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

REGULAR MEETING
OF THE
BOARD OF DIRECTORS

June 12, 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

June 12, 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			
Mr. Smith			
Mr. Rael			

NMRHCA BOARD OF DIRECTORS

June 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

Mr. James E. Smith
County Commissioner
Bernalillo County
One Civic Plaza NW, 10th Floor
W: 505-468-7212
F: 505-462-9821
District5@bernco.gov

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
505- 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
F: 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
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
505-476-9332

Mr. Lawrence Rael
400 Marquette Ave, 11th Floor
City/County Building
Albuquerque, NM 87102
lrael@cabq.gov
505-768-3700

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

June 12, 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 May 8, 2018	Mr. Sullivan, President	5
6.	Public Forum and Introductions	Mr. Sullivan, President	
7.	Committee Reports	Mr. Sullivan, President	
8.	Executive Director's Updates	Mr. Archuleta, Executive Director	
	a. HR Updates		
	b. Davis Vision and Versant Health		13
	c. Legislative		16
	d. Wise and Well Strategic Plan		27
	e. GASB 75		
	f. April 30, 2018 SIC Report		41
9.	Contract Amendment (Action Item)	Mr. Archuleta, Executive Director	42
10.	2019 Plan Recommendations	Mr. Archuleta, Executive Director	44
11.	Annual Board Meeting Agenda	Mr. Archuleta, Executive Director	66
12.	Board Policies and Procedures	Mr. Archuleta, Executive Director	68
13.	Other Business	Mr. Sullivan, President	
14.	Executive Session Pursuant to NMSA 1978, Section 10-15-1(H)(6) To Discuss Limited Personnel Matters	Mr. Sullivan, President	
15.	Date & Location of Next Board Meeting	Mr. Sullivan, President	

July 12, 2018, 9:30AM / July 13, 2018, 9:00AM
Sagebrush Inn & Suites
1508 Paseo Del Pueblo Sur
Taos, NM 87571

16. Adjourn

ACTION SUMMARY

RETIREE HEALTH CARE AUTHORITY/REGULAR BOARD MEETING

May 8, 2018

Item	Action	Page #
APPROVAL OF AGENDA	Approved	3
APPROVAL OF MINUTES: April 3, 2018	Approved	3
PUBLIC FORUM & INTRODUCTIONS	Informational	3
COMMITTEE REPORTS	Informational	3
EXECUTIVE DIRECTOR'S UPDATE Board Member Appointments: James Smith and Lawrence Rael FY19 Operating Budget HR Update Procurement Activities Presbyterian Health Plan/NM Heart Institute Legislative Wellness Strategic Plan Spring Newsletter GASB 75 March 31, 2018 SIC Report	Informational	4
RULEMAKING ON MIN. AGE & YEARS OF SERVICE REQUIREMENTS	Approved notice//publication	5
FY18 3RD QUARTER BUDGET REPORT	Informational	7
FY19 CONTRACTS	Approved	7
OUT OF STATE TRAVEL REQUEST	Approved	8
2019 PRELIMINARY PLAN DISCUSSION	Informational	8

NEXT MEETING: June 12, 2018

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

May 8, 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. Rick Scroggins
Mr. Terry Linton
Mr. Wayne Propst
Ms. Therese Saunders
Mr. James E. Smith

Members Excused:
None

Staff Present:
Mr. Dave Archuleta, Executive Director
Mr. Neil Kueffer, Interim Deputy Director
Mr. Greg Archuleta, Director of Communication & Member Engagement
Ms. Peggy Martinez, Chief Financial Officer
Mr. Tomas Rodriguez, IT Manager
Ms. Judith Beatty, Board Recorder

Others Present:
Mr. Luis Carrasco, General Counsel, Rodey Law Firm
[See sign-in sheet]

3. PLEDGE OF ALLEGIANCE

Mr. Linton led the Pledge.

4. APPROVAL OF AGENDA

Mr. Archuleta stated that some page numbers listed for the agenda items were incorrect.

Mr. Crandall moved approval of the agenda, as amended. Mr. Montaño seconded the motion, which passed unanimously.

5. APPROVAL OF REGULAR MEETING MINUTES: April 3, 2018

Mr. Archuleta stated that Crystal a2yü2èl· was referred to as Crystal Ml·ÑúÅyŜÎ on page 8.

Mr. Crandall moved approval of the April 3 minutes, as amended. Mr. Montaño seconded the motion, which passed unanimously.

6. PUBLIC FORUM AND INTRODUCTIONS

Chairman Sullivan welcomed former New Mexico State Representative Jim Smith to the board. Mr. Smith, a member of the Bernalillo County Commission, replaces former board member Wayne Johnson as a delegate of the New Mexico Association of Counties.

Mr. Archuleta introduced Connor Jorgensen, who replaces LFC analyst Anne Hanika-Ortiz, who will be retiring at the end of June; and Joseph Simon, with the Legislative Education Study Committee.

The Standard representative Martha Quintana announced that she would be leaving soon, and introduced Stephanie Crouch as her replacement.

7. COMMITTEE REPORTS

Executive Committee

Chairman Sullivan reported that the Executive Committee met last week to review and prepare today's agenda.

Finance Committee

Mr. Crandall stated that the Finance Committee met, and items discussed during that meeting would be addressed on today's agenda.

Legislative Committee

Mr. Montaño said the committee met and identified the stakeholders, unions, retired educators, retired public employees, municipalities and other entities that would be encouraged to support legislation that NMRHCA sponsors in the next session.

Mr. Montaño stated that the committee also discussed information to be requested from the actuaries around solvency issues.

8. EXECUTIVE DIRECTOR'S UPDATES

a. Board Member Appointment --

- **James Smith, Bernalillo County Commissioner/Association of Counties**
- **Lawrence Rael, COO City of Albuquerque/Municipal League**

Mr. Archuleta welcomed Mr. Smith to the board. He said the agency received notice last week that Lawrence Rael, Chief Operating Officer for the City of Albuquerque, would also be appointed to this board as a representative of the New Mexico Municipal League.

b. FY19 Operating Budget

Mr. Archuleta reviewed a high level summary of the Health Care Benefits Administration Program and Program Support budget, which was approved last month and submitted to DFA. The total approved operating budget for FY19 is $338.5 million, and includes $32,000 to support a 2 percent salary increase.

c. HR Updates

Mr. Archuleta announced that Melissa Larrañaga, the Santa Fe office's Customer Service manager, is leaving the agency after 17 years of service to work at the Public Schools Insurance Authority.

Mr. Archuleta stated that NMRHCA's Customer Service Representatives are officially classified as "Government Eligibility Interviewers," and NMRHCA is trying to have them reclassified as Retirement Specialists, a classification that PERA and NMERB share, and where the job functions are virtually identical. If the agency is successful in getting this position reclassified, 12 employees would be affected. He added that, when the NMERB and PERA reclassified these positions about two years ago, NMRHCA was unable to follow suit because the agency didn't have the funding to support any sort of increase in ƛΰă salaries. Obviously, it would have been a disservice to upgrade these employees without the salaries to support it.

Mr. Archuleta commented that, in the last year or two, a lot of the people who have filled vacant positions at NMRHCA are starting off with higher salaries than existing employees who have been on the job for a number of years. NMRHCA is working with SPO to bring those classifications up.

Mr. Archuleta introduced members of the NMRHCA management team to the board.

d. Procurement Activities

Mr. Archuleta reported that the IBAC will meet tomorrow, at which time ƛΰ should receive an update on the solicitation for a consultant to help in scoring the soon-to-be-released life insurance RFP. NMRHCA will look into hiring a consultant through a small purchase agreement to make sure that the scoring associated with the financial proposal is as accurate as possible.

Mr. Archuleta said the board will be asked to authorize issuance of the RFP jointly with the rest of the IBAC for the life insurance contract, beginning in FY 2020.

e. Presbyterian Health Plan – New Mexico Heart Institute Contract

Mr. Archuleta said NMRHCA has received notice about changes to the contracts Presbyterian has with the New Mexico Heart Institute, which will be terminating their contract on July 12. NMRHCA has 95 pre-Medicare and 155 Medicare Advantage participants who have sought services from that group within the past 12 months. All received outreach notification from Presbyterian regarding the change, with the option of helping them find a new provider. In addition, they received notice from NMRHCA, which offered them the opportunity to make a midyear change to their coverage.

f. Legislative

Mr. Archuleta said the Legislative Committee met last Friday to discuss the upcoming legislative session, as well as to identify stakeholder groups the agency needs to work with and get feedback from. Once the annual solvency study is complete, the committee will develop and finalize its basic request. The board's decision in July on how far out to extend the solvency period will determine the request that will be made from the legislature.

g. Wellness Strategic Plan

Mr. Archuleta reported that the Wellness Committee has been attempting to home in on measures that can be used to gauge the success of the wellness program. Next month, the Wellness Committee will receive an update on Presbyterian Health Plan's PCMH model as well as the Naturally Slim diabetes prevention program, which will be brought to the board for consideration in July.

h. Spring Newsletter

Mr. Archuleta reviewed highlights from the Spring Newsletter.

i. GASB 75

Mr. Archuleta said Segal has developed the employer allocation schedules, and this will be the final week of the audit process with Moss Adams. CliftonLarsonAllen has begun the independent audit process, and the deadline for the submission of the schedules and user guide to the State Auditor's Office is June 15. The process is taking place along the anticipated timeline.

j. March 31, 2018 SIC Report

Mr. Archuleta reported a fund balance at March 31 of $633 million.

9. RULE MAKING ON MINIMUM AGE & YEARS OF SERVICE REQUIREMENTS

Mr. Carrasco stated that the Attorney General's Office promulgated a new rule this year specifying the procedure that each public agency must follow in order to legally effectuate a new rulemaking

proceeding. Agencies that don't have their own rules, such as the NMRHCA, have to follow the Attorney General's default rulemaking procedure.

Mr. Carrasco said the rule is largely identical to the rulemaking procedure adopted by this board in 2016, with one notable exception. The AG's regulation now requires that the initiation of the rulemaking proceeding be taken in an open meeting by the governing body with a vote to initiate the rulemaking process.

Mr. Carrasco reviewed the resolution before the board. In the interest of being thorough, he did discuss this with his former colleague at the Attorney General's Office. While this resolution goes over and above what the Attorney General's Office is expecting, he prefers a very solid record on the steps taken to initiate the process.

Mr. Carrasco said the last two paragraphs on the first page consist of an amendment to the existing rule, which establishes subsidy levels on the basis on the years of creditable service (2.81.11 NMAC), and then a proposed new rule to modify the subsidy schedule to require 25 years of creditable service in order for participants to receive the maximum subsidy provided by NMRHCA. The rulemaking will contemplate both amending the existing rule and a brand-new rule relating to the 25 years of service requirement.

With respect to No. 7 in the "Resolved" section of the resolution, Mr. Linton asked whether it is common among state agencies for the executive director to be authorized to effectuate the rulemaking proceedings. Mr. Carrasco responded that this would occur in about 75 percent of his former public agency clients and was usually their preference. He said the board still is required to review the records of the rulemaking proceeding before taking a vote to enact the rule. While it is up to the board on how it wishes to approach this, it is the recommendation of the NMRHCA Executive Director to allow him to handle it the way he did last time in 2016, which seemed to run fairly smoothly.

Board members agreed with a recommendation by Mr. Linton that the resolution be made gender neutral.

Chairman Sullivan recalled that when the NMERB and PERA were doing their age and years of service changes several years ago, NMRHCA's position was that it would establish policy that would track with that. He noted that the resolution specifically references the enhanced plans, but thought NMRHCA did the "30 and out" and "Rule of 80." Mr. Archuleta clarified that, in 2015, when the board adopted moving in this direction, the enhanced people were excluded from this requirement; so right now it just would affect everyone else. While the minimum years of service and maximum subsidy levels are going from 20 to 25, this does not affect the approximately 1,200 enhanced members. While NMRHCA had already made the rules change to affect the non-enhanced plan, it was not yet codified in the Administrative Code pending possible consideration of increasing the years and age of service requirements before the January 1, 2010 date.

Mr. Propst clarified that the years of service for PERA members changed only for those hired after July 1, 2013. It is still 25 and out for non-enhanced members and 20 and out for public safety, police and fire.

Mr. Crandall moved adoption of the resolution initiating the rulemaking proceedings, with the changes to gender-neutral language. Mr. Smith seconded the motion, which passed unanimously.

10. FY 18 3RD QUARTER BUDGET REPORT

Mr. Archuleta reviewed this report. He commented that this is the largest year-over-year increase the agency has experienced in the last five years, with a $30 million increase overall in expenditures. A number of factors contribute to this increase, including 18 high-cost claimants totaling $6 million on the pre-Medicare side, compared to eight in the previous year totaling $2 million. On the Blue Cross Blue Shield side, a number of people are being treated for cancer, and there was a boost in the Medicare Advantage rates along with overall Medicare Advantage costs.

11. FY 19 CONTRACTS

Mr. Archuleta reviewed a list of proposed contracts for the upcoming fiscal year in the Healthcare Benefits Administration Program, all of which have been included in the approved operating budget. All of these contracts are with existing vendors. About $2 million remains available for end-of-year adjustments. Amount encumbered YTD is $330,300,000; FY18 projected, $326,064,847; FY19 proposed, $330,425,000.

- BCBS: Non-Medicare/Supplement and Medicare Advantage
- Presbyterian: Non-Medicare and Medicare Advantage
- NM Health Connections
- UnitedHealthcare
- Humana
- United Concordia
- Delta
- Davis Vision
- Express Scripts (old)
- Selected PBM Vendor
- The Standard

Mr. Archuleta reviewed a list of proposed contracts for the upcoming fiscal year in the Program Support operating budget. Amount encumbered YTD, $578,205; FY18 projected, $436,705; FY19 proposed, $548,350.

- Segal – Consulting, Solvency, GASB
- Wilshire – asset allocation review and follow-up
- Rodey – legal fees
- Moss Adams – Financial Audit/GASB 75
- CliftonLarsonAllen/GASB 75 Review
- Life Insurance RFP Consultant (New)
- Shred-IT
- RE/SPEC – ongoing maintenance related to CareView
- ABBA Technology
- RiskSense – risk assessment of computer systems

Mr. Crandall moved for approval of the FY19 contracts. Ms. Saunders seconded the motion, which passed unanimously.

12. OUT-OF-STATE TRAVEL REQUEST

Mr. Archuleta stated that the annual Express Scripts Outcomes Symposium is scheduled in Dallas on June 5-7, 2018. He requested that the board authorize Board Member Joe Montaño and Interim Deputy Director Neil Kueffer to attend this symposium.

Mr. Crandall moved for approval. Mr. Linton seconded the motion, which passed unanimously.

13. 2019 PRELIMINARY PLAN DISCUSSION

Mr. Archuleta reviewed 2019 preliminary plan recommendations.

Mr. Archuleta noted that Segal has prepared a series of scenarios addressing solvency, including a full funding scenario, for presentation at the annual meeting in July.

14. OTHER BUSINESS

Chairman Sullivan agreed to provide evaluation criteria forms and other materials to board members in anticipation of the annual performance evaluation of the Executive Director in executive session at the annual meeting.

15. EXECUTIVE SESSION

None.

16. DATE AND LOCATION OF NEXT MEETING:
June 12, 2018, 9:30 AM
Alfred R. Santistevan Board Room, Suite 207
4308 Carlisle Blvd., N.E.
Albuquerque, New Mexico 87107

17. ADJOURN

The meeting was adjourned at 10:45 a.m.

Accepted by:

_____

Tom Sullivan, President

May 29, 2018

Mr. David Archuleta
Director
NM Retiree Health Authority
4308 Carlisle Blvd, NE, Ste 104
Albuquerque, NM 87109-4849

Dear David,

In December 2017, we announced that Davis Vision was acquired by Centerbridge Partners, a private equity group and current owner of Superior Vision.

After extensive planning, collaborative development and internal integration of the companies, we are excited to embrace a new visual identity.

What does this mean for you?
Our contract remains intact, plan documents and member ID cards remain unchanged and our services continue to be fully-dedicated to you. As a Davis Vision client, you can expect the same level of service and care you have come to know and appreciate. Only the appearance of our brand is different.

We know you may have some questions. You'll find FAQs included with this letter. Of course if you have any questions or concerns, please give me a call.

Sincerely,

Sam Garcia, Davis Vision
National Marketing Associate, NM office
6121 Indian School Rd NE, Ste 240
Albuquerque, NM 87110
Telephone: 505-883-1796- Fax: 505-883-1668
sjgarcia@cba-inc.us | Cell: 505-250-8745

Davis Vision from Versant Health

Frequently Asked Questions

Why is there now a Versant Health name and logo?
We are now one company, Versant Health, which offers two products, the Davis Vision product and the Superior Vision product.

