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

REGULAR MEETING
OF THE
BOARD OF DIRECTORS

March 7, 2017
10:00 AM
PERA Building
Senator Fabian Chavez, Jr. (PERA) Board Room
33 Plaza La Prensa
Santa Fe, NM 87507

New Mexico Retiree Health Care Authority
Regular Meeting

BOARD OF DIRECTORS

ROLL CALL

March 7, 2017

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

NMRHCA BOARD OF DIRECTORS

March 2017

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

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

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

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

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

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

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

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

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

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

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

March 7, 2017
10:00 AM
PERA Building
Senator Fabian Chavez, Jr. (PERA) Board Room
33 Plaza La Prensa
Santa Fe, NM 87507

AGENDA

1.	Call to Order	Mr. Sullivan, President	Page
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder	
3.	Pledge of Allegiance	Mr. Sullivan, President	
4.	Approval of Agenda	Mr. Sullivan, President	4
5.	Approval of Regular Meeting Minutes February 7, 2017	Mr. Sullivan, President	5
6.	Public Forum and Introductions	Mr. Sullivan, President	
7.	Committee Reports	Mr. Sullivan, President	
8.	2018 Preliminary Plan Recommendations	Mr. Archuleta, Deputy Director	13
9.	5-Year Strategic Plan (2018-2022)	Mr. Archuleta, Deputy Director	16
10.	FY17 Contract Amendments (Action Item)	Mr. Archuleta, Deputy Director	19
11.	Executive Directors Updates	Mr. Tyndall, Executive Director	
	a. Healthcare Market/Corporate Mergers		21
	b. Medicare Outreach		27
	c. Legislative		
	a. HJM1		
	b. NM Health Connections/SB334		28
	c. SB354		37
	d. HB452		47
	e. HB2		52
	d. HR Updates		
	e. PBM Consultant RFP		
	f. County of Sierra		
	g. January 2017 SIC Report		54
	h. Executive Director's Resignation		
12.	Other Business	Mr. Sullivan, President	
13.	Date & Location of Next Board Meeting April 4, 2017, 9:30AM Alfredo R. Santistevan Board Room 4308 Carlisle Blvd. NE, Suite 207 Albuquerque, NM 87107	Mr. Sullivan, President	
14.	Executive Session Pursuant to Section 10-15-1H(2) NMSA 1978 to Discuss Limited Personnel Matters	Mr. Sullivan, President	
15.	Adjourn		

RETIREE HEALTH CARE AUTHORITY/REGULAR BOARD MEETING

February 7, 2017

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

February 7, 2017

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 10:00 a.m. in the Senator Fabian Chavez, Jr. (PERA) Board Room, 33 Plaza La Prensa, Santa Fe, New Mexico.

2. ROLL CALL TO ASCERTAIN QUORUM

A quorum was present.

Members Present:
Mr. Tom Sullivan, President
Mr. Joe Montaño, Vice President
The Hon. Tim Eichenberg, NM State Treasurer
Ms. Jan Goodwin
Ms. LeAnne Larrañaga-Ruffy
Mr. Terry Linton
Ms. Therese Saunders

Members Excused:
Mr. Doug Crandall, Secretary
Mr. Wayne Johnson

Staff Present:
Mr. Mark Tyndall, Executive Director
Mr. Dave Archuleta, Deputy Director
Ms. Josefina Roberts, CFO
Mr. Greg Archuleta, Director of Communication & Member Engagement
Ms. Judith Beatty, Board Recorder

Others Present:
[See sign-in sheet.]

3. PLEDGE OF ALLEGIANCE

Mr. Linton led the Pledge.

4. APPROVAL OF AGENDA

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

5. APPROVAL OF REGULAR MEETING MINUTES: December 6, 2016

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

6. PUBLIC FORUM AND INTRODUCTIONS

There were no speakers from the floor.

7. COMMITTEE REPORTS

Chairman Sullivan reported that the Executive Committee met in order to prepare today's agenda.

Mr. Tyndall reported that the Finance Committee met and reviewed the second quarter budget report. The committee also briefly went over the GASB 74 valuation, which will be reviewed in detail at today's meeting.

8. EXECUTIVE DIRECTOR'S UPDATES

a. 2016 Financial Audit

Mr. Tyndall reported that the Office of the State Auditor has released the audit, which has been distributed to board members and is posted on the NMRHCA website.

b. 2017 Newsletter

Mr. Tyndall said he has received some good feedback on the Winter Newsletter, and thanked Greg Archuleta for doing an excellent job in putting together the materials. He commented that Mr. Archuleta is a professional journalist and his editorial instincts are of great value to the agency.

c. New Mexico Health Connections
d. Clinical Reporting -- Presbyterian

Mr. Tyndall said there are five elements the NMRHCA has added into the contractual requirements of its health plan partners where it is saying it really wants to see actual improved outcomes. He reviewed a draft submitted by Presbyterian.

Mr. Tyndall said those five elements are demonstrated efficacy in:

- Management of chronic conditions (e.g., diabetes);

- Management of preference sensitive surgeries (e.g., knee arthroscopies and hernias);
- Use of third party pharmacy data for risk stratification, i.e., NMRHCA wants to be sure that the health plans, which have been receiving data from Express Scripts for many years, demonstrate that they're using those data to help control pharmacy costs;
- Management of acute care episodes, i.e., high dollar claimants. NMRHCA requires that the medical directors of each of the health plans review the medical records for individuals with costs above $100,000 and attest that the individual has been appropriately diagnosed and is undergoing a course of treatment that is applicable and appropriate for that diagnosis.
- The health plan must submit a report to the NMRHCA on the percentage of provider contracts covered by value-based agreements. These can include patient centered medical homes, accountable care organizations and bundled payment arrangements.

e. Legislative

Mr. Tyndall reviewed the highlights from the FY17 operating budget along with the FY18 request and corresponding recommendations made by the Legislative Finance Committee and Executive.

