The Health Security Act: New Mexico's Coming Single-Payer Health Care Disaster?

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Introduction

Policymakers in New Mexico, like those in many other states, are considering major reform of the state's health care system. Three comprehensive plans have been put forth here in New Mexico. Among the options New Mexico's policymakers are seriously considering is the Health Security Act.

Sponsored in the most recent legislative session by State Senator Carlos Cisneros and Representative Roberto Gonzales, the Health Security Act would create a single-payer health care system in New Mexico. It has the support not only of activist groups such as Health Security for New Mexicans Campaign and Health Action New Mexico, but also the 11 of the 19 members of Governor Bill Richardson's task force on health insurance reform, the Health Coverage for New Mexicans Committee.

The prospect of a single-payer system is seductive. It promises to offer every New Mexican health insurance coverage. It also simplifies the health care payment system, turning the state government into the primary payer of health care expenses. And as an analysis completed by Mathematica Policy Research Inc., has suggested, the Health Security Act would, if adopted, supposedly be the "least costly plan" of the reform initiative currently under consideration in New Mexico.[1]

Even if health care does indeed become "least costly" under the Health Security Act, that does not mean it will be "inexpensive." The Health Security Act creates a massive third-party payer system that pays for relatively generous health care benefits. Under such a system, patients will have incentives to over-use health care services, leading to a rapid rise in costs. That will, in turn, put pressure on the state budget, causing politicians to look for ways to control health care costs. Inevitably, that will result in the rationing so common in countries that have single-payer health care systems: waiting lists, cancelled surgeries, and delays in the adoption of new treatments.

Health Security Act: Is it Single-Payer?

Senator Cisneros has stated that the Health Security Act is "not a single-payer" option. That is true if one uses a strict definition of the term single-payer in which the government is *the only* payer of health care expenses. The Health Security Act will not provide coverage for

those employees who work for companies that self-insure, for Indian Tribes, military personnel, or those who are in Medicaid's long-term care program. Nor will it be the primary source of coverage for those on Medicare.

Yet most countries in the world that have health care systems dubbed single-payer actually have at least a small percentage of health care expenses paid for by private payers; In Sweden, for example, private insurance accounts for about 3% of health care expenses. Thus, in practice single-payer has come to mean a system in which the government is the *dominant* payer of health care expenses, usually paying up to at least 80% of such expenses.

Applying that definition, single-payer is an apt description the Health Security Act. Excluding the Medicare population, Mathematica Policy Research estimates that over 94% of New Mexico's population will be covered by the Health Security Act.[2] Even if the Medicare population is included, the Health Security Act will cover about 80% of New Mexico's population.[3] Covering 4 out of every 5 New Mexicans will mean that the Health Security Act will be the dominant payer in the state of New Mexico, making it, in effect, a single-payer system.

Structure

To implement the Health Security Act, the legislation establishes a "Health Care Commission." The Commission is to be comprised of fifteen members, nominated from a special nominating committee and appointed by the Governor. Five members of the committee will represent health care providers or facilities while the other ten will represent consumer and employer interests, the majority of whom must represent consumer interests. The Commission appoints a full-time "Chief Executive Officer" (CEO) who is charged with carrying out the daily operations of the Commission and the Health Security Act. The CEO may hire the necessary staff to help him or her implement the legislation.

Such a commission would have broad powers over the health care system in New Mexico, including, but not limited to:

- adopting a five-year plan for the initial implementation of the Health Security Act;
- designing a health security plan to fulfill the purposes of the Health Security Act;
- adopting other long- and short-range plans as needed; establishing reimbursement methods for health care providers and facilities;
- negotiating and entering into contracts with health care providers and facilities; establishing annual budgets for the Health Security Act;
- approving capital expenditures for a health facility and establishing capital budgets for health facilities;
- adopting a preferred-drug list (formulary),
- bulk purchasing or some other method for providing prescription drugs;
- establishing and making changes in the coverage and benefits offered under the health security plan;

- and making changes in the health security plan subject to approval by the legislature.

All persons who have been a resident of New Mexico for at least one year will automatically enrolled in the insurance program set up under the Health Security Act. The exceptions are those who are enrolled in Medicare, the Indian Health Service, the Veteran's Administration, or with an employer who has a self-insured plan. Everyone else in New Mexico must be covered by the Health Security Act; they are not permitted to buy private health insurance in lieu of the benefits provided under the Health Security Act.

