive care, outpatient office visits, annual checkups and chronic disease care. Use of emergency departments for routine or non-emergent care has decreased.[1] In addition, adults living in expansion states said they had experienced notable improvement in quality of care and health.[1–3]

KEY POINTS

- **Use of emergency departments for routine or non-emergent care would increase**
- **If Medicaid expansion is eliminated, approximately 1323 preventable deaths are projected to occur each year in that population.**
- **Additional excess deaths would occur among those who lost private coverage**

There is ample evidence that health insurance reduces mortality. Wilper and colleagues[1] found that nearly 45,000 deaths per year in the United States could be attributed to lack of health insurance. Their results were consistent with a 1993 study, which showed that lack of health insurance increased mortality risk by 25%.[51] A 10-year longitudinal study of mortality in Massachusetts after implementation of "Romneycare," the bipartisan insurance model that formed the basis for the ACA, found that insurance coverage reduced death rates by about 30 percent.[27] Researchers found that for every 830 people who gained public or private insurance, one death was prevented each year.

Similarly, Medicaid expansion under the ACA has been associated with a decrease in mortality. Sommers and colleagues found that for every 176 people covered by Medicaid, one death is prevented per year.[3] If this ratio is applied to New Mexico, and the 233,000 New Mexicans who gained health insurance under Medicaid were to lose coverage, approximately 1,323 preventable deaths would occur each year in that population. This does not include excess deaths for those who lose coverage under the exchange.

HOSPITALS AND HEALTH SYSTEMS

In medically underserved communities, Medicaid is the largest source of revenue for health-care providers.[42] Dramatic reductions in Medicaid enrollment would lead to an increase in uncompensated care – health care that is delivered but not paid for – for New Mexico's safety-net hospitals. Pre-ACA support structures for uncompensated care, including New Mexico's Medical Indigent Fund and the federal Disproportionate Share Hospital (DSH) program, have been largely dismantled and are being phased out. Before implementation of the ACA, New Mexico received $20 million in federal DSH funds, which was supplemented by an approximately 31% state match, providing a total of $30.1 million to New Mexico's hospitals in 2014; an amount that would be almost halved by

KEY POINTS

- **Hospitals would be required to provide more uncompensated care, placing them at financial risk and forcing them to reduce services**
- **Community health centers would be required to provide more uncompensated care with insufficient reimbursement to cover expenses**

2020 to $17 million.[39] Proposals for replacement are in disagreement about approaches to DSH funds. Out of six replacement proposals for the ACA, two would repeal the DSH phase-out altogether, one would create a national pool of uncompensated DSH funds beginning in 2021, two would leave the phase-out in place, and one does not specify.[52]

Community Health Centers would also lose significant revenue and resources in the advent of ACA repeal. Health centers form the backbone of New Mexico's primary care system. Through the ACA, community health centers in New Mexico have received $97,954,000 to provide primary care, establish new sites, and renovate existing centers to expand access to quality health care. New Mexico has approximately 150 health center sites, which serve about 30% of the state's low-income population, including 17% of Medicaid enrollees.[7] The AHCA increases funding to the nation's community health centers by $442 million in 2017. This amount would not offset losses health centers would incur were expanded Medicaid to be eliminated. Health centers would be required to deliver more uncompensated care as more low-income residents became uninsured.

PREVENTION AND PUBLIC HEALTH

The AHCA and other Republican repeal efforts eliminate Section 101 of the ACA, which provides funding for disease and injury prevention activities, including the capacity to respond to public health emergencies. ACA repeal would lead to a 12% reduction in budget for the federal Centers for Disease Control and Prevention (CDC); these cuts would be passed on to states. New Mexico would lose at least $43,257,135 in prevention funding over the next five years, according to an analysis from Trust for America's Health. Those funds are designated for health security to combat disease outbreaks, disasters, and bioterrorism; prescription painkiller overuse and heroin use; obesity and diabetes; and declining life expectancy.53

KEY POINT

> **New Mexico would lose at least $43,257,135 in prevention funding over the next five years[53]**

If the fund were cut, it would result in:

