(PLEASE FIND THE AGENDA/TABLE OF CONTENTS ON PAGE 4.)

REGULAR MEETING
OF THE
BOARD OF DIRECTORS

August 24, 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

August 24, 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

August 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

August 24, 2017
9:30 AM
Alfredo R. Santistevan Board Room
2nd Floor, Suite 207
4308 Carlisle Blvd. NE
Albuquerque, NM 87107

AGENDA

1.	Call to Order	Mr. Sullivan, President	Page
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 Annual Meeting Minutes July 13 & 14, 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 Consolidation/Updates		
	b. PBM Request for Proposal		21
	c. Legislative		23
	d. Newsletter/Switch Enrollment		61
	e. July 31, 2017 SIC Report		67
9.	Specialty Drug Costs Follow-up	Mr. Zeyaee, Express Scripts	68
10.	2018 Medicare Advantage Rates	Mr. Archuleta, Executive Director	70
11.	FY19 Appropriation Request (Action Item)	Mr. Archuleta, Executive Director	71
12.	2018 – 2022 Strategic Plan	Mr. Archuleta, Executive Director	77
13.	Other Business	Mr. Sullivan, President	
14.	Date & Location of Next Board Meeting October 3, 2017, 9:30AM Alfredo R. Santistevan Board Room Suite 207 4308 Carlisle Blvd. NE Albuquerque, NM 87107	Mr. Sullivan, President	
15.	Executive Session	Mr. Sullivan, President	
16.	Adjourn		

ACTION SUMMARY

RETIREE HEALTH CARE AUTHORITY/ANNUAL MEETING/DAY 1

July 13, 2017

Item	Action	Page #
APPROVAL OF AGENDA	Approved	3
APPROVAL OF MINUTES: June 6, 2017	Approved	3
PUBLIC FORUM AND INTRODUCTIONS	Informational	3
ELECTION OF BOARD OFFICERS	Reelect current slate	3
Board Policies and Procedures	Approved	3
Committee Assignments	No action	3
Code of Ethics	Disclosure statements signed	4
Open Meetings Act Resolution	Approved	4
COMMITTEE REPORTS	Informational	4
EXEC DIRECTOR'S UPDATE	Informational	4
Budget Adjustment Request/Benefits		
Budget Adjustment Request/Pgm Support		
BCBS MA Plan Network Changes		
Asset Allocation Update		
HR Updates		
Other		
PROVIDER PRESENTATIONS		
Express Scripts	Informational	6
Presbyterian Health Plan	Informational	6
Blue Cross Blue Shield of NM	Informational	6
NM Health Connections	Informational	6
ACTUARIAL PRESENTATIONS		
Demographic/Utilization Review	Informational	7
Solvency/GASB 74/75	Informational	7
REVIEW OF CALENDAR YEAR 2018 PLAN CHANGES	Informational	8
EXECUTIVE SESSION	No action	10

MINUTES OF THE

NM RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

ANNUAL MEETING/DAY 1

July 13, 2017

1. CALL TO ORDER

Day 1 of the Annual 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. at the Angel Fire Lodge, Rooms A&B, 10 Miller Lane, Angel Fire, New Mexico.

2. ROLL CALL TO ASCERTAIN QUORUM

A quorum was present:

Members Present:
Mr. Tom Sullivan, President
Mr. Joe Montaño, Vice President
Mr. Doug Crandall, Secretary
The Honorable Tim Eichenberg, State Treasurer
Mr. Rick Scroggins
Mr. Terry Linton
Ms. Leanne Larrañaga-Ruffy
Ms. Therese Saunders

Members Excused:
The Honorable Wayne Johnson

Staff Present:
Mr. David Archuleta, Executive Director
Mr. Neil Kueffer, Director of Product Development & Health Care Reform
Mr. Greg Archuleta, Director of Communication & Member Engagement
Ms. Judith S. Beatty, Board Recorder

Others Present:
Anne Hanika-Ortiz, LFC Analyst
[See sign-in sheet.]

3. PLEDGE OF ALLEGIANCE

Mr. Linton led the pledge.

4. APPROVAL OF AGENDA

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

5. APPROVAL OF REGULAR MEETING MINUTES: June 6, 2017

Mr. Montaño moved approval of the June 6 minutes, as submitted. Ms. Saunders seconded the motion, which passed unanimously by voice vote.

6. PUBLIC FORUM AND INTRODUCTIONS

Chairman Sullivan welcomed the members of the audience.

There were no speakers from the floor.

7. ELECTION OF BOARD OFFICERS

Ms. Larrañaga-Ruffy moved to retain the existing slate of Board Officers: Mr. Sullivan, Mr. Montaño and Mr. Crandall.

Ms. Saunders seconded the motion.

The nominees accepted these nominations.

There were no other nominations.

The motion passed unanimously by voice vote.

a. Board Policies and Procedures

Mr. David Archuleta said this is the time of year when the board conducts its annual review of the Board Policies and Procedures Mission Statement. No changes have been recommended to the document.

Mr. Crandall moved for approval, as presented. Mr. Linton seconded the motion, which passed unanimously by voice vote.

b. Committee Assignments

Chairman Sullivan asked if any board members wished to change their committee assignments.

There were no requests for changes.

c. Code of Ethics

Mr. Archuleta asked board members to sign Code of Ethics disclosure statements, an annual requirement, and to turn them in before the end of the day.

d. Open Meetings Act Resolution

There were no changes to the resolution, which is adopted annually by the board.

Mr. Crandall moved approval of the Open Meetings Act Resolution. Mr. Montaño seconded the motion, which passed unanimously by voice vote.

8. COMMITTEE REPORTS

Chairman Sullivan reported that the Executive Committee met by phone with Mr. Archuleta and staff to work on the retreat agenda.

Mr. Crandall reported that the Finance Committee heard a brief update on pending New Mexico State Investment Council changes to the asset allocation.

Mr. Crandall added that the Finance Committee is pleased that its investments have made positive changes to the fund's solvency.

Mr. Montaño said he hopes to schedule a Legislative Committee meeting to discuss whether it would be practical to introduce any legislation in the upcoming session, given that the state's fiscal picture is unchanged.

Mr. Archuleta stated that the Audit Committee will meet next week with the agency's new vendor, Moss Adams, to develop a timeline. This year, the audit will be due before Thanksgiving.

9. EXECUTIVE DIRECTOR'S UPDATE

a. Budget Adjustment Request – Benefits

Mr. Archuleta reported that NMRHCA submitted a budget adjustment request to the Legislative Finance Committee and Department of Finance & Administration, transferring $1,700 from the contractual services budget of the Healthcare Benefits Administration Program to the "other" category to pay the Patient-Centered Outcomes Research Institute (PCORI) fee to the IRS. The fee of $39,000 equals $2.26 multiplied by the average pre-Medicare membership for calendar year 2016 and will have to be paid at least through 2019.

b. Budget Adjustment Request – Program Support

Mr. Archuleta reported that the NMRHCA requested $1,997 in the personal services and employee benefits category for Program Support, for FY 2018, which included sufficient funding for all authorized positions, including two vacant FTE budgeted. Only $1,858.80 was appropriated for FY 2018, however. Current projections, including the need to fill four (and soon to be five) vacant

positions (Deputy Director, three customer services reps and soon-to-be vacant financial analyst with the retirement of Barbara Burns) indicated a $39,500 shortfall, assuming all vacancies are filled by the last pay period in September. He said the BAR NMRHCA is proposing would cover those positions. Mr. Archuleta said the BAR being requested would cover those positions at midpoint, beginning in September.

Ms. Hanika-Ortiz explained that LFC recommended funding for all of the positions; however, the consensus budget was developed without sufficient budget authority in Program Support to fill all of the positions. She agreed with a comment by Chairman Sullivan that the FTE issue in 2019 was therefore a concern.

c. BCBS MA Plan Network Changes

Mr. Archuleta said NMRHCA has received a notice from Blue Cross Blue Shield. To improve its Medicare Advantage plan and the star ratings associated with that program, BCBS is making some network plan changes, and 177 providers have been terminated for quality metrics. NMRHCA has approximately 400 retirees (about 10 percent of the population in the BCBS Medicare Advantage plan) who will be affected by this change, which goes into effect September 1.

Mr. Archuleta stated BCBS has set up a hotline to that goes directly to BCBSNM staff members who have been trained to assist members in finding a new primary care physician.

Responding to Mr. Linton, BCBSNM representative Lori Bell agreed that an individual letter to each affected retiree was not the most efficient way to make sure everyone involved understood the implications of these network changes.

Mr. Linton said he would like either NMRHCA's customer service reps or Blue Cross Blue Shield to contact the 400 retirees individually by telephone. Ms. Bell commented that this was BCBS' responsibility and she would work with Mr. Archuleta to make sure that happened.

d. Asset Allocation Update

Mr. Archuleta said he has received an email from the NMSIC announcing certain changes to the investment pool, including redemption of the absolute return pool, transitioning from the credit/structured pool into broader "non-core," and transitioning from the current core-plus to "core." The credit/structured pool represents about 10 percent of NMRHCA's investments and the absolute return pool represents 5 percent. NMSIC is doing away with these two pools because of the fees associated with them and because of underperformance, and will take action at its August meeting. Mr. Archuleta said NEPC can then make a recommendation to NMRHCA about an appropriate place for those investments.

e. HR Updates

Mr. Archuleta provided updates on candidates who have applied for vacant positions at the agency.

f. Other

Mr. Archuleta stated that NMRHCA has received formal notice of a suit being filed by the Attorney General's Office against Presbyterian regarding underpayment of certain tax fees. He said Presbyterian has denied the charges, and representatives will make a statement about this issue during their presentation later in this meeting.

10. PROVIDER PRESENTATIONS

a. Express Scripts: Harris Zayaee

Mr. Zayaee, senior clinical account executive with Express Scripts, presented.

In discussion on page 5 of the presentation (Top Line Performance Metrics: Peer Comparison), Mr. Linton expressed concern that the RHCA-EGWP per–member-per-month specialty plan costs were significantly higher than the national average at $111.87 versus $79.04 and that per-member-per-month plan costs were $273.09 versus $240.17. He asked Mr. Zayaee to look into this discrepancy and report back.

[Break.]

APPROVAL OF AGENDA -- AMENDED

Chairman Sullivan requested that the executive session scheduled for tomorrow be added to the end of today's agenda, as two board members would not be present tomorrow.

Mr. Crandall moved to amend the agenda to move Item #10 from tomorrow to Item #13 for today. Mr. Linton seconded the motion, which passed unanimously by voice vote.

b. Presbyterian Health Plan: Tom MacLean, Susie MacLean, and Keith Witt

Dr. Tom MacLean, Vice President of Clinical Operations, Susie MacLean, Vice President of Health & Wellness Solutions, and Keith Witt, ASO Large Group Supervisor, presented.

c. Blue Cross Blue Shield of New Mexico: Lori Bell and Lisa Hentz

Account representatives Lori Bell and Lisa Hentz presented.

d. New Mexico Health Connections: Rory Cobb

Rory Cobb, outreach coordinator, made this presentation.

Mr. Montaño said he was impressed by the presentations made today from all of the healthcare providers, particularly as it related to services they provided in the area of wellness. He said he would be interested in getting more information about the level of participation in each of the programs, the manner of communication, how members are made aware of these programs and how efforts can be coordinated between NMRHCA and each provider to get the message across.

Mr. Cobb responded that these programs are free of charge, primarily because NMRHCA did not elect to purchase a wellness component from New Mexico Health Connections as part of the Request for Proposal process. He said there is not an extensive program of communication to notify the members of these programs beyond what is provided in their basic enrollment kit. As a result, there has been low participation in some of the online tools that New Mexico Health Connections has, and it doesn't have the ability to quantify what members that are accessing the tool come from what group, as there is no ID attached to members who utilize the program. He said NMHC is working on this because it would like to report that information at some point.

[Recess for lunch from 12:45 – 2:00 p.m.]

11. ACTUARIAL PRESENTATIONS

[Presenters: Gary Petersen and Dr. Nura Patani, Segal; and Mike Madalena, Data Warehouse.]

a. Demographic/Utilization Review

Mr. Petersen presented an overview of Segal's objective and primary actuarial tasks.

In discussing the new GASB statements, Mr. Petersen commented that, rather than using a judgment call on the returns used to discount the liabilities, it now will be formula-driven. The result like will be a lower interest rate and subsequently a higher liability number. While there is always the threat that posting this information could change the state's bond rating or that of the individual members using the GASB 75 going forward, the board should be aware that the liabilities will look larger the next time they're measured than they otherwise would have.

Mr. Petersen noted that the use of Medicare Advantage plans has risen from 32 to 33 percent in New Mexico. He commented that NMRHCA's board has taken a positive step in encouraging the use of the Medicare Advantage plans, as they are cost effective.

Mr. Madalena reviewed CY 2016 incurred claims, including cost and utilization trends by type of service, claims distribution and a comparison to facility and professional benchmarks.

b. Solvency/GASB 74/75

Dr. Patani reviewed baseline assumptions and methodology used by Segal, showing that the projected year of insolvency is estimated to be fiscal year 2035.

Highlights of changes from previous years:

-- Annual growth in payroll will be flat for the first three fiscal years through 2020, then return to the original assumption of 3.5 percent growth every year. This is a conservative estimate to accommodate any changes between now and the end of the current Administration.

-- Prescription drug rebates: In comparing last year's assumptions with this year's, there is a significant change from $8.5 million in the assumption for rebates based on the guarantees through the Market Check agreement with Express Scripts, which is up to $18.3 million because of the improved guarantees.

Mr. Archuleta commented that this was built into the Express Scripts contract signed three years ago. This is finally coming to fruition, and NMRHCA took advantage of lower costs without having to implement anything or go back to the negotiating table.

-- Low-income subsidy: small change based on revised estimate received from Express Scripts.

-- Medical rates: change from last year, when the Value Plan was introduced. This year, an 8 percent increase is being modeled to the non-Medicare rates from 2018 to 2022, which then go down to 4 percent. The solvency model includes some automated modeling of the impact of the Cadillac tax. Once those costs naturally rise above the threshold, the model incorporates some automatic benefit reductions to bring the costs back down. The rate increase reduces to 4 percent at this point.

-- Voluntary Smart 90 program has been incorporated into the baseline scenario. The savings assumption is based on modeling from Express Scripts.

Dr. Patani said that, if all of the assumptions play out, the projected year of insolvency would be at the end of FY 2035, and deficit spending would begin in FY 2021.

Mr. Archuleta commented on two of the things that have helped NMRHCA achieve this level of solvency without taking aggressive action:

-- Investment earnings are much higher than anticipated. The agency expected to close the year with $509 million, but the balance at May 30 was $552 million.

-- Market Check Agreement through Express Scripts has saved an additional $10 million.

12. REVIEW OF CALENDAR YEAR 2018 PLAN CHANGES

Mr. Archuleta presented his report on the 2018 plan recommendations.

Baseline Scenario: Projected solvency 2035 (18 years) – deficit spending 2020 ($9.1 million)

1. Premium Increase:
   a. Pre-Medicare – 8% (Retirees: Premier, $17.88; Value, $13.97)
   b. Supplement – 6% (Retirees: $11.32)

2. Expansion of Value Option Resources – Addition of BlueAdvantage Network
3. Prescription Drug Changes – Voluntary Smart90 (Pre-Medicare/Supplement)
   Long-Term Medications:
   a. 3-month supply for less than cost of three 1-month supplies
   b. Express Scripts pharmacy or preferred retail pharmacy
   c. Members will receive communication directly from Express Scripts

4. Default Medicare Eligible Retirees to appropriate Medicare Advantage Plan
   a. All members still have option of selecting plans

b. Presbyterian Pre-Medicare Member default -= UnitedHealthcare Plan I
   a. 2017 Rate -- $94.69
   b. No Donut Hole
   c. Annual out-of-pocket limit $2,500
c. BCBS Pre-Medicare Member default – Humana Plan I
   a. 2017 Rate - $82.77
   b. No Donut Hole
   c. Annual out-of-pocket limit $4,000

Scenario A: Projected solvency 2035 (18 years) – deficit spending 2020 ($9.3 million)

1. Premium Increase:
   a. Pre-Medicare – 8% (Retirees: Premier, $17.88; Value, $13.97)
   b. Supplement – 5% (Retirees: $9.43)

2. Expansion of Value Option Resources – Addition of BlueAdvantage Network
3. Prescription Drug Changes – Voluntary Smart90 (Pre-Medicare/Supplement)
   Long-Term Medications:
   a. 3-month supply for less than cost of three 1-month supplies
   b. Express Scripts pharmacy or preferred retail pharmacy
   c. Members will receive communication directly from Express Scripts

4. Default Medicare Eligible Retirees to appropriate Medicare Advantage Plan
   a. All members still have option of selecting plans
   b. Presbyterian Pre-Medicare Member default -= UnitedHealthcare Plan I
      a. 2017 Rate -- $94.69
      b. No Donut Hole
      c. Annual out-of-pocket limit $2,500
   c. BCBS Pre-Medicare Member default – Humana Plan I
      a. 2017 Rate - $82.77
      b. No Donut Hole
      c. Annual out-of-pocket limit $4,000

5. Medicare Supplement Cost Sharing: Introduce $250 copay for inpatient stay (1 per year)

Scenario B: Projected solvency 2035 (18 years) – deficit spending 2020 ($8.4 million)

1. Premium Increase:
   a. Pre-Medicare – 8% (Retirees: Premier, $17.88; Value, $13.97)
   b. Supplement – 5% (Retirees: $9.43)

2. Expansion of Value Option Resources – Addition of BlueAdvantage Network
3. Prescription Drug Changes – Voluntary Smart90 (Pre-Medicare/Supplement)
   Long-Term Medications:
   a. 3-month supply for less than cost of three 1-month supplies
   b. Express Scripts pharmacy or preferred retail pharmacy
   c. Members will receive communication directly from Express Scripts

4. Default Medicare Eligible Retirees to appropriate Medicare Advantage Plan
   a. All members still have option of selecting plans
   b. Presbyterian Pre-Medicare Member default -= UnitedHealthcare Plan I
      a. 2017 Rate -- $94.69
      b. No Donut Hole
      c. Annual out-of-pocket limit $2,500
   c. BCBS Pre-Medicare Member default – Humana Plan I
      a. 2017 Rate - $82.77
      b. No Donut Hole
      c. Annual out-of-pocket limit $4,000

5. Medicare Supplement Cost Sharing: Introduce $250 copay for inpatient stay (1 per year)

6. Medicare Supplement Cost Sharing: Increase annual Part B cost sharing by $50

13. <u>EXECUTIVE SESSION</u>: 3:35 p.m.

Ms. Saunders moved to enter executive session for the purpose of discussing limited personnel matters and pending litigation, as permitted by the New Mexico Open Meetings Act. Mr. Linton seconded the motion, which passed on the following Roll Call vote:

For: Chairman Sullivan; Vice Chair Montaño; Secretary Crandall; Ms. Larrañaga-Ruffy; Mr. Scroggins; Mr. Linton; Ms. Saunders; Ms. Eichenberg.

Against: None.

[Board was in executive session until 4:20 p.m.]

Ms. Larrañaga-Ruffy moved to come out of executive session. Mr. Montaño seconded the motion, which passed unanimously by voice vote.

Chairman Sullivan stated that the only matters discussed in executive session were those stated in the motion to enter executive session, and that no action was taken.