Individuals in New Mexico who have not met the one-year residency requirement can still participate by paying a premium. Recipients of state health care programs like Medicaid and SCHIP will be folded into the Health Security Act. The Commission also will have the authority to negotiate with the U.S. Department of Health and Human Services to provide supplementary coverage for Medicare beneficiaries. Anyone covered by the Health Security Act will have the option of purchasing supplemental coverage from private insurance companies.

Funding

The Health Security Act is somewhat vague on how it will be funded. While the plan is to divert money currently used for state public programs like Medicaid and SCHIP to fund the Health Security Act, that will not be sufficient to pay for the health expenses for every person the Act expects to cover. Thus, where will the remainder of the funding come from?

The Health Security Act punts that question over to the Finance Committee of the State Legislature, saying that it "shall determine financing options for the health security plan."[4] It permits the Finance Committee to "set minimum and maximum" premium levels that beneficiaries must pay based on income, a "sliding scale premium," and to allow employers to cover their employee's premiums.[5] Beyond that, the only condition that the Health Security Act imposes on the Finance Committee is that funding must be sufficient to cover benefits equal to the "health care coverage afforded state employees."[6]

Clearly, the authors of the Health Security Act envisioned that New Mexicans with sufficient income would pay a "premium" to help finance the Health Security Act. The premium would act much like a tax in that all New Mexicans who made sufficient income and were not exempt from the Health Security Act would be forced to pay the premium. Yet there is nothing in the Health Security Act that requires the Finance Committee to structure the funding in that manner. The Finance Committee could increase income or sales taxes to pay for the Health Security Act, or impose a payroll tax on employers and employees.

However it is funded, one thing is clear: beneficiaries will not be spending their own money directly on health care services. Rather, they will be paying the State of New Mexico and the state will in turn use that money to provide benefits. As will be shown below, this sort of

funding scheme, commonly known as a third-party payer system, will cause health care costs to rise at an unsustainable rate in the long term.

Benefits

Every person covered by the Health Security Act will receive the following benefits:

-Preventive health services;
-Health care provider services;
-Health facility inpatient and outpatient services;
-Laboratory test and radiology procedures;
-Hospice care;
-In-home, community-based and institutional long-term care services;
-Prescription drugs;
-Inpatient and outpatient mental and behavioral health services;
-Drug and other substance abuse services;
-Preventive and prophylactic dental services, including an annual dental examination and cleaning;
-Vision appliances, including medically necessary contact lenses;
-Medical supplies, durable medical equipment and selected assistive devices, including hearing and speech assistive devices;
-Experimental or investigational procedures or treatments as specified by the Commission.

The Health Security Act allows the Commission to "establish a co-payment schedule if a required co-payment is determined to be an effective cost-control measure."[7] If the Commission does not adopt a co-payment schedule, then beneficiaries will have "first-dollar" coverage for their benefits. First-dollar coverage will impose no demand constraints on beneficiaries.

Co-payments in private sector insurance have proven a poor restraint on beneficiaries' demand for benefits. Thus, a system of co-payments will likely do little to restrain the demand of beneficiaries under the Health Security Act. The benefit structure of the Health Security Act, combined with how it is funded, will inevitably lead to rising health care costs that will put tremendous pressure on the New Mexico state budget.

The Cost Explosion

Should New Mexico enact the Health Security Act, health care costs will increase quickly, putting tremendous strain on the state budget. The reasons are two-fold: First, the Health Security Act adopts most of the dysfunctional parts of a payment system that causes large cost increases in the private-sector and public programs like Medicare and Medicaid. Second, it eliminates the only portion of the private-sector payment system that puts any downward pressure on health care costs.

The biggest driver of costs in the U.S. health care sector is its "third-party payer" system. A third-party payer system is one in which the consumer does not pay the provider directly. Rather, a "third-party" pays the provider for the services used by the consumer. In the case of health care, a third party, usually in the form of private insurance company or a government health-insurance program, pays providers such as hospitals and doctors for the costs incurred by patients.

