

OSI Health Insurance Brief (2)



The Uninsured Population in New Mexico

Health Care Access, Cost, and Quality Indicators Using the 2023 New Mexico Health Access Survey (NMHAS)¹

July 2025

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1. Introduction

OSI Health Insurance Brief 2 uses the NMHAS survey to present selected responses from the uninsured population's access, cost, and satisfaction with the service cost and quality and how these indicators may differ by ethnicity or region (Section 2). This access, cost, and quality and cost satisfaction information is not available from the ACS data.

In addition, the brief presents high-level comparisons of the uninsured population's access, affordability, and quality and cost satisfactions, as compared to the corresponding indicators for those with private and public insurance coverages (Section 3). This brief complements the OSI [Health Insurance Brief 1](#), which uses both the Census Bureau American Community Survey (ACS) and the 2023 New Mexico Health Access Survey (NMHAS) to analyze New Mexico's health insurance coverage by demographic characteristics and across different geographic areas in the state.

2. Access, Cost, and Quality and Cost Satisfaction, by Ethnicity and Region

This section utilizes uninsured responses to selected NMHAS questions with a focus on ethnic and geographic groupings' access, affordability, and quality and cost satisfaction. Similar analyses can be used for other comparisons, such as comparison by education attainment levels, gender, household income, or employment status of the uninsured population.

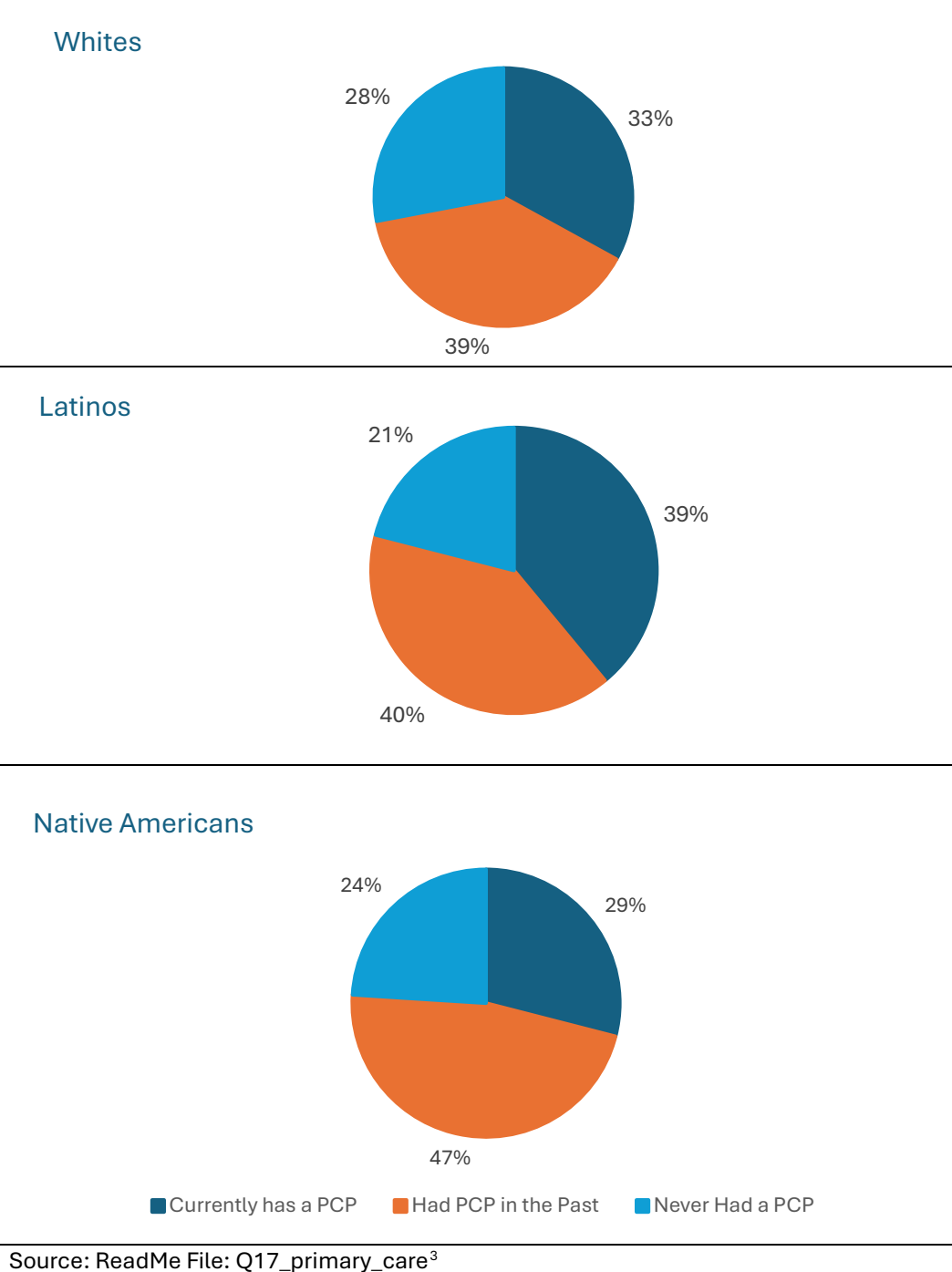
2.1. Access to Healthcare

Access to healthcare issues include having a primary care physician (PCP), visiting a healthcare provider, using mental healthcare services, and using telehealth services. Access to PCP care is essential for maintaining health and well-being and plays a vital role in disease prevention, chronic condition management, and early intervention, all of which help reduce the need for costlier treatments. Regular PCP access improves health outcomes through screenings, vaccinations, and coordinated care, while also reducing health disparities, particularly for underserved areas and reduces resort to emergency room services as a first source of receiving healthcare.²

In addition, this section presents the percentages of New Mexicans who indicate facing barriers to access, such as appointment wait times and inconvenient hours or locations. The analysis presents how these indicators differ by ethnicity or geographic area.

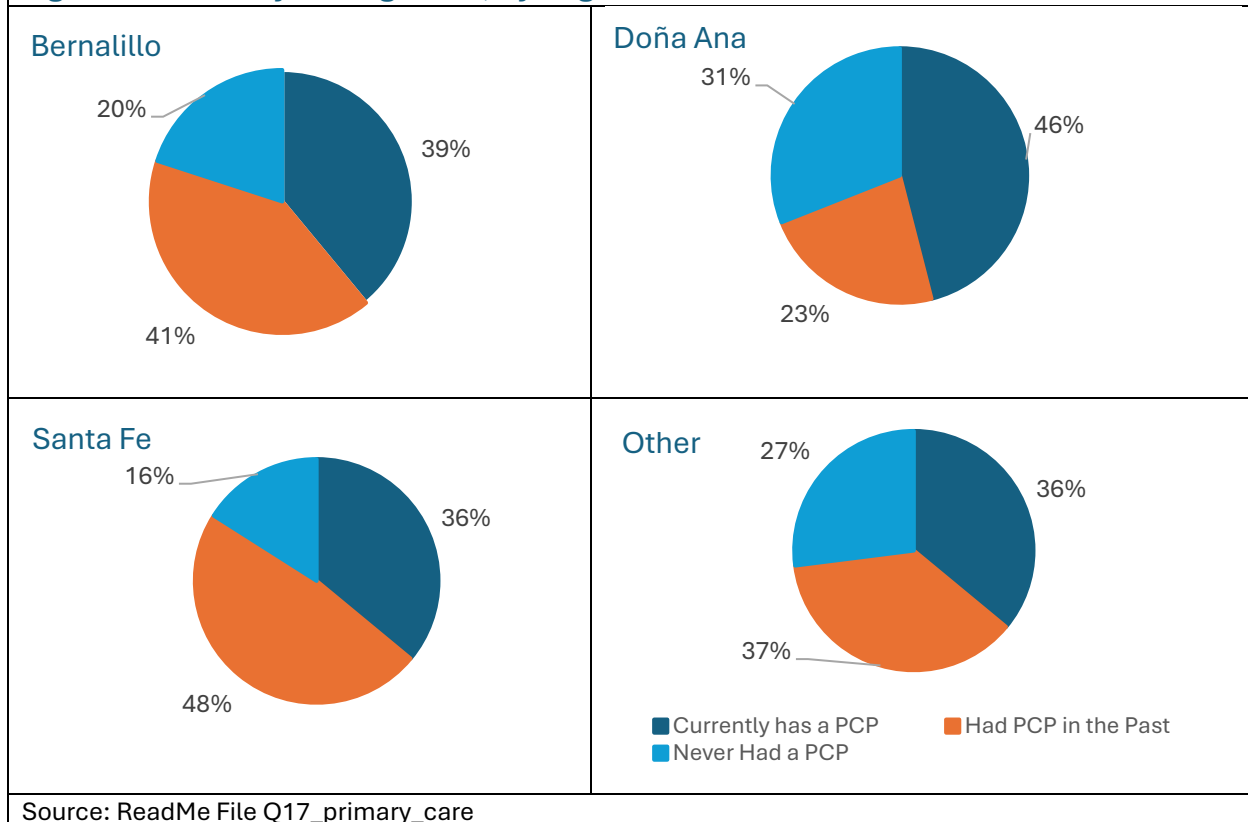
² Refer to Section 3.1 that compares access to PCP for the uninsured population, relative to the publicly- and privately insured populations, and the frequency of emergency room visits by insurance coverage type.

Figure 1: Currently Having a PCP, by Ethnicity



³ Refer to NMHAS ReadMe File and the NMHAS Survey Questionnaire File for the question/questions producing the results in each figure.

Figure 2: Currently Having a PCP, by Region



The uninsured respondents who have a PCP are between 30% and 40%, depending on ethnicity or geographic region. Regionally, Doña Ana has the highest rate (46%), Bernalillo is second at 39% and Santa Fe and Other tie at 36%. Ethnically, the highest rate is for Latinos who have a PCP (39%), followed by whites (33%), and then Native Americans at only 29%.

On the other end of the spectrum, the fraction of the currently uninsured who never had a PCP is around a quarter, with rates that range between 16% and 31%, depending on the ethnic group or the geographic region. This “Never-had-a-PCP” uninsured is likely to be the long-term uninsured, rather than the currently uninsured due to a temporary loss of insurance coverage, or the income-ineligible for Medicaid, etc. Given the one-point-in-time nature of the survey, the uninsured population that “had a PCP in the Past” and the uninsured who currently “Have a PCP”, represent 70% - 80% of the currently uninsured, and their uninsurance status may be temporary, or a result of normal loss of a PCP due to provider mobility, or a temporary provider shortage, or both.

Regarding actual utilization of healthcare services, Figures 3 and 4 present utilization of healthcare visits, telehealth, and mental health services by ethnicity and geographic regions. Figure 5 presents the results for selected access barriers such as wait and the inability to get an appointment at a convenient time or location, by ethnicity and region.