<u>RECESS</u>: 4:20 p.m.

[Recess until 9:00 a.m., July 14, 2017, in the same location.]

ACTION SUMMARY

RETIREE HEALTH CARE AUTHORITY/ANNUAL MEETING/DAY 2

July 14, 2017

MINUTES OF THE

NM RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

ANNUAL MEETING/DAY 2

July 14, 2017

1 & 2. RECONVENE – QUORUM PRESENT

The NMRHCA Board of Directors reconvened at 9:00 a.m.

Members Present:
Mr. Tom Sullivan, President
Mr. Joe Montaño, Vice President
Ms. Leanne Larrañaga-Ruffy
Mr. Terry Linton
Mr. Rick Scroggins
Ms. Therese Saunders

Members Excused:
Mr. Doug Crandall, Secretary
The Honorable Tim Eichenberg, State Treasurer
The Honorable Wayne Johnson

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

Others Present:
Ms. Anne Hanika-Ortiz, LFC Analyst
[See sign-in sheet.]

3. PLEDGE OF ALLEGIANCE

None.

4. PUBLIC FORUM AND INTRODUCTIONS

Chairman Sullivan welcomed guests.

There were no speakers from the floor.

5. PROVIDER PRESENTATIONS CONTINUED

a. United Concordia: Stephanie Anthony

Ms. Anthony presented.

b. Delta Dental: Richard Bolstad

Mr. Bolstad presented.

c. Davis Vision: Sam Garcia

Mr. Garcia presented.

d. The Standard: Martha Quintana

Ms. Quintana presented.

Ms. Quintana stated that The Standard receives 1,000 death claims each year. She said that if a surviving spouse or child were insured when a retiree passes away, the NMRHCA makes an effort to make sure that coverage doesn't get lost. The policy has a provision that if the retiree dies and there was spouse and child life as part of that, the coverage continues for five months without premium payment. She said she regularly reminds retirees of this benefit at the switch enrollment meetings.

Mr. Linton asked Mr. Archuleta to be proactive in approaching the members and letting them know about all of the benefits included in their life insurance policy. Mr. Archuleta responded that this would be emphasized in the September issue of the newsletter, which would also include information about action taken during today's annual meeting.

6. CY 2018 PLAN YEAR RECOMMENDATIONS

Mr. Archuleta reviewed the Baseline Scenario and Scenarios A and B.

Baseline Scenario: Projected solvency 2035 (18 years) – deficit spending 2020 ($9.1 million)

1. Premium Increase:
   a. Pre-Medicare – 8% (Retirees: Premier, $17.88; Value, $13.97)
   b. Supplement – 6% (Retirees: $11.32)

2. Expansion of Value Option Resources – Addition of BlueAdvantage Network
3. Prescription Drug Changes – Voluntary Smart90 (Pre-Medicare/Supplement)
   Long Term Medications:
   a. 3-month supply for less than cost of three 1-month supplies
   b. Express Scripts pharmacy or preferred retail pharmacy
   c. Members will receive communication directly from Express Scripts

4. Default Medicare Eligible Retirees to appropriate Medicare Advantage Plan
   a. All members still have option of selecting plans
   b. Presbyterian Pre-Medicare Member default -= UnitedHealthcare Plan I
      a. 2017 Rate -- $94.69
      b. No Donut Hole
      c. Annual out-of-pocket limit $2,500
   c. BCBS Pre-Medicare Member default – Humana Plan I
      a. 2017 Rate - $82.77
      b. No Donut Hole
      c. Annual out-of-pocket limit $4,000

Scenario A: Projected solvency 2035 (18 years) – deficit spending 2020 ($9.3 million)

1. Premium Increase:
   a. Pre-Medicare – 8% (Retirees: Premier, $17.88; Value, $13.97)
   b. Supplement – 5% (Retirees: $9.43)

2. Expansion of Value Option Resources – Addition of BlueAdvantage Network
3. Prescription Drug Changes – Voluntary Smart90 (Pre-Medicare/Supplement)
   Long-Term Medications:
   a. 3-month supply for less than cost of three 1-month supplies
   b. Express Scripts pharmacy or preferred retail pharmacy
   c. Members will receive communication directly from Express Scripts

4. Default Medicare Eligible Retirees to appropriate Medicare Advantage Plan
   a. All members still have option of selecting plans
   b. Presbyterian Pre-Medicare Member default -= UnitedHealthcare Plan I
      a. 2017 Rate -- $94.69
      b. No Donut Hole
      c. Annual out-of-pocket limit $2,500
   c. BCBS Pre-Medicare Member default – Humana Plan I
      a. 2017 Rate - $82.77
      b. No Donut Hole
      c. Annual out-of-pocket limit $4,000

5. Medicare Supplement Cost Sharing: Introduce $250 copay for inpatient stay (1 per year)

Scenario B: Projected solvency 2035 (18 years) – deficit spending 2020 ($8.4 million)

1. Premium Increase:
   a. Pre-Medicare – 8% (Retirees: Premier, $17.88; Value, $13.97)
   b. Supplement – 5% (Retirees: $9.43)

2. Expansion of Value Option Resources – Addition of BlueAdvantage Network
3. Prescription Drug Changes – Voluntary Smart90 (Pre-Medicare/Supplement)
   Long-Term Medications:
   a. 3-month supply for less than cost of three 1-month supplies

b. Express Scripts pharmacy or preferred retail pharmacy
c. Members will receive communication directly from Express Scripts

4. Default Medicare Eligible Retirees to appropriate Medicare Advantage Plan
   a. All members still have option of selecting plans
   b. Presbyterian Pre-Medicare Member default -= UnitedHealthcare Plan I
      a. 2017 Rate -- $94.69
      b. No Donut Hole
      c. Annual out-of-pocket limit $2,500
   c. BCBS Pre-Medicare Member default – Humana Plan I
      a. 2017 Rate - $82.77
      b. No Donut Hole
      c. Annual out-of-pocket limit $4,000

5. Medicare Supplement Cost Sharing: Introduce $250 copay for inpatient stay (1 per year)

6. Medicare Supplement Cost Sharing: Increase annual Part B cost sharing by $50

Mr. Archuleta said staff recommends adoption of the Baseline Scenario, which moves the solvency period to 2035, as well as pushes forward the deficit spending period from 2019 to 2020. Staff will continue to review these recommendations. He added that the board's review of the Strategic Plan in October would include a discussion of benefit reductions; as difficult as that is to swallow, it is absolutely necessary to maintain the long-term solvency of the program.

Mr. Archuleta said staff does not recommend approval of Scenario A or B. While the cost-sharing arrangements (or other cost-sharing arrangements) in the other scenarios would have to be considered down the road, staff felt the recommendation of the Baseline Scenario was a good option at this time and would achieve a reasonable solvency window.

Mr. Archuleta said meetings would take place over the next month about renewal of Medicare Advantage plans. If for some reason Humana or United Health foresees a need to significantly raise the rates next year, it will be necessary to revisit the recommended defaulting in August. Assuming rates are in accordance with the trends being experienced by the other plans, however, staff's recommendation will stand.

Chairman Sullivan, also speaking on Mr. Crandall's behalf, said the board is obviously pleased that the agency has been able to recoup the solvency period loss that was realized as a result of legislative action, but given that the recoupment was chiefly due to investment gains, this could be considered "soft money." In that light, pushing the solvency period out farther next year could ultimately create an undo burden on the retirees. With so many unknowns, especially at the national level, 15 to 18 years sounded like a sweet spot right now.

Mr. Archuleta agreed that investment gains have been significant but noted that NMRHCA has contributed $35 million in the last fiscal year, adding to the value of the fund. In the previous year, the agency contributed about $40 million, all of which was lost.

Mr. Montaño moved to accept the Baseline Scenario. Mr. Linton seconded the motion, which passed unanimously by voice vote.

7. PHARMACY BENEFIT MANAGEMENT RFP

Mr. Kueffer said staff is working with the other IBAC members and benefits consultant HealthLinx to finalize the scope of work, sequence of events, deadlines and evaluation criteria for this RFP, which is scheduled for release in early to mid-August.

Mr. Kueffer requested approval to issue an RFP for pharmacy benefit management services in cooperation with other members of the IBAC.

Ms. Saunders so moved. Ms. Larrañaga-Ruffy seconded the motion, which passed unanimously by voice vote.

8. OTHER BUSINESS

None.

9. DATE AND LOCATION OF NEXT BOARD MEETING
AUGUST 24, 2017, 9:30 A.M.
Alfredo R. Santistevan Board Room, Suite 207
4308 Carlisle Blvd., N.E.
Albuquerque, NM 87107

10. ADJOURN

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

_____

Tom Sullivan, President

The Interagency Benefits Advisory Committee (IBAC) consisting of:

State of New Mexico, Risk Management Division
New Mexico Public Schools Insurance Authority (NMPSIA)
New Mexico Retiree Health Care Authority (NMRHCA)
Albuquerque Public Schools (APS)

REQUEST FOR PROPOSALS (RFP)

Pharmaceutical Benefits Management Services

RFP#
2018-IBAC-0001

Issued Date: August 15, 2017

Proposal Due: September 14, 2017

II. CONDITIONS GOVERNING THE PROCUREMENT

This section of the RFP contains the schedule, description and conditions governing the procurement.

A. SEQUENCE OF EVENTS

The Procurement Manager will make every effort to adhere to the following schedule:

	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 5 & 6, 2017
9.	Oral Presentation and/or Product Demonstrations by Finalists	Offerors	December 5 & 6, 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

B. EXPLANATION OF EVENTS

The following paragraphs describe the activities listed in the sequence of events shown in Section II. A., above.

1. Issuance of RFP

This RFP is being issued on behalf of the New Mexico State IBAC on August 15, 2017.

2. Acknowledgement of Receipt

Investments and Pensions Oversight Committee

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

NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

Strategic Goals, Staff and Salary Structure
August 3, 2017

Tom Sullivan, Board President

Joe Montano, Vice President

Doug Crandall, Secretary

David Archuleta, Executive Director

Agency & Program Updates

Annual Board Meeting Action - 2018

- Retiree Premiums
  - Pre-Medicare - 8 percent (Premier and Value Plans)
  - Medicare Supplement – 6 percent
- Prescription Drug Plan Changes
  - Smart90 Program
- Increase Value Plan Options
  - Addition of Blue Cross Blue Shield BAV Narrow Network
- Medicare Default
  - UnitedHealthcare Plan I
    - Annual Out-of-Pocket Maximum - $2,500
    - 2018 Rate - $104.17
  - Humana Plan I
    - Annual Out-of-Pocket Maximum - $4,000
    - 2018 Rate - $87.45

Agency & Program Updates Cont.

Rate Increase – Member Impact:

Pre-Medicare	2017	2018	Difference	Annual
Premier	$223.56	$241.44	$ 17.88	$ 214.56
Value	$174.63	$188.60	$ 13.97	$ 167.64
Medicare				
Supplement	$188.64	$199.96	$ 11.32	$ 135.84

Medicare Advantage Rate Increase:

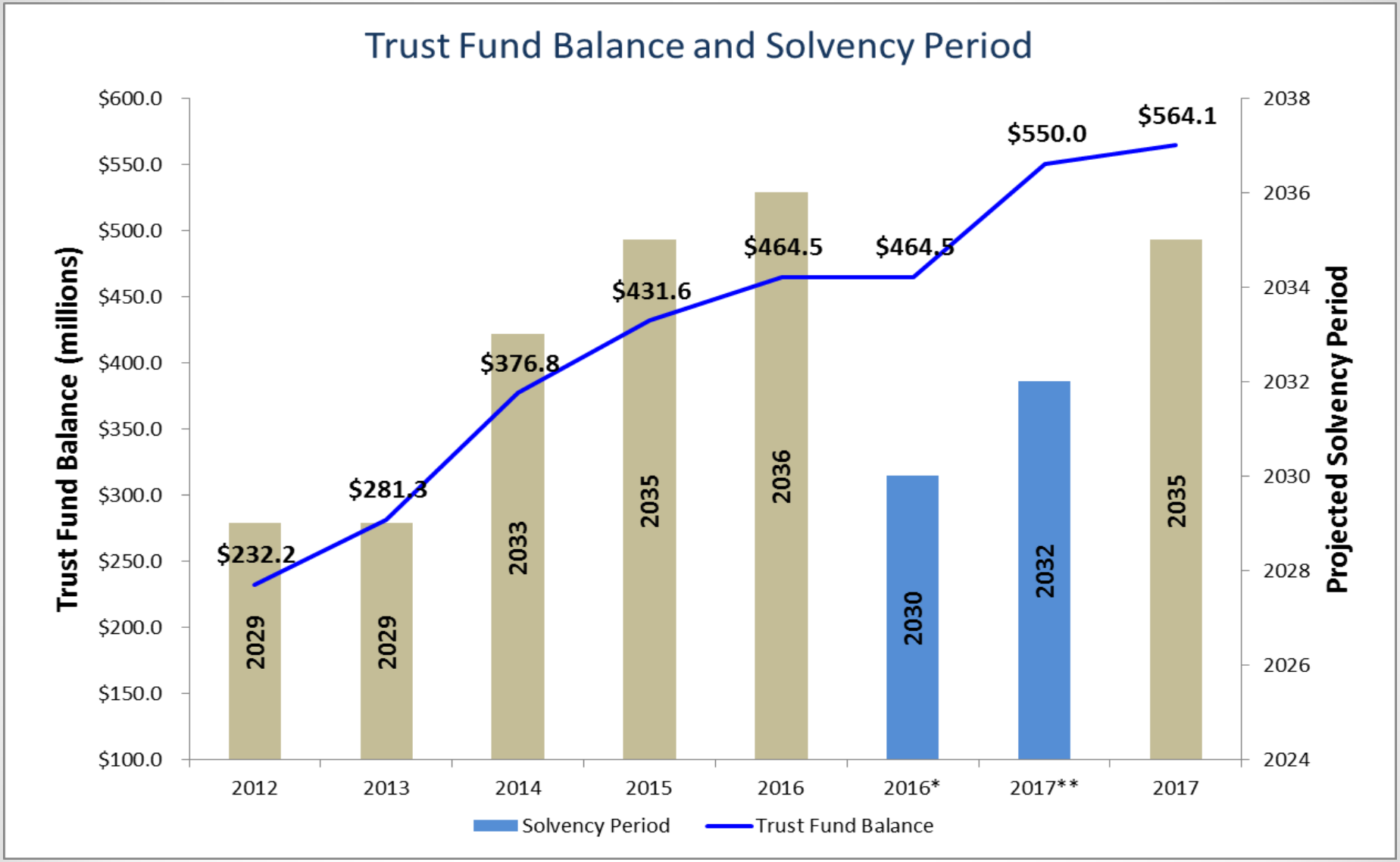
- 8 plans ranging from 6 – 27 percent increase ($3.20 - $15.50 per month)

	2017	2018	$	%
BCBS MA I	$ 61.20	$ 69.60	$ 8.40	14%
Presbyterian MA I	$ 89.00	$ 96.50	$ 7.50	8%
UHC MA I	$ 94.69	$ 104.17	$ 9.48	10%
Human MA I	$ 82.77	$ 87.45	$ 4.68	6%
BCBS MA II	$ 18.95	$ 23.30	$ 4.35	23%
Presbyterian MA II	$ 57.00	$ 72.50	$ 15.50	27%
UHC MA II	$ 49.68	$ 54.65	$ 4.97	10%
Human MA II	$ 49.86	$ 53.06	$ 3.20	6%

2017 Market Comparison

2017 Market Comparison of Commercially Available Plans (Pre-Medicare)

New Mexico Health Care Exchange Plans	Retiree Premium	Spouse Premium	Ret + Spouse Premium	Plan Type	Plan Level	Deductible	Out-of-Pocket Max	First Dollar Coverage: Y/N
Blue Cross Blue Shield - Age: 60 - Albuquerque	$767	$767	$1,534	HMO	Gold	$2,000	$3,150	N
NM Health Connections - Age: 60 - Albuquerque	$693	$693	$1,387	HMO	Gold	$1,000	$7,150	Y
Blue Cross Blue Shield - Age: 60 - Albuquerque	$633	$633	$1,266	HMO	Silver	$4,000	$6,100	N
NM Health Connections - Age: 60 - Albuquerque	$548	$548	$1,096	HMO	Silver	$4,000	$7,150	Y
Blue Cross Blue Shield - Age: 60 - Albuquerque	$539	$539	$1,077	HMO	Bronze	$7,000	$7,150	N
NM Health Connections - Age: 60 - Albuquerque	$452	$452	$904	HMO	Bronze	$7,000	$7,150	N
Blue Cross Blue Shield - Age: 60 - Santa Fe	$900	$900	$1,800	HMO	Gold	$2,000	$3,150	N
NM Health Connections - Age: 60 - Santa Fe	$779	$779	$1,557	HMO	Gold	$1,000	$7,150	Y
Blue Cross Blue Shield - Age: 60 - Santa Fe	$752	$752	$1,505	HMO	Silver	$4,000	$6,100	N
NM Health Connections - Age: 60 - Santa Fe	$616	$616	$1,231	HMO	Silver	$4,000	$7,150	Y
Blue Cross Blue Shield - Age: 60 - Santa Fe	$647	$647	$1,295	HMO	Bronze	$7,000	$7,150	N
NM Health Connections - Age: 60 - Santa Fe	$507	$507	$1,015	HMO	Bronze	$7,000	$7,150	N
Blue Cross Blue Shield - Age: 60 - Las Cruces	$987	$987	$1,975	HMO	Gold	$2,000	$3,150	N
NM Health Connections - Age: 60 - Las Cruces	$759	$759	$1,517	HMO	Gold	$1,000	$7,150	Y
Blue Cross Blue Shield - Age: 60 - Las Cruces	$828	$828	$1,657	HMO	Silver	$4,000	$6,100	N
NM Health Connections - Age: 60 - Las Cruces	$600	$600	$1,200	HMO	Silver	$4,000	$7,150	Y
Blue Cross Blue Shield - Age: 60 - Las Cruces	$715	$715	$1,430	HMO	Bronze	$7,000	$7,150	N
NM Health Connections - Age: 60 - Las Cruces	$494	$494	$989	HMO	Bronze	$7,000	$7,150	N



*Post 2016 2nd Special Session

**2017 Projected

Agency & Program Updates Cont.