Thanks to the federal tax code in which employees get a tax break for buying health insurance (but only if they purchase it through their employer) and to the massive government health-insurance programs Medicare and Medicaid, America's health care system is dominated by third-party payers. Furthermore, since every extra dollar spent on health insurance purchased through an employer is tax free, the tax code encourages employees to purchase more generous insurance coverage. As a result, much of what passes for health insurance isn't really health insurance but "pre-paid health care." Insurance, in the traditional sense, is supposed to cover catastrophic costs—unexpected illnesses that result in large health care expenses. However, most health insurance policies cover "routine" care, such as doctor's visits and lab tests.

This leads to an enormous amount of inefficiency and waste. In a third-party payer system, patients perceive that "someone else" (i.e., their private insurance company or the government) is paying for their health care, and thus they overuse it, especially routine care. Since providers such as hospitals and physicians are not paid directly by the patient, they have little incentive to innovate and find ways to make the care they provide both cheaper and more convenient. Insurance companies also waste expenditures on processing the claims for routine care, expenditures that would be eliminated if patients paid for routine care directly. As a result, health care costs grow quickly in a third-party payer system, surpassing growth in inflation and wages.

Research conducted by the RAND Corporation bears this out. In a study conducted by Joseph P. Newhouse for RAND, thousands of families were assigned to different types of insurance plans, ranging from ones that provided care at no cost to the participant to cost-sharing plans with deductibles as high as $1,000. The differences in health status among the participants in the different plans were minimal, but the differences in use of care were quite large. The "results show that the 40 percent increase in services on the free-care plan had little or no measurable effect on health status for the average adult."[8] Giving people coverage with no cost sharing substantially increases the use of care, most of it producing no added health benefits.

The Health Security Act does not permit the Commission to establish high deductibles as a cost-control measure. As noted above, it is only permitted to establish co-payments, a cost-control measure that has proven ineffective in the private sector. Rather, the Health Security Act will create a giant, centralized third-party payer system for health care in New Mexico. New Mexicans will pay their taxes or premiums for their coverage under the Health Security Act to the state government. Under the Health Security Act, residents of New Mexico will

perceive that the state government is paying for their routine health care. When a patient visits a health care provider in New Mexico, the state government will pay the provider for the visit. The Health Security Act adds to the problem by offering coverage for much routine care, such as doctor visits (outpatient care), laboratory test and radiology procedures, dental exams and cleanings, and vision ware such as glasses and contact lenses. That is a surefire recipe for a huge increase in health care costs.

Exactly *how big* of an increase is anyone's guess. Cost projections about government health care programs are notoriously inaccurate. In 1965, government actuaries forecast that Medicare would cost about $9 billion by 1990. It actually cost $66 billion that year.[9] New Mexico's Medicaid program should also give policymakers pause. The growth of New Mexico's Medicaid program averaged about 14 percent per year from 1995-2005. Medicaid has accounted for an ever-growing portion of the state budget, growing from 4.8 percent in 1995 to 9.4 percent in 2005.[10] The portion of the New Mexico budget consumed by Medicaid continues to grow.

The estimates of the cost growth of the Health Security Act in the Mathematica report when compared to recent state government revenue growth in New Mexico suggest that the Health Security Act would eventually put pressure on the state budget. The Mathematic report estimates that total health care expenditures under the Health Security Act would increase an average of 6.9 percent per year.[11] That outpaces revenue growth in New Mexico, which averaged 6.7percent from 1995-2005.[12] Over time, the Health Security Act would eat up an ever-larger portion of the state budget, much like Medicaid is currently doing.

Ultimately, the Health Security Act will force New Mexico's state politicians to either raise taxes or find ways to control health care costs. Yet taxes cannot be raised infinitely. Furthermore, raising taxes would likely prove unpopular with voters. Thus, politicians would eventually pressure the Commission to look for ways to control costs.

Will the Health Security Act Save Money?

