(Please find the Agenda/Table of Contents on Page 4.)

REGULAR MEETING
OF THE
BOARD OF DIRECTORS

December 12, 2017
9:30 AM
Alfredo R. Santistevan Board Room
Suite 207
4308 Carlisle Blvd. NE
Albuquerque, NM 87107

New Mexico Retiree Health Care Authority
Regular Meeting

BOARD OF DIRECTORS

ROLL CALL

December 12, 2017

	Member in Attendance		
Mr. Sullivan, President			
Mr. Montaño, Vice President			
Mr. Crandall, Secretary			
Mr. Propst			
Ms. Goodwin			
Mr. Johnson			
Mr. Linton			
Ms. Saunders			
Mr. Eichenberg			
Ms. Larranaga-Ruffy			

NMRHCA BOARD OF DIRECTORS
December 2017

Mr. Wayne Propst
Executive Director
Public Employees Retirement Association
33 Plaza La Prensa
Santa Fe, NM 87507
PO Box 2123
Santa Fe, NM 87504-2123
Wayne.Propst@state.nm.us
W: (505) 476-9301

Ms. Jan Goodwin
Executive Director
Educational Retirement Board
PO Box 26129
Santa Fe, NM 87502-0129
jan.goodwin@state.nm.us
(W) 505-827-8030
(F) 505-827-1855

The Honorable Mr. Wayne Johnson
NM Association of Counties
Bernalillo County Commissioner
One Civic Plaza, NW
Albuquerque, NM 87102
Ms. Mella Tyler
Deputy County Commissioner
Bernalillo County, District 5
mtyler@bernco.gov
505-468-7212 (office)
505-462-9821 (fax)

Mr. Terry Linton
Governor's Appointee
1204 Central Ave. SW
Albuquerque, NM 87102
terry@lintonandassociates.com
505-247-1530

Mr. Joe Montaño, Vice President
NM Assoc. of Educational Retirees
5304 Hattiesburg NW
Albuquerque, NM 87120
Jmountainman1939@msn.com
(H) 897-9518

Mr. Doug Crandall
Retired Public Employees of New Mexico
14492 E. Sweetwater Ave
Scottsdale, AZ 85259
dougcinaz@gmail.com

The Honorable Mr. Tim Eichenberg
NM State Treasurer
2055 South Pacheco Street
Suite 100 & 200
Santa Fe, NM 87505
Tim.Eichenberg@state.nm.us
(W) 505-955-1120
(Fax) 505-955-1195

Ms. Therese Saunders
NEA-NM, Classroom Teachers Assoc., & NM Federation of Educational Employees
5811 Brahma Dr. NW
Albuquerque, NM 87120
tsaunders3@mac.com
Phone: 505-934-3058

Mr. Tom Sullivan, President
Superintendents' Association of NM
800 Kiva Dr. SE
Albuquerque, NM 87123
tlsullivan48@gmail.com
505-330-2600

Ms. Leanne Larranaga-Ruffy
Alternate for PERA Executive Director
33 Plaza La Prensa
Santa Fe, NM 87507
PO Box 2123
Santa Fe, NM 87504
Leanne.Larranaga@state.nm.us

Regular Meeting of the
NEW MEXICO RETIREE HEALTH CARE AUTHORITY
BOARD OF DIRECTORS

December 12, 2017
9:30 AM
Alfredo R. Santistevan Board Room
2nd Floor, Suite 207
4308 Carlisle Blvd. NE
Albuquerque, NM 87107

AGENDA

			Page
1.	Call to Order	Mr. Sullivan, President	
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder	
3.	Pledge of Allegiance	Mr. Sullivan, President	
4.	Approval of Agenda	Mr. Sullivan, President	4
5.	Approval of Regular Meeting Minutes November 7, 2017	Mr. Sullivan, President	5
6.	Public Forum and Introductions	Mr. Sullivan, President	
7.	Committee Reports	Mr. Sullivan, President	
8.	Executive Directors Updates	Mr. Archuleta, Executive Director	
	a. HR Updates		
	b. San Juan IPA		
	c. Market Updates		12
	d. Legislative		21
	e. Switch Enrollment Update		54
	f. Medicare Outreach Meetings		56
	g. October 31, 2017 SIC Report		57
9.	GASB75 Allocation & Review Contract (Action Item)	Mr. Archuleta, Executive Director	58
10.	Other Business	Mr. Sullivan, President	
11.	Executive Session Pursuant to the Audit Section 12-6-5 NMSA 1978 and Section 10-15-1(H)(2) NMSA to discuss FY17 Financial Audit and Section 10-15-1.H(6) to discuss PBM RFP.	Mr. Sullivan, President	
12.	Pharmacy Benefits Manager RFP (Action Item)	Mr. Kueffer, Acting Deputy Director	59
13.	Date & Location of Next Board Meeting February 6, 2018, 9:30AM Alfredo R. Santistevan Board Rm, Suite 207 4308 Carlisle Blvd. NE Albuquerque, NM 87107	Mr. Sullivan, President	
14.	Adjourn		

ACTION SUMMARY

RETIREE HEALTH CARE AUTHORITY/REGULAR BOARD MEETING

November 7, 2017

Item	Action	Page #
APPROVAL OF AGENDA	Approved	3
APPROVAL OF MINUTES: October 3, 2017	Approved	3
PUBLIC FORUM & INTRODUCTIONS	Informational	3
COMMITTEE REPORTS	Informational	3
EXECUTIVE DIRECTOR'S UPDATE HR Updates Federal Health Care Reform FY17 Financial Audit PBM RFP Presbyterian Settlement The Standard Life Insurance Legislative Switch Enrollment Sept 30 SIC Report Asset Allocation Update	Informational	3
GASB 74 REPORT	Informational	6
FY 18 1ST QUARTER BUDGET REPORT	Informational	6
2018-2022 STRATEGIC PLAN	Approved	7

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

November 7, 2017

1. CALL TO ORDER

A Regular Meeting of the Board of Directors of New Mexico Retiree Health Care Authority was called to order on this date at 9:30 a.m. in the Alfredo R. Santistevan Board Room, 4308 Carlisle Boulevard, N.E., Albuquerque, New Mexico.

2. ROLL CALL TO ASCERTAIN QUORUM

A quorum was present.

Members Present:
Mr. Tom Sullivan, President
Mr. Joe Montaño, Vice President [telephonically]
Mr. Doug Crandall, Secretary
The Hon. Tim Eichenberg, NM State Treasurer
Ms. Jan Goodwin
Mr. Wayne Propst
Ms. Therese Saunders

Members Excused:
Mr. Wayne Johnson
Mr. Terry Linton

Staff Present:
Mr. Dave Archuleta, Executive Director
Mr. Neil Kueffer, Deputy Director/ Director of Product Development & Health Care Reform
Mr. Greg Archuleta, Director of Communication & Member Engagement
Mr. Tomas Rodriguez, IT Manager
Ms. Judith Beatty, Board Recorder

Others Present:
[See sign-in sheet.]

3. PLEDGE OF ALLEGIANCE

Mr. Propst led the Pledge.

4. APPROVAL OF AGENDA

Mr. Crandall moved for approval of the agenda, as published. Ms. Saunders seconded the motion, which passed unanimously by voice vote.

5. APPROVAL OF REGULAR MEETING MINUTES: October 3, 2017

Ms. Saunders moved for approval of the minutes of the October 3 meeting, as submitted. The motion was seconded by Mr. Crandall and passed unanimously by voice vote.

6. PUBLIC FORUM AND INTRODUCTIONS

There were no speakers from the floor.

7. COMMITTEE REPORTS

Executive Committee: Chairman Sullivan said the committee met last Thursday to set today's agenda.

Finance Committee: Mr. Crandall reported that the Finance Committee discussed the actuaries and State Investment Council asset allocation update.

8. EXECUTIVE DIRECTOR'S UPDATES

a. HR Updates

Mr. Archuleta reported that the agency received 15 applications for position of Deputy Director. The field was narrowed down to six of the most qualified, and all of those finalists were interviewed last week by a panel comprising David Archuleta, IT Manager Tomas Rodriguez, CFO Josefina Roberts, and Customer Service Manager Jason Ballard. The panel elected to temporarily promote Neil Kueffer to the deputy position for a period of up to one year, as permitted by SPO rules.

Mr. Archuleta said interviews for the Customer Service Representative position will take place in the Albuquerque office and should be filled within a month. In Santa Fe, Angelina Ruiz has been promoted to Customer Service Representative.

b. Federal Health Care Reform

Mr. Archuleta said President Trump signed an executive order in mid-October, the purpose of which was to repeal some of the subsidies that were provided to companies through the ACA to offset some of the cost that they charge on the exchange. Mr. Archuleta said most elements of the ACA remain intact, however. He assured the board that any changes to the ACA that could affect the NMRHCA would be communicated to the membership.

c. FY17 Financial Audit

Mr. Archuleta reported that the FY17 financial audit is nearing completion, and he expects to receive a draft for Management's Discussion and Analysis by tomorrow. The exit conference with Moss Adams is scheduled on November 21, the day before the audit is due at the State Auditor's Office. He said he has not received any indication at this point of any significant findings in the review of the financial statements. Based on new expanded requirements associated with GASB-74, Moss Adams is also conducting a mini claims audit using a sampling of claims data.

Mr. Archuleta said the audit will be public record after it is released by the State Auditor's Office. Moss Adams will be present at the December 12 board meeting to review the FY17 audit with the board in executive session.

Mr. Archuleta stated that, with GASB-75 (next year), NMRHCA will develop an employer allocation schedule (to be done by either Segal or Moss Adams), which has to be audited by an outside firm to verify its accuracy. At that point, the NMRHCA will start to communicate the portion of the unfunded liabilities out to employer groups for inclusion in their financial statements next year.

d. PBM RFP

Mr. Archuleta said the evaluation committee representing NMRHCA in the Interagency Benefit Advisory Committee consisted of Greg Archuleta and Neil Kueffer and him. Seven qualified proposals were received for the period 2018 through 2022, and four finalists will be selected with the other IBAC entities tomorrow. These four will have an opportunity to submit a best and final offer, which will be followed by a best and final interview.

e. Presbyterian Settlement

Mr. Archuleta reported that Presbyterian Healthcare Services recently agreed to pay $18.5 million to the state to settle a lawsuit that alleged it filed fraudulent tax forms to avoid Medicaid premium taxes dating back to 2003, and there was some concern that Presbyterian might have to recoup those charges from its plan participants. He said NMRHCA pays a flat administrative fee to Presbyterian, under a four-year agreement, to administer the program on behalf of the participants, so he did not anticipate any adverse effect related to this settlement.

Neal Spero, Presbyterian's vice president of sales and marketing, assured the board that this settlement would not impact rates or pricing and would come from their reserves. He noted that the settlement agreement included removing any reference to allegations of fraud.

f. The Standard Life Insurance

Mr. Archuleta stated that, as a result of a report aired on KRQE-TV last week by Larry Barker, some NMRHCA members thought they had lost their life insurance benefits, which was not the case. He said the report was focused on benefits offered to active state employees only for the period between 2007 and 2015, which resulted in a settlement to affected employees after a class action suit was filed.

g. Legislative

Mr. Archuleta reported that NMRHCA made its FY19 appropriate request to the Legislative Finance Committee and also gave a brief 2017 solvency update.

Mr. Archuleta said NMRHCA is scheduled to make a presentation to the Investments and Pensions Oversight Committee on November 13 regarding the actuarial valuation and transparency.

Mr. Archuleta said NMRHCA will join the other IBAC members to make a presentation to the Health & Human Services Subcommittee regarding state agency expenditures on prescription drug costs. This comes out of Senate Memorial 99 in the last legislative session regarding a study of the 30 most costly prescriptions for state agencies. Following the presentation, there will be a follow-up presentation on IBAC costs and utilization trends.

h. Switch Enrollment

Mr. Archuleta reported that the 16th and final meeting was concluded last week. Attendance overall was down somewhat this year, probably because there were no significant plan changes. About 2,400 people attended when the number is typically closer to 3,000, but he considers the meetings to be a success.

Ms. Saunders said she went to several of the switch enrollment meetings, and she was truly impressed with NMRHCA staff, particularly with Dave Archuleta and Neil Kueffer, who were very professional, yet very approachable. She said the vendors also did a wonderful job.

i. September 30, 2017 SIC Report

Mr. Archuleta said he was pleased to report that the balance as of 9/30/17 was $591 million, the highest on record. On October 2, NMRHCA transferred an additional $3 million into the fund.

j. Asset Allocation Update

Mr. Archuleta said SIC staff will appear before the board at the December meeting to discuss the asset allocation. The SIC has opted to do away with the Credit/Structured and Absolute Return pools and reorganize elements of them into what is now called the Core-Plus Bonds and Structured Absolute Return portfolios. He said the SIC is in the process of hiring a new investment manager for one of the investment pools; once that is finalized, NMRHCA will revise its Joint Powers Agreement with the SIC to include the new investment classes.