- **A 50% cut in funding for the Section 317 vaccines program**, the largest vaccines program in the nation. The fund works to ensure an adequate supply of vaccines to clinics, helps pay for vaccines for people who cannot afford them, and mobilizes responses to outbreaks of vaccine-preventable diseases
- **An 80% cut in funding for cardiovascular disease prevention programs**. Evidence-based education and health programs that help people learn about heart-healthy living and change their behaviors. This is especially concerning for New Mexico, where a high diabetes rate combines with other cardiovascular risk factors such as obesity, sedentary lifestyle, and poor diet. In addition, evidence is growing that poor cardiovascular health is linked to Alzheimer's disease and other forms of dementia, a growing concern for New Mexico's aging population.[54]

- **A 100% cut in the Emerging Infections Program.** The Prevention and Public Health Fund provides 100% of funding to prevent health-care associated infections in hospitals. No currently described replacement plan addresses this critical public health issue. Nationally, CDC data show there were an estimated 722,000 hospital-acquired infections in 2011, resulting in 75,000 deaths.[55] Recently released CDC data show overall improvement nationally and in most states, with inconsistent improvement on individual measures, between 2011 and 2014. New Mexico's hospitals perform poorly on almost all measures, compared to national benchmarks, but by 2014 saw a 45% decrease on central line-associated bloodstream infections and a 58% decrease in methicillin-resistant *Staphylococcus aureus* (MRSA) infections.[56] Other measures, such as *Clostridium difficile* infections, increased significantly. It is likely that without the program, New Mexico's hospitals would perform even more poorly.

TAXES

Repeal of the ACA would increase taxes on low and middle-income New Mexicans by taking away tax subsidies provided by the ACA for insurance coverage. In contrast, high-income New Mexicans would benefit from a repeal of the ACA's Medicare taxes. The ACA requires individuals with annual income of more than $200,000, and couples with annual income greater than $250,000, to pay an additional 0.9% hospital insurance tax on earnings above these amounts. They also pay a 3.8% tax on investments and other unearned income above those thresholds. Unearned income includes capital gains, dividends, taxable interest, and royalties.

KEY POINT

- **Taxes for low- and middle-income New Mexicans would increase under all ACA replacement proposals**
- **Taxes for high-income New Mexicans would decrease**

Researchers from the Center on Budget and Policy Priorities estimate the top 400 earners in the nation would receive benefits of an average of $7 million each annually, totaling $2.8 billion – roughly equivalent to ACA subsidies in the 20 smallest states and Washington DC.[57]

ECONOMIC IMPACT

Researchers at the Economic Policy Institute[25] estimated changes in spending that would result from the spending cut and tax cut that are at the heart of efforts to repeal the ACA. Based on their models, of all states, New Mexico would rank fourth in shouldering the relative economic burden of ACA repeal.

KEY POINTS

- **New Mexico would rank fourth in shouldering the economic burden of ACA repeal**
- **Nearly 32,500 New Mexicans would lose their jobs**
- **75% of job losses would be outside of the health-care sector**
- **New Mexico would lose more than $2 billion in federal revenue**

Annual spending cuts in New Mexico would include 1) $2,201,000,000 in federal dollars for Medicaid payments, 2) $77,000,000 in premium subsidies,