Figure 3: Healthcare Service Utilization, by Ethnicity

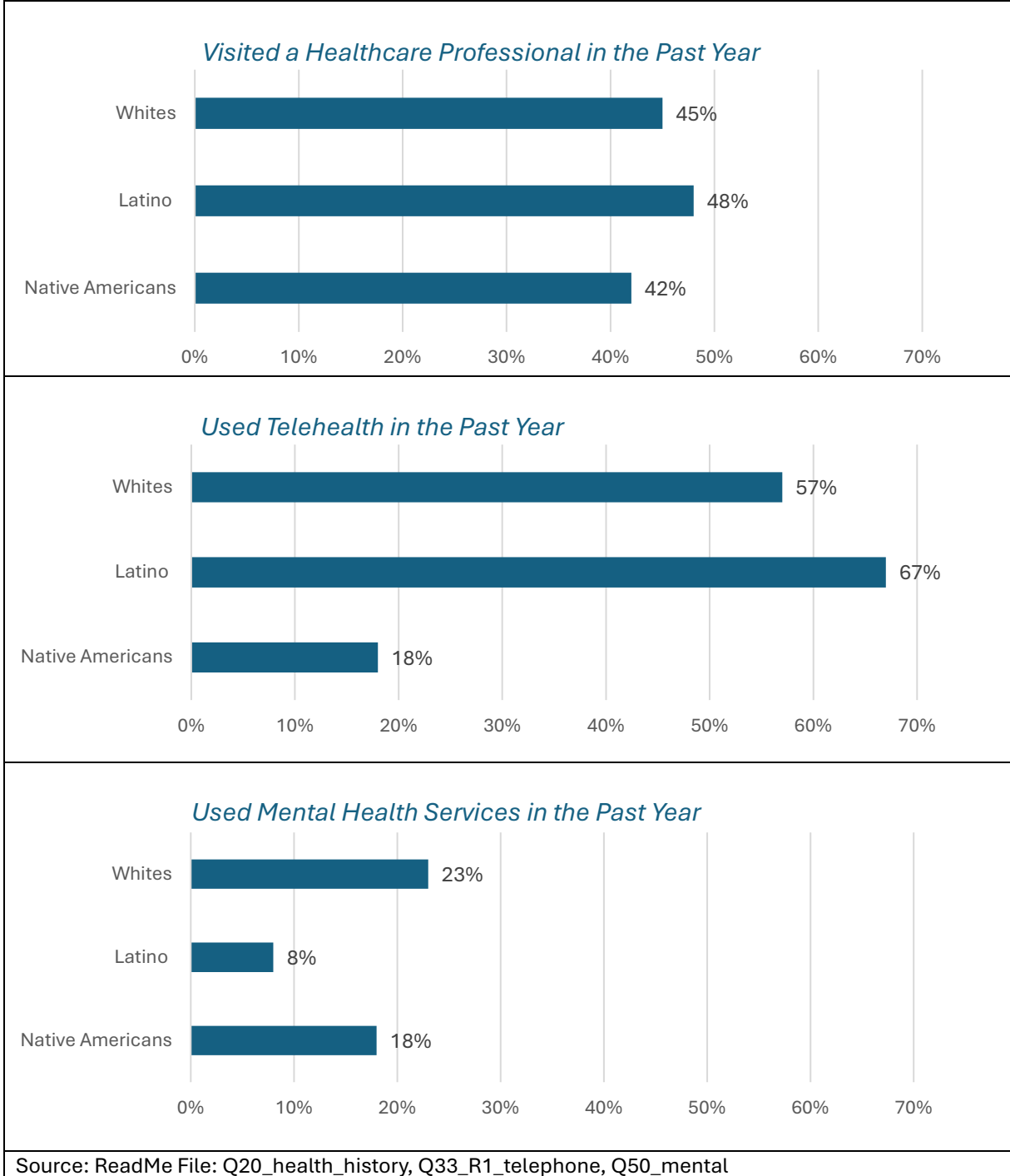


Figure 4: Healthcare Service Utilization, by Region

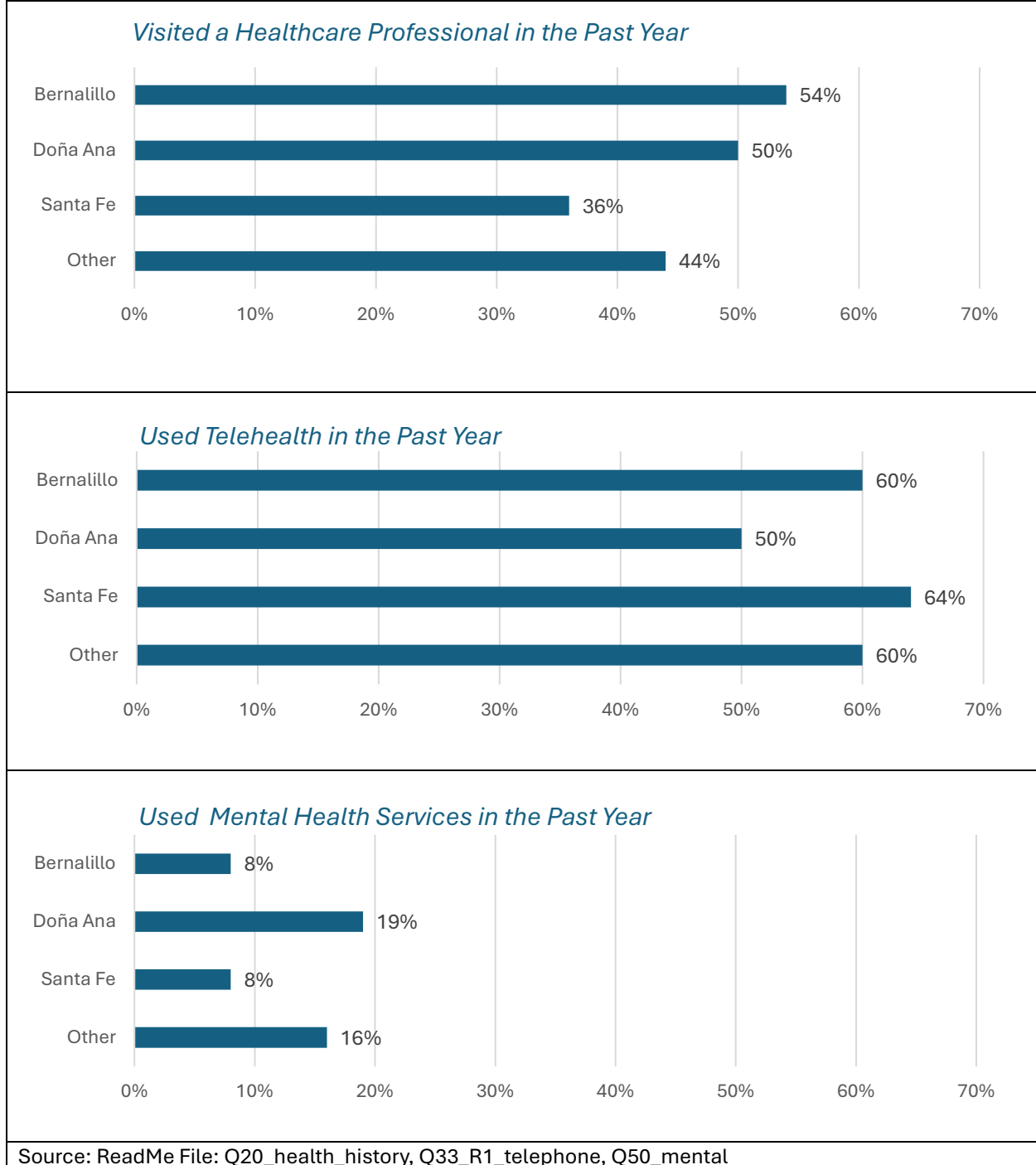
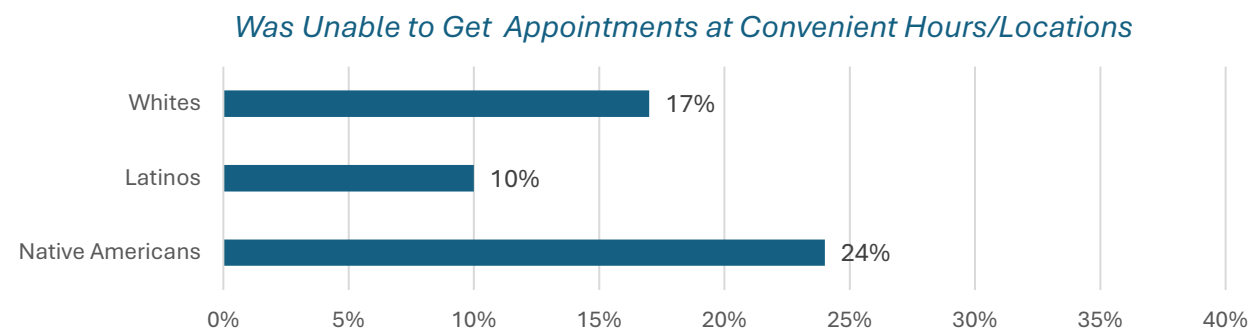
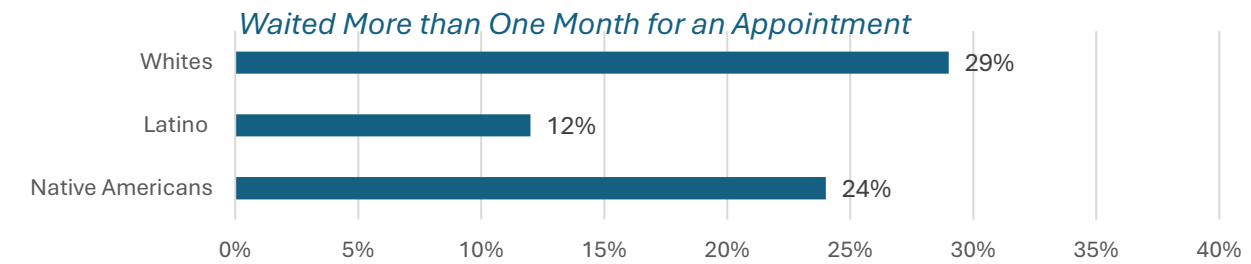
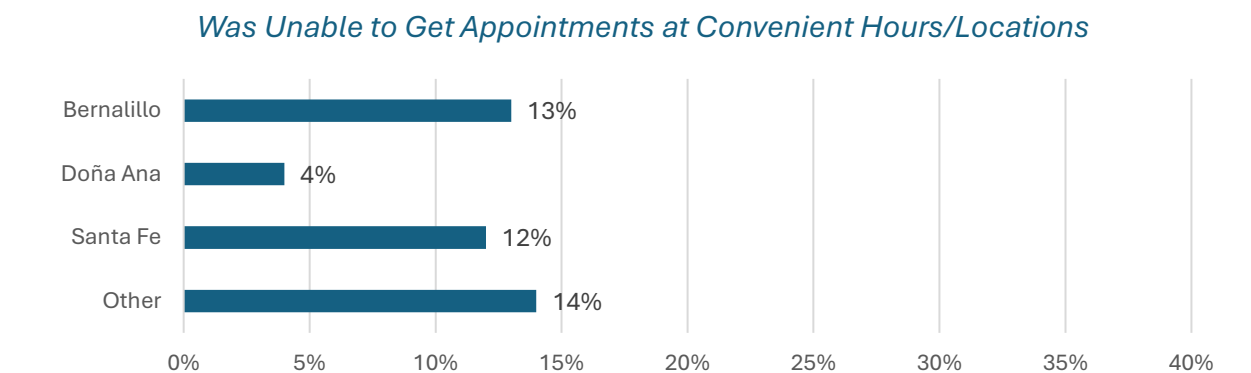
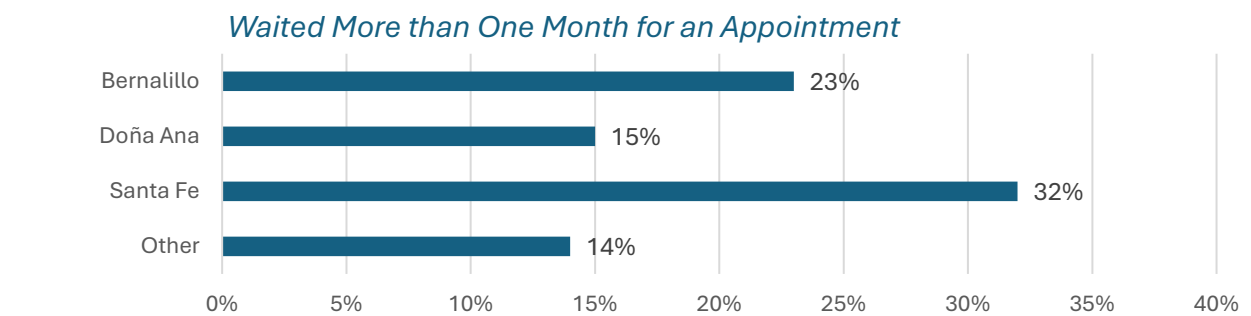