Mr. Archuleta said NMRHCA has been paying NEPC to make recommendations to the board every two years on asset allocations to meet short and long-term obligations and would make a request in the spring for NEPC to appear in 2018.

Mr. Crandall said he thought the investment adviser should make more frequent appearances before the board than once every two years.

9. GASB 74 REPORT

Mr. Archuleta reported that Segal finalized the GASB 74 review and made a presentation before the Finance Committee last week. He reviewed some highlights.

Mr. Archuleta noted that the NMRHCA's OPEB liability is $5.1 billion. Subtracting out the fiduciary net position (which includes all long-term and short-term assets as of 6/30 based on the audited adjustments), there was slightly over $575 million, or a net OPEB liability (UAAL) of $4.5 billion. Previously, it was $3.8 billion.

10. FY18 1ST QUARTER BUDGET REPORT

Mr. Archuleta presented this report. Based on the numbers, it is likely that NMRHCA will be able to meet the budget it has been given for FY 18.

Chairman Sullivan said he would be interested to know if there have been any recent changes in the number of years of service or retirement age among PERA and ERB members as a result of legislation passed in the last few years.

Ms. Goodwin and Mr. Propst indicated that, overall, the age at retirement has been creeping up. Ms. Goodwin said it is closing in on 60 at the ERB.

Chairman Sullivan commented that this means the NMRHCA is bridging a smaller number of years to Medicare eligibility.

Mr. Archuleta responded that, a year and a half ago, there were 17,800 pre-Medicare participants, and that number has shrunk to 16,600. In 2013, the average age of someone coming into the program was 58, and it is now just under 61.

Mr. Propst and Ms. Goodwin said they would put together a brief presentation for the board in the spring.

11. 2018-2022 STRATEGIC PLAN

Mr. Archuleta said he had indicated at the October meeting that he would be asking the board today to approve the strategic plan, as presented, as a working document subject to revision, as necessary. He said he thought the plan was a good road map for the board to follow over the next five years, obviously with the goal of extending the solvency period and reducing long-term liabilities while continuing to show improvements in solvency and in the GASB report.

Mr. Crandall moved to approve the strategic plan, as presented. Ms. Saunders seconded the motion, which passed unanimously by voice vote.

12. OTHER BUSINESS

None.

13. DATE & LOCATION OF NEXT BOARD MEETING

December 12, 2017, 9:30 AM
Alfredo R. Santistevan Board Room
4308 Carlisle Blvd., N.E.
Albuquerque, New Mexico 87107

14. EXECUTIVE SESSION

None.

15. ADJOURN

Its business completed, the board adjourned the meeting at 10:45 a.m.

Accepted by:

____

Tom Sullivan, President

The New York Times | https://nyti.ms/2nrEI3v

HEALTH

CVS and Aetna Say Merger Will Improve Your Health Care. Can They Deliver?

By REED ABELSON and KATIE THOMAS DEC. 4, 2017

When CVS Health and Aetna announced their merger on Sunday, their executives painted an image of a dawning health care utopia.

The new company, combining one of the country's biggest pharmacies with one of its largest health insurers, will create a world where patients will get the "human touch," they said. Fewer people will fall through the cracks, they promised, and getting high-quality, low-cost medical care will be as close as your corner drugstore.

With their merged data about people's health and vast reach, the two companies assert that they have the opportunity to make real change in a health care landscape that nearly everyone agrees is too convoluted, inefficient and expensive.

"It's not going to immediately shake up the world, but I think you have two behemoths — two battleships that are slow to turn — and it will at least create an environment by which information can be shared and innovation can take place," said Nadina J. Rosier, the health and group benefits pharmacy practice leader at the consulting firm Willis Towers Watson.

Whether this rosy future will become reality, however, is far from certain. The announcement of the $69 billion merger set off a wave of speculation over just how

much it will upend the way people get medical care in this country. And few expect drug costs, which have been rising, to decline under this arrangement.

Skeptics say CVS and Aetna entered into the deal not to benefit consumers but to strengthen their competitive positions at a tumultuous time for the industry, in the hopes that the combination will yield new business opportunities. The two are already major health care players. If they wanted to change the world, critics asked, why haven't they done so already? Others pointed out that a major rival, UnitedHealth Group, already owned a large pharmacy benefit manager, OptumRx, yet drug prices have continued to rise, and consumers remain frustrated.

Some worry that the nation's health care system will come to resemble a series of kingdoms, where consumers are locked into separate ecosystems of pharmacies, doctors and health care clinics depending on their insurance provider.

Given that many people change insurance plans frequently, "you may be bounced from kingdom to kingdom," said B. Douglas Hoey, the chief executive of the National Community Pharmacists Association, the trade group for independent pharmacists.

The deal, which still needs approval by the two companies' shareholders as well as regulators, would create community-based hubs at the roughly 10,000 stores that CVS now operates, where consumers would be able to get some array of care. By overseeing patients' medical benefits as well as their pharmacy benefits, the companies hope to better coordinate treatments for customers.

Instead of getting lost in what Aetna's chief executive, Mark T. Bertolini, describes as the "rat maze" of health care, patients could go somewhere near their home to have a chronic condition like diabetes followed by a nurse or to a clinic to check out if a sore throat is strep.

While the traditional health care system could be overseeing people's care, it isn't, said Larry J. Merlo, the chief executi the merger as a way of capitalizing on "the opportunity to meet a huge unmet need."

3 ARTICLES REMAINING SIGN UP Subscriber login

“You have a really good strategy,” said Brian Tanquilut, a health care equity analyst for Jefferies. Aetna and CVS “really want to transform the way care is delivered,” he said, but “unless you can really execute well, a good strategic goal and vision will not automatically translate into better health care and reduced costs.”

The prospect of significant cuts to government programs like Medicare due to the Republicans’ proposed tax overhaul, as well as uncertainty over the future of the Affordable Care Act, is forcing many hospital groups and health companies to rethink their business plans and potential partners.

The possibility that retailers like Amazon will enter the pharmacy business and that technology companies will offer medical care via cellphone is a threat that the established players see the need to combine to combat.

“It’s an industry highly in flux,” said Benjamin Gomes-Casseres, a professor at Brandeis International Business School. “What we have here is a remixing of assets.”

While the deal between Aetna and CVS is a vertical merger that blurs different health care businesses, others are still looking to get larger within the same field. On Monday, Advocate Health Care, a large Chicago system of hospitals and doctors that failed in its attempt to merge with another Chicago-area group this year, said it planned to combine instead with Aurora Health Care, a Wisconsin system. The deal could make it one of the nation’s largest nonprofit systems.

Analysts and others said one of CVS’s biggest obstacles, requiring significant investment and time, would be to transform its drugstores into a broader medical setting.

“It’s going to face many hurdles,” said Adam J. Fein, president of Pembroke Consulting, who researches the drug-distribution industry. He said changing people’s minds about what happened inside a CVS — and persuading them to seek out medical services there beyond getting a flu shot — could be difficult. And some have raised questions about whether the care will be disjointed and low quality.

“I wouldn’t underestimate the barriers that existing providers” will throw in the way, Mr. Fein said. He noted that in recent years hospitals had been competing in

the same area, setting up urgent-care clinics and more closely coordinating with primary-care doctors.

CVS was unable to develop this new model with its existing stores, said Martin Gaynor, a health economist at Carnegie Mellon University, who noted retail clinics had not yet shown they saved money over all, even if people found it easier to get care. “What are they going to do different here?” he asked.

If the idea succeeds, the transformation could give patients more options and better convenience. Patients would also benefit if the new company got better at coordinating care, such as improving the transition from the hospital to home, or managing chronic conditions like diabetes.

Employers could use the merger to their advantage, said David Dross, a pharmacy benefits expert for the consultant Mercer. With UnitedHealth owning OptumRx and CVS teamed with Aetna, employers may be in a better position to demand guarantees about overall costs, he said.

“There is the ability there to move the needle a little bit,” Mr. Dross said.

Brian Marcotte, the chief executive of the National Business Group on Health, said, “There are elements of this that could be tremendously beneficial if it’s executed on and flows through the system.” But Mr. Marcotte, whose group represents large employers that offer health benefits to their workers, is wary of claims that mergers will result in savings for employers and consumers.

“In most scenarios, I don’t think we have these synergies flow back,” he said.

While the combination could lead to much lower costs, it may not ultimately change the existing pharmacy model, Mr. Marcotte said, but could “further entrench an already entrenched business model.”

“It is too soon to tell,” he said.

Still, others said the merger could further limit options for consumers, who have already seen a steady narrowing of their choices, from which pharmacy they can visit to which doctor they can see.

The deal could also have a ripple effect, leading other companies to team up in an effort to compete.

The merger will leave Express Scripts as the only remaining major pharmacy benefit manager to not be tied to an insurer. The distinction could become a selling point for Express Scripts — a point its chief executive, Timothy C. Wentworth, made in an interview with CNBC last week.

“Right now I love where we sit,” he said. “As an independent company, we don’t have stores to feed. We don’t have health plans to feed.”

But others noted that Express Scripts could also decide to merge with a health insurer — such as Humana or Cigna — or combine with a retail chain like Walgreens.

David Mitchell, the founder of Patients for Affordable Drugs, a nonprofit that does not take money from the insurance or drug industries, said he was skeptical that consumers would see much benefit. He noted that CVS Health and Aetna were already industry behemoths that had had ample opportunity to improve conditions for patients.

“They’re not doing this to provide better care to people,” he said. “They’re doing this to make more money.”

A version of this article appears in print on December 5, 2017, on Page B1 of the New York edition with the headline: Skepticism About What CVS and Aetna Can Deliver if They Merge.

© 2017 The New York Times Company

The New York Times | https://nyti.ms/2nxI0lP

HEALTH

UnitedHealth Buys Large Doctors Group as Lines Blur in Health Care

By REED ABELSON DEC. 6, 2017

In another example of the blurring boundaries in the health care industry, UnitedHealth Group, one of the nation's largest insurers, said on Wednesday that it is buying a large physician group to add to its existing roster of 30,000 doctors.

UnitedHealth's Optum unit will acquire the physician group from DaVita, a large for-profit chain of dialysis centers, for about $4.9 billion in cash, subject to regulatory approval. DaVita operates nearly 300 clinics across a half-dozen states, including California and Florida.

With the purchase, UnitedHealth is increasingly moving into the direct delivery of medical care.

"Combining DaVita Medical Group and Optum advances our shared goal of supporting physicians in delivering exceptional patient care in innovative and efficient ways," Larry C. Renfro, Optum's chief executive, said in a statement.

Analysts praised the move as keeping with UnitedHealth's broader goal of building a large ambulatory care business.

4
ARTICLES REMAINING
SEE MY OPTIONS
Subscriber login

announced.

The proposed acquisition comes after the announcement that another big insurer, Aetna, planned to merge with CVS Health. That transaction, if approved, could transform CVS's 10,000 drugstores into community-based health care "hubs," where people could get blood tests or help managing a chronic disease like diabetes. Executives at Aetna and CVS said that this new model would result in better care and lower costs for patients.

At a time of growing uncertainty in the health care marketplace, doctors, drugstores, hospitals and insurers are looking outside their traditional businesses to join forces. The tax overhaul proposed congressional Republicans could cut payments to federal programs like Medicare sharply and upend the Affordable Care Act, and employers and consumers are increasingly worried about the high cost of medical care.

The potential threat of new competitors like Amazon entering the pharmacy business and technology companies delivering medical care through cellphones has led former adversaries to become partners, driving insurers to team up with hospitals and doctors' groups. They are seeking to deliver care in novel ways, outside the expensive setting of a hospital. While the combination with CVS allows Aetna to experiment with providing medical care in a retail setting, insurers are also looking to partner directly with doctors and health systems.

To change how people receive medical care, particularly when managing chronic, and costly, diseases like diabetes and asthma, the parties "are going to have to reorganize," said Craig Garthwaite, a health economist at the Kellogg School of Management at Northwestern University.

"There's no chance that the existing companies, be they hospital or insurers, have the right configuration of assets to be successful" at turning health care into a business where the parties are able to produce better outcomes at a lower cost, he said.

What is striking about the recent combinations, Professor Garthwaite said, is that insurers are the ones seeking to integrate the delivery of care into their

operations, as opposed to a large health system like Kaiser Permanente, the health maintenance organization based in California, directing members to its hospitals and doctors. "For a long time, we thought there was a world in which Kaiser was the future," he said.