Mr. Tyndall stated that the NMRHCA's request assumed a 3 percent growth in participation and a 6 percent growth in medical trend (medical and prescription combined). He noted that the Executive took the agency's FY16 actuals and added 3 percent, while the LFC recommendation considered a couple of years of growth as well as 3-4 percent in medical cost trend.

Mr. Tyndall said staff is hopeful that the LFC recommendation will be approved, as the appropriation the NMRHCA receives is not applicable to the general fund.

Mr. Tyndall discussed a bill being introduced by Sen. Jeff Steinborn that would create a prescription purchasing council. They want to create a joint purchasing entity in the administrative structure of the General Services Division that would include 13 different constituent entities. These would include all of the IBAC members as well as the State Risk Management Division, UNM, UNMH, HSD, Department of Corrections, Department of Health, and CYFD. The council would be responsible for coordinating the procurements.

Mr. Tyndall said that Sen. Steinborn stressed this would not remove any authority that has been granted to the NMRHCA Board.

f. HR Updates

Mr. Tyndall announced that Deb Whitmore has retired after many years of service to NMRHCA, and has been replaced by Crystal Montoya.

Mr. Tyndall also noted that Anna Arellanes was promoted internally to take Rudy Bantista's old job. He added that there are 27 full time employee spots, and all but one has been filled.

Mr. Montaño asked Mr. Tyndall if the 27 positions were enough to provide the necessary services and functions for NMRHCA. Mr. Tyndall responded that the current number is sufficient for now, but next year it may be necessary to request another FTE customer services position.

Mr. Tyndall said the State Personnel Office is planning to consolidate some of the state's human resources functions centrally, which could potentially affect the NMRHCA.

g. November-December 2016 Investment Report

Mr. Tyndall reported that the fund was at $495.6 million at December 31, 2016. He said another $3 million was added to the account at the beginning of January.

h. Annual Meeting – July 2017

Mr. Tyndall announced that this year's annual board meeting/retreat is scheduled to take place in Angel Fire on July 13-14.

9. GASB 74 REPORT

Mr. Tyndall stated that, starting next fiscal year, GASB 74 will replace GASB 43, which the NMRHCA has been reviewing since 2006 and has been published on the website as the official unfunded liability for the end of FY 2016. In order to get a head start on any changes, NMRHCA asked Segal to do another draft of the GASB valuation for FY 2016 using the GASB 74 methodology.

Mr. Tyndall said the major difference is that the discount rate has changed. Historically with GASB 43, since the NMRHCA's funding level is so low that it has used a flat 5 percent rather than an expected rate of return. The NMRHCA will be able to use the rate of expected return for its investment account for as long as they calculate it to have a positive balance. In this case, it is 7.25 percent. Once the balance of the investment account is gone, the NMRHCA will switch over to a discount rate that is calculated based on the average AAA-rated municipal bond portfolio, which in this case Is 3.05 percent and would increase the unfunded actuarial liability.

Mr. Tyndall said that, in terms of the present value of funds necessary to cover the NMRHCA's future benefits, right now under GASB 43 the NMRHCA needs $4.3 billion. Under GASB 74, it is $5.9 billion. This means the unfunded liability goes from $3.8 billion to $5.4 billion, and the funding level goes from 11 percent to 8 percent.

Mr. Tyndall commented that these calculations were based upon what the benefit structure was at the end of June 2016, so do not take into consideration any of the plan design changes made effective January 2017. Also, it provides the NMRHCA with some alternative scenarios.

Mr. Tyndall stated that the calculations were done on a closed basis, i.e., they only calculate contributions from current vested employees and not future employees. Instead of the solvency window going to 2030, it goes to 2027; so the NMRHCA gets to use the new expected rate of return of 7.25 percent for about 10 years.

Mr. Tyndall said the NMRHCA would give participating entities the option of early adoption. GASB 74 will be part of the NMRHCA's official report in the fall of 2017.

Chairman Sullivan commented that the board and staff have worked very hard to get to 20+ years of solvency. Mr. Tyndall said he shared the Chairman's frustration, adding that he hoped the positive result of this would be that it attracts an appropriate level of attention to the NMRHCA's long-term challenges from a funding perspective.

Ms. Goodwin commented that one of the keys to long-term sustainability is increasing contributions. She asked if the NMRHCA has done a survey to see what other states have set as contribution levels to address sustainability. Mr. Tyndall responded that he would provide a report in the near future. He added that very few states deal with this as a standalone entity with statutorily guaranteed contributions.

10. 5-YEAR STRATEGIC PLAN

Mr. Tyndall reviewed staff's preliminary recommendations for the 5-Year Strategic Plan for 2018-2022:

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

*Consensus to carry over items from previous plan

**To include but not limited to: patient centered medical homes, accountable care organizations, bundled payments for certain procedures and reference-based reimbursements

Ms. Goodwin said it is important to point out to retirees the need to think in the long term and to ask whether it makes sense to retire at the moment they become eligible for it. If a person retires at 50, they should consider that their premiums will double in nine years and quadruple in 18 years. She said this particular point should be included in retirement seminars.

Mr. Tyndall reviewed an updated solvency report. While solvency was projected to 2036 in July 2016, Senate Bill 7 reeled that back to 2032 by taking $50 million from the tax suspense fund for the next five years. In addition, the July 2016 report included an expected rate of return of 7.75 percent, which was lowered to 7.25 percent based on NEPC's recommendations. Payroll growth is also assumed to be zero over the next three years. He said solvency is now at 2030, and he expects staff to make recommendations for July 2017 that would take it to at least 2032.