Figure 5: Selected Barriers: Wait Time and Inconvenient Hours or Locations

By Ethnicity



By Region

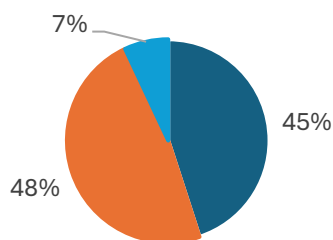


Source: ReadMe File: Q25_R1_wait_time, Q25_R3_convenience

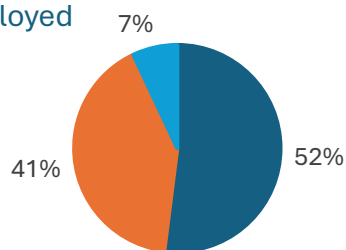
One important source of access, affordability, and utilization of healthcare services is employer-sponsored health insurance. For the employed uninsured, the NMHAS asked full-time and part-time uninsured respondents whether their employers offered health insurance. For all the employed uninsured, 45% indicated that their employer offers sponsored health insurance, 48% indicated that the employer does not offer health insurance, and seven percent were unsure (Figure 6). Broken down by full-time vs. part-time employment, the percentage of the part-time uninsured who were not offered/not eligible for employer-sponsored health insurance increases to 77% percent. The corresponding rate for the full-time employed is 41% percent. Thus, any state policies that encourage private employers to offer health insurance to part-time employees may be an effective mechanism for reducing the uninsured rates in New Mexico.

Figure 6: Employer-Sponsored Insurance Offers

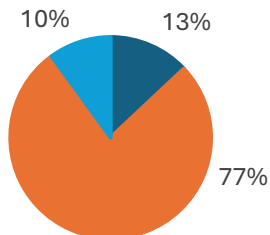
Any Employment



Full-Time Employed



Part-Time Employed

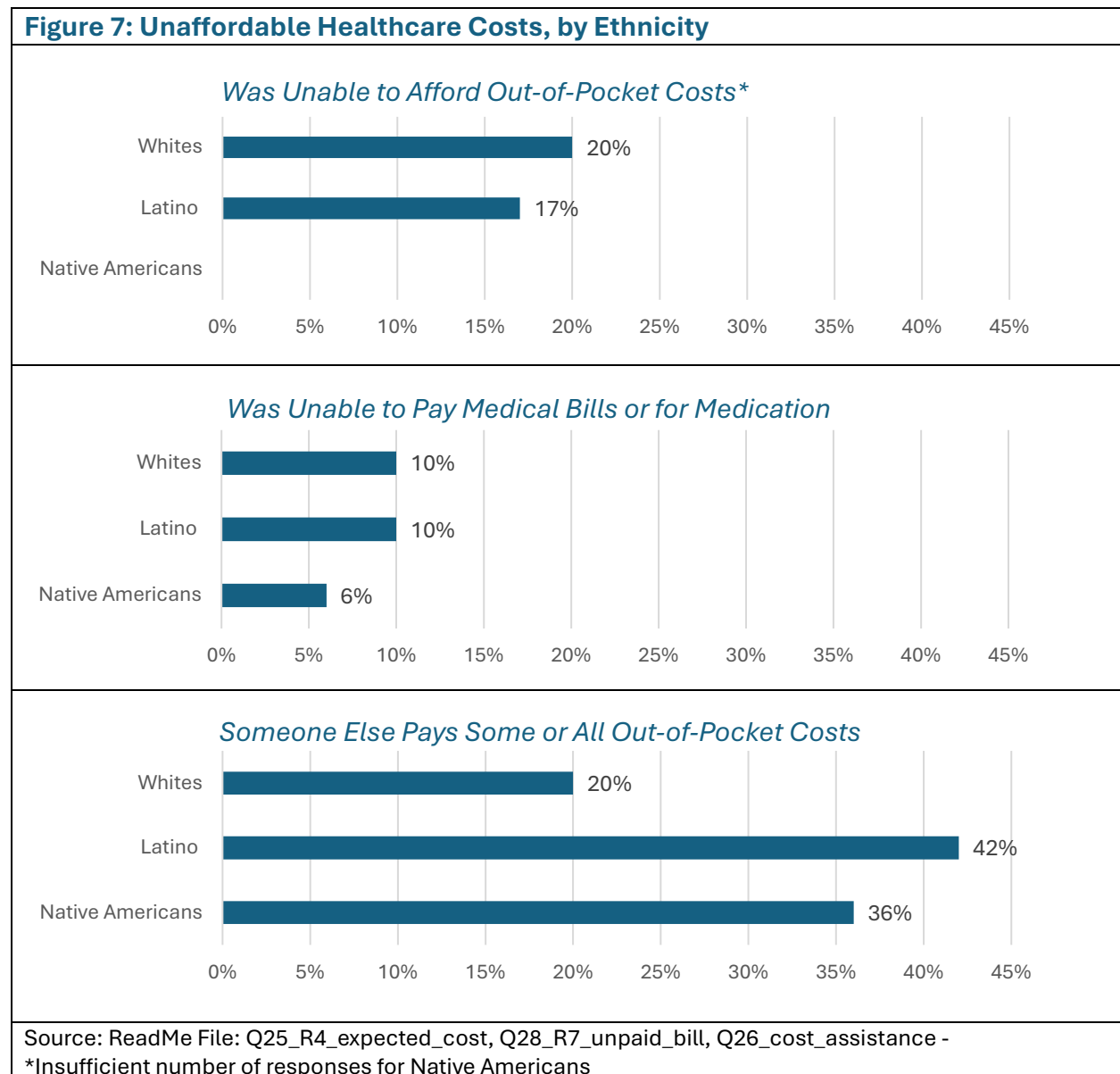


■ Insurance offered ■ Insurance not offered ■ Not sure

Source: ReadMe File: D1_R1_employed_full, D1_R2_employed_part, D2_employer_insurance

2.2. Cost and Affordability

The NMHAS [survey instrument](#) includes a list of questions that focus on the cost and affordability of receiving health care in general. Figure 7 presents the results for a set of selected questions, such as the uninsured person's inability to pay medical bills or out-of-pocket costs, or if individuals rely on others to pay some or all their out-of-pocket cost, by ethnicity.⁴ Figure 8 presents response results for questions related to behaviors the uninsured uses to reduce the cost of necessary healthcare, by ethnicity.



⁴ Thirty-four percent of uninsured respondents indicate that someone else pays some or all out-of-pocket costs, where close to 80% indicate assistance from family members, followed by employer-sponsored medical accounts (12%).

Figure 8: Behaviors to Avoid or Reduce Healthcare Cost, by Ethnicity

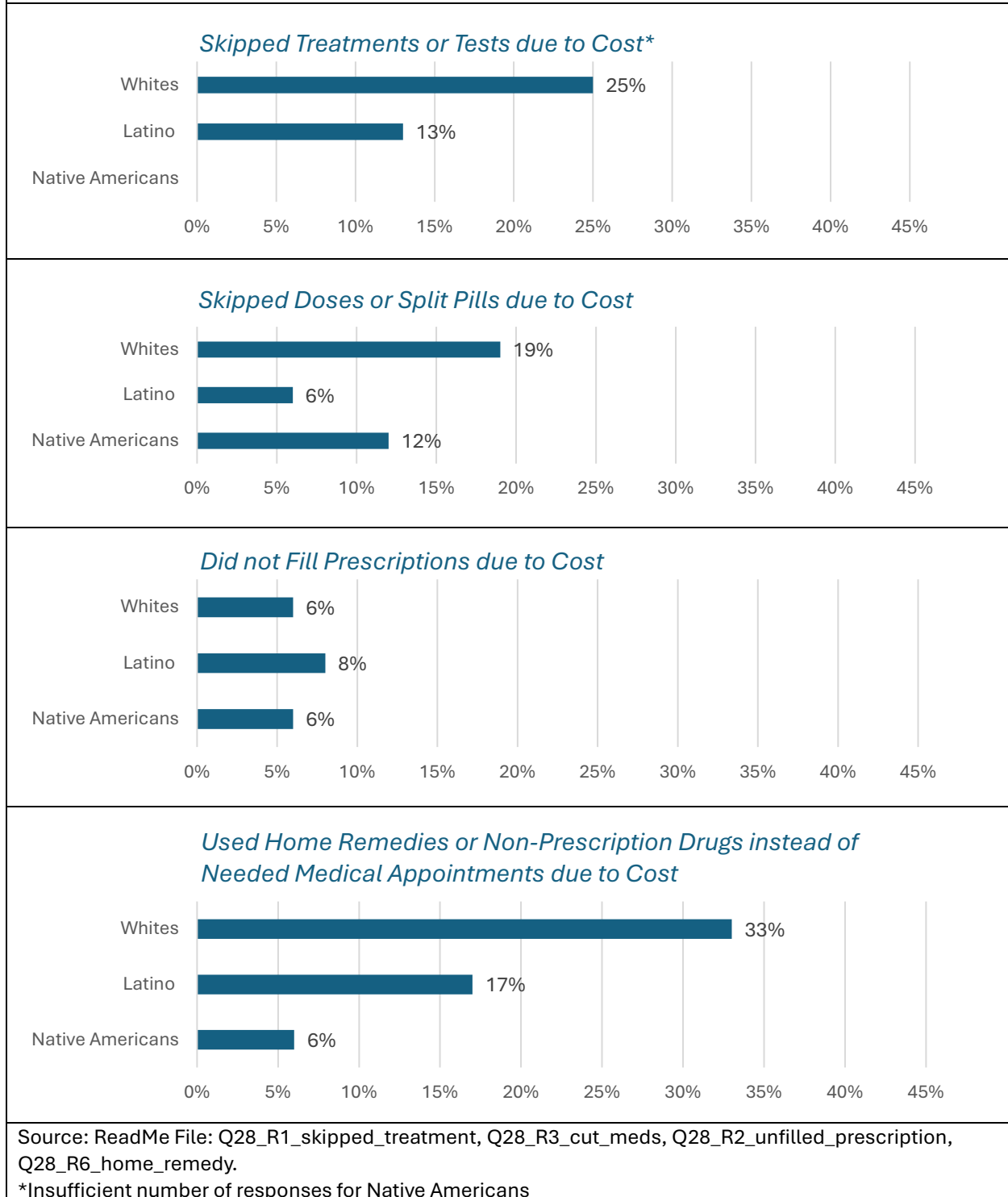
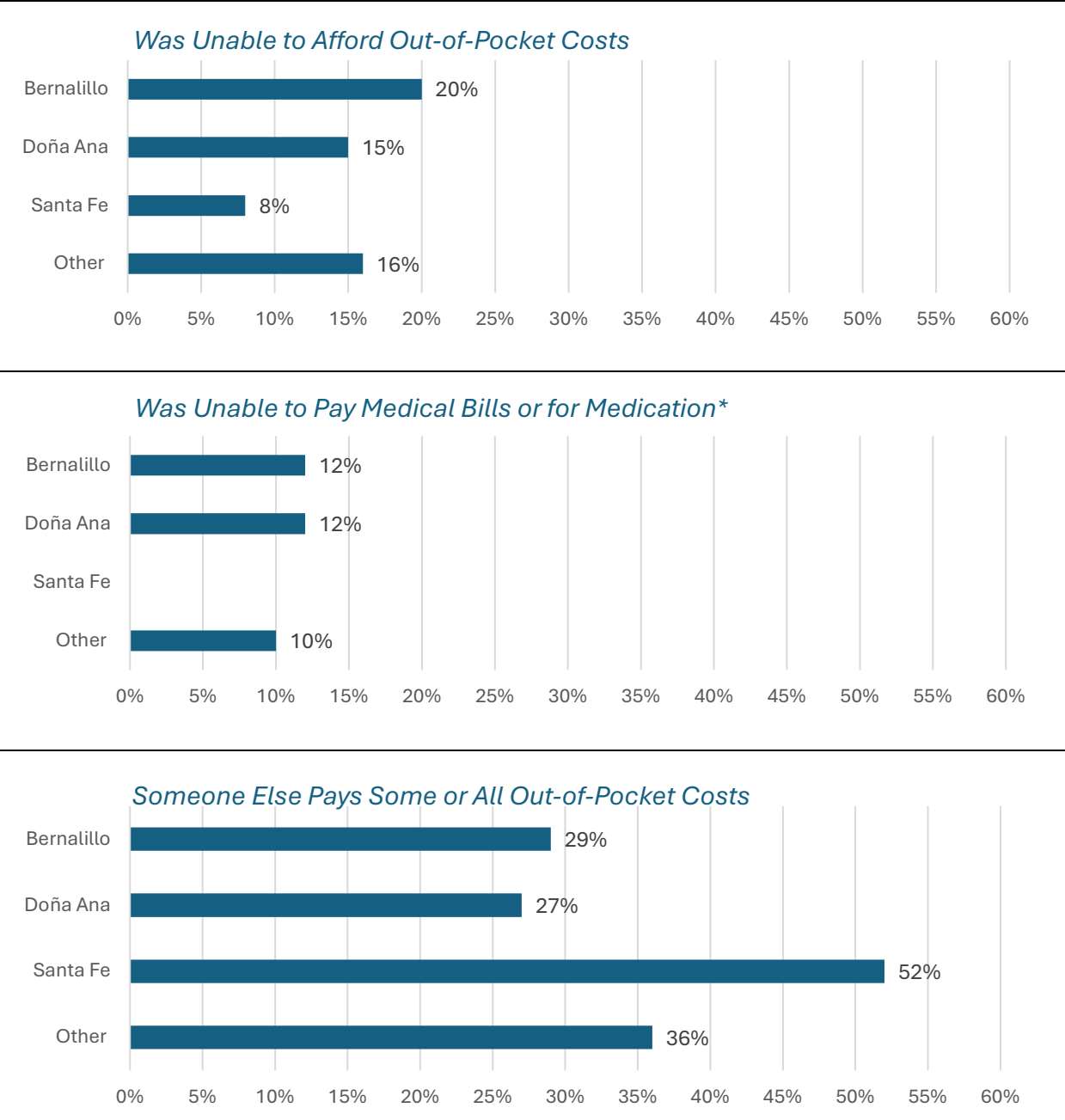


