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REGULAR MEETING
OF THE
BOARD OF DIRECTORS

March 6, 2018
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

March 6, 2018

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

NMRHCA BOARD OF DIRECTORS

March 2018

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

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

March 6, 2018
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 Regular Meeting Minutes February 6, 2018	Mr. Sullivan, President	5
6.	Public Forum and Introductions	Mr. Sullivan, President	
7.	Committee Reports	Mr. Sullivan, President	
8.	Executive Directors Updates	Mr. Archuleta, Executive Director	
	a. HR Updates		
	b. Legislative		13
	c. Federal Updates		
	d. New Mexico Health Connections		26
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9.	State Investment Council Update	Mr. Wollmann, Director of Communications, Legislative and Client Relations	33
10.	Temporary Asset Allocation (Action Item)	Mr. Archuleta, Executive Director	42
11.	FY18 Budget Adjustment Request (Action Item)	Mr. Archuleta, Executive Director	43
12.	FY18 New Contract (Action Item)	Mr. Archuleta, Executive Director	45
13.	2018 Revised Medicare Advantage Default Strategy (Action Item)	Mr. Archuleta, Executive Director	66
14.	Out-of-State Travel Request (Action Item)	Mr. Archuleta, Executive Director	67
15.	2019 Preliminary Plan Discussion	Mr. Archuleta, Executive Director	68
16.	Other Business	Mr. Sullivan, President	
17.	Executive Session	Mr. Sullivan, President	
18.	Date & Location of Next Board Meeting April 3, 2018, 9:30AM Alfredo R. Santistevan Board Rm, Suite 207 4308 Carlisle Blvd. NE Albuquerque, NM 87107	Mr. Sullivan, President	
19.	Adjourn		

ACTION SUMMARY

RETIREE HEALTH CARE AUTHORITY/REGULAR BOARD MEETING

February 6, 2018

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COMMITTEE REPORTS	Informational	3
EXECUTIVE DIRECTOR'S UPDATE HR Updates Legislative NM Health Connections United Healthcare/Presbyterian HS 2018 Winter Newsletter FY17 Financial Audit Update PBM RFP Annual Meeting November 30/December 31 SIC Report	Informational	4
2019 PRELIMINARY PLAN REVIEW	Informational	7
FY18 2ND QUARTER BUDGET REPORT	Informational	7
FY18 BUDGET ADJUSTMENT REQUEST	Approved	7
OUT-OF-STATE TRAVEL REQUEST	Approved	7

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

February 6, 2018

1. CALL TO ORDER

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

2. ROLL CALL TO ASCERTAIN A QUORUM

A quorum was present.

Members Present:
Mr. Tom Sullivan, President
Mr. Joe Montaño, Vice President
Mr. Doug Crandall, Secretary
The Hon. Tim Eichenberg, NM State Treasurer
Mr. Rod Ventura [representing Ms. Jan Goodwin]
Mr. Terry Linton
Ms. LeAnne Larrañaga-Ruffy
Ms. Therese Saunders

Members Excused:
None.

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

Others Present:
[See sign-in sheet]

3. PLEDGE OF ALLEGIANCE

Mr. Linton led the Pledge.

4. APPROVAL OF AGENDA

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

5. APPROVAL OF REGULAR MEETING MINUTES: December 12, 2017

Mr. Montaño moved approval of the December 12 minutes, as submitted. Mr. Linton seconded the motion, which passed by voice vote, with Mr. Ventura in abstention.

6. PUBLIC FORUM AND INTRODUCTIONS

Chairman Sullivan welcomed guests and staff.

There were no speakers from the floor.

7. COMMITTEE REPORTS

Wellness Committee

Ms. Saunders reported that the committee met in December and heard an interesting presentation by Grand Rounds, an organization formed to deal with patients with catastrophic illnesses. When a patient presents with an especially complex medical situation, Grand Rounds connects the patient and the patient's primary care physician with a field of experts trained to deal with that medical issue. In doing so, they can confirm that the original diagnosis was correct and make recommendations for treatment; or they can present a possible other diagnosis with a recommended treatment for it. Grand Round states that, by homing in on exactly what treatment is appropriate, it can reduce cost for not just the patient, but for NMRHCA. Grand Rounds reported to the committee that one-third of the cases it deals with result in a substantial reduction in cost.

Chairman Sullivan recalled that NMRHCA looked at a similar program a few years ago and found it wasn't cost effective. Mr. Archuleta responded that Grand Rounds is different in that it has a set of predetermined diagnoses and then helps people with those diagnoses to better manage their care. Under the current system, performance measures in the NMRHCA's health plan contracts calls for the medical director to review cases that are projected to be expensive to be sure the patient is following the correct course of treatment. Grand Rounds introduces an outside perspective by bringing in those people with the necessary medical expertise to address the medical issue in question and to review the patient's health records, medical tests, blood

work, etc., and either confirm the diagnosis or recommend an alternative. The medical experts also assist with a treatment plan.

Mr. Archuleta said the FY19 budget review will include a discussion about a possible pilot project with Grand Rounds. When NMRHCA spoke with Grand Rounds two years ago, Grand Rounds' proposal was to charge on a per-member per-month basis, which at about $2 or $3 per member would not have been cost effective for the agency. He said paying on a per-episode or per-encounter basis could be a viable alternative. He added that NMRHCA is talking with Blue Cross Blue Shield and Presbyterian to see whether it could establish some kind of funding arrangement through their programs for their members on NMRHCA's behalf.

Mr. Linton commented that the Wellness Committee's discussion was not just about cost drivers, but also better outcomes for the members.

Mr. Archuleta said staff would be bringing a recommendation forward at the annual meeting.

Executive Committee

Chairman Sullivan reported that the Executive Committee met by phone to discuss today's agenda.

Finance Committee

Mr. Crandall reported that the Finance Committee met to discuss two items that are on today's agenda. The committee also discussed investment returns, and that discussion will be taken up at a later date.

8. EXECUTIVE DIRECTOR'S UPDATE

a. HR Updates

Mr. Archuleta reported that NMRHCA is under a shared service agreement with the State Personnel Office (SPO). Under the new consolidated model, NMRHCA goes to SPO for everything from recruitment and retention to discipline matters. NMRHCA's new contact at SPO is Donna Vigil.

Mr. Archuleta reported that the Chief Financial Officer position was posted for 10 days and closed late last week. Interviews will be scheduled as soon as possible.

b. Legislative

Mr. Archuleta presented an overview of the recommendations made by both DFA and the LFC for the NMRHCA's FY19 budget. The LFC recommendation totaled $338 million, which was a

$15 million increase over the existing operating budget. The Executive recommendation was for a $7.9 million increase over the current operating budget. He said the LFC recommendation was adopted.

Mr. Archuleta said he expects NMRHCA will be submitting a budget adjustment request by the end of the year to cover claim costs. That number is currently projected at $13 million.

Mr. Archuleta shared a fact sheet updated by staff each year that is shared with legislators and other interested parties. The fact sheet includes information about legislative changes, board actions and projected solvency information. He said he met with Senators Ingall, Smith and Kernan last week. Senator Kernan, as she has in the past, offered her support to introduce legislation next year to increase employee/employer contributions to the plan.

Mr. Montaño suggested to Mr. Archuleta that he consider including in future discussions the possibility of having at least a portion of the monies lost through Senate Bill 7 restored as part of the overall request to increase the employer/employee contribution rate.

c. <u>New Mexico Health Connections</u>

Mr. Archuleta reviewed recent newspaper reports on solvency issues with respect to New Mexico Health Connections (NMHC), which serves 350 pre-Medicare NMRHCA enrollees. A letter was written on behalf of the IBAC expressing concerns about allegations that NMHC has been under the financial supervision of the state's Superintendent of Insurance since June 2017 and that payments are outstanding. IBAC has requested evidence to support that providers and facilities are being reimbursed for services incurred by its members.

d. <u>UnitedHealthcare/Presbyterian Health Services</u>

Mr. Archuleta stated that he has received calls from NMAER Executive Director Russell Goff, as well as board member Montaño, regarding some members who discovered that their medical provider, Presbyterian Health Services, was no longer accepting UnitedHealthcare. Mr. Archuleta explained that there had been some miscommunication between Presbyterian and UnitedHealthcare that has since been resolved.

Mr. Archuleta noted that there is no contractual arrangement for the Medicare Advantage services between the two agencies. Last year, the NMRHCA developed a Medicare defaulting strategy that moved the people in the Presbyterian pre-Medicare plans to UnitedHealthcare's Plan I. On the other side, people in the Blue Cross Blue Shield pre-Medicare plans, as well as with New Mexico Health Connections, were moved into Humana's Plan I. With that said, NMRHCA will be developing a revised recommendation to the board for that defaulting strategy just to make sure that it does not run into the same problem down the road because of some miscommunication.

e. 2018 Winter Newsletter

Mr. Archuleta reviewed the winter newsletter.

Mr. Crandall asked if the NMRHCA Wellness Incentive Program, which offers a $50 Visa gift card for completing two wellness activities, continues to be successful. Mr. Greg Archuleta responded that there were 320 gift cards distributed in the first year, and that number is now at 400.

Mr. David Archuleta said the agency is developing a revised wellness strategic planning policy, with the assistance of Presbyterian Health Plan, and will be bringing that forward at the annual meeting.

Mr. Crandall commented that there are probably many members who are taking advantage of the program but have not submitted an application for the Visa card. Mr. Archuleta agreed. Mr. Crandall suggested that NMRHCA find a way to track those people.

f. FY 17 Financial Audit Update

Mr. Archuleta reported that there were two findings, neither of them material. One was that the Plan did not have formal policies and procedures to verify the accuracy of employee information received from PERA and ERB; and the second was the need to conduct an annual review of the financial reports submitted by the self-funded health plans. Mr. Archuleta said the agency has developed a corrective action plan to address both findings.

g. PBM RFP

Mr. Archuleta stated that the IBAC is under contract negotiations with the selected vendor and a public announcement will be made at the conclusion of that process, in April or May.

h. Annual Meeting – July 12 and 13, 2018

Mr. Archuleta stated that the annual meeting is scheduled at the Sagebrush Inn & Suites in Taos. Bids were solicited from three locations.

i. November 30/December 31, 2017 SIC Report

Mr. Archuleta reported a total balance of $608 million at November 30, which included income earned of about $800,000 as well as capital appreciation of $5 million; and a total balance of $621 million at December 31. This included a $3 million contribution.

9. 2019 PRELIMINARY PLAN REVIEW

Mr. Archuleta reviewed the actions taken by the board in recent years to adjust elements of the plan, as well as actions proposed for this year. At the March board meeting, he will present a list of specific recommendations, including possibilities for saving money, and those recommendations will evolve in subsequent board meetings as additional numbers are received from the various health providers.

10. FY18 2ND QUARTER BUDGET STATUS REPORT

Mr. Kueffer made this report.

11. FY18 BUDGET ADJUSTMENT REQUEST

Mr. Kueffer stated that current projections in the FY18 Program Support budget indicate a $132,000 surplus in the personal services and employee benefits category at the end of FY18, and a projected deficit of $46,000 under contractual services.

Mr. Kueffer said NMRHCA has requested quotes for investment advisory services to NEPC, Meketa Investment Group, and Wilshire Associates.

Mr. Kueffer requested approval of a BAR to transfer $50,000 from the personal services and employee benefits category to the contractual services category to support the procurement of investment advisory services and development of a revised asset allocation schedule.

Mr. Crandall said he continued to feel that NMRHCA should have an investment advisor on a regular contractual basis rather than on an ad hoc basis. He pointed out that the fund has now grown to more than $600 million.

Mr. Crandall said the Finance Committee reviewed this budget adjustment request and recommended approval.

Mr. Crandall moved approval of the BAR, as requested. Ms. Larrañaga-Ruffy seconded the motion, which passed unanimously.

12. OUT-OF-STATE TRAVEL REQUEST

Mr. Kueffer stated that NMRHCA is a member of the State and Local Government Benefits Association (SALGBA), which represents 5 million members in 48 states. The organization distributes information on the latest resources, news, conferences, education and networking opportunities.

Mr. Kueffer requested permission for him and Mr. Archuleta to attend the SALGBA national conference on April 29-May 2 in Jacksonville, Florida.

Ms. Saunders moved for approval of this request. Mr. Crandall seconded the motion, which passed unanimously.

13. OTHER BUSINESS

None.

14. EXECUTIVE SESSION

None.

15. DATE AND LOCATION OF NEXT MEETING:
March 6, 2018, 9:30 AM
Alfred R. Santistevan Board Room, Suite 207
4308 Carlisle Blvd., N.E.
Albuquerque, New Mexico 87107

16. ADJOURN

The meeting was adjourned at 10:40 a.m.

Accepted by:

_____

Tom Sullivan, President

F I S C A L I M P A C T R E P O R T

SPONSOR Armstrong/ Small **ORIGINAL DATE** 1/23/18 **LAST UPDATED** 1/25/18 **HM** 9

SHORT TITLE Explore Medicaid Buy-In Plan **SB**

ANALYST Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY18	FY19	FY20	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		See Fiscal Implications	See Fiscal Implications			

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates Senate Memorial 3, Study NM Medicaid Buy-In Plans

SOURCES OF INFORMATION
LFC Files

Responses Received From
Office of Superintendent of Insurance
Public School Insurance Authority
Retiree Health Care Authority
University of New Mexico Health Sciences Center

Response Not Received From
Human Services Department (HSD)

SUMMARY

Synopsis of Bill

House Memorial 9 requests the interim Legislative Health and Human Services Committee analyze the policy and fiscal implications of offering a Medicaid buy-in plan to non-Medicaid eligible New Mexico residents to increase low-cost health coverage options. The bill charges the Legislative Health and Human Services Committee to work with the Office of the Superintendent of Insurance, Human Services Department, other state agencies, the New Mexico health insurance exchange, health insurers, and health care providers to provide health plan cost and coverage information.

FISCAL IMPLICATIONS

The memorial does not include an appropriation.

The Human Services Department may need to utilize the services of its actuarial contractor and other Medicaid staff to analyze the provisions contained in the memorial.

The Office of Superintendent of Insurance may need to utilize its health insurance regulatory staff to analyze the provisions contained in the memorial.

SIGNIFICANT ISSUES

The University of New Mexico Health Sciences Center (UNMHSC) reports the memorial could analyze creation of an insurance option for Medicaid buy-in for individuals and families with incomes between 138 percent of the federal poverty level (FPL) and 200 percent FPL. This concept has been proposed in New Mexico historically as the "Basic Insurance Plan" that would provide a coverage option with reduced benefits for members with higher incomes, and was the broad concept behind the implementation of the State Insurance Coverage Plan (SCI) in which UNM Hospital was a participant along with several other SCI plans.

UNMHSC indicates lower income households can struggle with the deductions, co-pays and co-insurance requirements of health insurance plans offered on the New Mexico health exchange. These plans have also offered narrower provider networks resulting in less choice and access for patients. With the elimination of the individual mandate to obtain coverage by the federal government, it is likely that offerings under the ACA through the New Mexico health exchange will continue to decline or become cost prohibitive. Consideration of implementing a buy-in product for households with income below 200 percent FPL merits discussion in the current healthcare environment.

ADMINISTRATIVE IMPLICATIONS

The University of New Mexico Health Sciences Center (UNMHSC) indicates the memorial does not specify if other administrative requirements for Medicaid, with the exception of the income limit, would remain in force or not. There is already significant statewide infrastructure around determining Medicaid eligibility and to add a Medicaid buy-in product to that existing platform might not prove to be excessively administratively burdensome, along with the collection of premiums or other out-of-pocket costs. This would require either the Human Services Department or Medicaid managed care organizations (MCOs) to develop premium payment and tracking mechanisms related to collecting member premiums, deductibles and co-pays, similar to existing MCO infrastructure. Also, the Medicaid program would have to determine if a Medicaid buy-in product would require a federal state plan amendment, which it probably would, and would need to conduct those administrative processes.

The New Mexico Retiree Health Care Authority reports it can provide information requested regarding health plan cost and coverage to the Legislative Health and Human Services Committee or other legislative entities within existing resources.

OTHER SUBSTANTIVE ISSUES

The Office of Superintendent of Insurance (OSI) indicates the memorial explores a national current issue regarding affordable health care access in conjunction with stabilizing risk pools. OSI suggests the committee explore how a Medicaid-buy in program will change the risk make-

up of the commercial market and Medicaid market risk pools, analyze churn between these markets, and consider how continuous coverage through one managed care organization impacts continuity and quality of care.

The University of New Mexico Health Sciences Center (UNMHSC) reports a Medicaid buy-in product line would need to be better defined and decisions around the proposed benefits package outlined. It is unclear if the proposal envisions a product that has a benefit package like Medicaid, or if the product would function more like a commercial product with benefit limitations and potentially narrower defined networks, or a hybrid of the two. How these issues are determined would have a significant impact on the viability and sustainability of this product and the establishment of a provider network willing to accept patients under the new product. If the vision of this new product is that it would be basically a Medicaid benefit that is extended to higher income groups the reimbursement dynamics may prove to be challenging for providers as there is already significant cross subsidization required for existing Medicaid services based on lower reimbursement rates. If the vision is to move to a commercial-like product with benefit limits and other commercial insurance attributes, the reimbursement structure may be attractive to more healthcare providers.

RAE/sb

F I S C A L I M P A C T R E P O R T

SPONSOR SCORC **ORIGINAL DATE** 2/01/18 **LAST UPDATED** 2/13/18 **HB**

SHORT TITLE Guidelines for Step Therapy for Drug Coverage **SB** CS/CS/11/SPACS/SCORC /aHFl#1

ANALYST Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY18	FY19	FY20	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	NFI	Up to $7,500.0	Up to $7,500.0	Up to $15,000.0	Recurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates House Bill 42 (prior to committee substitutions and amendment)
Similar to 2017 Senate Bill 179 and House Bill 244

SOURCES OF INFORMATION
LFC Files

Responses Received From
Public School Insurance Authority (PSIA)
Retiree Health Care Authority (RHCA)(to identical House Bill 42)
Human Services Department (HSD)
General Services Department (GSD)
Responses received from these four agencies before committee substitutions; received also from HSD after committee substitutions but before the floor amendment.

Response Not Received From
Department of Health (DOH)

SUMMARY

Synopsis of HFl#1 Amendment

The House Floor #1 amendment adds identical language to each section of the bill that serves to define the term "not in the best interest of the patient," which term is one of the reasons for which an exception (from step therapy) request could be made. A drug "not in the best interest of the patient" is defined as one that would

- Cause a significant barrier to the patient's adherence or compliance with the patient's plan of care, or
- Worsen another medical condition the patient had, or

- Decrease the patient's ability to maintain activities of daily living.