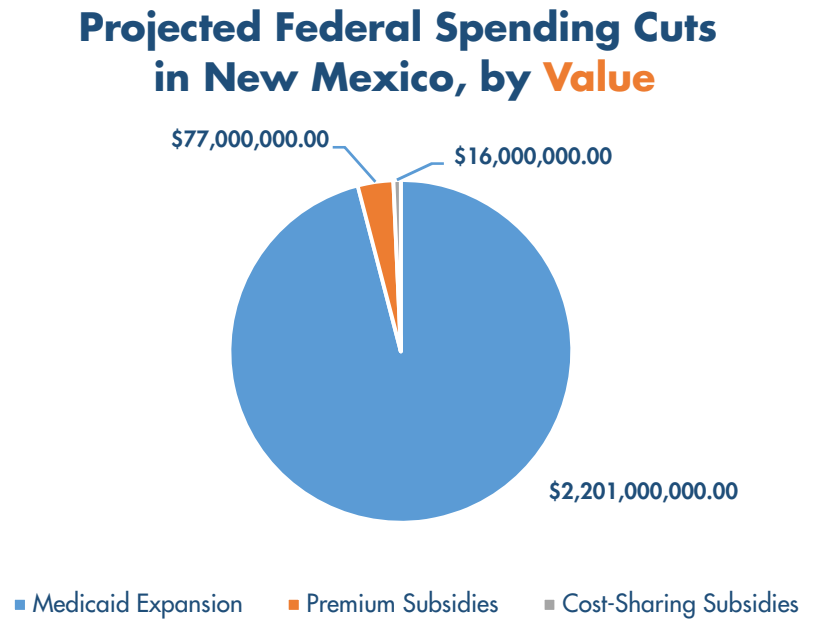

Figure 2: Federal spending cuts under ACA repeal, by value, New Mexico. Source: Economic Policy Institute. Http://www.epi.org/publication/repealing-the-affordable-care-act-would-cost-jobs-in-every-state/

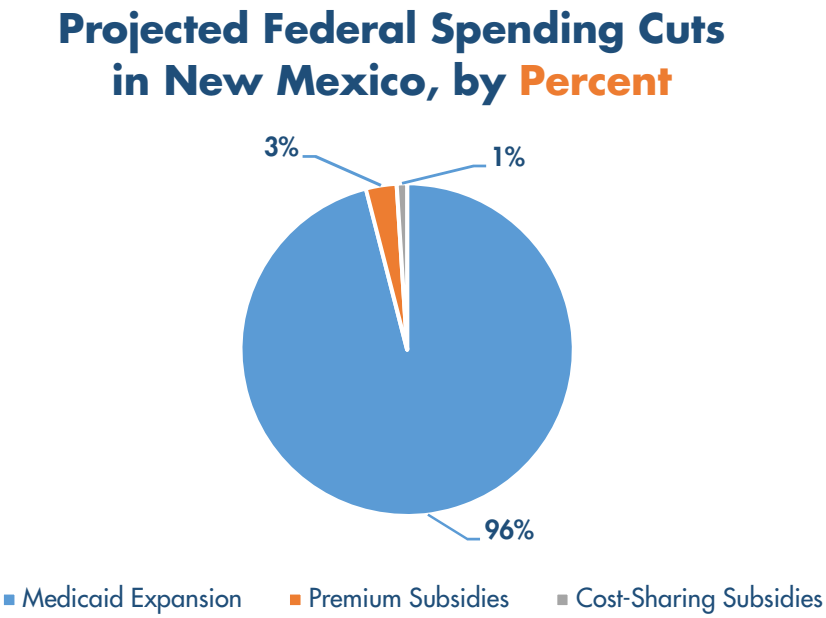

Figure3: Federal spending cuts under ACA repeal, by percent, New Mexico. Source: Economic Policy Institute. Http://www.epi.org/publication/repealing-the-affordable-care-act-would-cost-jobs-in-every-state/

and 3) $16,000,000 in cost-sharing subsidies (see Figures 1 and 2). Thus, New Mexico would lose a total of nearly $3 billion ($2,294,000,000) in federal revenue. Tax cuts would add $292,000,000 to the state economy, bringing the net loss to $2,002,000,000.

These spending cuts would profoundly affect employment, EPI investigators observe, because there is currently "productive slack" in the U.S. economy. That is, Americans are not spending as much as they would be if all resources, including workers, were fully employed. The gap in spending, called the *aggregate demand*, limits the economy's growth rate. If the federal government were to suddenly stop spending on Medicaid expansion and health care subsidies, that gap would grow suddenly and exponentially, leading to job loss. In addition to losing access to health care and financial security, "tens of millions of Americans"[25] would also face job loss. In New Mexico, 32,494 jobs would be lost by 2019, while tax cuts could lead to 641 jobs gained. The net job loss would reach 31,853, representing 3.9% of all jobs in New Mexico (see Figure 3). Job losses would spill across sectors, with up to 75 percent of losses outside of health care.[25]

These estimates do not include the additional impact of untreated illnesses in low income populations, such as individuals' decreased productivity or inability to work. Nor does it include prevention funding for public and population health activities and system redesign, health-