When will I see the new look for Davis Vision?
The rollout of the new Davis Vision visual identity and materials will begin May 14, 2018 and will phase in over the remainder of the year. We plan on having all member and client materials updated by January 1, 2019.

Where will I see Versant Health?
You will see Versant Health and branding on some of the communications we send to you. Usually you will see Davis Vision with Versant Health.

What does the new logo look like?
The logo we've used in the past is DAVIS VISION EYECARE REFRAMED. The logos we're now using look like this DavisVision and VersantHealth.

Will there be changes to Davis Vision member benefits or coverage?
No changes will be made to current member benefits at this time, and there will be no disruption in coverage or service.

Are there changes to the products?
No, there are no changes to our products. The only changes you may notice are the appearance of our logo and collateral.

Will there be any changes to our provider network?
No, you will still have access to the same provider network.

Will my contacts at Davis Vision remain the same?
Yes, your regular points of contact and customer service numbers will remain the same. You may notice that our company email addresses have been updated to reflect Versant Health, although we will continue to receive emails through our "@davisvision.com" email address.

Are pricing or billing procedures changing?
No, our pricing and product offerings will remain the same. Any contracts, rate guarantees and member rates/benefits will also remain the same as well as banking information for ACH payments. Simply follow the same payment processes and procedures you currently have in place.

Will our group number / plan number stay the same?
Yes, there will be no changes to group or plan numbers.

Will you send out new ID cards with the new logo?
No. Member ID cards with the "old" Davis Vision logo are still valid.

Will there be changes to the website or customer portals for Davis Vision?
Our web address remains www.davisvision.com, where customers can still access their accounts in the portal using the same login credentials. By the end of the year, our website appearance will be updated to reflect our new appearance. Visit versanthealth.com for more information on our new identity.

Will your telephone and fax numbers or addresses be changing?
All telephone and fax numbers will remain the same along with all mailing and physical addresses.

Will you be communicating with members?
No. The member materials we provide to you will be updated over time. If they call us, we'll still answer the phones as Davis Vision.

We use the Davis Vision logo on internal communications. Can you send us your new logo?
Yes. Please contact me. You will need to sign a licensing agreement before you will be able to use the new logo.

Will Davis Vision offer plan enhancements?
We are always looking for ways to improve the plan, benefits, and offering provided to you. That will continue. Now that Davis Vision is part of the Versant Health family, we expect that as a larger organization, we'll be able to improve efficiency, options, and other enhancements that come with the scale of a company that services 33 million members nationwide.

Is there anything I need to do?
No, if your employees ask about our new look, remind them it's the same plan.

NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

Investments & Pensions Oversight Committee

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

New Mexico Retiree Health Care Authority Updates
June 7, 2018

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

Background Information

Retiree Health Care Authority Act

- Created in 1990 (no appropriation or material pre-funding period)
- Governed by 11-member Board of Directors
  - Broad authority for administration of the Health Care Benefits Administration Program
    - Staff, procurement activities, eligibility guidelines, strategic planning, policies and procedures
  - Board composition
    - Superintendent's Association, NMAER, RPENM, State Treasurer, Association of Counties, Municipal League, PERA, ERB, NEA-Classroom Teachers Association, Governor's Appointee, and Classified State Employee

Mission and Purpose

- NMRHCA seeks to provide an affordable, comprehensive group health insurance benefits plan for present and future retirees and eligible dependents.
- Retirement planners at Fidelity estimate that couples retiring in 2017 at the age of 65 will need on average $275,000 to cover medical expenses through retirement, which applies to retirees with traditional Medicare insurance coverage.

• Average PERA monthly pension	$2,449*
• Average ERB monthly pension	$1,831*
• Average Social Security monthly benefit	$1,370
• NMRHCA average retirement age	61 years

*2016 CAFR Reports

Composition, Budget & Finance

- FY19 Approved Operating Budget - $338,587,900
  - Health Care Benefits Administration - $335,540,300
  - Program Support - $3,047,600
- Public Employer Groups - 301
  - All school districts and charter schools – 50%
  - All state agencies – 25%
  - Municipalities, counties & universities – 25%
- Active members - 97,349 as of 6/30/17
- Covered Members - 62,219 (June 1, 2018)
  - Medicare - 38,220 / Pre-Medicare - 15,916 / Voluntary Only – 8,083
  - Average Age - 71.35
  - Members Under age 55 - 2,287
  - Retirees - 39,111
  - Spouses/domestic partners – 12,990
  - Dependent children – 2,035

2018 Changes and Rates for Medicare

Rate Increases

- Medicare Supplement Premiums by 6 percent to $199.96 per month
- BCBS Medicare Advantage
  - Plan I (14 percent) $69.60 / Plan II (23 percent) $23.30
- Presbyterian Medicare Advantage
  - Plan I (8 percent) $96.50/Plan II (27 percent) $72.00
- United Healthcare
  - Plan I (10 percent) $104.16/ Plan II (10 percent) $54.65
- Humana
  - Plan I (6 percent) $87.45 / Plan II (6 percent) $53.06
- All rates based on 20 years of service
- Introduction of Voluntary Smart90 Program (Supplement Plan)
  - Gives members choice to purchase 90-day prescriptions for lower cost than three one-month prescriptions

2018 Changes and Rates (Pre-Medicare/All Plans)

Pre-Medicare

- Expanding the Value Plan option to include Blue Cross Blue Shield narrow network HMO plan
- Increase Pre-Medicare Premiums 8 percent
- Defaulting aged in members to appropriate Medicare Advantage Plan when selection not made by member
- Introduction of Voluntary Smart90 Program
  - Gives members choice to purchase 90-day prescriptions for lower cost than three one-month prescriptions

All Plans

- Continuation of Wellness Program
- Incentivize healthy behaviors and disease management programs
- This year enrollment for medical plan only allows for a switch in enrollment

Solvency Analysis

- Solvency Study Performed Annually
  - Analysis of future cash inflows and outflows
  - Used for strategic planning purposes
    - Plan design i.e., copays, deductibles, coinsurance
    - Subsidy levels
    - Network/medical and prescription drug access
- 2017 Projected Year of Deficit Spending - 2020
  - Expenditures exceed revenues - $9.1 million
- 2017 Projected Year of Insolvency: FYE 2035 (18 years)
  - FY35 Projected Expenditures - $1.2 billion
  - FY35 Projected Revenues - $1.1 billion
- 2018 Solvency Study is currently being developed

GASB 74

- Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans (OPEB)
  - Replaced GASB 43 – Fall 2017 for period ending June 30, 2017
  - Compares existing assets to future liabilities
  - Total OPEB Liability - $5,111,141,659
  - Plan Fiduciary Net Position - $575,649,501
  - Net OPEB Liability - $4,535,492,158
    - 1% decrease in discount rate - $5,500,667,903
    - 1% increase in discount rate - $3,778,225,036
    - 1% decrease in trend - $3,858,319,120
    - 1% increase in trend - $5,063,519,724
  - Plan Fiduciary Net Position as a percentage of total – 11.26%
  - Information included as a note in NMRHCA financial statements

GASB 75

- Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions
  - Replaces GASB 45 – July 2018 for period ending June 30,2017
  - GASB 75 Employer allocation based on GASB 74 Valuation
    - Schedule of employer allocations – Segal
    - Separate auditor's report and separate opinions – Moss Adams
    - Concurring review of audit – CliftonLarsonAllen
  - Due to the Office of the State Auditor by June 15, 2018
    - Upon review and release of schedule information will be made available to participating employers
  - Allocation information will include an employer guide that illustrates the correct use of the schedule with plan-level reporting and employer specific items

Upcoming Events and Updates

- Annual Board Meeting
  - July 12 & 13 – Taos
  - Election of Board Officers
  - Review of plan data
  - Adoption of changes for 2019
- Announcement of selected Pharmacy Benefits Manager resulting from RFP # 2018-IBAC-0001 upon approval by the Department of Finance and Administration, Contracts Review Bureau
- 2018 Fall Switch Enrollment
  - October 1 – November 9
  - 16 meetings – 13 locations
- 2019 Open Enrollment
  - January 1 – 31, 2019

New Mexico Retiree Health Care Authority

David Archuleta, Executive Director

505-222-6416

david.archuleta@state.nm.us

Please call 800-233-2576 / 505-222-6400

Or visit us at: www.nmrhca.org or www.facebook/nmrhca

Office Hours: 8:00AM – 5:00PM (Monday through Friday)

New Mexico Retiree Health Care Authority
Wellness Program

Five Year Strategic Plan

2018 – 2022

D R A F T

New Mexico Retiree Health Care Authority
Wellness Program Five Year Strategic Plan

D R A F T

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EXECUTIVE SUMMARY

The New Mexico Retiree Health Care Authority (NMRHCA) currently provides medical, dental, vision and life insurance benefits to over 62,000 retirees end eligible participants. The provision of these services presents significant long-term challenges associated with the growth and prevalence of chronic disease and the cost of treatments used to manage these conditions. Given the growing population of the retiree demographic and the increasing prevalence of lifestyle-related chronic diseases, health care is a monumental issue for NMRHCA. With much at stake and a demanding journey that lies ahead, there is a critical need for a proactive retiree wellness program to serve as a means to help stem the health care trends facing the program.

Retirees are an important demographic for wellness programs because this age group is growing, both as a proportion of the overall population and as a contributor to health care cost escalation. The intent of the NMRHCA Wellness Program is to improve the overall health of retirees through a variety of approaches, including physical activity, nutrition awareness and education, diabetes management, and support of other healthy behaviors. Below are the focused five-year goals for the NMRHCA Wellness Program:

1. Expand **COMMUNICATION** and **REACH**: Aggressive pursuit of methods that draw attention to wellness awareness, education and services.
2. Increase overall **ENGAGEMENT**: Achieve frequent participation and sustained engagement for a larger, positive impact on overall health status.
3. Focused chronic disease **PREVENTION** and **MANAGEMENT**: Manage the health care continuum to include wellness management for the healthy, at risk, chronic disease and complex case management.
4. **INCENTIVIZE** participation and value-based care: Connect incentives to motivate engagement, bring awareness and increase participation.

What is healthy aging and wellness for retirees?

Health and wellness for retirees involve a complex interaction of numerous factors, including personal choices, life events, supportive environment, strong community action and a health system that contributes to the pursuit of good health. Maintaining control and choice over one's personal circumstances is vital if healthy aging and wellness are to take place. The Center for Medicare and Medicaid Services found that Medicare enrollees in wellness programs were more aware of their mental health needs and had increased engagement with physicians and ancillary services. These programs "prevented or delayed normal deterioration that comes with age."[1]

Place Holder: Possible paragraph on summarizing the retiree population health data.

To gain recognition and give the wellness program an identity, NMRHCA has named its program the **NMRHCA Wise and Well Program.** By consistently using the program's name on all communications from all wellness carriers and NMRHCA staff, this conveys to members that the program is here to stay and is here for them. Finally, members may be more likely to participate and be inspired to adopt healthier habits by connecting to the program.

NMRHCA is defining Wellness as *the active process of becoming aware of and making choices toward a healthy and fulfilling life.* The wheel below brings this definition to life by embracing six major components that encompass wellness for the NMRHCA Wise and Well program.

ELEMENT	DEFINITION
Quality of Life	A measure of well-being focused on factors that affect physical and mental health — socioeconomic status, ability to perform activities of daily living, level of social support, and health risks and conditions.
Health Status	Personal awareness of how well you feel and how comfortable you are on a daily basis.
Happy and Social Interaction	Developing a sense of connection, belonging and a well-developed support system.
Physical Activity	Staying physically active to help maintain a healthy weight and body composition, reducing the risk of weight-related medical conditions and maintain the health of your muscles, bones and joints with age.
Nutrition and Positive Behaviors	Devoting your time to healthy eating, restful sleep, and healthy behaviors every day, to ensure that your whole body stays as healthy as possible for as long as possible.
Disease Management	An approach of coordinated heath care interventions and communications for populations with conditions where self-care efforts can be implemented. **Disease management** empowers individuals, working with other health care providers to manage their **disease** and prevent complications.

BACKGROUND AND CONTEXT

Review of Retiree Wellness Programs

Many studies demonstrate that reduced inpatient admissions and health care costs, as well as improved health-related quality of life, are a direct result of participation in large-scale retiree wellness programs. Programs that effectively engage retirees in, and change behavior as a direct result of, participation provide strong evidence of health improvements and decreased health care costs being achieved. Overcoming the challenges to facilitate broader enrollment and sustained participation in these programs will further increase the impact of outcomes and health-related benefits.

The findings also demonstrate that activities of daily living (ADLs) are less impaired for retirees who have access to programs such as those made available through Silver Sneakers—thus providing an outcome that can be linked directly to decreases in morbidity, accidental injury, health care costs and, potentially, even mortality. Exploration of and investments in retiree fitness programs should continue as a means to improve the health and well-being of retirees. The combination creates the potential for reducing overall health care costs and the burden on an increasingly strained health care delivery system. However, given the rural nature of New Mexico combined with the broad age-group served by NMRHCA, not all members have the same access to programs and facilities commonly found in most major cities and towns. Therefore, the **NMRHCA Wise and Well Program** seeks to leverage all available resources to better serve all of its members.

Key Takeaways:

- Fitness programs, including Silver Sneakers, and a workplace wellness program demonstrated significant health care cost savings for participants.
- Reduced hospital utilization was a common outcome across evaluated senior fitness and wellness programs.
- Regular and sustained engagement was a key factor to program success.

Key Takeaways Specific to NMRHCA:

- NMRHCA offers Silver Sneakers with each of its Medicare Advantage Plan offerings.
- NMRHCA incentivizes engagement in fitness programs even when Silver Sneakers is not offered.

Multiple studies have demonstrated the overall effectiveness of retiree wellness initiatives at improving emotional health, physical functioning and quality of life while reducing costs. Moreover, these studies show that such improvements are materially influenced by frequency of participation.

The Burden of Chronic Disease

In any given year, those who have chronic conditions tend to have health care costs from 100 to 500 times greater than the costs for healthy employees. But healthy today doesn't mean healthy tomorrow. Up to 20 percent of low-risk employees will move to a higher-risk category within one year, according to research at the University of Michigan Health Management Research Center. When an employee loses low-risk status, an additional cost of $350 per year is added to that person's health care.

Chronic disease and associated comorbidities also are taking on an ever-increasing role in driving Medicare spending. Nearly 91 percent of people age 65 and older have one chronic condition or more. More than half of this population are treated for five or more conditions, and this group accounts for a disproportionate amount of spending (79 percent).[5,6] Approximately one-fourth of people with chronic illness also have one or more limitations in activities of

daily living (ADLs), such as walking, bathing, and dressing, and their health care spending often more than doubles in cost.[5,7,8] Not surprisingly, most people with activity limitations are Medicare members.[5]

"In addition to disease-related morbidity and functional decline, seniors often face loneliness, social isolation, and depression, which can have additional negative influences on their health and overall quality of life. These factors working in combination with chronic conditions and impairments can seriously compromise seniors' health and well-being. Social interactions have been shown to be associated with positive physiological benefits that can promote better health outcomes" Population Health

Metabolic Syndrome

Using the clevelandclinic.org definition, metabolic syndrome is a collection of heart disease risk factors that increase your chance of developing heart disease, stroke, and diabetes. This condition is also known as Syndrome X, insulin resistance syndrome, and dysmetabolic syndrome. According to a national health survey, more than one in five Americans have metabolic syndrome. The number of people with metabolic syndrome increases with age, affecting more than 40 percent of people in their 60s and 70s. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services, including such high-cost services as hospitalizations and emergency department visits, which translates into increased Medicare spending.2

Common consequences of metabolic syndrome include:

- Damage to the lining of coronary and other arteries, a key step toward the development of heart disease or stroke.
- Changes in kidney's ability to remove salt, leading to high blood pressure, heart disease and stroke.
- An increase in triglyceride levels, resulting in an increased risk of developing cardiovascular disease.
- An increased risk of blood clot formation, which can block arteries and cause heart attacks and strokes.
- A slowing of insulin production, which can signal the start of type 2 diabetes, a disease that is in itself associated with an increased risk for heart attack or stroke.

A Special Segment on Diabetes

NMRHCA is committed to the collaboration and implementation of programs aimed at preventing and controlling diabetes and its complications. Interventions that are both cost-saving and feasible may include: blood glucose control, blood pressure control, foot care, screenings and treatments for retinopathy (which causes blindness), blood lipid control (to regulate cholesterol levels) and screenings for early signs of diabetes related kidney disease and treatment. (World Health Organization.)

Diabetes is a major cause of blindness, kidney failure, heart attacks, stroke and lower limb amputation. Over time, diabetes can damage the heart, blood vessels, eyes, kidneys and nerves.

STATISTICS ABOUT DIABETES
(American Diabetes Association)

Prevalence: In 2015, 30.3 million Americans, or 9.4% of the population had diabetes. Approximately 1.25 million American children and adults have type 1 diabetes.