Synopsis of Original Bill

Step therapy involves the requirement by health insurers that their enrollees be treated with a more effective and/or less expensive drug or device before moving to a more expensive one if the lower-cost therapy proves ineffective. It is used to attempt to reduce the cost of care, and is sometimes disparagingly referred to as "Fail First therapy." The Senate Corporations and Transportation Committee Substitute for the Senate Public Affairs Committee Substitute for Senate Bill 11 would regulate the use of step therapy and establish review procedures both before an insurer would institute step therapy for a given disorder, and to resolve complaints by insured patients subject to step therapy.

Insurers would have to base their step therapy protocols on recommendations of "an interdisciplinary panel of experts," which would use analytical and methodological experts to help with data analysis and interpretation of high-quality research studies in recommending the steps patients would be required to take. Articles published in peer-reviewed journals could form the basis of the step therapy, or, if published guidelines were not available, expert opinion could be used. Patients and prescribers would have access to a clear method to request an exception to a given step therapy determination (based on "medical necessity," a term defined below and on a "clinically valid explanation" from the prescriber), and insurers would have to respond within 72 hours, or 24 hours in an urgent situation and in accordance with medical necessity (defined below) and an explanation from the prescriber. Exceptions would be mandated in the following cases:

- The drug indicated in the step therapy protocol is contraindicated in that patient's case or could cause physical or mental harm in that patient.
- The patient's particular circumstances make it appear the indicated step therapy drug will be ineffective in that given patient.
- The patient has used the drug or a similar product before (under coverage from the same or a previous insurer), and found it either ineffective or causing an adverse effect.
- The drug indicated in the step therapy protocol is "not in the best interest of the patient, based on "medical necessity" (defined as concerning a drug that "is appropriate or necessary according to any applicable, generally accepted principles and practices of good medical care, practice guidelines developed by the federal government or professional medical groups, or applicable clinical protocols developed by the health plan "consistent with federal, national and professional guidelines.")

Patients could appeal the insurer's decisions through the Patient Protection Act. Health plans would be required to authorize continuing coverage of a prescription drug subject to an exception request until final adjudication of the request, including the appeal.

Plans could still require the use of a generic version of a patented drug. Medical practitioners would not be prevented from prescribing medications that they had determined to be "medically necessary."

Separate sections of Senate Bill 11 make the same requirements of a number of insurer types as indicated in the table below:

Section of Senate Bill 11	Type of insurance affected
1	Group health plans
2	Medical assistance plans
3	Individual health insurance policies, health care plans or certificates of insurance
4	Group or blanket health insurance policies, health care plans or certificates of health insurance
5	Individual or group health maintenance organizations
6	Individual or group nonprofit health care plans

According to the National Conference of State Legislatures, the states of West Virginia, Iowa, and Colorado enacted legislation during 2017 restricting the use of step therapy in various ways.

FISCAL IMPLICATIONS

PSIA states, "This bill would have a significant fiscal impact on the PSIA self-insured Rx Plan. Currently, there are step therapy rules in place that save PSIA approx. $1.3 annually based on the current formulary and prescription drugs currently out on the market today. The "up to $1.3 million" in the yearly financial impact is an estimate and is subject to change. Without the current step therapy rules in place, members would no longer be required to try using lower cost drugs that have proven to be effective (before using a more costly drug).

Similarly, RHCA (in its response to identical House Bill 42) notes, "For FY17, the savings associated with Step-Therapy Programs administered by NMRHCA totaled $1,731,590."

The RHCA continues, however, to state that "the bill does not propose to eliminate Step Therapy program. Rather it establishes the criteria for approval of exceptions to the program and timelines for the approval and response process."

HSD initially expressed concern over the possibility that this bill might result in large increases to the medication expenses of Medicaid managed care organizations. These concerns have decreased with the substitution, but remain in part:

> The bill provides protections for Medicaid enrollees; it lists the reasons for a Medicaid enrollee to be granted an exception from the first step of the step therapy process. The exception criteria regarding a Medicaid enrollee who is already stabilized on a medication is particularly important for treating some diseases such as heart disease, epilepsy, diabetes and several other chronic conditions. For behavioral health, HSD does not allow step therapy for psychotropic medications.
>
> The primary impact to HSD would be on the Medicaid Managed Care Organizations, the entities which primarily use step therapy in administering the state's Medicaid managed care program.

Changes to developing step therapy protocols could have a significant financial impact for HSD. HSD has calculated that a shift of just 1% of generic drug items to brand name items, due to ending some step therapy protocols or by exempting individuals from step therapy, would cost HSD approximately $10 million annually (combined state and federal funds).

The bill may delay new step therapy protocols from being applied to brand name drugs as they become available. Such delays in implementing new protocols or removing existing protocols would have a significant financial impact to the department.

Currently, the Medicaid Managed Care Organizations (MCOs) have protocols for a step therapy exception process that is developed and managed by their Pharmacy and Therapeutics (P&T) committees. The initial step therapy medication must be filled first or the member must fail the medication in order to allow the subsequent medication to proceed. With documented clinical notes, an exception is to be granted if:

- The treatment has been ineffective in the treatment of the medical condition in the past;
- The drug in question is likely to be ineffective based on the patient's physical or mental characteristics and the known characteristics of the drug;
- The preferred treatment will likely cause an adverse reaction or physical harm;
- The drug regimen is not in the best interest of the patient based on medical necessity;
- A provider certifies medical necessity in writing by noting "Brand Medically Necessary" and supporting documentation is charted indicating why a generic or alternative drug does not meet therapeutic needs.

If an enrollee is new to the MCO, a request for an exception must be initially submitted with clinical notes indicating that the patient has tried and failed the step therapy or failed the first drug to obtain an exception for the drug requested. Provisions of SCORCS/SB 11 bill would require similar exception criteria.

Additionally, in section 4.10.2.10.5 of the Medicaid MCO contracts, the MCOs are required to have an open formulary for all psychotropic medications and not able to apply step therapy or fail first criteria. Furthermore, if the prescriber certifies medical necessity by noting "brand medically necessary" or "brand necessary" on the prescription, and maintains supporting documentation in the member's medical record indicating that a generic or alternative medication does not meet the therapeutic needs of the member, then prior authorization is not necessary for use of a brand psychotropic drug.

SCORCS/SB 11 also includes requirements for how step therapy protocols are to be implemented: Most significantly, Section 2, A. (2) (a) of the bill [prescribes] that the interdisciplinary panel manage conflicts of interest among the members of the panel of experts by "requiring members to disclose any potential conflicts of interest with health care plans, medical assistance plans, health maintenance organizations, pharmaceutical manufacturers, pharmacy benefits managers and other entities" and requiring members to recuse themselves if there is a conflict of interest. . ."

If each medical assistance plan were to convene its own panel, this requirement could potentially prohibit a medical director or any other health professional employed or contracted by the Medical Assistance Program, including a Medicaid MCO, from participating in any part of the process to determine step therapy protocols that will be implemented within their own entity.

It could also remove the participation of the organization's "Pharmacy and Therapeutics Committee" which is the standard body within a MCO that typically considers preferred drug lists, prior authorization requirements, and step pharmacy through a multi-disciplinary panel charged with this responsibility. It could also potentially exclude any participation by a health professional employed by a Pharmacy Benefits Manager who may have expertise and experience derived from other states and other lines of business.

Other aspects of the requirements, such as the involvement of appropriate medical experts is beneficial because of the very complex nature of drug treatments, particularly in specialized medical fields. But otherwise, the requirements of the bill completely separate the management of step therapy from the managed care organizations' operations and responsibility.

In the bill, there is also no allowance for economy in selecting the step therapy drug items. In reality, the difference in cost between an older but very reliable and well-established drug and very new drug therapy may be drastically different. The bill does not seem to recognize that there may be significant economic reasons for trying the less expensive drug first in a step therapy protocol.

The consideration of "economy" within the Medical Assistance Programs is a primary tenet of the federal regulations that created the Medicaid programs and is still applicable.

Use of long established drug therapy may even provide some protections to the enrollee by requiring the use of more known standard therapies before using very expensive, newly marketed drugs.

Staff at Blue Cross Blue Shield of New Mexico, asked to estimate the cost to the state of the proposed legislation, gave the following response:

The bill(s) in question will result in the following higher drug costs for the state, health plans, and New Mexico citizens:

- State employees **$6.4 million** over three years according to a 2017 NM bill FIR
- BCBS-NM private employers and employees **$6 million** annually
- BCBS-NM Medicaid recipients and taxpayers **$1.1 million** annually
- These costs could ultimately be passed on to New Mexico citizens via higher premiums or higher out-of-pocket medicine costs…

Some details on the methodology that was used to develop the above numbers:

- Standard quarterly and yearly industry pharmacy utilization reports for BCBSNM were used.
- The numbers include savings from both combined step therapy and prior authorization programs as it would be difficult to tease out the individual program cost savings, and it is also not clear how the bill is written how it might affect both step therapy and prior authorization programs.
- The $1.1M estimate is for BCBS NM Centennial recipients only. Based on current relative Centennial membership the total cost to the Medicaid program could be three to four times higher.
- The assumption was made that the savings from those programs would be completely nullified, as the bill would require automatic approvals in many circumstances, including instances where patients were provided samples.

Representatives of HSD indicate that roughly one half of all exemption requests made by members of Medicaid managed care organizations are approved using current mechanisms. If this holds true for exemption requests made through all of the types of medical insurance plans, then the possible cost of the implementation of SCORCS/SB 11 would be likely to be less than one half of the amount indicated in the Blue Cross assessment above.

In summary, the fiscal impact of SCORCS/SB 11 depends on the extent to which step therapy would be circumvented. If the eventual outcome of the bill is only to regulate the means by which therapy protocols are generated and to speed up the process of step therapy exemption granting or denial, the resulting increase in medication costs for state medical benefit programs and for Medicaid would be small. If, on the other hand, fewer step therapy protocols were to be generated and exemptions from step therapy were to be much more frequent, the resulting increase in cost could be much greater. It should be clear that SCORCS/SB 11 does not intend to eliminate step therapy, only to regulate it.

SIGNIFICANT ISSUES

In the 2017 Legislature, two identical bills (House Bill 244 and Senate Bill 179) similar to SCORCS/SB 11 were introduced. An amendment eliminated clinical review criteria in the bill, eliminated application of the Patient Protection Act, and eliminated the 24- and 72-hour time limitations for reviews of exception requests, replacing them with “expeditious”. These changes are not included in SCORCS/SB 11.

The definition of “medical necessity” has been extensively revised in the current committee substitute to be more congruent with the term as used by the Superintendent of Insurance.

HSD raises the issue that the conflicts of interest provisions in the bill may be restrictive and “seem to include anyone working within the MCO, such as the Medical Director, from having any input when selecting the step therapies process.” HSD continues, “The bill does not seem to recognize that significant economic reasons may exist for trying the less expensive drug first in a step therapy protocol.”

HSD also discusses the new language in the amendment requiring plans to authorize continued use of a drug until the determination of the applicability of the step therapy protocol is made:

- Federal requirements regarding a continuation of a disputed benefit, which HSD has implemented, currently exist. When the recipient is receiving a service, such as a drug item that is going to be discontinued by the medical plan, the recipient has the right to request the continued use of the drug and the medical plan cannot deny that request.

- The federal rules specifically state that a recipient request for "a continuation of benefits" must be a separate request from the exception request. This is because the federally required timeframe for requesting continuing benefits are different from that of filling an appeal or for a fair hearing. It is also important that a recipient separately request a continued use of the drug item because if the recipient does not prevail in the appeal or final fair hearing decision, the recipient may be responsible for paying for the continued use of that drug item during the appeal and administrative hearing process as allowed under federal and current state rules.

- The bill is also in conflict with federal rules in that, when a recipient requests a continuation of a benefit such as a drug item, the benefit does not end with the decision on the exception request but continues through the full appeals and fair hearing process.

In Subsection I-2 of each section, practitioners are not prevented from prescribing a "prescription drug the provider has determined to be medically necessary," but it is not clear in that instance whether the insurer would be required to pay for that medication.

The American Medical Association (AMA) states, in a policy statement entitled "Prior Authorization and Utilization Management Reform Principles" that "Utilization management programs, such as prior authorization and step therapy, can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes. The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies and hospitals) and divert valuable resources away from direct patient care." The AMA proposes 21 "principles" which it states should govern the use of step therapy and other forms of utilization management, as follows:

1. Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. The referenced clinical information should be readily available to the prescribing/ordering provider and the public.
2. Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.
3. Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.
4. Utilization review entities should offer a minimum of a 60-day grace period for any step therapy or prior authorization protocols for patients who are already stabilized on

a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.

5. A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.
6. A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment.
7. No utilization review entity should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy.
8. Utilization review entities should publically disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every prior authorization and step therapy override request.
9. Utilization review entities should provide, and vendors should display, accurate, patient specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.
10. Utilization review entities should make statistics regarding prior authorization approval and denial rates available on their website (or another publically available website) in a readily accessible format. The statistics shall include but are not limited to the following categories related to prior authorization requests:
    a. Health care provider type/specialty;
    b. Medication, diagnostic test or procedure;
    c. Indication;
    d. Total annual prior authorization requests, approvals and denials;
    e. Reasons for denial such as, but not limited to, medical necessity or incomplete prior authorization submission; and
    f. Denials overturned upon appeal. These data should inform efforts to refine and improve utilization management programs.
11. Utilization review entities should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination (e.g., national medical specialty society guidelines, peer-reviewed clinical literature, etc.), provide the plan's covered alternative treatment and detail the provider's appeal rights.
12. A utilization review entity requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. Facsimile, proprietary payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.

13. Eligibility and all other medical policy coverage determinations should be performed as part of the prior authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.
14. In order to allow sufficient time for care delivery, a utilization review entity should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received.
15. If a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.
16. Should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the provider and patient within 24 hours. Providers and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider who (a) is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider and (b) was not involved in the initial adverse determination.
17. Prior authorization should never be required for emergency care.
18. Utilization review entities are encouraged to standardize criteria across the industry to promote uniformity and reduce administrative burdens.
19. Health plans should restrict utilization management programs to "outlier" providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.
20. Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways.
21. A provider that contracts with a health plan to participate in a financial risk-sharing payment plan should be exempt from prior authorization and step-therapy requirements for services covered under the plan's benefits.
    https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf

From the perspective of an insurance company chief medical officer, Dr. Eugene Sun of Blue Cross Blue Shield of New Mexico, wrote in the Albuquerque Journal on January 3, 2018, in a guest column entitled "Step therapy vital to appropriate care:"

> It's [step therapy is] critical to maintain affordable access to appropriate care and medications… Step therapy is a process that health insurance companies use selectively to ensure that existing, highly effective, and more cost-efficient medications are tried first before approving coverage for new high-cost medications. For many of the conditions that require specialty medications, there is at least one, and sometimes several, U.S. Food and Drug Administration (FDA)-approved medication that has been used successfully for years, if not decades, to treat the condition. All step therapy does is to ask if those drugs have been tried and were successful, or not, in treating a condition… In my opinion, a call for legislation to require a clear and timely appeals process for step therapy is unnecessary. There are already a number of regulatory and legislative requirements in

> place for health insurers to provide transparent and expeditious appeals rights for all of our members.
>
> All physicians, nurses and health care providers in the state work tirelessly to care for all New Mexicans. By maintaining step therapy processes, we are ensuring appropriate care for our patients and the community."
> https://www.abqjournal.com/1113883/step-therapy-vital-to-appropriate-care.html

In summary, patients and practitioners often dispute the necessity of step therapy, contending that it infringes on a practitioner's right and ability to determine the best therapy for a given patient. On the other hand, insurers, noting practitioners' vulnerability to pharmaceutical detailing and patients' vulnerability to direct-to-patient advertising, indicate the need to control costs by step therapy, which insists upon use of proven, less-expensive therapy before more expensive, often non-generic therapy is tried. Again, it must be emphasized that SCORCS/SB 11 does not advocate for ending step therapy.

DUPLICATION of House Bill 42 (prior to SCORCS/SB11), near duplication with 2017 HB 244 and SB 179.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL.

Step therapy would be established by each medical insurance company as it deemed fit, and there would be no uniformity or specified limit to the time an exemption adjudication might take.

LAC/sb/jle/al

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

January 24, 2018

Dr. Martin Hickey, Chief Executive Officer
True Health New Mexico
2440 Louisiana Blvd., NE, Suite 601
Albuquerque, NM 87110

Dear Dr. Hickey:

On behalf of the Interagency Benefits Advisory Committee (IBAC), I am writing to express our concerns regarding the articles written in the December 22, 2017 and January 9, 2018 editions of the Albuquerque Journal. Specifically, the allegations that New Mexico Health Connections (NMHC) has been under the financial supervision of the state's Superintendent of Insurance since June 2017, and that outstanding payments owed to the University of New Mexico, Presbyterian Health Services and the 2017 Risk Adjustments owed under the ACA.

Additionally, actions taken by your board of directors requesting the Superintendent take immediate control of Health Connections, in order to act in the best interest of policyholders, had not been communicated to the IBAC. While the first article quotes you as stating that these accusations are attempts to undermine a competitor, we do not think the Superintendent of Insurance would have placed the health plan under financial supervision absent concerns about its solvency.

Of particular concern to our membership is the suggestion that providers may attempt to recoup unpaid bills directly from people insured by NMHC/True Health New Mexico. If this practice occurs, it will result in confusion, a lack of confidence in our health plan selections, and member dissatisfaction.

In response to these concerns, the IBAC is requesting evidence to support that providers and facilities are being reimbursed for the services incurred by our members, based upon the provider reimbursement agreements applicable to our membership, and contemporaneously with the weekly funding requests received by each of our entities. We would like to ensure that our members are not being

affected by accusations of unpaid bills and to avoid situations in which our members are being balance-billed for services covered by our plans. In addition, if you would provide any independent financial report, audit or Service Organization Controls (SOC) 1 Report to support the financial condition of the health plan, would be greatly appreciated.

In addition, the IBAC would like an affirmation that, as part of the assignment, True Health New Mexico will assume all indemnification obligations of NMHC for matters arising out of the performance of the contract by NMHC as set forth in each of the participating IBAC entities' contracts (as well as being responsible for indemnifying the IBAC agencies for anything arising out of the performance of the contract by True Health New Mexico).

We look forward to your written response to this letter. If you have any questions or concerns regarding this request, please contact me at ernestine.chavez@state.nm.us, or at 505.988.2736.

Sincerely,

Ernestine Chavez
Chair
Interagency Benefits Advisory Committee

February 5, 2018

Ms. Ernestine Chavez
Chair, Interagency Benefits Advisory Committee
410 Old Taos Highway
Santa Fe, NM 87501

Dear Ms. Chavez,

Thank you for your letter of January 24, 2018 regarding the articles published in the *Albuquerque Journal* on December 22, 2017 and January 9, 2018. I understand why you might have concerns. However, the sources for both those articles were not privy to the complete story and because of that, the *Journal*'s articles were fundamentally misinformed.