Pharmacy Benefits Manager RFP

- Release mid-August
- Effective July 1, 2018 – June 30, 2022

Open/Switch Enrollment

- October/early November
- Medical
  - Premier - Value
  - Value - Premier
  - Supplement – Medicare Advantage
  - Medicare Advantage – Supplement
  - Medicare Advantage – Medicare Advantage
- Dental & Vision
  - Switch/Open*
- Life
  - Subject to underwriting

*Eligible if not initially elected or member hasn't had coverage in last 4 years

Issues Confronting the Authority

Challenges

- Competition w/other state priorities i.e., Schools, Medicaid, Courts, Corrections, Public Safety
- Reduction in Tax Suspense Fund revenue
- Prescription drug costs continue to escalate with no clear-cut remedy on the horizon
- Public payroll from which NMRHCA draws contributions continues to remain stagnant
- Volatility in the health insurance market as a result of changes to, or the complete repeal of, the Affordable Care Act and the resulting impact to the system as a whole
- The President's and Congress's disposition toward Medicare is unclear at the federal level

Progress

- Over $226 million transferred to long-term investment account since 2010
- Measurements of long-term viability have consistently shown progress
- NMRHCA plans remain predictable and stable for over 60,000 members (2/3 of which are Medicare participants)

Mission and Strategic Goals

Mission

- Maintain comprehensive and affordable health insurance benefits for public retirees and eligible dependents

Goals

- Extend the solvency of the program
  - Trust fund contributions and investment earnings
  - Avoiding deficit spending
- Meet customer service needs
  - Communication
  - Education
  - Wellness Programs

5-Year Strategic Plan (2012 – 2017)

1. Phase out “family coverage” subsidies for retirees with multiple dependent children
2. Increase cost sharing on prescription-drug coverage
3. Increase cost sharing of pre-Medicare plans
4. Implement graduated minimum-age requirement
5. Increase years of service required to receive maximum subsidy
6. Reduce pre-Medicare retiree subsidies
7. Reduce pre-Medicare spousal subsidies
8. Implement enhanced-wellness programs
9. Increase Employee/Employer contribution levels

<u>Other Significant Actions</u>

Conversion of $6,000 basic life (NMRHCA-paid) insurance to supplemental (retiree-paid) life insurance over four years beginning in 2018

Updated Strategic Plan (2018 – 2022)

Board Recommendations to include in 2018 - 2022:

1. Apply downward pressure on prescription drug costs for all members (network, contracts, cost-sharing)
2. Apply downward pressure on pre-Medicare medical plans (network, contracts, cost-sharing)
3. Reduce pre-Medicare retiree subsidies
4. Reduce pre-Medicare spousal subsidies
5. Evaluate existing and emerging wellness/population health programs for inclusion in either plan coverage or incentive support
6. Develop and implement value-based purchasing initiatives either through existing health plan partners or directly with health care delivery systems
7. Evaluate emerging and ongoing demographic trends and make program adjustments commensurate with fiduciary responsibilities
8. Increase employee/employer contribution levels (requires legislative action)

Staff & Salary Structure

Board of Directors

- State Treasurer
- Governor's Appointee
- State Employee
- Teacher
- PERA
- ERB
- Retired Public Employee of NM
- NM Association of Educational Retirees
- Municipal League
- Superintendents Association
- Association of Counties

Staff

- Executive Director
- Deputy Director
  - Chief Financial Officer
  - Customer Service
  - Health Care Reform/Procurement
- IT Director
  - IT Generalist/Systems Analyst
- Chief Financial Officer
  - Accountant/Auditor, Bus Ops Spec, Fin Spec
- HR Manager --- SPO Shared Svs.
- Director of Communication
- Director of Healthcare Reform
- Customer Service Manager – Alb
  - Customer Service Representatives
- Customer Service Manager – SF
  - Customer Service Representatives

Health Notes

Program Evaluation Unit
Legislative Finance Committee
Date: August 18, 2017

IBAC Cost and Utilization Trends, 2012—2016

AT A GLANCE

The Interagency Benefits Advisory Council (IBAC), created by the Health Care Purchasing Act in 1997, has yet to reach the full fiscal promise of the combined purchasing power of the state's public employees and retirees. The IBAC agencies include Albuquerque Public Schools (APS), the General Services Department (GSD), the New Mexico Public School Insurance Authority (NMPSIA), and the Retiree Health Care Authority (RHCA). Together they provide coverage for over 150 thousand members and are second only to the Medicaid program in terms of state dollars spent on health care. The IBAC agencies are challenged to contain health care costs that are rising faster than utilization. Although the agencies have used an array of techniques to try to manage expenditures, they have not been able to address one of their key cost drivers: the relatively high payment rates negotiated on their behalf by the commercial carriers with virtually no transparency or accountability.

As this Health Note demonstrates, the IBAC agencies are paying higher average rates than Medicare, which in turn pays higher rates than Medicaid. The primary tools IBAC agencies have used to attempt to contain rising costs are increased premiums and out-of-pocket costs like deductibles and copayments, but this approach simply shifts more costs to members—and the state—and does not address the root cause. Rising healthcare costs and higher premiums also impact compensation for state employees as more money is locked up in benefits rather than take-home pay.

In 2010, 2013, and 2015, LFC evaluations found the IBAC agencies generated significant savings from their one venture into truly consolidated purchasing, the contracting of a common pharmacy benefits manager (PBM). Other opportunities for savings previously recommended by the LFC, including consolidation of all purchasing as well as administrative tasks such as data collection and analysis, and actuarial and auditing functions, remain promising but elusive.

This brief reviews IBAC cost and utilization trends from FY12 through FY16, and identifies key cost drivers such as outpatient services, emergency room utilization, and high-cost claimants. The brief also offers a first-of-its-kind direct benchmarking of IBAC agency expenditures to Medicare. The comparison to Medicare costs shows IBAC frequently pays higher rates for similar services. In addition to the previous LFC recommendations listed above, there are further opportunities for state savings through greater IBAC agency participation in negotiating provider rates rather than continued and potentially unsustainable cost-shifting to members. True consolidation of the IBAC agencies could likely facilitate greater influence over rates, as may a shift away from straight fee-for-service payments.

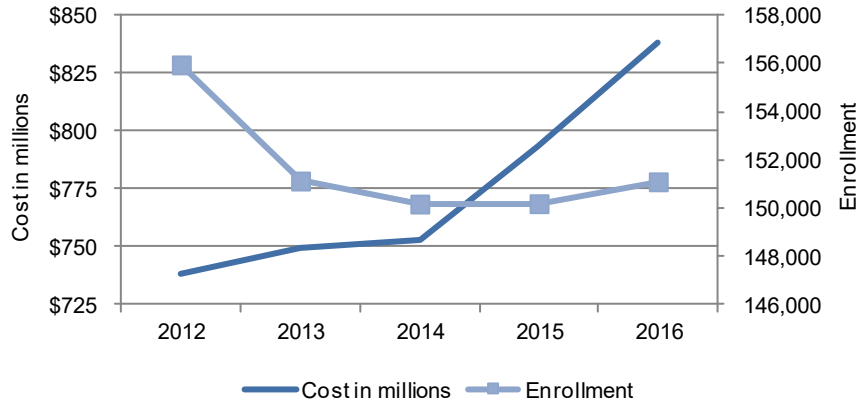
The IBAC agencies in brief

IBAC enrollment overall has declined 3 percent since FY12, while total healthcare costs have risen by nearly 14 percent, driven more by high prescription drug prices and spiraling payment rates than increased member utilization.

The four IBAC agencies each run their own self-funded healthcare plans and each is able to design its plan independently, but they are required by law to combine the negotiating power of their populations and issue joint requests for proposal (RFP) for health care and pharmacy benefit management services. The IBAC estimates it saves approximately $25 million per year through joint purchasing, about $10 million of which is associated with pharmacy spending.

IBAC's escalating healthcare costs are driven more by the combination of steep prescription drug price increases and spiraling payment rates than member utilization. In FY12, the IBAC agencies had a total enrollment of 155,976 members – by FY16, that number had dropped to 151,662, approximately a 3 percent decline. Total healthcare costs, which include medical claims paid, prescription drug costs net of rebates and discounts, and member out-of-pocket deductible and copayment amounts, have gone in the other direction, rising from $738 million to $838 million, or almost 14 percent. The role of payment rates can also be seen in overall higher claims costs per member, which have increased by 16 percent.

Chart 1: IBAC Health Care Costs and Enrollment
Total costs include medical claims paid, prescription drug costs and member out of pocket costs.



Source: LFC analysis of agency data

Albuquerque Public Schools (APS) runs its own health benefits program and covered over 18 thousand school employees and their eligible dependents in FY16. APS enrollment data shows a 6 percent increase in total covered lives from FY12 through FY16. Notably, that increase is driven by a 14 percent increase in employee spouses and eligible dependents, counterbalanced by a 3 percent drop in enrolled employees. During the same period, APS's total healthcare costs increased by about 3 percent, driven largely by a 28 percent increase in prescription drug spending, second highest among the IBAC agencies.

The General Services Department's (GSD) Risk Management Division is the employee health benefits purchasing agency for state government as well as an array of local public bodies and higher education institutions. GSD is experiencing declining enrollment, although with over 62 thousand covered lives in FY16 and over $285 million in healthcare spending it is still the largest IBAC agency. From FY12 to FY16, GSD had a 4 percent decrease in enrollment; during the same period, total healthcare costs rose by over 11 percent.

Table 1. IBAC Five-Year Growth Rates

IBAC Agency	Covered Lives Growth	Medical Cost Growth	Rx Cost Growth
APS	6.1%	-6.5%	28.1%
GSD	-4.2%	8.9%	12.8%
NMPSIA	-5.2%	19.4%	20.1%
RHCA	-1.4%	15.6%	43.1%

Source: LFC analysis of IBAC agency and health carrier data

The New Mexico Public School Insurance Authority (NMPSIA) is the health insurance purchasing agency for public school districts, post-secondary educational entities, and charter schools, and currently covers over 52 thousand school employees and eligible dependents. NMPSIA is also experiencing declining enrollment with rising medical and pharmacy costs. From FY12 to FY16, NMPSIA had a 5 percent decrease in enrollment. During the same period, its total health care costs grew by 16 percent, driven almost equally by rising prescription drug spending and increased medical costs.

The Retiree Health Care Authority (RHCA) members come from the state's public schools, state agencies, and over a hundred local public service and governmental entities. The agency provides healthcare coverage to two distinct populations of retirees: those under age 65 not yet eligible for Medicare, and those older than age 65 who are enrolled in Medicare, as well as their eligible dependents. This Health Note will focus only on the pre-Medicare fully insured population because that is the area fully under state control and funding. From FY12 to FY16, RHCA had a 17 percent increase in total enrollment, but the pre-Medicare population declined by about one and a half percent, likely related to a nationwide trend of fewer individuals opting to retire before age 65. Despite declining enrollment, total healthcare costs for the pre-Medicare population grew by 19 percent, driven largely by a 43 percent increase in prescription drug spending.

See Appendix A for more detailed data for each IBAC agency.

IBAC agencies cannot provide meaningful oversight of the health carriers they contract with because they do not receive consistent and comparable data from all carriers. For the same reasons, the cost and utilization information presented in this report is as accurate as possible but does contain some estimates as noted. If all the IBAC agencies used the same data warehouse the result would be improved access to truly consistent and useful IBAC-wide data. RHCA has its own data warehouse, but the other IBAC agencies are dependent on the carriers to gain access to their own information. However, both APS and NMPSIA have recently added data warehouse services to their benefits consulting and actuarial services contracts with Segal.

APS cost and utilization data had to be estimated for CY12-CY14 due to incomplete data from a now defunct carrier. For purposes of this brief APS agreed to have LFC staff use CY15 and CY16 data to approximate the missing data points. Lastly, some IBAC agencies run on calendar years and others use fiscal years, so this report smoothes calendar year and fiscal year data wherever possible.

Three IBAC agencies do not have full access to their own healthcare utilization and cost data and instead must rely on their contracted health carriers for basic information. As a result, data can be difficult to obtain and even more difficult to compare.

Premium structure and trends

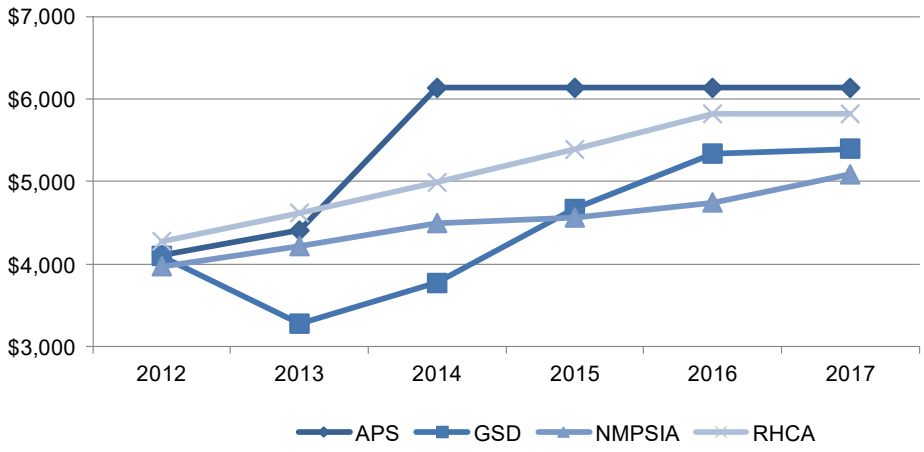
IBAC premiums have increased significantly over the last five years despite the fixed subsidy structure and the fact that in most cases the larger portion of the increase will ultimately fall on employers and the state.

Health care premiums for all IBAC agencies are, by statute, subsidized by state appropriations. For APS, GSD, and NMPSIA, subsidies are structured by employee salary, while for RHCA subsidies are based on years worked prior to retirement. Each agency offers at least two different plan options for its members, but the contribution rates for employee/retiree and the state remain the same regardless of which plan the member selects. (Appendix C has a complete chart of contribution levels.)

This fixed subsidy structure limits the agencies' ability to raise premiums to offset rising costs, since in most cases the larger portion of the increase will fall on the employer or the state. Premiums have nonetheless increased, although the IBAC agencies have approached the timing and extent of premium increases very differently, as chart 2 shows.

- APS had a 5 percent increase in 2013, a much larger 39 percent increase in 2014, and has since held premiums flat.
- GSD actually had a decrease in 2013 as it added a new high deductible plan, followed by a 15 percent increase in 2014, a 24 percent increase in 2015 (using the average of premiums for the first and second half of that year), a 14 percent increase in 2016, and then just a one percent increase for 2017.
- NMPSIA premiums increased 6 and 7 percent in 2013 and 2014, respectively, one percent in 2015, 4 percent in 2016 and 7 percent for 2017.
- RHCA held to a steady 8 percent annual increase from 2013 through 2016. Retirees had the option of avoiding any premium increase for 2017 if they were willing to switch to the agency's new leaner Value HMO plan..

Chart 2: IBAC Premiums for Lowest Cost Individual Plans



Source: Agency rate sheets

Premiums for the IBAC agencies compare favorably to the most commonly-used national benchmark, the Kaiser Family Foundation's annual survey of employer health benefits. For 2016, the national average annual individual premium for employer-sponsored health insurance was $6,435 for all types of plans, and $5,762 for the very lowest cost high deductible plans. The lowest individual premiums for the IBAC agencies ranged from $4,566 for NMPSIA to $6,135 for APS, or an average of $5,511 for all four. On the other hand, the IBAC agencies are higher than the national average in terms of employee contributions to premiums. The national average is 18 percent for individual coverage, and no IBAC member pays less than 20 percent of premium.

According to the Kaiser Family Foundation, the national average for employee contribution to health care premiums is 18 percent for individual coverage. No IBAC member pays less than 20 percent of premium.

Benefit plan design trends

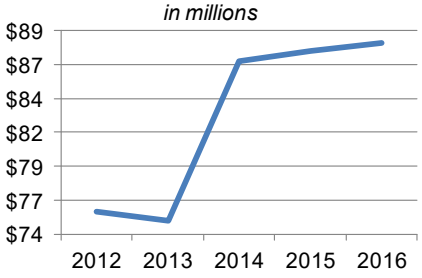
Plan design changes to deductibles, annual out-of-pocket maximums and copayments for various services can be another way to shift rising costs to members and encourage members to be more cost-conscious in their use of healthcare services.

All the IBAC agencies made some major plan revisions for 2017, some of which are described in this summary. However, due to the time frame of this brief the cost savings that may result from these recent changes are not captured here.

Utilization increases are not a major cost driver for the IBAC agencies, and rising out-of-pocket costs could be part of the explanation. Average out-of-pocket expenses per IBAC member rose 15 percent between 2012 and 2016. The IBAC agencies have all followed a pattern of some years with significant increases to their annual deductibles and out of pocket maximums, while holding both stable for most of the years from 2012 through 2017. Annual deductible increases during that time period were 67 percent for APS, 117 percent for GSD, 33 percent for NMPSIA, and 167 percent for RHCA. Out-of-pocket maximum increases were generally lower: 13 percent for APS, 17 percent for GSD, 7 percent for NMPSIA, and a 50 percent increase for RHCA in 2017. See charts 4 and 5.

Chart 3: Aggregate IBAC Member Out of Pocket Amounts

in millions

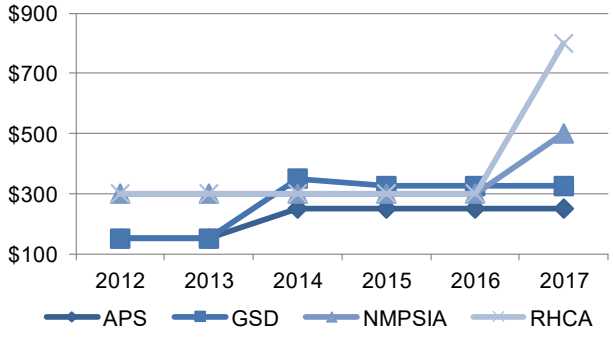


Source: LFC analysis of agency data

According to Kaiser, the national average individual deductible for 2016 was $1,478, significantly higher than any IBAC deductible. Further, average IBAC deductibles increased 31 percent between 2012 and 2016, slightly slower than the national rate of 35 percent.

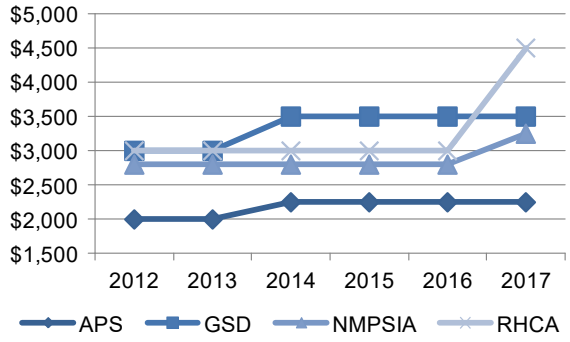
Nationally, 14 percent of workers with employer-sponsored health coverage had out-of-pocket maximums of less than $2,000 in 2016, while 18 percent had maximums of $6,000 or more. The IBAC agencies, with 2016 out-of-pocket maximums ranging from $2,250 to $3,500, fall towards the lower end of the national spectrum.

Chart 4: Lowest Individual Annual Deductible



Source: Agency benefit summaries

Chart 5: Individual Annual Out of Pocket Maximums



Source: Agency benefit summaries

A brief review of agency-level trends for copayments for select medical services and pharmacy benefits shows differing strategies for using plan design as a tool for constraining rising costs.

APS increased copayments for specialist, urgent care, and emergency room visits by about 14 to 25 percent between 2012 and 2016. Copayments for hospital stays shifted from a set $750 in CY12 to a 20 percent coinsurance in CY16. The APS pharmacy benefit plan design remained stable from 2012 through 2016, with slight increases in copayments for everything but generic drugs. For 2017, APS made a complex plan design change and implemented a new single plan with three tiers.

The IBAC agencies, with 2016 out of pocket maximums ranging from $2,250 to $3,500, fall towards the lower end of the national spectrum.

Between 2012 and 2016, GSD increased copayments for primary care, specialist visits, and hospital stays by 67 percent, 33 percent, and 25 percent, respectively. GSD's pharmacy benefit plan remained essentially the same from 2012 through 2016.