But Kaiser Permanente has proved to be mostly an exception to the rule. Several large systems began offering health plans under the Affordable Care Act, only to end up losing money and getting out of the business.

Aetna and UnitedHealth appear to be trying to develop their own in-house network of doctors to try to change how care is delivered. UnitedHealth, which already operates a large pharmacy-benefit manager and a variety of health care services through its Optum unit, is among the most diversified and most successful insurers.

The acquisition of DaVita Medical Group, which includes such high profile organizations as HealthCare Partners and the Everett Clinic, is the latest move by UnitedHealth to expand into the realm of delivering medical care as a way of reducing costs. The company already operates medical practices in Southern California and elsewhere, and it owns nearly 250 MedExpress urgent-care clinics. The company says the clinics offer much of the same care available at a hospital emergency room but at a significantly lower cost.

Last January, UnitedHealth also acquired a chain of surgery centers, a move the company said could lower the expense of having an outpatient surgery by more than 50 percent. The company expects to perform roughly 1 million surgeries and other procedures this year.

Insurers are also increasingly experimenting with different methods of paying for care and attempting to provide better oversight of potentially expensive chronic conditions like diabetes or heart failure. To date, Aetna and Cigna have favored joint ventures with large health groups.

While these new partnerships promise to change how people get care, by marshaling better information about patients and steering them to less expensive and more convenient places, whether an urgent-care clinic or drugstore, delivering

on that promise may prove challenging. DaVita, which bought HealthCare Partners five years ago as a way to become a major player in the care of people with chronic conditions, found itself struggling to make money on its medical group. In describing the group's most recent quarterly financial results, DaVita's chief executive, Kent J. Thiry, said they were "extremely disappointing."

The sale, which is expected to close next year, return DaVita to its core kidney dialysis business, although Mr. Thiry said in a statement that the company expected "to pursue other investments in health care services outside of kidney care." DaVita has been under scrutiny for its relationship with a charity, the American Kidney Fund, that helps pay the cost of private insurance for patients receiving dialysis treatment.

Consumers could also see their choice of doctor or pharmacy sharply limited under these arrangements as insurers attempt to steer patients into the groups over which they have the most control. Both Aetna and UnitedHealth insist their goal is to develop a new model of care that will be available to people outside their respective health plans, and Optum says it now works with more than 80 health plans.

Even if insurers succeed in lowering medical costs as a result of the new ventures, economists and other experts warn that shareholders, not consumers, could benefit unless the lower costs yield lower prices for coverage. There must be sufficient competition among insurers for consumers to benefit, Professor Garthwaite said.

"You need three, four or five insurance companies trying to pull that strategy off," he said. "That's really hard to do."

Follow Reed Abelson on Twitter: @reedabelson.

A version of this article appears in print on December 7, 2017, on Page B3 of the New York edition with the headline: In Shift to Care Delivery, Insurer Buys Doctors Unit.

© 2017 The New York Times Company

Investments & Pensions Oversight Committee

Representative Tomas E. Salazar, Chair
Senator George K. Munoz, Vice Chair

Actuarial Valuation: Government Accounting Standards Board (GASB) Statements 74 & 75
Transparency
November 13, 2017

Tom Sullivan, Board President
Joe Montano, Vice President
Doug Crandall, Secretary
David Archuleta, Executive Director

Valuation Summary – GASB 74

Based on following inputs:

- Plan provisions as of June 30, 2017
- Characteristics of covered active members, inactive vested members, retired members and beneficiaries
- Plan assets as of June 30, 2017
- Economic assumptions regarding future salary increases and investment earnings
- Other (health and non-health) actuarial assumptions i.e., employee terminations, retirement, death, health care trend and enrollment

Outcomes:

- Net OPEB Liability (NOL) = Total OPEB Liability (TOL) minus Plan's Fiduciary Net Position
- Plan's Fiduciary Net Position = Market Value of Assets
- NOL reflects all investment gains and losses as of the measurement date

Key Assumption:

- Investment returns includes a blend of 7.25% (assumed rate of return) a 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (3.58% as of June 30, 2017)

Summary of Key Valuation Results

Net OPEB Liability Components (June 30, 2017):

• Total OPEB Liability:	$5,111,141,659
• Plan Fiduciary Net Position:	$575,649,501
• **System's Net OPEB Liability:**	**$4,535,492,158**
• Plan Fiduciary Net Position as a percentage of the Total OPEB Liability:	11.26%

Retired members, beneficiaries and married dependents	51,208
Vested terminated members entitled to, but not yet receiving benefits	11,478
Active members	97,349
Total members receiving or expecting to receive benefits	**160,035**

Sensitivity to Changes in Discount/Trend Rate

Net OPEB Liability (June 30, 2017):

System's Net OPEB Liability: **$4,535,492,158**

Change in Discount Rate:	Net	Change
1% Decrease (2.81%)	$5,500,667,903	(-$965,175,745)
1% Increase (4.81%)	$3,778,225,036	($757,267,122)

Change in Trend Rate:	Net	Change
1% Decrease	$3,858,319,120	($677,173,038)
1% Increase	$5,063,519,724	(-$528,027,566)

Current trend rates: 8% graded down to 4.5% over 14 years for non-Medicare plans and 7.5% graded down to 4.5% over 12 years for Medicare plan costs

NMRHCA GASB History

Year	Actuarial Accrued Liability/Total OPEB Liability	Acturial Value of Assets/Plan Fiduciary Net Position	Unfunded Acturial Accrued Liabilty/Net OPEB Liability	Funded Ratio	Covered Payroll	Total Participants
2006	$ 4,264,180,967	$ 154,538,668	$ 4,109,642,299	3.62%	$4,073,731,873	140,292
2008	$ 3,116,915,900	$ 170,626,271	$ 2,946,289,629	5.47%	$4,020,508,902	130,381
2010	$ 3,523,664,871	$ 176,922,935	$ 3,346,741,936	5.02%	$4,001,802,240	146,166
2012	$ 3,915,114,104	$ 227,487,895	$ 3,687,626,209	5.81%	$3,876,220,608	146,590
2014	$ 3,740,369,299	$ 377,087,017	$ 3,363,280,282	10.08%	$3,941,587,760	155,098
2016	$ 4,277,042,499	$ 471,978,347	$ 3,805,064,152	11.04%	$4,271,183,612	159,642
2017	$ 5,111,141,659	$ 575,649,501	$ 4,535,492,158	11.26%	$4,165,647,340	160,035

Major changes (2006-2017) include:

- AAL/Total OPEB Liability Change: $846,960,692
- AVA/Plan Fiduciary Net Positions Change: $421,110,833
- UAAL/Net OPEB Liability Change: $425,849,859
- Funded Ratio Change: 7.64%
- Covered Payroll Change: $91,915,467
- Total Participants Change: 19,743

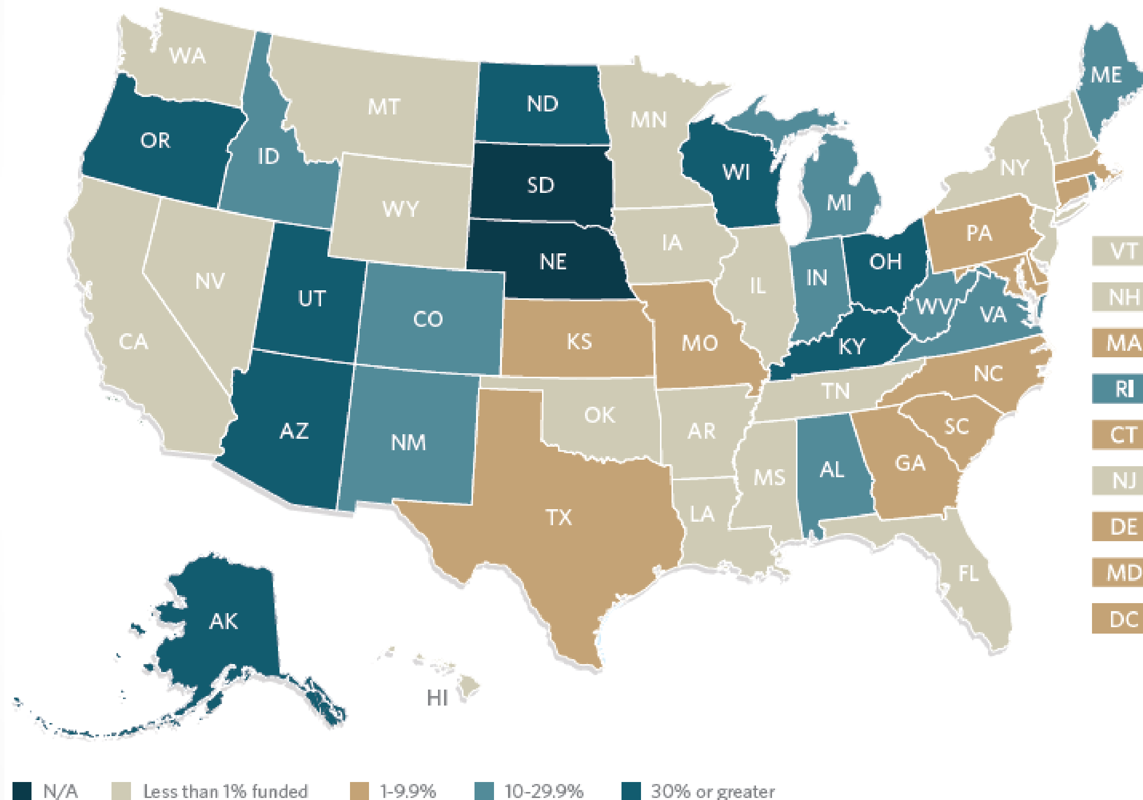
The PEW Charitable Trusts

State Retiree Health Care Liabilities Key Stats:

- States paid a total of $20.8 billion in 2015 for OPEB benefits (almost all retiree healthcare)
  - Represents an increase of $1.2 billion, or 6 percent over the previous year
  - Total liabilities (cost of benefits in today's dollars, to be paid in future years) = $693 billion, a 5 percent increase over 2014
  - Total assets = $48 billion, yielding a funded ratio of 6.9% ($44 billion/2014)
- Average funded ratio is low because most states pay for retiree health care benefits on a pay-as-you-go basis, rather than pre-funding liabilities
- Funded Ratios vary by state – less than 1 percent in 19 states to 92 percent in Arizona, only 8 have funded ratios above 30 percent
- Data collected from 166 OPEB plans, including multiple plans in many states
- Most data comes from 2015 CAFRs from each state

Source: http://www.pewtrusts.org/~/media/assets/2017/09/opeb-liablitly-brief_v3.pdf

State OPEB Funded Ratios, 2015



GASB 75

Accounting and Financial Reporting for Postemployment Benefits Other Than Pension

Net OPEB Liability (June 30, 2017):	$4,535,492,158
Participating employer groups	
• School Districts/Educational Institutions	203
• State Agencies	1 group (74 agencies)
• Cities	26
• Counties	23
• Towns	8
• Villages	12
Total	**301**

- GASB 75 will require participating employer groups to report their portion of Net OPEB Liability on their financial statements
- Reported amounts based upon percent of contributing employers percentage of reported payroll

Transparency

Website

- Annual Financial Audits
- GASB Reports
- Annual Summary of Benefits
  - Eligibility and participation rules
  - Contact information
  - Side by side comparison: non-Medicare, Medicare, dental, vision and life insurance
  - Monthly premium rate sheet based on years of service
- Board Information
  - Monthly Meeting Documents
  - Meeting Minutes
  - Meeting Notices
  - Meeting Agendas
- Contracts
  - New contracts located on Sunshine Portal
- Future Additions
  - Investment Reports

Contact Information

Albuquerque :	4308 Carlisle Blvd. NE, Suite 104 Albuquerque, NM 87107 Phone: (505) 222-6400 Fax: (505) 884-8611
Santa Fe	33 Plaza La Prensa, Suite 101 Santa Fe, NM 87507 Phone: (505) 476-7340 Fax: (505) 476-9415
Toll Free:	800-233-2576
Website:	www.nmrhca.org

David Archuleta
david.archuleta@state.nm.us
(505) 222-6416

Representative Patricia A. Lundstrom
Chairwoman

Representative Paul C. Bandy
Representative Randal S. Crowder
Representative George Dodge, Jr.
Representative Jimmie C. Hall
Representative Larry A. Larrañaga
Representative Nick L. Salazar
Representative Jim R. Trujillo

State of New Mexico
LEGISLATIVE FINANCE COMMITTEE

325 Don Gaspar, Suite 101 • Santa Fe, NM 87501
Phone: (505) 986-4550 • Fax (505) 986-4545

David Abbey
Director

Senator John Arthur Smith
Vice-Chairman

Senator William F. Burt
Senator Pete Campos
Senator Carlos R. Cisneros
Senator Carroll H. Leavell
Senator Howie C. Morales
Senator George K. Munoz
Senator Steven P. Neville

November 16, 2017

MEMORANDUM

TO: Representative Patricia Lundstrom, Chair, LFC
Senator John Arthur Smith, Vice-Chair, LFC
Representative Deborah Armstrong, Chair, LHHS
Senator Gerald Ortiz y Pino, Vice-Chair, LHHS
LFC and LHHS Members

THROUGH: David Abbey, LFC Director
Charles Sallee, LFC Deputy Director

FROM: Jenny Felmley, Ph.D., Program Evaluator, LFC

SUBJECT: Senate Memorial 99, State Agency Prescription Drug Savings

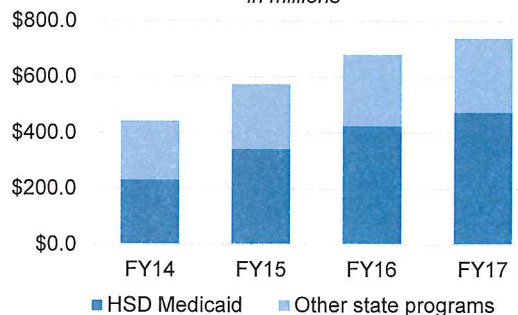
---

Summary. Senate Memorial 99 (SM99), sponsored by Senator Jeff Steinborn and passed during the 2017 legislative session, requested the LFC to gather new prescription drug spending data from the 10 state agencies and entities included in the 2016 LFC Health Note, *Prescription Drug Costs: Maximizing State Agency Purchasing Power*, and then compile this information and identify the top 30 prescription drugs by total fiscal impact, per unit price, price growth, and total rebates captured.