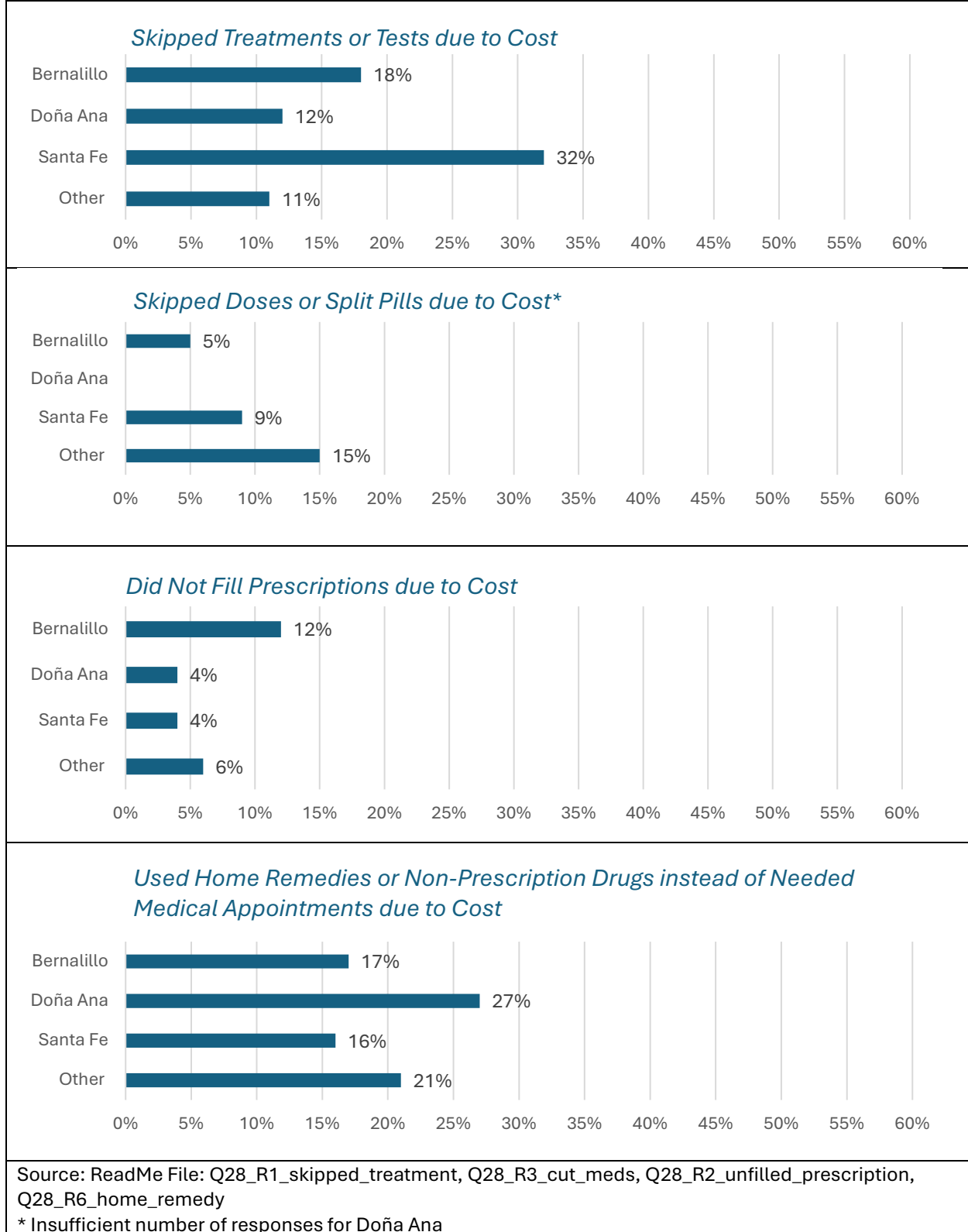
Figure 9: Unaffordable Healthcare Costs, by Region



Source: ReadMe File: Q25_R4_expected_cost, Q28_R7_unpaid_bill, Q26_cost_assistance.

* Insufficient number of responses for Santa Fe

Figure 10: Behaviors to Avoid or Reduce Healthcare Costs, by Region



The relatively high percentage of respondents indicating the use of home remedies and non-prescription drugs instead of seeking needed medical appointments is worth further investigation, especially if the reason for resorting to home remedies is not limited to cost considerations but is a result of cultural and religious health practices. The NMHAS survey did not explore this potential reason.

2.3. Quality and Cost Satisfaction

The NMHAS survey asks respondents about their satisfaction with the quality and the cost of medical care received in the past couple of years. Thus, the questions are not associated with a specific category of services, or a particular encounter with a healthcare provider. Respondents can choose very satisfied, somewhat satisfied, neutral, somewhat dissatisfied, very unsatisfied, or unsure.

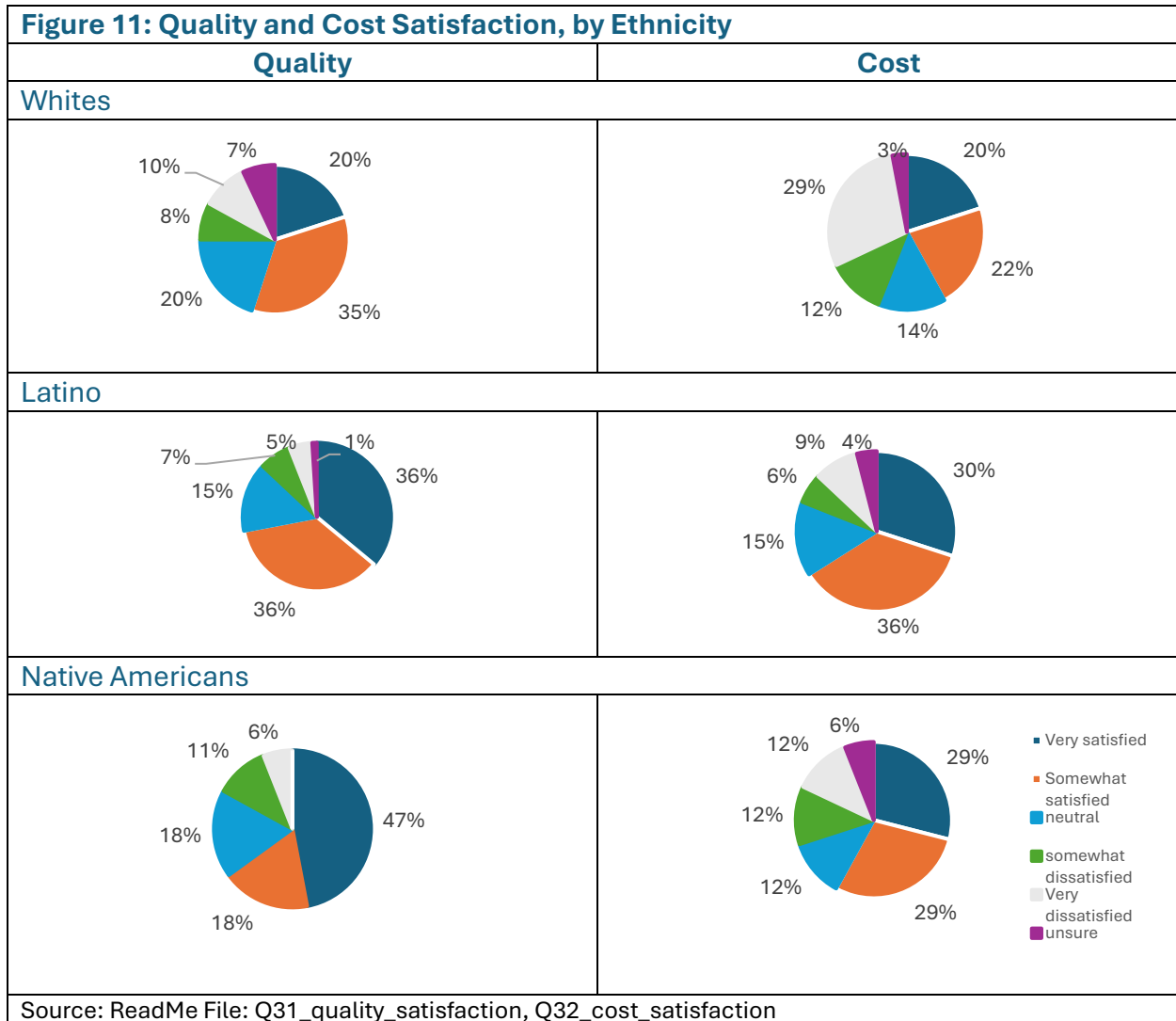
To analyze these results, we combine very satisfied and somewhat satisfied to indicate satisfaction with healthcare quality or cost and very dissatisfied and somewhat dissatisfied to indicate dissatisfaction with healthcare quality or cost.⁵ For example, using this aggregation of responses methodology, 55% of whites are quality-satisfied (Figure 11, panel A) and 42% of whites are cost-satisfied. The remaining sections of the brief utilize this response aggregation methodology for quality and cost satisfaction results.