The most distinctive change to GSD's benefit package came with the September 2015 opening of the Stay Well Health Center in Santa Fe. The clinic provides urgent and routine primary care to members with no deductibles or copayments. This is an effort to provide prompt access to care as well as reduce overall medical costs as a result of better disease management through health coaching. The clinic was initially slow to attract state workers, but during 2016, the total number of patients seen (new and returning) increased by over 600 percent, with a 48 percent return rate.

GSD tracks utilization of the Stay Well Health Center separately and cost savings will be difficult to determine without more in-depth analysis.

NMPSIA increased premiums as noted above, but until 2017 held copayments for both medical services and prescription drugs relatively stable. Beginning in 2017, however, NMPSIA made significant increases to copayments for primary care, specialist visits, and urgent care, as well as for prescription drugs.

RHCA, after years of virtually no changes, made its medical plan options significantly leaner for 2017. Copayments for most medical services have increased considerably. RHCA has made no changes to its pharmacy benefit package since 2012, although it is worth noting that the existing RHCA plan already has the highest member cost sharing of the IBAC agencies.

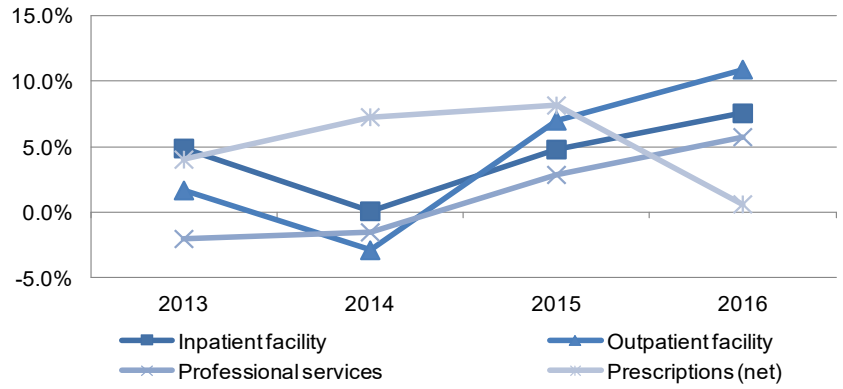
Medical Services and Prescription Drug Trends

IBAC's total medical expenditures, including inpatient services, outpatient services, professional services, and prescription drug costs (net), increased by 13 percent between 2012 and 2016, from $662 million to $750 million. In the same time period, overall IBAC enrollment dropped by nearly 3 percent. Outpatient medical costs grew from $235 million to $275 million, or 17 percent, representing the

largest portion of total medical spend over the five-year period. Inpatient hospitalization costs rose steadily from $124 million to $147 million, or 18 percent, while professional service costs declined from $125 million in 2012 to $120 million in 2014 and then rose steeply to $131 million by 2016, for a five-year growth trend of 5 percent. See charts 6 and 7.

IBAC's total medical expenditures increased by 13 percent between 2012 and 2016. During the same time period, overall IBAC enrollment dropped by nearly 3 percent.

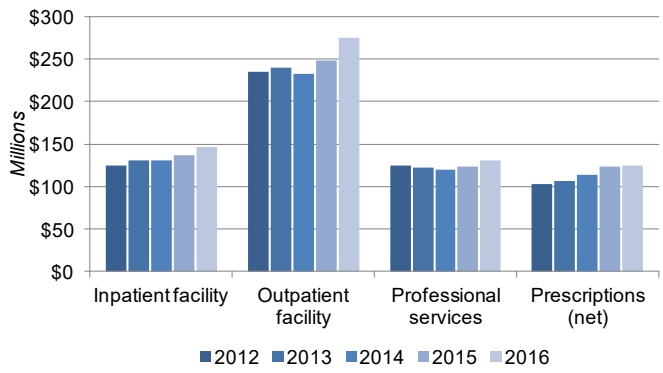
Chart 6: Year-Over-Year Growth Rates for Major Service Categories



Source: LFC analysis of agency data.

Outpatient facility services was the most costly medical cost category for all IBAC agency plans between FY12 and FY16. Similar to national trends, outpatient facility services are becoming an ever-larger portion of overall medical expenses. The Center for Medicare and Medicaid Services (CMS) Office of the Actuary reported the ratio of total hospital Medicare fee-for-service payments for outpatient services grew from 15.7 percent in 2000 to 26.5 percent in 2014, serving as the main driver of hospital payment increases. Medicare defines outpatient facility services as services provided in an eligible hospital setting including emergency or observation services, same-day surgery, hospital laboratory tests, and radiological services.

Chart 7: Total Expenditures by Major Service Category



Source: LFC analysis of agency data

Between 2012 and 2016, the amount IBAC agencies paid per claim increased at a much faster rate than the total number of claims, indicating payment rates have increased faster than utilization.

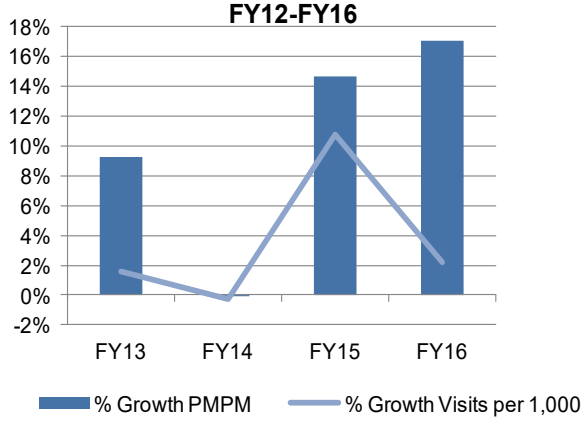
Two other utilization trends offer further support for the LFC's concern that IBAC costs are being driven more by payment rates than increases in utilization. Between 2012 and 2016, the total number of claims increased by less than one percent, while both the amount paid per claim and the amount paid per claimant increased by approximately 6 percent.

Emergency room costs increased significantly between FY12 and FY16 for GSD and NMPSIA, far outpacing growth in utilization. As the two largest membership pools within the IBAC, GSD and NMPSIA have both shown significant cost growth for emergency room visits, from $20.20 PMPM in FY12 to $29.94 PMPM in FY16, an increase of 48 percent.

Emergency room costs and utilization continue to require attention from IBAC agencies in order to control overall cost growth.

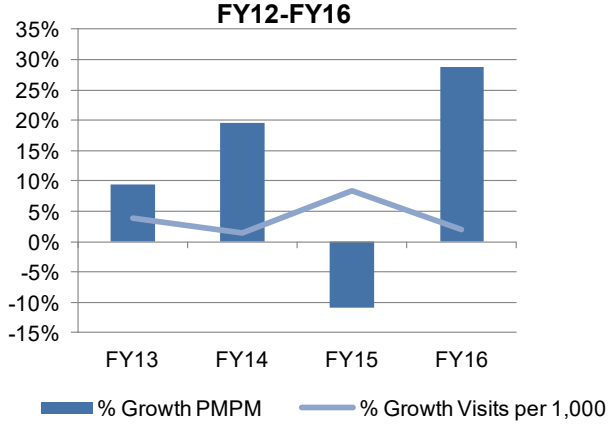
Emergency room visits per 1,000 members also increased over the same time period, but only by 16 percent. Service rates appear to be a driver in overall cost growth, especially considering the disproportionate growth rates in ER expenditures and utilization. According to New Mexico data collected by the Kaiser Family Foundation, there were an average of 490 ER visits per 1,000 New Mexicans in 2015. In FY16, GSD's and NMPSIA's combined average ER utilization rate per 1,000 members was 180.56. This total is significantly less than the state ER utilization rate, but the upward trend is still a point of concern. Emergency room costs and utilization continue to be a service category requiring attention from IBAC agencies in order to control overall cost growth. See charts 8 and 9.

Chart 8: GSD ER Cost and Utilization Growth Rates FY12-FY16



Source: LFC analysis of IBAC health plan data

Chart 9: NMPSIA ER Cost and Utilization Growth Rates FY12-FY16



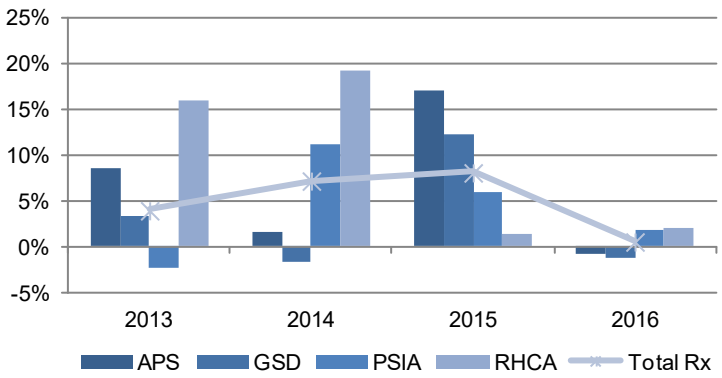
Source: LFC analysis of IBAC health plan data

IBAC prescription drug costs, net of discounts and rebates, rose from $102 million to $124 million, or 21 percent, between FY12 and FY16. Prescription drug costs are clearly a driver of overall medical costs for the IBAC agencies, but the rate of increase for all agencies has slowed over the last couple of years, from highs between 12 percent and 19 percent in 2014 and 2015 to more manageable 2 percent increases for NMPSIA and RHCA and even negative growth rates for APS and GSD in 2016 (chart 10).

The primary reason for this slowing trend is very likely less utilization of costly drugs for the hepatitis C virus (HCV). Because these drugs provide a cure for the disease, once the majority of IBAC members with HCV have received treatment agency spending in this disease area can be expected to drop significantly.

The LFC completed a comprehensive review of prescription drug spending among state agencies in 2016; please see that brief for more detailed information about IBAC trends for specific conditions and drugs.

Chart 10: IBAC Prescription Drug Costs Year-Over-Year Rate of Increase



Source: LFC analysis of agency data

Differences in demographics of each IBAC agency lead to some interesting differences in cost trends. Highlights of agency-specific trends include:

APS is the one IBAC agency that appears to run counter to the trend just identified: its total number of claims has increased very little over the five-year time span of this review, but average amounts paid per claim and per claimant have decreased by 14 percent and 20 percent, respectively. In CY16, APS spent nearly 46 percent more on outpatient facility than inpatient, in line with IBAC trends overall, although the agency has seen a 30 percent increase in inpatient costs over the last five years, including a nearly 87 percent increase in per admission costs. Between CY12 and CY16, APS experienced a 28 percent increase in prescription drug costs, the second highest growth rate of all IBAC agencies; the agency's plan design changes may be turning this trend around as CY16 prescription costs were lower than CY15.

APS appears to have a trend unique among IBAC agencies: its total number of claims has increased very little over the five year time span of this review, while average amounts paid per claim and per claimant have actually decreased.

For GSD, total claims dropped by nearly 2 percent between FY12 and FY16, while the average amount paid per claim rose by 10 percent. In the same time period, GSD saw a 13 percent increase in prescription drug costs, the lowest growth rate of all the IBAC agencies. GSD's outpatient medical costs grew from $97 million to $108 million, or 12 percent, between FY12 and FY16, representing the largest portion of total medical spend over the five-year period. Inpatient hospitalization costs increased by nearly 15 percent, from $52 million to $60 million, while professional services costs rose 8 percent, from $28 million to $39 million.

NMPSIA's total number of claims increased nearly 3 percent over the last five years, while the average amount paid per claim increased 17 percent. NMPSIA's medical expenditures were dominated by outpatient facility costs, which increased 29 percent between FY12 and FY16, and by FY16 made up 46 percent of total expenditures. Inpatient facility costs increased by 24 percent, but still made up only 23 percent of total FY16 costs. Between FY12 and FY16 NMPSIA experienced a 20 percent increase in prescription drug costs, although the rate of cost increases leveled out somewhat from FY15 to FY16.

RHCA's total claims dropped by one and a half percent between FY12 and FY16, while the average amount paid per claim rose by 17 percent. In the same time period, RHCA saw the highest rate of increase in prescription drug costs, 43 percent, with spending rising from about $18 million in FY12 to nearly $26 million in FY16. Almost half of RHCA's total pre-Medicare medical expenses were related to outpatient care, which increased by 26 percent between FY12 and FY16, from $36 million to nearly $46 million, and by FY16 made up 44 percent of total medical expenditures. Inpatient hospitalization costs increased by 18 percent, from $21 million to $25 million, while professional service costs rose just over 2 percent, from $33 million to about $34 million.

High-cost clients are another key IBAC cost driver

The percentage of clients deemed high-cost is significantly higher for IBAC agencies when compared to other large employers, and represent a much larger portion of total expenditures. For the purposes of this analysis, a high-cost client is defined as a claimant with greater than $50 thousand in claims in a single year. In 2016, the non-partisan American Health Policy Institute (AHPI) conducted a survey of 26 large private employers, looking specifically at high-cost clients. In the table below, some of the metrics from the AHPI survey are listed with corresponding measures for IBAC agencies.

Table 2: IBAC Agency High-Cost Client Comparison, 2016

	AHPI Survey	APS	GSD	NMPSIA	RHCA
Percent of plan members identified as high-cost clients	1.2%	0.8%	1.2%	2.8%	2.2%
Average annual high-cost client cost	$122,382	$117,915	$116,628	$124,355	$127,147
Percent of total plan expenditures associated with high-cost clients	31.0%	17.2%	34.5%	37.4%	46.9%

Source: LFC analysis of FY16 IBAC health plan data (CY16 APS data) and AHPI

IBAC agencies were more heavily impacted in all three categories measured in the AHPI survey by high-cost clients, with a few exceptions. For example, GSD had an equal percentage of plan members designated as high-cost clients and a lower annual average cost per high-cost client than AHPI-surveyed employers. However, it is noteworthy all but one IBAC agency had a noticeably higher percentage of expenditures related to high-cost clients than the 26 participating employers in the AHPI survey, as noted in Table 2. APS scored the best in two out of three metrics when compared to both other IBAC agencies and the AHPI-surveyed employers. RHCA's average annual cost per high-cost client and percent of expenditures associated with high-cost clients are likely heavily influenced by the health characteristics of retirees including greater prevalence of chronic disease and increased medical acuity.

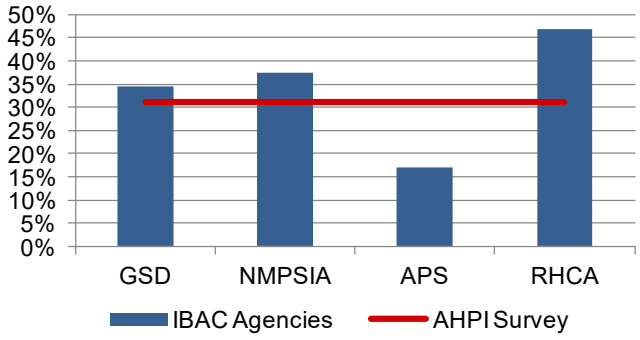
Looking broadly at the three performance metrics identified in the survey, IBAC agencies generally performed worse when cost was a factor. IBAC had a low per-

centage of plan members deemed high-cost, but when expenditures for these clients are considered, it becomes clear how much of a cost driver they are. While it is possible higher acuity could be a contributing factor, as is the case with RHCA, it stands to reason price is also a driver of high average annual cost and percent of expenditures associated with high-cost clients.

The AHPI survey also identified the percentage of high-cost client expenditures related to acute medical episodes and those tied to chronic illness. For surveyed employers, 53 percent of high-cost client medical expenditures were tied to chronic conditions.

This data could prove very useful in targeting disease management and wellness initiatives. However, this type of data is not reported by the health carriers administering IBAC plans.

Chart 11: Percent of Total Plan Expenditures from IBAC High-Cost Clients vs. AHPI Survey Results

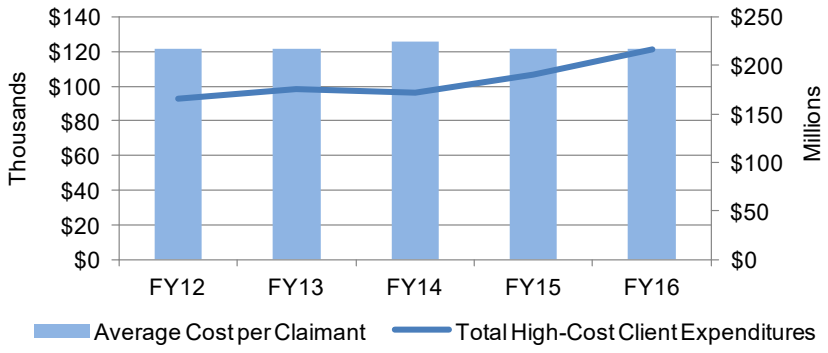


Source: LFC analysis of FY16 IBAC health plan data (CY16 APS data) and AHPI

While average cost per high-cost client remained relatively flat between FY12 and FY16, total high-cost client expenditures increased 30 percent. Average cost per client for annual claims over $50 thousand remained stable as the number of clients falling into this cost category also increased 30 percent between FY12 and FY16.

This trend is most likely driven by the increasing cost of health care. Further solidifying this is the fact more general diagnoses are costing over $50 thousand in annual claims, making what were previously somewhat routine acute interventions into high-cost claims.

Chart 12: IBAC High-Cost Claims Cost per Client FY12-FY16
**Excludes APS*



Note: LFC was unable to calculate APS data for this metric.
Source: LFC analysis of IBAC health plan data

Comparing IBAC and Medicare costs

Medicare data is the best available benchmark for IBAC expenditures, with data that is transparent, consistent, and available on the state level. Despite demographic differences between the Medicare population and the workers and retirees covered by IBAC plans, evaluating how Medicare costs in New Mexico compare with IBAC costs is informative.

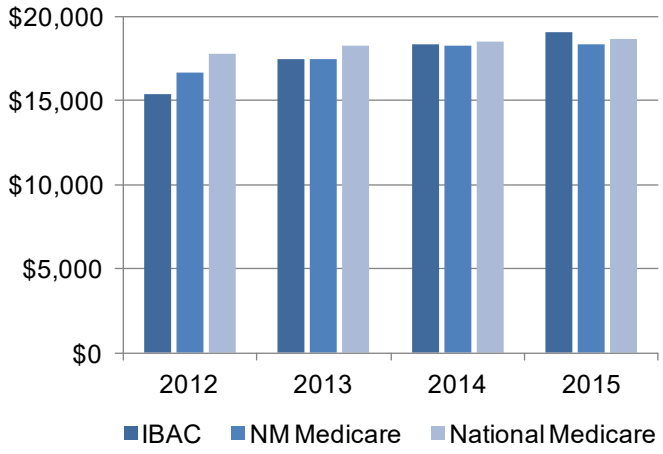
The Kaiser Family Foundation annual report on employer health benefits is the national standard for benchmarking the type, scope, and cost of benefits for employers and workers; unfortunately, there is no similar national benchmark for expenditures. Healthcare costs in general are not transparent, as health plans and providers generally consider cost and payment information proprietary. Costs can also vary greatly by a host of factors including everything from patient demographics, conditions, and acuity, to provider availability, healthcare infrastructure, and geographic location.

One available benchmark with data that is transparent, consistent, and available on the state level is Medicare. While there are demographic differences between the Medicare population and the workers and retirees covered by IBAC plans, evaluating how Medicare costs in New Mexico compare with IBAC costs takes us a step closer to understanding the degree to which IBAC costs are driven by payment rates. The most recent data available for Medicare is 2015, so the range of comparison for this section is 2012 through 2015.