State agencies spent over $737.8 million on prescription drugs in FY17, an 8 percent increase from FY16. Growth is driven by an 11 percent increase for the Medicaid program alone, and a 3 percent increase for all other state agencies combined. Some of the change is due to more prescriptions, but as the following sections will show, most is due to the continued rise in drug costs.

Some state agencies were unable to provide all of the data requested for this review, highlighting the finding from last year's report that state agencies need better oversight, reporting and transparency regarding their prescription drug spending.

Chart 1: State Prescription Drug Spending
in millions



Source: LFC analysis of agency data

Background. The state agencies and entities included in the 2016 LFC Health Note were: the Children, Youth and Families Department (CYFD), the Corrections Department (NMCD), the Department of Health (DOH), the Human Services Department (HSD), the UNM employee and UNM Hospital employee health plans, and the member agencies of the Interagency Benefits Advisory Committee (IBAC): Albuquerque Public Schools (APS), the General Services Department (GSD), the New Mexico Public School Insurance Authority (NMPSIA), and the Retiree Health Care Authority (RHCA).

The previous study reviewed in some depth total spending and utilization trends for prescription drugs for each agency, as well as each agency's structure for purchasing drugs, key cost drivers and conditions, and unique challenges. One key finding of that review was that in New Mexico, as is true around the country, drug costs were rising faster than utilization, increasing from $442 million in FY14 to over $679 million in FY16. A second key finding was there appeared to be further opportunities for cost savings to the state through collaborative purchasing arrangements and improved state agency oversight, reporting and transparency.

SM99 requested a deeper dive into specific areas of the earlier report. The LFC was tasked to collect information from each agency/entity identifying:

- The 30 most utilized prescription drugs;
- The 30 prescription drugs with the highest per unit price;
- The 30 prescription drugs with the highest price growth between FY12 and FY16; and
- The 30 prescription drugs that constitute the greatest expenditure to the agency budget.

The LFC was further tasked to compile the data and identify:

- The total fiscal impact of each of the top 30 prescription drugs;
- The per unit price paid for the top 30 prescription drugs;
- The price growth between FY12 and FY16 for each of the top 30 prescription drugs; and
- The total rebates captured for the top 30 prescription drugs.

Lastly, the LFC was requested to report its findings and recommendations for achieving greater state agency savings in prescription drug and pharmacy benefits purchasing to the LFC and the LHHS. The following sections of this report review the key findings from each set of categories, and the compiled and aggregated data for each 'top 30' list can be found in Attachments A – J.

For some state agencies, providing the data for this review was challenging. Changing pharmacy benefit managers (PBM) and wholesalers made it impossible for some agencies and individual DOH facilities to gather the data necessary to determine price growth from FY12 through FY16, as they could only provide data from the current contractor – in some cases the agency/facility was able to determine detailed spending for just the last year. Because of gaps and inconsistencies in agency data, the totals included in each of the attached 'top 30' sheets will not necessarily match and all totals presented in this memo are approximate.

Total fiscal impact of each of the top 30 prescription drugs. Spending on the top 30 drugs increased by 9 percent from FY16 to FY17, from $266.4 million to $291.6 million. The major cost drivers identified in last year's Health Note are still present, and the top 30 list is dominated by spending on very expensive, mostly non-generic drugs to treat diabetes, cancer, inflammatory conditions, and hepatitis C. Also among the top 30 are drugs to treat asthma, HIV, and narcotic withdrawal, as well as several behavioral health medications. See Attachments A and B.

It is interesting to note that none of the drugs on the top spending list are in the top 30 of any other category: they are not the most prescribed, they are not the highest per unit cost, and they are not among the highest in cost growth. These drugs reach the top of the spending list by a combination of all of the factors that go into drug costs.

Table 1: FY17 New Mexico State Prescription Drug Spending
in millions

	HSD – Medicaid	IBAC employee and retiree plans	UNM and UNMH employee plans	NMCD	DOH	CYFD	Total
Total spending on prescription drugs	$473.5	$229.8	$24.9	$6.3	$3.1	$0.2	$737.8
Change in spending, FY16 – FY17	10.9%	4.5%	5.3%	- 33.7%	13.5%	0.9%	8%
Prescription drug rebates received	$300.4	$47.0	$2.5*	n/a	$0.13*	n/a	$350

* No rebates reported for UNMH; not all DOH facilities reported rebates.
Source: LFC analysis of agency data

The per unit price paid for the top 30 prescription drugs. This review looked at price increases at the granular level: per-unit pricing, meaning the price for an individual pill, capsule, injection, etc. For the top 30 drugs each year, the average per unit price increased by approximately 34 percent, from $5,701 in FY16 to $7,643 in FY17. That increase is partly due to actual price increases, but also reflects differences in the mix of top 30 drugs – there are some very expensive drugs on the FY17 list that were not on the FY16 list. Notably, every drug on this list is a brand name drug, and many are specialty biologic drugs. See Attachments E and F. Equally notable is that these very high cost drugs typically do not make up a large portion of total agency spend. For example, HSD reported that for Medicaid, the top 30 most expensive drugs made up only 6.7 percent of the total drug spend.

Other drugs whose high cost have been of great concern to the state do not appear on this list for a variety of reasons. The various medications for hepatitis C, for example, are usually spoken of as cost per course of treatment, rather than per unit. Although all priced at over $1,000 per unit, none made the top 30 list because the lowest cost drugs on those lists were even more costly, at over $2,000 per unit. Similarly, spending for diabetes and inflammatory conditions is driven by not just the cost of the drugs but also the fact that these are chronic conditions and require frequent medication.

It is very difficult to aggregate and compare per unit drug prices. Many drugs are dispensed in multiple dosage strengths and possibly also delivery systems (eg pills, inhalers,

injections, etc.). To avoid having the top 30 drug lists be dominated by 10 or 12 drugs with all of their multiple formulations listed, each drug was aggregated onto a single line for each agency, and then again for the whole set of agencies. The per-unit prices found here are not the precise amount paid by any agency, but rather the average across all formulations and all agencies.

Per unit costs were possibly the greatest challenges to the agencies. Some simply did not have access to this information, others were not able to provide accurately and therefore chose not to provide at all. Agency difficulties with providing per unit data arose for different reasons. The DOH facilities, for example, purchase drugs by the box or package, and dispense them directly. Some facilities have records indicating how many units were in a package but some do not, and without that information no per unit price can be calculated. Due to lack of data from some agencies and the need to aggregate and average costs across multiple agencies, it turned out to simply not be possible to collect uniform and accurate unit price costs. Therefore price per-unit data is a best estimate using available information.

The price growth between FY12 and FY16 for each of the top 30 prescription drugs.
The drugs in the top 30 list by price increase saw their per unit prices increase between 1,228 percent and an astounding 8,078 percent for the top drug, a commonly prescribed, generic antibiotic. Dozens of other drugs increased in price by between 100 percent and 1,000 percent. See Attachment G for FY12 – FY16 price changes; Attachments H and I have additional FY16 to FY17 price change information, submitted by some agencies, that shows some drugs continuing their upward price trajectory, and others stalling or even dropping in price.

Please note that the top 30 list is driven by a host of low cost drugs where even small increases in price result in large percentage gains. Other drugs whose price increases have made big news, like the Epipen and naloxone, with 500 percent and 250 percent increases respectively, do not make this list. Whether many small increases in dollar amount are more or less significant than other, larger increases would depend on an individual agency's or plan's utilization, ability to negotiate discounts, and other pricing factors. For example, Express Scripts, the PBM for IBAC, reported that although Anosul-HC showed a 3,500 percent increase between FY12 and FY16, it has had very low utilization, only six prescriptions at a total cost of $2,500, making the change in price insignificant. HSD reported the top 30 by price increase represented only 1.1 percent of its total FY17 spend.

That said, the increases shown on the top 30 list are remarkable and merit further investigation, and they help demonstrate the overall trend of increases in drug prices that drive state agency spending on drugs far more than increases in utilization. They also demonstrate the variety of reasons a drug may increase in price: while new brand and generic drugs, protected by periods of low competition, can raise prices annually, other price increases may be the result of market consolidation which gives the remaining manufacturer greater ability to raise prices on even common generics; Express Scripts reported this was the case for antibiotics tetracycline hcl and doxycycline hyclate. Interestingly, as Attachment H shows, the price per unit state agencies paid for tetracycline

dropped by 13 percent between FY16 and FY17, while Attachment I shows the price for doxycycline hyclate continued to climb by another 85 percent.

However, it is also important to remember that the per unit prices used in this brief review are aggregates of multiple forms of the same drug – meaning, for example, that very high dose formulations are averaged in with lower dose, or relatively lower cost pills may be averaged with typically higher cost injections. The same drug may also have different prices when used for different conditions. Best efforts were made to keep drugs separated by indication, but there may be cases where multiple indications were merged, leading to an overstatement of price growth. A truer evaluation of drug price increases would require more exacting comparison.

The total rebates captured for the top 30 prescription drugs. State agencies reported a total of $258.2 million in rebates collected for all drugs in FY16, and $307.7 million collected in FY17, a 19 percent increase. These numbers are imprecise, however, because some agencies and facilities were unable to provide even the total amount of subsidies received. Gathering comprehensive detailed data on drug rebates was impossible, because no pharmacy benefit manager (PBM) will release drug-specific rebates out of concern for compromising their future negotiating position with drug manufacturers. Express Scripts, the PBM for the IBAC agencies and for the UNM employee health plan, provided drug rebates by major conditions, as did Blue Cross Blue Shield, the PBM for the UNM Hospital employee plan; see Attachment J. HSD provided data regarding the total rebates received, but reported that detail by drug or therapeutic class is not available to the agency.

Agency responses. This report follows the line of inquiry established by SM 99 closely, and does not provide the same in-depth analysis of agency spending as last year's Health Note. After reading a draft of the report, several participating agencies requested that at least some discussion be included regarding factors other than price that influence their spending. For example, HSD pointed out that the increase in its drug costs are driven somewhat by increased enrollment, as well as the persistently high prices of specialty medications. HSD reported that while its cost per course of treatment for hepatitis C has dropped from an average of $89,000 in 2015 to a projected average of $39,000 for 2018, hepatitis C continues to be a cost driver for the Medicaid program because HSD is focused on treating as many people as possible to reduce longer term health costs.

In response to high prices and/or large price increases, all of the employee plans as well as the Medicaid MCOs may make adjustments to their formulary and prior authorization processes to encourage members to use less-expensive medications when clinically appropriate. So as noted above, many of the high per unit cost drugs, and the drugs with high price increases, have less of an impact on total agency spending than it might appear.

Several agencies also pointed out that the total spending amounts included here are gross or plan cost, and do not subtract subsidies or rebates. That is because no agency could provide drug-specific rebate or subsidy information, and total and per-drug spending was reported consistently throughout.