Undiagnosed: Of the 30.3 million adults with diabetes, 7.2 million were undiagnosed.

Prevalence in Seniors: The percentage of Americans age 65 and older remains high, at 25.2%, or 12.0 million seniors (diagnosed and undiagnosed).

New Cases: 1.5 million Americans are diagnosed with diabetes every year.

Prediabetes: In 2015, 84.1 million Americans age 18 and older had prediabetes.

Deaths: Diabetes remains the 7th leading cause of death in the United States in 2015, with 79,535 death certificates listing it as the underlying cause of death, and a total of 252,806 death certificates listing diabetes as an underlying or contributing cause of death.

Cost of Diabetes (updated 3/6/2013)

- $245 billion: total costs of diagnosed diabetes
- $176 billion: direct medical costs
- $69 million: reduced productivity

After adjusting for population age and sex differences, average medical expenditures among people with diagnosed diabetes were 2.3 times higher than what expenditures would be in the absence of diabetes.

The burden of diabetes can be reduced with simple lifestyle measures. Healthy diet, regular physical activity, maintaining a normal body weight and avoiding tobacco use are ways to prevent or delay the onset of type 2 diabetes. Diabetes can be treated and its consequences avoided or delayed with diet, physical activity, medication and regular screening and treatment for complications.

The complications and prevalence of diabetes commands an aggressive and proactive role within the **NMRHCA Wise and Well Program.** The table on page 11 outlines a vigilant management of diabetes programs that will greatly contribute to fighting the detrimental and life-threatening complications of this disease within the retiree population.

PLACE HOLDER - Preference Sensitive Surgeries and Data/Information on the health profile of the member population.

NMRHCA WISE and WELL PROGRAM APPROACH TO IMPROVE ENGAGEMENT and HEALTH OUTCOMES

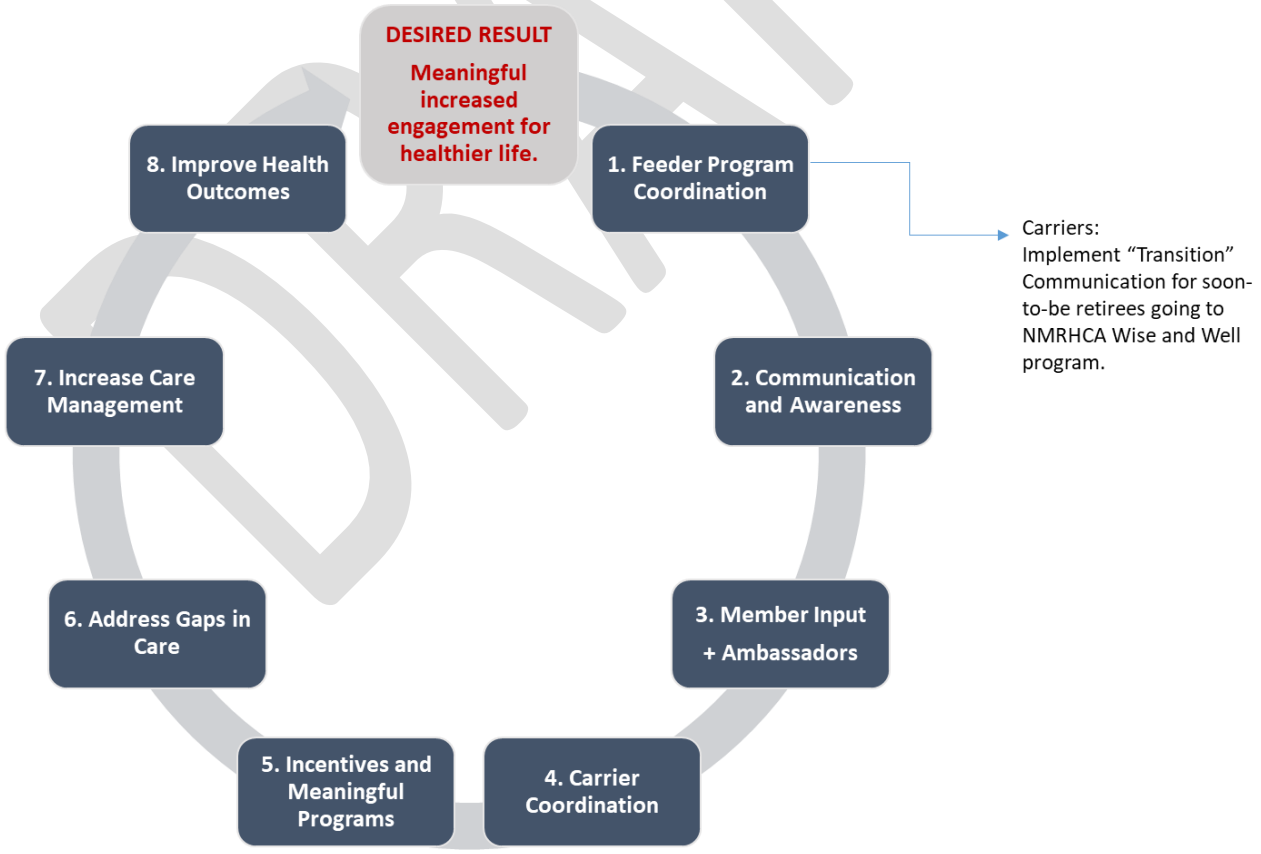
The fundamental purpose to the **NMRHCA Wise and Well Program** is to increase engagement in order to achieve better health outcomes for the member population thereby managing health care costs. Two approaches; the Visual Model and the Care Continuum model are described below to emphasize the paths necessary for focused care and resources.

The Visual Program Model

This visual representation highlights the general activities or initiatives that when linked together will ideally lead to the desired result of *meaningful increased engagement for a healthier life.* These activities are further supported in detail with the goals, objectives and action plans outlined on pages 11 and 12.

An ongoing assessment and review of these general activities will help make course corrections to produce better results and generate new possibilities throughout the development and implementation of the **NMRHCA Wise and Well Program**. This visual model approach helps create shared understanding of and focus on program inputs and methodology relating to projected outcomes.

Further, **NMRHCA Wise and Well Program** will use the following annual markers to determine progress within the program:
Year 1 and 2 – Reach, Awareness, Engagement (e.g. % of employees participating, change in activity levels)
Year 3 and 4 - Shift in Physiological Markers (e.g. weight, cholesterol, blood pressure)
Year 5 - Cost Avoidance and Savings (e.g. reductions in medical & pharmacy claims)



The Continuum of Care for the Population and Individuals.

Chronic Disease is increasing rapidly; the World Health Organization predicts that by the year 2020 chronic disease will account for three quarters of all deaths and warns that the causes of deaths today are attributable to diseases that were either preventable in the first place or could have been managed to prolong life expectancy. Effective prevention and management is a key goal for the **NMRHCA Wise and Well Program**. More than 400,000 people die each year in the United States as a direct result of obesity and sedentary lifestyle, and perhaps that same amount again is attributable to heart disease, hypertension, and type 2 diabetes.

Changes need to be on the horizon for the NMRHCA Wise and Well Program. Facing the fact that the affordability to cover the costs associated with treating these diseases over a broad percentage of the population or for such long periods of time requires a wellness model for the continuum of care. Wellness incentive programs must become more aligned to get retirees who are at risk into the best program for prevention and management. As retirees start to embrace that their own behavioral change can be as important a part of managing health as a visit to the doctor, they will become more aligned with becoming empowered to take control of their own health and wellbeing.

In general, health risks flow from low to high. The same is true for health care costs. Low-risk individuals, won't stay low-risk forever.

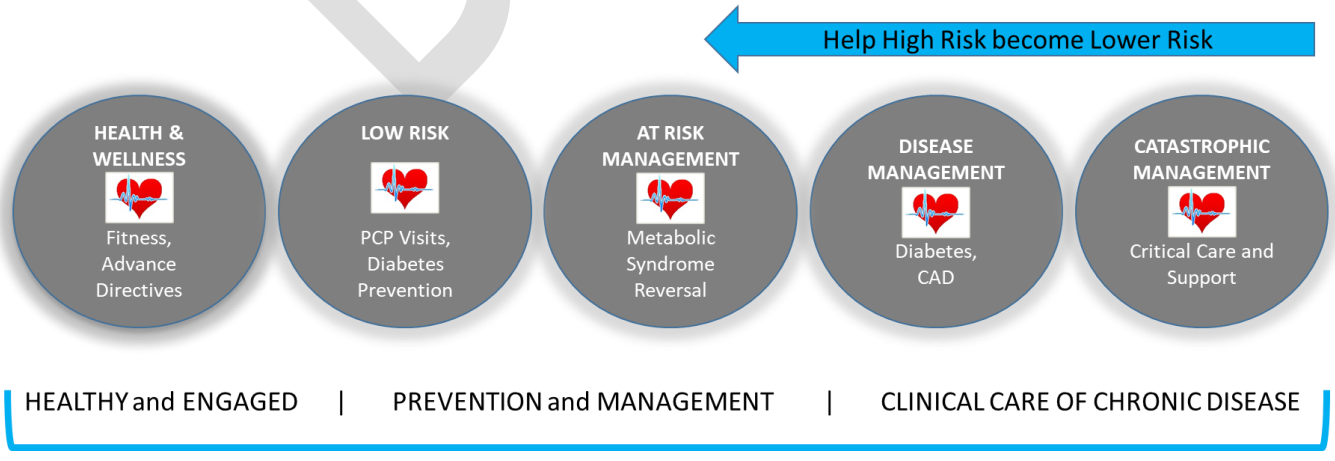
- As many as 10-20% of low-risk individuals will move to a higher risk category in a year.

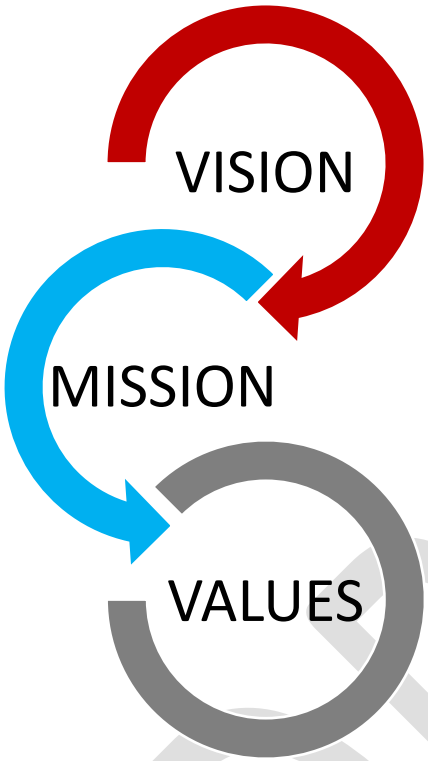
The intent of the **NMRHCA Wise and Well Program** is to be integrated into the continuum of care to address both high-risk and low risk retirees with appropriate initiatives:

1. Healthy and Engaged (pre-prevention)
2. Prevention and Management
3. Clinical Care of Chronic Diseases

Success Factors associated with positive impact within the Continuum of Care:

- Partnerships with carriers must show a demonstrable impact on improved outcomes across a broad sample of the target population.
- Even in the most clinical settings, the program must be easy to use for the patient/consumer.
- Programs need to operate in a way that seamlessly integrates with provider and health system workflows.
- Programs need to include meaningful human interaction/coaching to sustain engagement over a long period of time.
- Programs need to have some measure of positive social re-enforcement in the manner of a classic multi-step program.3





VISION

We believe in creating opportunities and encouraging our members to embrace the benefit of developing and maintaining healthy living habits to enjoy a happy retirement.

MISSION

Nurture, cultivate and encourage our community of retirees to discover and use all wellness offerings for an active life, active mind and social encounters in their retirement years.

CORE VALUES

Opportunity

We are dedicated to supporting RHCA members with every *opportunity* to access health and wellness needs and interests.

Partnerships

We will create *partnerships* with community centers and liaisons to bring wellness to you.

Personal Responsibility

We encourage and foster *personal responsibility* for making healthy choices.

Quality of Life

We connect wellness interventions and health care to things people care about to realize *quality of life*.

Sustainability

We dedicate financial resources to achieve *sustainability* and security with health care.

GOALS AND OBJECTIVES

GOALS	OBJECTIVES	ACTION PLANS/TACTICS
1. Expand COMMUNICATION and Reach Aggressive pursuit of methods that draw attention to wellness awareness, education and services.	1. Capture member success stories and testimonials; document and communicate. 2. Brand messages addressing individual apathy to inspire the desire to live a long, active and independent retirement life at home. 3. Develop community partnerships where members have deep connections to draw crowds and to have access to central meeting locations.	• Post cards, newsletters. • Hold public consultations/meetings on health aging and wellness. • Health People 2020 – Health People in Action (Office of Disease Prevention and Health Promotion) • Six ways to use a Wellness Calendar: incentive, prize, promotion for tracking event, bundle with other communication, community events, holidays
2. Increase ENGAGEMENT Achieve frequent participation and sustained engagement for a larger, positive impact on overall health status of retirees.	1. True on-site integration whenever possible to overcome barriers and expand reach. 2. Develop social tactics and approaches to increase engagement. 3. Maximize all carrier resources with one voice and consistent execution of objectives. 4. Implement Strategic Planning meetings with carriers designed for short term implementation, collaboration, and efficient use of all resources. 5. Proactively coordinate wellness efforts, culture, and awareness with Feeder Programs.	• Design programs that foster social ties and create a community of social network. Buddy Programs? • Allocate part of the webinars to help with technology. • Phone contact as a priority. • Create attention-generating and FUN in wellness activities and exercise (square dancing) program roll-outs. • Schedule two annual strategic planning meetings for all carriers.
3. Focused Chronic Disease PREVENTION AND MANAGEMENT Manage the health care continuum to include wellness management for the healthy, at risk, chronic disease and complex case management.	1. Aggressively implement quality (over quantity) programs designed for pre-diabetes population and for managing current diabetes prevention. 2. Polypharmacy – Reduce number of adverse outcomes associated with taking 5 or more medications. 3. Deliver the right care at the right time, teach "Demand Management."* 4. Use specialized resources to help patients with chronic illnesses, catastrophic illnesses, or injuries to promote healthful, cost-effective interventions and outcomes.	• Carriers to identify population for pre-diabetes and diabetes and implement educational and intervention focused programs. • Implement Polypharmacy initiative to identify population, create intervention and communication program between PBMS, Patients and Providers. • Partner with experts in managing complex cases. • Self-care guides.
4. INCENTIVIZE Participation and Value-Based Care Connect incentives to motivate engagement, bring awareness and increase participation.	1. Reduce the number of preference sensitive surgeries and redirect care to lesser costing facilities. 2. Decide which behaviors, activities or health status to incentivize. 3. Incentivize adherence to diabetes population.	• Within the plan design, implement flat cost for certain identified procedures vs. percent of total cost. • Incentivize the completion of Personal Health Assessments. • Carriers to present their design.

***"Demand Management."** Wise consumerism includes seeking preventive care and avoiding unnecessary or routine use of hospital emergency rooms. "Approximately 55 percent of all emergency room visits are for non-urgent problems, and about 25 percent of all physician visits could have been treated at home," Powell said. "Demand can be managed by helping employees become more knowledgeable about when they need medical assistance and when they can take care of themselves." SHRM/Resources and Tools

Cost of Care – Paragraph Pending

NMRHCA WISE AND WELL PROGRAM

PROGRAMS, RESOURCES and TOOL KIT

Growth of the Medicare population and associated trends of increasing morbidity and functional decline, support the need for retiree oriented wellness programs that improve health and preserve or extend functional capabilities that will effectively improve retiree quality of life.