The IBAC agencies have higher cost hospital stays—despite the fact that their members are generally younger and healthier than Medicare recipients—at least in part because they are paying higher rates than Medicare.

From 2012 through 2015, IBAC inpatient per user costs – the actual cost of an average hospital stay – caught and then surpassed Medicare costs. In 2012, IBAC costs were about 8 percent lower than New Mexico Medicare costs and 15 percent lower than national Medicare costs, while by 2015 they were approximately 4 percent and 2 percent higher, respectively. The Medicare population has different demographic characteristics than IBAC members, including an average age of 70, and Medicare patients may have more acute or multiple reasons for a hospital stay, and may stay longer in the hospital than the average IBAC member. However, there does not seem to be any meaningful economic impact of those differences when comparing average inpatient costs per user.

Chart 13: Inpatient Per User Costs



Source: LFC analysis of IBAC and Medicare data

A reasonable conclusion to draw from this information is that the IBAC agencies, despite their younger, generally healthier members, end up with higher cost hospital stays at least in part because they are paying higher rates than Medicare.

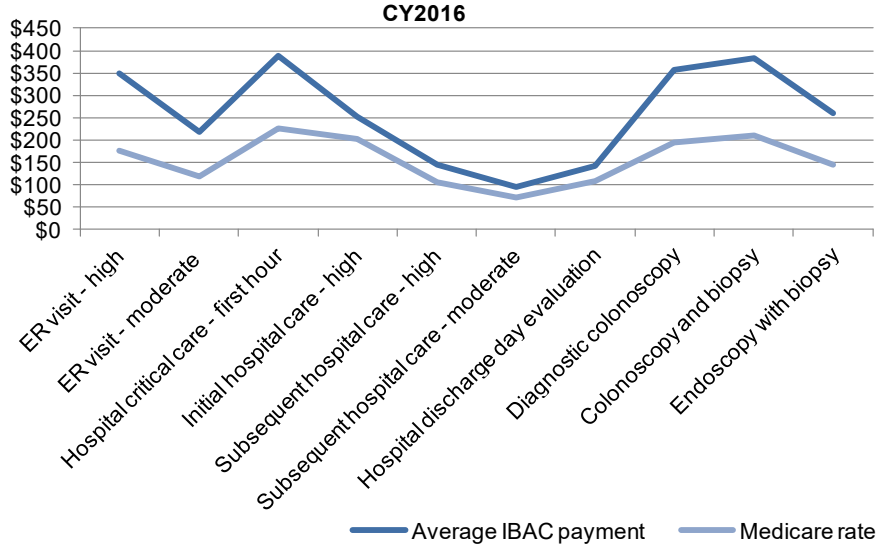
Evidence from one IBAC agency shows that agency pays higher rates than Medicare for many facility-based services. The full cost of facility-based procedures typically includes payments to multiple providers of different types as well as facility charges and fees. Total costs for the same procedure can vary widely from facility to facility and provider to provider, depending on agreements reached between providers, facilities, and health plans. The amount IBAC agencies eventually pay is based on a formula that begins with billed charges and is then reduced by a series of health plan discounts, coverage limits, patient cost sharing, and other adjustments. The details of these payment arrangements are considered proprietary.

One IBAC agency's data showed higher payment rates than Medicare for all of its top ten facility-based physician services.

However, one IBAC agency was willing to share with the LFC the average payment amounts for the physician services portion of its top ten facility-based and outpatient services (based on total costs). Although there are clearly limits to extrapolating from this limited set of data, it is reasonable to assume no one IBAC agency is, on average, being charged substantially more or less for the same services than the others, and analysis of this payment-specific information provides a new glimpse into how much IBAC costs are being driven by high payment rates.

The one IBAC agency's data showed it is paying higher rates than Medicare for all of its top ten facility-based physician services. For emergency room visits of high and moderate complexity, average IBAC payments appear to be between 81 percent and 97 percent higher than Medicare rates; for hospital critical care and high and moderate complexity visits, average IBAC payments appear to be between 25 and 71 percent higher than Medicare. Average IBAC payments for diagnostic colonoscopies, colonoscopies with biopsies, and endoscopies with biopsies appear to be between 80 and 84 percent higher than Medicare. See chart 14.

Chart 14: Comparison of Payment for Select Facility-Based Procedures
CY2016

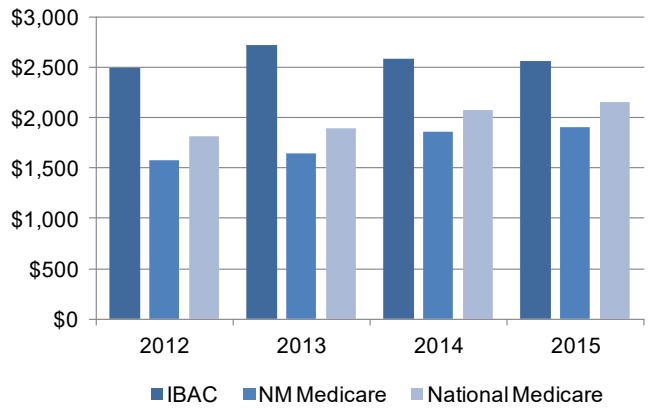


Source: LFC analysis of IBAC and Medicare data

IBAC per capita outpatient costs have been even more markedly higher than Medicare both in New Mexico and nationally.

IBAC per user outpatient costs have been even more markedly higher than Medicare both in New Mexico and nationally. As noted previously, high outpatient costs are a key driver of healthcare costs around the country, but the per user gap between IBAC and Medicare is large enough to offer further evidence IBAC agencies, through their contracted health carriers, appear to be paying considerably higher rates for services than Medicare does. See chart 15.

Chart 15: Outpatient Per User Costs

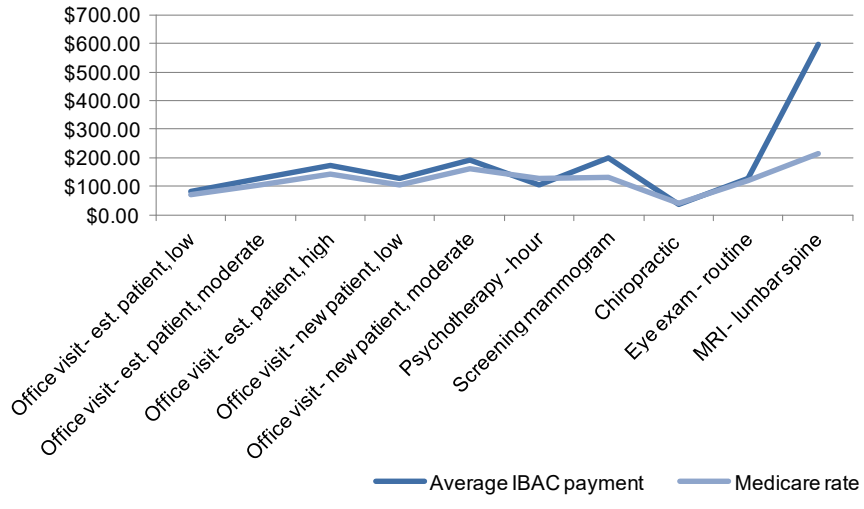


Source: LFC analysis of IBAC and Medicare data

IBAC agencies also paid higher rates than Medicare for many outpatient services. For all but two of the outpatient services the one IBAC agency provided payment data for, physician service payments were higher than Medicare rates for the same services. For office visits for new and established patients, ranging from low to high complexity, average IBAC payments appear to be between 16 percent and 21 percent higher than Medicare rates. For screening mammograms, average IBAC payments appear to be 53 percent higher than Medicare rates, and for MRIs of the lumbar spine, average IBAC payments appear to be nearly 180 percent higher than Medicare rates.

On the other hand, average IBAC rates for routine eye exams appear to be only about 6 percent higher than Medicare rates, while psychotherapy and chiropractic visits appear to be about 17 percent and 13 percent lower than Medicare rates, respectively. See chart 16.

Chart 16: Comparison of Payment for Select Outpatient Services CY16



Source: LFC analysis of IBAC and Medicare data

Conclusion

Review of IBAC cost and utilization trends from 2012 through 2016 found while IBAC agencies have used an array of techniques at their disposal to work to contain rising healthcare costs, they have not been able to address one of their key cost drivers: the relatively high payment rates negotiated on their behalf by the commercial carriers with virtually no transparency or accountability.

This lack of involvement with payment rates is characteristic of the basic administrative services nature of the IBAC agencies. Some influence in this area could be gained through redesign of agency contracts with the carriers. However, the issue can likely only be fully addressed by true consolidation of the individual agencies into a state healthcare purchasing organization with wider decision-making authority. It may also be worthwhile to explore options other than straight fee-for-service purchasing, such as the bundled rates for certain conditions that Medicare is piloting.

The high facility and provider rates IBAC is paying can likely only be fully addressed by true consolidation of the individual agencies into a state healthcare purchasing organization with broader decision-making authority.

Appendix A:
Agency-level Overviews

Albuquerque Public Schools - Employee Health Insurance

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	17,308	17,465	19,452	18,862	18,359	6.1%
year-over-year change		0.9%	11.4%	-3.0%	-2.7%	
Medical*	$58,411	$58,277	$58,392	$52,898	$54,601	-6.5%
year-over-year change		-0.2%	0.2%	-9.4%	3.22%	
Prescription Drugs (Rx)*	$10,270	$11,154	$11,327	$13,259	$13,153	28.1%
year-over-year change		8.6%	1.6%	17.0%	-0.8%	
Total Medical and Rx*	$68,681	$69,431	$69,719	$66,157	$67,754	-1.3%
year-over-year change		1.1%	0.4%	-5.1%	2.4%	
Per Member Medical/Rx Claims Paid Per Year	$3,968	$3,975	$3,584	$3,507	$3,691	-7.0%
year-over-year change		0.2%	-9.8%	-2.1%	5.2%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: APS

General Services Department State Health Benefit Utilization

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	65,490	61,509	59,021	60,383	62,724	-4.2%
year-over-year change		-6.1%	-4.0%	2.3%	3.9%	
Medical *	$224,537	$221,113	$198,991	$227,689	$244,550	8.9%
year-over-year change		-1.5%	-10.0%	14.4%	7.4%	
Prescription Drugs (Rx)*	$36,700	$37,900	$37,300	$41,900	$41,400	12.8%
year-over-year change		3.3%	-1.6%	12.3%	-1.2%	
Total Medical and Rx*	$261,237	$259,014	$236,291	$269,589	$285,951	9.5%
year-over-year change		-0.9%	-8.8%	14.1%	6.1%	
Per Member Medical/Rx Claims Paid Per Year	$3,989	$4,211	$4,003	$4,465	$4,559	14.3%
year-over-year change		5.6%	-4.9%	11.5%	2.1%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: GSD

Public School Insurance Authority Health Benefit Utilization

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	55,520	54,345	53,624	53,260	52,643	-5.2%
year-over-year change		-2.1%	-1.3%	-0.7%	-1.2%	
Medical*	$185,841	$193,627	$194,953	$202,257	$221,984	19.4%
year-over-year change		4.2%	0.7%	3.7%	9.8%	
Prescription Drugs (Rx)*	$37,400	$36,514	$40,621	$43,035	$43,848	20.1%
year-over-year change		-2.4%	11.2%	5.9%	1.9%	
Total Medical and Rx*	$223,241	$230,141	$235,574	$245,292	$265,832	19.1%
year-over-year change		3.1%	2.4%	4.1%	8.4%	
Per Member Medical/Rx Claims Paid Per Year	$4,021	$4,235	$4,393	$4,606	$5,050	25.6%
year-over-year change		5.3%	3.7%	4.8%	9.6%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: PSIA

Retiree Health Care Authority Health Benefit Utilization for Non-Medicare Members

(Medical, rx and total are in thousands of dollars)	FY12	FY13	FY14	FY15	FY16	Change
Covered Lives	17,620	17,803	18,070	17,678	17,365	-1.4%
year-over-year change		1.0%	1.5%	-2.2%	-1.8%	
Medical*	$90,557	$93,909	$99,774	$99,150	$104,450	15.3%
year-over-year change		3.7%	6.2%	-0.6%	5.3%	
Prescription Drugs (Rx)*	$18,100	$20,999	$25,036	$25,390	$25,903	43.1%
year-over-year change		-16.0%	19.2%	-1.4%	2.0%	
Total Medical and Rx*	$108,657	$114,908	$124,810	$124,540	$130,353	20.0%
year-over-year change		5.8%	8.6%	-0.2%	4.7%	
Per Member Medical/Rx Claims Paid Per Year	$6,167	$6,454	$6,907	$7,045	$7,507	21.7%
year-over-year change		4.7%	7.0%	2.0%	6.6%	

* Prescription costs are net discounts and rebates; Total includes medical and prescription only, does not include dental, vision, life and disability.

Source: RHCA

Appendix B:
Current IBAC Medical and Pharmacy Benefit Plans

Table 2: IBAC Medical and Pharmacy Benefit Plans
Lowest Cost Options
2017

	APS	GSD	PSIA	RHCA
	Preferred narrow network	*HMO network only*	*HMO network only*	*HMO network only*
Annual Deductible *Individual/Family*	$250/ $750	$350/ $1,000	$500/ $1,000	$1,500 (individual only)
Annual Out-of-Pocket Limit *Individual/Family*	$2,250/ $6,750	$3,500/ $10,500	$3,250/ $6,500	$5,500 (individual only)
Medical Copayments				
Preventive	$0	$0	$0	$0
Primary care[1]	$25	$25	$25	$35
Specialty[2]	$40	$45	$35	$55
Urgent Care[2]	$50	$50	$45	$40
Emergency room[2]	$150 + 20%	$225	$150 + 20%	$175
Hospitalization[3]	20%	$500	$500 + 20%	30%
Pharmacy Copayments - retail				
Generic	20% ($10 - $25)	$6	$10	$5 - $15
Brand formulary	30% ($35 - $65)	30% ($35 - $95)	30% ($30 - $60)	$20 - $50
Non-formulary	40% ($70 - $140)	40% ($60 - $130)	70%	$40 - $100
Specialty[5] Generic Brand formulary Non-formulary	 $70 $100 $150	 $60 $85 $125	 $55 $80 $130	 Specialty through mail order only
Diabetes insulin and supplies - formulary	$0	n/a	$0	$0

[1]Not subject to deductible.
[2]Per visit.
[3] Per admission after deductible. Includes medical/surgical, acute care and maternity-related admissions.
[4]Specialty meds must be filled through mail order after 2 refills at retail.
Source: Agency summaries of benefits.

Appendix C:
Current IBAC Premium Contributions

Table 3: IBAC Employer and Employee Contribution Percentages		
Salary	**Employee**	**Employer**
APS		
< $30,000	20%	80%
$30,000 +	40%	60%
GSD		
< $50,000	20%	80%
< $60,000	30%	70%
$60,000 +	40%	60%
NMPSIA		
< $15,000	25%	75%
< $20,000	30%	70%
< $25,000	35%	65%
$25,000 +	40%	60%
RHCA		
Years of service	**Retiree**	**RHCA**
5 years	96%	4%
10 years	76%	24%
15 years	56%	44%
20+ years	36%	64%
Source: APS, GSD, NMPSIA and RHCA		

Appendix D:
References

1. American Health Policy Institute. *High Cost Claimants: Private vs. Public Sector Approaches.* 2016. Available at: www.americanhealthpolicy.org/Content/documents/resources/High_Cost_Claimants.pdf

2. Center for Medicare and Medicaid Services. *Single State and County Comparison to National Data.* 2015. Available at: www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-geographic-variation/gv_puf.html

3. Kaiser Family Foundation. *State Health Facts: Hospital Emergency Room Visits per 1,000 Population by Ownership Type*. 2015. Available at: www.kff.org/other/state-indicator/emergency-room-visits-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

4. Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 2016 Annual Survey.* 2016. Available at: www.kff.org/health-costs/report/2016-employer-health-benefits-survey.

5. Medicare Payment Advisory Commission (MedPAC). *A Data Book: Health Care Spending and the Medicare Program.* June 2016. Available at: www.medpac.gov/docs/default-source/data-book/june-2016-data-book-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0

6. New Mexico Legislative Finance Committee. *Health Notes: Prescription Drug Costs: Maximizing State Agency Purchasing Power.* September 2016. Available at: www.nmlegis.gov/Entity/LFC/Documents/Health_Notes/Health%20Notes%20-%20Prescription%20Drugs.pdf

INTERAGENCY BENEFITS ADVISORY COMMITTEE

Albuquerque Public Schools
New Mexico Public Schools Insurance Authority
New Mexico Retiree Health Care Authority
Risk Management Division, General Services Department, State of New Mexico

August 14, 2017

MEMORANDUM

TO: Dr. Jenny Felmley, PhD, Program Evaluator, Legislative Finance Committee

FROM: Inter-agency Benefits Advisory Committee
Vera Dallas, Senior Director, Employee Benefits, Albuquerque Public Schools; Ernestine Chavez, Deputy Director, New Mexico Public School Insurance Authority; David Archuleta, Executive Director, New Mexico Retiree Health Care Authority; Lara White-Davis, Director, State of New Mexico (SONM)

SUBJECT: Health Notes: IBAC Cost and Utilization Trends, 2012 – 2016

The Inter-agency Benefits Advisory Committee (IBAC), consisting of the Albuquerque Public Schools (APS), New Mexico Public School Insurance Authority (NMPSIA), New Mexico Retiree Health Care Authority (NMRHCA), and the State of New Mexico (SONM) always appreciates the opportunity to share information with the Legislative Finance Committee regarding its business activities, relationships, strategic initiatives and efforts to improve the health and well-being of individuals covered by its programs. The recommendations and observations included in the Health Notes: IBAC Cost and Utilization Trends, 2012 – 2016, provide the IBAC an opportunity to both reflect upon our successes and identify areas for improvement.

This response, made on behalf of all IBAC member entities, will address the contention that the IBAC has yet to reach the full fiscal promise of the combined purchasing power of the state's public employees and retirees. It will address concerns about provider payment rates negotiated on our behalf by the commercial carriers without full transparency or accountability. Lastly, we will also address whether consolidation of individual IBAC entities into a state

healthcare purchasing organization with wider decision-making authority will result in savings to the State of New Mexico.

The US health care industry is constantly evolving due to rapidly developing technical advancements in procedures, diagnostic capabilities and especially pharmaceutical therapies. The challenges of financing health care in this environment are best demonstrated by the very effective but also very expensive pharmaceutical cure for Hepatitis C. The recent release of drugs to provide immediate treatment of Hepatitis C in turn reduced the potential for liver failure/replacement years later. The immediate fiscal crush of skyrocketing specialty drug costs are not eased with illusory, actuarial promises of reduced long term medical costs.

Adjusting to dynamic industry changes is made further complicated by rapidly developing federal regulations and State statutes intended to "stabilize" health insurance markets by dictating the scope of coverage plans to be extended to their members. New Mexico's status as a perpetually underserved market by medical providers further complicates the analytical landscape even before considering the vast changes in medical provider capacity caused by increased Medicaid enrollment and utilization.