Conclusion. Establishing the real prices paid for prescription drugs by state agencies is an enormously complex task, as this brief review shows. At the agency level, there are serious problems with the ways some agencies and state facilities maintain – or fail to maintain – basic information about what they are spending. The LFC has noted the difficulties posed when state data is owned by contractors rather than state agencies in previous evaluations; prescription drug data is one more unfortunate example of this phenomenon. Even the agencies that do retain good access to their data, however, like the Human Services Department and the IBAC agencies, are barred by contractual arrangements from obtaining some details like per-drug rebates and subsidies.

That said, the true challenge to obtaining full data about prescription drug costs is the systemic lack of transparency of the drug industry itself. There are many complex and interactive factors at work: multiple formulations, dosages and indications for every drug; brand name and generic versions; different prices to every buyer dependent on a host of factors including PBM negotiating power, plan size, membership and plan design; different discounts and rebates for each drug and for each purchaser. Because of all of these factors, even the four IBAC agencies, which consolidate their pharmacy benefits with a single PBM, pay different prices for most drugs.

This brief review is able to provide some insight into some approximate data about state agency spending on prescription drugs. The next steps in any effort to fully understand state spending and, perhaps, to gain some measure of control over it, require both addressing the shortcomings of state agencies in oversight of their own spending information and obtaining even more granular data that allows more direct, apples-to-apples comparison.

Attachment A: Top 30 drugs by spending, FY16				
2016 Rank	**Drug name**	**Brand drug**	**Indication**	**Total cost to agencies**
1	Harvoni	Y	Hepatitis C	$33,798,126
2	Lantus	Y	Diabetes	$24,664,397
3	Sovaldi	Y	Hepatitis C	$24,408,214
4	Humira	Y	Inflammatory conditions	$22,272,174
5	Viekira Pak	Y	Hepatitis C	$14,021,004
6	Aripiprazole	N	Antipsychotic	$13,486,439
7	Enbrel	Y	Inflammatory conditions	$12,751,159
8	Novolog	Y	Diabetes	$10,619,851
9	Suboxone	Y	Narcotic withdrawal	$10,015,882
10	Levemir	Y	Diabetes	$9,073,381
11	Humalog	Y	Diabetes	$8,372,441
12	Daklinza	Y	Hepatitis C	$8,222,299
13	Ventolin HFA	Y	Asthma	$6,806,045
14	Januvia	Y	Diabetes	$6,165,239
15	Lyrica	Y	Pain/inflammation	$5,781,429
16	Symbicort	Y	Asthma	$5,563,756
17	Methylphenidate	N	ADHD	$5,048,135
18	Truvada	Y	HIV	$5,032,692
19	Flovent HFA	Y	Asthma	$4,887,476
20	Advair	Y	COPD/asthma	$3,984,989
21	Stribild	Y	HIV	$3,885,985
22	Revlimid	Y	Cancer	$3,880,057
23	Crestor	Y	High blood cholesterol	$3,843,153
24	Copaxone	Y	Multiple sclerosis	$3,308,469
25	Qvar	Y	Asthma	$2,989,794
26	Vyvanse	Y	ADHD	$2,982,917
27	Epinephrine	N	Anaphylaxis	$2,917,509
28	Xifaxan	Y	Hepaticencephalopathy, irritable bowel syndrome	$2,772,488
29	Quetiapine fumarate	N	Antipsychotic	$2,635,772
30	Esomeprazole magnesium	N	Heartburn/ulcer disease	$2,209,410
			TOTAL	$266,400,682

Source: LFC analysis of agency data

Attachment B: Top 30 drugs by spending, FY17				
2017 Rank	Drug name	Brand drug	Indication	Total cost to agencies
1	Humira	Y	Inflammatory conditions	$29,955,439
2	Epclusa	Y	Hepatitis C	$27,275,632
3	Symbicort	Y	Asthma	$26,453,318
4	Zepatier	Y	Hepatitis C	$24,678,149
5	Lantus	Y	Diabetes	$21,864,693
6	Harvoni	Y	Hepatitis C	$16,986,016
7	Enbrel	Y	Inflammatory conditions	$16,387,774
8	Novolog	N	Diabetes	$13,139,905
9	Suboxone	Y	Narcotic withdrawal	$12,625,150
10	Humalog	Y	Diabetes	$10,070,576
11	Ventolin HFA	N	Asthma	$8,324,405
12	Januvia	Y	Diabetes	$7,194,205
13	Sovaldi	Y	Hepatitis C	$6,851,665
14	Aripiprazole	N	Antipsychotic	$6,245,502
15	Lyrica	Y	Pain/inflammation	$6,192,207
16	Methylphenidate	N	ADHD	$5,754,138
17	Genvoya	Y	HIV	$5,217,300
18	Revlimid	Y	Cancer	$4,885,425
19	Flovent HFA	N	Asthma	$4,486,882
20	Levemir	Y	Diabetes	$4,379,382
21	Truvada	Y	HIV	$4,016,256
22	Daklinza	Y	Hepatitis C	$3,724,361
23	Xifaxan	Y	Hepaticencephalopathy, irritable bowel syndrome	$3,533,470
24	Viekira Pak	Y	Hepatitis C	$3,508,876
25	Qvar	Y	Asthma	$3,311,009
26	Tivicay	Y	HIV	$3,202,126
27	Vyvanse	Y	ADHD	$3,045,427
28	Quetiapine fumarate	N	Antipsychotic	$2,803,402
29	Epinephrine	N	Anaphylaxis	$2,791,754
30	Copaxone	Y	Multiple sclerosis	$2,672,460
			TOTAL	$291,576,904

Source: LFC analysis of agency data

Attachment C: Top 30 drugs by utilization (number of scripts), FY16

2016 rank	Drug name	Brand drug	Indication	Total cost to agencies	Number of scripts
1	Lisinopril	N	High blood pressure/heart disease	$705,792	282,556
2	Levothyroxine sodium	N	Thyroid disorders	$2,914,209	249,435
3	Amoxicillin	N	Infections	$2,101,715	246,094
4	Ibuprofen	N	Pain/inflammation	$1,093,284	242,125
5	Hydrocodone-acetaminophen	N	Pain/inflammation	$2,631,128	218,161
6	Omeprazole	N	Heartburn/ulcer disease	$1,234,809	202,738
7	Metformin	N	Diabetes	$1,146,248	172,474
8	Gabapentin	N	Pain/inflammation	$2,728,934	158,459
9	Oxycodone	N	Pain/inflammation	$3,567,627	132,867
10	Azithromycin	N	Infections	$1,231,266	131,852
11	Ventolin HFA	Y	Asthma	$6,806,045	125,235
12	Fluticasone	N	Allergies	$1,250,394	117,244
13	Sertraline	N	Depression/anxiety	$451,540	110,415
14	Simvastatin	N	High blood cholesterol	$393,137	108,937
15	Atorvastatin calcium	N	High blood cholesterol	$1,111,311	104,417
16	Amlodipine besylate	N	High blood pressure/heart disease	$356,843	99,030
17	Hydrochlorothiazide	N	High blood pressure/heart disease	$167,705	93,841
18	Cetirizine hcl	N	Antihistamine	$554,556	93,043
19	Montelukast sodium	N	Asthma	$1,191,272	82,021
20	Fluoxetine	N	Depression	$825,759	75,810
21	Alprazolam	N	Anxiety	$290,335	73,197
22	Tramadol	N	Pain/inflammation	$310,833	72,218
23	Citalopram	N	Depression	$172,371	72,134
24	Trazodone hcl	N	Sleep disorders	$330,855	69,670
25	Cyclobenzaprine hcl	N	Skeletal muscle relaxants	$238,202	59,127
26	Prednisone	N	Inflammation/immune disorders	$266,517	58,676
27	Cephalexin	N	Infections	$681,144	56,621
28	Clonazepam	N	Anticonvulsants	$166,157	48,371
29	Metoprolol	N	High blood pressure/heart disease	$558,128	40,095
30	Losartan potassium	N	High blood pressure/heart disease	$202,854	35,220
			TOTAL	$35,680,970	3,632,083

Source: LFC analysis of agency data

Attachment D: Top 30 drugs by utilization (number of scripts), FY17					
2017 rank	**Drug name**	**Brand drug**	**Indication**	**Total cost to agencies**	**Number of scripts**
1	Lisinopril	N	High blood pressure/heart disease	$696,855	285,744
2	Ibuprofen	N	Pain/inflammation	$1,184,210	254,264
3	Levothyroxine sodium	N	Thyroid disorders	$2,814,611	247,757
4	Amoxicillin	N	Infections	$2,028,369	235,036
5	Hydrocodone-acetaminophen	N	Pain/inflammation	$2,165,145	194,625
6	Gabapentin	N	Pain/inflammation	$3,020,932	192,089
7	Omeprazole	N	Heartburn/ulcer disease	$1,099,702	179,422
8	Metformin	N	Diabetes	$1,233,068	175,969
9	Ventolin HFA	Y	Asthma	$8,324,405	142,676
10	Atorvastatin calcium	N	High blood cholesterol	$1,597,778	129,808
11	Fluticasone	N	Allergies	$1,368,895	127,957
12	Oxycodone	N	Pain/inflammation	$3,049,386	120,947
13	Azithromycin	N	Infections	$1,044,785	117,989
14	Sertraline	N	Depression/anxiety	$483,265	113,759
15	Amlodipine besylate	N	High blood pressure/heart disease	$389,853	102,655
16	Cetirizine hcl	N	Antihistamine	$615,768	98,830
17	Simvastatin	N	High blood cholesterol	$368,182	95,370
18	Hydrochlorothiazide	N	High blood pressure/heart disease	$161,576	91,773
19	Montelukast sodium	N	Asthma	$1,316,100	89,081
20	Trazodone	N	Antidepressant	$419,750	85,879
21	Prednisone	N	Inflammation/immune disorders	$290,499	82,019
22	Tramadol	N	Pain/inflammation	$301,458	70,013
23	Citalopram	N	Depression	$163,238	68,745
24	Alprazolam	N	Anxiety	$261,763	67,960
25	Fluoxetine	N	Depression	$742,882	59,956
26	Cyclobenzaprine hcl	N	Skeletal muscle relaxants	$238,547	58,970
27	Cephalexin	N	Infections	$707,554	58,687
28	Ranitidine	N	Ulcers, GERD, heartburn	$284,088	50,048
29	Losartan potassium	N	High blood pressure/heart disease	$272,906	36,640
30	Metoprolol succinate	N	High blood pressure/heart disease	$514,197	29,254
			TOTAL	$37,159,767	3,663,922

Source: LFC analysis of agency data

Attachment E: Top 30 drugs by per unit price, FY16					
2016 rank	**Drug name**	**Brand drug**	**Indication**	**Total cost to agencies**	**Average per unit price**
1	Supprelin LA	Y	Precocious puberty (implant)	$23,357	$23,357
2	Stelara	Y	Inflammatory conditions	$1,396,584	$17,635
3	Signifor	Y	Endocrine disorders	$116,945	$11,695
4	Somatuline	Y	Endocrine disorders	$80,577	$11,511
5	Neulasta	Y	Blood cell deficiency	$258,588	$8,158
6	H.P. Acthar	Y	Multiple sclerosis, inflammatory conditions	$962,669	$6,906
7	Simponi	Y	Inflammatory conditions	$717,174	$6,276
8	Strensiq	Y	Enzyme deficiencies	$953,551	$5,758
9	Lupron Depot- pediatric	Y	Endocrine disorders	$94,480	$5,621
10	Plegridy pen	Y	Multiple sclerosis	$400,560	$5,549
11	Entyvio	Y	Inflammatory conditions	$10,220	$5,110
12	TNKase	Y	Thrombolytic enzymes, blood clots	$4,945	$4,945
13	Avonex	Y	Multiple sclerosis	$2,683,599	$4,850
14	Evzio	Y	Opioid overdose	$3,701	$4,626
15	DermacinRx SilaPak	Y	Skin conditions	$17,236	$4,309
16	Natpara	Y	Endocrine disorders	$84,916	$4,228
17	Sandostatin	Y	Endocrine disorders	$165,224	$4,085
18	Xiaflex	Y	Tendon contractures	$22,072	$3,678
19	Eligard	Y	Cancer	$23,745	$3,230
20	Cosentyx	Y	Inflammatory conditions	$190,941	$3,167
21	Cimzia	Y	Inflammatory conditions	$1,695,453	$3,061
22	Lupron Depot	Y	Cancer, endometriosis	$375,890	$2,988
23	Lupaneta	Y	Endocrine disorders	$2,962	$2,962
24	Ninlaro	Y	Cancer	$97,804	$2,934
25	Synagis	Y	Respiratory virus	$1,186,388	$2,719
26	Crofab	Y	Antivenins	$15,455	$2,576
27	Nucala	Y	Asthma	$12,549	$2,546
28	Firazyr	Y	Hereditary angioedema	$307,365	$2,329
29	Sylatron	Y	Cancer	$17,113	$2,139
30	HyperRAB	Y	Post-exposure rabies vaccine	$43,754	$2,084
			TOTAL/AVERAGE	$11,965,816	$5,701