Diabetes Programs

	DIABETES PREVENTION Low Risk and Pre-diabetic	**DIABETES MANAGEMENT** Ongoing and Control	**DIABETES EMERGING RISK** Utilization Management Cost Containment
Objective	Reverse or delay the diagnosis of type 2 diabetes with lifestyle change.	To help people already diagnosed with diabetes take charge of their health.	Clinical management program focusing on access to care, adherence to treatment plan, and behavior change.
Early Identification Processes	• Primary Care Relationship • Screening Data • Current Data • PHAs		
Community Resources	Chronic Disease Self-Management Program (MyCD, NM DOH)	Kitchen Creations (Diabetes Cooking Classes via NMSU Extension Services) Diabetes Self-Management Program (NM DOH)	
Care Management			
Case Management			
Programs (type of access, e.g., on-site events, in-person, virtual, clinics)	Presbyterian: Good Measures Virtual access (coming April 2018) National Diabetes Prevention Program Diabetes Academy	Presbyterian: 1. Diabetes Support Program – work with a dietitian who specializes in diabetes management. 2. Good Measures Connected Diabetes Program – provide glucose monitor for virtual tracking, clinical team support for enhanced management options.	Presbyterian: Healthy Solutions Disease Management
Incentives	Primary Care		

NMRHCA WISE AND WELL – CARRIER PROGRAMS and RESOURCES *

	Wellness Awareness and Engagement	**Risk Reduction**	**Clinical Care of Chronic Disease**
Program Goal	Proactive reach to drive engagement and personal responsibility.	Improve health status, reduce or mange the progression of health risk and early chronic illness.	Improve health status through comprehensive integrated action with wellness, clinical support and case management.
Programs	• Biometric Screenings (B,P) • PHA (B,P,U,H) • Healthy Wellness Challenges(B, P) • Wellness Incentive Campaigns (B,P,U) • Wellness Webinars (B) • Health Library (B, P, U, H) • Wellness @ Work Portal (P) • Health/Wellness Trackers (B,P,U, H) • Wearables (B) • Custom Text Messages (B) • Wellness Coaching (B, U, H) • 24/7 Nurse Line (B, U, H) • Wellness Calendar (U) • Food and Exercise Diary/logs (P) • Self-Directed online Health and Wellness workshops via Wellness at Work (P) • Diabetes Learning Academies (educational presentation& materials, cooking demo (P)) • Blood Pressure Learning Academy (educational presentation & materials, cooking demo(P)) • Dinner with a Dietitian: 4 week video course on cooking healthier with diabetes (P) • Better Bone Strength: 6 wk video course on nutrition & exercise to build & maintain bone strength and density(P) • Change is Possible: 9 wk video course on weight management & behavior change • Silver Sneakers (H) • Go365 Wellness Program (H)	• Preventive Screenings (B,P,U, H) • Self-Directed online Health and Wellness Courses (B, P) • Good Measures Diabetes Prevention Program, 1 year w/Registered Dietitian (P) • Good Measures Better Health program, 1 year w/Registered Dietitian (P) • Health Coaching - Telephonic and Online (P, H) • Wellness at Work Online Wellness Portal (P) • Video/Virtual Visits (P,T,U,H) • 24/7 Nurse Line (B,P,H) • Omada Health (B) • Quit for Life – tobacco cessation program(P,H) • Naturally Slim Program (B) • Dinner with a Dietitian – 4 week email video course focused on cooking healthier with diabetes • Better Bone Strength – 6 wk video course on nutrition and exercise to build, maintain bone strength and density (P) • Change is Possible – 9 wk video course on weight management & behavior change (P) • Promotion of community programs: Kitchen Creations for Type 2 Diabetes and Health Pathways for Stanford Manage Your Chronic Disease classes	• Healthy Solutions Disease Management Programs including condition management, coaching and courses (P,H) • Care Coordination and Early Intervention, Education and Support before, during and after hospital admission (B) • Discharge Planning (U,H) • Case Management/Care Coordination (P, B, U) • Condition Management for Chronic Conditions (B,U,H) • Diabetes Management Programs (B,H) • 24/7 Nurse Line (P,U,H) • Video Visits (P,H) • Good Measures Better Health program, one year program w/Registered Dietitian – fill gaps between healthy and unmanaged chronic conditions • Behavioral Health (B,U,H) • Home Monitoring (U,H) • Community Transitions (U,H*) *Humana care managers connect members to community resources as needed and available.
Scope	No Risk to Low Risk Offered to Whole Population	At Risk to Medium Risk Whole Population and Selected Individuals	High-Risk Selected Population with High-Risk Disease
Outcomes	PARTICIPATION AND ENGAGEMENT	LIFESTYLE MODIFICATION	CHRONIC DISEASE MANAGEMENT

Legend: B = BCBS P = Presbyterian U = United Healthcare

*Footnotes from BCBS

- Premedicare plan: This group does have Blue Care Connection and would have access to all the resources that we listed for the NMPSIA population. I have revised a few things that have changed since 2017, to include our Naturally Slim, Omada Health and Livongo programs (listed in Blue). We will also be adding a lot of new self directed courses and coaching topic areas on our Well onTarget portal, however those changes won't roll out until 7/1/18 and 1/1/19 (two phases) and I didn't make the formal changes. I will bring a list of new topic areas to the retreat.

The other plans below are more limited in programs, but please see the details I confirmed with our account management team.

- NMRHCA Medicare Supplement plans are secondary to Medicare. They do not have the full suite of BCC available to them. The selected programs they do have are 24/7 Nurseline and Case Management. As for other resources, those would have to come from the community or other on-line resources. This population would have the opportunity to participate in the Naturally Slim, Omada Health or Livongo weight loss and diabetes prevention programs should NMRHCA decide to offer, since they are billed through claims and not part of the BCC core offerings. *** Please note that we would need to have additional provisions in place for this group before claims are filed to make sure that Medicare does not pay as primary. I have spoken to the account team about this and they feel like we can provide a solution to streamline.

- MAPD (Medicare Advantage Prescription Drug) program is managed very tightly by CMS regulations. An in person HA is tried to be obtained at the point of enrollment. They also have Utilization Management, Case Management as well as Silver Sneakers.

MEASURES OF SUCCESS AND EVALUATION PLAN

The highlighted metrics are the most meaningful for understanding the current and evolving state of the **NMRHCA Wise and Well Program**.

TYPE	METRIC	Data Source	BASELINE	TARGET FOR 2018
Member Population Health Measures	Percent of plan participants completed personal health assessment	Vendor Data	TBD	TBD
	Percent of individuals referred to case management, engaged in case management	Health Plan Data	TBD	TBD
	1. Number of wellness events 2. Number of people attending wellness events	Vendor Data	TBD	TBD
	Percent of members receiving age-appropriate screenings	Health Plan Data		
	Total number of completed coaching appointments	Vendor/Health Plan Data		
	Total number of community outreach centers.	Vendor Data	TBD	TBD
	Percent of members receiving flu shot	Health Plan Data	TBD	TBD
	Identification and management of pre-diabetics	Health Plan Data	TBD	TBD
	Percent of diabetics actively engaged in disease management programs	Vendor/Health Plan Data	TBD	TBD
Member Input Measures	Member interest/feedback surveys	Organization/Vendor Data	TBD	TBD
	Program satisfaction surveys	Vendor Data	TBD	TBD

Footnotes

- 1 - **http://www.modernhealthcare.com/article/20180226/NEWS/180229934**
- 1 - **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3870597/**
- 2 - https://www.cdc.gov/pcd/issues/2013/12_0137.htm
- 2 - **https://www.shrm.org/ResourcesAndTools/hr-topics/benefits/Pages/10StepsforWellness.aspx**
- 2 - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3870597/
-
- 3 - https://www.health.qld.gov.au/__data/assets/pdf_file/0025/156706/hlthsrvpln14.pdf

NEW MEXICO RETIREE HEALTH CARE AUTHORITY
CHANGE IN NET ASSET VALUE
FOR THE MONTH ENDED
April 30, 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 3/31/2018	$113,221,583.89	$136,744,639.82	$72,805,778.78	$99,889,362.88	$17,509,511.34	$61,264,075.61	$28,670,837.37	$68,237,553.82	$34,574,177.95	$632,917,521.46
CONTRIBUTIONS	45,942,000.00	0.00	2,211,000.00	0.00	1,817,000.00	2,462,725.86	50,888.49	0.00	0.00	52,483,614.35
WITHDRAWALS	0.00	(12,975,000.00)	0.00	(6,629,000.00)	0.00	(50,888.49)	(28,721,725.86)	(2,465,000.00)	(1,642,000.00)	(52,483,614.35)
FEES	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
INCOME EARNED	502,254.98	132,618.95	287,589.47	113,947.89	4,503.70	53,230.34	0.00	31,636.23	77,362.02	1,203,143.58
CAPITAL APPR/DEPR	(1,197,905.08)	286,041.79	1,346,719.90	(636,746.79)	147,374.33	140,862.02	0.00	(196,362.40)	(113,316.98)	(223,333.21)
Market Value 4/30/2018	$158,467,933.79	$124,188,300.56	$76,651,088.15	$92,737,563.98	$19,478,389.37	$63,870,005.34	$0.00	$65,607,827.65	$32,896,222.99	$633,897,331.83

Life and Disability Insurance Consultant RFP/Contract Amendment – Action Item

Background: Consistent with the requirements contained in the Health Care Purchasing Act, the New Mexico Retiree Health Care Authority (NMRHCA) in cooperation with the other members of the interagency benefits advisory committee (IBAC) including: Albuquerque Public Schools (APS), New Mexico Public School Insurance Authority (NMPSIA) and the State of New Mexico (SONM) released a request for quotation (RFQ) for professional services related to the consulting functions associated with the upcoming life and disability procurement scheduled for release in the fall of 2018. NMPSIA is serving as the lead on this procurement and has assigned Ms. Pamela Vigil, to serve as procurement manager.

Process: In accordance with 1.14.1.52 NMAC Small Purchase of Professional Services, a Request for Quotations was issued on May 18, 2018. The notice was advertised on www.nmpsia.com and sent out to the following firms: Arthur J. Gallagher, Segal Consulting, Aon Risk Solutions, McGriff, Seibels & Williams, Reden-Anders and Buck Consultants. Reponses were due May 29, 2018.

Evaluation Team: Ernestine Chavez, Deputy Director, NMPSIA, Richard Valerio, Chief Financial Officer, NMPSIA, David Archuleta, NMRHCA, Neil Kueffer, NMRHCA, Vera Dallas, APS, Ann Johnson, APS, Cynthia Maestas, RMD and Lara White-Davis, RMD.

Evaluation: The IBAC received four competitive proposals from Arthur J. Gallagher, Segal Consulting, Aon Risk Solutions, and McGriff, Seibels & Williams. Given the nature of this procurement, a set criterion for evaluating each quote was not pre-determined. Rather, each IBAC entity was allowed to use their discretion in assessing the quality of the quotes and perceived desire to serve as consultant on the Life and Disability RFP combined with the cost proposal, in ranking the offerors.

The IBAC met telephonically on Thursday, May 31 to discuss each groups review of the quotes received and recommended actions for the selection of a vendor. Cost proposals were as follows:

Aon Risk Solutions	$40,500
McGriff, Seibels and Williams	$45,000
Segal Consulting	$48,000
Arthur J. Gallagher	$48,400

Based on this discussion and subsequent contract negotiations, it was determined that Segal would be recommended to each of the IBAC governing authorities.

Action Item: Each of the IBAC members will be responsible for amending or entering into a small purchasing agreement with Segal to accommodate a prorated share of the total cost as follows:

NMRHCA	$8,000
SONM	$8,000
NMPSIA	$16,000
APS	$16,000

NMRHCA staff respectfully requests approval to amend its existing contract with Segal to accommodate the scope of work related to the upcoming Life and Disability Insurance procurement.

2019 Preliminary Plan Recommendations

Pre-Medicare/Medicare Rates

1. Increase retiree premiums in accordance with projected medical trend for all self-insured plans based on upon loss ratios calculated in May --- estimate available by June Board meeting for the following plans:
   - BCBS Premier
   - BCBS Value Plan
   - Presbyterian Premier
   - Presbyterian Value Plan
   - BCBS Medicare Supplement

Pre-Medicare Plan Design

2. Presbyterian Health Plan - Bundled Payment Agreements
   - Assumes all central NM and 50% of regional surgeries performed under bundle agreement
   - Presbyterian Health Care Services
     - Hernia
     - Laparoscopic Cholecystectomy
   - NM Orthopedics
     - Shoulder Arthroscopy
     - Knee Arthroscopy
   - Service Expansion
     - Santa Fe – October 2018
     - Farmington – TBD
     - Las Cruces – TBD

     Estimated Savings - $50,000 annually

3. BCBS 3rd Tier Coverage for Restricted Network Use
   - Premier Plan
     - Tier 1 – Blue Preferred Plus ($500 deductible$3,000 OOP Max)
     - Tier 2 – Preferred Provider ($800 deductible/$4,500 OOP Max)
     - Tier 3 – Non-Preferred ($1,500/$6,000 OOP Max)
   - Blue Preferred Primary Care Provider (PCP) Selection is required
     - Referrals are not required
     - Standard pre-authorization applies
     - Presbyterian Healthcare Services is not included in Blue Preferred (Tier 1) network

     Estimated Savings - $1 million

4. Pilot Project w/Grand Rounds to provide Expert Medical Opinions
   - Sample size of 8-12 expert medical opinion cases in order to assess overall member experience and partnership experience
   - Types of cases supported by Pilot Project
     - Orthopedics - 32%
     - Neurology - 13%
     - Oncology - 10%
     - GI - 8%
     - All other 37%
   - Should be considered for the following situations:

- Clinically complex or ambiguous medical situations where there is a lack of clarity on diagnosis or treatment
- Rare or unusual medical conditions for which local/regional expertise is limited
- Catastrophic, often emotionally charged situations such as late stage cancer diagnosis for which there are wide variations in care practices
- Elective surgeries for which there may be more appropriate or effective treatment options (musculoskeletal procedures, cardiac stenting, hysterectomy, carpal tunnel, bariatric, etc.)
- Situations in which a member is planning to travel out of state for diagnosis/treatment, Grand Rounds is a member-friendly, cost effective way to clarify diagnosis, and/or confirm the need to travel for treatment
- Any situation where the member is experiencing high anxiety, uncertainty, and lack of understanding about their diagnosis, treatment options, or just feels "stuck"

Medicare Supplement Plan Design

5. Supplement – introduce $250 copay for inpatient stay (1 per year)
   - 2017 – 189 admits per 1,000 people
     Estimated Savings - $1 million

6. Supplement – increase annual Part B cost sharing by $50
   - 2017 – approximately 21,000 x $50
     Estimated Savings - $1,052,350

Pharmacy Benefits

7. Brand Increase
   - Commercial Savings - $364,000
   - EGWP Savings - $738,000
8. Generic Increase
   - Commercial Savings - $430,000
   - EGWP Savings - $571,800
9. Specialty Copay Tier
   - Commercial Savings - $187,000
   - EGWP Savings - $1.7 million
10. Other Programs - $1.7 million
    - Additional clarification and details will be presented upon announcement of PBM selection

Wellness

11. Addition of Naturally Slim Program
12. Addition of Better Health for Weight Loss Program through Good Measures

Additional Variables Impacting Solvency Report/Year End Goals:

- Savings associated w/new PBM agreement
- Investment earnings and end-of-year trust fund balance

New Mexico Retiree Health Care Authority
Baseline Assumptions for Long-Term Solvency Projections