Ms. Goodwin recommended the NMRHCA come up with a strategy to get it to 100 percent funding over time. Similar to the task force the legislature had a few years ago with the pension plans, NMRHCA needs to have a dialogue with the legislature and executive branches on what are considered reasonable long-term goals and what they are willing to support.

Mr. Montaño said he would like to see a plan that gets to 100 percent funded, "but I worry about the point where you have to pay so much out of your pocket that it's no longer insurance, and at what point do we reach that?" He said this should be evaluated.

Mr. Linton said that, in addition to the recommendations for the 5-Year Plan, he would like to look at a range of aggressive recommendations to consider, reject, or postpone.

11. OUT-OF-STATE TRAVEL REQUEST

Mr. Tyndall stated that staff requests permission to attend the following two events:

1. Dave Archuleta and Neil Kueffer to attend the National Conference on the State and Local Government Benefits Association, on May 7-10 in Anaheim, California; and

2. Mark Tyndall to attend the Express Scripts Outcomes Symposium and Government Advisory Panel on June 5-8 in Dallas, Texas.

Ms. Larrañaga-Ruffy moved for approval. Ms. Goodwin seconded the motion, which passed unanimously by voice vote.

12. 2ND QUARTER BUDGET STATUS REPORT

[Presenter: Dave Archuleta.]

Health Care Benefit Fund: Between July 1, 2016 and December 31, 2016, expenditures from the Healthcare Benefits Administration Program were $148 million and revenues were $158.8 million, creating a surplus of $10.8 million. Current projections indicate a $22.7 million surplus at end of FY17.

Program Support Fund: Approved operating budget for FY17 totals $3,118,300. Projected expenditures are expected to remain within the total appropriation for FY17.

13. PHARMACY BENEFITS MANAGER CONSULTANT RFP

[Presenter: Dave Archuleta]

Mr. Archuleta stated that the NMRHCA, in cooperation with other members of the IBAC, is proposing to issue a request for proposals (RFP) for professional services related to the consulting functions associated with the upcoming pharmacy benefits manager RFP tentative scheduled for release in July 2017.

Mr. Montaño moved for approval to issue the RFP. Ms. Goodwin seconded the motion, which passed unanimously by voice vote.

14. FY17 FINANCIAL AUDIT RFP

[Presenter: Dave Archuleta]

Mr. Archuleta requested approval to issue an RFP for Audit Services upon review and approval by the Audit Committee.

Mr. Archuleta said the current auditor, Atkinson, has been on contract with the NMRHCA for 12 years, having gone through the RFP cycle every 3 years, and has reached the statutory maximum.

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

15. OTHER BUSINESS

None.

16. DATE & LOCATION OF NEXT REGULAR BOARD MEETING

March 7, 2017, 10:00 A.M.
Senator Fabian Chavez, Jr. (PERA) Board Room
33 Plaza La Prensa
Santa Fe, NM 87507

17. EXECUTIVE SESSION

None.

18. ADJOURN

Its business completed, the Board adjourned the meeting at 11:45 a.m.

_____
Tom Sullivan, President

2018 Preliminary Plan Recommendations

Background: The items listed below provide detailed information regarding specific actions taken by the Board of Directors, since 2014 (effective January 1, 2015) to improve the solvency of the program, reduce its unfunded liabilities and accommodate changing market conditions:

Effective January 1, 2015:

1. Increased pre-Medicare rates by 8 percent and Medicare rates by 5 percent
2. Decreased pre-Medicare spousal subsidy by 2 percent (from 40 percent to 38)
3. Instituted minimum age of 55 in order to receive subsides (except: PERA enhanced plans) after January 1, 2020
4. Increased years of service requirement for maximum subsidy from 20 to 25 (except: PERA enhanced plans) after January 1, 2020
5. Addition to 5-year Strategic Plan: conversion of basic life insurance to supplemental life

Effective January 1, 2016:

1. Increased pre-Medicare rates by 8 percent and Medicare rates by 6 percent
2. Decreased pre-Medicare spousal subsidy by 2 percent (from 38 percent to 36)
3. Decreased pre-Medicare retiree subsidy by 1 percent (from 65 percent to 64)
4. Reduced multiple dependent subsidy by 12.5 percent (from 25 percent to 12.5)
5. Implemented timeline for phasing out subsidy of $6,000 basic life policy beginning in 2018
6. Implemented enhanced wellness program with financial incentives

Effective January 1, 2017:

Pre-Medicare

1. Eliminated Premier Plus Plan
    a. Near Platinum Level Plan
    b. $300 Deductible
    c. $3,000 Annual Out-of-Pocket Maximum
2. Migrated Premier Plus Participants into Premier Plan
    a. Premier Plus Plan Membership – 4,400
    b. Premier Plan Membership – 13,000
3. Created Value Plan
    a. Silver Level Plan
    b. $1,500 Deductible
    c. $5,500 Out-of-pocket Maximum (includes deductible and medical copayments)
    d. Narrow networks compared to Premier Plan
    e. Same 1st dollar coverage as Premier Plan
    f. Same Rx Benefit as Premier Plan
4. Adjusted rates commensurate with New Risk Pools

	2016	**2017**
a. Premier Plus – Retiree	$326	NA

Premier Plus – Spouse	$516	NA
Premier PPO – Retiree	$175	$225
Premier PPO – Spouse	$331	$400
Value HMO – Retiree	NA	$175
Value HMO – Spouse	NA	$331

Premier PPO: Presbyterian – NM Residents Only
BCBS – Nationwide including NM
Value HMO: Presbyterian – NM Residents Only
NM Health Connections – NM Residents Only