In order to respond to your specific concerns, I need to explain some of the context. The December 22 article was based in part on statements placed into the public record by New Mexico Health Connections' (NMHC) competitors and the University of New Mexico Hospital (UNMH). Both UNMH and Presbyterian Healthcare System (PHS) dramatically overstated the amounts that were in dispute. Payors and providers regularly have disagreements about billed charges. It is part of the process of doing business, and those differences are typically resolved through negotiation. In this case, both PHS and UNMH saw an opportunity to leverage a legal proceeding to make their case. The statements placed into the record reflect only their view of the situation, and NMHC categorically and strongly refutes these views as completely false.

Since that time, we have made significant progress with PHS, and the discussion with UNMH continues through arbitration, which is where it belongs. As you know, we take our responsibility as administrator for IBAC members seriously. We consider ourselves to be stewards of your money. In that role, we challenge providers to be fully transparent, and accurate in their billed charges. We will continue to stand for our members, and require providers to justify and document their claims, especially when there is a lack of clarity about their billing.

Secondly, when the board resigned on June 30, 2017, the Office of the Superintendent of Insurance (OSI) increased its oversight of NMHC but did not put NMHC into receivership. The OSI was familiar with the strengths inherent in the foundation of NMHC's financial structure and chose to work with the NMHC Senior Leadership Team (SLT) to put in place a new board that was better equipped to find solutions to strengthen NMHC as an organization. These were highly confidential, internal discussions and decisions between NMHC and the OSI that were

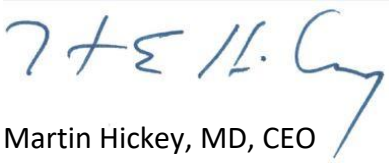
under nondisclosure agreements at the time. Therefore, we could not have communicated any detailed information to the IBAC. I understand your concern that the IBAC was not made aware of the changeover in the NMHC board, but I hope you can understand the position that NMHC was in to maintain a high level of confidentiality at the time. It is regrettable that a highly confidential internal memo was leaked to the media out of context, causing concern for you.

NMHC's financial stability will be demonstrated amply in our end-of-year filings with the National Association of Insurance Commissioners, which will be available for public review in March 2018. NMHC's Risk-Based Capital (RBC) metric will be significantly over 300. Regarding your request for audit or other financial reporting to confirm NMHC's financial health, we would point you to that filing. We will continue to work with each IBAC entity to provide reports that support you request for information on provider reimbursement.

True Health New Mexico and NMHC are now two separate legal entities. Per the terms of the asset purchase agreement, True Health New Mexico does not have liability for NMHC's obligations. Therefore, we are unable to meet your request that True Health New Mexico will assume all indemnification obligations for NMHC. NMHC will continue to be responsible for any obligations to the IBAC for the period of time that NMHC was contracted with the IBAC. Under the assignment, True Health New Mexico will indemnify the IBAC agencies as contractually agreed.

True Health New Mexico takes very seriously its responsibility to the IBAC, just as seriously as NMHC did. Evolent Health brings new resources and opportunities to True Health New Mexico, and we are very optimistic about our partnership with the IBAC going forward. We remain firmly committed to managing costs by caring for members' health, and to changing the health of New Mexico for the better.

Sincerely yours,



Martin Hickey, MD, CEO

Segal Consulting

MEMORANDUM

To: David Archuleta, Executive Director

From: Melissa Bissett

Date: February 27, 2018

Re: NMRHCA GASB75 (OPEB) Reporting Status

David,

Segal proposed the following process to complete the June 30, 2018 GASB75 report to NMRHCA's auditor, MossAdams, on January 26th, 2018. The auditor approved this methodology via e-mail on February 2nd, 2018. This memo serves to inform the Board and request confirmation.

1.) Reporting Date – The reporting date for NMRHCA's 2017/2018 fiscal year is June 30, 2018. The measurement date and the valuation date will both be June 30, 2017. This means that assets and liabilities are determined as of June 30, 2017 and are not adjusted or "rolled forward" to June 30, 2018. This methodology will apply to all fiscal years going forward. This also means that we can use many of the results already found in the GASB 74 reports such as Total OPEB Liability (TOL), Net OPEB Liability (NOL), etc.

2.) Numbers of Years – We proposed showing one year of changes in the NOL for the GASB75 report. This would be for the period from July 1, 2016 through June 30, 2017 based on those measurement dates. There would be an NOL as of the beginning of the year and as of the end of the year along with changes in the NOL during year. There would be an OPEB expense determined for that year. The deferred inflows and outflows would be zero as of the beginning of the year, but would have values as of the end of the year.

3.) Allocation of Net OPEB Liability (NOL) – The Net OPEB Liability (NOL) is allocated (based upon a proportionate share) between employers. The auditor provided us with contributions for the July 1, 2016 to June 30, 2017 fiscal year by employer. We will use those contributions to allocate the NOL between the employers at June 30, 2017. We proposed usage of the exact same allocation percentages for the retiree health plan allocation as of June 30, 2016 as the contributions for the July 1, 2015 to June 30, 2016 fiscal year are not readily available. This means that the proportionate shares used for the allocation of NOL at June 30, 2017 and June 30, 2016 will be the same. The audit team approved this methodology.

4.) Compile results and present report – Segal is in the process of applying the fiscal year 2017 contributions by employer to the applicable components and developing results for review and ultimately, the valuation report. We anticipate completion by mid-April for internal review and May 4, 2018.

Should the Board have any questions or concerns, please let us know as soon as possible.
If none, please acknowledge your confirmation. We do not anticipate needing additional information from NMRHCA.

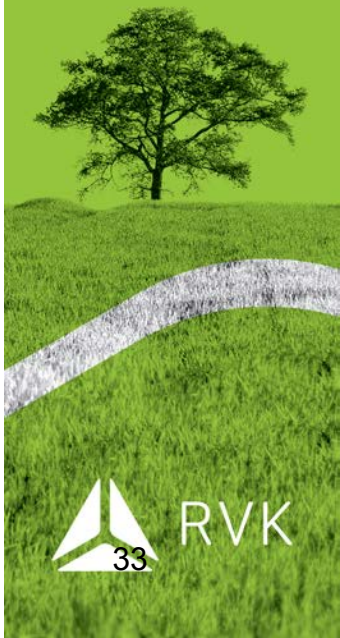
cc: Dave Bergerson, Segal Consulting
Gary Petersen, Segal Consulting
Kory Hoggan, Moss Adams
Aaron Hamilton, Moss Adams

5527922v3/05496.019

NEW MEXICO RETIREE HEALTH CARE AUTHORITY
CHANGE IN NET ASSET VALUE
FOR THE MONTH ENDED
January 31, 2018

	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 12/31/2017	$112,423,418.58	$135,922,988.29	$72,987,052.57	$97,370,595.50	$17,679,898.05	$59,338,924.36	$27,605,695.03	$64,932,836.92	$32,902,991.42	$621,164,400.72
CONTRIBUTIONS	1,000,000.00	1,000,000.00	600,000.00	750,000.00	150,000.00	500,000.00	250,000.00	500,000.00	250,000.00	5,000,000.00
WITHDRAWALS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FEES	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
INCOME EARNED	331,592.89	139,016.70	46,644.34	150,822.97	3,940.74	3,210.34	1,184.84	10,801.04	147,868.00	835,081.86
CAPITAL APPR/DEPR	(1,071,622.83)	7,370,729.76	3,373,650.58	7,865,620.18	300,375.41	251,041.96	225,767.17	269,085.18	(83,728.65)	18,500,918.76
Market Value 1/31/2018	$112,683,388.64	$144,432,734.75	$77,007,347.49	$106,137,038.65	$18,134,214.20	$60,093,176.66	$28,082,647.04	$65,712,723.14	$33,217,130.77	$645,500,401.34

Retiree Health Care Authority



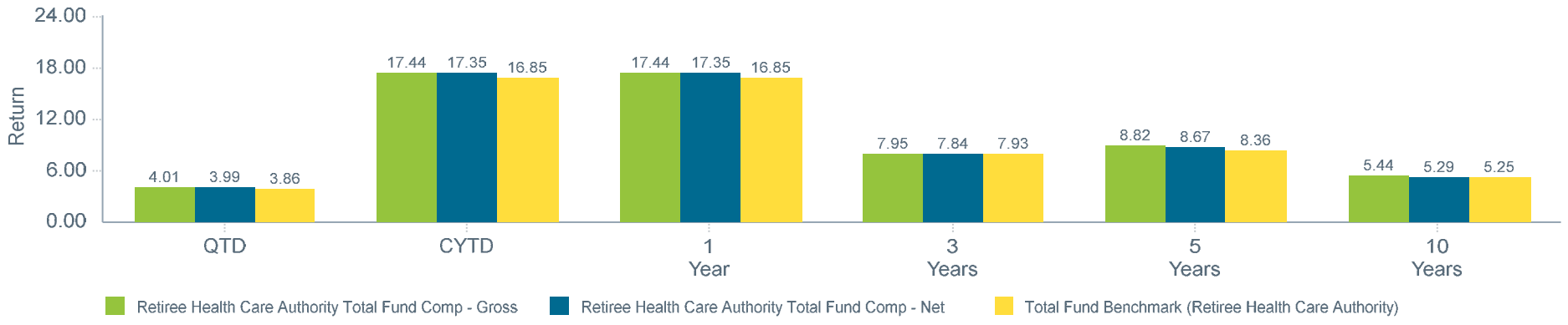
Overview

The New Mexico Retiree Health Care Authority (NMRHCA) was established in 1990 to provide health care coverage to retirees of state agencies and eligible participating public entities. Approximately 300 public entities including cities, counties, universities and charter schools participate in NMRHCA. The agency provides medical plans for both non Medicare and Medicare eligible retirees and their dependents as well as dental, vision and life insurance. The Authority currently provides coverage to approximately 58,000 retirees and their dependents.

Asset Allocation vs. Target Allocation

	Market Value ($)	Allocation (%)	Target (%)	Difference (%)
Large Cap US Equity Index	135,922,977	21.88	20.00	1.88
Small/Mid Cap US Equity Active	17,679,785	2.85	3.00	-0.15
Non-US Developed Markets Index	72,986,956	11.75	12.00	-0.25
Non-US Emerging Markets Index	97,370,518	15.68	15.00	0.68
US Core Plus Bonds	112,423,349	18.10	20.00	-1.90
Credit & Structured Finance	59,338,926	9.55	10.00	-0.45
Absolute Return	27,605,695	4.44	5.00	-0.56
Private Equity	64,932,494	10.45	10.00	0.45
Real Estate	32,902,991	5.30	5.00	0.30
Total Fund	621,163,690	100.00	100.00	0.00

Comparative Performance



Comparative Performance

	QTD	CYTD	1 Year	3 Years	5 Years	10 Years	2016	2015	2014
Retiree Health Care Authority Total Fund Comp - Gross	**4.01**	**17.44**	**17.44**	**7.95**	**8.82**	**5.44**	**8.09**	**-0.90**	**4.71**
Total Fund Benchmark (Retiree Health Care Authority)	*3.86*	*16.85*	*16.85*	*7.93*	*8.36*	*5.25*	*8.42*	*-0.76*	*4.88*
Difference	0.15	0.59	0.59	0.02	0.46	0.19	-0.33	-0.14	-0.17
Retiree Health Care Authority Total Fund Comp - Net	**3.99**	**17.35**	**17.35**	**7.84**	**8.67**	**5.29**	**7.99**	**-1.03**	**4.48**
Total Fund Benchmark (Retiree Health Care Authority)	*3.86*	*16.85*	*16.85*	*7.93*	*8.36*	*5.25*	*8.42*	*-0.76*	*4.88*
Difference	0.13	0.50	0.50	-0.09	0.31	0.04	-0.43	-0.27	-0.40

Schedule of Investable Assets

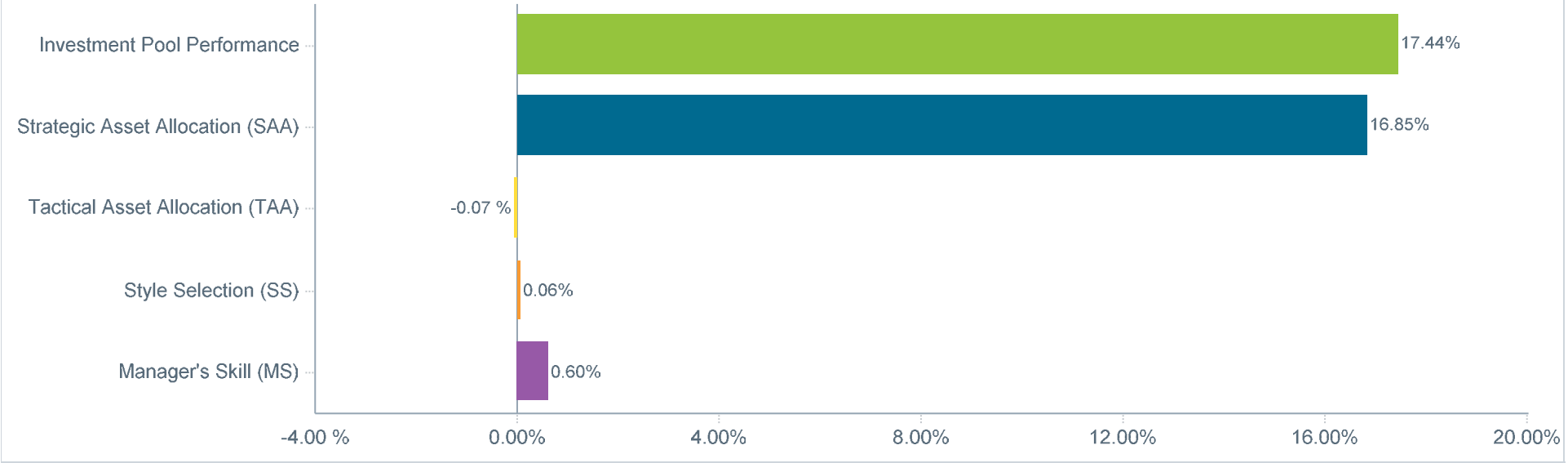
Periods Ending	Beginning Market Value ($)	Net Cash Flow ($)	Gain/Loss ($)	Ending Market Value ($)	% Return
CYTD	**495,629,841**	**36,000,000**	**89,533,848**	**621,163,690**	**17.35**

Allocations shown may not sum up to 100% exactly due to rounding. Performance shown is net of fees, except where noted otherwise.

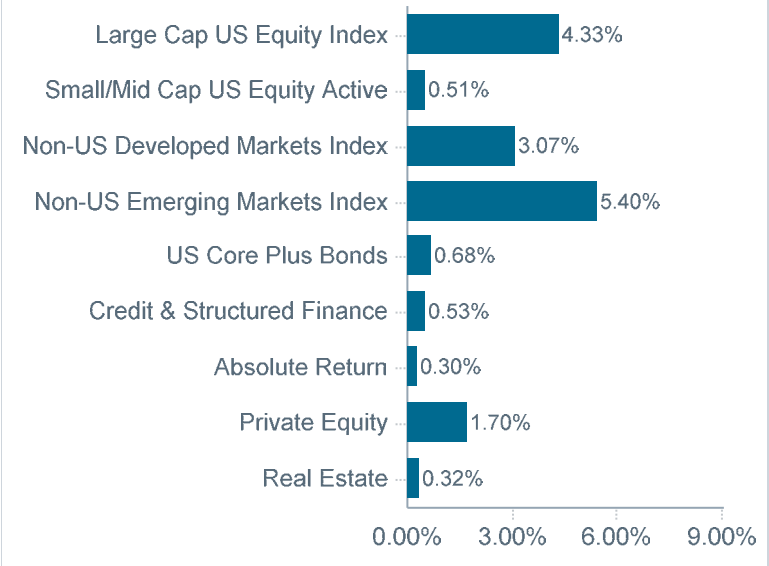
New Mexico State Investment Council
Retiree Health Care Authority Total Fund Comp
Total Fund Attribution - IDP

1 Year Ending December 31, 2017

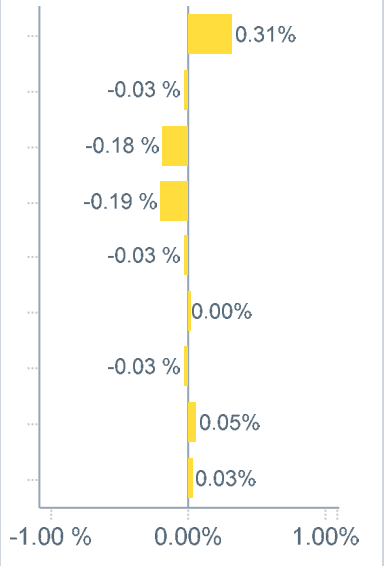
Performance Attribution



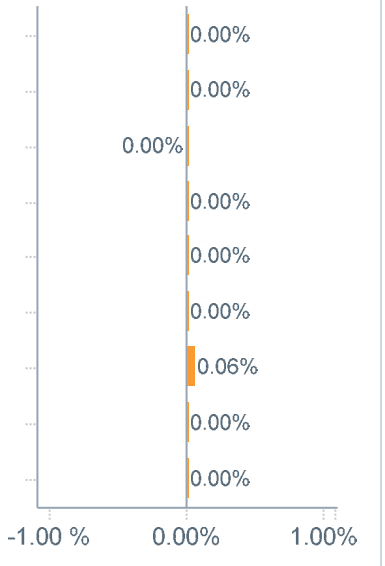
SAA: 16.85%



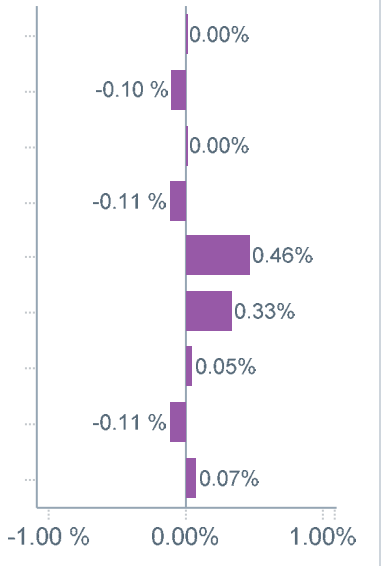
TAA: -0.07 %



SS: 0.06%



MS: 0.60%



Performance shown is gross of fees. Calculation is based on monthly periodicity. See Glossary for additional information regarding the Total Fund Attribution - IDP calculation.