Assumption	Prior Assumption July 2014	Prior Assumption July 2015	Prior Assumption July 2016	Prior Assumption July 2017	Current Assumption July 2018
Asset Balance	Use May 31, 2014 fund balance of $369,131,762 as an estimate for 7/1/2014 fund balance	Use May 31, 2015 fund balance of $429,925,522 as an estimate for 7/1/2015 fund balance	Use May 31, 2016 fund balance of $455,592,072 as an estimate for 7/1/2016 fund balance	Use May 31, 2017 fund balance of $551,412,183 as an estimate for 7/1/2017 fund balance	Use March 31, 2018 fund balance of $632,917,521 as an estimate for 7/1/2018 fund balance
Investment Return	No Change	No Change	No Change	7.25%	No Change
Annual Growth in Payroll	F20Y14 payroll estimated to be $3,941,587,760, increasing 3% through 6/30/15 and 3.5% thereafter	F20Y15 payroll estimated to be $4,040,779,736, increasing 3.5% annually	FY2016 payroll estimated to be $4,126,747,451, increasing 3.5% annually	FY2017 payroll estimated to be $4,165,647,339, increasing 0.0% through FY2020 and 3.5% thereafter	FY2018 payroll estimated to be $4,169,085,993, increasing 2.0% in FY2019, 0.0% in FY2020, and 3.5% thereafter
Contribution Rates (Employer/Employee)					
Public Safety, et al	2.50%/1.25%	No Change	No Change	No Change	No Change
Other Occupations	2.00%/1.00%	No Change	No Change	No Change	No Change
Annual Growth in Retirees					
Non-Medicare	1.75% annually through 6/30/2015, then based on FY2009 open valuation output table	No Change	based on FY2014 open valuation output table	No Change	No Change
Medicare	5.8% through 6/30/2015, then based on FY2009 open valuation output table	No Change	based on FY2014 open valuation output table	No Change	No Change
Retiree Ancillary Costs	Assumed to equal premium expenses and is paid fully by retirees	No Change	No Change	No Change	No Change
Pension Tax Revenue	$20,931,300 for FY2014, increasing 12% thereafter	$23,443,056 for FY2015, increasing 12% thereafter	$26,256,200 for FY2016, increasing 12% thereafter	$28,306,470 for FY2017, frozen through FY2019 and increasing 12% thereafter	$26,256,221 for FY2018, frozen through FY2019, increasing 12% thereafter
HB 728/573 Revenue	$3 million annually, no sunset	No Change	No Change	Eliminated effective 1/1/2017	No Change
Rx Rebates	Rebates of $8,407,050 estimated for FY14, reflecting proposed contract terms through FY18; all annual figures increased at retiree growth rate	Rebates of $8,960,237 estimated for FY15, reflecting proposed contract terms through FY18; all annual figures increased at retiree growth rate	Rebates of $8,566,058 estimated for FY2016, reflecting proposed contract terms through FY2018; all annual figures increased at retiree growth rate	Rebates of $18,321,264 estimated for FY2017, reflecting proposed contract terms through FY2018; all annual figures increased at retiree growth rate	Rebates of $32,085,060 estimated for FY2019; proposed contract terms reflected through FY2020, increased at retiree growth rate thereafter.
EGWP Revenue Components:					
Direct Subsidy	CY2014-15 projected by ESI; thereafter increases annually at retiree growth rate, plus one half of Medicare Rx trend +1% for donut hole closure CY16 through CY20 (one half of Medicare Rx trend CY2021+)	CY2015-16 projected by ESI; thereafter increases annually at retiree growth rate, plus one half of Medicare Rx trend +1% for donut hole closure CY17 through CY20 (one half of Medicare Rx trend CY2021+)	CY2016 and CY2017 projected by ESI; thereafter increases annually at retiree growth rate, plus one half of Medicare Rx trend +1% for donut hole closure CY2018 through CY2020 (one half of Medicare Rx trend CY2021+)	CY2017 and CY2018 projected by ESI; thereafter increases annually at retiree growth rate, plus one half of Medicare Rx trend +1% for donut hole closure CY2019 through CY2020 (one half of Medicare Rx trend CY2021+)	CY2018 and CY2019 projected by ESI; thereafter increases annually at retiree growth rate, plus one half of Medicare Rx trend +1% for donut hole closure through CY2020 (one half of Medicare Rx trend CY2021+)
Federal Reinsurance	CY2014-15 projected by ESI; CY2016+ annual increase at only retiree growth rate	CY2015-16 projected by ESI; CY2017+ annual increase at only retiree growth rate	CY2016 and CY2017 projected by ESI; CY2018+ annual increase at only retiree growth rate	CY2017 and CY2018 projected by ESI; CY2019+ annual increase at only retiree growth rate	CY2018 and CY2019 projected by ESI; CY2020+ annual increase at only retiree growth rate
Low Income Subsidy	0.0% annual increase to CY2014 estimate of $2.85 PMPM	0.0% annual increase to CY2015 estimate of $3.40 PMPM	0.0% annual increase to CY2016 estimate of $3.40 PMPM	0.0% annual increase to CY2017 estimate of $2.84 PMPM	0.0% annual increase to CY2018 estimate of $2.87 PMPM
Coverage Gap Discount Program	CY2014-15 projected by ESI; CY2016+ annual increase at only retiree growth rate	CY2015-16 projected by ESI; CY2017+ annual increase at only retiree growth rate	CY2016 and CY2017 projected by ESI; CY2018+ annual increase at only retiree growth rate	CY2017 and CY2018 projected by ESI; CY2019+ annual increase at only retiree growth rate	CY2018 and CY2019 projected by ESI; CY2020+ annual increase at only retiree growth rate
Short Term Interest	$0 projected for FY2014, increasing 0.0% annually	No Change	No Change	No Change	No Change
Subrogation	$239,932 estimated for FY2014, increased at retiree growth rate	$277,326 estimated for FY2015, increased at retiree growth rate	$327,942 estimated for FY2016, increased at retiree growth rate	$279,589 estimated for FY2017, increased at retiree growth rate	$283,753 estimated for FY2018, increased at retiree growth rate

New Mexico Retiree Health Care Authority
Baseline Assumptions for Long-Term Solvency Projections

Assumption	Prior Assumption July 2014	Prior Assumption July 2015	Prior Assumption July 2016	Prior Assumption July 2017	Current Assumption July 2018
Annual Trend					
Medical					
Medicare Advantage	8.00%	No Change	No Change	No Change	No Change
Medicare Supplement	8.00%	No Change	No Change	No Change	No Change
Medicare Rx	8.00%	No Change	No Change	No Change	No Change
Non-Medicare Medical	8.00%	No Change	No Change	No Change	No Change
Mental Health	Included in Medical Trend	No Change	No Change	No Change	No Change
Non-Medicare Rx	8.00%	No Change	No Change	No Change	No Change
Medical Rates	Annual Non-Medicare rate increases of 8% in 2015-2020 and 3% thereafter, 5% Medicare Supplement rate increase in 2015 and 6% thereafter	Annual Non-Medicare rate increases of 8% in 2016-2021 and 4% thereafter, 6% Medicare Supplement rate increase in 2016-2033 and 3% thereafter	2017 rates for Premier and new Value plan set per pricing exercise; Annual Non-Medicare rate increases of 8% in 2018-2022 and 4% thereafter, 6% Medicare Supplement rate increase in 2017-2030 and 3% thereafter	Annual Non-Medicare rate increases of 8% in 2018-2022 and 4% thereafter, 6% Medicare Supplement rate increase in 2017-2031 and 3% thereafter	Annual Non-Medicare rate increases of 8% in 2019-2023 and 4% thereafter, 6% Medicare Supplement rate increase in 2019-2033 and 3% thereafter
Life Insurance	Assumes level total premium on Basic Life for duration of projection	Assumes level total premium on Basic Life through CY17 decreasing 25% per year through CY21	No Change	No Change	No Change
Dental	0.06	No Change	No Change	No Change	No Change
Vision	5.00%	No Change	No Change	No Change	No Change
Program Support	$2,929,300 budgeted for FY2015, increasing 2.5% annually thereafter	$3,012,900 budgeted for FY2016, increasing 2.5% annually thereafter	$3,118,300 budgeted for FY2016, increasing 2.5% annually thereafter	$2,936,800 budgeted for FY2017, increasing 2.5% annually thereafter	$3,015,200 budgeted for FY2018, increasing 2.5% annually thereafter
Administrative Services Fee	Individual fee components based on existing contract terms in place, increasing 2.00% annually thereafter	No Change	No Change	No Change	No Change
Plan Design Changes					
Medical					
Medicare	Annual plan changes in CY2034 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Annual plan changes in CY2034 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Annual plan changes in CY2031 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Annual plan changes in CY2032 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Annual plan changes in CY2034 and beyond such that projected claims and expenses remain beneath Excise Tax threshold
Non-Medicare	Consolidation of Non-Medicare plans in CY2017, annual plan changes in CY2021 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Consolidation of Non-Medicare plans in CY2017, annual plan changes in CY2022 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Beginning CY2017: Elimination of Premier Plus plan, introduction of Value plan, Premier plan OOP max increase to $4,500, deductible and copays accumulating to OOP max; annual plan changes in CY2023 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Beginning CY2018, expanding value option to BCBS; annual plan changes in CY2023 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Discontinue NM Health Connections Value plan effective 6/30/18 with members assumed to migrate to BCBS Value plan. Beginning CY2019, add 3rd BCBS Premier plan tier with restricted network; annual plan changes in CY2024 and beyond such that projected claims and expenses remain beneath Excise Tax threshold
Rx					
Medicare	Annual plan changes in CY2034 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Annual plan changes in CY2034 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Eliminate coverage for drugs now available over the counter (OTC); Annual plan changes in CY2031 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Add Voluntary Smart90 program; annual plan changes in CY2032 and beyond such that projected claims and expenses remain beneath Excise Tax threshold	Beginning CY2019, increase brand copays; annual plan changes in CY2034 and beyond such that projected claims and expenses remain beneath Excise Tax threshold
Non-Medicare	No changes for 1/1/2015 or beyond	No changes for 1/1/2016 or beyond	Eliminate coverage for drugs now available over the counter (OTC)	Add Voluntary Smart90 program	Beginning CY2019, add SavOnSP Copay Assistance Program and increase brand copays
Basic Life and AD&D	No new entrants	No new entrants	No new entrants	No new entrants	No new entrants
Annual Index in Cadillac Tax Thresholds	3%	3%	3%	3%	3%

New Mexico Retiree Health Care Authority
Baseline Assumptions for Long-Term Solvency Projections

Assumption	Prior Assumption July 2014	Prior Assumption July 2015	Prior Assumption July 2016	Prior Assumption July 2017	Current Assumption July 2018
Annual Increase in PCORI Fee	Projected increase in National Health Expenditures, per CMS Office of the Actuary	Projected increase in National Health Expenditures, per CMS Office of the Actuary	Projected increase in National Health Expenditures, per CMS Office of the Actuary	Projected increase in National Health Expenditures, per CMS Office of the Actuary	Projected increase in National Health Expenditures, per CMS Office of the Actuary
Member Rate Share					
Retiree					
Medicare	50%	No Change	No Change	No Change	No Change
Non-Medicare	35%	36% in CY2016+	No Change	No Change	No Change
Spouse					
Medicare	75%	No Change	No Change	No Change	No Change
Non-Medicare	62% in CY2015+	64% in CY2016+	No Change	No Change	No Change
Child(ren)					
Medicare	100%	No Change	No Change	No Change	No Change
Non-Medicare	100%	No Change	No Change	No Change	No Change
Minimum Service to Receive Full Subsidy	20 years	No Change	No Change	No Change	No Change
Minimum Participation Age	None	No Change	No Change	No Change	No Change

New Mexico Retiree Health Care Authority
July 2018 Long-Term Solvency Modeling

Scenario Name	2017 Solvency Model*	Baseline 1	Scenario 1A	Scenario 1B	Scenario 1C	Scenario 1D	Baseline 2	Baseline 2A	Baseline 2B	Scenario 2C	Scenario 2D
CY2018 Plan Changes: Non-Medicare											
Discontinue NMHC Value plan effective 6/30/18	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
CY2019 Plan Changes: Non-Medicare											
Add 3rd BCBS Premier plan tier with restricted network	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
SaveOnSP Copay Assistance Program	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Increase brand copays	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
CY2019 Plan Changes: Medicare											
Increase brand copays	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
$250 inpatient hospital copay	☐	☐	☑	☑	☐	☐	☐	☑	☑	☐	☐
Increase Part B cost share $50	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	☐
CY2019 Premium Rate Changes: Non-Medicare											
Premier	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	9.0%/10.0%/10.0%**	9.0%/10.0%/10.0%**	9.0%/10.0%/10.0%**	9.0%/10.0%/10.0%**	9.0%/10.0%/10.0%**
Value	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	7.0%	7.0%	7.0%	7.0%	7.0%
CY 2019 Premium Rate Changes: Medicare											
	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
Non-Public Safety Contribution Rate (EE/ER)* **											
FY2019 & FY2020	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%
FY2021	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.125%/2.25%	1.25%/2.25%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.125%/2.25%	1.25%/2.25%
FY2022	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.25%/2.50%	1.50%/2.50%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.25%/2.50%	1.50%/2.50%
FY2023	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.375%/2.75%	1.75%/2.75%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.375%/2.75%	1.75%/2.75%
FY2024	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.50%/3.00%	1.75%/2.75%	1.0%/2.0%	1.0%/2.0%	1.0%/2.0%	1.50%/3.00%	1.75%/2.75%
Pre-Medicare Rate Share Retiree/Spouse											
CY2019 & CY2020	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%
CY2021	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	37.0%/66.0%	37.0%/65.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	37.0%/66.0%	37.0%/65.0%
CY2022	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	38.0%/68.0%	38.0%/66.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	38.0%/68.0%	38.0%/66.0%
CY2023	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	39.0%/69.0%	39.0%/67.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	39.0%/69.0%	39.0%/67.0%
CY2024	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	40.0%/70.0%	40.0%/68.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	40.0%/70.0%	40.0%/68.0%
CY2023	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	40.0%/70.0%	40.0%/69.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	40.0%/70.0%	40.0%/69.0%
CY2024	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	40.0%/70.0%	40.0%/70.0%	36.0%/64.0%	36.0%/64.0%	36.0%/64.0%	40.0%/70.0%	40.0%/70.0%
Projected Year of Deficit Spending	FY2021	FY2023	FY2023	FY2023	FY2029	FY2029	FY2023	FY2023	FY2023	FY2029	FY2029
Assets as of July 1, 2036	($292,431,756)	$140,620,624	$203,592,864	$269,940,844	$2,566,524,859	$2,654,305,752	$171,150,761	$234,123,000	$300,470,981	$2,599,089,980	$2,686,769,743
Projected Year of Insolvency	FY2035	FY2037	FY2038	FY2038	Exceeds Projection Period	Exceeds Projection Period	FY2037	FY2038	FY2038	Exceeds Projection Period	Exceeds Projection Period

*2018 Solvency Model reflects the terms of the new PBM contract effective 7/1/2018, whereas the 2017 model does not.
**Rate Changes for Retiree/Spouse/Dependent
***Public Safety Contribution Rates assumed to be 1.25 X Non-Public Safety Rates

NMRHCA Non-Medicare Premier PPO Plan – 01/01/18

Blue Cross and Blue Shield of New Mexico

The following highlights are for the New Mexico Retiree Health Care Authority Preferred Provider Organization (PPO) Plan that is administered by Blue Cross and Blue Shield of New Mexico (BCBSNM). This plan is offered statewide; the BCBSNM Plan is available to members living out of state. This summary contains highlights only and is subject to change. Any services received must be medically necessary to be covered. ***The specific terms of coverage, exclusions, and limitations are contained in the carrier's Member Benefit Booklet.***

PPO Benefits (This plan has no lifetime maximum benefit, though certain services have maximum annual limits. See below).	What You Pay		
	Blue Preferred Plus	**Preferred Provider**	**NonPreferred**
Annual Deductible [1] (Deductible applies to all services unless indicated as "waived" below. There are no family deductible; ~~preferred and nonpreferred amounts cross apply.~~)	$500/Individual	$800/Individual	$1,500/Individual
Annual Out-of-Pocket Limit (Includes copayments, deductible and coinsurance only-NOT penalty amounts, or noncovered charges. No family out of pocket amount; preferred and nonpreferred amounts cross apply.)[2]	$3,000	$4,500	$6,000
Primary Preferred Provider (PPP)*Office Services *(Deductible waived for Preferred Providers.)* Office Visit (Includes mental health and chemical dependency services. Other services received during the office visit, such as therapy or surgery, are subject to deductible and coinsurance as listed in the rest of the summary.)	$20	$30	50%
Specialist Provider Office Services *(Deductible waived for Preferred Providers.)* Office Visit (Services received during the office visit, such as therapy or surgery, are subject to deductible and coinsurance as listed in the rest of the summary.)	$35	$45	50%
Office Surgery (including casts, splints, and dressings)[4]	10%	25%	50%
Allergy Injections, Tests, Serum	10%	25%	50%
Preventive Services Routine Adult Physicals and Gynecological Exams, certain services for Family Planning, Well-Child Care; Routine Vision or Hearing Screenings (only through age 18) and Immunizations. *(Deductible waived.)*	Plan pays 100%		50%
Related Testing (includes routine Pap tests, mammograms, cholesterol tests, urinalysis, etc.), & Immunizations *(Deductible waived.)*	Plan pays 100%		50%
Lab, X-Ray, and Pathology (*Deductible waived for Preferred Providers.)*[4]	Plan pays 100%		50%
EKG	10%	25%	50%
High-Tech Radiology (e.g., MRI, MRA, CT Scan, PET Scans)[4] (Office /Free Standing Radiology)	$100 copay (deductible and coinsurance waived)		50%
High-Tech Radiology (e.g., MRI, MRA, CT Scan, PET Scans)[4] (Outpatient Department of Hospital)	10%	25%	50%
Ambulance Services, Ground or Emergency Air Transport	10%	25%	50%
Biofeedback (for specified medical conditions only)	10%	25%	50%
Cardiac and Pulmonary Rehabilitation, Outpatient[4]	10%	25%	50%
Colonoscopies (initial routine or medical diagnostic)	Plan pays 100%		50%
Emergency Room/Observation Room Treatment (Emergency only. *Deductible waived;* copay waived if admitted inpatient.)[3]	$125		$125
Physician and Other Professional Provider Charges [3]	10%	25%	50%
Hearing Aids and Related Services: Hearing aids for members under age 21 are paid at 100% of covered charges *(deductible waived)* up to a maximum of **$2,200** per ear during any 3-year period. Exams/testing subject to usual cost-sharing provisions. For members age 21 and older, benefits for hearing aids are limited to **$500** per member during any 3- year period, subject to Plan deductible and coinsurance.			
Home Health Care/Home I.V. Services[4]	10%	25%	50%
Hospice Services [4]	10%	25%	50%

* A Primary Preferred Provider (PPP) is a preferred physician or other professional provider in one of the following categories of practice: Family/General Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, and Gynecology

PPO Benefits (This plan has no lifetime maximum benefit, though certain services have maximum annual limits. See below).	What You Pay		
	Blue Preferred Plus	**Preferred Provider**	**Preferred Provider**
Inpatient Hospital/Facility Services (See "Short-Term Rehabilitation - Inpatient" for rehabilitation and skilled nursing facility admissions. See "Transplant Services," if applicable.)			
Medical/Surgical, Mental Health & Chemical Dependency (includes partial hospitalization) and Maternity-Related Room and Board and Covered Ancillaries [5]	10%	25%	50%
Physician and Other Professional Provider Charges	10%	25%	50%
Maternity Services, including Routine Pediatrician Care for Covered Newborns (See "Inpatient Hospital/Facility)	10%	25%	50%
Prosthetics and Orthotics [4,6] (Max. $1,000/yr. Nonpreferred)	10%	25%	50%
Short-Term Rehabilitation - Inpatient (Includes services in a rehabilitation facility or skilled nursing facility)	10%	25%	50%
Short-Term Rehabilitation- Outpatient			
Physical Therapy Services (copy on first 4 visits); Obtained as alternative to Surgery.	$30 copay/per visit (deductible waived), thereafter No Charge for the remaining of the calendar year		50%
Occupational and Speech Therapy Services	10%	25%	50%
Chiropractic Services, Acupuncture, Massage Therapy, and Rolfing (combined max. **$1,500/year**) [7]	10%	25%	50%
Smoking/Tobacco Use Cessation	Plan Pays 100%		50%
Supplies and Durable Medical Equipment [4, 6] (Incontinence supplies limited to **$200/month**; wigs, if covered, limited to **$200** every 3 years.)	10%	25%	50%
Outpatient Facility & Physician Services (Including surgery, outpatient and intensive outpatient mental health and chemical dependency.) [4,5]	10%	25%	50%
Therapy: Chemotherapy, Dialysis, and Radiation [4]	10%	25%	50%
TMJ Services, Dental Accident, Oral Surgery [4]	10%	25%	50%
Transplant Services (Must be received at a facility that contracts with BCBSNM or the national BCBS transplant networks.)			
Cornea, Kidney, and Bone Marrow [4,5] **Heart, Heart-Lung, Liver, Lung, and Pancreas-Kidney** [4,5]	10%	25%	**No benefit**
Urgent Care Facility (Includes physician services. *Deductible waived for Preferred Provider services.)*	$35		50%
Prescription Drugs – Administered by the pharmacy benefit manager (PBM). Please refer to literature provided by the PBM for benefit and copay information or call NMRHCA at 1-800-233-2576.			