Source: LFC analysis of agency data

Attachment F: Top 30 drugs by per unit price, FY17					
2017 rank	Drug name	Brand drug	Indication	Total cost to agencies	Average per unit price
1	Eylea	Y	Ophthalmic conditions	$30,860	$38,233
2	Supprelin LA	Y	Precocious puberty (implant)	$55,707	$27,853
3	Somatuline	Y	Endocrine disorders	$64,672	$12,934
4	Signifor	Y	Endocrine disorders	$131,169	$11,924
5	Stelara	Y	Inflammatory conditions	$2,373,662	$11,486
6	Neulasta	Y	Blood cell deficiency	$298,215	$8,924
7	Iluvien	Y	Ophthalmic conditions	$8,259	$8,259
8	Actimmune	Y	Immune deficiency	$238,376	$7,946
9	H.P. Acthar	Y	Multiple sclerosis, inflammatory conditions	$717,099	$7,171
10	Zinbryta	Y	Multiple sclerosis	$96,925	$6,988
11	Simponi	Y	Inflammatory conditions	$873,099	$6,920
12	Plegridy pen	Y	Multiple sclerosis	$505,633	$6,124
13	Lupron Depot-pediatric	Y	Endocrine disorders	$54,233	$5,771
14	Sandostatin	Y	Endocrine disorders	$100,985	$5,610
15	Avonex	Y	Multiple sclerosis	$2,993,000	$5,393
16	TNKase	Y	Thrombolytic enzymes	$10,572	$5,286
17	Entyvio	Y	Inflammatory conditions	$182,533	$5,228
18	Evzio	Y	Opioid overdose	$17,909	$4,980
19	Fabrazyme	Y	Metabolic disease enzyme replacement	$129,383	$4,792
20	Taltz autoinjector	Y	Inflammatory conditions	$60,815	$4,766
21	Natpara	Y	Endocrine disorders	$314,709	$4,339
22	Xiaflex	Y	Tendon contractures	$88,803	$3,711
23	Cimzia	Y	Inflammatory conditions	$1,557,123	$3,463
24	Firazyr	Y	Hereditary angioedema	$256,311	$3,164
25	Lupron Depot	Y	Cancer, endometriosis	$386,322	$3,155
26	Ninlaro	Y	Cancer	$893,668	$3,081
27	Cosentyx	Y	Inflammatory conditions	$967,815	$3,053
28	Cinryze	Y	Hereditary angioedema	$8,839	$2,946
29	Lupaneta	Y	Endocrine disorders	$5,891	$2,945
30	Synagis	Y	Respiratory virus	$1,440,589	$2,857
			TOTAL/AVERAGE	$ 14,863,176	$7,643

Source: LFC analysis of agency data

Attachment G:
Top 30 drugs by price increase between FY12 and FY16

Rank	Drug name	Brand drug*	Indication	List Price Per Unit FY12	List Price Per Unit FY16	Percent increase in price growth
1	Tetracycline hcl	N	Infections	$0.09	$7.36	8,078%
2	Cefazolin sodium	N	Antibiotic	$0.03	$1.66	4,930%
3	Vancomycin hcl	N	Antibiotic	$0.21	$8.94	4,172%
4	Nitroglycerin	N	Vasodilators, coronary	$0.77	$24.01	3,020%
5	Methergine	N	Child birth	$1.50	$43.06	2,771%
6	Epinastine hcl	N	Eye antihistamines	$0.40	$11.02	2,655%
7	Zantac	Y	Acid reflux, stomach ulcers	$0.20	$5.40	2,653%
8	Anusol-HC	Y	Rectal preparations	$1.39	$36.37	2,522%
9	RID	Y	Topical anti-parasitic	$0.09	$1.95	2,194%
10	Provera	Y	Hormone therapy	$0.18	$3.95	2,157%
11	Thiola	Y	Kidney stone agents	$1.12	$24.72	2,107%
12	Zyvox	Y	Antibiotic	$8.07	$177.02	2,094%
13	Sodium chloride	N	Sodium/saline preparations	$0.02	$0.52	2,046%
14	Syprine	Y	Metallic poison	$10.09	$213.00	2,012%
15	Viagra	Y	Erectile dysfunction	$1.78	$37.09	1,988%
16	Cordran	Y	Topical anti-inflammatory steroidal	$14.57	$291.03	1,897%
17	Ampicillin sodium	N	Antibiotic	$0.51	$10.00	1,870%
18	Clomipramine hcl	N	Pain/inflammation	$0.48	$9.03	1,781%
19	Vimovo	Y	Pain/inflammation	$1.67	$31.00	1,756%
20	Mometasone furoate	N	Skin conditions	$0.66	$11.86	1,690%
21	Colchicine	Y	Gout	$0.33	$5.52	1,573%
22	Potassium citrate-citric acid	N	Low potassium, kidney stones	$0.04	$0.64	1,566%
23	Risperdal	Y	Antipsychotic	$0.76	$12.60	1,560%
24	Anucort-HC	N	Rectal disorders	$0.87	$14.36	1,551%
25	Captopril	N	High blood press/heart disease	$0.07	$1.14	1,529%
26	Millipred	N	Inflammation/immune disorders	$0.43	$6.94	1,514%
27	Midazolam hcl	N	General anesthetic, injectable	$0.07	$1.02	1,411%
28	Pennsaid	Y	Pain/inflammation	$1.10	$15.84	1,340%
29	Zosyn	Y	Antibiotic	$0.05	$0.72	1,262%
30	Donnatal	Y	GI disorders	$0.47	$6.24	1,228%

* Some drugs may have shifted from brand to generic
Source: LFC analysis of agency data

Attachment H:
Same top 30 drugs as Attachment G, with FY17 price changes

Rank	Drug name	Brand drug*	Indication	Increase in price FY12 – FY16	Change in price FY16 – FY17
1	Tetracycline hcl	N	Infections	8,078%	-13%
2	Cefazolin sodium	N	Antibiotic	4,930%	33%
3	Vancomycin hcl	N	Antibiotic	4,172%	-84%
4	Nitroglycerin	N	Vasodilators, coronary	3,020%	-97%
5	Methergine	N	Child birth	2,771%	-4%
6	Epinastine hcl	N	Eye antihistamines	2,655%	-11%
7	Zantac	Y	Acid reflux, stomach ulcers	2,653%	6%
8	Anusol-HC	Y	Rectal preparations	2,522%	-12%
9	RID	Y	Topical antiparasitics	2,194%	-89%
10	Provera	Y	Hormone therapy	2,157%	-2%
11	Thiola	Y	Kidney stone agents	2,107%	-13%
12	Zyvox	Y	Antibiotic	2,094%	-37%
13	Sodium chloride	N	Sodium/saline preparations	2,046%	-52%
14	Syprine	Y	Metallic poison	2,012%	-1%
15	Viagra	Y	Erectile dysfunction	1,988%	46%
16	Cordran	Y	Topical anti-inflammatory steroidal	1,897%	84%
17	Ampicillin sodium	N	Antibiotic	1,870%	-5%
18	Clomipramine hcl	N	Depression, OCD	1,781%	-15%
19	Vimovo	Y	Pain/inflammation	1,756%	47%
20	Mometasone furoate	N	Skin conditions	1,690%	n/a
21	Colchicine	Y	Gout	1,573%	-1%
22	Potassium citrate-citric acid	N	Low potassium, kidney stones	1,566%	-87%
23	Risperdal	Y	Antipsychotic	1,560%	-19%
24	Anucort-HC	N	Rectal disorders	1,551%	12%
25	Captopril	N	High blood press/heart disease	1,529%	-7%
26	Millipred	N	Inflammation/immune disorders	1,514%	29%
27	Midazolam hcl	N	General anesthetics	1,411%	9%
28	Pennsaid	Y	Pain/inflammation	1,340%	43%
29	Zosyn	Y	Antibiotic	1,262%	-33%
30	Donnatal	Y	GI disorders	1,228%	147%

* Some drugs may have shifted from brand to generic
Source: LFC analysis of agency data

Attachment I:
Top 30 drugs by price increase between FY16 and FY17

Rank	Drug name	Brand drug*	Indication	List Price Per Unit FY16	List Price Per Unit FY17	Percent increase in price growth
1	Theophylline anhydrous	N	Asthma	$0.24	$2.27	850%
2	Ortho tricyclen	Y	Contraceptive	$1.62	$15.27	843%
3	Neurontin	N	Pain/inflammation	$1.32	$11.00	736%
4	Pacerone	N	Irregular heart beat	$0.56	$3.47	521%
5	Metronidazole vaginal	N	Vaginal antibiotic	$0.67	$3.73	457%
6	Terbutaline sulfate	N	Asthma	$1.36	$3.76	176%
7	Donnatal	Y	GI disorders	$3.80	$9.37	147%
8	Xylocaine	Y	Local anesthetic	$2.83	$6.61	134%
9	Doxycycline hyclate	N	Antibiotic	$3.92	$7.27	85%
10	Cordran	Y	Topical anti-inflammatory steroidal	$291.03	$534.88	84%
11	Clindamycin hcl	N	Antibacterial	$5.19	$9.14	76%
12	Lanoxin	Y	Heart disease	$3.91	$6.69	71%
13	Actemra	Y	Inflammatory conditions	$969.54	$1,611.79	66%
14	Duexis	Y	Pain/inflammation	$15.70	$24.94	59%
15	Zonegran	Y	Anticonvulsants	$5.14	$7.97	55%
16	Prudoxin	N	Skin conditions	$8.53	$13.14	54%
17	Chlorpromazine hcl	N	Antipsychotic	$5.79	$8.92	54%
18	Adrenalin	Y	Anaphylaxis	$65.32	$100.28	54%
19	Vimovo	Y	Pain/inflammation	$24.84	$36.54	47%
20	Isoniazid	N	Anti-tuberculosis	$32.54	$47.82	47%
21	Viagra	Y	Erectile dysfunction	$37.09	$54.31	46%
22	Metformin	N	Diabetes	$1.64	$2.40	46%
23	Pennsaid	Y	Pain/inflammation	$13.73	$19.60	43%
24	Gentamicin sulfate	N	Skin infections	$1.80	$2.49	38%
25	Cefazolin sodium	N	Antibiotic	$1.66	$2.22	33%
26	Crestor	Y	High blood cholesterol	$40.94	$53.22	30%
27	Millipred	N	Inflammation/immune disorders	$5.53	$7.12	29%
28	Ativan	N	Anxiety	$25.49	$32.27	27%
29	Depo-estradiol	Y	Hormone therapy	$14.07	$17.68	26%
30	Pyrazinamide	N	Anti-tuberculosis	$103.08	$128.70	25%

* Some drugs may have shifted from brand to generic
Source: LFC analysis of agency data

Attachment J: Rebates received by IBAC agencies and the UNM and UNMH employee plans, by major indication/condition, FY17

Note: The UNMH employee plan provided data for its own set of core conditions; shaded rows indicate conditions reported by all.

Indication	Total Plan Cost	Rebates	Plan Cost Net of Rebates
Diabetes	$40,998,142	$19,417,795	$21,580,347
Inflammatory conditions	$35,834,403	$7,130,725	$28,703,677
Cancer	$26,055,357	$113,683	$25,941,674
Multiple sclerosis	$15,270,620	$1,985,486	$13,285,134
Asthma	$9,661,706	$4,409,299	$5,252,407
Pain/inflammation	$7,479,711	$323,661	$7,009,026
Hepatitis C	$6,847,688	$2,158,057	$4,689,631
Hemophilia	$5,277,799	$0	$5,277,799
Pulmonary hypertension	$5,070,393	$356,755	$4,713,639
HIV	$4,872,156	$572	$4,123,296

Source: LFC analysis of agency data

Is Spaceport America taking flight?

NMPolitics.net | (http://nmpolitics.net/index/2017/11/its-time-for-nm-government-to-negotiate-lower-rx-drug-prices/)

It’s time for NM government to negotiate lower Rx drug prices

By **Jeff Steinborn** | November 30, 2017

COMMENTARY: Last April, Gov. Susana Martinez vetoed legislation that could have saved New Mexico millions of dollars a year in prescription drug costs for state agencies and its employees and retirees. **Senate Bill 354 (https://nmlegis.gov/Legislation/Legislation?Chamber=S&LegType=B&LegNo=354&year=17)** , which passed the Legislature with strong bipartisan support, would have required all New Mexico state agencies that purchase pharmaceutical drugs to work together to aggressively seek a better deal on prices.