	Allocation		Performance (%)										
	Market Value ($)	%	QTD	FYTD	CYTD	1 Year	3 Years	5 Years	10 Years	2016	2015	Since Incep.	Inception Date
NMSIC Total Fund Composite	**23,675,012,495**	**100.00**	**3.50**	**6.90**	**15.07**	**15.07**	**7.49**	**9.06**	**5.56**	**7.60**	**0.30**	**5.47**	**01/01/2000**
US Equity													
US Equity Composite	**6,236,849,771**	**26.34**	**6.55**	**10.90**	**21.20**	**21.20**	**10.96**	**15.24**	**8.59**	**12.02**	**0.63**	**6.52**	**05/01/1999**
Russell 3000 Index			*6.34*	*11.20*	*21.13*	*21.13*	*11.12*	*15.58*	*8.60*	*12.74*	*0.48*	*6.27*	
US Large Cap Equity Composite	**5,678,144,229**	**23.98**	**6.80**	**11.36**	**22.08**	**22.08**	**11.19**	**15.39**	**9.01**	**10.96**	**1.46**	**6.04**	**05/01/1999**
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*6.10*	
IM U.S. Large Cap Equity (SA+CF)			*6.63*	*11.47*	*21.72*	*21.72*	*11.06*	*15.69*	*8.77*	*10.98*	*0.95*	*6.99*	
US Large Cap Active Pool	**1,202,439,521**	**5.08**	**6.86**	**11.92**	**27.13**	**27.13**	**12.29**	**15.84**	**8.93**	**6.98**	**4.11**	**5.80**	**05/01/1999**
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*6.10*	
IM U.S. Large Cap Equity (SA+CF)			*6.63*	*11.47*	*21.72*	*21.72*	*11.06*	*15.69*	*8.77*	*10.98*	*0.95*	*6.99*	
Brown Brothers Harriman	583,982,843	2.47	6.24	8.62	20.27	20.27	8.84	12.62	N/A	9.03	-1.68	14.13	06/01/2012
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*16.02*	
IM U.S. Large Cap Core Equity (SA+CF)			*6.67*	*11.62*	*21.82*	*21.82*	*11.16*	*15.76*	*8.75*	*10.49*	*1.39*	*15.97*	
T. Rowe Price LC Growth	614,751,723	2.60	7.49	15.60	38.95	38.95	16.68	20.38	N/A	3.40	10.58	19.90	06/01/2012
Russell 1000 Grth Index			*7.86*	*14.23*	*30.21*	*30.21*	*13.79*	*17.33*	*10.00*	*7.08*	*5.67*	*16.90*	
IM U.S. Large Cap Growth Equity (SA+CF)			*6.91*	*12.63*	*28.10*	*28.10*	*12.14*	*16.53*	*9.55*	*4.64*	*4.97*	*16.18*	
US Large Cap Alternative Wtd Index Pool	**2,887,188,886**	**12.20**	**6.86**	**11.07**	**16.36**	**16.36**	**N/A**	**N/A**	**N/A**	**15.84**	**N/A**	**11.23**	**02/01/2015**
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*12.64*	
IM U.S. Large Cap Enhanced Index Equity (SA+CF)			*6.85*	*12.35*	*22.24*	*22.24*	*11.56*	*16.24*	*9.00*	*12.45*	*1.01*	*13.01*	
AQR US SPLO	1,220,683,643	5.16	7.30	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	10.05	08/01/2017
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*9.20*	
NT SciBeta US HFE Index	964,936,784	4.08	6.26	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	7.36	08/01/2017
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*9.20*	
NT Russell Fundamental LC Index Fund	672,119,444	2.84	7.07	11.88	17.33	17.33	N/A	N/A	N/A	16.69	N/A	11.76	02/01/2015
Russell RAFI US Index			*6.92*	*11.79*	*16.95*	*16.95*	*10.07*	*15.17*	*9.79*	*17.26*	*-2.76*	*11.73*	
NT S&P 600 Index Fund	28,250,146	0.12	3.96	10.75	N/A	N/A	N/A	N/A	N/A	N/A	N/A	14.05	06/01/2017
S&P Sm Cap 600 Index (Cap Wtd)			*3.96*	*10.16*	*13.23*	*13.23*	*12.00*	*15.99*	*10.43*	*26.56*	*-1.97*	*13.45*	

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	Allocation		Performance (%)										
	Market Value ($)	%	QTD	FYTD	CYTD	1 Year	3 Years	5 Years	10 Years	2016	2015	Since Incep.	Inception Date
US Large Cap Index Pool	**1,588,515,822**	**6.71**	**6.58**	**11.34**	**21.62**	**21.62**	**11.25**	**15.72**	**9.50**	**12.07**	**1.01**	**6.57**	**05/01/1999**
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*6.10*	
NT Russell 1000 Index Fund	1,588,144,577	6.71	6.58	11.31	21.60	21.60	11.21	15.70	N/A	12.06	0.93	14.21	08/01/2011
Russell 1000 Index			*6.59*	*11.36*	*21.69*	*21.69*	*11.23*	*15.71*	*8.59*	*12.05*	*0.92*	*14.28*	
IM U.S. Large Cap Core Equity (SA+CF)			*6.67*	*11.62*	*21.82*	*21.82*	*11.16*	*15.76*	*8.75*	*10.49*	*1.39*	*14.24*	
US Small/Mid Cap Equity Composite	**558,705,543**	**2.36**	**4.09**	**6.39**	**13.35**	**13.35**	**8.52**	**13.35**	**N/A**	**21.79**	**-7.42**	**9.85**	**05/01/2011**
US Small/Mid Cap Equity Custom Index			*4.15*	*9.38*	*15.84*	*15.84*	*9.89*	*14.42*	*8.88*	*19.06*	*-3.79*	*10.91*	
IM U.S. SMID Cap Equity (SA+CF)			*5.57*	*10.08*	*17.66*	*17.66*	*10.25*	*14.86*	*10.21*	*16.39*	*-1.42*	*11.68*	
US Small/Mid Cap Active Pool	**558,705,539**	**2.36**	**4.09**	**6.40**	**13.44**	**13.44**	**8.09**	**12.89**	**6.62**	**22.31**	**-8.99**	**8.54**	**11/01/1998**
US Small/Mid Cap Equity Custom Index			*4.15*	*9.38*	*15.84*	*15.84*	*9.89*	*14.42*	*8.88*	*19.06*	*-3.79*	*9.38*	
IM U.S. SMID Cap Equity (SA+CF)			*5.57*	*10.08*	*17.66*	*17.66*	*10.25*	*14.86*	*10.21*	*16.39*	*-1.42*	*11.80*	
Seizert Capital Partners	108,664,665	0.46	2.95	0.50	7.43	7.43	6.45	13.91	N/A	25.31	-10.39	15.32	01/01/2012
Russell Mid Cap Index			*6.07*	*9.75*	*18.52*	*18.52*	*9.58*	*14.96*	*9.11*	*13.80*	*-2.44*	*15.34*	
IM U.S. Mid Cap Equity (SA+CF)			*5.97*	*10.13*	*20.00*	*20.00*	*10.44*	*15.13*	*9.78*	*12.46*	*-1.19*	*15.54*	
Donald Smith & Company	203,673,430	0.86	7.77	10.13	17.54	17.54	5.70	10.35	N/A	13.87	-11.76	11.89	01/01/2012
Russell 2000 Val Index			*2.05*	*7.26*	*7.84*	*7.84*	*9.55*	*13.01*	*8.17*	*31.74*	*-7.47*	*13.83*	
IM U.S. Small Cap Value Equity (SA+CF)			*3.70*	*9.19*	*11.59*	*11.59*	*10.54*	*14.59*	*10.10*	*26.10*	*-4.30*	*15.17*	
BlackRock Alpha Tilts	162,989,768	0.69	2.23	7.19	11.70	11.70	9.79	14.97	N/A	23.29	-3.90	14.81	02/01/2012
Russell 2000 Index			*3.34*	*9.20*	*14.65*	*14.65*	*9.96*	*14.12*	*8.71*	*21.31*	*-4.41*	*13.39*	
IM U.S. SMID Cap Equity (SA+CF) Median			*5.57*	*10.08*	*17.66*	*17.66*	*10.25*	*14.86*	*10.21*	*16.39*	*-1.42*	*14.35*	
Cortina Asset Management	83,335,921	0.35	0.89	4.03	13.77	13.77	10.02	12.88	N/A	24.10	-5.67	12.00	01/01/2012
Russell 2000 Grth Index			*4.59*	*11.09*	*22.17*	*22.17*	*10.28*	*15.21*	*9.19*	*11.32*	*-1.38*	*15.10*	
IM U.S. Small Cap Growth Equity (SA+CF)			*4.84*	*11.17*	*23.62*	*23.62*	*11.44*	*15.76*	*9.51*	*11.40*	*-0.74*	*15.70*	

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	Allocation		Performance (%)										
	Market Value ($)	%	QTD	FYTD	CYTD	1 Year	3 Years	5 Years	10 Years	2016	2015	Since Incep.	Inception Date
Non-US Equity													
Non-US Equity Composite	**4,918,048,874**	**20.77**	**5.22**	**12.28**	**30.80**	**30.80**	**8.72**	**6.27**	**1.89**	**3.77**	**-5.32**	**5.98**	**05/01/1999**
Non-US Equity Custom Index			*5.23*	*11.82*	*27.81*	*27.81*	*7.89*	*6.25*	*1.82*	*4.41*	*-5.90*	*6.13*	
Non-US Developed Markets Composite	**4,109,168,202**	**17.36**	**4.82**	**11.40**	**29.02**	**29.02**	**9.62**	**9.14**	**2.77**	**2.48**	**-0.39**	**5.03**	**05/01/1999**
Non-US Developed Markets Custom Index			*4.50*	*10.45*	*26.16*	*26.16*	*8.27*	*8.19*	*2.08*	*1.15*	*-0.53*	*4.38*	
IM Int'l Equity Developed Markets (SA+CF)			*4.97*	*11.42*	*28.91*	*28.91*	*9.87*	*9.46*	*4.06*	*1.83*	*1.32*	*6.81*	
Non-US Developed Markets Active Pool	**2,305,356,738**	**9.74**	**5.01**	**11.93**	**30.60**	**30.60**	**10.08**	**N/A**	**N/A**	**3.15**	**-0.98**	**8.82**	**09/01/2013**
Non-US Developed Markets Custom Index			*4.50*	*10.45*	*26.16*	*26.16*	*8.27*	*8.19*	*2.08*	*1.15*	*-0.53*	*7.54*	
IM Int'l Equity Developed Markets (SA+CF)			*4.97*	*11.42*	*28.91*	*28.91*	*9.87*	*9.46*	*4.06*	*1.83*	*1.32*	*9.15*	
LSV Int'l Large Cap Value	577,964,534	2.44	5.30	12.80	28.29	28.29	8.06	N/A	N/A	7.10	-8.16	7.43	09/01/2013
MSCI ACW Ex US Val Index (USD) (Net)			*4.23*	*10.48*	*22.66*	*22.66*	*6.31*	*5.58*	*1.23*	*8.92*	*-10.06*	*5.92*	
IM Int'l Large Cap Value Equity (SA+CF)			*4.22*	*10.06*	*26.27*	*26.27*	*8.93*	*8.96*	*3.64*	*3.96*	*-1.92*	*8.06*	
T. Rowe Price Int'l Core	582,933,952	2.46	3.84	11.31	28.92	28.92	9.38	N/A	N/A	3.41	-1.83	8.92	09/01/2013
MSCI EAFE Index (USD) (Net)			*4.23*	*9.86*	*25.03*	*25.03*	*7.80*	*7.90*	*1.94*	*1.00*	*-0.81*	*7.21*	
IM Int'l Large Cap Core Equity (SA+CF)			*4.25*	*10.35*	*26.49*	*26.49*	*8.81*	*9.10*	*3.21*	*1.19*	*0.33*	*8.52*	
Neuberger Berman Int'l	236,056,717	1.00	4.00	11.18	28.31	28.31	N/A	N/A	N/A	-0.52	N/A	11.42	12/01/2015
MSCI EAFE Index (USD) (Net)			*4.23*	*9.86*	*25.03*	*25.03*	*7.80*	*7.90*	*1.94*	*1.00*	*-0.81*	*11.13*	
IM Int'l Large Cap Core Equity (SA+CF)			*4.25*	*10.35*	*26.49*	*26.49*	*8.81*	*9.10*	*3.21*	*1.19*	*0.33*	*11.94*	
MFS Int'l Large Cap Growth	408,093,331	1.72	6.17	11.96	34.12	34.12	11.90	N/A	N/A	2.96	1.46	8.27	10/01/2013
MSCI ACW Ex US Grth Index (USD) (Net)			*5.77*	*12.47*	*32.01*	*32.01*	*9.29*	*7.97*	*2.40*	*0.12*	*-1.25*	*6.94*	
IM Int'l Large Cap Growth Equity (SA+CF)			*4.98*	*11.51*	*31.26*	*31.26*	*9.76*	*9.22*	*4.21*	*-0.07*	*2.08*	*7.79*	
Templeton Int'l Small Cap Equity	500,300,993	2.11	5.59	11.96	33.64	33.64	11.01	N/A	N/A	0.06	2.31	8.38	10/01/2013
MSCI ACW Ex US Sm Cap Index (USD) (Net)			*6.56*	*13.92*	*31.65*	*31.65*	*11.96*	*10.03*	*4.69*	*3.91*	*2.60*	*8.41*	
IM Int'l Small Cap Equity (SA+CF)			*6.19*	*14.91*	*34.99*	*34.99*	*14.12*	*13.20*	*7.06*	*1.13*	*10.32*	*10.60*	
Non-US Developed Mkts Alt Wtd Index Pool	**996,987,025**	**4.21**	**4.69**	**10.82**	**27.69**	**27.69**	**N/A**	**N/A**	**N/A**	**2.12**	**N/A**	**13.42**	**12/01/2015**
MSCI EAFE IM Index (USD) (Net)			*4.50*	*10.45*	*26.16*	*26.16*	*8.64*	*8.54*	*2.42*	*1.15*	*0.49*	*11.84*	
IM Enhanced and Indexed Int'l Equity (SA+CF)			*4.99*	*11.37*	*26.20*	*26.20*	*8.20*	*8.27*	*2.62*	*4.52*	*-1.90*	*13.94*	
BLK MSCI World Ex-US IM Custom Factor Index	759,169,741	3.21	4.31	11.37	N/A	N/A	N/A	N/A	N/A	N/A	N/A	11.37	07/01/2017
MSCI Wrld Ex US IM Index (USD) (Net)			*4.46*	*10.59*	*25.17*	*25.17*	*8.11*	*7.97*	*2.28*	*2.95*	*-1.95*	*10.59*	
BLK FTSE Developed Ex US Min Var Index	236,700,715	1.00	6.00	9.45	26.76	26.76	N/A	N/A	N/A	4.26	N/A	14.01	12/01/2015
FTSE Developed Ex US Min Var Index			*6.08*	*9.45*	*26.77*	*26.77*	*10.38*	*9.61*	*6.01*	*3.90*	*2.11*	*13.89*	

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	Allocation		Performance (%)										
	Market Value ($)	%	QTD	FYTD	CYTD	1 Year	3 Years	5 Years	10 Years	2016	2015	Since Incep.	Inception Date
Non-US Developed Markets Index Pool	**806,824,439**	**3.41**	**4.46**	**10.54**	**25.84**	**25.84**	**8.34**	**8.02**	**2.25**	**1.11**	**-0.07**	**4.74**	**05/01/1999**
Non-US Developed Markets Passive Custom Index			*4.46*	*10.59*	*25.82*	*25.82*	*8.02*	*8.03*	*2.00*	*1.00*	*-0.81*	*4.34*	
IM Int'l Large Cap Core Equity (SA+CF)			*4.25*	*10.35*	*26.49*	*26.49*	*8.81*	*9.10*	*3.21*	*1.19*	*0.33*	*6.06*	
Alliance Bernstein MSCI World Ex US IM Index	806,713,451	3.41	4.46	10.55	25.83	25.83	8.06	8.00	2.13	1.07	-0.80	5.96	06/01/1998
AB Non-US Developed Markets Custom Index			*4.46*	*10.59*	*25.82*	*25.82*	*8.02*	*8.03*	*2.00*	*1.00*	*-0.81*	*4.64*	
IM Int'l Large Cap Core Equity (SA+CF)			*4.25*	*10.35*	*26.49*	*26.49*	*8.81*	*9.10*	*3.21*	*1.19*	*0.33*	*6.14*	
Non-US Emerging Markets Composite	**808,880,672**	**3.42**	**7.28**	**16.89**	**39.90**	**39.90**	**10.17**	**3.84**	**0.86**	**10.50**	**-13.49**	**8.94**	**05/01/1999**
MSCI Emg Mkts Index (USD) (Net)			*7.44*	*15.92*	*37.28*	*37.28*	*9.10*	*4.35*	*1.68*	*11.19*	*-14.92*	*8.70*	
IM Emerging Markets Equity (SA+CF)			*6.96*	*14.79*	*37.03*	*37.03*	*9.78*	*5.84*	*3.12*	*9.96*	*-12.66*	*10.92*	
Non-US Emerging Markets Active Pool	**702,278,346**	**2.97**	**7.30**	**17.13**	**40.70**	**40.70**	**11.02**	**N/A**	**N/A**	**10.34**	**-11.87**	**5.76**	**10/01/2013**
BlackRock Emg Mkts Opp Fund	414,969,237	1.75	7.88	16.92	39.85	39.85	11.92	N/A	N/A	13.74	-11.87	8.37	10/01/2013
MSCI Emg Mkts Index (USD) (Net)			*7.44*	*15.92*	*37.28*	*37.28*	*9.10*	*4.35*	*1.68*	*11.19*	*-14.92*	*6.24*	
IM Emerging Markets Equity (SA+CF)			*6.96*	*14.79*	*37.03*	*37.03*	*9.78*	*5.84*	*3.12*	*9.96*	*-12.66*	*7.15*	
William Blair Emg Mkts	287,289,994	1.21	6.38	17.43	42.23	42.23	N/A	N/A	N/A	4.09	N/A	18.69	12/01/2015
MSCI Emg Mkts Index (USD) (Net)			*7.44*	*15.92*	*37.28*	*37.28*	*9.10*	*4.35*	*1.68*	*11.19*	*-14.92*	*21.19*	
IM Emerging Markets Equity (SA+CF)			*6.96*	*14.79*	*37.03*	*37.03*	*9.78*	*5.84*	*3.12*	*9.96*	*-12.66*	*21.00*	
Non-US Emerging Markets Index Pool	**106,602,326**	**0.45**	**7.08**	**15.38**	**36.11**	**36.11**	**8.67**	**4.09**	**0.98**	**11.08**	**-15.14**	**9.02**	**05/01/1999**
MSCI Emg Mkts Index (USD) (Net)			*7.44*	*15.92*	*37.28*	*37.28*	*9.10*	*4.35*	*1.68*	*11.19*	*-14.92*	*8.70*	
Alliance Bernstein Emerging Markets Index	106,602,162	0.45	7.08	15.38	36.11	36.11	8.58	4.04	N/A	11.07	-15.33	5.15	11/01/2012
MSCI Emg Mkts Index (USD) (Net)			*7.44*	*15.92*	*37.28*	*37.28*	*9.10*	*4.35*	*1.68*	*11.19*	*-14.92*	*5.43*	
IM Emerging Markets Equity (SA+CF)			*6.96*	*14.79*	*37.03*	*37.03*	*9.78*	*5.84*	*3.12*	*9.96*	*-12.66*	*6.89*	
Fixed Income													
Fixed Income Composite	**5,899,178,095**	**24.92**	**0.86**	**2.31**	**5.86**	**5.86**	**3.75**	**3.83**	**4.87**	**5.53**	**-0.03**	**5.18**	**05/01/1999**
Fixed Income Custom Index			*0.48*	*1.50*	*3.97*	*3.97*	*3.23*	*2.54*	*2.34*	*5.32*	*0.45*	*3.33*	
US Core & Core Plus Bonds Composite	**2,949,929,332**	**12.46**	**0.67**	**1.95**	**5.37**	**5.37**	**3.50**	**3.34**	**4.82**	**5.19**	**0.03**	**5.49**	**05/01/1999**
US Core & Core Plus Bonds Custom Index			*0.39*	*1.29*	*3.71*	*3.71*	*2.40*	*2.19*	*2.67*	*3.06*	*0.46*	*3.51*	
IM U.S. Broad Market Core+ FI (SA+CF)			*0.61*	*1.78*	*4.87*	*4.87*	*3.24*	*3.02*	*5.32*	*4.74*	*0.27*	*5.72*	

Performance shown is gross of fees, except for Credit & Structured Finance, Absolute Return, Private Equity, Real Estate, and Real Return investments, which are shown net of fees. Since Inception date shown represents the first full month following initial funding. Fiscal year ends June 30. For other performance-related comments, please see the Addendum. For additional information, please see the Glossary. *Indicates performance is lagged 1 quarter.