Footnotes:

1. The deductible must be met before benefit payments are made (excluding emergency room facility charges; preferred provider routine/preventive services, office visits, urgent care facility visits, and lab, x-ray and diagnostic tests; and hearing aids for members under age 21).
2. After a member reaches the applicable out-of-pocket limit, the Plan pays 100 percent of most of that member's covered charges.
3. Initial treatment of a medical emergency is paid at Preferred Provider level. Follow-up treatment from a Nonpreferred provider and treatment that is not for an emergency is paid at Nonpreferred Provider level. Emergency/observation room copayment waived if admitted.
4. Certain services are not covered if prior approval is not obtained from the Claims Administrator. See a Member's Benefit Booklet for a list of services requiring prior approval.
5. Admission review is required for inpatient admissions. You pay a $300 penalty for covered medical/surgical facility services if approval is not obtained. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive approval for these individually identified procedures and services, benefits for any related admissions will be denied. See a Member's Benefit Booklet for details.
6. Rental benefits for medical equipment and other items will not exceed the purchase price of a new unit.
7. Services administered by a licensed medical doctor (M.D.), doctor of osteopathy (D.O.), physical therapist (R.P.T. or L.P.T.), licensed massage therapist (L.M.T.), doctor of oriental medicine (D.O.M.), and doctor of chiropractic (D.C.) are covered. Rolfing must be provided by a certified rolfer.

Deductibles, copayments, and coinsurance percentages are applied to covered charges, which may be less than billed charges. Claim Administrators provide administrative claims payment services only and do not assume any financial risk or obligation with respect to claims, except as may be specified in the Professional Services Agreement.

Population: 5037 - NM Retiree Authority COMM
Members: 16,594

Current Plan

Non-Specialty

	Retail	Home Delivery
Generic	20% $5 Min $15 Max	20% $12 Min $35 Max
Formulary	30% $25 Min $50 Max	30% $50 Min $100 Max
Non-Formulary	50% $40 Min $100 Max	50% $100 Min $150 Max

Specialty

	Retail	Home Delivery
Generic	20% $5 Min $15 Max	20% $12 Min $35 Max
Formulary	30% $25 Min $50 Max	30% $50 Min $100 Max
Non-Formulary	50% $40 Min $100 Max	50% $100 Min $150 Max

Member Cost

Total	11.0%

Annualized Contributions

Member	$3,952,083
Plan	$32,074,994
Plan Cost PMPM	$161.08

Home Delivery

Current Home Delivery Rate	40%

Brand Increase

Non-Specialty

	Retail	Home Delivery
Generic	20% $5 Min $15 Max	20% $12 Min $35 Max
Formulary	30% $30 Min $60 Max	30% $60 Min $120 Max
Non-Formulary	50% $50 Min $125 Max	50% $100 Min $250 Max

Specialty

	Retail	Home Delivery
Generic	20% $5 Min $15 Max	20% $12 Min $35 Max
Formulary	30% $30 Min $60 Max	30% $60 Min $120 Max
Non-Formulary	50% $50 Min $125 Max	50% $100 Min $250 Max

Member Cost

Total	12.0%

Annualized Contributions

Member	$4,316,608
Plan	$31,710,469
Plan Cost PMPM	$159.25

Annualized Plan Cost Savings

Total	$364,525
Percent	1.1%

Generic Increase

Non-Specialty

	Retail	Home Delivery
Generic	20% $7 Min $15 Max	20% $15 Min $35 Max
Formulary	30% $25 Min $50 Max	30% $50 Min $100 Max
Non-Formulary	50% $40 Min $100 Max	50% $100 Min $150 Max

Specialty

	Retail	Home Delivery
Generic	20% $7 Min $15 Max	20% $15 Min $35 Max
Formulary	30% $25 Min $50 Max	30% $50 Min $100 Max
Non-Formulary	50% $40 Min $100 Max	50% $100 Min $150 Max

Member Cost

Total	12.2%

Annualized Contributions

Member	$4,382,090
Plan	$31,644,987
Plan Cost PMPM	$158.92

Annualized Plan Cost Savings

Total	$430,007
Percent	1.3%

Speciaty Copay Tier

Non-Specialty

	Retail	Home Delivery
Generic	20% $5 Min $15 Max	20% $12 Min $35 Max
Formulary	30% $25 Min $50 Max	30% $50 Min $100 Max
Non-Formulary	50% $40 Min $100 Max	50% $100 Min $150 Max

Specialty

	Retail	Home Delivery
Generic	20% $20 Min $50 Max	20% $20 Min $50 Max
Formulary	30% $100 Min $200 Max	30% $100 Min $200 Max
Non-Formulary	50% $200 Min $400 Max	50% $200 Min $400 Max

Member Cost

Total	11.5%

Annualized Contributions

Member	$4,139,810
Plan	$31,887,267
Plan Cost PMPM	$160.13

Annualized Plan Cost Savings

Total	$187,727
Percent	0.6%

Savings is annualized using 12 months of data starting 2017-01-01 and does not include rebates

Plan Cost = Ingredient Cost + Dispense Fee - Member Copay

The above estimates are projections of potential performance based on information available at the time the document was generated and do not constitute a guarantee of results. Actual results may vary based on a number of factors.

EGWP Modeling

State of New Mexico - RHCA

2018

EXPRESS SCRIPTS®

2018 EGWP savings analysis

NMRHCA - Medicare Part D Options

Projected Cost Components Per Member Per Month (PMPM) [1, 2]	EGWP 2018	Brand increase	Generic increase	Specialty Copay
Total Prescription Drug Cost	$333.66	$333.61	$333.66	$333.66
Member Cost Share	($31.85)	($34.63)	($33.95)	($34.40)
Coverage Gap Discount Program	($27.08)	($26.54)	($26.98)	($26.35)
Federal Reinsurance	($45.36)	($45.73)	($45.41)	($49.96)
Plan Liability for Coverage	$229.37	$226.70	$227.31	$222.95
Administrative Fee	$8.27	$8.27	$8.27	$8.27
Rebates	($50.29)	($50.28)	($50.29)	($50.29)
Total Estimated Cost Prior to Subsidy	$187.35	$184.69	$185.29	$180.93
Federal Subsidy	($12.87)	($12.87)	($12.87)	($12.87)
Estimated Liability After Subsidy	$174.48	$171.83	$172.42	$168.06
Estimated Members	23,159	23,159	23,159	23,159
Estimated Annualized Savings vs EGWP 2018		**$738,115**	**$571,818**	**$1,784,538**

All data is for discussion purposes only and does not represent an offer from Express Scripts.

The analysis is based on 23,159 Medicare Part D eligibles. 1/18/2018

Benefit Designs	EGWP 2018	Brand increase	Generic increase	Specialty Copay
Deductible	$0	$0	$0	$0
Member Cost Share as a % of Gross Cost	9.5%	10.4%	10.2%	10.3%
Retail Generic Copay (31-34 Day)	20% Min $5.00 Max $15.00	20% Min $5.00 Max $15.00	20% Min $7.00 Max $15.00	20% Min $5.00 Max $15.00
Retail Formulary Brand Copay (31-34 Day)	30% Min $25.00 Max $50.00	30% Min $30.00 Max $60.00	30% Min $25.00 Max $50.00	30% Min $25.00 Max $50.00
Retail Non-Formulary Brand Copay (31-34 Day)	50% Min $40.00 Max $100.00	50% Min $50.00 Max $125.00	50% Min $40.00 Max $100.00	50% Min $40.00 Max $100.00
Retail Specialty Copay (31-34 Day)	30% Min $25.00 Max $50.00	30% Min $30.00 Max $60.00	30% Min $25.00 Max $50.00	30% Min $100.00 Max $200.00
Mail Generic Copay (90 Day)	20% Min $12.00 Max $35.00	20% Min $12.00 Max $35.00	20% Min $15.00 Max $35.00	20% Min $12.00 Max $35.00
Mail Formulary Brand Copay (90 Day)	30% Min $50.00 Max $100.00	30% Min $60.00 Max $120.00	30% Min $50.00 Max $100.00	30% Min $50.00 Max $100.00
Mail Non-Formulary Brand Copay (90 Day)	50% Min $100.00 Max $150.00	50% Min $100.00 Max $250.00	50% Min $100.00 Max $150.00	50% Min $100.00 Max $150.00
Mail Specialty Copay (90 Day)	30% Min $50.00 Max $100.00	30% Min $60.00 Max $120.00	30% Min $50.00 Max $100.00	30% Min $100.00 Max $200.00
Member OOP Max (including Deductible)	$0.00	$0.00	$0.00	$0.00
Coverage Gap	Same as Initial Coverage Limit	Same as Initial Coverage Limit	Same as Initial Coverage Limit	Same as Initial Coverage Limit
Coverage of Non-Part D Drugs	Yes	Yes	Yes	Yes
Catastrophic Co-Pay Option	CMS Standard with ICL as Max	CMS Standard with ICL as Max	CMS Standard with ICL as Max	CMS Standard with ICL as Max
Initial Coverage Limit	$3,750	$3,750	$3,750	$3,750
CMS Standard TrOOP	$5,000	$5,000	$5,000	$5,000
Member Pays the MSB Difference	No	No	No	No
ASO/Fully-Insured	ASO	ASO	ASO	ASO

Modeling assumptions and limitations

- Estimates based on most recent CMS guidance and are subject to change if these regulations are amended.
- Estimates are based on a specific set of actuarial assumptions for the annual increase in the Standard Part D Benefit parameters. The estimates are sensitive to these assumptions. Different assumptions will create different estimates. The actual values will not be known until they are announced by CMS.
- EGWP subsidy is an estimate and may vary based on national bidding process and risk score adjustments.
- Plan designs must meet CMS Actuarial Equivalence standards. Consultation can be provided upon request.
- All modeling is based on 2017 plan year data.
- Assumes pharmaceutical manufacturers will continue to offer the same level of rebates as they do today in addition to the proposed discount on 50% of brands in the gap.
- Assumes use of Express Scripts Medicare approved formulary, all associated UM rules and retail network.
- Modeling assumes CMS approved retail and mail days supply limits.
- Per CMS requirements, member will always pay the lower of the discounted price of the drug or the minimum copay.
- Member premium charged by Plan Sponsor will not exceed the value of the benefit.
- All estimates assume one plan design. Incremental charges will apply to additional plan designs.
- There is potential impact on the commercial pricing if the plan sponsor decides to select an EGWP or drop retirees from coverage
- Part D monthly premiums are subject to Income Adjusted Tax under IRMAA Tax as determined by the Social Security Administration.
- Coverage determinations required for Part B/D co-eligible medications.
- Drugs without FDA approval cannot be covered under Part D Plans.
- The attached does not represent an offer from Express Scripts and is for discussion purposes only.

SaveonSP

Utilizes Affordable Care Act state benchmarks to maximize the value of manufacturer copay assistance programs

SAVEONSP

Copay offset savings program

About the Program

- Utilizes Affordable Care Act (ACA) state benchmark to **change client plan design**
- Select drugs designated as **Non-Essential Health Benefits**
- **Copays increased** to maximize manufacturer funding
- Targets **80+** specialty drugs in **7** therapy classes
- Reduces patient's responsibility to **zero**

Sample Medications Covered

Therapy Class	# of Drugs	Assistance/Fill
Oncology	38	$1,750
Inflammatory	21	$1,375
Multiple Sclerosis	8	$1,690
Blood Cell Deficiency	7	$1,500
Hepatitis C	6	$5,900
Hereditary Angioedema	3	$1,200
Pulmonary Arterial Hypertension	1	$750

Program basis

Affordable Care Act (ACA) Compliance: Essential Health Benefits

- SaveonSP uses the definition of “Essential Health Benefits” (EHB) as the basis of the program
  - Plan Sponsors are required to provide a minimum number of drugs in a class as directed by the State Benchmark chosen in 2012
    - SaveonSP reviews the State Benchmark EHB requirements to the ESI formulary to determine the minimum number of “essential” products in each class
      - Other products are then designated “non-essential”
    - “Non-essential” products are not subject to ACA requirements or out of pockets benefits
    - This distinction is important as many manufacturers provide copay assistance funding in excess of out of pocket maximum limits
- Copays are also increased the maximum amount funded by the copay assistance programs

SAVEONSP

Client Savings - RHCA Pre-Medicare

CLIENT EXAMPLE

- **16.6 K** lives
- **266** members **1,860** refills
- **$75** average copay per rx

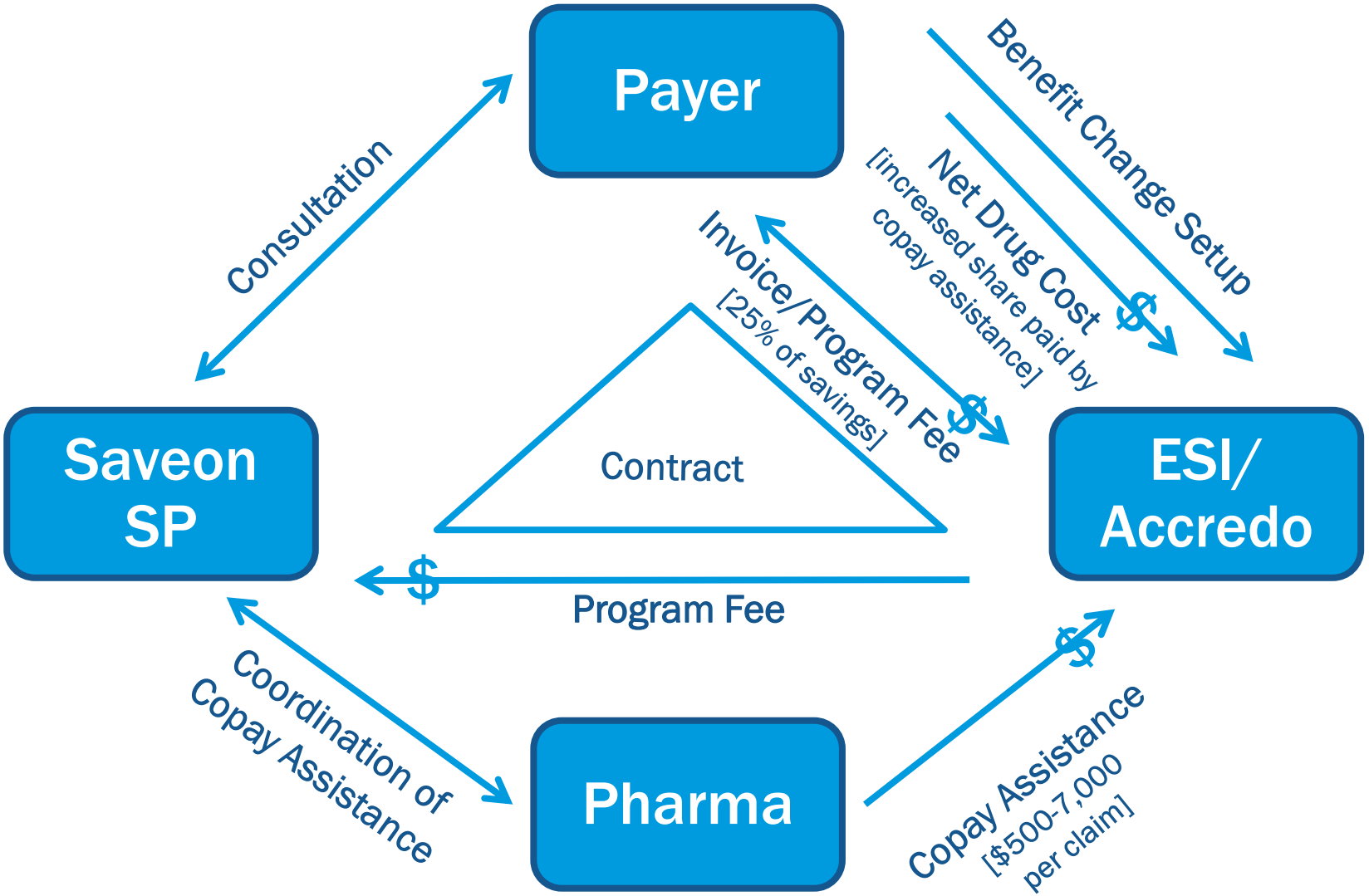
IMPACT FOR PATIENTS AND THE CLIENT

- **$1.7 M** annual savings for the plan
- **$8.39 PMPM** client savings*
- **$0** member cost

BY IMPLEMENTING SAVEON SP COPAY OFFSET PROGRAM

Savings based on sponsor's utilization, the most restrictive state benchmark and ESI National Preferred Formulary. Savings may vary based on sponsor's actual utilization or a different benchmark or formulary. Savings do not represent any type of guarantee by SaveonSP or ESI.