Courtesy photo

Jeff Steinborn

Citizens pay a huge cost for high drug prices. In fiscal year 2016, New Mexico state government spent over $670 million on prescription drugs, a staggering 54 percent increase in just two years. Senate Bill 354 would have leveraged the purchasing power of all of our state agencies that purchase prescription drug benefits, including the departments of Health, Human Services, Corrections, Medicaid, General Services, UNM and other agencies, to aggressively pursue lower prices.

Even though the legislation passed the Senate unanimously and the House with broad bipartisan support, it was vetoed by Governor Martinez without explanation.

Several weeks ago the **National Academy for State Health Policy (http://www.nashp.org)** invited me to speak at their annual conference about my prescription drug purchasing reform legislation. The Academy, a nonprofit and nonpartisan organization of state health professionals, had identified this bill as a key strategy that states could implement to better control the rising health care and prescription drug costs.

Aggressively negotiating lower prescription drug prices could save New Mexico’s state government millions every year. It can be done. The U.S. Department of Veterans of Affairs negotiates at least a 24 percent discount on the drugs it buys. Many other industrialized countries pay a fraction of what U.S. citizens and governments pay for the same drugs. Members of Congress have sought for decades to leverage the federal government’s purchasing power for Medicare, but have been fought tooth and nail by the pharmaceutical industry.

Other states are working to achieve savings and reform as well. Recently, citizen-led referendums in Ohio and California have fought to lower drug prices, and California just passed legislation requiring the pharmaceutical industry to notify the state in advance of increases in prices.

Advertisement

At a time when budgets for classrooms and other key public services are being cut, and proposals are being pushed to force tens of thousands of public employees to pay more for their retirement and benefits, negotiating lower drug prices is just common sense.

The opponents of lower drug prices are formidable, however, and have many methods to stop progress. The pharmaceutical industry, one of the most profitable in America, has spent millions of dollars fighting efforts in Congress and in state legislatures across America to get citizens a better deal on prices.

In addition, the industry continues to make large contributions to politicians to maintain their foothold of opposition to reform. The pharmaceutical industry was the 10th largest single contributor to the Republican Governors Association (RGA) in the most recent election cycle, according to **OpenSecrets.org (http://www.nmsenate.com/sendpress/eyJpZCI6IjM1MSIsInJlcG9ydCI6IjI4NzkyIiwidmlldyI6InRyYWNrZXIiLCJ1cmwiOiJodHRwOlwvXC9vcGVuc2VjcmV0cy5vcmdcLyJ9/)** .

This coming legislative session it’s time for Governor Martinez to stand on the side of our citizens and use all the tools at our disposal to demand the very best deal possible on the purchase of prescription drugs. Requiring our state government to maximize its nearly $700 million in pharmaceutical purchasing power to lower the cost of prescription drugs is not just good business — it’s common sense.

__Jeff Steinborn__ __(https://nmlegis.gov/Members/Legislator?SponCode=SSTEI)__ , a Democrat, represents the Las Cruces-area District 36 in the N.M. Senate. Agree with his opinion? Disagree? We welcome your views. Learn about submitting your own commentary __here (http://www.nmpolitics.net/index/commentary-submissions/)__ .

State of New Mexico
Legislative Council Service

411 State Capitol, Santa Fe, New Mexico 87501 (505) 986-4600 Fax: (505) 986-4680

Information Memorandum

DATE: November 14, 2017

TO: Interested Persons

FROM: Raúl E. Burciaga

SUBJECT: GERMANE BILLS IN THE EVEN-YEAR REGULAR SESSION

This memorandum discusses when a bill is constitutionally germane in the even-year regular session. Any opinions expressed are those of the author and do not necessarily reflect the opinions of the New Mexico Legislative Council or any other member of its staff.

DETERMINATION OF GERMANENESS DURING A REGULAR 30-DAY SESSION

The legislature is restricted in the type of bills that it may consider in regular sessions in even-numbered years. Article 4, Section 5 of the Constitution of New Mexico reads, in pertinent part, as follows:

> B. Every regular session of the legislature convening during an even-numbered year shall consider only the following:
> (1) budgets, appropriations and revenue bills;
> (2) bills drawn pursuant to special messages of the governor; and
> (3) bills of the last previous regular session vetoed by the governor.

Each chamber has designated a committee to make recommendations on the germaneness of specific legislation. In the house, recommendations are made by the House Rules and Order of Business Committee, and in the senate, it is the Senate Committees' Committee.

As a general practice, neither body attempts to determine the germaneness of bills originating in the other house of the legislature.

.204286

The New Mexico Supreme Court has not been asked to rule on whether a law has been enacted in violation of this provision. The court has generally refused to go behind the enrolled and engrossed bill to determine whether the bill was constitutionally enacted, but in 1974, the court made it clear that the enrolled bill rule would not apply if a law was challenged as having been passed in violation of another provision of Article 4, Section 5 of the Constitution of New Mexico (*Dillon v. King*, 87 N.M. 79, 529 P.2d 745).

BUDGET, APPROPRIATION AND REVENUE BILLS

A frequently asked question is what constitutes a budget, an appropriation or a revenue bill. The attorney general in 1966 opined that the principal purpose of the bill should determine whether it is a budget, appropriation or revenue bill (Attorney General Opinion No. 66-8).

Budget Bills

The attorney general interpreted the word "budget" to mean "a plan or method by means of which the expenditures and revenues are so controlled for a definite period by some budgetary authority as to effect a balance between income and expenditures". A general appropriation bill (traditionally House Bill 2) fits this definition.

Appropriation Bills

In the same opinion, an "appropriation bill" was interpreted to mean a bill that "authorizes the expenditure of public moneys and stipulates the amount, manner and purpose of the various items of expenditure". This, again, fits the description of the general appropriation bill as well as special appropriation bills. However, with respect to a special appropriation bill, the attorney general warns that it *does not include* a bill proposing general legislation simply because it has engrafted upon it a section making an appropriation.

Revenue Bills

The attorney general interpreted the term "revenue bill" to mean "legislation providing for the assessment and collection of taxes to defray the expenses of government". Under this interpretation, a bill is not a revenue bill if its principal object is not the production of revenue, even though it incidentally levies or imposes a tax. For example, a bill that creates a new program and then imposes a fee or tax to fund it would likely not be considered a revenue bill under the constitution because the principal object of the bill is the creation of the new program. In addition, a bill providing for a tax credit, deduction or exemption might call into question whether it would be considered a revenue bill if the principal object is not the production of revenue, but rather to create jobs, encourage the growth of certain industries, reduce tax pyramiding or provide some other economic incentive or result.

However, if a bill's principal object is to assess and collect taxes to defray the expenses of government, whether establishing a new tax or increasing or decreasing an existing tax, it would most likely be considered a revenue bill.

Summary

In summary, the primary test as to what is a budget, appropriation or revenue bill must be, "What is the principal purpose or object of the bill?".

VETOED BILLS

The constitution also permits the consideration during even-numbered-year regular sessions of "bills of the last previous regular session vetoed by the governor".

The attorney general, early in the history of annual sessions in this state, interpreted the provision regarding consideration of vetoed bills as limited to an attempt to override the veto, not to the introduction of an identical bill (Attorney General Opinion No. 65-140). The attorney general said that the term "vetoed bill" includes partially vetoed bills and pocket-vetoed bills. As a matter of practice, since the adoption of the limited, even-year session provision in the constitution, the legislature generally has followed this interpretation.

Another interpretation has been maintained that the wording of the limitation in Subsection B of Section 5 of Article 4 of the Constitution of New Mexico means simply that a

new bill that is identical to a vetoed bill could be introduced. The house followed this interpretation at least once, in 2008. There does not appear to be any attorney general opinion or New Mexico case law that addresses this interpretation.

SPECIAL MESSAGE OF THE GOVERNOR

Subsection B of Section 5 of Article 4 of the Constitution of New Mexico permits the legislature to consider bills drawn pursuant to special messages of the governor. Special messages are those numbered executive messages that are transmitted by the governor to one or both houses of the legislature. Special messages do not mean the subjects touched upon in the governor's opening address to the joint session of the legislature. The question frequently arises as to the extent the legislature can depart from the substance of a message submitted by the governor. The legislature generally takes the position that it has a fair amount of latitude, within reason, to amend a bill introduced pursuant to a special message from the governor. The attorney general, while not addressing this question in a general manner, touched upon it as it applied to a specific bill (Attorney General Opinion No. 66-25):

> "In order to be germane a provision must be auxiliary to and promotive of the bill's main purpose; and it must have a necessary and natural connection with such purpose. *Los Angeles County v. Frisbie*, Cal. App. 115 P. 2d 900."

The legislature may, based upon a special message, find that more than one bill is germane, and neither chamber is restricted to solely using the special message directed to it to find bills germane.

OTHER MATTERS IN A SHORT SESSION

The question of whether memorials and resolutions fall within the purview of the constitutional limitation has been raised.

Since the adoption of annual sessions, the legislature has consistently permitted the introduction and passage of memorials and joint resolutions in a 30-day regular session. The New Mexico Supreme Court concluded that constitutional amendments proposed by the legislature in the short session are not prohibited by Article 4, Section 5 of the Constitution of

New Mexico (*State ex rel. Chavez v. Vigil-Giron, et al*., 108 N.M. 45, 766 P.2d 305 (1989)).

The court held that when the legislature acts to propose constitutional amendments, it does not act pursuant to its lawmaking capacity under Article 4 but, rather, pursuant to its capacity as a constitutional "convention" under Article 19. The legislature's authority to consider constitutional amendments is not affected by the list of legislative topics in Article 4.

.204286

Medical Plans
January 2018 Switch Enrollment Counts
Additional Members and Members who Cancelled

		NON-MEDICARE					MEDICARE									
	FROM	**TO** BCBS Premier	**TO** BCBS VP	**TO** NMHC VP	**TO** Pres Premier	**TO** Pres VP	**TO** BCBS Supp	**TO** BCBS MA I	**TO** BCBS MA II	**TO** Humana Plan I	**TO** Humana Plan II	**TO** Pres Plan I	**TO** Pres Plan II	**TO** United Plan I	**TO** United Plan II	**TOTAL TERMED FROM EACH**
NON-MEDICARE	BCBS Premier		225	1	28	12	46	5	1	-	2	1	-	3	8	**332**
		-	-	-	-	-	-	-	-	-	-	-	-	-	-	**-**
	NM Health Connections VP	14	66	-	3	2	2	-	1	-	1	-	-	-	-	**89**
	Presbyterian Premier	68	19	5	-	236	7	-	-	1	-	36	4	5	4	**385**
	Presbyterian Value Plan	25	51	10	34	-	3	-	-	-	-	3	2	-	2	**130**
MEDICARE	BCBS Supplemental	-	-	-	-	-		47	12	13	19	43	3	45	29	**211**
	BCBS MA Plan I	-	-	-	-	-	33		10	10	7	29	5	25	23	**142**
	BCBS MA Plan II	-	-	-	-	-	11	10		1	11	5	8	5	17	**68**
	Humana MA Plan I	-	-	-	-	-	2	-	-		4	1	-	-	-	**7**
	Humana MA Plan II	-	-	-	-	-	-	4	-	1		1	-	-	5	**11**
	Presbyterian MA Plan I	-	-	-	-	-	19	16	1	3	4		14	17	8	**82**
	Presbyterian MA Plan II	-	-	-	-	-	2	3	2	1	8	52		2	37	**107**
	United Healthcare MA Plan I	-	-	-	-	-	19	5	1	2	-	9	-		66	**102**
	United Healthcare MA Plan II	-	-	-	-	-	5	1	5	3	10	1	5	17		**47**
	TOTAL ADDITIONS TO EACH	**107**	**361**	**16**	**65**	**250**	**149**	**91**	**33**	**35**	**66**	**181**	**41**	**119**	**199**	**1,713**
	NET +/-	**(225)**	**361**	**(73)**	**(320)**	**120**	**(62)**	**(51)**	**(35)**	**28**	**55**	**99**	**(66)**	**17**	**152**	**-**

Medicare Plans	Cancelled Participation in the NMRHCA									Total Members Cancelled
	BCBS Supp	BCBS MA I	BCBS MA II	Humana I	Humana II	Pres Senior I	Pres Senior II	United I	United II	
Cancelled	66	11	13	1	3	5	5	8	13	125

Non-Medicare Plans	Cancelled Participation in the NMRHCA					Total Members Cancelled
	BCBS Premier	BCBS VP	NMHC VP	Pres Premier	Pres VP	
Cancelled	67	0	6	37	26	136

Medicare Plans	New Enrollments in the NMRHCA									Total New Members
	BCBS Supp	BCBS MA I	BCBS MA II	Humana I	Humana II	Pres Senior I	Pres Senior II	United I	United II	
New	34	4	2	2	6	36	7	11	6	108