	Allocation		Performance (%)										
	Market Value ($)	%	QTD	FYTD	CYTD	1 Year	3 Years	5 Years	10 Years	2016	2015	Since Incep.	Inception Date
US Core Plus Bonds Pool	**2,084,656,703**	**8.81**	**0.86**	**2.33**	**6.26**	**6.26**	**4.05**	**3.66**	**4.98**	**6.41**	**-0.36**	**5.57**	**05/01/1999**
Bloomberg US Unv Bond Index			*0.41*	*1.42*	*4.09*	*4.09*	*2.80*	*2.50*	*4.33*	*3.91*	*0.43*	*5.16*	
IM U.S. Broad Market Core+ FI (SA+CF)			*0.61*	*1.78*	*4.87*	*4.87*	*3.24*	*3.02*	*5.32*	*4.74*	*0.27*	*5.72*	
PIMCO Bloomberg US Universal	817,376,182	3.45	0.65	2.25	6.41	6.41	3.96	3.41	N/A	5.27	0.30	4.51	04/01/2011
PGIM Bloomberg US Universal	653,079,111	2.76	0.94	2.39	7.09	7.09	4.45	4.22	N/A	6.35	0.06	5.70	04/01/2011
Loomis Sayles Bloomberg US Universal	614,201,404	2.59	1.03	2.36	5.22	5.22	3.76	3.45	N/A	8.19	-1.86	5.05	04/01/2011
Bloomberg US Unv Bond Index			*0.41*	*1.42*	*4.09*	*4.09*	*2.80*	*2.50*	*4.33*	*3.91*	*0.43*	*3.65*	
IM U.S. Broad Market Core+ FI (SA+CF)			*0.61*	*1.78*	*4.87*	*4.87*	*3.24*	*3.02*	*5.32*	*4.74*	*0.27*	*4.27*	
US Core Bonds Index Pool	**865,272,629**	**3.65**	**0.22**	**1.06**	**3.36**	**3.36**	**2.17**	**N/A**	**N/A**	**2.64**	**0.53**	**2.20**	**11/01/2014**
BlackRock Core Bonds Fund	865,272,629	3.65	0.22	1.06	3.36	3.36	2.17	N/A	N/A	2.64	0.53	2.31	11/01/2014
Bloomberg US Agg Bond Index			*0.39*	*1.24*	*3.54*	*3.54*	*2.24*	*2.10*	*4.01*	*2.65*	*0.55*	*2.38*	
IM U.S. Broad Market Core FI (SA+CF)			*0.52*	*1.45*	*4.05*	*4.05*	*2.61*	*2.49*	*4.63*	*3.10*	*0.82*	*2.76*	
US Short Duration Fixed Income Pool	**379,983,837**	**1.60**	**-0.05**	**0.41**	**1.29**	**1.29**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**0.86**	**05/01/2016**
J.P. Morgan Asset Mgmt Short Duration	379,983,837	1.60	-0.05	0.41	1.29	1.29	N/A	N/A	N/A	N/A	N/A	0.86	05/01/2016
Bloomberg US Gov't Crdt 1-3 Yr Bond Index			*-0.21*	*0.13*	*0.84*	*0.84*	*0.93*	*0.84*	*1.85*	*1.28*	*0.65*	*0.61*	
IM U.S. Short Duration Fixed Income (SA+CF)			*0.00*	*0.49*	*1.51*	*1.51*	*1.36*	*1.25*	*2.35*	*1.60*	*0.93*	*1.11*	
Credit & Structured Finance Pool	**1,275,503,934**	**5.39**	**1.87**	**4.08**	**8.85**	**8.85**	**5.50**	**6.92**	**6.04**	**6.86**	**0.94**	**3.14**	**04/01/2006**
C&SF Primary Benchmark			*0.79*	*2.35*	*5.86*	*5.86*	*5.46*	*4.01*	*-5.19*	*13.64*	*-2.51*	*N/A*	
C&SF Secondary Benchmark			*0.92*	*2.41*	*6.05*	*6.05*	*4.95*	*4.05*	*-5.17*	*11.10*	*-1.87*	*N/A*	
Unconstrained Fixed Income Pool	**694,609,765**	**2.93**	**0.15**	**1.76**	**5.77**	**5.77**	**3.58**	**N/A**	**N/A**	**6.48**	**-1.32**	**3.24**	**12/01/2013**
ICE 3 Month LIBOR Index+2.50%			*0.91*	*1.86*	*3.64*	*3.64*	*3.19*	*3.02*	*3.36*	*3.18*	*2.74*	*3.07*	
GAM Unconstrained	307,581,120	1.30	-0.44	0.93	7.02	7.02	N/A	N/A	N/A	6.93	N/A	4.48	04/01/2015
ICE 3 Month LIBOR Index+2.50%			*0.91*	*1.86*	*3.64*	*3.64*	*3.19*	*3.02*	*3.36*	*3.18*	*2.74*	*3.22*	
PIMCO Unconstrained	159,312,965	0.67	0.61	2.61	5.57	5.57	2.80	N/A	N/A	5.17	-2.14	2.44	12/01/2013
Loomis Sayles Unconstrained	227,704,298	0.96	0.70	2.38	4.11	4.11	3.44	N/A	N/A	7.36	-0.99	3.45	12/01/2013
ICE 3 Month LIBOR Index+2.50%			*0.91*	*1.86*	*3.64*	*3.64*	*3.19*	*3.02*	*3.36*	*3.18*	*2.74*	*3.07*	
Absolute Return													
Absolute Return Composite*	**599,151,227**	**2.53**	**1.88**	**4.13**	**7.84**	**7.84**	**2.65**	**4.23**	**1.57**	**2.20**	**-1.86**	**2.66**	**09/01/2005**
Credit Suisse Hedge Fund Index (Lagged 1 Qtr)			*1.82*	*2.59*	*5.91*	*5.91*	*1.73*	*3.77*	*3.00*	*-0.01*	*-0.57*	*4.78*	
HFRI FOF Comp Index (Lagged 1 Qtr)			*2.31*	*3.13*	*6.50*	*6.50*	*1.91*	*3.58*	*0.88*	*0.38*	*-0.99*	*2.64*	

Performance shown is gross of fees, except for Credit & Structured Finance, Absolute Return, Private Equity, Real Estate, and Real Return investments, which are shown net of fees. Since Inception date shown represents the first full month following initial funding. Fiscal year ends June 30. For other performance-related comments, please see the Addendum. For additional information, please see the Glossary. *Indicates performance is lagged 1 quarter.

	Allocation		Performance (%)										
	Market Value ($)	%	QTD	FYTD	CYTD	1 Year	3 Years	5 Years	10 Years	2016	2015	Since Incep.	Inception Date
Cash Equivalent Composite	**169,675,405**	**0.72**	**0.38**	**0.61**	**1.24**	**1.24**	**0.58**	**0.60**	**0.91**	**0.39**	**0.12**	**3.62**	**07/01/1988**
BofA ML 3 Mo US T-Bill Index			*0.28*	*0.55*	*0.86*	*0.86*	*0.41*	*0.27*	*0.39*	*0.33*	*0.05*	*3.27*	
Private Equity													
Private Equity Composite (Ex. State)*	**1,995,579,105**	**8.43**	**3.66**	**7.65**	**15.93**	**15.93**	**9.59**	**10.39**	**7.31**	**7.39**	**5.73**	**5.18**	**06/01/2001**
Cambridge US Prvt Eq Index (Lagged 1 Qtr)			*3.87*	*7.57*	*16.79*	*16.79*	*10.39*	*13.27*	*9.59*	*8.65*	*6.01*	*11.39*	
Real Estate													
Townsend-Reported Real Estate Composite*	**1,947,901,911**	**8.23**	**2.28**	**4.49**	**8.04**	**8.04**	**11.30**	**11.61**	**2.44**	**11.52**	**14.42**	**4.82**	**10/01/2004**
NCREIF ODCE Index (AWA) (Net) (Lagged 1 Qtr)			*1.64*	*3.14*	*6.70*	*6.70*	*9.84*	*10.57*	*4.08*	*9.08*	*13.86*	*7.09*	
NCREIF/Townsend Wtd Index (Lagged 1 Qtr)			*2.15*	*4.07*	*8.19*	*8.19*	*11.13*	*11.79*	*3.71*	*10.57*	*14.71*	*7.73*	
Real Return													
Real Return Composite*	**2,144,040,044**	**9.06**	**1.10**	**1.54**	**5.74**	**5.74**	**1.83**	**4.09**	**N/A**	**9.30**	**-8.65**	**4.33**	**06/01/2012**
Real Return Custom Index			*2.05*	*3.43*	*3.27*	*3.27*	*1.24*	*0.10*	*1.57*	*6.23*	*-5.41*	*0.93*	
Financial Real Return Composite	**854,959,671**	**3.61**	**0.55**	**0.23**	**0.25**	**0.25**	**0.55**	**N/A**	**N/A**	**13.34**	**-10.53**	**2.15**	**06/01/2013**
Real Return Custom Index			*2.05*	*3.43*	*3.27*	*3.27*	*1.24*	*0.10*	*1.57*	*6.23*	*-5.41*	*0.56*	
Voya Floating Rate Bank Loans	179,163,979	0.76	1.05	2.06	3.29	3.29	4.41	N/A	N/A	9.26	0.86	4.02	06/01/2013
S&P/LSTA Lvg'd Loan Index			*1.11*	*2.16*	*4.12*	*4.12*	*4.44*	*4.03*	*4.85*	*10.16*	*-0.69*	*3.75*	
IM U.S. Bank Loans (SA+CF)			*1.24*	*2.45*	*4.46*	*4.46*	*4.78*	*4.52*	*5.20*	*9.51*	*0.76*	*4.15*	
Credit Suisse Floating Rate Bank Loans	149,853,126	0.63	1.10	2.34	3.74	3.74	4.58	N/A	N/A	8.60	1.54	4.01	08/01/2013
CS Lvg'd Loan Index			*1.17*	*2.24*	*4.25*	*4.25*	*4.50*	*4.33*	*4.57*	*9.88*	*-0.38*	*4.01*	
IM U.S. Bank Loans (SA+CF)			*1.24*	*2.45*	*4.46*	*4.46*	*4.78*	*4.52*	*5.20*	*9.51*	*0.76*	*4.18*	
Harvest MLP	390,427,020	1.65	-0.35	-2.59	-5.66	-5.66	N/A	N/A	N/A	19.55	N/A	-8.77	05/01/2015
S&P MLP Index (TR)			*-0.29*	*-2.74*	*-5.58*	*-5.58*	*-9.24*	*0.87*	*6.61*	*21.95*	*-35.07*	*-11.33*	
Waterfall Eden Fund, LP*	135,515,546	0.57	1.82	4.73	13.35	13.35	6.29	8.91	N/A	0.82	5.07	8.58	06/01/2012
BofA ML US HY Master II Index (Lagged 1 Qtr)			*2.03*	*4.22*	*9.06*	*9.06*	*5.87*	*6.38*	*7.72*	*12.82*	*-3.56*	*6.88*	
Townsend-Reported Real Return*	**1,202,156,905**	**5.08**	**1.79**	**2.89**	**10.69**	**10.69**	**3.84**	**8.81**	**N/A**	**9.94**	**-8.00**	**9.68**	**04/01/2011**
ETI													
Economically Targeted Investments	**38,618,811**	**0.16**	**0.26**	**1.84**	**-0.80**	**-0.80**	**2.86**	**1.92**	**-0.61**	**5.01**	**4.48**	**-0.98**	**07/01/1998**
BofA ML 3 Mo US T-Bill Index			*0.28*	*0.55*	*0.86*	*0.86*	*0.41*	*0.27*	*0.39*	*0.33*	*0.05*	*1.99*	
Severance Tax State PE Program*	**306,666,017**	**1.30**	**-3.85**	**-3.61**	**-4.28**	**-4.28**	**4.57**	**5.47**	**1.72**	**5.70**	**13.02**	**-2.89**	**08/01/2001**
Cambridge US VC Index (Lagged 1 Qtr)			*3.23*	*4.62*	*8.00*	*8.00*	*10.44*	*14.12*	*8.91*	*2.01*	*22.28*	*3.31*	

Performance is assumed 0.00% for one manager within the Absolute Return Composite as the data is currently unavailable.

Performance shown is gross of fees, except for Credit & Structured Finance, Absolute Return, Private Equity, Real Estate, and Real Return investments, which are shown net of fees. Since Inception date shown represents the first full month following initial funding. Fiscal year ends June 30. For other performance-related comments, please see the Addendum. For additional information, please see the Glossary. *Indicates performance is lagged 1 quarter.

Temporary Asset Allocation
Effective April1, 2018
Action Item

Background

In June 2017, New Mexico Retiree Health Care Authority (NMRHCA) received notice that the State Investment Council (SIC) would be making several changes to the pools in which NMRHCA current invests. Currently, NMRHCA's asset allocation is as follows:

Investment	Long Term Target
Large Cap Index	20.0%
Mid/Small Cap	3.0%
Non US Developed	12.0%
Emerging Markets	15.0%
Core Bonds	20.0%
Private Equity	10.0%
Real Estate	5.0%
Credit & Structured Finance	10.0%
Absolute Return	5.0%
	100.0%

The SIC has begun to divest from the Absolute Return Pool, which will require the reallocation those investments ($28 million). Professional investment advisory services are currently being procured to perform an updated asset allocation review and recommendation to the Board of Directors at its meeting in June. In the meantime, the SIC has recommended divesting from the Absolute Return pool.

Staff Recommendation

	Investment	Market Value January 31, 2018		Policy Range	Target March 31, 2018	Target April 1, 2018
1	Large Cap Index	$ 144,432,734.75	22%	15-25%	20%	20%
2	Mid/Small Cap	$ 18,134,214.20	3%	0-6%	3%	3%
3	Non US Developed	$ 77,007,347.49	12%	9-15%	12%	12%
4	Emerging Markets	$ 106,137,038.65	16%	12-18%	15%	15%
5	Core Bonds	$ 112,683,388.64	17%	10-30%	20%	25%
6	Private Equity	$ 65,712,723.14	10%	5-15%	10%	10%
7	Real Estate	$ 33,217,130.77	5%	2-8%	5%	5%
8	Credit & Structured Finance	$ 60,093,176.66	9%	5-15%	10%	10%
9	Absolute Return	$ 28,082,647.04	4%	0-10%	5%	0%
		$ 645,500,401.34	100%		100%	100%

NMRHCA staff is recommending the temporary asset allocation highlighted in the chart above. This includes the transfer of approximately $28 million in assets from the Absolute Return pool to Core Bonds. This recommendation is within the policy range recommended in 2015.

Requested Action

Staff respectfully requests permission to eliminate holding in the Absolute Return pool and increase holding in Core Bonds, until a revised asset allocation is adopted by the Board.

Budget Adjustment Request (BAR)
Healthcare Benefits Administration – Action Item

Background

The approved FY18 operating for the Healthcare Benefits Administration Program of the New Mexico Retiree Health Care Authority (NMRHCA) is show by category below. Current projections indicate a $13.1 million deficiency in the contractual services category to meet obligations related to our self-insured, Medicare Advantage and voluntary benefit contracts through the remainder of FY18.