High level overview



Patient experience at implementation

Existing Patient:

1. Patient identified through claims history prior to go-live
2. SaveonSP Customer Service (CS) reaches out to educate patient
3. SaveonSP CS and patient call manufacturer together to enroll
4. SaveonSP CS notifies pharmacy of secondary billing information
5. Accredo adjudicates claim and patient receives drug at no cost

New Patient: *(or one who has not enrolled prior to implementation)*

1. Physician/patient sends Rx to Accredo
2. Accredo processes claim; claim is stopped by indication member needs to speak with SaveonSP
3. Accredo calls member and warm transfers to SaveonSP CS
4. Go through steps 3-5 above

NATURALLY SLIM:

BACKED BY SCIENCE, PROVEN BY RESULTS.

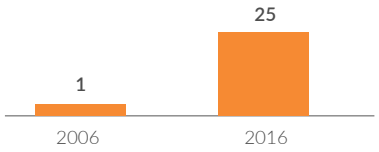
natura)(yslim®
offered by acaphealth

Naturally Slim® is a digital program focused on metabolic syndrome (MetS) reversal, diabetes prevention and weight management. Backed by more than 10 years of clinical research and measurable results, Naturally Slim has been the focus of peer-reviewed studies published by Journal of Metabolic Syndrome and Related Disorders (2015) and Journal of Occupational and Environmental Medicine (2016).

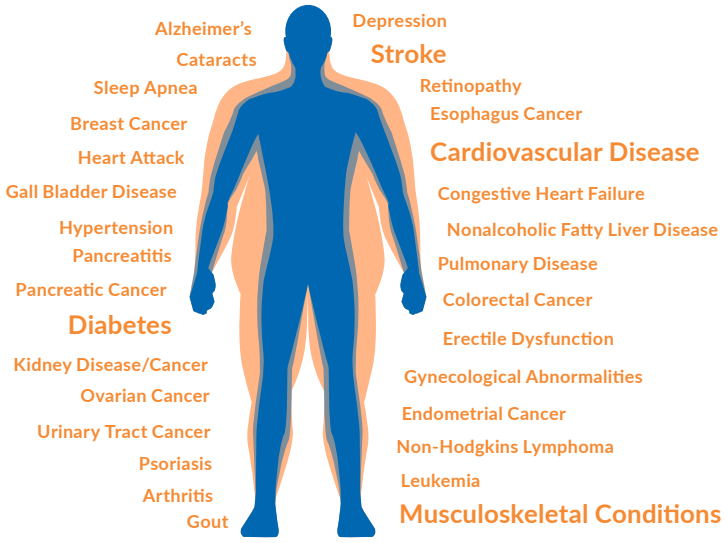
THE "WEIGHT" OF OBESITY

More than 70% of American adults are overweight or obese[1] and obesity rates continue to surge. Half of the states in the U.S. now have obesity rates above 30% compared to just one state 10 years ago.

Number of states with obesity rate above 30%[2]

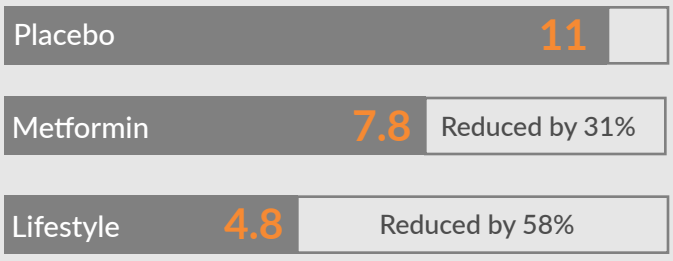


Unfortunately, obesity is highly correlated with MetS, heart disease, diabetes, stroke, cancers and more. Consequently, MetS is an accurate predictor of both current and future high-cost medical claims.



Clinical studies prove that intensive lifestyle intervention (ILI) programs are the most-effective treatment for diabetes prevention[3].

Diabetes Incidence Rate



Cases per 100 person-yrs

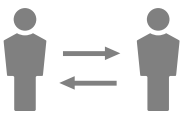
Naturally Slim's proprietary engagement model and unique curriculum produce unmatched engagement rates.

72%
of Naturally Slim participants "graduate"[4]
(attend at least 8 of first 10 lessons)

78%
of participants still follow Naturally Slim skills one year later[5]

In contrast, only 37% of patients with heart disease maintain their medication regimen one year later[6].

REACHING THE MASSES



1:1
In-person

1:50
Telephone, Group, Virtual Coaching

1: Unlimited
Digital + Support (Unlimited Reach)

Individual counseling, such as Diabetes Prevention Programs (DPP), are not scalable across large populations, especially geographically dispersed groups. The Naturally Slim program utilizes video lessons to deliver consistent, high-quality instruction, which is augmented with individual coaching when needed.

natura)(yslim®

offered by acaphealth

Each year, the average American adult gains 1-2 pounds[7]. The Naturally Slim program combats that trend by teaching participants the skills they need to lose weight and maintain their weight loss for the long term.

84%
of Naturally Slim participants lose weight[8]

10.6 lbs
average weight loss in first 10 weeks[9]

83%
of Naturally Slim participants maintain weight loss after one year[6]

CLINICAL RESULTS

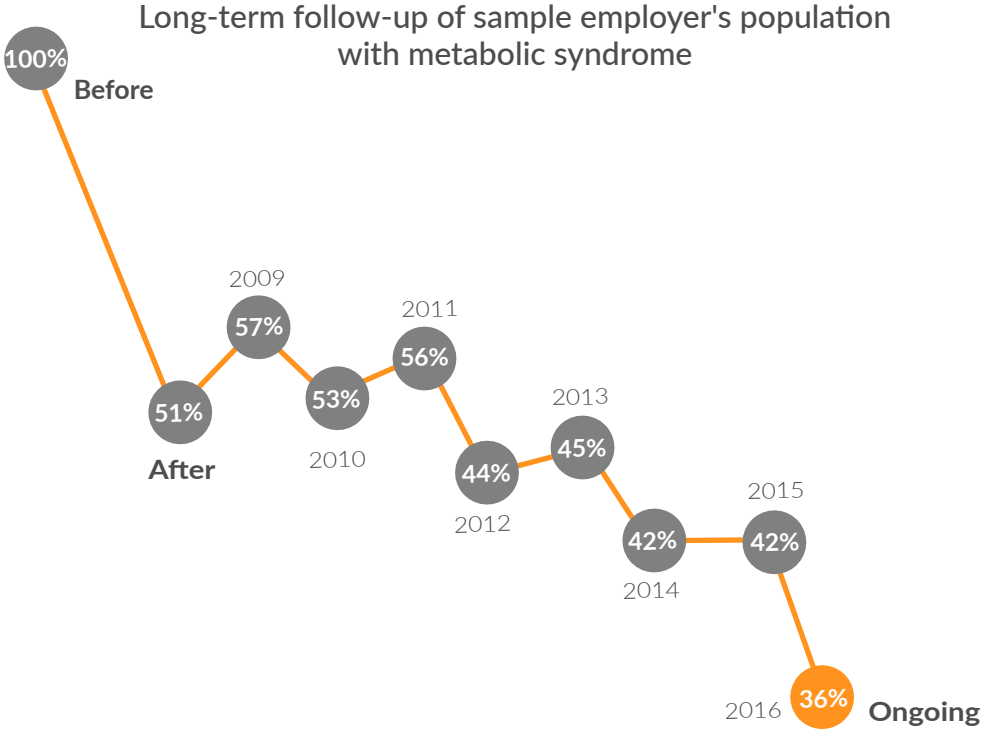
In addition to weight loss, the Naturally Slim program produces measurable, sustainable results. These clinical improvements lead to less chronic disease and lower healthcare costs.

50%
of participants reversed MetS[9]

55%
of participants reduced their type 2 diabetes risk[8]

50%
of participants reversed high blood pressure (of those who lost 5% or more in body weight[8])

Long-term follow-up of sample employer's population with metabolic syndrome



Our company's DNA is fueled by more than 85 years of experience in the employee benefits industry. This level of expertise provides a unique understanding of the needs of all major healthcare stakeholders including employers, providers, insurance carriers, consultants, members, and the federal government. Our industry expertise allows us to deliver value to all our stakeholders, customizing each program for the very best result.

INDUSTRY EXPERTISE

- Technology
- Government
- Healthcare
- Education
- Transportation
- Manufacturing

REFERENCES

1 Centers for Disease Control and Prevention (2016)
2 Robert Wood Johnson Foundation (2017)
3 United States Preventative Services Task Force (USPSTF – 2014)
4 Naturally Slim internal analysis (2017)
5 Intermountain Medical Center Heart Institute (2017)
6 Naturally Slim internal research survey of 2,000+ participants (2017)
7 National Health and Nutritional Examination Survey (2010)
8 Journal of Occupational and Environmental Medicine (2016)
9 Journal of Metabolic Syndrome and Related Disorders (2015)

Effectiveness of Naturally Slim on Hypertension

TITLE

Evaluation of a Voluntary Work Site Weight Loss Program on Hypertension

JOURNAL

Journal of Occupational and Environmental Medicine, Volume 58, Issue 12, December 2016

AUTHORS

Conrad P. Earnest, PhD and Timothy S. Church, MPH, MD, PhD

POPULATION

5,998 employees from 93 companies (1,997 men and 4,001 women)

ALL PARTICIPANTS MUST HAVE:

- Enrolled in the the Naturally Slim program (*although there is no minimum level of participation*)
- Completed both a pre- and post-biometric screening
- Completed their post-biometric screening within 20 weeks of the program start date
- Provided all their necessary demographic data including age and gender

DESCRIPTION

The direct and indirect costs of hypertension create a significant financial burden for employers. Meanwhile, evidence supports that hypertension is highly treatable and positively affected by lifestyle interventions targeting weight loss, nutrition, and physical activity. In this article, the effect of a voluntary, online, work site weight loss program, Naturally Slim, on hypertension is examined.

CONCLUSION

This examination demonstrates that offering Naturally Slim can lead to substantial reductions in the prevalence of hypertension among employees.

HYPERTENSION:

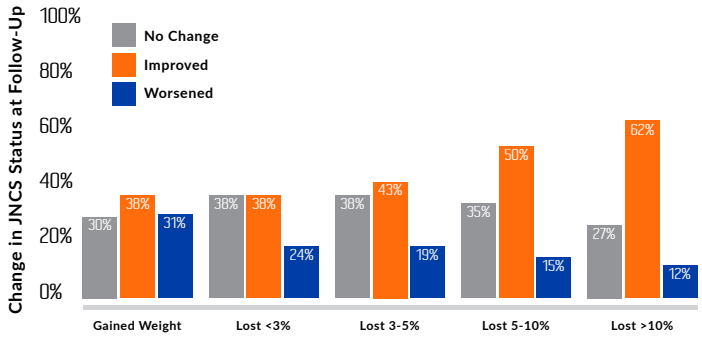
Hypertension, or high blood pressure, is the most common condition seen in primary care and currently affects 34% of the US population. It is a risk factor for myocardial infarction, stroke, renal failure, and death. Hypertension is heavily correlated with obesity with some studies reporting that 66% of those with hypertension are overweight.

Hypertension is highly treatable and positively affected by lifestyle interventions targeting weight loss, nutrition and physical activity.

ALL WEIGHT LOSS IMPROVES CARDIOVASCULAR RISK:

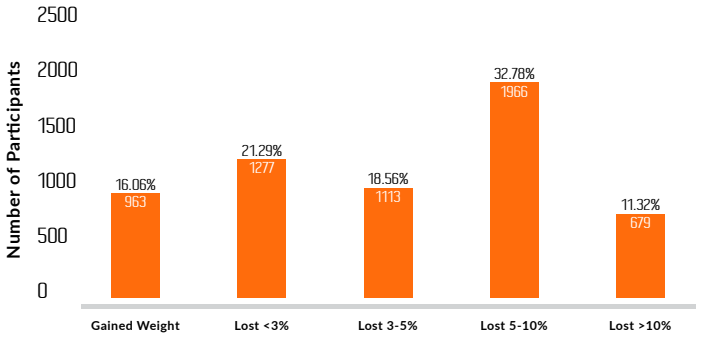
In this study, participants were represented in the analysis based on their post-program weight loss. Those participants losing 5% or more of their body weight demonstrated significant improvement and reduced prevalence of hypertension. 50% of those losing 5% or more of their body weight no longer exhibited high blood pressure. However, even small reductions in weight are positively associated with improved hypertension prevalence. In fact, an incremental improvement was observed as weight loss progressed.

PREVALENCE OF HYPERTENSION:



WEIGHT LOSS ASSOCIATED WITH NATURALLY SLIM:

Of the 5,998 participants in the Naturally Slim program, almost 84% lost weight after participating in the 10 week Foundations® program. In fact, more than 44% of all participants saw weight loss of greater than 5% of their initial body weight. As illustrated previously, this level of weight loss accompanies significant reductions in high blood pressure demonstrating that this program can lead to a substantial reduction in the prevalence of hypertension among an employee population.



LONG-TERM IMPACT:

Evidence, including results from the Diabetes Prevention Program, shows that individuals who can maintain weight loss long-term can maintain their improved blood pressure status. Therefore, offering a skill-building program like Naturally Slim that teaches participants how to lose and maintain weight loss through behavior modification, not dieting, can have long-term impact on corporate health care burden for employees. And, because the program is delivered digitally, it can be used to reach hundreds of thousands of employees across the country.

Effectiveness of Naturally Slim on Metabolic Syndrome

TITLE

Evaluation of Voluntary Worksite Weight Loss Program on Metabolic Syndrome

JOURNAL

Journal of Metabolic Syndrome & Related Disorders, Volume 13, Issue 8, October 2015

AUTHORS

Conrad P. Earnest, PhD and Timothy S. Church, MPH, MD, PhD

POPULATION

3,880 people (1,251 men and 2,629 women)

ALL PARTICIPANTS MUST HAVE:

- Enrolled in the the Naturally Slim program (*although there is no minimum level of participation*)
- Completed both a pre- and post-biometric screening
- Completed their post-biometric screening within 20 weeks of the program start date
- Provided all their necessary demographic data including age and gender

DESCRIPTION

Health care costs increase with the presence of metabolic syndrome and present a significant burden to companies throughout the world. In this article, the effect of a voluntary worksite program, Naturally Slim, on weight loss and metabolic syndrome was examined.

CONCLUSION

The results of the examination demonstrate that offering Naturally Slim, is an effective strategy to reduce weight and improve the components of metabolic syndrome among at-risk employees.

METABOLIC SYNDROME

Metabolic Syndrome (MetS) is defined as having three or more of the following risk factors: high blood pressure, elevated fasting glucose, high triglycerides, elevated waist circumference, and low HDL (good) cholesterol.

MetS is a well-recognized independent risk factor for cardiovascular disease, cancer and all-cause mortality.