5. Plan Enhancements
    a. Increased annual out-of-pocket maximum of Premier Plan by $500 to $4,500 to include $800 deductible as well as medical copayments to maximum calculation creating net positive for high-cost members
    b. Implemented first dollar coverage (waive deductible and coinsurance) on all plans for advanced radiology services (CT, MRI and PET scans) received at free-standing imaging centers with $100 copayment
    c. Implemented first dollar coverage (waive deductible and coinsurance) on all plans for physical therapy services as an alternative to surgery with same copayment as PCP visit with a maximum of 4 copayments per course of treatment

Medicare

1. Commitment to increase member awareness of Medicare Advantage offering through newsletters, website and seminars/workshops throughout 2017
2. All members will maintain the ability to select any eligible Medicare Plan
3. Members who do not make an active choice will be defaulted into the most appropriate Medicare Advantage offering when they turn 65 beginning January 2018
4. Increased Medicare Supplement rate by 6 percent

All Self-Insured Prescriptions Plans

1. Eliminated coverage for drugs available over the counter (OTC)
    a. Primarily antihistamines (i.e. Clarinex), inhalable nasal steroids (i.e. Nasonex) and proton pump inhibitors (i.e. Nexium)

All

1. Eliminated Multiple Dependent Subsidy (12.5 percent in 2016)
2. Implemented Open Enrollment Period
    a. Except for IRS Section 125 qualifying events enrollment into NMRHCA programs is not allowed outside of open enrollment period every other year

Preliminary Staff Recommendations for January 1, 2018

Pre-Medicare/Medicare

1. Increase retiree premiums in accordance with projected medical trend for all self-insured plans

2. Expand Value Option Resources
    a. Applies downward pressure on costs

3. Increase Cost Sharing on Prescription Plan
    a. Narrower network
    b. Increase copays

Medicare

4. Default folks to the appropriate Medicare Advantage Plan (assumed based on last year's board adoption)
    a. Details forthcoming

5. Supplement – introduce $250 copay for inpatient stay (1 per year)

6. Supplement – increase annual Part B cost sharing by $50

Related factors

Investment Returns

Market Check Agreement through Express Scripts

NMRHCA 5-Year Strategic Plan

Background: In October 2012, the Board of Directors adopted a five-year strategic plan focused on nine elements listed below. Each element served as a strategy to extend the solvency of the program, reduce future liabilities, and more closely align contributions into the program over the course of an average career to the benefits received over the course of an average retirement. At the time of adoption, the combination of proposals listed served to achieve a solvency period projected to 2045.

As of June 30, 2016, every element of the strategic plan has (at least to some extent) been implemented indicating a 20-year solvency period (2036). However, subsequent events outside the control of the agency have resulted in permanent changes to our funding structure, effectively reducing our solvency period by six years (2030). In response to this change, it is necessary to carry several items over to the next version of the five-year strategic plan.

5-Year Strategic Plan
2013 – 2017

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

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

1. Apply downward pressure on prescription drug costs for all members (network, contracts, cost-sharing)*

2. Apply downward pressure on pre-Medicare medical plans (network, contracts, cost-sharing)*

3. Reduce pre-Medicare retiree subsidies*

4. Reduce pre-Medicare spousal subsidies*

5. Evaluate existing and emerging wellness/population health programs for inclusion in either plan coverage or incentive support*

6. Develop and implement value-based purchasing initiatives either through existing health plan partners or directly with health care delivery systems**

7. Evaluate emerging and ongoing demographic trends and make program adjustments commensurate with fiduciary requirements

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

*Consensus carry over items from previous plan

** To include but not limited to: patient centered medical homes, accountable care organizations, bundled payments for certain procedures and reference-based reimbursements.

Timeframe Proposed in November 2016:

December 2016 - Determine carry-over items from current plan

January 2017 – Discuss specific solvency / GASB goals associated with 2017 – 2022 plan

February 2017 – Staff recommendation of new items for 2017 – 2022 plan

March 2017 – Refinement of recommendations based on board input

April 2017 – Actuarial input / evaluation of plan elements

May 2017 – Revisions and discussions resulting from actuarial input/evaluation

June 2017 – Discussion of 2018 plan recommendations as related to proposed 5-year plan

July 2017 – Annual retreat (emphasis on action necessary for plan year 2018)

August 2017 – Final recommendations for 5 year strategic plan (possible adoption contingent on consensus)

September 2017 – No meeting planned

October 2017 – Adoption of NMRHCA 5-Year Strategic Plan (2017 – 2022)

Requested Action: None – additional comments and suggestions can be incorporated through adopted of the plan scheduled for October.

FY17 Contract Amendments / New Contract (Action Item)

The New Mexico Retiree Health Care Authority (NMRHCA) requests permission from the Board of Directors to amend or enter into new contracts with our health plan partners and other vendors, for the current fiscal year. For FY17, NMRHCA staff proposed the list of contracts below along with the corresponding compensation based upon prior year, actuals, assumptions with regard to specific participation and limited budget availability. Typically, the agency leaves a portion of the budget "unobligated/unencumbered" to accommodate changes in participation or plan costs. As the fiscal year progresses and projected costs become more apparent, particularly with the plans that have a fixed per member, per month, unit cost, NMRHCA staff periodically requests permission from the Board to amend certain contracts to accommodate expenses through the remainder of the fiscal year.

The charts below identify a list of existing contracts and associated compensation with each of those contracts under the 'amount encumbered YTD' column. These amounts correspond to the compensation specified in each of their respective contracts. Estimated costs project the need to amend the compensation upward for the agreements with Presbyterian Medicare Advantage and United Healthcare Medicare Advantage (amounts shown in blue), to reflect participation and projected costs through the remainder of FY17.

The proposed amendments are supported by "available budget" that has not been designated toward any other health plan. Please note - approval of the proposed amendments will leave $5,083,400 unencumbered and available for additional amendments, prior to the end of FY17.