By ethnicity, for quality satisfaction, the responses show that the percentage of whites who are satisfied with the quality of health care is lowest, at 55% and highest for Latinos at 72%. At the same time, 65% of Native Americans are satisfied with the quality of healthcare. Regarding quality dissatisfaction, 17% of both whites and Native Americans are dissatisfied, while the corresponding percentage for Latinos is 12%.

Conducting a high-level assessment of whether the education level (irrespective of ethnicity) has an impact on a respondent's satisfaction or dissatisfaction with healthcare quality, the percentages by education level range from 53% to 74% and for quality dissatisfaction, from 10% to 19%. Splitting respondents into only two education groups: group 1:(education levels up to some college) and group 2: (education levels starting with trade/tech school up to postgraduate degrees), the quality satisfaction and dissatisfaction are as follows: satisfaction is 66.51% and dissatisfaction is 13.29% for group 1, while for group 2, satisfaction is 64.4% and dissatisfaction with quality is 13.07%. So, at this high-level aggregation, the impact of education on quality satisfaction appears to be limited.

By ethnicity, cost satisfaction for whites is at 42%, 66% for Latinos, and 58% for Native Americans. As for cost dissatisfaction the percentage is 41% for whites, 15% for Latinos, and 24% for Native Americans. In general, however, the percentages of the uninsured New Mexicans of all ethnicities who are satisfied with the quality of healthcare are higher than the percentages who are satisfied with healthcare costs (Figure 11).

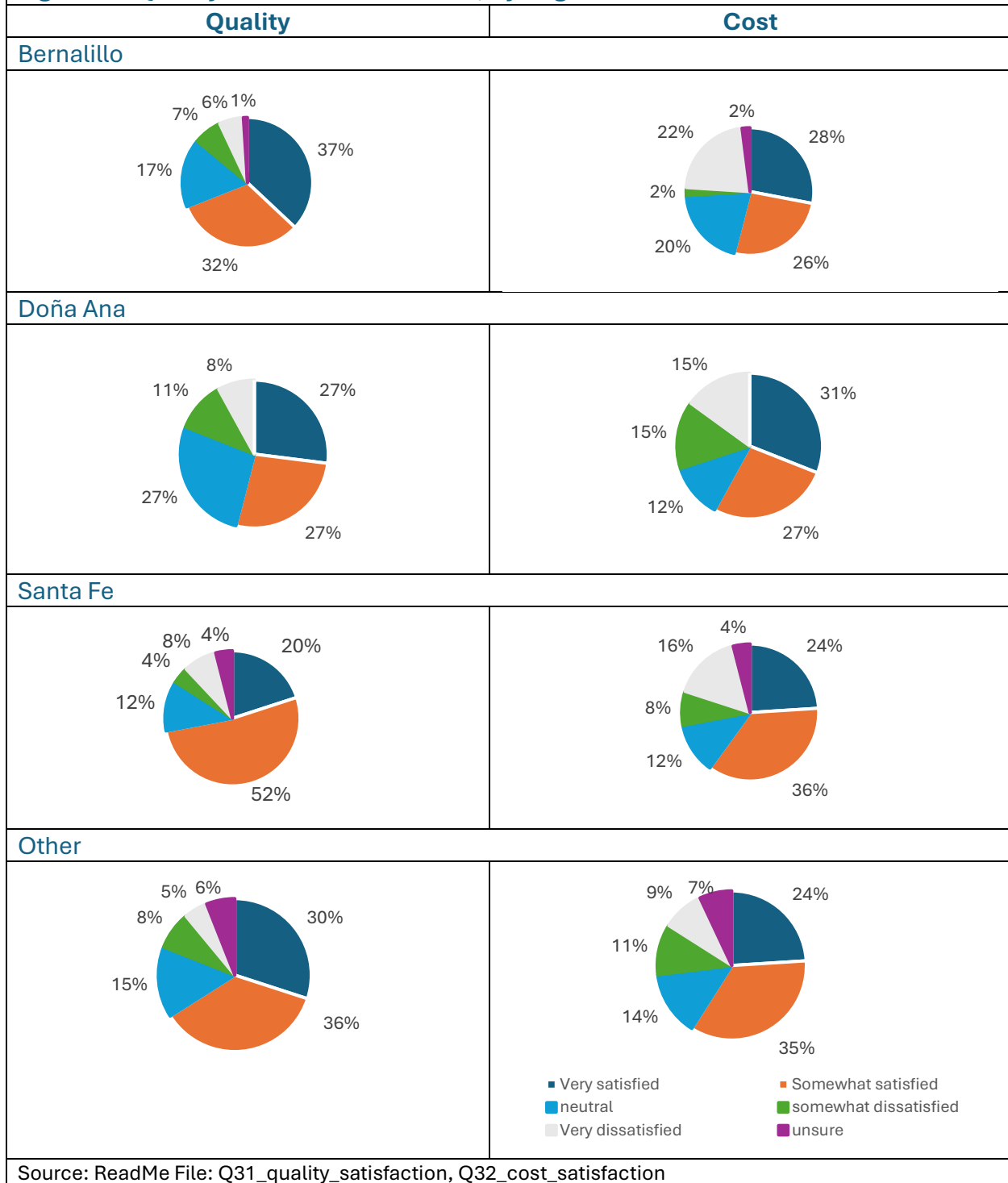
⁵ Across all groups, the percentages for neutral satisfaction range between 20% and 14% and the percentage for unsure assessment of quality and cost is typically small, 0% - 7%.



By region, quality satisfaction percentages are as follows: Bernalillo's rate is 69%, Doña Ana's is 54%, Santa Fe is 72%, and Other is 66%. In terms of **quality dissatisfaction**, Doña Ana's respondents have the highest percentage (19%), Santa Fe's rate is 12% and Bernalillo's and Other are at 13% (Figure 12).

By region, cost satisfaction percentages are 54% for Bernalillo, 58% for Doña Ana, 60% for Santa Fe, and 59% for Other, while the cost dissatisfaction rate is 24% for Bernalillo, 30% for Doña Ana, 24% for Santa Fe, and 20% for Other.

Figure 12: Quality and Cost Satisfaction, by Region



Within regions, the percentage of respondents who indicate satisfaction with quality and cost satisfaction relative to the percentages who indicate dissatisfaction with quality and cost are as follows (Figure 12):

- **Bernalillo County:** The percentage for the quality-satisfied respondents is 5.3 times⁶ the percentage for the quality dissatisfied respondents, while the percentage for the cost-satisfied respondents is 2.3 times the percentage for the cost-dissatisfied respondents.
- **Doña Ana County:** The percentage for the quality-satisfied respondents is 2.8 times the percentage for the quality-dissatisfied respondents, while the percentage for the cost-satisfied respondents is 1.9 times the percentage for the cost-dissatisfied respondents.
- **Santa Fe County:** The percentage for the quality-satisfied respondents is 6.0 times the percentage for the quality-satisfied respondents, while the percentage for the cost-satisfied respondents is 2.5 times the percentage for the cost-dissatisfied respondents.
- **Other:** The percentage for the quality-satisfied respondents is 5.1 times the percentage for the dissatisfied respondents, while the percentage for the cost-satisfied respondents is 3.0 times the percentage for dissatisfied respondents.

3. The Uninsured vs. Private and Public Insurance

Using selected questions from NMHAS where sufficient data was available, the following charts show how the uninsured population may have different access, cost and affordability issues, and levels of quality and cost satisfaction that are different from those with private or public health insurance coverage. While some indicators are comparable to the ones that Section 2 presents for ethnicities and regional variations for the uninsured (e.g. wait time for an appointment, convenient appointment times/hours, inability to pay out-of-pocket cost, someone else pays medical bills, quality and cost satisfaction) Using selected questions from NMHAS where sufficient data was available, the following charts show how the uninsured population may have different access, cost and affordability issues, and levels of quality and cost satisfaction that are different from those with private or public health insurance coverage.

Some indicators are comparable to the ones that Section 2 presents for ethnicities and regional variations for the uninsured (e.g. wait time for an appointment, convenient appointment times/hours, inability to pay out-of-pocket cost, someone else pays medical bills, quality and cost satisfaction). Other indicators are more relevant for comparing

⁶ For Bernalillo County, Satisfied percent = 37% (very satisfied) +32% (somewhat satisfied = 69%), dissatisfied percent = 6% (very dissatisfied) +7% (somewhat dissatisfied) = 13%. The percentage for the quality-satisfied respondents = 69% /13% = 5.3 times.

across insurance types, such as a doctor not accepting insurance, surprise billing, and the potential for insurance and provider disputes.⁷