2018 Budget Adjustment Request

Healthcare Benefits Administration Program					
		FY18 Approved / Adjusted Operating	Budget Adjustment Request	Adjusted Total	Projected Exp/Rev
300	Contractual Services	$ 317,089.5	$ 13,100.0	$ 330,189.5	$ 326,280.70
400	Other	$ 39.5		$ 39.5	$ 39.50
500	Other Financing Uses	$ 2,936.8	$ -	$ 2,936.8	$ 2,936.80
	Total	**$ 320,065.8**	**$ 13,100.0**	**$ 333,165.8**	**$ 329,257.00**
	Sources				
402101	Tax Suspense Fund	$ 26,256.00		$ 26,256.00	$ 26,256.20
441203	Interest	$ 60.00		$ 60.00	$ 50.00
471508	Employee/Employer Contributions	$ 126,066.10		$ 126,066.10	$ 127,000.00
471608	Retiree Contributions	$ 143,337.50	$ 13,100.00	$ 156,437.50	$ 170,000.00
496903	Miscellaneous	$ 24,346.00		$ 24,346.00	$ 25,000.00
		$ 320,065.60	$ 13,100.00	**$ 333,165.60**	**$ 348,306.20**

Healthcare Benefits Administration Contractual Services Information

FY18 Approved/Adjusted Operating Budget	**$317,089,500**	*	**$1,700 BAR Processed July 2017**				
Contracts	**Amount Encumbered YTD**		**Expended 2.26.18**	**Contract Balance**	**Percent Remaining**	**Projected Expenditure**	**Expenditures - Encumbrances**
BCBS -- Self Insured	105,000,000.00		72,191,606.24	32,808,393.76	31.2%	$ 112,670,606.00	$ (7,670,606.00)
NMHC	1,000,000.00		442,426.01	557,573.99	55.8%	$ 700,000.00	$ 300,000.00
Presbyterian -- Self Insured	47,500,000.00		29,612,129.17	17,887,870.83	37.7%	$ 47,054,129.17	$ 445,870.83
Presbyterian MA	12,950,000.00		8,962,081.90	3,987,918.10	30.8%	$ 14,082,081.90	$ (1,132,081.90)
BCBS MA	5,500,000.00		3,426,582.10	2,073,417.90	37.7%	$ 4,676,582.10	$ 823,417.90
Humana MA	750,000.00		317,586.57	432,413.43	57.7%	$ 767,856.57	$ (17,856.57)
UnitedHealthcare MA	6,500,000.00		4,218,860.41	2,281,139.59	35.1%	$ 5,858,860.41	$ 641,139.59
Express Scripts	100,000,000.00		67,025,851.69	32,974,148.31	33.0%	$ 107,025,851.09	$ (7,025,851.09)
United Concordia	10,500,000.00		6,649,648.05	3,850,351.95	36.7%	$ 10,039,648.05	$ 460,351.95
Delta	9,750,000.00		6,453,152.80	3,296,847.20	33.8%	$ 9,823,152.80	$ (73,152.80)
Standard	11,250,000.00		7,408,362.38	3,841,637.62	34.1%	$ 11,301,935.86	$ (51,935.86)
Davis Vision	2,500,000.00		1,501,994.22	998,005.78	39.9%	$ 2,279,994.22	$ 220,005.78
Total	**$313,200,000**		**$208,210,282**	**$104,989,718**	**33.5%**	**$ 326,280,698.17**	**$ (13,080,698.17)**
Unencumbered Balance	**3,889,500.00**		**3,889,500.00**	**3,889,500.00**	**100.0%**		
Contractual Services Category	**317,089,500.00**		**212,099,781.54**	**108,879,218.46**		**326,280,698.17**	**-13,080,698.17**

In September 2016, the New Mexico Retiree Health Care Authority submitted its FY18 appropriation request. This requested totaled $342.1 million, including $338.9 million for healthcare related services including all self-insured, Medicare Advantage and voluntary benefits. The chart below highlights the recommendations made by the Legislature, Executive and resulting Legislative and Executive action.

Amounts shown in thousands:

	FY17 Approved Operating	FY18 Request	LFC Recommendation	Exec Recommendation	HAFC
Healthcare Benefits Administration					
Contractual Services	$ 309,883.4	$ 338,970.4	$ 325,051.8	$ 298,860.0	$ 317,091.2
Other	$ 48.0	$ 42.3	$ 41.5	$ 37.8	$ 37.8
Other Financing Uses	$ 3,118.3	$ 3,118.3	$ 3,118.3	$ 2,807.7	$ 2,936.8
Subtotal	**$ 313,049.7**	**$ 342,131.0**	**$ 328,211.6**	**$ 301,705.5**	**$ 320,065.8**

Fiscal Implications

The BAR proposes to increase the use of retiree premiums (FY18 projected - $170 million) to support claim costs and meet obligations on behalf of existing participants through the remainder of FY18. This will ensure that all claims are paid within the fiscal year incurred. The legal authority granted under the applicable section of the General Appropriation Act allows for increases up to 5 percent of the total operating budget for agencies who collect revenues in excess of appropriated amounts. The request represents a 4.1 percent increase above the approved operating budget:

Approved Operating Budget: $320,065,800

5 percent allowance: $16,003,290

Requested amount: $13,100,000

Legal Authority

Laws of 2017, 1st Session, Chapter 135, Section 9 (D) allows for FY17 budget increases subject to the five percent rule

D. Unless a conflicting budget increase is authorized in Subsection E of this section, a program with internal service funds/interagency transfers appropriations or other state funds appropriations that collects money in excess of those appropriated may request budget increases in an amount not to exceed five percent of its internal service funds/interagency transfers ***or*** *other state funds appropriation contained in Section 4 of the General Appropriation Act of 2017.*

Requested Action

Staff respectfully requests authority to submit a budget adjustment request increasing the contractual services category of the Healthcare Benefits Administration program totaling $13.1 million to the State Budget Division and Legislative Finance Committee.

Investment Advisory Services
New Contract - Action Item

Background

The SIC has begun to divest from the Absolute Return Pool, which will require the reallocation those investments ($28 million). The timing of the need to convert these investments coincides with our biennial asset allocation review, last performed in October 2016. In response to upcoming changes, NMRHCA staff solicited qualified proposals to perform the scope of work described below.

Scope of Work

The Contractor shall perform the following work:

A. Asset and Liability Study

Contractor will review and assess the current asset allocation, and make recommendations associated with the asset classes available through State Investment Council investment pools as well as other investment channels that would be to the maximum benefit of the Agency.

B. Asset Allocation Policy

Contractor will develop an asset allocation recommendation based on asset classes currently available through current state statute and amended Joint Powers Agreement. This will involve analyzing current and historical market trends in the asset classes offered by the State Investment Council. It will also include a comparison of NMRHCA's investment strategy vs. a limited number of Other Post Employment Benefit ("OPEB") plans. Part of the asset allocation process will be the determination of the optimal rebalancing range. The recommended asset allocation should include a short-term projected rate of return (1 – 5 years) and a long-term projected rate of return (5 – 20 years).

C. Setting Investment Policies and Guidelines

Contractor will review and make recommendations on NMRHCA's statement of investment policy, which will reflect not only the results of the asset and liability projection, but will also incorporate a qualitative assessment of the Fund's risk tolerance.

Contractor will provide a written and oral report on its findings to the Board of Directors.

D. Warranties

Contractor agrees and warrants to the following:

1. That it is registered as an investment advisor under the investment Advisors Act of 1940 and that it shall maintain such registration at all times during the term of the contract.

2. That it will be a fiduciary of the NMRHCA and will not delegate its fiduciary responsibilities assumed under contract.

3. That is has completed, obtained, and performed all registrations, filings, approvals, authorizations, consents, or examinations required by any applicable regulatory body or governmental authority, including the State of New Mexico for acts contemplated under the contract.

NMRHCA acknowledges and agrees that:

1. Contractor has not made and cannot make any promise, guarantee or other statement or presentation regarding the future performance of NMRHCA's account;

2. The past performance of the accounts of other clients of Contractor is not necessarily indicative of future performance of NMRHCA's account;

3. Anything in this Agreement to the contrary notwithstanding, Contractor shall not be liable as a fiduciary for any activities not deemed to be fiduciary activities under applicable law.

Proposals Received

NEPC, LLC

Principal Consultant: Alan Martin

Founded in 1986, NEPC is employee-owned and one of the industry's largest independent, full-service investment consulting firms, serving over 360 retainer clients with total assets over $1 trillion. According to: http://www.nepc.com/about-us,"NEPC's collective client base has outperformed the InvestorForce/ICC median in 26 of the 31 years" since its founding.

Cost: $45,000 – paid in full at the completion of the project.

Wilshire Consulting

Principal Consultant: Thomas Toth

Started in 1972, Wilshire Associates evolved from an investment technology firm to a global advisory company specializing in investment products, consulting services and technology solutions. In 1981, Wilshire Consulting was established to provide the fund sponsor community with customized solutions. According to: https://wilshire.com/aboutus, as of September 30, 2017, Wilshire Consulting has more than $988 billion in assets under advisement and $8.3 billion in discretionary assets under management.

Cost: $40,000 – paid in full at completion of the project.

Meketa Investment Group

Principal Consultant: Ted Benedict

Meketa Investment Group is a full service investment consulting and advisory firm, founded in 1974. The firm originated by providing investment strategy and systems advice to Harvard Management Company (Harvard University Endowment). Since 1978, Meketa Investment Group has grown and consults on over $600 billion in assets for 166 clients. For additional information see: http://www.meketagroup.com/about-meketa-group-investment-advisors.asp

Cost: $47,500 – payable half in advance at the time of engagement and remaining half within 30 days of submission of report to Board of Directors.

Staff Recommendation

NMRHCA staff recommends the selection of Wilshire Consulting to perform the Scope of Work described above and include a six-month follow-up offered as part of proposal.

BOSTON MA
CHICAGO IL
MIAMI FL
PORTLAND OR
SAN DIEGO CA
LONDON UK

Via Email: david.archuleta@state.nm.us

February 7, 2018

Mr. David Archuleta
Executive Director
New Mexico Retiree Health Care Authority
4308 Carlisle Boulevard, NE, Suite 104
Albuquerque, NM 87107

RE: ASSET ALLOCATION REVIEW SERVICES FOR THE NEW MEXICO RETIREE HEALTH CARE AUTHORITY

Dear Mr. Archuleta:

Thank you for considering Meketa Investment Group to provide NMRHCA with an Asset Allocation and Investment Policy & Guidelines Review. We respectfully submit the enclosed proposal. We are a full-service investment consulting firm, advising on over $600 billion in assets for 166 clients.

We have significant experience with the services requested as these are services we provide regularly to our full-retainer clients. We have also conducted Asset Allocation Reviews as one-time projects for a number of clients. The breadth of experience we bring, given our history of work with public funds, healthcare entities, and clients in the state of New Mexico makes us well-qualified and excited about the opportunity to work on this project. We are prepared to provide a review that will include an examination of the existing Investment Policy Statement, a review of the current asset allocation and recommendations for current asset allocation as well as for a short-term projected rate of return and a long-term projected rate of return.

As noted in our proposal, our fee to provide this project will be $47,500. We have the staff and the resources to begin as quickly as NMRHCA would like to proceed.

Again, we appreciate your consideration and look forward to working with you. If our proposal is acceptable, we would be happy to proceed with a sending you a draft contract for the scope of services for you to review and execute. In the meantime, please do not hesitate to contact me at (760) 795-3450 if you have any questions.

Sincerely,

Ted G. Benedict, CFA, CAIA
Managing Principal

enclosures

BOSTON MA
CHICAGO IL
MIAMI FL
PORTLAND OR
SAN DIEGO CA
LONDON UK

MEKETA INVESTMENT GROUP

PROPOSAL TO PROVIDE
ASSET ALLOCATION REVIEW SERVICES
FOR THE
NEW MEXICO RETIREE
HEALTH CARE AUTHORITY

Submitted by
Meketa Investment Group
February 7, 2018

5796 ARMADA DRIVE SUITE 110 CARLSBAD CA 92008
760 795 3450 fax 760 795 3445 www.meketagroup.com

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FIRM OVERVIEW AND QUALIFICATIONS

Meketa Investment Group is a full service investment consulting and advisory firm, founded in 1974. We have been in business continuously for four decades providing investment consultant services to institutional clients. The firm originated by providing investment strategy and systems advice to Harvard Management Company (Harvard University Endowment). The firm was hired by its first client in 1978, a relationship that continues to this day. Since 1978, Meketa Investment Group has grown steadily and consults on over $600 billion in assets for 166 clients.

Meketa Investment Group has a staff of 143, including 96 investment professionals. The firm's Investment Advisory Services Department is composed of 46 consultants, 31 investment analysts, and 19 performance/data analysts. Our consultants are highly experienced and well trained in the field of investment consulting; 23 are CFA Charterholders and 16 are CAIA Charterholders. Our consultants average 9 years of experience at Meketa Investment Group and 20 years in the industry, providing stable, long-term relationships for our clients.

We have significant experience with the services requested as these are services we provide regularly to our full-retainer clients. We have also conducted Asset Allocation Reviews as one-time projects for a number of clients. The breadth of experience we bring, given our history of work with public funds and health care funds, and clients in the state of New Mexico makes us well-qualified and excited about the opportunity to work on this project. With every new retainer client, we undertake a comprehensive Initial Fund Review. The Initial Fund Review includes an examination of the existing Investment Policy Statement, asset allocation policy and asset allocation structure, among other issues. Our review includes appropriate recommendations, and prioritizes these recommendations within an appropriate timeframe for implementation. In addition, we continuously provide review and recommendations on asset allocation for our clients.

We feel we would excel at a mandate such as this one for the following reasons:

- We have experience conducting one-time reviews for various plan sponsors with similar objectives and tasks for the review. We can provide referrals as needed.
- We specialize in providing custom solutions to our clients. As such, conducting this type of review is integral to our organization.
- We have the resources to conduct this project. Meketa Investment Group has significant resources to allocate to each client. Each consultant works with an average of 5-8 clients, allowing us to focus on every client's unique needs. This allows us to conduct specialized research and projects for the benefit of our clients.

Finally, we are not shy about making recommendations to our clients. That is our job, and the reason we are retained. We would be pleased to provide a review of the Fund, as well as our direct recommendations.

SCOPE OF SERVICES

Meketa Investment Group has the experience, staff, and resources to complete the scope of services requested by the NMRHCA. We will review the current asset allocation and make recommendations regarding asset classes available through State Investment Council investment pools; as well as other investment channels. We will develop an asset allocation recommendation based on asset classes currently available through current state statute and amended JPA. We will analyze current and historical market trends in the asset classes offered by State Investment Council (SIC). We will also compare NMRHCA's investment strategy vs. a number of peer plans. Our review will include a short-term and long-term projected rate of return. In addition, we will review and make recommendations on NMRHCA's Investment Policy Statement.

METHODOLOGY

We have been providing strategic asset allocation services since our inception and consider it a core competency of the firm. In addition to providing asset allocation review for all of our full service retainer clients, we are frequently engaged to provide asset allocation services on a project basis.

More than any other decision, the asset allocation decision will determine the risk and return behavior of a fund. Because asset allocation is crucial to a fund meeting its long-term objectives, our consultants spend considerable time developing, implementing, monitoring, and adjusting client asset allocations. Our asset allocation services for all clients share the following elements:

- **Identification and clarification of client objectives and constraints**

  The success of any asset allocation strategy can only be judged in the context of client-specific circumstances. Meketa Investment Group works closely with our clients and their other professionals (e.g., actuaries) to define clearly and explicitly quantify the return objectives and risk parameters governing their funds. We regularly review and make recommendations regarding our client's Investment Policy Statements to establish documented governance procedures, and to ensure consistency and ongoing compliance with the investment program.

- **Establishment of target asset allocations and acceptable variance ranges**

  In recommending target asset allocations for our clients, we rely on a combination of resources. We utilize analytical software to examine historical asset class behavior and to evaluate optimum portfolios under various scenarios and constraints. However, we believe our value added does not stem from our ability to use computerized analytical tools, but from our ability to use qualitative research, experience, and common sense to evaluate quantitative data and apply real-world solutions. Our target asset allocations typically include variance ranges designed to avoid frequent rebalancing and the associated costs.

- **Development of cost-effective transition and rebalancing plans**

  Asset allocations will drift gradually over time, and may change more abruptly in certain circumstances. Meketa Investment Group works with clients to implement cost-effective, non-disruptive methods for restoring or adjusting fund asset allocations. In all cases, the specific plan for rebalancing will identify those assets that can be shifted at the lowest possible risk and cost, if the rebalancing cannot be accomplished solely by allocating contributions and withdrawals.

- **Ongoing review and monitoring of asset allocation, with recommendations, as needed**

  Meketa Investment Group continuously monitors client asset allocations, and addresses asset allocation explicitly each quarter in our written fund reviews.

Our asset allocation methodology includes employing both market expectations and market history. That is, we use both probabilistic and deterministic methods in evaluating the sensitivity of the fund's assets to different capital market environments.

Meketa Investment Group uses strict definitions to identify appropriate asset classes for long-term investments. From the essentially limitless universe of assets, we identify those assets that exhibit characteristics that make them accessible and investable to institutional investors. From the group of asset classes that can be utilized by long-term investors, we then identify those asset classes that we believe are appropriate for long-term allocations of client funds.

Asset Allocation Process

Given that asset allocation will be the primary determinant of the fund's risk and return characteristics, the first step is to review the fund's asset allocation policy. The past decade has underscored many shortcomings of institutional asset allocation processes. Among these is an inordinate reliance on mean-variance optimization, which - as practiced by institutional investors - systematically obscures the dynamism and risk in capital markets. In response, there is a growing movement toward an asset allocation framework that incorporates a more complete picture of investing environments, but that still retains the simplicity and practicality of traditional approaches. Our asset allocation review involves multiple steps that are designed to provide an all-encompassing analysis of the risks facing a fund and how they affect its assets.

First, we fully evaluate the fund's current status, which includes interfacing with the client's staff and professional service providers. In this step, we strive to understand the overall goal of the fund, how it is invested, and what its spending and distribution goals are.

Second, we analyze both assets and liabilities through the lens of a constrained mean-variance optimization ("MVO"). Though imperfect, MVO presents a rough picture of the portfolios that will provide the best return for the funding risk. The inputs we use are generated annually by our own research staff, providing us a solid understanding of the caveats that accompany these inputs.

Third, we seek to further dissect the risk compositions of the portfolios. We perform a risk budgeting analysis to highlight the source and scale of portfolio-level risk, including identification of the portfolios' true risk exposures by asset class. We conduct MVO-based risk analytics, include worst-case return expectations and Value at Risk ("VaR") analyses. We stress test our proposed allocations using a variety of relevant scenarios, including both historical and

hypothetical. These scenario analyses reveal the best and the worst possible performance the fund could reasonably expect based on history, both in terms of asset levels and liabilities.

Fourth, we view our proposed allocations through the lens of economic regime allocation. In this analysis, we seek to identify how the portfolio will perform (from both an asset and a distribution standpoint) in common economic environments, such as low growth or high inflation. This analysis provides added perspective about the economic risks the fund may be assuming.

We then conduct a thorough liquidity analysis of our proposed portfolios that evaluates the fund's shorter term spending and distribution needs given a variety of economic and capital market scenarios (e.g., rising interest rates, deflation, recession, etc.).

Finally, it is important that this process be open and iterative. We would expect this process to take at least several months with ongoing and meaningful communication between the Meketa Investment Group and the Board. We would provide full transparency to the Board on how we produce our assumptions and arrive at our recommendations.

Following the selection of an appropriate asset allocation policy for the fund, we would then work with the Board to devise a comprehensive implementation plan and timeline.

Investment Policy and Guidelines

Our review of the Investment Policy Statement will identify goals and objectives, investment constraints (legal/regulatory, time horizon, liquidity, taxes), risk and return, diversification, asset allocation (permissible asset classes, expected returns, risks, correlations, target ranges, rebalancing), costs, proxy voting, and forbidden assets and strategies. We will establish guidelines for implementation and define responsibilities of the Board, investment managers, consultants and other service providers. We will make recommendations to the improvement to NMRHCA's Investment Policy Statement. The result of this review is an investment policy statement that describes the fund's return expectations, the types of investment risks that can be assumed, and the rules used to measure these returns and risks. Most importantly, this document includes our recommendations for a long-term asset mix for the fund.