FY17 Approved Operating Budget Healthcare Benefits Administration						
	$309,883,400					
Contract	**Amount Encumbered YTD**	**Expended 2.27.17**	**Contract Balance**	**Proposed Amendment**	**Revised Total**	**Projected Expenditures**
BCBS						
Supplemental/PreMed	$ 110,000,000.00	$ 62,969,629.14	$ 47,030,370.86	NA*	$ 110,000,000.00	$ 110,000,000.00
Advantage	$ 4,500,000.00	$ 2,968,904.60	$ 1,531,095.40	NA	$ 4,500,000.00	$ 4,494,910.10
Presbyterian						
Non-Medicare	$ 43,500,000.00	$ 26,940,737.99	$ 16,559,262.01	NA*	$ 43,500,000.00	$ 43,500,000.00
Medicare	$ 11,500,000.00	$ 7,427,107.60	$ 4,072,892.40	$ 50,000.00	$ 11,550,000.00	$ 11,517,107.60
Express Scripts	$ 95,000,000.00	$ 58,776,314.66	$ 36,223,685.34	NA*	$ 95,000,000.00	$ 95,000,000.00
United Health Care	$ 4,500,000.00	$ 3,443,415.55	$ 1,056,584.45	$250,000.00	$ 4,750,000.00	$ 4,733,415.55
Humana	$ 750,000.00	$ 63,108.15	$ 686,891.85	NA	$ 750,000.00	$ 153,108.15
NM Health Connections	$ 1,000,000.00	$ -	$ 1,000,000.00	NA	$ 1,000,000.00	$ 1,000,000.00
United Concordia	$ 11,000,000.00	$ 6,714,380.15	$ 4,285,619.85	NA	$ 11,000,000.00	$ 9,974,380.15
Delta	$ 9,000,000.00	$ 6,646,876.62	$ 2,353,123.38	NA	$ 9,000,000.00	$ 901,876.62
Standard	$ 11,500,000.00	$ 7,056,888.24	$ 4,443,111.76	NA	$ 11,500,000.00	$ 10,696,888.24
Davis Vision	$ 2,250,000.00	$ 1,440,508.32	$ 809,491.68	NA	$ 2,250,000.00	$ 2,186,008.32
Total	**$ 304,500,000.00**	**$ 184,447,871.02**	**$120,052,128.98**	**$300,000**	**$304,800,000**	**$ 294,157,694.73**
Unencumbered Balance	$ 5,383,400.00			$5,083,400		
*Proposed amendments at April Board meeting.						

NMRHCA staff is also proposing to enter into a statewide price agreement for professional services under the contractual services category for the design and development of a new website for the agency. The proposed agreement would designate $20,000 of the available $91,000 for this purpose.

FY17 Approved Operating Budget - Program Support/Contractual Services						
	$624,400					
Contract	**Amount Encumbered YTD**	**Expended 2.27.17**	**Contract Balance**	**Percent Remaining**	**Proposed Amendment**	**Revised Total**
Operations						
Segal	$ 315,000.00	$ 149,525.00	$165,475	52.5%	$0	$315,000
NEPC	$ 45,000.00	$ 45,000.00	$0	0.0%	$0	$45,000
Atkinson	$ 37,450.00	$ 35,310.00	$2,140	5.7%	$0	$37,450
Judith Beatty	$ 6,000.00	$ 3,401.18	$2,599	43.3%	$0	$6,000
SHRED IT	$ 1,656.71	$ 1,656.71	$0	0.0%	$0	$1,657
SHRED IT (PO 1760)	$ 2,900.00	$ 2,376.81	$523	18.0%	$0	$2,900
Rodey	$ 50,000.00	$ 10,432.90	$39,567	79.1%	$0	$50,000
Information Technology						
POD Inc	$ 60,000.00	$ -	$60,000	100.0%	$0	$60,000
Real Time Solutions	$ -				$20,000	$20,000
ABBA Technology	$ 8,600.00	$ 3,554.73	$5,045	58.7%	$0	$8,600
ABBA Technology	$ 6,707.03	$ -	$6,707	100.0%	$0	$6,707
Total	**$ 533,313.74**	**$ 251,257.33**	**$282,056**	52.9%	**$20,000**	$553,314
Unencumbered Balance	$ 91,086.26		NA	NA	$71,086	$71,086

Conclusion: NMRHCA staff respectfully requests approval to amend the compensation associated with the existing agreements between NMRHCA and the Presbyterian and United Healthcare Medicare Advantage Plans in the amounts indicated in the 'proposed amendment' column. In addition, NMRHCA staff is requesting permission to enter into an agreement with Real Time Solutions for the design and development of a new website for the agency with an approximate cost of $20,000.

The Washington Post

Wonkblog

Federal judge blocks Aetna-Humana health insurance megamerger

By Carolyn Y. Johnson January 23

This story has been updated.

A federal judge has prohibited the merger of two health insurance giants, Aetna and Humana, upholding the Justice Department's decision that the $37 billion deal would hurt competition and raise prices for consumers.

"The Court is unpersuaded that the efficiencies generated by the merger will be sufficient to mitigate the anticompetitive effects for consumers in the challenged markets," U.S. District Judge John D. Bates wrote in his 158-page opinion.

In July, the Justice Department sued to block the merger, arguing that it would reduce competition in the Medicare Advantage market and in some of the exchanges set up under the Affordable Care Act. Medicare Advantage plans are Medicare health plans offered by private insurers.

"We are reviewing the opinion now and giving serious consideration to an appeal, after putting forward a compelling case," Aetna spokesman T.J. Crawford said. The companies' merger agreement, which has already been extended twice, will expire Feb. 15.

Humana did not immediately respond to a request for comment.

Bates wrote in his opinion that the proposed merger would have decreased competition substantially in the Medicare Advantage market in 364 counties. Aetna and Humana had argued that Medicare Advantage plans also competed against traditional Medicare options, but the judge sided with the Justice Department that the private Medicare plans were a separate market. The companies also proposed that divesting some of that business to a smaller insurer, Molina Healthcare, could have addressed those concerns, but the judge did not agree.