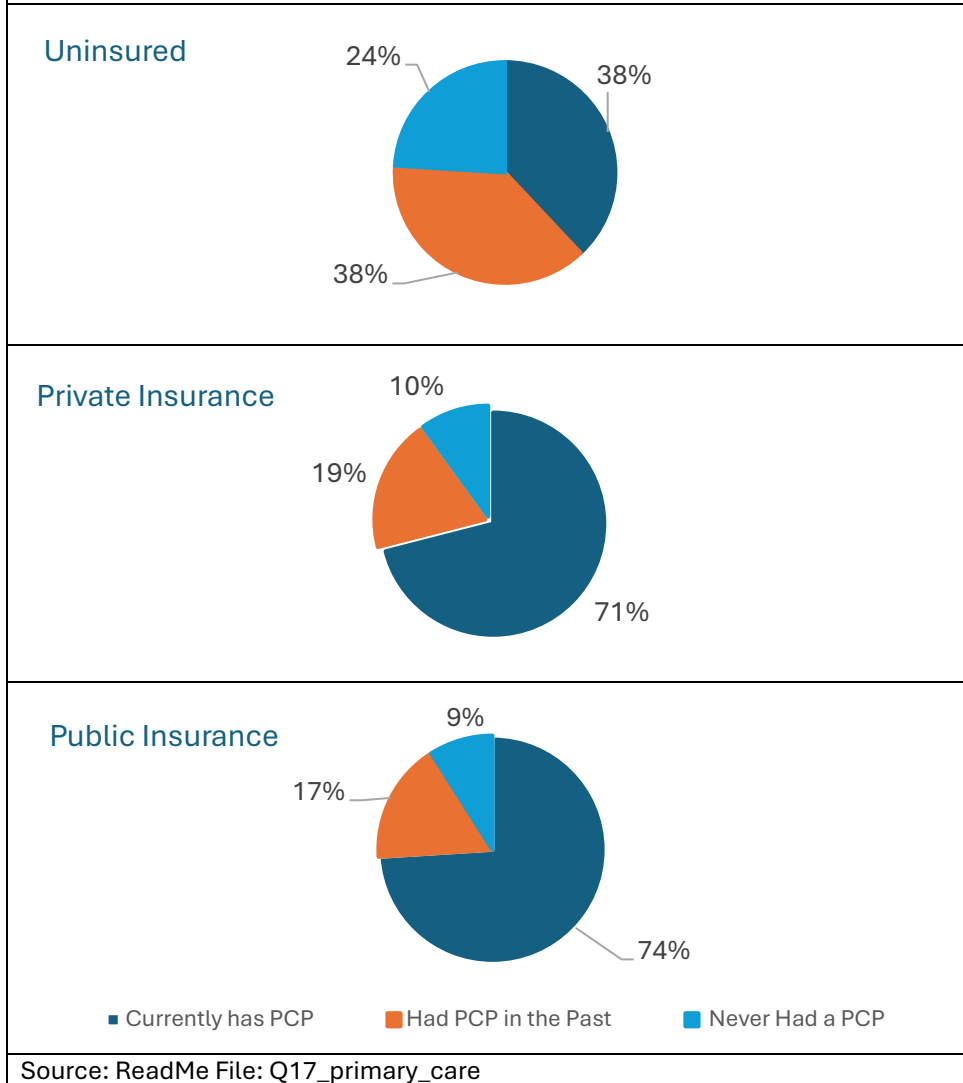
3.1. Access to Healthcare

The following results are responses to questions examining several features of access to healthcare. Starting with steady access to a primary care physician, when asked about whether they currently have a primary care physician (PCP), the percentage of the uninsured indicating they have a PCP is only 38% compared to 74% and 71% for those currently with public insurance coverage and private insurance coverage, respectively. For the presently uninsured, 24% indicated that they never had a PCP, compared to 10% of those who currently have private insurance and 9% of those who currently have public insurance (Figure 13).

For the uninsured population, 38% of the uninsured have a PCP, which is notable and may suggest the existence of consistent basic management of healthcare for uninsured individuals in the form of reasonably priced PCP visits through clinics, or the currently uninsured maintaining a previous PCP relationship, if they were previously insured (Figure 13). The second share to highlight is 24% of the currently uninsured who never had a PCP. Compared to the 10% and 9% of the privately and publicly insured, the high share of the currently uninsured who never had a PCP may indicate an inherent lack of eligibility for insurance coverage in this group, rather than a voluntary or intermittent falling out of insurance coverage due to employment or income eligibility criteria.

⁷ The NMHAS has other questions that relate to access and cost and affordability that may be of interest to other researchers to explore in depth, or to explore for a specific ethnicity, region, or for the publicly or privately insured.

Figure 13: Currently Having a Primary Care Physician (PCP)



Lack of steady access to a PCP may result in resort to ER utilization for non-emergency needs. Figure 14 suggests that close to 80% of the uninsured and privately insured respondents did not visit the ER in the six months, while the corresponding percentage for the publicly insured is only 60% (Figure 14). In addition, for respondents who visited the ER once in the past six months, the percentage for the publicly insured is significantly higher (22%) compared to 13% for private insurance and 14% for the uninsured. Furthermore, 2% of the publicly insured visited the ER between 5 and 10 times in the past 6 months, compared to 0% for the other two groups.

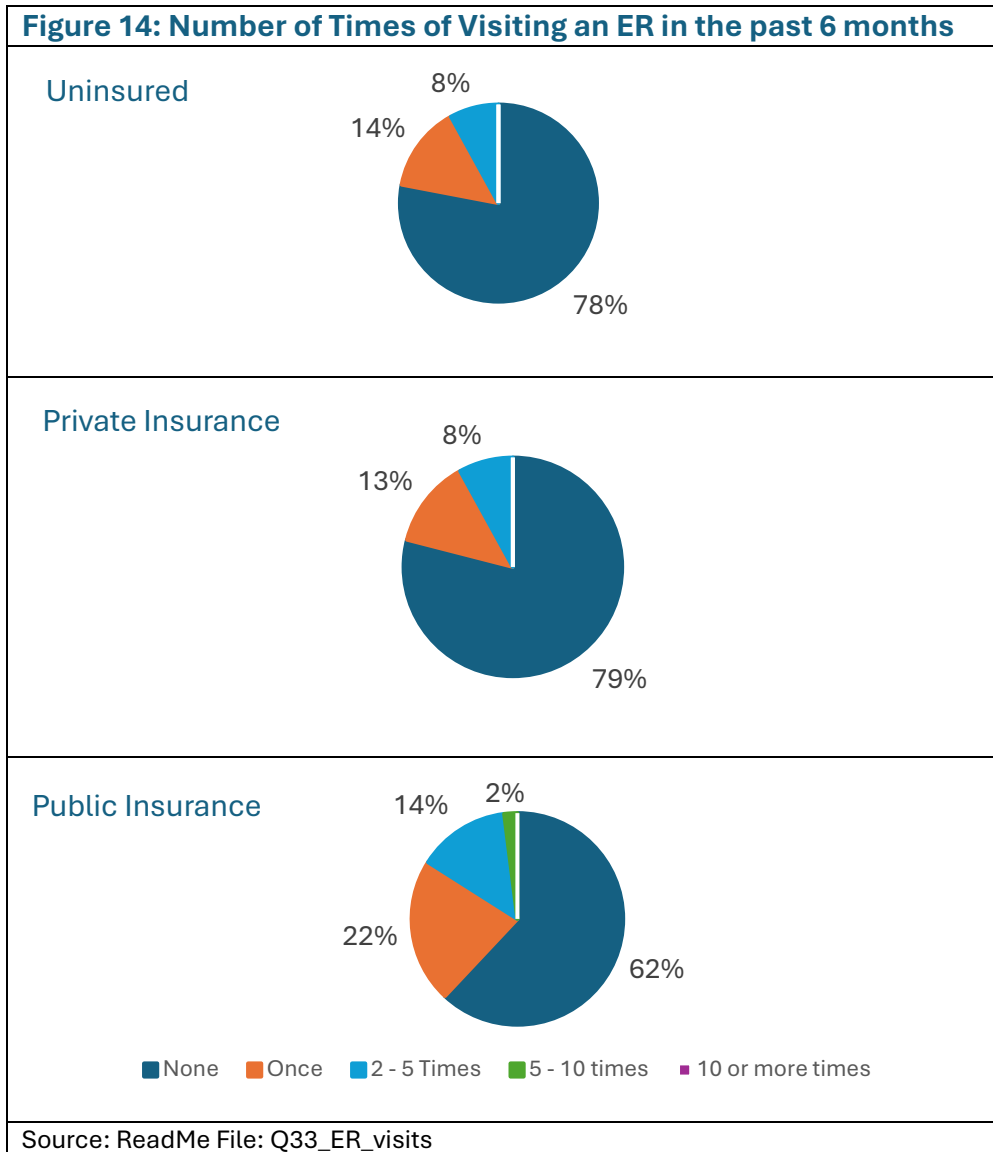
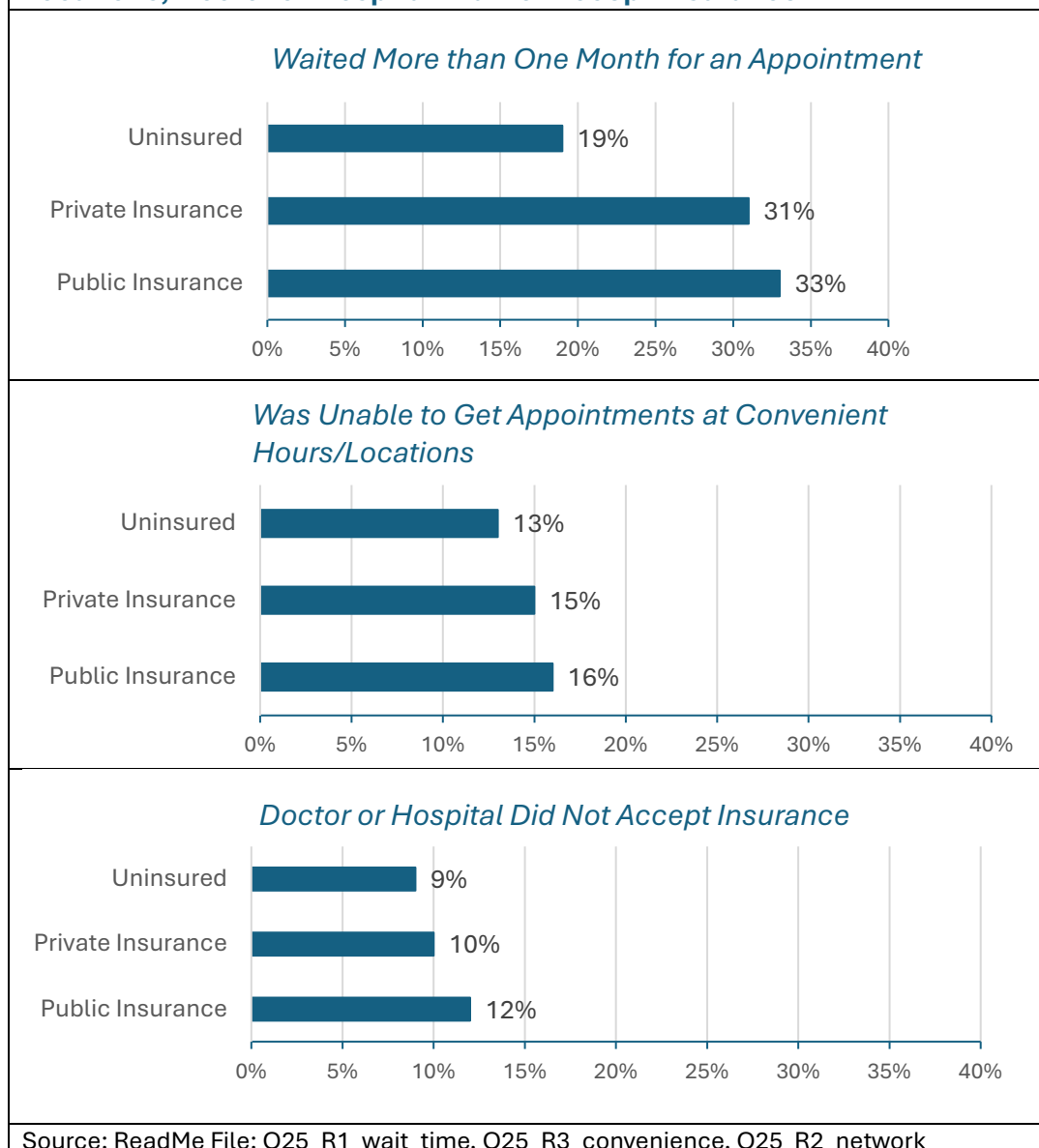


Figure 15 provides the percentages of respondents who faced selected healthcare access barriers such as extended appointments, inconvenient appointment times or locations, or doctors or hospitals not accepting an individual's insurance. This section compares the barrier incidence for the uninsured, relative to those who have private or public insurance. For wait times that exceed one month, the publicly insured have the highest percentage of respondents who had to wait more than one month for an appointment (33%), with the privately insured closely following (31%).⁸ The corresponding rate for the uninsured is significantly lower (19%). The lower percentage for the uninsured can be due to the smaller

⁸ The NMHAS questionnaire has other barriers. See Q.55: In the past 12 months, have you faced any of the following challenges that prevented you from being able to access mental health services that you felt you needed? Choices: 1. I was worried about the cost. 2. My health plan wouldn't pay for the treatment. 3. I couldn't get an appointment that worked with my schedule. 4. I was too busy.