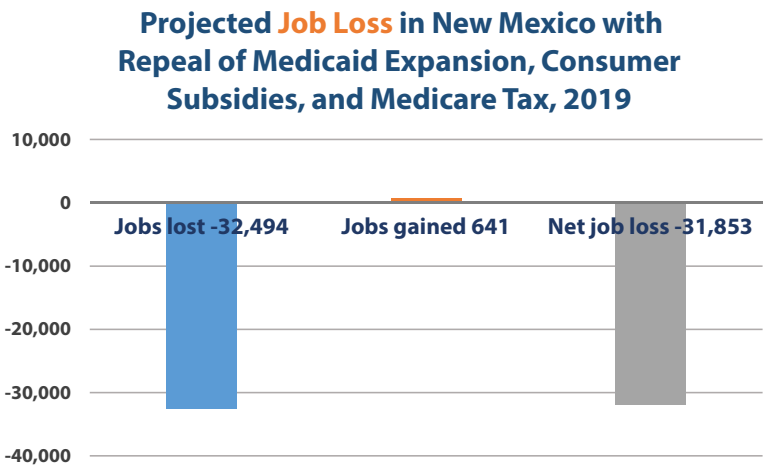

Figure 4: Projected Job Loss in New Mexico with ACA Repeal. Data Source: Economic Policy Institute. http://www.epi.org/publication/repealing-the-affordable-care-act-would-cost-jobs-in-every-state/

care workforce development, and investments in community health centers.

Employers, too, would see significant losses under repeal, as they would no longer receive subsidies for insuring their employee (who, in many cases, are themselves). New Mexico is home to more than 155,000 small businesses, 121,000 of which do not have employees.[58] Small businesses employ more than half of the state's private workforce and make up more than 95% of all employers in the state.[58] These businesses rely heavily on the ACA's tax credits and Medicaid expansion to provide coverage to workers and owners. Small businesses and their employees will be disproportionately affected by repeal of the health-care law. Before the ACA, small business owners paid an average 18% more than larger businesses for health-care coverage; their workers represented a disproportionate share of the uninsured. Since 2010, however, the increase in small business health-care costs has been at the lowest level in years.

HEALTH-CARE WORKFORCE

New Mexico has historically faced shortages in health-care provider availability. Of New Mexico's 33 counties, 32 are federally designated as primary care Health Professional Shortage Areas (HPSAs) by the Health Resources and Services Administration (HRSA); all 33 are dental health and behavioral health HPSA. New Mexico is home to two medical schools, four primary care residency programs; 25 schools of nursing, one physician assistant program, and multiple training programs for allied health professionals including emergency medical technicians, radiology technicians, occupational and physical therapists, etc.

KEY POINTS

- New Mexico would lose more of its already sparse health-care workforce
- Funding for medical training programs in New Mexico would be jeopardized
- Cuts to the National Health Service Corps would reduce the health-care workforce, especially in rural areas of the state

The ACA increased federal support for the National Health Service Corps, which provides loan forgiveness to health professional students in return for their agreement to practice in underserved areas. The number of primary care providers in the National Health Service Corps has more than doubled since 2008, the result of the Recovery Act and the Affordable Care Act.[7] Grants to states through the National Health Service Corps State Loan Repayment Program have increased 50 percent.

CONCLUSION

Repeal of the ACA would have far-reaching and negative consequences for every facet of life in New Mexico. While most discussion about the ACA focuses on loss of health coverage, this research shows that the effects would go far beyond the financial and health effects of lack of health insurance. The complex policy levers enacted by the ACA have increased coverage, improved health-care quality, and reduced growth in costs of both health-care delivery and coverage premiums. The law has strengthened the state's prevention efforts, primary care systems, and health-care workforce, as well as the overall economy.

The implications of repeal include loss of health coverage, damage to health-care systems, providers, insurers, and patients, and serious economic challenges throughout New Mexico. Increased taxes on low and middle income New Mexicans, combined with significant job loss, would increase poverty and have a potentially destabilizing effect on the state's entire economy.

This analysis suggests that ACA is an investment in the infrastructure of health care in New Mexico, an infrastructure as real and concrete as the roads, parks, transportation systems, and other public goods that we share. Seen in this light, health-care is a common good that strengthens our communities, economy, and enables people to live productive, full lives. Wholesale or partial repeal of the ACA would harm New Mexico significantly, from both health and economic standpoints. Rather than repealing the Act, New Mexicans should advocate for strengthening it to meet the needs of rural and frontier residents and broadening its protections.

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