Non-Medicare Plans	New Enrollments in the NMRHCA					Total New Members
	BCBS Premier	BCBS VP	NMHC VP	Pres Premier	Pres VP	
New	72	18	7	48	70	215

Medicare Outreach Meetings

Date	Time	Location	Number Attended
3/8/17	9:30 AM	Albuquerque	25
3/8/17	1:30 PM	Santa Fe	9
4/5/17	9:30 AM	Albuquerque	29
4/5/17	1:30 PM	Santa Fe	9
4/11/17	9:00 AM	Las Cruces	15
5/10/17	9:30 AM	Albuquerque	28
5/10/17	1:30 PM	Santa Fe	12
6/7/17	9:30 AM	Albuquerque	35
6/7/17	1:30 PM	Santa Fe	14
7/5/17	9:30 AM	Albuquerque	23
7/5/17	1:30 PM	Santa Fe	8
7/7/17	9:00 AM	Las Vegas	3
8/9/17	9:30 AM	Albuquerque	35
8/9/17	1:30 PM	Santa Fe	13
9/6/17	9:30 AM	Albuquerque	19
9/6/17	1:30 PM	Santa Fe	6
11/8/17	9:30 AM	Albuquerque	14
11/8/17	1:30 PM	Santa Fe	6
11/8/17	10:00 AM	Roswell	3
12/6/17	9:30 AM	Albuquerque	6
12/6/17	1:30 PM	Santa Fe	11
		Total 2017	**323**

NEW MEXICO RETIREE HEALTH CARE AUTHORITY
CHANGE IN NET ASSET VALUE
FOR THE MONTH ENDED
October 31, 2017

	Core Plus Bonds	Large Cap Index	Non US Dev Index	Non US Emg Index	Small Mid Cap	Credit and Structure	Absolute Return	Private Equity	Real Estate	Total
Market Value 9/30/2017	$110,325,995.84	$126,363,410.26	$69,164,287.85	$90,036,210.01	$16,833,518.37	$57,654,329.85	$27,012,234.54	$62,042,012.38	$31,953,918.51	$591,385,917.61
CONTRIBUTIONS	600,000.00	600,000.00	360,000.00	450,000.00	90,000.00	300,000.00	150,000.00	300,000.00	150,000.00	3,000,000.00
WITHDRAWALS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FEES	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
INCOME EARNED	291,995.07	138,236.00	48,851.97	44,843.20	3,234.21	65,975.56	69.78	17,792.51	205,426.46	816,424.76
CAPITAL APPR/DEPR	2,552.67	2,771,351.34	880,749.55	3,105,179.50	218,389.76	429,934.72	65,735.02	37,642.33	(220,305.44)	7,291,229.45
Market Value 10/31/2017	$111,220,543.58	$129,872,997.60	$70,453,889.37	$93,636,232.71	$17,145,142.34	$58,450,240.13	$27,228,039.34	$62,397,447.22	$32,089,039.53	$602,493,571.82

Program Support Contract Amendment/New Contracts – Action Item*

The charts below include a list of existing contracts and proposed amendments fiscal year 2018 needed to meet our business obligations with regard to the development of an employer allocation schedule as required by GASB Statement 75, as well as the concurrent review of the employer allocation schedule.

Program Support FY18 Proposed Contract Amendments/New

The proposed contracts administered through Program Support are as follows:

FY18 Approved Operating Budget (Contractual Services)		$544,800			$544,800
Proposed Contract Amendment/New	**Amount Encumbered YTD**	**Proposed Amendment/New**	**Type**	**Contract Term**	
Segal	$ 315,000	$ 30,000	Scope of Work/Compensation	July 1, 2016 - June 30, 2020	
Financial Audit/GASB 74 & 75 (New)	$ 81,532	$ -	NA	July 1, 2017 - June 30, 2019	
Rodey	$ 30,000	$ -	NA		
HealthLinx	$ 15,750	$ -	NA	May 15, 2017 - June 30, 2018	
Shred IT	$ 7,000	$ -	NA	July 1, 2017 - June 30, 2018	
POD	$ 50,000	$ -	NA	July 1, 2017 - June 30, 2018	
ABBA Technologies	$ 887	$ -	NA	July 1, 2017 - June 30, 2018	
Clifton, Larson, Allen	$ -	$ 10,000	New	February 1, 2018 - June 30, 2018	
Total	**$ 500,169**	**$ 40,000**			**$540,169**
Unobligated Balance					**$4,631**

The proposed contracts and amounts for FY18 assume the following:

1. Segal – Development of employer allocation schedule (Scope of work and increase in compensation).
2. Clifton, Larson, Allen (CLA) – concurrent review of employer allocation schedule (new/small contract).

Conclusion: NMRHCA staff respectfully requests approval of the proposed contract amendment and two new contracts as listed in the tables above.

Pharmacy Benefits Manager RFP (Action Item)

Summary of the Evaluation Committee Activity: A Request for Proposal for Pharmaceutical Benefits Management Services (RFP# 2018-IBAC-0001) was issued on August 15, 2017, by the Interagency Benefits Advisory Committee (IBAC) consisting of the New Mexico Retiree Health Care Authority (NMRHCA), Albuquerque Public Schools (APS), New Mexico Public School Insurance Authority (NMPSIA) and State of New Mexico (SONM). The evaluation process followed the timelines listed below:

	Action	Responsibility	Date
1.	Issue of RFP	Procurement Manager	August 15, 2017
2.	Acknowledgement of Receipt Form	Potential Offerors	August 21, 2017
3.	Deadline To Submit Questions	Potential Offerors	August 25, 2017
4.	Response to Written Questions/RFP Amendments	Agency	September 1, 2017
5.	Submission of Proposal	Offerors	September 14, 2017 3:00 pm MST
6.	Proposal Evaluation	Evaluation Committee	September 15 – September 29, 2017
7.	Selection of Finalists	Evaluation Committee	November 3, 2017
8.	Best and Final Offers from Finalists	Offerors	December 4 & 5, 2017
9.	Oral Presentation and/or Product Demonstrations by Finalists	Offerors	December 4 & 5, 2017
10.	Finalize Contract	Agency/Finalist Offeror	January 12, 2018
11.	Contract Award	Agency/Finalist Offeror	February 1, 2018
12.	Protest Deadline	Protest Manager	15 Days after the Contract Award

Responses to the RFP were received from the seven qualified offerors. All seven proposals were determined to have met the minimum requirements set forth in the RFP and were distributed to the Evaluation Committee on September 15, 2017.

Neil Kueffer, Acting Deputy Director, NMRHCA, served as Procurement Manager for the RFP. Other IBAC members of the Evaluation Committee included: Vera Dallas, Director, Employee Benefits, Ann Johnson, Benefits Analyst, from APS; Ernestine Chavez, Deputy Director, Richard Valerio, CFO, from NMPSIA; David Archuleta, Executive Director, Greg Archuleta, Director of Communication, from NMRHCA; Lara White-Davis, Director, Cynthia Archuleta, Employee Benefits Manager, from SONM. In addition, HealthLinx provided consulting services to the IBAC throughout the process to include an analysis of the cost proposals received from each of the qualified offerors.

Scoring of the proposals was based upon the following evaluation factors:

IV.A	TECHNICAL SPECIFICATIONS	MAXIMUM POINTS
1.	Organizational Experience	30
2.	Organizational References & Questionnaire (APPENDIX F)	25
3.	Oral Presentation- Statement of Agreement	Pass/Fail
4.	Mandatory Specification- Statement of Agreement	Pass/Fail
5.	Desirable Specification- Statements of Agreement	Pass/Fail
IV.B	**BUSINESS SPECIFICATIONS**	**MAXIMUM POINTS**
1.	Financial Stability (APPENDIX H)	Pass/Fail
2.	*Performance Surety Bond- Reserved*	*Not Applicable*
3.	Letter of Transmittal (APPENDIX E)	Pass/Fail
4.	Signed Campaign Contribution Form (APPENDIX B)	Pass/Fail
5.	Cost Form (APPENDIX D supplied in Binder 2)	*See Cost Section*
6.	Signed Employee Health Coverage Form (APPENDIX L)	Pass/Fail
7.	Pay Equity Reporting- Statement of Concurrence	Pass/Fail
8.	Resident Business or Resident Veterans Preference (if applicable) (APPENDIX G)	*See Section II.C.35*
VI.	**QUESTIONNAIRE RESPONSES**	**MAXIMUM POINTS**
	Company Background	10
	Financial Strength/Corporate Stability	20
	Claim Administration	30
	Compound Claim Administration	10
	Eligibility File Processing	20
	Accumulators (Potential HDHP)	10
	Reporting	20
	Plan Account Service	20
	Customer Service Member	10
	Pharmacy Call Center	10
	Clinical Services	40
	EGWP	20
	Auditing/Fraud and Abuse Management	20
	Communications	10
	Pharmacy Network Services	20
	Mail Service	40
	Pricing Components	50
	Rebates	40

	Professional/Ethical	10
	Specialty Pharmacy	40
	ADDITIONAL ATTACHMENTS	**MAXIMUM POINTS**
	Response to Contract Terms and Conditions (APPENDIX C)	20
	Implementation Plan (APPENDIX J)	10
	PBM Quarterly Reporting Package (APPENDIX I)	20
	Staff Resumes and Experience (APPENDIX K)	15
	COST PROPOSAL	**MAXIMUM POINTS**
	Cost Form (Appendix D, Binder 2)	260
The Evaluation of each Offeror's cost was conducted using the following formula: (Lowest Responsive Offer Bid / This Offeror's Bid) X Available Award Points In order to determine vendor pricing, each Offeror's pricing was applied to each IBAC agency's actual claims, thus taking into account weighting for retail, mail, specialty, and drug mix.		
	Performance Guarantee Form (APPENDIX M)	20
	FINALISTS ONLY	**MAXIMUM POINTS**
	Oral Finalist Presentation & BAFO	150
TOTAL POINTS: 1,000		

Each IBAC entity submitted their respective scores and supporting justification to the Procurement Manager on October 17, 2017. These scores were then averaged to determine an initial ranking prior to incorporating the cost proposals. The cost proposals were evaluated by HealthLinx, and final scores were provided to the IBAC based upon an average for the group as well as individual scores for each entity.

The combined technical and cost proposal were scored and ranked as follows:

Overall Score/Rank	NMRHCA Combined	APS	NMPSIA	SONM	Average	Rank
Company A	804.5	715	781	744	761.125	2
Company B	812	809	830	746	799.25	1
Company C	588	618	660.5	600	616.625	7
Company D	694	598	654.5	573	629.875	6
Company E	786.5	726	755.5	717	746.25	3
Company F	787	682	750	743	740.5	4
Company G	747	662	700.5	695	701.125	5

The evaluation committee met on November 8, 2017, to review the finals scores for each vendor and select finalists to make and oral presentation and best and final offer. Selected finalists included: Company A, B, E & F.

A request for a best and final offer was solicited from the selected finalists to include revised cost proposals resulting in the following revised scoring and ranking:

Post BAFO						
Overall Score/Rank	NMRHCA Combined	APS	NMPSIA	SONM	Average	
Company A	788.425	676.19	764.64	711.06	735.08	2
Company B	825	809	830	763	806.75	1
Company F	763.605	635.17	719.8	712.67	707.81	3
Company E	768.665	682.84	726.53	650.27	707.08	4

The finalist interviews were scored and ranked as follows:

Finalist Interview	NMRHCA Combined	APS	NMPSIA	SONM	Average	
Company A	149	148	148	132.5	144.38	2
Company B	140	140	141	117.5	134.63	3
Company F	135	130	135	110	127.50	4
Company E	150	150	150	140	147.50	1

Combining the technical, financial and finalist interview scoring, the total composite scoring and ranking is as follows:

Overall Score/Rank	NMRHCA Combined	APS	NMPSIA	SONM	Average	
Company A	937.425	824.19	912.64	843.56	868.415	2
Company B	965	949	971	880.5	960	1
Company F	898.605	733.17	800.3	727.67	766.735	4
Company E	918.665	755.84	836.53	708.27	796.185	3

Summary: Each of the finalists made a presentation to the Evaluation Committee on December 4 and 5. Based upon the technical scoring, best and final cost, and finalist interview a selection is going to be made to the governing authorities of each IBAC entities to support the selection of Company B in order to serve the needs of the IBAC. However, an announcement of these selections cannot be made public until final approval by the Department of Finance and Administration.

Action Item Request: NMRHCA staff respectfully requests approval to enter into contract negotiations effective July 1, 2018, with highest scoring offeror. An official announcement will be made upon approval by the Department of Finance and Administration.