The merger was also deemed to lessen competition in the exchanges set up by the ACA in three Florida counties. Aetna withdrew from the majority of the exchanges that it had participated in this year, citing financial losses. The judge, however, wrote that Aetna withdrew from 17 counties highlighted in the case "specifically to evade judicial scrutiny of the merger."

Deputy Assistant Attorney General Brent Snyder, current head of the Justice Department's Antitrust Division, said in a statement the decision a victory for consumers. He said taxpayers and customers would save up to a half-billion dollars each year.

"This merger would have stifled competition and led to higher prices and lower quality health insurance," Snyder said.

In a research note, Ana Gupte, an analyst at Leerink Partners wrote that she had expected the deal to have a one in three chance of closing. She added that other bidders could now emerge for Humana.

In a separate case, Anthem and Cigna are fighting the Justice Department's decision last summer to block its $54 billion merger. The decision in that case is still pending, but Gupte said she expects that deal will be blocked, as well.

Matthew Cantor, a partner at Constantine Cannon, an antitrust law firm, said that the decision was based on a thorough analysis by the judge and argued that an appeal likely would be difficult from a legal standpoint. But he noted that a wild card could be the role of the Trump administration, which is pressing to replace the ACA and will be negotiating with insurers who sell plans in the marketplaces and in whatever replaces them.

"You have a White House -- at least when they were in the president-elect phase -- that has seemingly been receptive to having discussions with executives whose mergers are under review," Cantor said. "It could be that the independence of the Justice Department is cast aside here, in order to create a settlement which would benefit, from a political standpoint, the Trump administration. If they, in fact, revise the ACA so drastically and they can get public statements from these insurers -- these large insurers -- that they support the transition."

Dan Mendelson, president of Avalere Health, said that he expects insurers to continue to make acquisitions or attempt mergers, whether on appeal or in new deals. He said it's possible that insurers could turn to acquiring data and analytics firms.

"Health plans have been and will continue to be acquisitive," Mendelson said. He pointed out that the largest health insurer, UnitedHealth Group, "has already scaled up to a very large degree, so the other companies are interested in following suit."

The stock prices of both companies fell on the news, although Humana's stock recovered and closed at a higher price. Aetna's share price closed down 2.7 percent, and Humana's stock closed up 2.2 percent.

The decision was applauded by advocates for doctors and patients.

"The court ruling halts Aetna's bid to become the nation's largest seller of Medicare Advantage plans and preserves the benefits of health insurer competition for a vulnerable population of seniors," Andrew Gurman, president of the American Medical Association, said in a statement.

Sen. Richard Blumenthal (D-Conn.) released a statement applauding the decision, as well.

"Today's ruling is a decisive victory for jobs, consumers, and healthcare. Mega-mergers like the proposed consolidation of Aetna and Humana raise prices, lower health care quality – and kill jobs," Blumenthal said.

More from Wonkblog:

Drugmakers question the future of drug prices under Trump

Why Obamacare's insurance marketplaces won't necessarily collapse with a repeal

Only 1 in 5 Americans supports Republicans' 'repeal and delay' Obamacare strategy

Carolyn Johnson is a reporter covering the business of health. She previously wrote about science at The Boston Globe. Follow @carolynyjohnson

The New York Times | https://nyti.ms/2kQc6hu

DealB%k WITH FOUNDER ANDREW ROSS SORKIN

Judge, Citing Harm to Customers, Blocks $48 Billion Anthem-Cigna Merger

By MICHAEL J. de la MERCED and LESLIE PICKER FEB. 8, 2017

A federal judge on Wednesday blocked a proposed $48 billion merger of Anthem and Cigna, derailing another effort by top health insurers to reshape the industry by combining.

The ruling, by Judge Amy Berman Jackson of the Federal District Court for the District of Columbia, came two weeks after another federal judge blocked a proposed $37 billion merger between Aetna and Humana on antitrust grounds.

Judge Jackson wrote in her order that she found the Justice Department's arguments against the deal persuasive, and that putting Anthem and Cigna together would harm customers.

"The evidence has also shown that the merger is likely to result in higher prices, and that it will have other anticompetitive effects," the judge wrote. "It will eliminate the two firms' vigorous competition against each other for national accounts, reduce the number of national carriers available to respond to solicitations in the future, and diminish the prospects for innovation in the market."

Under the merger agreement's terms, Anthem is obligated to pay Cigna a $1.85 billion breakup fee.

A representative for Cigna declined to comment. A spokeswoman for Anthem also declined to comment.

The merger process between Anthem and Cigna has been notoriously contentious. In September, the Justice Department revealed court documents that showed the two had accused each other of breaching their agreement.

The government argued that the disputes ran counter to a major defense offered by the companies — that the deal could enhance competition by creating billions of dollars in savings. The government argued that such savings required the companies to cooperate in integrating their businesses.

Judge Jackson referred in her order to the disagreements between the companies — she called them "the elephant in the courtroom" — citing testimony by Cigna executives who argued that projections of future cost savings were wrong, and Cigna declining to sign off on Anthem's findings of fact.

"Anthem urges the court to look away, and it attempts to minimize the merging parties' differences as a 'side issue,' a mere 'rift between the C.E.O.'s," she wrote. "But the court cannot properly ignore the remarkable circumstances that have unfolded both before and during the trial."

The huge mergers involving Anthem and Cigna and Aetna and Humana were announced a year and a half ago. The health insurers sought the deals in part to adapt to changes in the market wrought by the Affordable Care Act and to gain greater clout in their negotiations with hospital systems, which have also been actively merging in recent years.

Together, the two deals would have winnowed the five biggest insurers to three.