IBAC entities often hear from our members that they have difficulty obtaining medical care due to access issues. We believe attempting to contract with providers to accept Medicare reimbursement rates for our population would create serious access to care issues. There is no shortage of numbers to slice, dice and narrowly focus upon when considering costs, capacities and utilization of our State's metropolitan populations; remote geographic locations; premium contributions; reimbursement rates; co-pays, etc., etc., etc., nevertheless, it is crucial to recognize the fact that New Mexico's medical service sphere is very small and completely interconnected – any changes in one area are certain to have impacts elsewhere in the sphere. The suggestion that the IBAC could reduce healthcare costs by taking advantage of market competition and *leveraging its collective bargaining power* to reduce reimbursements to network providers is based on the assumption that there are enough providers in the marketplace to create a competitive environment.

Because of the low numbers of provider in New Mexico, the State is characterized as medically underserved, and "downward leverage" from the IBAC (the largest consortium of self-insured employers) is certain to make New Mexico an even less attractive place to practice medicine. It is expected that reducing network reimbursements would result in a more narrow network of willing providers which would set in motion a course of events likely to reduce our members' access to preventative and primary care and cause costs to rise as our members' health conditions deteriorate and become more expensive to treat.

The report makes reference to high cost claimants. Several of the IBAC agencies are struggling with higher than usual catastrophic claims. However, the situations that lead to these claims are unpredictable. APS has carried stop-loss insurance for several years and NMPSIA recently added this coverage to help offset these escalating costs. Regardless of wellness initiatives and other employee education efforts, there will always be disease states that cannot be cured or prevented, and those that can be treated but only at a very high cost.

It is important for the LFC to understand that achieving cost control via multiple means was a central focus of the most recent procurement process used to contract for the IBAC's network services. This complex joint procurement (RFP) for group medical, dental, vision and Medicare coverage evaluated contractors was based on the following criteria: organizational strength and administrative/technology capabilities, client management team qualifications, strengths and experience, network composition and access, utilization management, disease management, wellness and cost transparency tools, cost/network discounts and value-based reimbursement strategies. In response to this RFP, the IBAC received 17 proposals from the following organizations:

- Medical: Blue Cross Blue Shield, Presbyterian Health Plan, Cigna, New Mexico Health Connections, HealthSCOPE, Mayo Clinic Health Solutions, United Healthcare, and Healthcare Blue Book
- Dental: United Concordia, Delta Dental, Metlife, and Blue Cross Blue Shield
- Vision: Davis Vision, VSP, United Healthcare, and Metlife
- Medicare Advantage: Blue Cross Blue Shield, Presbyterian Health Plan, Humana, and United Healthcare

Because every IBAC entity is sensitive to costs, we placed emphasis (42% of the total score) on cost/network discounts and demonstrated value-based reimbursement arrangements with providers. In order to score this particular criteria, IBAC takes the sum of all funding arrangements (as proposed by each plan), multiplied by our individual claim experience to project our anticipated costs in the future. The lowest costing proposal receives the highest number of points for this category. However, none of the proposals offered rates comparable to those paid by Medicare.

Based upon the IBAC's analysis and assessment of the quality and thoroughness of the responses received, combined with the projected cost of each plan offering, the IBAC entered into similar, but separate agreements aimed at serving the differing and sometimes competing needs of each of the IBAC entities. For example, in order to accommodate the healthcare needs of employees located in remote locations across the state, or retirees who reside in other

states; NMPSIA, SONM and NMRHCA selected plans that offer broad access that, in some cases were less cost neutral. APS, however, because it is able to take advantage of broader discounts associated the concentration of providers residing in and around the Albuquerque metro area, where their population lies, was able to realize some cost savings not available to the other IBAC entities. Ultimately, all four IBAC entities selected Presbyterian Health Plan and Blue Cross Blue Shield of New Mexico to serve their plan participants, while NMPSIA, NMRHCA and APS also selected New Mexico Health Connections to add competition and broaden their plan offerings.

For the past several years, the IBAC has been encouraged by the Legislative Finance Committee to minimize our rich plan designs, thereby increasing member cost-share through plan design changes and, in some cases, premium contributions. These changes also correspond with the notional value of increased consumer/insured directed care and awareness – a central philosophical trend in health care financing. The changes in plan design resulted in the IBAC shifting costs to our members. In addition, §10-7-4 NMSA 1978 requires that every public school district contribute minimum and maximum percentage amounts towards premiums. For NMPSIA and APS, this means we cannot set our contribution rates to drive enrollment in value-based plan designs or in plans with high-performance networks.

Collectively and individually, the IBAC entities have an absolute commitment to transparency and accountability in all of our transactions. We would note, however, that the agreements between health plans and providers are legally confidential and can only be made public to the extent that we review our billed and paid costs for every service and procedure performed on our member's behalf. However, the usefulness of this data has limits, as it does not account for network access, patient outcomes, demographic limitations or disease prevalence. As responsible community health purchasers, it is important to avoid a situation where healthcare providers are discouraged from practicing in certain locations across the state, particularly in rural communities.

It is true that the IBAC has not directly interjected itself in individual contract negotiations between health plans, provider groups or individual providers, either to approve, deny or negotiate specific reimbursement rates. However, it has met with most of the major provider groups, physician practices and hospital organizations in New Mexico including: Christus St. Vincent, Presbyterian Medical Plan, Presbyterian Medical Services, Lovelace Health Systems, University of New Mexico Hospital, and New Mexico Orthopaedics. Surprisingly, none of these organizations claimed to be overpaid for the services they provide, however, several mentioned the challenges associated with recruiting and retaining health care professionals in the state, related to the competiveness of the salaries being offered. Most online searches comparing healthcare professional salaries across the nation, suggests that healthcare professionals in

New Mexico are already paid less than their counterparts in most other states (44th according to http://247wallst.com/special-report/2016/03/30/doctor-pay-by-state/3/).

Every single county in New Mexico has the dubious designation of being listed by the US Department of Health and Human Services as Health Professional Shortage Areas (HPSAs).[1] Further evidence to support the State's dire medical provider situation can be found in the key findings identified in a report produced by the Legislative Finance Committee in May 2013, titled *Adequacy of New Mexico's Healthcare Systems Workforce.* The most relevant findings include:

[1] https://datawarehouse.hrsa.gov/Tools/Analyzers/HpsaFindResults.aspx

"New Mexico's supply of healthcare professionals, particularly in primary care, does not adequately address current needs, let alone those brought about by the ACA and Medicaid expansion, or longer-range demands from population growing and aging."

"Nurse Practitioners and Physician Assistants could help mitigate the doctor shortage, but their numbers are also inadequate."

"New Mexico has a nursing shortage – as do other states."

"New Mexico has too few dentists, and they are unevenly distributed across the state."

"New Mexico also experiences a pronounced shortage of clinically-trained behavioral health professionals."

"Given the growing shortage of healthcare professionals and their distribution across the state, New Mexico should expect some deterioration in access to health care in the near-term."

The suggested consolidation of the individual IBAC entities into a larger purchasing organization does not immediately appear to provide opportunities for cost savings and other efficiencies – especially if the IBAC were to engage in the detailed level of network management proposed by the Health Notes analysis. The staffing model required for medical cost management contemplated by the Health Note would require the "consolidated" entity to add staff and technical capacity with sufficient experience and expertise to constantly manage data associated with hundreds of health outcomes and pharmaceutical market data points in order to analyze, negotiate, audit and re-negotiate provider reimbursements. Sufficient staff to accomplish these task would likely require the addition of three health actuaries (estimated

salary requirements of $98,000 per year) https://www.bls.gov/ooh/Math/Actuaries.htm) as well as additional management analysts and IT specialists.

Even if additional network management responsibilities were not assumed by the "consolidated" IBAC entity, the individual needs of each group, administrative and otherwise, would transfer to the new larger organization, but would not change. Any purported savings resulting from consolidation might be limited to a handful of salaries eliminated by a reduction in the number of senior-level administrators (currently 4) in each organization, but the need to manage enrollment processes, answer phone calls and assist customers in dealing with their individual needs will remain. The potential savings may also be offset by the possible volatility in direction and strategic planning, as changes in leadership occur.

In summary, there are a significant number of variables and challenges associated with the financing of healthcare benefits. None of which, can be resolved by any single action. However, the IBAC will continue to research and identify opportunities to limit the growth in healthcare related expenses in collaboration with its health plan partners, pharmacy benefit managers, and other healthcare professionals to improve the health of its members by encouraging healthy behaviors, incentivizing the use of high-value services, directing members to lower-costing treatment alternatives, and discouraging the use of low-value services. Recent efforts to emphasize these priorities is found in our self-insured contracts as shown in the clinical performance measurements below:

I. Managing Chronic Illness

Prior to December 31, 2016, plan shall define a subpopulation of its membership covered under this agreement for which the following Health Performance Criteria may be measured and provide baseline performance results:

1. Diabetics with A1c <8%
2. Diabetics with nephropathy
3. Diabetics with A1c <8% AND medical attention for nephropathy

Subsequent agreements may require measurable improvements from the baseline subject to a mutually agreed upon penalty structure based on a percentage of administrative and/or disease management fees.

II. Managing Acute Care Episodes

Plan agrees to identify high risk cases based on the algorithms for identification and risk stratification. All members who agree to participate will be assigned to a care manager. Care management guidelines are based on diagnosis and treatment protocol. Cases will be reviewed by the Medical Director and Care Team for appropriateness and coordination of care. Activity related to cases under management will be reported to the Agency on a quarterly basis no sooner than the last day of the month following the end of the quarter.

Failure to report cases under care management in a timely manner as described above will result in financial penalties of $500 per quarter.

III. Use of Third-Party Prescription Data

Plan agrees to use third-party prescription data for the purposes of enhancing the risk stratification process to determine risk score and identify potential members for care management.
Failure to incorporate the use of prescription data as described above will result in financial penalties of $500 per quarter. Penalty does not apply if the Prescription Benefit Manager (PBM) does not supply timely and actionable data to the Plan.

IV. Preference Sensitive Surgeries

Prior to December 31, 2016, plan shall measure and provide baseline utilization data associated with the following preference-sensitive procedures (specific codes for these services to be defined).

1. Knee Arthroscopy
2. Hernia
3. Acromioplasty and Rotator Cuff Repair Subsequent agreements may require measurable improvements from the baseline subject to a mutually agreed upon penalty structure based on a percentage of administrative and/or disease management fees.

V. Value-Based Provider Agreements

Prior to December 31, 2016, plan shall report the percentage of contracted physicians and inpatient hospital facilities covered by value-based agreements applicable to the Agency's membership including but not limited to patient-centered medical homes, accountable care organizations, bundled payments (must include facility charge and at least one professional component).

With a target date of January 1, 2018 contractor will work with the Agency to assist in the design of benefits which will be used for the implementation of bundled payments. The initial list of services (which may change based upon agreed upon criteria) includes knee and shoulder arthroscopies, hernia, laparoscopic cholecystectomy and complex radiology including MRI and CT scans.

(a) All reporting will be structured and delivered in a HIPAA compliant manner.

In conclusion, the IBAC again expresses its appreciation for the work of LFC staff in preparing this Health Notes and to the Committee for its commitment to ensuring that cost effective, comprehensive health insurance is available to New Mexico's public employees and educators.

SWITCH ENROLLMENT MEETING SCHEDULE

DATE	LOCATION	TIME		VENUE
10/2/2017 10/31/2017	Santa Fe	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Santa Fe Community College Jemez Room 6401 Richards Ave. Santa Fe, NM 87508
10/3/2017	Silver City	1 p.m. 2:15 p.m. 3:30 p.m.	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Western New Mexico University Besse-Forward Global Resource Center Corner of 12th and Kentucky Silver City, NM 88061
10/4/2017 10/5/2017	Las Cruces	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	NM Farm & Ranch Heritage Museum 4100 Dripping Springs Rd. Las Cruces, NM 88011
10/12/2017	Clovis	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Clovis Civic Center 801 Schepps Blvd. Clovis, NM 88101
10/13/2017	Las Vegas	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	NM Highlands University Student Center 800 National Ave. Las Vegas, NM 87701
10/16/2017 10/30/2017	Albuquerque	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	UNM Continuing Education Auditorium 1634 University Blvd., NE Albuquerque, NM 87131
10/17/2017	Roswell	9:30 am. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Roswell Convention & Civic Center 912 N. Main St. Roswell, NM 88202
10/18/2017	Hobbs	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	NM Junior College Training and Outreach Facility 5317 North Lovington Highway Hobbs, NM 88240
10/24/2017	Farmington	10:30 a.m. 11:45 a.m. 1 p.m.	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Farmington Civic Center 200 W. Arrington St. Farmington, NM 87401
10/25/2017	Gallup	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Red Rock State Park Dining and Conference Room Gallup, NM 87311
10/26/2017	Rio Rancho	9:30 a.m. 10:45 p.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Santa Ana Star Center 3001 Civic Center Circle NE Rio Rancho, NM 87144
11/1/2017	Española	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Northern NM College - Nick. L Salazar Center for Performing Arts 921 Paseo de Oñate Española, NM 87532
11/2/2017	Raton	9:30 a.m. 10:45 a.m. Noon	Medicare Medical/RX Voluntary Coverage Non-Medicare Medical/RX	Raton Convention Center 901 S. 3rd St. Raton, NM 87740

Reminder: Free flu shots and screenings, including a take-home Fecal Occult Blood Test to check for symptoms of colorectal cancer, will be offered at all Switch Enrollment meetings. Those unable to attend the Switch Enrollment meetings may request an FOBT to be sent to them by calling 505-923-8105 and leaving their name, number and short message regarding the kit.

NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

PRESORT STD
US POSTAGE
PAID
ABQ., NM
PERMIT #1645

Find us on Facebook: https: www.facebook.com/nmrhca




NMRHCA CONTACT INFORMATION

4308 Carlisle Blvd NE, Suite 104
Albuquerque, NM 87107-4849

33 Plaza La Prensa
Santa Fe, NM 87507

800-233-2576 (Toll Free)
505-476-7340 (Santa Fe)
505-884-8611 (Fax)
Email: customerserivce@state.nm.us

Hours: 8 a.m.-5 p.m. Monday-Friday

Please visit us online at www.nmrhca.org

CONTACT YOUR HEALTHCARE PROVIDERS DIRECTLY

Blue Cross Blue Shield
BCBSNM.....800-788-1792
BCBSNM Medicare Advantage.....877-299-1008
www.bcbsnm.com

Express Scripts
Express Scripts Medicare.....800-551-1866
Express Scripts Non-Medicare ..800-501-0987
www.express-scrips.com

Presbyterian Health Services
Presbyterian Health Plan 888-275-7737
Presbyterian Medicare Advantage .800-797-5343
www.phs.org

Humana 866-396-8810
www.humana.com

New Mexico Health Connections ... 877-210-8239
http://www.mynmhc.org/nmrhca

United Healthcare 866-622-8014
www.uhcretiree.com

United Concordia Companies 888-898-0370
www.ucci.com

Delta Dental.....877-395-9420
www.deltadentalnm.com

Davis Vision 800-999-5431
www.davisvision.com

Standard Insurance.....888-209-9763
www.standard.com/mybenefits/newmexico_rhca

Inside: Wellness Incentive Update...Pg 4...NMRHCA Switch Enrollment Calendar...Pg 5

your Benefit Messenger

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

NMRHCA 2017 Newsletter Vol. 2 ~ Fall Edition

NMRHCA BOARD MEASURES EXTENDS AGENCY'S SOLVENCY

During the New Mexico Retiree Health Care Authority's annual meeting in July, its Board of Directors approved measures that will help extend the solvency of NMRHCA programs by five years.

Budget-deficit actions that the state legislature took in the 2016 special session reduced that solvency from 20 to 13 years (2030). But the countermeasures the board has taken will return solvency to 2035 (18 years).

NMRHCA's Board of Directors takes its fiduciary responsibility to the program seriously and strives to constantly balance the needs of current retirees with the actions necessary to ensure the viability of the program for active employees in the future. Its approved changes for 2018 include:

- Increasing retiree premiums in accordance with projected medical trend for all self-insured plans (8 percent increase in pre-Medicare rates, 6 percent increase in Medicare Supplement rates.
- Expanding the Value Plan option resources to include the BlueAdvantage Network — an HMO network that represents 53 percent of the PPO network (a statewide narrow network).
- Increasing cost sharing/narrow network on Pre-Medicare and Supplement prescription plans through the introduction of Voluntary Smart90 — a long-term medications option that gives members the choice to purchase 90-day prescription supplies for less cost than three one-month supplies.
- Defaulting incoming members to the appropriate Medicare Advantage Plan (based on last year's board adoptions; all members still can select their own plans). Presbyterian Pre-Medicare members not electing a plan would default to UnitedHealthcare Plan I; Blue Cross Blue Shield Pre-Medicare members would default to Humana Plan I.

See *2018* on Page 2

GREETINGS TO OUR MEMBERS FROM THE BOARD PRESIDENT

As the current President of the New Mexico Retiree Health Care Authority (NMRHCA) Board of Directors, it is my pleasure to provide an update on the current status of the program and the future direction of your post-employment healthcare benefit.

Whether you are one of the 60,000 formally retired members participating and receiving benefits now or one of the 100,000 active employees who invest in the program with an expectation of receiving a future benefit — I hope you have an interest in this program.

Your Board of Directors, which includes representation from both active and retired groups, has been working diligently to preserve the viability of the Authority during this turbulent era in both the state of New Mexico's finances and the overall national health care scene.

It is the Board's duty to find a balance between meeting the existing demands of the agency today and maintaining a benefit for future participants. This duty includes the pursuit of revenue enhancements, combined with strategies to limit the growth in health care costs, to maintain the long-term viability of the program.

But we also are sympathetic to the impact any changes may have on our retirees with fixed incomes or on active employees whose incomes have been depressed during the national recession and our state's slow recovery.

See *Greetings* on Page 2

GREETINGS FROM THE DESK OF PRESIDENT OF BOARD

With legislative support through increases in employee and employer contributions — combined with strategic Board initiatives — the plan's solvency improved from seven years in 2007 to 20 years in 2016. These initiatives included modest premium increases, a reduction in the subsidies provided to retirees and eligible dependents, plan-design changes and increases to copays and out-of-pocket expenses.

Despite the changes, the program still offers incredible value to its plan participants, especially when compared to other health care market options. I encourage you to evaluate your other options through the New Mexico Health Insurance Exchange: www.bewellnm.com.

Unfortunately, the state's financial crunch last year led to legislation that reduced a important subsidy to NMRHCA and shaved over six years off our projected solvency period. But thanks to solid investment gains and another series of prudent plan-design changes, NMRHCA will enter 2018 having reclaimed much of that lost ground and will be on solid footing through 2035.

This Board will continue efforts to push our solvency projections even further as we strive to maintain a commitment to all those employees who have so selflessly served the public throughout the state in so many different capacities.

Please contact NMRHCA staff if you have comments or suggestions about improving the value of the program.

—TOM SULLIVAN
NMRHCA BOARD PRESIDENT

2018 MEASURES BALANCE NEEDS OF NMRHCA

Continued From Page 1

- Implementation of a graded schedule in premium payment of basic life insurance through The Standard in which retirees will gradually assume 100 percent of the cost. Retirees will assume 25 percent of the premium cost in 2018 and increase by 25 percent of the cost each subsequent year.

Combined these actions serve to offset the rising cost of prescriptions and other medical related expenses currently being experienced by the NMRHCA program.

NMRHCA will continue to offer its Medicare Supplement as well as numerous Medicare Advantage plans to all of its Medicare-eligible members in 2018, regardless of where they live.