Mathematica Policy Research, Inc., a respected research firm, released a report in June of this year examining the Health Security Act along with two other reform proposals and compared them to New Mexico's current health care system. Mathematica estimated that the Health Security Act, in its first year, would cost between $63 million and $209 million *less* than the current system. The report also shows that the Health Security Act could save over $2.4 billion by 2011 compared to the current system.[13]

Yet Deborah Chollet, the lead author of the report, conceded that the report was based on "heroic" assumptions. She claimed "the models assumed things would happen in New Mexico that have never happened anywhere else – for example, an ability to slow medical costs."[14] According to the report,

> …because all of the reform models would attempt to address medical cost

> growth, we presume that all would succeed at least modestly in doing so. By reducing medical cost growth just one percentage point below projected current-case rates, all of the reform models would either reduce total costs absolutely by 2011 or come within a few percentage points of the projected total cost of health care in the current case. [15]

This is a highly dubious assumption, especially considering that the 432,000 uninsured New Mexicans (estimated by the report) would now receive coverage. That insurance coverage increases the use of health care is well established in the academic literature.[16] Giving nearly 22 percent of New Mexico's population access to health insurance with few cost constraints is a surefire way to increase health care spending.[17]

The report also assumes that savings will be generated by lower administrative costs due to the fact that the Health Security Act would reduce the number of payers in New Mexico's health care system. The report estimates that administrative costs would be between 9.9 and 10.2 percent of total health care costs, lower than the 13.5 percent of the current system.[18] This assumption is dubious as well because, as examined below, the Health Security Act establishes a claims review process to control health care costs.

Controlling health care costs in this manner would likely require substantial administrative costs. How much? Consider than between 1995-2000, private health insurance payments to health care providers rose at a real annual rate of 15 percent, while private administrative costs rose at a real annual rate of 6.8 percent. From 2000-2005, private insurance payments to health care providers rose at a much lower rate of 5.6 percent. But private administrative costs rose at 11 percent annually.[19] Thus, the private sector had to *increase* its rate of spending on administrative costs to slow its cost of payments to health care providers. If the Health Security Act is to control health care costs, then administrative costs will likely have to increase.

Yet the Health Security Act's ability to control health care costs is dependent upon the citizens of New Mexico accepting its claims review process. If history is any guide, they will not tolerate for long.

Cost Control: Managed Care

One way that the Commission might try to control costs is by functioning like a giant "managed care" company. The early 1990s were the heyday of managed care health insurance companies. The health maintenance organization (HMO) was the dominant form of managed care. Facing runaway health insurance costs at the end of the 1980s, employers were looking for a more frugal approach. HMOs won the day with promises of reducing unnecessary health expenses by managing care. The switch to managed care seemed to work. Increases in health insurance costs experienced a sharp decline in the early to mid-1990s .[20]

There was only one problem: HMOs were unpopular with their members. HMOs managed health expenses by denying care, to the ire of patients. Studies showed that satisfaction among patients enrolled in HMOs was much lower than those enrolled in other types of insurance, such as traditional indemnity or fee-for-service.[21] By the beginning of this decade, enrollment in HMOs had declined while enrollment in less restrictive types of managed care, like preferred provider organizations, increased.[22]

The Health Security Act gives the Commission considerable power to transform New Mexico's health care system into one giant HMO. First, the Health Security Act declares that the Commission "shall adopt rules to provide a comprehensive claims review program."[23] The "final decision to deny payment for services based on medical necessity or utilization shall be based on a recommendation made by a health care professional having appropriate and adequate qualifications to make the recommendation."[24] If the Commission is serious about claims review, it will likely have to employ health care professionals whose full-time job will be to review claims.

Another hallmark of HMOs that is present in the Health Security Act is the "gatekeeper." A gatekeeper is a health care professional, usually a primary care physician, whose approval is necessary before a patient can see another health care professional, such as a cancer specialist. Under the Health Security Act, primary care physicians act as gatekeepers. It states that "health care provider specialists shall be paid pursuant to the health security plan only if the patient has been referred by a primary care provider."[25]

Presumably, the intent of these provisions in the Health Security Act is to keep health care costs under control in New Mexico. Yet it is doubtful that over the long-term that objective can be achieved. If the experience of the 1990s is any indication, a giant state-run HMO would prove very unpopular with patients in New Mexico. Those patients, of course, are also voters who would surely complain to their elected representatives about being denied care. Feeling the pressure from voters, state legislators would in turn apply pressure to the Commission to relax its claims review process. The end result is that few claims would be denied.

Such pressure would also likely lead to a removal of gatekeepers. The Health Security Act also states that the Commission "shall by rule specify when and under what circumstances a beneficiary may self-refer."[26] With sufficient political pressure, the Commission would eventually dilute the rules to the point that a beneficiary could self-refer under most any circumstances.