Several deals in other industries announced around the time were notable in their ambition, seeking consolidation in a quest for larger scale and lower costs. But

biggest of those proposed mergers, successfully blocking combinations like one between the oil field services providers Halliburton and Baker Hughes.

The Justice Department's efforts to block Anthem's deal for Cigna revolved around the argument that diminished competition would lead to higher prices for doctors, hospital and policy holders.

"If these mergers were to take place, the competition among insurers that has pushed them to provide lower premiums, higher-quality care and better benefits would be eliminated," Loretta E. Lynch, then the United States attorney general, said in July.

Other organizations, including groups representing hospital operators, also testified against the proposed merger.

The deal involving Anthem and Cigna had been seen as riskier than the one between Aetna and Humana because the two companies had significant overlap nationally. In her order, Judge Jackson found that the merger would have harmed customers in the 14 areas where Anthem competes in commercial health insurance, as well as in the Richmond, Va., market for large group customers.

A version of this article appears in print on February 9, 2017, on Page B3 of the New York edition with the headline: Judge Halts Anthem and Cigna Merger on Grounds It Would Hurt Customers.

Schedule of Medicare Outreach Presentations

Month	Date	City	Location	Time
March	8	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
April	5	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
	11	Las Cruces	City Hall	9:00 - 10:30AM
May	10	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
June	7	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
July	5	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
	7	Las Vegas	City Council Chambers	9:00 - 10:30AM
August	9	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
September	6	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
October	NA	Albuquerque	Albuquerque Office	NA
		Santa Fe	SF Office	NA
November	8	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM
	8	Roswell	Basset Auditorium	10:00 - 11:30AM
December	6	Albuquerque	Albuquerque Office	9:30 - 10:30AM
		Santa Fe	SF Office	1:30 - 3:00PM

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

SPONSOR Stewart **ORIGINAL DATE** 02/13/17 **LAST UPDATED** **HB**

SHORT TITLE Health Care Purchasing Disclosures **SB** 334

ANALYST Hanika-Ortiz

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$5.0-$100.0				Various

(Parenthesis ( ) Indicate Expenditure Decreases)

Responses Received From
New Mexico Public School Insurance Authority (NMPSIA)
New Mexico Retiree Health Care Authority (NMRHCA)
Office of the Attorney General (OAG)

No Response Received From
General Services Department ("State of New Mexico or SONM")

SUMMARY

Synopsis of Bill

SB 334 amends the Health Care Purchasing Act to require NMRHCA, NMPSIA, SONM and the Albuquerque Public Schools (APS), collectively known as the interagency benefits advisory committee or "IBAC", to study and provide a status report on the consolidation of administrative functions to the Legislative Health and Human Services Committee by December 1, 2017.

SB 334 also requires the IBAC to ensure enrollees are informed verbally, in writing, and via a website of their health plan choices including the cost-sharing associated with each plan; requires the IBAC to ensure that all plan participants review their options each year and reenroll; and allows a participant to switch plans in the middle of the year if these provisions are not followed.

FISCAL IMPLICATIONS

The bill requires the IBAC to study combining administrative functions. This could result in savings from collectively purchasing services from benefits consultants, actuaries, and other experts. The IBAC has been successfully collectively purchasing healthcare services for years.

If the bill is requiring enrollees participating in an IBAC health plan to review their options and

reenroll each year, there could be a notable impact on IBAC staff time and resources. Last fall, the IBAC reported membership of about 190,000 employees, retirees and dependents.

The informational and notification requirements as well as the term "full and open" when describing the annual enrollment process is vague and open to interpretation. As such, there would be a cost impact if the IBAC was required to go beyond what is currently being provided.

SIGNIFICANT ISSUES

Since 2002, several studies supporting the consolidation of the IBAC have been performed by LFC. However, legislation proposing the consolidation of these entities has not been introduced.

NMRHCA reports that each October the authority initiates an annual switch enrollment process that allows members to increase or decrease coverage levels. NMRHCA communicates dates, times and location of meetings across the state where plan options are presented. In addition, a summary of plan changes, meeting times and locations are communicated by email and by newsletter. Lastly, individual packets with information specific to the member including a summary of existing coverage, coverage costs, future costs, side-by-side comparison of available options, plan information, and calendar of information events are mailed to each member.

NMRHCA also reports that the information presented in communities also include presentations from carriers (Blue Cross Blue Shield, Presbyterian, New Mexico Health Connections, United Healthcare, Humana, Delta Dental, United Concordia, Davis Vision and Standard Life Insurance.) Each carrier is invited to set up an information booth to educate members about the benefits associated with each plan offered. Information can also be viewed on the website.

NMPSIA reports it serves as a group plan administrator for 88 school districts, 101 charter schools, and 25 educational entities. NMPSIA communicates via email blasts with announcements and open/switch enrollment activities to benefits specialists who enroll employees. Each October, NMPSIA conducts an annual open/switch enrollment process that allows members to change their plan elections. This information is relayed to employers and the employer is charged with notifying employees. Additionally, an online enrollment system also has an open/switch enrollment feature to complete enrollments. If an employee does not wish to change their enrollment, they do not have to participate in the switch enrollment process. NMPSIA also uses its website to provide information to school employees, including a medical plan side-by-side comparison, program guides, and marketing materials from the plan carriers.

PERFORMANCE IMPLICATIONS

OAG noted that the provisions regarding open enrollment may benefit from the addition of further detail, or conferral of rulemaking authority to implement uniform regulations.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

IBAC will continue to collectively purchase healthcare services but administer their programs separately including when they procure consultants, actuaries and other expert services.