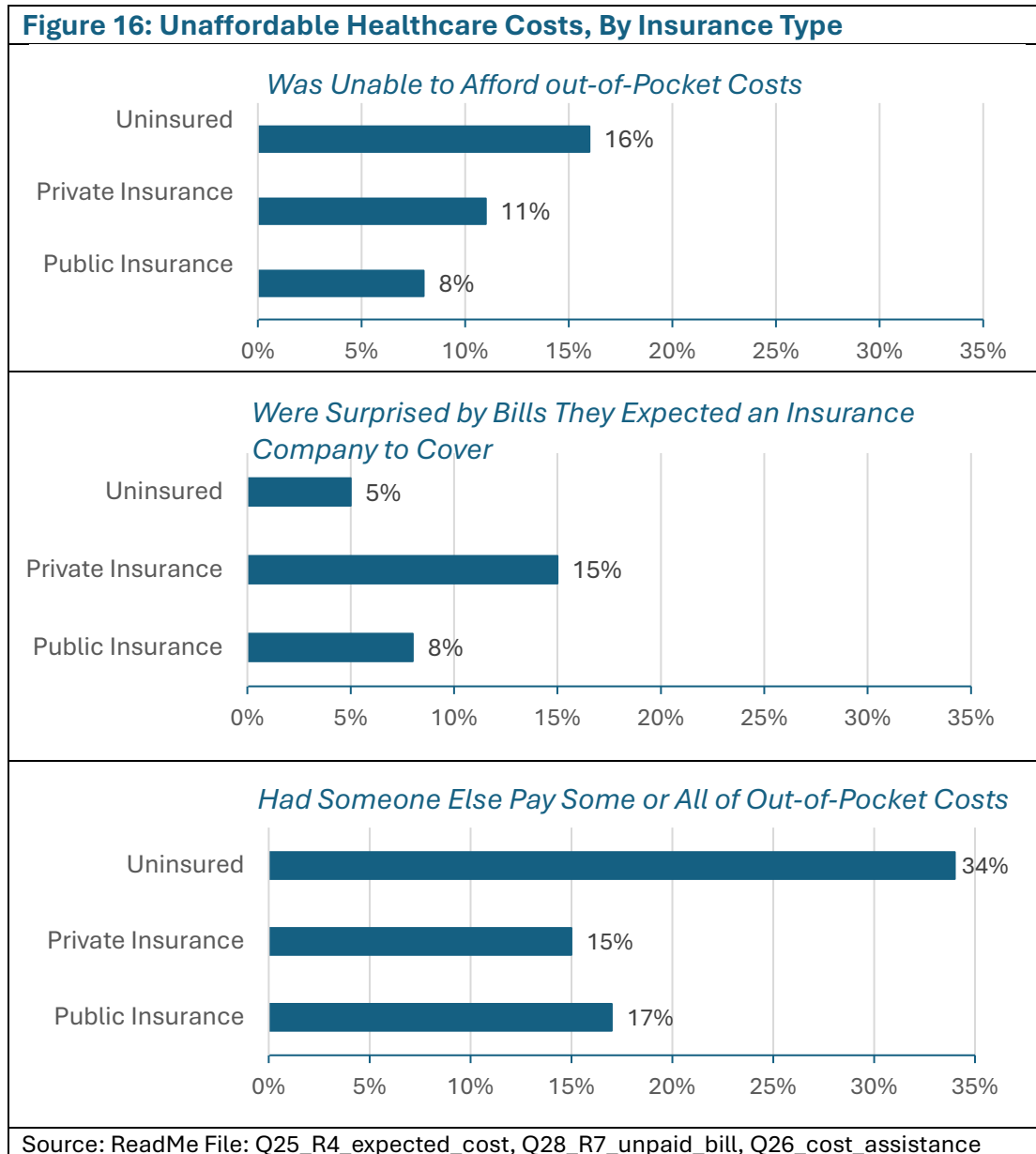
uninsured numbers seeking healthcare and thus competing with a few individuals for the provider slots allotted for the uninsured, and/or the lack of insurance-related paperwork that is involved in public and private insurance. For the inability to get appointments at convenient hours/locations, the rates are closer, with the uninsured, the privately insured, and the publicly insured at 13%, 15%, and 16%, respectively. Finally, with respect to doctors or hospitals not accepting a respondent's insurance, the percentages are comparable, yet the incidence is highest for public insurance.

Figure 15: Selected Barriers: Wait Time, Inconvenient Hours or Locations, Doctor or Hospital Did Not Accept Insurance



3.2. Cost and Affordability

Figures 16 and 17 provide cost and affordability indicators across insurance coverage types that are comparable to those in Figures 7- 10 in Section 2.2, such as the inability to pay out-of-pocket costs and having someone else pay these costs. This section, however, introduces the possibility of facing a surprise bill, which is an issue related to having insurance coverage.



The uninsured have the highest percentage of not being able to pay out-of-pocket costs (16%), which is double the percentage for the publicly insured (8%). The percentage of the privately insured who indicated they could not pay out-of-pocket costs is still high, and not significantly different from the percentage for the uninsured. This inability to pay can be a

result of individuals selecting high-deductible private insurance plans, which are often attractive due to lower premiums (Figure 16).

For surprise billing, which is more closely related to private insurance, the percentage of the privately insured who were surprised by a bill is almost double the percentage of the publicly insured (15% vs. 8%) and is triple the uninsured rate (15% vs 5%). The low incidence of surprise billing for the uninsured is plausible, since the uninsured person's expected cost does not involve a third party (insurance company), where the person's expectation of their share in the cost may be unclear. While the high incidence of surprise bills for the privately insured relative to the uninsured is understandable, the high privately insured surprise bill rate (15%) is concerning when compared to the rate for the publicly insured.

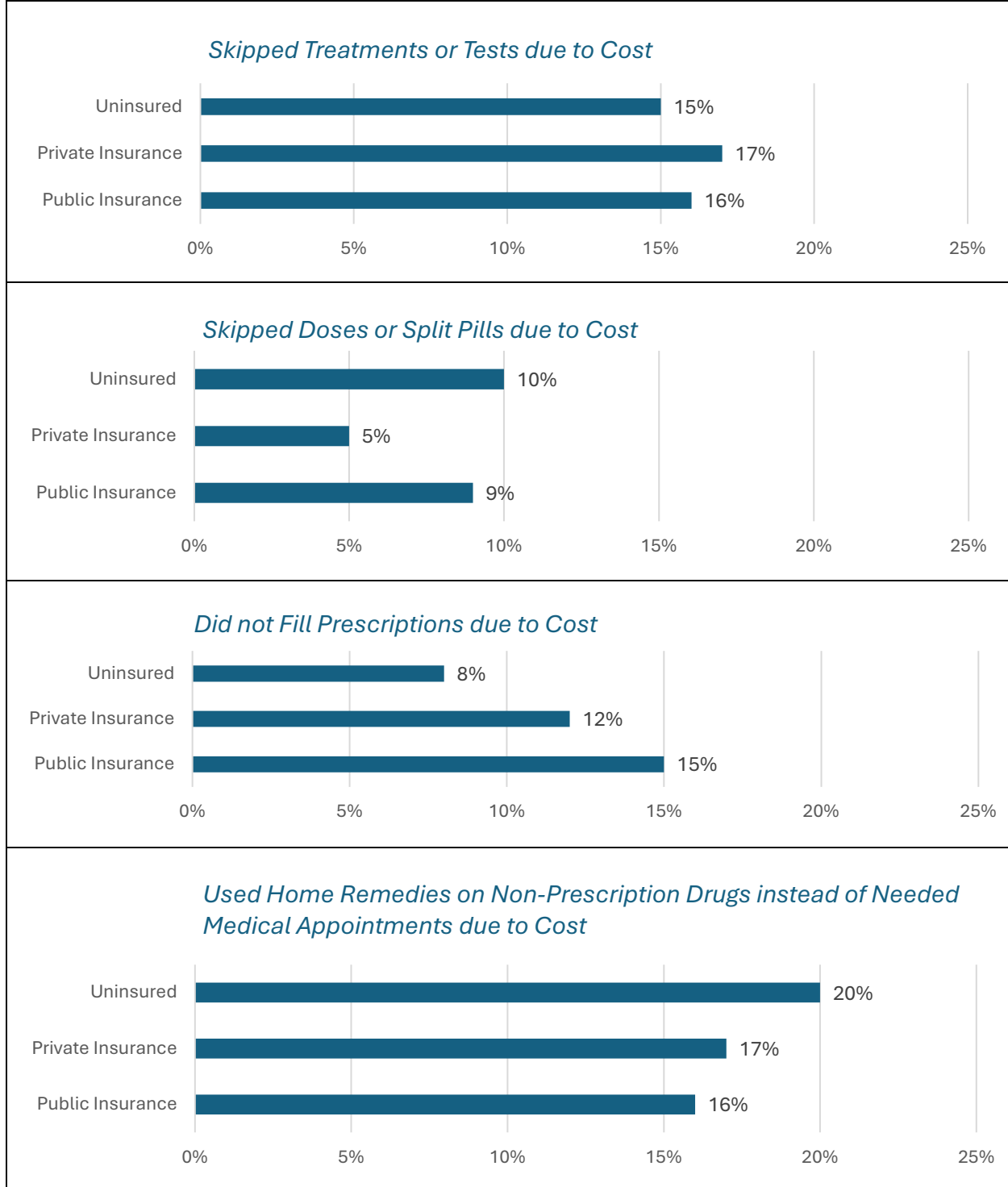
When asked whether they rely on someone else to pay some or all out-of-pocket cost, 34% of the uninsured respondents indicated the existence of the need for such financial assistance (Refer to Figures 7 and 9 for the breakdown of these percentages by ethnicity and region). This percentage is almost double the percentages for the other two groups: privately insured at 15% and publicly insured at 17%. For the publicly insured population, who are typically with limited income, such as Medicaid recipients, or older people with limited retirement incomes, they may need financial assistance. However, the fact that 15% of the privately insured need help with out-of-pocket costs raises questions about the financial burden of healthcare costs, even for those with private insurance, and the resulting impact on their utilization of needed health care services.

As a result of the financial burden that healthcare services can impose on New Mexicans, the survey asked respondents if they use behaviors such as skipping services, or prescriptions, or using home remedies in lieu or receiving professional health services. Comparing how the uninsured in this respect differs from those who are insured appears in figure 17. With respect to skipping treatments or tests due to cost, it appears that all insurance status or types do not produce significant difference in this area; with all groups indicating between 15% -17% of skipping treatments or tests because of cost.

For skipping drug doses or splitting pills to reduce the cost of medication, the uninsured and the publicly insured have similar rates of this behavior (10% and 9%, respectively), while the privately insured resort to this behavior is significantly less, at only 5%. For not filling prescription, the publicly insured have the highest rate (15%), followed by the privately insured (12%), then the uninsured (8%), where the low rate for the uninsured be a function of their not seeing healthcare provider as often as the insured people, or resorting to home remedies instead.