WORK PLAN

Meketa Investment Group has a clear understanding of the scope of work and is available to start working immediately to make sure the review is done in a timely manner. We would plan for the following timeline:

Week 1 to Week 3

- Gather all critical data for NMRHCA (providers, policies, investments, and assets owned, etc.)
- Begin review of investment policy, asset allocation, risk, liquidity and other critical components

Week 4 to Week 6

- Complete initial investment policy review
- Complete initial asset allocation review
- Finalize draft report for review and comment

Week 7 to Week 9

- Review investment policy with NMRHCA
- Review asset allocation review with NMRHCA
- Create final report, including executive summary and recommendations
- Deliver and present final comprehensive report and recommendations incorporating initial feedback and comments from NMRHCA to the Board of Directors

COST PROPOSAL

Meketa Investment Group is excited to work with NMRHCA and we would welcome the opportunity to discuss our proposal with the Board of Directors.

Our proposed fee to provide a review of investment policies, guidelines and asset allocation including providing recommendations would be:

One-time project-based fee of $47,500,
payable half in advance at the time of the engagement
and the remaining half within 30 days of submission of our report to the Trustees.

WILSHIRE ASSOCIATES

Wilshire Consulting

Wilshire Project Proposal

Prepared for

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

Mr. David Archuleta
Executive Director
New Mexico Retiree Health Care Authority
4308 Carlisle Blvd. NE, Suite 104
Albuquerque, NM 87107-4849

Prepared by

Thomas Toth
Managing Director | Wilshire Consulting
Wilshire Associates Incorporated
370 Interlocken Blvd., Suite 620
Broomfield, CO 80021
Office: 303.626.7448

INTRODUCTION

Thank you for inviting Wilshire Associates Incorporated ("Wilshire") to submit a proposal to conduct an asset and liability study for the New Mexico Retiree Health Care Authority ("NMRHCA"). In the attached, you will find our approach to and experience with projects of this nature, the credentials of the key Wilshire individuals assigned to this project and our fee based upon the scope of work described.

SCOPE OF SERVICES

The objective of this project is to conduct an asset allocation analysis of the current portfolio and offer an opinion on how to best optimize capital moving forward.

Asset and Liability Study

Wilshire will review and assess the current asset allocation and make recommendations associated with the asset classes available through State Investment Council investment pools; as well as other investment channels which would be to the maximum benefit of the Agency.

Asset Allocation Policy

Wilshire will develop an asset allocation recommendation based on asset classes currently available through current state statute and amended Joint Powers Agreement. This will involve analyzing current and historical market trends in the asset classes offered by State Investment Council (SIC). It will also include a comparison of NMRHCA investment strategy vs. a limited number of Other Post Employment Benefit ("OPEB") plans. Part of the asset allocation process will be the determination of the optimal rebalancing range. The recommended asset allocation should include a short-term projected rate of return (10 years) and a long-term projected rate of return (30 years).

Setting Investment Policies and Guidelines

Wilshire will review and make recommendations on NMRHCA's statement of investment policy which will reflect not only the results of the asset and liability projection, but will also incorporate a qualitative assessment of the Fund's risk tolerance.

Wilshire will provide a written and oral report on its findings to the Board of Directors and a follow-up report approximately 6 months later.

RELEVANT EXPERIENCE

Our Mission

Wilshire Consulting's mission is to empower its clients to achieve the financial strength necessary to fuel secure retirements, further philanthropic endeavors and advance unique objectives.

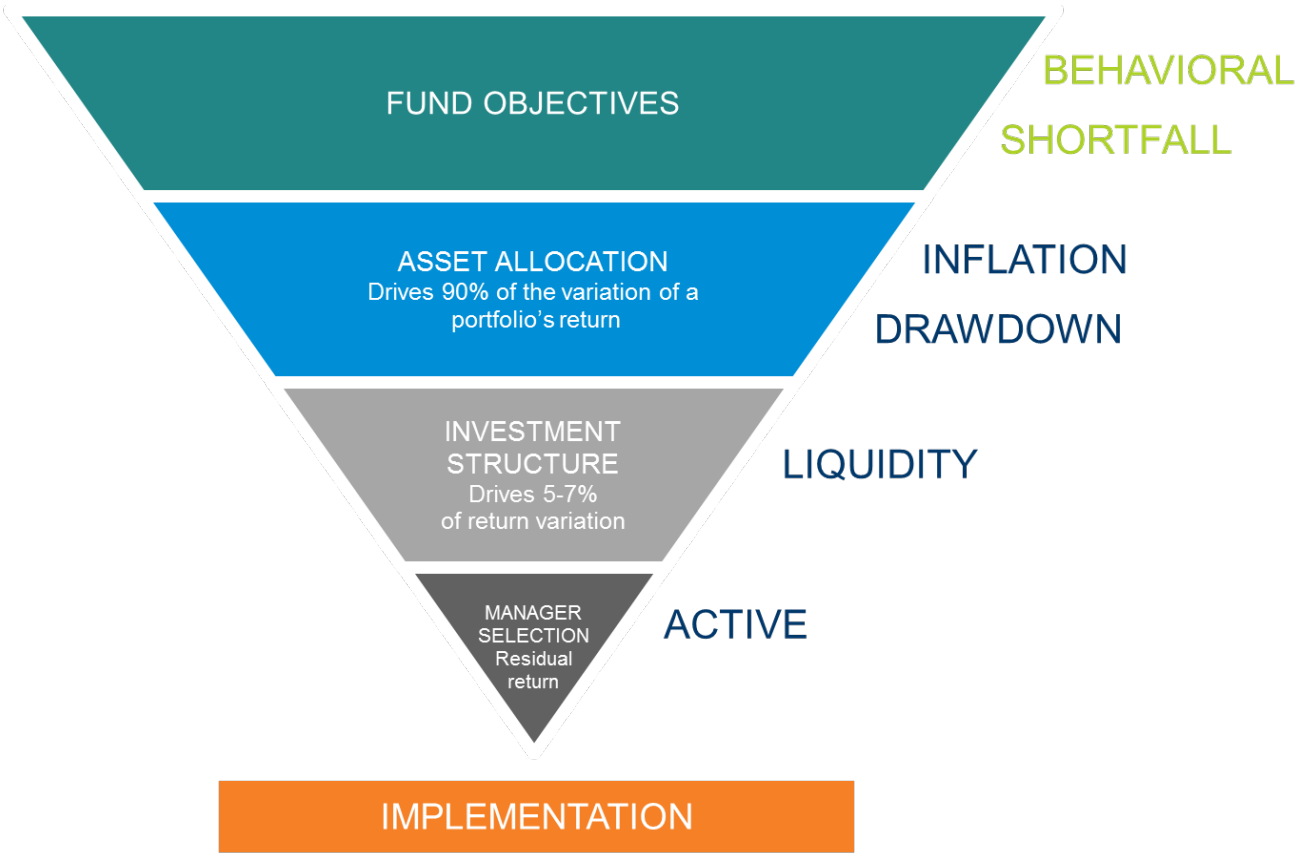
We fulfill our mission by leveraging Wilshire's global footprint, culture of risk management, and four decades of experience and expertise to assist our clients in successfully addressing the challenges presented to institutional investors by ever-evolving capital markets. We are our clients' trusted advocate for building disciplined, efficient and innovative portfolios.

For over 35 years, Wilshire has provided investment consulting services to public entities and many of the nation's largest plans. We strive to provide the highest-caliber investment consulting services all the while taking into consideration the clients' values based principles. Experienced senior consultants are involved in the day- to-day relationship rather than handing off most of the work to junior staff. We assist our clients in meeting their objectives in a number of ways through thoughtful recommendations based upon sound and objective investment principles and not emotion-driven short term phenomena.

Our Philosophy

Wilshire Consulting's philosophy is built upon years of capital market research and a culture oriented toward risk management. We believe that every client is subject to six key governance risks, to varying degrees, and our philosophy is tied to viewing consulting engagements through these risk lenses. The key risk lenses for governance are shortfall risk, behavioral risk, drawdown risk, inflation risk, liquidity risk, and active risk. While each client's portfolio and risk tolerance profile is unique, we have found that the key points below serve as general guidelines to building a sound investment program that seeks to achieve an organization's goals with a thorough knowledge of the inherent risks.

As the following illustration outlines, we view our philosophy through our six "risk lenses." Our investment philosophy begins with the tenet that asset allocation is the key determinant of a portfolio's risk and return profile, and therefore is the primary factor in determining the success of an investment program. While investment structure and manager selection are still important, we encourage our clients to focus on their specific objectives and risk tolerance and allocate their time and energy in working with Wilshire on building an appropriate asset allocation policy.



Our Team

For this project, we are proposing that NMRHCA be serviced by a team of Wilshire professionals led by Thomas Toth, CFA, Managing Director. While any number of Wilshire professionals will work on various facets of the required services, Mr. Toth will be the central point of contact and will be available to assist with day-to-day communications.

Name:	Thomas Toth, CFA
Title:	Managing Director
Address:	370 Interlocken Blvd., Suite 620 Broomfield, CO 80021
Email address:	ttoth@wilshire.com
Phone Number:	(303) 626-7448

Mr. Toth will work closely with Wilshire's Asset Allocation Group consisting of Ned McGuire, FSA, CFA, FRM, Managing Director, and Brice Shirimbere, Senior Associate.

Wilshire's Asset Allocation Group is staffed and supported by a diverse and broad team of investment professionals and will leverage resources across Wilshire Consulting including: Capital Markets Research (six professionals), Manager Research (70+ professionals, combined resources within Wilshire), Wilshire Compass (three professionals), Operations (eight professionals), Performance Reporting (21 professionals), Securities and Index Database Technology (seven professionals, combined resources within Wilshire) as of September 30, 2017.

ASSET ALLOCATION METHODOLOGY

We believe that strategic asset allocation is the key to a successful investment program. Industry research and our experience indicate that the asset allocation decision has the greatest impact on a portfolio's long- term return and risk profile. Wilshire embraced this important concept the 1970's when Wilshire became an early innovator in creating integrated asset/liability analysis / simulation models. Since that time, Wilshire has added to its asset allocation credentials by performing thousands of asset allocation studies and continually evaluating and enhancing our methodology.

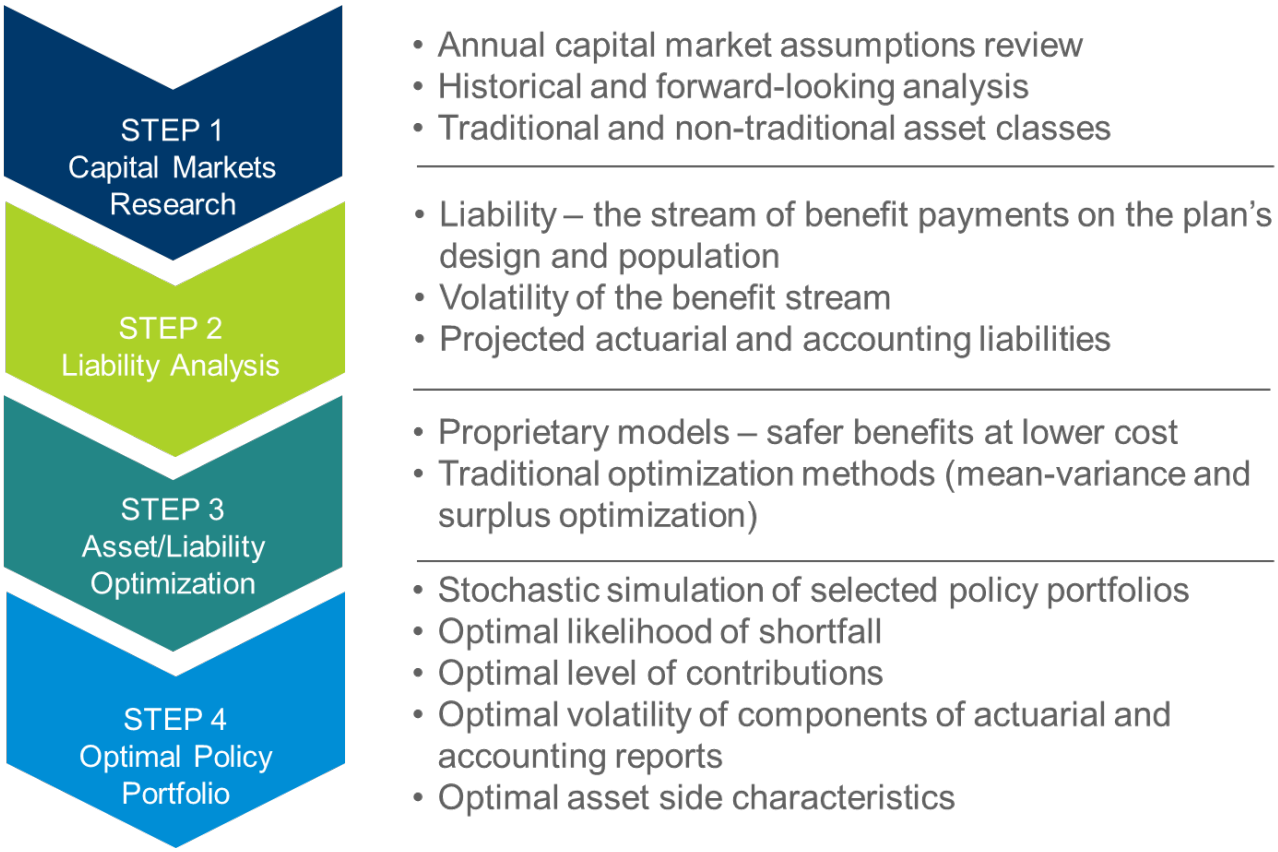
Wilshire has continued this tradition by offering an integrated approach to asset / liability modeling. This approach is based on the dual objective of maximizing the safety of benefits at a given level of resources while simultaneously minimizing the long-term costs at an acceptable level of risk. Risk is defined differently for specific investor objectives, and our approach explicitly looks to minimize the risk that is important to the fund.

Wilshire utilizes proprietary optimization methodologies (as well as existing ones, such as mean-variance and surplus optimization) to select a comprehensive set of efficient policy portfolios. A stochastic simulation program illustrates the impact of the policy portfolio choice on contribution requirements and balance sheet impacts. These simulations are based on forward-looking expectations (return, risk and correlations) for the major asset classes as projected by Wilshire's annual asset allocation study. The model simultaneously projects assets and liabilities consistent with the plan's actuarial and capital market assumptions for as many years as needed.

The optimal policy portfolio is a function of the client's current financial condition, tolerance for various risks, overall investment objectives, liquidity needs, applicable legal constraints, unique considerations with respect to plan design or participants, and the capital market opportunities available to the client.

The Decision Process

The following diagram depicts a four-step process that Wilshire uses for recommending an allocation policy.



Wilshire consultants work with each client to identify the opportunity set of asset classes to be considered and alternative portfolios that best meet long-term goals while minimizing short-term risks. After selecting the optimal policy portfolio, Wilshire prepares a written asset allocation policy that includes target allocations as well as a plan for ongoing "rebalancing" of assets to the target asset allocation. When a dynamic asset allocation policy is being adopted, the parameters for de-risking would be included in the written policy.

Step 1: Capital Markets Research
Wilshire believes that the quality of asset class assumptions for return and risk is as important as the sophistication of its asset allocation technology. Clients comment favorably upon the intellectual process Wilshire uses to forecast asset class expected returns, risk, and correlations.

Wilshire uses forward-looking valuation models that capture market consensus expectations rather than relying solely on the common practice of extrapolating past performance to project future performance. For example, a dividend discount model used to forecast stock returns and Treasury Inflation Protection Security ("TIPS") yields are compared to traditional Treasury yields to forecast inflation. Wilshire also developed a unique method for forecasting returns and risk on alternative investments. This is particularly important because most practitioners overstate returns and understate risk on alternative investments.

Wilshire prepares a research report for its clients at the beginning of every year describing its recommended long-term asset class return and risk assumptions for all the asset classes.

Step 2: Liability Analysis
Wilshire's integated asset-liability model focuses on the true liability of the plan – the stream of benefit payments promised to plan participants. The structure of the liability is at the front and center of the analysis. In order to develop the stream of benefit payments, Wilshire relies on actual participant data and long-term demographic assumptions developed by the plan's actuary for the purposes of the annual actuarial valuation. Wilshire's objective is to expand the work your actuary has already performed by including the volatility of the liability and incorporate the resulting object ("the benefit commitment") into the asset allocation framework. As a result, the model presents an internally consistent approach to both actuarial and asset allocation work.

The plan has made a commitment to provide health benefits to plan participants. The goal of the plan sponsor is to fund the commitment – the stream of benefit payments determined by the plan's population and benefit package. The volatility of the benefit stream is, for the most part, caused by healthcare inflation. The plan's actuary usually provides a point estimate for each payment in the stream (otherwise, Wilshire uses its internal models to do so). Then Wilshire analyzes the volatility of the stream and incorporates potential benefit changes, if any. Given the inflation-related nature of the volatility of the benefit stream, it is critical to ensure that our modeling of inflation impacts the asset and liability sides in a consistent manner. The augmented benefit stream is one of the cornerstones of Wilshire's asset / liability optimization model.

The funding and accounting liabilities are important, as well. Starting with the plan's demographic characteristics at the present, Wilshire models future funding and accounting liabilities by moving the existing population forward, utilizing the demographic assumptions provided by the actuary. Where appropriate, future new entrants replace plan participants who leave active status. Wilshire's models can incorporate growing or declining active populations as well. As a result, Wilshire generates a series of liabilities for as many years as needed. Some of those liabilities are modeled in a deterministic way, while others are modeled in a stochastic way in order to stay consistent with certain bond portfolios on the asset side. All these liabilities are subsequently used in stochastic simulations of the plan's reporting condition.

Step 3: Asset / Liability Optimization
Optimization procedures are at the heart of the portfolio selection process. Wilshire has extensive experience in dealing with traditional portfolio optimization methodologies such as mean-variance and surplus optimizations. We realize that mean-variance optimization is still popular among many plan sponsors; surplus optimization has gained popularity lately as well. Consequently, these methodologies are frequently incorporated into our process. However, we believe that Wilshire's optimization technique is a superior approach as it is directly related to the plan's core business.

The following principles are the foundation of Wilshire's approach to asset / liability optimization: 1) The core business of a plan is to fund the benefits promised to participants; 2) The primary risk to the core business is to run out of money before the plan has met the terms of its commitments; 3) The role of the policy portfolio is to manage the riskiness of the plan's core business.