The following rates below are based on a retiree with 20 years of service. A complete rate sheet and benefit summary will be provided with your Switch Enrollment Packet. Dental plans rate sheets and benefit summaries from Delta Dental, United Concordia and Davis Vision also will be provided.

Plan — Pre-Medicare	2017	2018	$ Change
Premier PPO - Retiree (BCBS or PHP)	$223.56	$241.44	$17.88
Premier PPO - Spouse (BCBS or PHP)	$424.32	$458.27	$33.95
Premier PPO - Child (BCBS or PHP)	$217.00	$234.36	$17.36
Value HMO - Retiree (PHP or NMHC)	$174.63	$188.60	$13.97
Value HMO - Spouse (PHP or NMHC)	$331.43	$357.95	$26.52
Value HMO - Child (PHP or NMHC)	$169.21	$182.75	$13.54
Value HMO - Retiree (BCBS)	N/A	$188.60	N/A
Value HMO - Spouse (BCBS)	N/A	$357.95	N/A
Value HMO - Child (BCBS)	N/A	$182.75	N/A
Plan - Medicare	**2017**	**2018**	**$ Change**
Medicare Supplement - Retiree (BCBS)	$188.64	$199.96	$11.32
Medicare Supplement - Spouse (BCBS)	$282.96	$299.94	$16.98
BCBS MA Plan I - Retiree	$61.20	$69.60	$8.40
BCBS MA Plan I - Spouse	$91.80	$104.40	$12.60
BCBS MA Plan II - Retiree	$18.95	$23.30	$4.35
BCBS MA Plan II - Spouse	$28.42	$34.95	$6.53
Humana MA Plan I - Retiree	$82.77	$87.45	$4.68
Humana MA Plan I - Spouse	$124.16	$131.17	$7.01
Humana MA Plan II - Retiree	$49.86	$53.06	$3.20
Humana MA Plan II - Spouse	$74.79	$79.59	$4.80
PHP MA Plan I - Retiree	$89.00	$96.50	$7.50
PHP MA Plan I - Spouse	$133.50	$144.75	$11.25
PHP MA Plan II - Retiree	$57.00	$72.00	$15.00
PHP MA Plan II - Spouse	$85.50	$108.00	$22.50
United Health Care MA Plan I - Retiree	$94.69	$104.16	$9.47
United Health Care MA Plan I - Spouse	$142.04	$156.25	$14.21
United Health Care MA Plan II - Retiree	$49.68	$54.65	$4.97
United Health Care MA Plan II - Spouse	$74.52	$81.97	$7.45

TAKING MEDICINES SAFELY: HOW TO MEASURE LIQUID DOSES THE RIGHT WAY

A dose is the amount of medicine you take each time. You may take several doses in one day. It is very important to take the right dose, especially for children. This "Choosing Wisely" report helps you measure the dose for liquid medicines correctly.

Don't use a kitchen spoon

The teaspoons and tablespoons you use for cooking and eating are not very accurate. Some teaspoons can hold twice as much liquid as others. Also, it is easy to confuse a teaspoon (tsp) with a tablespoon (Tbsp).

It is more precise to measure medicines in milliliters. The American Society of Health-System Pharmacists, along with many other medical societies and safety groups, advise using milliliters to prescribe and take liquid medicine.

Use milliliters for liquid medicines

Milliliters (mL) are a standard unit of measurement in medicine. They are used around the world. Milliliters can accurately measure very small to large amounts.

Avoid an overdose

For adults, getting slightly too much of an over-the-counter medicine probably won't cause much harm. For children, though, it's important to give exactly the amount of medicine recommended or prescribed. Children weigh less than adults, so even a little too much medicine can be harmful. Doses for children are usually based on a child's weight.

An overdose can cause serious problems, even death. One 5-year study found that over 3,000 children under 12 had side effects from cough and cold medicines. The side effects included restlessness, extreme sleepiness, hallucinations, and rapid heartbeat. Twenty of the children, most of them younger than 2 years old, died. One in three children were given the wrong amount of medicine. The rest found and took the medicine by accident.

Use the dosing device that comes with the medicine

Most liquid medicines come with an oral syringe or a small cup. These dosing devices should have milliliter markings.

Always use the dosing device that comes with the medicine.

When you pick up a prescription, make sure a dosing device is included. If it isn't, ask the pharmacist for a cup or syringe, so you can measure accurately.

If a prescription calls for teaspoons or tablespoons, ask your doctor or pharmacist to give you the dosage in milliliters.

If your doctor prescribes a liquid medicine, make sure you understand how much medicine to give, and how often.

Ask your doctor or pharmacist to show you how to measure the medicine correctly if you're not sure.

If you lose the dosing device, ask your doctor or pharmacist for a new one. For over-the-counter medicines, call the help line on the package.

You can call Poison Control

You can call the American Association of Poison Control Centers at 1-800-222-1222 for advice and help. Keep this phone number handy to call immediately in case of an accidental overdose.

This report is for you to use when talking with your healthcare provider. It is not a substitute for medical advice and treatment. Use of this report is at your own risk.

MEDICINE SAFETY TIPS

Using the dosing device that comes with your medicine is one way to take medicines safely. Here are some other safety tips.

- Read the insert: Review the information that comes with medicines. If you have questions, ask your pharmacist.
- Don't skip doses to save money: Ask your doctor if there is a lower cost generic or brand name drug that you could try. Compare costs at CRBestBuyDrugs.org.
- Don't forget to take your medicine: Take your medicine at the same time every day.
- Check with your doctor before you split pills: Some medicines should not be split. If your doctor says it's OK to split your pills, use a pill splitter for accurate results.
- Don't take drugs you don't need: Too many people still take antibiotics to treat viruses like colds or the flu. Antibiotics only kill bacteria. If you take antibiotics when you don't need them, they may not work when you do need them.
- Review all your medicines with your primary doctor: Bring the original containers or take photos of each label.

WELLNESS UPDATE: A 2ND SUCCESS STORY

This is the second testimonial about New Mexico Retiree Health Care Authority member experiences with our Wellness Incentive Program that allows members to earn a $50 Visa gift card upon completion of two structured wellness programs. If you wish to share your experience, please call 505-222-6403 or email NMRHCA.wellness@state.nm.us.

It started off as a numbers game for Rio Rancho residents Anna and Gary King. It ended up being a lot more than they bargained for — in a good way.

In December, the couple learned their cholesterol counts had shot up to unacceptable levels. Anna, who prides herself on keeping fit by going to the gym and bicycling, knew they had to make changes.

Anna and Gary made an appointment for a wellness checkup with their doctor. But Anna also wanted tackle their high cholesterol.

"I wanted my husband to be involved," she said. "He's kind of a junk-food junkie. He's not the kind to participate in (on-site) classes. He would much rather talk to somebody on the phone or have me get on the computer and us do it that way."

Enter the New Mexico Good Measures program that combines nutrition science, personalized registered-dietitian coaching and digital tools to help people improve their health.

Good Measures connected the Kings with a registered dietitian, Gina, who guided the couple in their nutritional journey.

While Gina helped put the Kings on track with the program, the eye-opening experience for Anna was the tracking of what they ate by logging their meals and snacks on the Good Measures website.

Gary and Anna King

"The tracking showed you how much (of specific) nutrients you needed for the day or the week, she said. "I was trying to fine-tune what I knew, but I ended up learning a lot more than I had envisioned."

Anna added that their wellness check with their doctor confirmed their improved health when they re-checked their cholesterol numbers.

"When we went to see him, he asked, "What are you doing?' And I had a chance to tell him this is what we're doing.

"He said, 'Whatever you're doing, keep it up because it's had a very, very positive impact,'" Anna said.

To learn more or sign up for Good Measures, visit nm.goodmeasures.com or call 888-320-1776 to speak with a Wellness Technician.

NMRHCA AT A GLANCE

CHECK OUT OUR NEW WEBSITE!

NMRHCA's website has a new look! We hope the new website will be more user-friendly and will help members find what they're looking for more easily. At the same time, we hope to provide more news and information for member use. Go to www.nmrhca.org.

BETTER CHOICES, BETTER HEALTH EXTENDED TO FY18

The Better Choices Better Health online chronic disease self-management program will be available to members through June, 2018. Go to https://enroll-nmrhca.self-manage.org/.

MEDICARE SEMINAR UPDATE

Because of our involvement with October's Switch Enrollment meetings, our next Medicare seminar will be Nov. 8 in Albuquerque (9:30 a.m.), Santa Fe (1:30 p.m.) and Roswell (10 a.m.).

WE WANT YOUR EMAIL ADDRESS

Help us help you by cutting down our postage costs! Those wishing to receive their newsletter online can email us, CustomerService@state.nm.us, or call us at 800-233-2576.

FIND US ON FACEBOOK

Our Facebook page provides wellness information as well as notifications for upcoming NMRHCA events. Like us at www.facebook.com/nmrhca/.

NEW MEXICO RETIREE HEALTH CARE AUTHORITY
CHANGE IN NET ASSET VALUE
FOR THE MONTH ENDED
July 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 6/30/2017	$107,756,491.90	$119,944,383.36	$64,777,855.37	$82,734,237.48	$16,319,355.25	$55,942,038.17	$26,274,561.25	$59,338,406.08	$31,053,570.52	$564,140,899.38
CONTRIBUTIONS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
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	306,912.36	175,080.16	53,514.08	353,700.38	3,712.21	33,181.91	72.01	76,496.46	60,549.66	1,063,219.23
CAPITAL APPR/DEPR	316,735.17	2,325,580.98	1,906,067.95	4,514,107.23	67,590.80	286,083.99	42,458.19	159,305.46	(30,803.46)	9,587,126.31
Market Value 7/31/2017	$108,380,139.43	$122,445,044.50	$66,737,437.40	$87,602,045.09	$16,390,658.26	$56,261,304.07	$26,317,091.45	$59,574,208.00	$31,083,316.72	$574,791,244.92

Archuleta, David, NMRHCA

Subject: FW: Follou up from RHCA Annual Retreate
Attachments: EGWP Specialty Statistics.xlsx

From: Zeyaee, Harris A. (ABQ) [mailto:HAZeyaee@express-scripts.com]
Sent: Wednesday, August 2, 2017 2:42 PM
To: Archuleta, David, NMRHCA; Kueffer, Neil, NMRHCA
Subject: Follou up from RHCA Annual Retreate

David/Neal,
We got several questions at the retreat about what is driving drug cost, specialty and traditional. As you know, Demographics, utilization, drug mix and cost share all play roles in the Plan Cost PMPM. RHCA has a higher % of patients utilizing specialty medications which will also naturally make your Plan Cost PMPM higher than the peer.

While the Plan Cost PMPM may be higher for RHCA based on those factors above, another more comparable peer comparison may be to look at Specialty Plan Cost/Day. Based on the data within the CPS deck, the Specialty Plan Cost/Day for RHCA was $171.29 and the peer was $169.80. When we break the spend out on a per day basis for a true apples to apples comparison, the spend is more in line. When we strip member cost share out, as the peer has a higher % of member cost share on specialty, the Gross Cost/Day for RHCA is $172.79 vs the peer at $172.76. The numbers are very much in line with one another. Please keep in mind that these numbers do not include any rebates or EGWP subsidy reimbursements.

The above should hopefully help regarding the cost comparison. I am including a few indication/drugs and patient count for RHCA& EGWP.

- Here are the groups that make up the peers for EGWP and Commercial compare .
  - EGWP – Colorado PERA EGWP , ROC – OHPRS – PDP (JWAA), ROC – OH State Teachers Retirement System (K49A), ROC-OH School Employee Retirement System PDP (TJRA)
  - Commercial – Colorado PERA (6499), School Employees Retirement System (A89A), State Teachers Retirement System (A8NA), Ohio Highway Patrol Ret. (AJ9A), KTRS (KGJA)

- Specialty plan costs: for EGWP, cancer increased plan cost PMPM by $7.86. Revlimid, Xtandi among top 5 drugs. Highest mover was Imatinib Mesylate with a 195.7% plan cost PMPM increase ($1.16 à $3.42). Imbruvica with a 83.7% plan cost increase ($2.05 à$3.77) and Bexarotene with a 95% PMPM increase ($1.21 à $2.35)

Thank you,
Harris A. Zeyaee
Sr. Clinical Account Executive

Top 3 Indications Among Specialty

Indications	% of total patients	Peer % of total Patients
Cancer	0.7%	0.6%
Inflammatory Conditions	0.8%	0.5%
Multiple Sclerosis	0.2%	0.2%

Top Drugs Among the Top Indications

Cancer	% of total patients	Peer % of total Patients
Revlimid	0.11%	0.12%
Xtandi	0.11%	0.06%
Imbruvica	0.10%	0.06%

Inflammatory Conditions	% of total patients	Peer % of total Patients
Enbrel	0.19%	0.16%
Humira Pen	0.17%	0.12%
Humira	0.07%	0.04%

Multiple Sclerosis	% of total patients	Peer % of total Patients
Aubagio	0.05%	0.02%
Copaxone	0.03%	0.04%
Gilenya	0.02%	0.01%

2018 Medicare Advantage Rates

Background: The New Mexico Retiree Health Care Authority recently completed an RFP resulting in the issuance of contracts for Medicare Advantage Plans effective July 1, 2017 – June 30, 2018. The provision of services and rates contained in these agreements are subject to approval by the Centers for Medicare and Medicaid Services, subject to changes annually beginning January 1st of each year. The rates shown below provide a comparison of premiums for 2016/2017 and 2017/2018. The rates shown below reflect a Medicare Plan participant with 20 years of service.

	2016 Rates			2017 Rates			Retiree	Retiree
	Retiree	NMRHCA	Total	Retiree	NMRHCA	Total	$ Change	% Change
Blue Cross Blue Shield								
Plan I	$ 61.20	$ 61.20	$ 122.40	$ 61.20	$ 61.20	$ 122.40	$ -	0%
Plan II	$ 17.85	$ 17.85	$ 35.70	$ 18.95	$ 18.95	$ 37.90	$ 1.10	6%
Presbyterian								
Plan I	$ 84.00	$ 84.00	$ 168.00	$ 89.00	$ 89.00	$ 178.00	$ 5.00	6%
Plan II	$ 54.00	$ 54.00	$ 108.00	$ 57.00	$ 57.00	$ 114.00	$ 3.00	6%
Humana								
Plan I	$ 82.78	$ 82.78	$ 165.55	$ 82.78	$ 82.78	$ 165.55	$ -	0%
Plan II	$ 49.86	$ 49.86	$ 99.72	$ 49.86	$ 49.86	$ 99.72	$ -	0%
United Healthcare								
Plan I	$ 88.50	$ 88.50	$ 177.00	$ 94.70	$ 94.70	$ 189.39	$ 6.19	7%
Plan II	$ 46.43	$ 46.43	$ 92.86	$ 49.68	$ 49.68	$ 99.36	$ 3.25	7%

	2017 Rates			2018 Rates			Retiree	Retiree
	Retiree	NMRHCA	Total	Retiree	NMRHCA	Total	$ Change	% Change
Blue Cross Blue Shield								
Plan I	$ 61.20	$ 61.20	$ 122.40	$ 69.60	$ 69.60	$ 139.20	$ 16.80	14%
Plan II	$ 18.95	$ 18.95	$ 37.90	$ 23.30	$ 23.30	$ 46.60	$ 4.35	23%
Presbyterian								
Plan I	$ 89.00	$ 89.00	$ 178.00	$ 96.50	$ 96.50	$ 193.00	$ 7.50	8%
Plan II	$ 57.00	$ 57.00	$ 114.00	$ 72.50	$ 72.50	$ 145.00	$ 15.50	27%
Humana								
Plan I	$ 82.78	$ 82.78	$ 165.55	$ 87.45	$ 87.45	$ 174.90	$ 9.35	6%
Plan II	$ 49.86	$ 49.86	$ 99.72	$ 53.06	$ 53.06	$ 106.12	$ 6.40	6%
United Healthcare								
Plan I	$ 94.70	$ 94.70	$ 189.39	$ 104.17	$ 104.17	$ 208.34	$ 9.48	10%
Plan II	$ 49.68	$ 49.68	$ 99.36	$ 54.65	$ 54.65	$ 109.30	$ 4.97	10%

In addition to the premium rate changes for 2018, several plan design changes have been incorporated in the Presbyterian Plan MA plans in order to limit the increase including additional cost sharing on the prescription drug copays, inpatient hospitalization and emergency rooms visits. These changes will be communicated directly to the MA plan participants from Presbyterian Health Plan by mail, approximately 2 weeks prior to the beginning of our switch enrollment period.

NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

FY19 Appropriation Request

Presented to the Board of Directors

August 24, 2017

FY19 Appropriation Request (Action Item)

Background

The statutory deadline for submission of the FY19 Appropriation Request to the State Budget Division and Legislative Finance Committee is September 1, 2017. The information presented includes actual expenditures for period between July 1, 2016 and June 30, 2017 (FY17), the approved operating budget for July 1, 2017 – June 30, 2018 (FY18), and proposed increases for the period beginning July 1, 2018 (FY19).

Summary

The chart below provides a summary of NMRHCA's programs:

	FY18 Operating	FY19 Request	Increase	Percent
Healthcare Benefits Administration				
Contractual Services	$ 317,091.2	$ 344,989.4	$ 27,898.2	8.8%
Other	$ 37.8	$ 42.0	$ 4.2	11.1%
Other Financing Uses	$ 2,936.8	$ 3,067.2	$ 130.4	4.4%
Total	$ 320,065.8	$ 348,098.6	$ 28,032.8	8.8%
Program Support				
PS&EB	$ 1,858.8	$ 1,931.5	$ 72.7	3.9%
Contractual Services	$ 544.8	$ 581.3	$ 36.5	6.7%
Other	$ 533.2	$ 554.4	$ 21.2	4.0%
Total	$ 2,936.8	$ 3,067.2	$ 130.4	4.4%
Agency Total				
PS&EB	$ 1,858.8	$ 1,931.5	$ 72.7	3.9%
Contractual Services	$ 317,636.0	$ 345,570.7	$ 27,934.7	8.8%
Other	$ 571.0	$ 596.4	$ 25.4	4.4%
Other Financing Uses	$ 2,936.8	$ 3,067.2	$ 130.4	4.4%
Total	$ 323,002.6	$ 351,165.8	$ 28,163.2	8.7%

Health Care Benefits Administration

Overall, the FY19 request totals $348.1 million, an 8.8 percent increase above approved FY18 approved operating budget. Assumptions with regard to revenues are shown in the table below and described thereafter.