Finally, in terms of the incidence of reliance on home remedies to avoid or reduce the cost of healthcare, the uninsured percentage is the highest at 20%, the privately insured at 17% and publicly insured at 16%, which suggests that all individuals resort to some of these behaviors, irrespective of insurance coverage type.

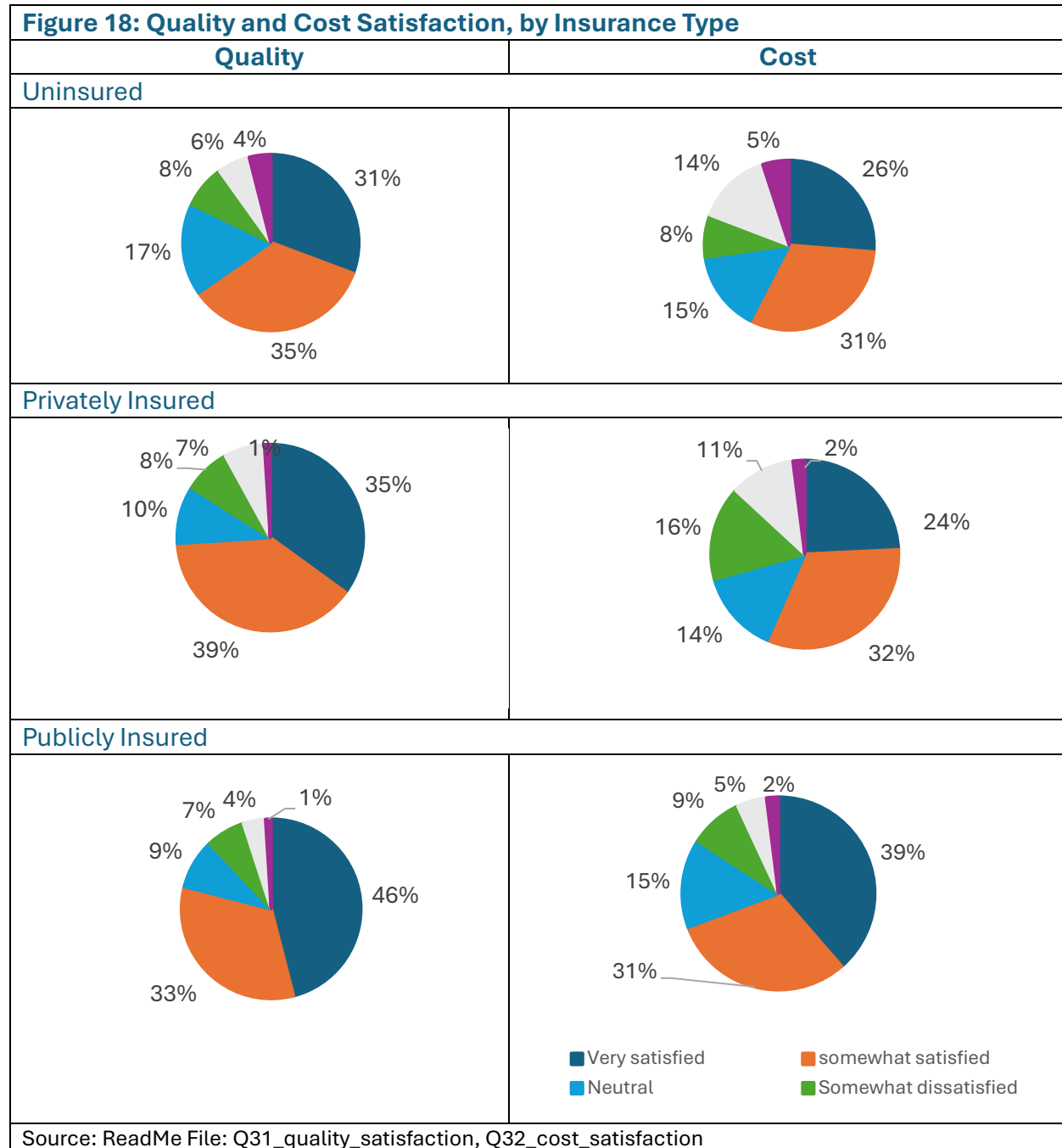
Figure 17: Behaviors to Avoid or Reduce Healthcare Cost, by Insurance Type



Source: ReadMe File: Q28_R1_skipped_treatment, Q28_R3_cut_meds, Q28_R2_unfilled_prescription, Q28_R6_home_remedy

3.3. Quality and Cost Satisfaction

Using the same approach as section 2.3, the **quality satisfaction rates** are as follows: 66% for the uninsured, 74% for the privately insured, and 79% for the publicly insured. The quality dissatisfaction rates are closer across insurance groups: 15% for the privately insured, 14% for the uninsured, and 11% for the publicly insured (Figure 18).



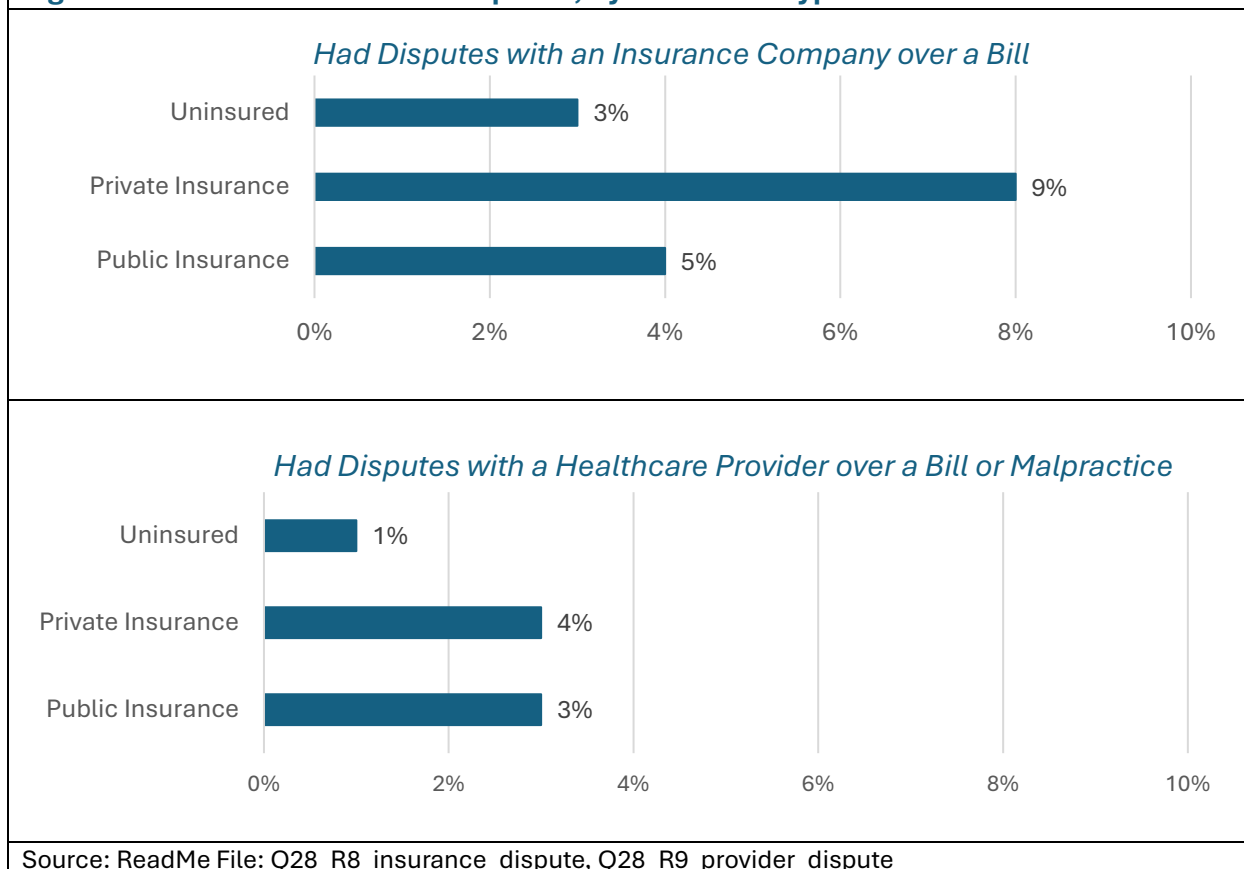
For cost satisfaction, 57% of the uninsured and 56% of those with private insurance are satisfied with the cost of the healthcare services that they receive. For individuals with

public insurance, however, the corresponding percentage is 70%. **As for cost dissatisfaction**, the highest share of dissatisfaction belongs to those with private insurance coverage (27%), followed by the uninsured (22%), while for the publicly insured, the percentage of cost-dissatisfied respondents is only 14%.

3.4. Insurer or Provider Disputes

The highest incidence of disputes with an insurance company is for the privately insured, at 9%, followed by the publicly insured at 5% (Figure 19). Unexpectedly, 3% of the uninsured indicated having a dispute with an insurance company, which appears implausible. For disputes with a provider over a bill or malpractice, 3% of the publicly insured and 4% of the privately insured indicated having had disputes with providers, respectively. On the other hand, only 1% percent of the uninsured indicated having a dispute with a provider, which may be a result of the uninsured population's unawareness of or reluctance to resort to dispute resolutions related to bills or malpractice that may be available to them.⁹

Figure 19: Insurer or Provider Disputes, by Insurance Type



⁹ Dispute resolution options that may be available for the uninsured include: the [New Mexico Medical Board](#), the [New Mexico Department of Justice](#), the [Office of the Superintendent of Insurance](#) enforcement of the Patients Debt Collection Protection Act - NM OSI, and hospital systems' patient advocates such as [the University of New Mexico Patient Advocates](#) for UNM affiliated providers and Hospitals, and [Lovelace Health System Patient Advocates](#) for Lovelace Health System hospitals and affiliated providers.

4. Takeaways

- OSI Health Insurance Brief (2) provides a picture of how the uninsured population in New Mexico utilizes healthcare services, how it perceives access and affordability, and how the patterns vary by ethnicity and region. It also shows how the uninsured population's service utilization, access, and affordability landscape compares to that of the publicly and privately insured New Mexicans.
- Periodic assessment of these patterns is essential for monitoring the impact of state or national policies or events and measuring their impact on New Mexicans.
- **In terms of substantive issues**, there are several matters for which further analysis is warranted:
 1. Doña Ana County's access and utilization of PCP and healthcare services in general is not materially different from the metropolitan and urban counties of Bernalillo and Santa Fe, and it seems to report the highest access to PCPs for the uninsured. Considerations may include those who cross the border for their medical care, which the questionnaire did not ask about, and it would be beneficial for future survey questions to capture.
 2. The aggregation of all "other" regions is likely to mask stark variations in access, affordability, and cost and quality satisfaction for non-urban New Mexico regions. Future surveys that draw samples along the lines of the New Mexico Department of Health administrative regions (NE, NW, SE, SW, Metro) can shed better light on the status of health insurance and health access and utilization status in each of these areas and align results with the state's reporting at the regional level.
 3. Approaching employment-sponsored insurance as an important access-to-healthcare vehicle contributing to access and affordability of healthcare monitoring
 4. The need for further investigation of dispute resolution options for the uninsured, who may not have the complete set of dispute resolution resources available to the publicly and privately insured New Mexicans.