Ultimately, the Commission will be unable to restrain demand for health care in New Mexico. As a result, health care costs will continue to rise, putting tremendous pressure on the state budget. To keep costs from exploding, the Commission will have no other option but to ration care.

Cost Control: Rationing Care

Countries that have single-payer health care systems ration care using waiting lists, canceling of surgeries and by delaying access to new treatments such as prescription drugs. The results can be tragic:

- In Canada, Diane Gorsuch waited over two years for a surgery to fix the clogged arteries leading to her heart. She twice had appointments to get that heart surgery. Both appointments, however, were cancelled. Before her third appointment came, she suffered a fatal heart attack.[27]

- In Great Britain, Mavis Skeet had her cancer surgery cancelled four times before her cancer was determined to have become inoperable.[28] Another Brit, Brian Booy, became the ultimate victim of bureaucracy in that he was finally assigned an appointment for bypass surgery a year after he died from a heart attack.[29]

- Swedish Prime Minister Goran Persson had to wait for eight months for a hip replacement. As a result he suffered in great pain and was unable to perform some of his governmental duties.[30] The latest data shows that about 60 percent of Swedish patients needing a hip replacement wait more than three months.[31]

- Alice Mahon, a former member of the British parliament, needs the drug Lucentis to slow her macular degeneration. Because of delays due to the National Health Service not yet having approved Lucentis at the time of her diagnosis, Mahon lost much of the sight in her left eye.[32]

- In Australia, eight-year-old Kyle Inglis has lost 50 percent of his hearing while waiting nearly 11 months for an operation to remove a tumor in his ear. Kyle is one of over 1,000 children waiting over 600 days for ear, nose and throat surgery in Warnbro, a suburb in Western Australia.[33]

These are just a few of the stories about rationing in countries with single-payer systems. It is difficult to fathom that these industrialized, democratic nations would permit their public health-care systems to treat some of the most severely ill so poorly. But, as health care expert John Goodman explains, such stories are the necessary result of a publicly financed health care system combined with democratic governance:

> Countries with national health insurance limit health care spending by limiting supply. They do so primarily by imposing global budgets on hospitals and area health authorities and skimping on high-tech equipment. The result is rationing by waiting….

> The characteristics described above are not accidental byproducts of government-run health care systems. They are the natural and inevitable consequences of placing the market for health care under the control of politicians. Health care delivery in countries with national health insurance does not just happen to be as it is. In many respects, it could not be otherwise….
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> Why do national health insurance schemes skimp on expensive services to the seriously ill while providing so many inexpensive services to those who are only marginally ill? Because the latter services benefit millions of people (read: millions of voters), while acute and intensive care services concentrate large amounts of money on a handful of patients (read: small numbers of voters). Democratic political pressures in this case dictate the redistribution of resources from the few to the many.[34]

Should New Mexico follow the path of nations that have traveled the single-payer route, patients will find it relatively easy to get a visit with their primary-care physician, since a large number of voters have routine doctor's visits during any given year. However, far fewer voters will need more expensive treatments and procedures, such as heart surgery, hip replacements, or chemotherapy in any given year. Faced with ever increasing budget costs due to the Health Security Act, politicians will have to control costs, but they will want to do so in ways that anger the fewest voters. As the experience of other nations show, that will mean rationing.

A brief statistical look at other nations demonstrates the depth of the problem. In Britain, the most recent data shows about 784,000 people waiting for surgery and 52,000 cancelled surgeries.[35] About 50 percent of patients in Sweden wait longer than three months for surgery.[36] In Canada, estimates of the median wait times for treatment range from 11 weeks to 17.8 weeks.[37] The median wait time for elective surgery in Australia (not including any additional time waiting to see a specialist or receive a diagnostic procedure) is about one month.[38] A recent audit of waiting lists for elective surgery in Australia's Northern Territory found that 14 people who were on a waiting list were already dead.[39]

A plethora of academic research exists showing the health problems caused or exacerbated by rationing. A study of over 8,000 patients on a waiting list for cardiac catheterization in Ontario, for example, found that 107 experienced heart attacks while on the waiting list — 50 of whom died.[40] A study of Swedish patients on a wait list for heart surgery found that the "risk of death increases significantly with waiting time."[41] Another study in Sweden found that reducing waiting times reduced the heart surgery mortality rate from seven percent to just under three percent.[42] In a 2000 article in the journal *Clinical Oncology*, British researchers studying 29 lung cancer patients waiting for treatment further found that about 20 percent "of potentially curable patients became incurable on the waiting list."[43]