	Health Benefit Fund - Revenue Detail							
		FY16 Actuals	FY17 Actuals	FY18 OPBUD	FY19 Inc/Dec	FY19 Request	Percent Change	
	REVENUE:							
1	Employer/Employee Contributions	$ 126,463.8	$ 125,150.4	$ 126,066.1	$ -	$ 126,066.1	0.0%	1
2	Retiree Contributions	$ 145,811.9	$ 153,958.4	$ 143,337.5	$ 24,252.8	$ 167,590.3	16.9%	2
3	Taxation and Revenue Suspense Fund	$ 29,021.8	$ 23,930.4	$ 26,256.2	$ -	$ 26,256.2	0.0%	3
4	Other Miscellaneous Revenue	$ 24,671.2	$ 27,289.8	$ 24,346.0	$ 3,780.0	$ 28,126.0	15.5%	4
5	Interest Income	$ 27.8	$ 92.2	$ 60.0	$ -	$ 60.0	0.0%	5
6	**TOTAL REVENUE:**	$ 325,996.5	$ 330,421.2	$ 320,065.8	$ 28,032.8	$ 348,098.6	8.8%	6

- Employee and employer contributions are expected to remain flat with FY18 approved operating amounts.
- Retiree contributions are expected to grow by 17 percent compared to the FY18 approved operating budget, but less than 10 percent compared to FY17 actuals, to include following assumptions:
    - Premium increases on the self-insured plans of 8 and 6 percent effective for half of FY19 (July 1, 2018 – December 31, 2018), with additional increases in premium effective January 1, 2019 - June 30, 2019.
    - Medicare Advantage Rate increase ranging from 6 – 27 percent beginning January 1, 2018, also effective for half of FY19, with additional increase expected January 1, 2019 applicable to the remaining half of FY19.
    - Flat/limited growth in participation with the Pre-Medicare Plans.
    - Continued growth in Voluntary Programs (dental, vision and life insurance) – does not have a financial impact to the agency, but it does have a budgetary impact.
    - Beginning January 1, 2018 retiree will begin paying 25 percent of the $4 million annual cost associated with providing the basic life insurance policy granted to members who retired prior to December 31, 2012. This will have an approximate $1.5 million impact in FY19, as the member cost share grows to 50 percent on January 1, 2019, or the second half of FY19.
- Revenues received from the Tax Suspense Fund are established by statute and distributed according to a schedule developed by TRD. These amounts are scheduled to remain flat through FY19.
- Miscellaneous revenues are expected to grow compared to FY17 actuals and the FY18 approved operating budget.
- Interest income is expected to remain flat with the approved FY18 operating budget.

Assumptions with regard to expenditures are shown in the table below and described thereafter.

Health Benefit Fund Expenditure Summary

		FY16	FY17	FY18	FY19	FY19		
	Contractual Services	**Actuals**	**Actuals**	**OPBUD**	**Inc/Dec**	**Request**	**Percent Change**	
1	Prescriptions	$ 90,353.1	$ 91,535.6	$ 100,000.0	$ 12,500.0	$ 112,500.0	13.1%	1
2	Medical - Supplement/Self- Insured	$ 148,772.8	$ 148,703.3	$ 155,000.0	$ 7,000.0	$ 162,000.0	4.4%	2
3	Medicare Advantage	$ 17,076.7	$ 20,219.8	$ 28,091.2	$ 4,998.2	$ 33,089.4	22.0%	3
4	ACA Transitional Reinsurance Fee	$ 786.9	$ 472.3	$ -	$ -	$ -	0.0%	4
5	Voluntary Coverages	$ 30,847.1	$ 31,334.3	$ 34,000.0	$ 3,400.0	$ 37,400.0	10.3%	5
6	**Total Contractual Services**	$ 287,836.6	$ 292,265.3	$ 317,091.2	$ 27,898.2	$ 344,989.4	9.0%	6
	Other							
7	PCORI Fee	$ 37.8	$ 38.8	$ 37.8	$ 4.2	$ 42.0	11.1%	7
8	**Total Other**	$ 37.8	$ 38.8	$ 37.8	$ 4.2	$ 42.0	11.1%	8
	Other Financing Uses							
9	Program Support	$ 3,012.9	$ 3,118.3	$ 2,936.8	$ 130.4	$ 3,067.2	4.4%	9
10	**Total Other Financing Uses**	$ 3,012.9	$ 3,118.3	$ 2,936.8	$ 130.4	$ 3,067.2	4.4%	10
11	**Total Expenditures**	$ 290,887.3	$ 295,422.4	$ 320,065.8	$ 28,032.8	$ 348,098.6	8.8%	11

- Expenditures related to the prescription drug plan (line 1) are expected to grow by over 13 percent compared to the FY18 approved operating budget. This projection is about half-way between last year's trend of 15.9 percent and trend through the first 6 months of 2017. As reported during our annual meeting, we anticipate savings from market check agreement included in our Express Scripts contract along with the introduction of the Smart90 program to generate savings. However, specialty drug plan costs continue to grow at an increasing rate and are expected to represent a growing share of our total drug spend.
- Expenditures for the medical plan (line 2) reflect projected expenditures for the pre-Medicare plans and Medicare Supplement plan which reflect continued growth in participation along with medical trend minus migration (2,000 members in FY19) toward the additional Value Plan option resources being made available January 1, 2018.

- Expenditures related to Medicare Advantage (MA) Plans are expected to account for a growing percentage of our overall costs. The increase includes assumptions with regard to continued growth in participation as well as assumed rate increases approved by CMS for each of our Medicare Advantage offerings. Beginning January 1, 2018 MA rates increases ranged between 6 and 27 percent. Similar increases are expected for calendar year 2019.
- Expenditures related to voluntary coverages (dental, vision and life) are expected to grow at a rate in line with increased participation (10.6 percent in FY15, 10.8 percent in F16 and 9.8 percent in FY17). Voluntary coverages (except for basic life) are 100% paid for by the retiree.
- NMRHCA will request $42,000 to cover the estimated cost (average pre-Medicare participation in 2017 x $2.35 per participant) for the Patient Centered Outcomes Research Institute Fee.
- Lastly, the request will include an amount sufficient to support the operating activities of the agency as reflected in the "Other Financing Uses" category.

Program Support

The chart below provides a categorical summary of expenditures related to the operating activities of the agency. Overall, the request includes a $130 thousand increase above the FY18 approved operating budget, but remains less than the approved FY17 operating budget ($3,118,300).

	Program Support Expenditure Summary							
	Uses		FY17 Actual	FY18 OPBUD	FY19 Inc/Dec	FY19 Request	Percent Change	
1	200	Personal Services/ Employee Benefits	1,840.8	1,858.8	72.7	1,931.5	3.9%	1
2	300	Contractual Services	550.9	544.8	36.5	581.3	6.7%	2
3	400	Other Costs	509.5	533.2	21.2	554.4	4.0%	3
4		**TOTAL**	**2,901.2**	**2,936.8**	**130.4**	**3,067.2**	**4.4%**	4
	Summary of Revenues							
	Sources		FY17 Actual	FY18 OPBUD	FY19 Inc/Dec	FY19 Request	Percent Change	
5	112	Other Transfers	3,118.3	2,936.8	130.4	3,067.2	4.4%	5
6		Total	3,118.3	2,936.8	130.4	3,067.2	4.4%	6
7		**FTE**	**27.0**	**27.0**	**0.0**	**27.0**	**0.0%**	7

Changes in projected expenditures are shown in the table below and described thereafter.

		Expenditure Detail (Personal Services and Employee Benefits)						
			FY17	FY18	FY19	FY19	Percent	
			Actual	OPBUD	Inc/Dec	Request	Change	
1	520100	Exempt Positions	134.5	146.2	29.3	175.5	20.0%	1
2	520300	Classified Perm. Positions	1,149.6	1,158.7	39.0	1,197.7	3.4%	2
3	520800	Annual & Comp Paid	17.6	-	-	-	0.0%	3
4	521100	Group Insurance Premium	184.6	189.9	4.8	194.7	2.5%	4
5	521200	Retirement Contributions	218.1	220.5	(0.6)	219.9	-0.3%	5
6	521300	FICA	95.0	105.3	(0.2)	105.1	-0.2%	6
7	521400	Workers Comp	0.3	0.2	-	0.2	0.0%	7
8	521410	GSD Work Comp Ins	3.7	2.1	(0.5)	1.6	-23.8%	8
9	521500	Unemployment Comp	3.0	-	-	-	0.0%	9
10	521600	Employee Liability Insurance	8.8	8.4	0.9	9.3	10.7%	10
11	521700	Retiree Health Care	25.6	27.5	-	27.5	0.0%	11
12	521900	Other Employee Benefits	-	-	-	-	0.0%	12
13		**TOTAL**	**1,840.8**	**1,858.8**	**72.7**	**1,931.5**	**3.9%**	13

		Expenditure Detail (Contractual Services)						
			FY17	FY18	FY19	FY19	Percent	
			Actual	OPBUD	Inc/Dec	Request	Change	
14	535200	Professional Services	410.1	304.8	55.0	359.8	18.0%	14
15	535300	Other Services	15.7	30.0	(15.0)	15.0	-50.0%	15
16	535400	Audit Services	37.5	80.0	1.5	81.5	1.9%	16
17	535500	Attorney Services	18.9	40.0	(5.0)	35.0	-12.5%	17
18	535600	Information Technology Services	68.7	90.0	-	90.0	0.0%	18
19		**TOTAL**	**550.9**	**544.8**	**36.5**	**581.3**	**6.7%**	19

		Expenditure Detail (Other)						
			FY17	FY18	FY19	FY19	Percent	
			Actual	OPBUD	Inc/Dec	Request	Change	
20	542100	Employee In-State Mileage & Fares	0.9	2.0	-	2.0	0.0%	20
21	542200	Employee In-State Meals & Lodging	1.9	1.9	0.1	2.0	5.3%	21
22	542300	Board & Commission - In-State	8.6	10.0	-	10.0	0.0%	22
23	542500	Transportation-Fuel & Oil	0.7	1.0	-	1.0	0.0%	23
24	542600	Transportation	0.3	0.1	-	0.1	0.0%	24
25	542700	Transporation Insurance	0.0	0.2	-	0.2	0.0%	25
26	542800	State Transportation Pool Charges	4.7	4.4	0.3	4.7	6.8%	26
27	543200	Maintenance - Furniture, Fixtures & Equipment	1.7	3.7	-	3.7	0.0%	27
28	543300	Maintenance - Building & Structure	-	3.0	-	3.0	0.0%	28
29	543400	Maintenance - Property Insurance	0.3	0.5	(0.2)	0.3	-40.0%	29
30	543820	IT Maintenance	-	12.6	(2.6)	10.0	-20.6%	30
31	544000	Supply Inventory IT	14.1	20.0	-	20.0	0.0%	31
32	544100	Supplies - Office Supplies	9.1	8.5	1.5	10.0	17.6%	32
33	544900	Supplies - Inventory Exempt	2.7	0.3	2.7	3.0	900.0%	33
34	545600	Reporting & Recording	0.2	0.0	0.5	0.5	***	34
35	545609	Report/Record Inter St Agency	0.1	0.0	0.5	0.5	***	35
36	545700	DoIT ISD Services	4.0	4.1	-	4.1	0.0%	36
37	545710	DoIT HCM Assessment	9.5	10.4	-	10.4	0.0%	37
38	545900	Printing & Photo. Services	47.9	56.0	10.0	66.0	17.9%	38
39	546100	Postage & Mail Services	130.2	115.9	4.1	120.0	3.5%	39
40	546400	Rent of Land & Buildings	112.1	112.1	0.4	112.5	0.4%	40
41	546409	Rent Expense - Interagency	6.8	7.4	0.4	7.8	5.4%	41
42	546500	Rent of Equipment	42.3	57.0	-	57.0	0.0%	42
43	546600	Communications	19.4	21.0	-	21.0	0.0%	43
44	546610	DOIT Communications	59.2	63.6	(1.5)	62.1	-2.4%	44
45	546700	Subscriptions & Dues	11.0	4.0	-	4.0	0.0%	45
46	546800	Employee Training & Edu.	2.0	5.0	-	5.0	0.0%	46
47	546801	Board Member Training	-	2.0	-	2.0	0.0%	47
48	546900	Advertising	2.8	0.2	-	0.2	0.0%	48
49	547900	Miscellaneous Expense	1.5	1.3	-	1.3	0.0%	49
50	547999	Request to Pay Prior Year	0.2	-	-	-	0.0%	50
51	548300	Information Technology Equipment	12.8	-	5.0	5.0	***	51
52	549600	Employee Out-Of-State Mileage & Fares	0.8	1.0	-	1.0	0.0%	52
53	549700	Employee Out-Of-State Meals & Lodging	1.0	1.0	-	1.0	0.0%	53
54	549800	B&C-Out-Of-State Mileage & Fares	0.7	1.5	-	1.5	0.0%	54
55	549900	B&C- Out-Of-State Meals & Lodging	-	1.5	-	1.5	0.0%	55
56		**TOTAL**	**509.5**	**533.2**	**21.2**	**554.4**	**4.0%**	56

- Personal services and employee benefits includes a $72,700 or 3.9 percent increase above FY18 approved operating levels to include full funding for all 27 FTE according to the E1 calculation in the budget preparation system.
- The request includes sufficient funding for the 3rd year of our 4 year agreement to perform actuarial services through Segal, as well as asset allocation review services related to NMRHCA's long-term investments.
- Lastly, the request in the other category includes sufficient amounts to support the projected operating expenses of the agency in FY19.

Performance Measures

The table below provides a list of performance measures approved by DFA and LFC, FY17 targets, FY17 reported performance, FY18 targeted performance and FY19 requested targets.

		Healthcare Benefits Administration	FY17 Target	FY17 Actuals	FY18 Target	FY19 Requested Target
1	Output	Minimum number of years of positive fund balance	20	18	18	18
2	Outcome	Number of years of projected balanced spending	5	4	4	4
3	Outcome	Percent of diabetics properly managed according to clinical guidelines	65%	Not yet Avail.	65%	65%
4	Outcome	Emergency room visits per thousand members	200	344	200	350
	Program Support					
5	Outcome	Percent of deposits made within 24 hours	100%	100%	100%	100%
6	Efficiency	Percent of payments made within 30 days	99%	99%	99%	99%

Requested Action

NMRHCA staff respectfully requests Board approval of the FY19 appropriation request as detailed above and approved by the Finance Committee to be submitted to the State Budget Division and Legislative Finance Committee on September 1, 2017.

NMRHCA Executive Committee Recommendations for Five-Year Strategic Plan – Positive Fund Balance Through 2045

X Phase out "Family Coverage" subsidies for retirees with multiple dependent children

X Increase cost sharing on prescription coverage (stabilize plan/member share percentage)

X Increase cost-sharing of pre-Medicare Plans

Implement graduated minimum age requirement (to receive subsidies)*

Increase years of service required to receive maximum subsidy (currently 20 years)

Reduce pre-Medicare retiree subsidies

Reduce pre-Medicare spousal subsidies

Implement enhanced wellness programs (premium incentives for participation/health status)

Increase Employee/Employer contribution levels (requires legislative action)

X indicates implementation starting in 2013

*NMRHCA will implement any minimum age requirements adopted by PERA and/or ERB

NOTE: NMRHCA will evaluate financial and market circumstances each year in determining a specific order and chronology of implementation

5-Year Strategic Plan (2018 – 2022)

Background: In October 2012, the Board of Directors adopted a five-year strategic plan that focused on nine specific elements. The goals of these elements were aimed at improving and extending the solvency of the program, reducing future liabilities and aligning contributions made to the program over the course of an average career more closely to benefits received over the course of an average retirement. Initial projections indicated a projected solvency through 2045 (over 30 years). The plan included the following elements:

1. Phase out "family coverage" subsidies for retirees with multiple dependent children
2. Increase cost sharing on prescription coverage (stabilize plan/member share percentage)
3. Increase cost sharing of pre-Medicare plans
4. Implement graduated minimum-age requirement (to receive subsidies)
5. Increase years of service required to receive maximum subsidy (currently 20 years)
6. Reduce pre-Medicare retiree subsidies
7. Reduce pre-Medicare spousal subsidies
8. Implement enhanced wellness programs (premium incentives for participation/health status)
9. Increase employee/employer contribution levels (requires legislative action)

A chronological list of events is summarized below:

Strategic Item	2013	2014	2015	2016	2017
1	Reduced Subsidy 100 - 50%	Reduced Subsidy 50 - 37.5%	Reduced Subsidy 37.5 - 25%	Reduced Subsidy 25 - 12.5%	Eliminated Subsidy 12.5 - 0%
2	Intro coinsurance on mail order prescriptions (including Medicare)				Elimination of coverage for drugs available over the counter (OTC)
3	Introduced $15 copayment differential for specialty office visits				Elimination of Premier Plus plan/Introduction of Value HMO Plan
4			Minimum Age of 55 to receive subsidies for new retirees after January 1, 2020 (excludes PERA enhanced plans)		
5			Increased years of service requirement from 20 to 25 years for new retirees after January 1, 2020 (excludes PERA enhanced plans)		
6				Reduced maximum pre-Medicare retiree subsidy from 65 - 64%	
7			Reduced maximum pre-Medicare Spousal Subsidy from 40 - 38%	Reduced maximum pre-Medicare Spousal Subsidy from 38 - 36%	
8				Implementation of enhanced wellness programs including financial incentive w/emphasis on smoking cessation	Continuation of wellness programs
9	Legislative proposal to increase contributions 2.5%	Legislative proposal to increase contributions 2.5%	Legislative proposal to increase contributions 1.25%	Legislative proposal to increase contributions 1.25%	Legislative proposal to study long-term solutions

NMRHCA Executive Committee Recommendations for Five-Year Strategic Plan – Positive Fund Balance Through 2045

X ~~Phase out "Family Coverage" subsidies for retirees with multiple dependent children~~

X Increase cost sharing on prescription coverage (stabilize plan/member share percentage)

X Increase cost-sharing of pre-Medicare Plans

~~Implement graduated minimum age requirement (to receive subsidies)*~~

~~Increase years of service required to receive maximum subsidy (currently 20 years)~~

Reduce pre-Medicare retiree subsidies

Reduce pre-Medicare spousal subsidies

Implement enhanced wellness programs (premium incentives for participation/health status)

Increase Employee/Employer contribution levels (requires legislative action)

X indicates implementation starting in 2013

*NMRHCA will implement any minimum age requirements adopted by PERA and/or ERB

NOTE: NMRHCA will evaluate financial and market circumstances each year in determining a specific order and chronology of implementation

Preliminary Staff Recommendations for NMRHCA 5-Year Strategic Plan 2018 – 2022

1. Apply downward pressure on prescription drug costs for all members (network, contracts, cost-sharing)*
    - FY19 – FY22 Contract
    - Annual market check agreement
    - Network attribution
    - Copays

2. Apply downward pressure on pre-Medicare medical plans (network, contracts, cost-sharing)*
    - Narrower networks
    - Deductibles
    - Copays
    - FY20 – FY23 Contracts

3. Reduce pre-Medicare retiree subsidies*
    - Currently 64 percent

4. Reduce pre-Medicare spousal subsidies*
    - Currently 36 percent

5. Evaluate existing and emerging wellness/population health programs for inclusion in either plan coverage or incentive support*
    - Monitor the development and progress of such programs and make recommendations with regard to reimbursements through health plans

6. Develop and implement value-based purchasing initiatives either through existing health plan partners or directly with health care delivery systems
    - Incentivize care through most cost effective solutions
    - Data-driven evaluation of care
    - Patient-centered medical homes
    - Accountable-care organizations
    - Bundled-payment arrangements

- Referenced-based reimbursements

7. Evaluate emerging and ongoing demographic trends and make program adjustments commensurate with fiduciary requirements
    - Continue monitoring ongoing trends and identifying potential solutions

8. Wellness Programs*
    - Management of chronic illness
    - Management of acute care episodes
    - Use of third-party prescription data
    - Reduction in the number of preference sensitive surgery
    - Identification of specific polypharmacy patients
    - Efforts to de-prescribe
    - Adherence

9. Increase employee/employer contribution levels (requires legislative action)*

10. Employee and member education and communication
    - Outreach
    - Professional development

*Concensus carryover items from previous strategic plan