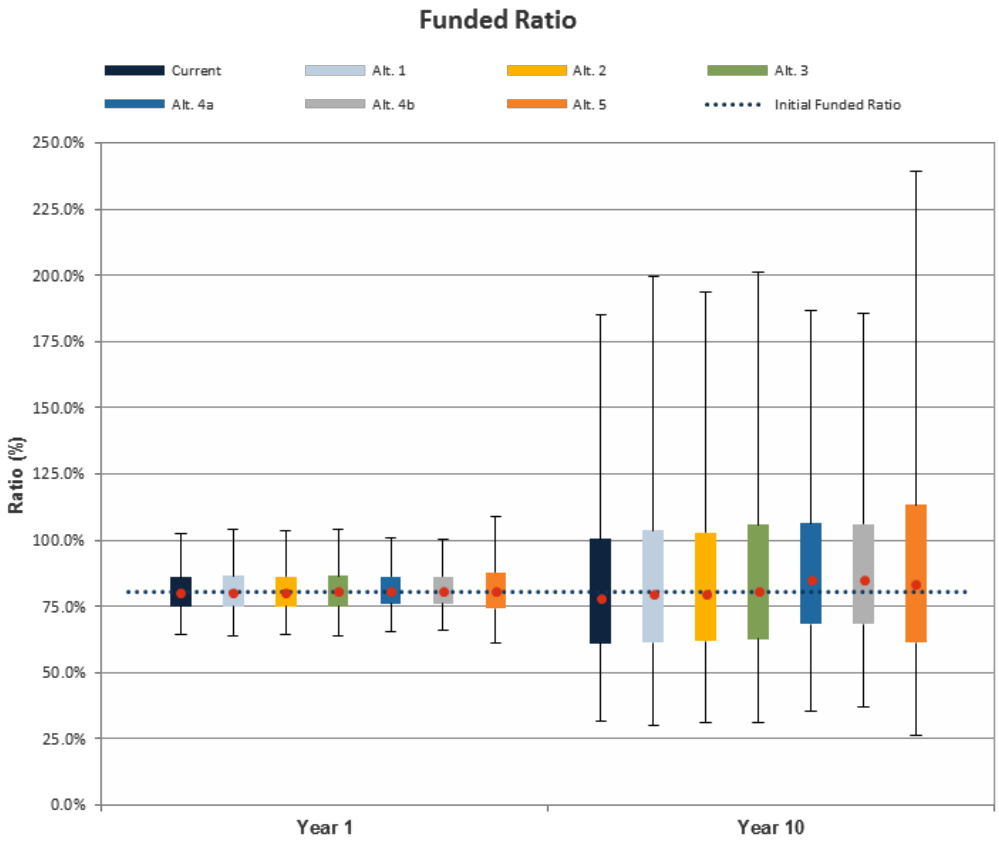
This recognition implies two objectives for the optimal policy portfolio. First, for every level of future contributions, it is desirable to produce the policy portfolio that maximizes the likelihood that this level of contributions is sufficient to fund promised benefits. In this case, it is in the best interests of the plan participants to maximize the safety of benefits at reasonable cost. Second, for each level of risk, it is

desirable to minimize the present value of future contributions that is sufficient to fund promised benefits at this risk level. It is clearly in the best interests of shareholders to minimize the cost of providing pension benefits at a reasonable risk level. Wilshire can demonstrate that both objectives lead to the same set of policy portfolios. The resulting efficient frontier ("the cost-risk frontier") contains policy portfolios that take into account the primary concerns of plan participants ("safer benefits") and plan sponsor ("lower cost"). The frontier also helps to identify the tradeoff between the plan's potential funding shortfall and future costs.

Wilshire considers the funded status of the plan to help determine the optimal asset allocation strategy. In most cases, in recognition of the fact that each client faces a multitude of objectives, Wilshire builds several efficient frontiers that meet each of the objectives.

Step 4: Optimal Policy Portfolio
The optimal policy portfolio can be selected based on an acceptable level of contributions or shortfall risk. However, Wilshire recognizes the importance of the components of funding and accounting reports. We employ stochastic simulation to allow the client to hypothetically pre-experience the impact of alternative investment strategies on the components of those reports in the future.

Several policy portfolios – from conservative to aggressive – are selected on the frontier(s) generated during the asset / liability optimization step. A dynamic asset allocation policy is included as an alternative where appropriate as well. A stochastic simulation program illustrates the impact of the policy portfolio choice on funded status, unfunded liabilities, and required contributions. These simulations are based on forward- looking expectations (return, risk and correlations) for the major asset classes as determined by Wilshire's Capital Market Assumptions. The model simultaneously projects assets, actuarial liabilities, contributions and benefits consistent with the plan's actuarial and capital market assumptions for as many years as needed. The policy portfolios that generate unacceptable volatility levels of relevant plan statistics would be eliminated from consideration as acceptable options.



(%)	2012				2014				2016				2021			
	Current Portfolio	Starting Portfolio	Ending Portfolio	Glide Path	Current Portfolio	Starting Portfolio	Ending Portfolio	Glide Path	Current Portfolio	Starting Portfolio	Ending Portfolio	Glide Path	Current Portfolio	Starting Portfolio	Ending Portfolio	Glide Path
Very Optimistic	61.67	61.67	61.67	61.67	106.91	105.32	95.66	104.78	127.57	125.66	106.99	118.42	157.79	156.21	108.97	119.23
Optimistic	61.67	61.67	61.67	61.67	92.99	92.32	86.70	92.18	109.69	109.25	99.02	106.65	124.59	125.09	101.96	108.88
Median (Expected)	**61.67**	**61.67**	**61.67**	**61.67**	**84.54**	**84.47**	**81.51**	**84.55**	**99.38**	**99.56**	**94.12**	**98.91**	**107.68**	**109.83**	**97.74**	**102.58**
Pessimistic	61.67	61.67	61.67	61.67	77.15	77.63	76.36	77.81	89.84	90.49	89.08	91.50	94.43	97.02	93.56	96.66
Very Pessimistic	61.67	61.67	61.67	61.67	73.74	73.78	73.74	73.78	78.26	79.77	82.11	81.45	81.37	83.91	87.84	88.57

Wilshire works closely with clients to determine the optimal policy portfolio for their needs. This also means deciding how much risk to take. This can only be done by close evaluation of the tradeoffs between long-term funding and possible short-term losses from negative investment returns or asset/liability mismatch. The clear identification of objectives and the hierarchy of the objectives is an important part of this strategy. We have found that there is no simple formula; rather, our responsibility is to give decision- makers the tools they need to make an informed decision.

Like any asset / liability model, the input assumptions have a great deal of impact on the results. We spend considerable internal resources in developing our annual view of expected returns, volatility, and correlations. In performing our studies, we examine the sensitivity of the results to initial assumptions and discuss the import of this with our client. In cases where the staff of investment professionals will likely have well-defined views on the capital markets, we would incorporate their views into the range of initial inputs. By varying these inputs and discussing the ramifications thoroughly with our clients, we are able to convey a more robust and richer picture of the risk / return tradeoffs.

After selecting the optimal asset mix, Wilshire formulates policy ranges for each asset class and identifies the rebalancing strategy. Wilshire recommends performing an asset / liability study at the inception of a new relationship. This initial study is intended to help your consulting team gain a better understanding of your plan and ensure that your fund currently has the optimal asset allocation given your objectives.

Wilshire's 2018 Asset Allocation Report is provided as an attachment.

PROPOSED FEE

The fee proposed for the project and scope of work outlined in this proposal is $40,000 to be paid in full at the completion of the project.

MOVING FORWARD

Additional Materials Requested (should Wilshire be select for this assignment)

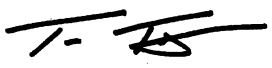
- Most recent asset allocation study report if available
- Most recent and year end 2017 performance report, if available
- Most recent valuation report, the benefit stream that discounts to the liability in that report, and a ten-year projection of the liability and cash flows.
- Historical monthly returns of total fund (please specify whether returns are gross or net of fees).

Proposed Project Timeline

Week 1	Evaluating data, setting up model
Week 2	Universe comparison and simulation analysis
Week 3	Draft report and discussion with staff regarding draft report
Week 4	Revise draft report and finalize
Week 5	Delivery of final report

Thank you for the opportunity to assist NMRHCA for this important project, please feel free to contact me at (303) 626-7448 or ttoth@wilshire.com should you require any additional information.

Sincerely,



Thomas Toth, CFA

ATTACHMENT 1: BIOGRAPHIES

Lead Consultant

Thomas Toth, CFA, *Managing Director*
Tom Toth is a Managing Director of Wilshire Associates and a member of Wilshire Consulting. He provides client service for a variety of pension, endowment, and foundation clients, working out of the Denver office. Mr. Toth is a member of Wilshire Consulting's Investment Committee and currently sits on both the Hedge Fund of Funds and Private Equity/Credit Asset Class Committees, where he is responsible for the evaluation and monitoring of a variety of products in the alternative investment arena.

Mr. Toth joined Wilshire in 2004 and initially worked in Wilshire Consulting's Investment Research Group, where he was responsible for writing white papers on topics such as hedge funds, private equity, and infrastructure. Prior to joining Wilshire, Mr. Toth worked in New York for fixed income asset manager Fischer Francis Trees and Watts. Mr. Toth earned his BA from the University of California, San Diego, and an MBA with a concentration in finance / capital markets from the USC Marshall School of Business. Mr. Toth also holds the Chartered Financial Analyst designation.

Asset Allocation Group

Wilshire's Asset Allocation Group consisting of Ned McGuire, FSA, CFA, FRM, Managing Director, and Brice Shirimbere, Senior Associate. The Asset Allocation Group is responsible for the day-to-day support of the senior consultants in the asset allocation work they do for clients.

Ned McGuire, CFA, FSA, FRM, *Managing Director*
Ned McGuire, a Managing Director with Wilshire Associates, is a member of Wilshire Consulting's Pension Risk Solutions group. Mr. McGuire is responsible for researching and maintaining Wilshire's proprietary asset allocation models, conducting asset allocation studies and serves as an actuarial consultant to plan sponsors. He is also a member of Wilshire Consulting's Fixed Income/LDI Asset Class Committee.

Mr. McGuire joined Wilshire in 2011. Previously, he worked as a risk management consultant overseeing asset-liability management and pension risk projects, and as an actuarial consultant to defined benefit plan clients. He earned an MS in operational research from the University of North Carolina, Chapel Hill, and a BA in mathematics from St. Olaf College. Mr. McGuire is a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, a Certified Financial Risk Manager, and a CFA charterholder.

Brice Shirimbere, *Senior Associate*
Brice Shirimbere is a Senior Associate with Wilshire Associates and a member of Wilshire Consulting. He develops and communicates customized risk management solutions, including asset allocation studies and investment strategy reviews for defined benefit, defined contribution, endowment and foundation clients. He also provides ongoing monitoring services, and researches and maintains Wilshire's proprietary asset allocation models.

Mr. Shirimbere joined Wilshire in 2015. Previously, Mr. Shirimbere worked as a consultant for two actuarial firms where he was responsible for actuarial valuation and plan design for public and private pension plans. He completed an MBA from the Anderson School of Business at the University of California Los Angeles and a BA in economics from the University of San Diego.

2018 Revised Medicare Advantage Default Strategy
Action Item

Background

- In July 2016, staff recommended and the Board of Directors voted to approve the defaulting of members into the most appropriate Medicare Advantage offering when they turn 65 starting January 1, 2018.
    - Plan savings was estimated at $1.2 million annually assuming 50% opt-out rate into the Medicare Supplement Plan.

- In July 2017, staff recommended and the Board of Directors voted to approve the following default strategy:
    - Pre-Medicare (Premier and Value) Plans administered by Presbyterian Health Plan will be defaulted to UnitedHealthcare Medicare Advantage Plan I.
    - Pre-Medicare (Premier and Value) Plans administered by Blue Cross Blue Shield and New Mexico Health Connections will be defaulted to Humana's Medicare Advantage Plan I.
    - All Medicare eligible participants still reserve the option of electing to participate in the Medicare Supplement Plan or 1 of 8 Medicare Advantage options.

Presbyterian's Medicare Advantage Plan was not recommended as a default for Presbyterian members as participation in their plans requires the submission of a separate application for enrollment.

- The recommendation was based on the following strategies:
    - Network of access between UnitedHealthcare and Presbyterian Health Services (doctors and facilities) and Humana and Lovelace (doctors and facilities).
    - Broader nation-wide access available through PPO plans administered by both UnitedHealthcare and Humana.
    - No gap in coverage with prescription drug plans (donut hole).

During the 3rd week in January, NMRHCA began to receive phone calls and complaints regarding Presbyterian Health Services (PHS) providers and facilities no longer accepting UnitedHealthcare Medicare Advantage. Some members received communication from UnitedHealthcare, some directly from their provider, while others were told their insurance would no longer be accepted, when they called to make appointments.

The situation has since been resolved and UnitedHealthcare plan participants can access Presbyterian Health Services providers. However, the resolution does not include the implementation of a contract between Presbyterian Health Services and UnitedHealthcare; therefore, the potential for the disruption of services remains.

In response to the potential for future disruptions, NMRHCA staff worked with Ms. Rosanne Tena, account manager for Presbyterian Medicare Advantage to develop a solution that would allow our members to be defaulted into a Presbyterian MA plan.

Requested Action

Staff respectfully requests authority to implement a revised default strategy that would transfer members aging into Medicare from the Presbyterian Premier and Value Plans to Presbyterian Medicare Advantage Plan I.

Out-of-state Travel Request (Action Item)

Background. The executive director of the New Mexico Retiree Health Care Authority has been invited to attend Blue Cross Blue Shield's Major Account Council, Spring Meeting on April 24 – 26, 2018 in Phoenix, Arizona.

Large national accounts include: Boeing, American Airlines, Texas Retirement System, UPS, and NMRHCA. Information will be presented regarding health care market products, trends and other solutions affecting similar accounts.

Requested Action. NMRHCA staff respectfully requests permission to attend the Major Accounts Council meeting on April 24 – 26, 2018 in Phoenix Arizona.

2019 Plan Discussion

Current Solvency Status (July 2017)

Projected fiscal year of insolvency: 2035

Assets as of July 1, 2034: $32,360,816

Discount Rate: 7.25%

Sensitivity

Low Trend 1%:	$727,788,083	2042
High Trend 1%:	($488,617,997)	2032
Low Payroll Growth 0.5%:	($91,381,433)	2034
High Short Term Increase (Non-Medicare) +1%:	$147,716,651	2035
Low Short-Term Increase (Non-Medicare) -1%:	($77,809,612)	2034
High Short Term Increase (Medicare) +1%:	$67,596,454	2035
Low Short Term Increase (Medicare) -1%	($2,803,265)	2034
Low Investment Return -1%	($153,417,847)	2034
Low Investment Return – 2%	($299,763,818)	2033

Plan Design Pre-Medicare

Value-based Incentives

Presbyterian – Premier and Value Plan

a. Flat copay for certain procedures tied to bundled agreements
    i. Shoulder Arthroscopy
    ii. Knee Arthroscopy
    iii. Laparoscopic Cholecystectomy
    iv. Hernia

Phase I of the bundled payment initiative became effective on January 1, 2018, with Presbyterian Health Services removing Hernias and performing Laparoscopic Cholecystectomy's at Rust Medical Center and Kaseman Medical Center and New Mexico Orthopedics performing Shoulder and Knee Arthroscopy's.

Blue Cross Blue Shield - Premier

b. 3rd Tier coverage for restricted network use
    i. Blue Preferred Plus ($500 deductible/$3,000 OOP Max)
    ii. Preferred Provider ($800 deductible/$4,500 OOP Max)
    iii. NonPreferred ($1,500/$6,000 OOP Max)

Medicare

Medical

1. Introduction of $250 copay for inpatient stay (1 per year)
2. Increase annual Part B cost sharing $50

Prescription Drug Benefit (all self-insured)

1. Increase member cost sharing
2. Explore value-based plan design

Plan Enhancements

1. Pilot project with Grand Rounds focused on high-cost / complex medical cases.

Other Revenue Enhancements

1. Begin charging administrative fee - $1.00 - $1.25 per retiree per month for access to voluntary benefits
2. Begin charging cost of GASB 75 employer allocation schedules ($75,000-$100,000)/300 employer groups = $300 - $330 per employer group

Plan Rates

Increase retiree premiums in accordance with projected medical trend for all self-insured plans based upon loss ratios calculated in May/June. Examples of the average increase for each self-insured plan including 1 percent above and 1 percent below are provided in the chart below.

	2018		
	Retiree	NMRHCA	Total
Premier PPO	$ 241.44	$ 429.22	$ 670.66
Value HMO	$ 188.60	$ 335.28	$ 523.88
Supplement	$ 199.96	$ 199.96	$ 399.92
	2019 (8/6 percent increase)		
Premier PPO	$ 260.75	$ 463.56	$ 724.31
Value HMO	$ 203.68	$ 362.11	$ 565.79
Supplement	$ 211.96	$ 211.96	$ 423.92
	Dollar Change		
Premier PPO	$ 19.31	$ 34.34	$ 53.65
Value HMO	$ 15.08	$ 26.83	$ 41.91
Supplement	$ 12.00	$ 12.00	$ 24.00
	2019 (9/7 percent increase)		
Premier PPO	$ 263.17	$ 467.85	$ 731.02
Value HMO	$ 205.57	$ 365.46	$ 571.03
Supplement	$ 213.96	$ 213.96	$ 427.91
	Dollar Change		
Premier PPO	$ 21.73	$ 38.63	$ 60.36
Value HMO	$ 16.97	$ 30.18	$ 47.15
Supplement	$ 14.00	$ 14.00	$ 27.99
	2019 (7/5 percent increase)		
Premier PPO	$ 258.34	$ 459.27	$ 717.61
Value HMO	$ 201.80	$ 358.75	$ 560.55
Supplement	$ 209.96	$ 209.96	$ 419.92
	Dollar Change		
Premier PPO	$ 16.90	$ 30.05	$ 46.95
Value HMO	$ 13.20	$ 23.47	$ 36.67
Supplement	$ 10.00	$ 10.00	$ 20.00

Other Considerations

2019

1. Impact of pharmacy benefit manager (PBM) procurement effective July 1, 2018 has yet to be incorporated in solvency projection. New four-year agreement will reset expenditure baseline – similar to Market Check Agreement in 2017.

2. Investment earnings and projected beginning of year balance (7/1/2018) of $622 million. January 31, 2018 balance - $645 million.

3. Calendar year 2019 will be second year of 4-year phased in conversion of basic life insurance.
    a. 2018 – 25 percent
    b. 2019 – 50 percent
    c. 2020 – 75 percent
    d. 2021 – 100 percent

2020

1. Increase in years of service (20-25) to receive maximum subsidy
2. Minimum age of 55 to receive subsidy