Waiting lists are cruel in other ways. Patients often experience great pain, anxiety and a deteriorating quality of life while waiting for surgery. An analysis of multiple studies on waiting lists for cataract surgery in Canada found that patients who had to wait more than six months suffered more vision loss, a reduced quality of life and more falls related to their condition.[44] Other Canadian studies have found that patients seeking bypass surgery suffer greater rates of anxiety, deteriorating physical and mental health and more post-operative problems the longer they are on a waiting list.[45] Then, there is the experience of families like those of Kyle Inglis, the Australian child mentioned above. A study of families waiting for pediatric surgery found that a whopping 94 percent reported the wait to be emotionally stressful for their family.[46]

An abundance of other research found adverse consequences for those on waiting lists for knee and hip replacements. In Britain, those patients who experienced the worst outcomes after their hip surgery tended to be on waiting lists longer than those who had better outcomes.[47] Research in Australia found that women waiting for hip and knee replacement experienced a lower health-related quality of life and high psychological distress.[48] A case study in Sweden found high rates of powerlessness, hopelessness and depression among patients on waiting lists for hip and knee replacement. One patient lamented, "I feel as though I've lost my human dignity. You get depressed and fed up with the pain. Still I try to be patient. But you lose the desire (to live)." She further complained of her treatment by the clinic where her surgery was to take place: "I felt so neglected, you get treated, yes, worse than an animal because you can take an animal to the veterinary… I feel so powerless."[49]

Then there is the delayed access to new treatments, such as prescription drugs. Due to price controls and other regulation, a Lewin Group study found that statins, a class of drugs for those with high cholesterol, were slow to be utilized in Europe in the 1990s. The study estimated that over a five-year period, this led to 28,000 preventable deaths in Germany, 26,000 in Italy, and 19,000 in the United Kingdom.[50]

Conclusion

The Health Security Act has all of the ingredients necessary for a health care policy debacle. It creates a giant third-party payer system for health care expenses while also offering a relatively generous benefit plan. This will give patients incentive to over-use health care, leading to a rapid rise in health care costs. Rising health care costs will strain the state budget, putting pressure on politicians to control health care expenses.

Eventually, politicians will have little choice but to ration health care. Such rationing will mean waiting lists for surgery, cancelled surgeries, and delays in approval of new treatments. Rationing will have a detrimental effect on the health of those who are the sickest among us. New Mexicans can avoid this future of health care rationing by rejecting the Health Security Act.