At the beginning of the program, 1,781 participants or 45.9% of the sample population had MetS. Of those participants, more than half, 903 participants (50.7%) reversed their condition.

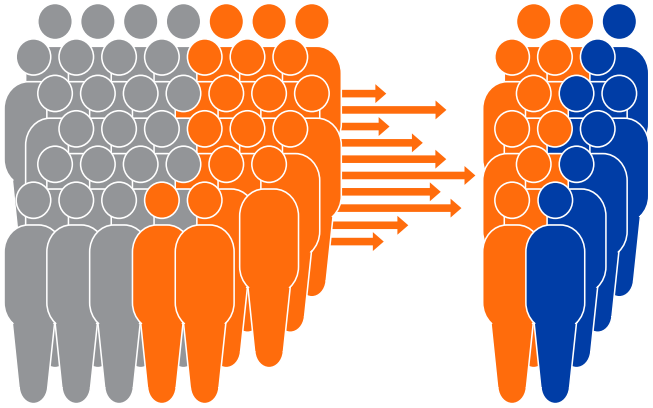
Overall prevalence of MetS within the entire population was reduced to 28.7%, a 37.5% reduction in prevalence.

RISK FACTOR REVERSAL

All five MetS risk factors saw improvement to varying degrees. The chart below shows the reversal rate for each risk factor among the entire population.

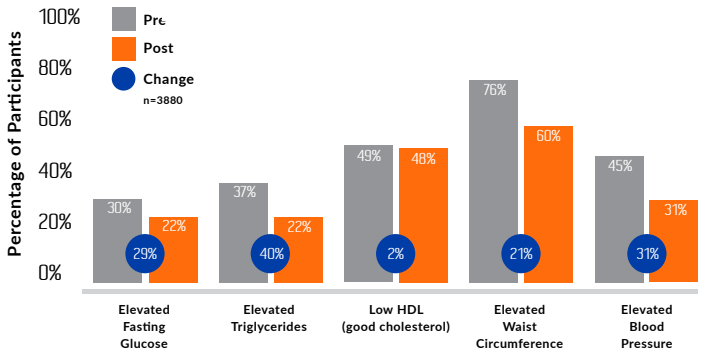
KEY LEARNINGS

- **All participants benefit** - All participants, regardless of initial weight, had similar risk factor improvement illustrating that all participants, regardless of BMI, benefit from the program - not just obese participants.
- **Most benefit for severe MetS** - There was a strong correlation between the magnitude of improvement of each risk factor and the number of MetS risk factors present at baseline. This suggests that the people with the most improvement are those who had the most metabolic dysfunction when they started the program.
- **More than 10 pounds of weight loss on average** - The average weight loss for all participants was 10.6 pounds (5.2% of total body weight) at the post-biometric screening. The average was 13.2 pounds (5.8%) for men and 9.4 pounds (4.8%) for women.
- **More weight loss equals more risk factor improvement** - As expected, the greater the weight loss, the greater the magnitude of changes in metabolic risk factors. This was observed in all risk factors except HDL cholesterol in women.



NO METS	METS	REVERSED METS	CONTINUED METS
2099 people (50.1%)	1781 people (45.9%)	903 people (50.7%)	878 people (48.3%)

PREVALENCE OF SPECIFIC RISK FACTORS



This chart shows the percentage of participants who had each risk factor before and after the program.

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

July 12 / 13, 2018
9:30 AM / 9:00 AM
Sagebrush Inn & Suites
1508 Paseo Del Pueblo Sur
Taos, NM 87571

AGENDA – July 12th

1.	Call to Order	Mr. Sullivan, President
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder
3.	Pledge of Allegiance	Mr. Sullivan, President
4.	Approval of Agenda	Mr. Sullivan, President
5.	Approval of Regular Meeting Minutes June 12, 2018	Mr. Sullivan, President
6.	Public Forum and Introductions	Mr. Sullivan, President
7.	Election of Board Officers (Action Item) a. Board Policies and Procedures b. Committee Assignments c. Code of Ethics d. Open Meetings Act Resolution	Mr. Sullivan, President
8.	Committee Reports	President
9.	Executive Director's Update	Mr. Archuleta, Executive Director
10.	Asset Allocation Review	Mr. Toth, Managing Director, Wilshire
11.	Provider Presentations a. Express Scripts b. Presbyterian Health Plan c. Blue Cross Blue Shield of New Mexico	Mr. Archuleta, Executive Director

(Recess for lunch at the pleasure of the Board)

12.	Actuarial Presentations	Mr. Archuleta, Executive Director
	a. Demographic/Utilization Review	Mr. Madalena, Data Warehouse
	b. Solvency/GASB 74/75	Mr. Petersen, Segal
13.	Review of Calendar Year 2019 Plan Changes	Mr. Archuleta, Executive Director

(Recess until 9:00AM, July 13, 2018, in the same location)

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

July 12 & 13, 2017
9:30 AM / 9:00 AM
Sagebrush Inn & Suites
1508 Paseo Del Pueblo Sur
Taos, NM 87571

AGENDA – July 13th

1.	Call to Order	President
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder
3.	Pledge of Allegiance	President
4.	Public Forum and Introductions	President
5.	Provider Presentations Continued a. United Concordia b. Delta Dental c. Davis Vision d. The Standard	Mr. Archuleta, Executive Director
6.	Wise and Well Strategic Plan	Ms. Loehr, The Solutions Group
7.	Retiree Health Care Program Comparisons	Mr. Kueffer, Interim Deputy Director
8.	Pharmacy Benefit Management Contract (Action Item	Mr. Kueffer, Interim Deputy Director
9.	CY2019 Plan Year Recommendations (Action Item)	Mr. Archuleta, Executive Director
10.	Other Business	President
11.	Date & Location of Next Board Meeting Tentative -- August 28, 2018, 9:30 AM Alfredo R. Santistevan Board Rm., Suite 207 4308 Carlisle Blvd. NE Albuquerque, NM 87107	President
12.	Executive Session Pursuant to NMSA 1978, Section 10-15-1(H)(6) To Discuss Limited Personnel Matters	President
13.	Adjourn	

BOARD POLICIES AND PROCEDURES MISSION STATEMENT

The New Mexico Retiree Health Care Authority ("NMRHCA" or "Authority") is committed to offering an affordable, comprehensive health care program for present and future eligible retirees and their dependents.

ADMINISTRATION

The Authority is governed by a Board of Directors ("Board"), which is composed of not more than 12 members (the "Board Members" or individually a "Board Member"). The Board is authorized to take all actions reasonably necessary to implement the Retiree Health Care Act (the "Act"). Currently, the Authority maintains two offices and a full time staff of 27 employees. The Authority offers comprehensive medical, dental, vision and life insurance to more than 61,000 retired public employees. NMRHCA receives revenue from premiums paid by retirees, contributions from active employees and their employers, and funding and revenue from other various sources. The Board and Authority administer the Authority's Trust Fund ("Fund"), which is invested and managed by the New Mexico State Investment Council, as required by the Act.

Currently, the Authority has approximately 300 participating public entities including all State agencies, public and charter schools, many counties and cities, as well as several universities.

ANNUAL REVIEW OF BOARD POLICIES AND PROCEDURES

The Board will review its Policies and Procedures annually. –Proposed changes will first be solicited by NMRHCA staff from the Board's Executive Committee. Once approved by the Executive Committee, the initial revised Policies and Procedures will be presented to the full Board at its next regularly scheduled meeting. –The Board will review the changes and make final recommendations to the Executive Committee, which will meet to revise the Policies and Procedures in accordance with those recommendations, and then present the Board with the Policies and Procedures for final action at the next regularly scheduled Board meeting.

OFFICERS, TERM OF OFFICE, DUTIES

Term of Office

Terms of office for the president and chairperson (the "Chairperson"), the vice president and vice-chairperson (the "Vice-Chairperson"), and the secretary (the "Secretary") will be from the date elected until a successor is sworn in, unless the office is vacated, in which case, the next lower officer shall automatically assume the duties of the higher officer.

Procedure for Electing Officers

The Board will elect a slate of officers annually to serve for the ensuing ~~twelve~~12-month period.

The three officers will comprise the Board's Executive Committee.

In the event of a vacancy in the office of Chairperson, the Vice-Chairperson will succeed the Chairperson. In the event of a vacancy in the office of the Vice-Chairperson, the Secretary will succeed the Vice-Chairperson. In the event of a vacancy in the office of Secretary, an election will be held at the next Board meeting. Nominations will be taken from the floor. ~~–~~The individual receiving the highest vote count will be elected to the office of Secretary.

Duties of the Chairperson

The duty of the Chairperson is, primarily, to ensure the integrity of the Board's processes and oversee the conduct of the Board at Board and committee meetings.

Duties of the Vice-Chairperson

The duty of the Vice-Chairperson is to act as temporary Chairperson in the absence of the Chairperson.

Duties of the Secretary

The duty of the Secretary is to act as temporary Chairperson in the absence of the Chairperson and Vice-Chairperson.

BOARD COMMITTEES

The Board has the following standing committees:

1 The Executive Committee, consisting of the officers of the Board.

2 The Audit Committee, consisting of four Board Members, including the Chairperson.

3 The Finance and Investment Committee consisting of five Board Members, including the Chairperson.

4 The Legislative Committee consisting of five Board Members, including the Chairperson

5 The Wellness Committee consisting of five Board Members.

The Chairperson is responsible for establishing membership in each standing committees. Additionally, the Chairperson has authority to establish, from time ~~-~~to ~~-~~time, other committees for specific purposes and will appoint the membership of those committees. All committee members are entitled to per diem and mileage, as authorized under 2.81.1.21, NMAC.

Comment [GA1]: Right now, we only have four. Do we need to ask for an appointment

Comment [GA2]: This committee currently has only four as well.

CODE OF CONDUCT

Board Members are expected to adhere to the highest ethical standards and, at all times, comply with their fiduciary responsibilities. Board Members will avoid any conflict of interest or perceived conflict of interest and may not have a direct financial or direct personal interest in any company or business that has a contractual obligation with the NMRHCA.

Board Members, as fiduciaries, should discharge their duties solely in the interest of the Authority and be governed by all applicable State and Federal laws, rules and regulations.

Each year at its annual meeting, Board Members will complete a financial disclosure form as set out in 2.81.3.8, NMAC.

Board Members will adhere to all requirements set forth in ~~2~~ 2.81.3, NMAC, which establishes a Code of Ethics for Board Members.

BOARD TRAVEL

Board Members must submit to the Chairperson any request to participate in an event requiring travel where that travel is paid for by the Authority.

Speakers: Any Board Member that accepts a request to be a speaker at a conference or seminar requiring travel will notify the Chairperson of the request and ~~their~~ his/her intention to participate in ~~their~~ his/her capacity as a member of the Authority.

Payment for Travel: All travel paid for by the Authority is subject to 2.81.1.21, NMAC, the New Mexico Per Diem and Mileage Act, NMSA 1978, 10-8-1 and current New Mexico Department of Finance and Administration rules and regulations.

PROCEDURES FOR CONDUCT OF NMRHCA BOARD MEETINGS

In general, the Board will follow a modified version of Robert's Rules of Order, Revised ("RRO"). In addition, the Board will adhere to the Open Meetings Act and all other applicable provisions of State laws and the Board's rules and regulations.

A quorum of the Board must be present in order to convene and conduct any official meeting. A quorum is a majority of Board Members. Once a quorum is present, action may be taken by majority vote of participating Board Members. Although physical attendance by Board Members is encouraged, Board Members may attend meetings by telephone, provided that each Board Member participating telephonically can be identified when speaking, all participants are able to hear each other at the same time, and members of the public attending the meeting are able to hear any Board Members who speak during the meeting.

Regular Meetings

The date, time, and place of the regular Board meeting will be established by Board action and be announced to the public pursuant to the requirements of the Open Meetings Act (Section 1015-1 et seq. NMSA 1978).

The Board will meet at least once a year.

Special or Emergency Meetings

A special meeting of the Board is a meeting other than a regular or emergency meeting and may be called by the Chairperson, Vice-Chairperson or any three (3) Board Members for the specific purposes specified in the call.

An emergency meeting of the Board is a meeting other than a regular or special meeting and may be called by the Chairperson, Vice-Chairperson, or any two (2) Board Members to consider a sudden or unexpected set of circumstances affecting the NMRHCA which require the immediate attention of the Board.

Public Notice

The New Mexico Open Meeting Act, Section 10-15-1, NMSA 1978, provides that any meeting of a quorum of the members of a public body held for the purpose of formulating public policy discussing public business, or taking action within the authority of the Board, or at which the discussion or adoption of any proposed resolution, rule, regulation, or formal action occurs will be held only after reasonable notice to the public. In accordance with the Open Meetings Act, the Board will establish, at least annually, what constitutes reasonable notice of its meetings.

Agenda

The Chairperson, in consultation with the Executive Committee and the Executive Director, will prepare an agenda for each regular meeting of the Board. The Executive Director will ensure timely dissemination of the agenda to the Board and public.

Any Board Member may request of the Chairperson to have an item placed on, or removed from, the agenda.

Open and Closed Meetings

In addition to requiring public notice of Board meetings, the Open Meetings Act requires all Board meetings to be open to the public at all times unless an exception found in the Open Meetings Act permits a closed meeting.

Minutes

Pursuant to the Open Meetings Act, written minutes will be kept of all public Board meetings, as well as committee meetings, and all minutes shall be open to public inspection. Draft minutes will be approved, amended or disapproved at the next meeting where a quorum is present. Draft minutes may be inspected by members of the public after completion in final draft form but will not become official until approved by the Board.

Board Meeting Attendance

Board Members will ensure strict compliance with 2.81.1.11, NMAC which governs Board meeting attendance.

EXECUTIVE DIRECTOR

General Provisions

The Executive Director will comply with the Code of Ethics established for the Authority (2.81.3, NMAC) and may not have a direct financial or direct personal interest in any company or business that has a contractual obligation with the NMRHCA.

The Executive Director will ensure that all employees of the Authority are aware of their rights and responsibilities and ensure at a minimum:

1 Confidentiality of retiree and dependent enrollment and medical and fiscal records.

2 No conflict of interest or appearance thereof with respect to participation on boards, corporations, or public or private organizations. No conflict of interest or appearance thereof with respect to professional, occupations, or business licenses.

3 Adherence to a pertinent professional code of ethics and standard of professional conduct as prescribed by the Board.

4 No solicitation of gifts, favors, or other items of value from persons with whom the NMRHCA transacts business or companies with whom the NMRHCA may contract.

5 No acceptance of unsolicited items of value that are of such character as to manifest, or appear to manifest, influence upon an employee in carrying out his/her responsibilities to the NMRHCA.

Responsibilities of the Executive Director

The Executive Director is responsible for organizational performance and exercises authority over the day-to-day operations of the Authority. The Executive Director is responsible for the management of all staff and the Board delegates authority for staff management to the Executive Director.

In general, all personnel decisions made by the Executive Director are final. However, the Authority may utilize an appeals process that allows for personnel decisions to be reviewed by the Board.

Employment of the Executive Director

Employment of the Executive Director will be by the Board. The terms of employment for the Executive Director will be subject to applicable policies as they pertain to exempt employees and conditions outlined by the Board.

The Board believes that the selection of an Executive Director is one of the most important tasks performed by the Board. To that end, the Board will carefully consider the following:

- Specifying what the Board expects the Executive Director to do;
- Specifying the education and experience the Board considers essential to performing the work of Executive Director;
- Developing and implementing a recruitment strategy for the position; and
- Applying screening processes, interviewing qualified candidates, and selecting the candidate deemed to be most qualified for the position.

Executive Director Evaluations

The Executive Committee of the Board is responsible for evaluating the Executive Director and will utilize mechanisms to provide periodic feedback on Executive Director performance and on the overall performance of the agency.

The Board endorses the use of an evaluation instrument as a tool in planning, goal setting, establishing shared understandings, providing feedback, and making other decisions. For this reason, the Board may implement a written evaluation form with the Executive Director, whether or not one is required by other controlling agencies such as the Department of Finance and Administration.

Sound personnel practices provide that evaluation instruments are most effective when done at least annually, when the raters and individual establish shared understandings at the beginning of the evaluation period concerning expectations and performance criteria, and when feedback is provided on an ongoing basis.

Executive Director Leave

The Executive Director will notify the Chairperson for approval when annual leave is to be taken. The notice will be given as far in advance as possible.

APPEAL OF BENEFIT DETERMINATIONS

The Board will not consider appeals of medical, dental or visions benefit determinations made by contracted carriers or staff of the Authority. As such, it is the policy of the Board that beneficiaries wishing to appeal benefit determinations made by contracted carriers or staff should make their appeal to the Office of the Superintendent of Insurance.

The Executive Director will report to the board the outcome of any appeals determined by the Office of the Superintendent of Insurance.