[1] Dianai Del Mauro, "Publicly Run Insurance Has Smallest Price Tag," *The Santa Fe New Mexican* (New Mexico), June 22, 2007, p. C-1.
[2] Deborah Chollet, Su Liu, Cheryl Falman, Beth Gillia, Paul Biderman, Lee Reynis, and William Wiese, "Quantitative and Comparative Analysis of Reform Options for Extending Health Care Coverage in New Mexico: Final Draft Report," Mathematica Policy Research, Inc., June 19, 2007, p. 45.
[3] Calculation based on data in Mathematica report except for date on New Mexico Medicare recipients which comes from U.S Census Bureau, "Historic Health Insurance Tables," Table HI-4, found at http://www.census.gov/hhes/www/hlthins/historic/hihistt4.html
[4] "House Bill 1222," 48th Legislature – State of New Mexico – First Session, 2007, Introduced by Roberto "Bobby" J. Gonzales, , p.54.
[5] *Ibid.*
[6] *Ibid.*
[7] *Ibid*., p.42.
[8] Joseph P. Newhouse and the Insurance Experiment Group, *Free For All? Lessons from the Rand Health Insurance Experiment*, Harvard University Press, 1993, p.243.
[9] Sue A. Blevins, *Medicare's Midlife Crisis*, Cato Institute, 2001, p.55.
[10]Author's calculations based on numbers from *State Expenditure Reports*, 1996-2006, National Association of State Budget Officials. Found at http://www.nasbo.org/publications.php. Calculations only included state expenditures; funding from the federal government was excluded.
[11] Deborah Chollet, et al, p. 62.
[12] Calculation of revenue growth based *The Fiscal Survey of the States*, various editions, National Association of State Budget Officials, found at http://www.nasbo.org/publicationsReport.php.
[13] Deborah Chollet, et al, p.64.
[14] Winthrop Quigley, "State Health Care Could Cut Costs," Albuquerque Journal, May 17, 2007, found at http://www.healthactionnm.org/about_us/news.php?ID=81
[15]Deborah Chollet et al, p.xviii.
[16] See, for example, Catherine E. Ross and John Mirowsky, "Does Medical Insurance Contribute to Socioeconomic Differentials in Health?" *The Milbank Quarterly,* 2000, Vol. 78, No. 2; H.R. Burstin, K. Swartz, A.C. O'Neil, E.J. Orav, and T.A. Brennan, "The Effect of Change of Health Insurance on Access to Care," *Inquiry*, Winter 1998-1999, Vol. 35, No. 4; and Marie C. McCormick, Barbara Kass, Anne Elixhauser, Joe Thompson and Lisa Simpson, "Annual Report on Access to and Utilization of Health Care for Children and Youth in the United States, 1999," *Pediatrics*, January 2000, Vol. 105, No.1.
[17] The Mathematica report attempts to account for increased costs due to the uninsured in New Mexico receiving coverage by using an "induction factor," which is a measure used to measure the change in total spending associated with a change in out-of-pocket spending. For example, an induction factor of 0.7 means that every one dollar decrease in out-of-pocket health care expenditures results in an increase of total health care expenditures of 70 cents. Yet the induction factors that the report uses are based on insurance status, poverty status, and location. What the report apparently does not account for is whether the uninsured are healthy or unhealthy. Healthy people who are uninsured use health care at much higher rates once they gain coverage than do people who are not healthy. (See, for example, Dhalia K. Remier and Adam J. Atherly, "Health Status and Heterogeneity of Cost-Sharing Responsiveness: How Do Sick People Respond to Cost-Sharing?" *Health Economics*, September 2002, Vol. 12, No. 4) By leaving health status out of the induction factors, the report is likely underestimating the cost of the Health Security Act.
[18]Deborah Chollet, et al, p.60.
[19]Calculations based on data from Aaron Catlin, Cathy Cowan, Stephen Heffler, Benjamin Washington and the National Health Expenditure Accounts Team, "National Health Spending In 2005: The Slowdown Continues," *Health Affairs*, January/February 2007, Vol. 26, No.1; and Katherine Levit, Cathy Cowan, Helen Lazenby, Arthur Sensenig, Patricia McDonnell, Jean Stiller, Anne Martin and the Health Accounts Team, "Health Spending In 1998: Signals Of Change," *Health Affairs*, January/February 2000, Vol. 19, No. 1.
[20] The Henry J. Kaiser Family Foundation, "Medicare: Medicare Spending and Financing," *Fact Sheet*, June 2007, found at http://www.kff.org/medicare/7305.cfm
[21] K Donelan, R J Blendon, J Benson, R Leitman, and H Taylor, "All Payer, Single Payer, Managed Care, No Payer: Patients' Perspectives in Three Nations," *Health Affairs,* 1996, Vol. 15, Issue 2; and . R. Rubin, B.

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[22] J Gabel, L Levitt, J Pickreign, H Whitmore, E Holve, D Rowland, K Dhont, and S Hawkins, "Job-Based Health Insurance in 2001:Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs*, September/October 2001, Vol. 20, No. 5.

[23] "House Bill 1222,", p.35

[24] *Ibid*., p.35-36.

[25] *Ibid*., p.34.

[26] *Ibid*.

[27] Stuart Browning, "Dead Meat", On the Fence Films, at http://www.onthefencefilms.com

[28] "Cancer Inoperable After Flu Delay," *BBC News*, January 13, 2000, found at http://news.bbc.co.uk/2/hi/health/602393.stm

[29] "Surgery a Year Too Late," *BBC News*, March 1, 2000, found at http://news.bbc.co.uk/2/hi/health/662651.stm

[30] Waldemar Ingdahl, "His Hip, Hooray!" *TCSDaily*, June 4, 2004, found at http://www.tcsdaily.com/Article.aspx?id=060404D

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