AHO/jle

SENATE BILL 334

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

Mimi Stewart

AN ACT

RELATING TO PUBLIC EMPLOYEES AND RETIREES; AMENDING SECTIONS OF THE HEALTH CARE PURCHASING ACT TO REQUIRE CERTAIN DISCLOSURES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 13-7-4 NMSA 1978 (being Laws 1997, Chapter 74, Section 4) is amended to read:

"13-7-4. MANDATORY CONSOLIDATED PURCHASING.--

A. The publicly funded health care agencies shall enter into a cooperative consolidated purchasing effort to provide plans of health care benefits for the benefit of eligible participants of the respective agencies. The single request for [~~proposal~~] proposals shall set forth one or more plans of health care benefits and shall include accommodation of fully funded arrangements as well as varying degrees of self-funded pool options.

underscored material = new
[~~bracketed material~~] = delete

B. A consolidated purchasing request for proposals for all health care benefits by the publicly funded health care agencies shall be issued on or before July 1, 1999 and any contracts for health care benefits renewed or issued on or after July 1, 2000 shall be the result of consolidated purchasing.

C. [~~All requests~~] The request for proposals issued as part of the consolidated purchasing shall include at least one distinct service area consisting of the Albuquerque metropolitan area. Proposals on a distinct service area shall be evaluated separately."

SECTION 2. Section 13-7-7 NMSA 1978 (being Laws 2001, Chapter 351, Section 3, as amended) is amended to read:

"13-7-7. CONSOLIDATED ADMINISTRATIVE FUNCTIONS--BENEFIT--DISCLOSURES--PENALTIES.--

A. By December 1, [~~2001~~] 2017, the publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act shall cooperatively study and provide a status report on the consolidation of administrative functions to the legislative health and human services committee and the governor.

B. By December 31, 2003, the publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process

underscored material = new
[~~bracketed material~~] = delete

pursuant to the Health Care Purchasing Act shall consolidate, standardize and administer the administrative functions that those entities can effectively and efficiently administer as reflected in the study.

C. The publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act may enter into a joint powers agreement pursuant to the Joint Powers Agreements Act with the publicly funded health care agencies and political subdivisions to determine assessments or provisions of resources to consolidate, standardize and administer the consolidated purchasing single process and subsequent activities pursuant to the Health Care Purchasing Act. The publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act may enter into contracts with nonpublic persons to provide the service of determining assessments or provision of resources for consolidation, standardization and administrative activities.

D. Each agency will retain its responsibility to determine policy direction of the benefit plans, plan development, training and coordination with respect to participants and its benefits staff, as well as to respond to benefits eligibility inquiries and establish and enforce

underscored material = new
[bracketed material] = delete

eligibility rules.

E. Notwithstanding Subsection D of this section, publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the department of health; provided that eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) annually for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in [~~7.30.8 NMAC who are working in early intervention programs approved by the~~] department of health rules. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.

F. The publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act shall ensure that enrollees are informed on a readily accessible website and are individually notified in writing of all premiums, deductibles, copayments, coinsurance and other cost-sharing associated with each group health plan offered in a side-by-side comparison pursuant to the Health

underscored material = new
[~~bracketed material~~] = delete

Care Purchasing Act.

G. Each publicly funded health care agency shall conduct a full and open annual enrollment period. Regardless of whether an eligible participant is newly enrolling in group health coverage or is seeking to re-enroll in group health coverage, each eligible participant shall be provided with thorough written, verbal and web-based education relating to each group health plan, including the side-by-side comparison required pursuant to Subsection F of this section.

H. Any violation of the provisions of Subsection F of this section shall entitle an enrollee to rescission of that enrollee's enrollment in a group health plan and eligibility to enroll in another group health plan for the same plan year.

I. The provisions of this section shall be applicable to a new open enrollment period for all publicly funded health care agencies that shall begin on or after July 1, 2017."

underscored material = new
[bracketed material] = delete

FIFTY-THIRD LEGISLATURE **SB 334/a**
FIRST SESSION, 2017

February 23, 2017

Mr. President:

Your **PUBLIC AFFAIRS COMMITTEE**, to whom has been referred

SENATE BILL 334

has had it under consideration and reports same with recommendation that it **DO PASS**, amended as follows:

1. On page 2, line 15, strike "--PENALTIES".

2. On page 2, line 16, remove the brackets and line-through and strike "2017".

3. On page 4, line 21, after "Act", insert "shall offer for enrollment to each applicant and enrollee each health plan that the publicly funded health care agencies approve and".

4. On page 4, line 22, after "website", strike the remainder of the line.

5. On page 4, line 23, strike "writing".

6. On page 5, line 1, after the period, insert a closing quotation mark.

7. On page 5, lines 2 through 17, strike Subsections G, H and I in their entirety.,

and thence referred to the **JUDICIARY COMMITTEE.**

Respectfully submitted,

_____
Gerald Ortiz y Pino, Chairman

Adopted_____ Not Adopted_____
(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 6 For 0 Against
Yes: 6
No: 0
Excused: Brandt, Ingle
Absent: None

SB0334PA1.wpd .207577.1

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

SPONSOR Steinborn/Ferrary **ORIGINAL DATE** 02/13/17 **LAST UPDATED** **HB**

SHORT TITLE Interagency Pharmaceutical Purchasing Council **SB** 354

ANALYST Hanika-Ortiz

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY17	FY18	FY19	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		(see fiscal impact)				Various

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
New Mexico Retiree Health Care Authority (NMRHCA)
New Mexico Public School Insurance Authority (NMPSIA)
New Mexico Department of Health (NMDOH)

No Response Received Yet From
General Services Department (GSD "State of New Mexico")

SUMMARY

Synopsis of Bill

Senate Bill 354 (SB 354) creates the interagency pharmaceuticals purchasing council, administratively attached to GSD beginning in 2019. The council is tasked with reviewing and coordinating cost-containment strategies for the procurement of pharmaceuticals and pharmacy benefits management in the state. The GSD secretary is named as the director of the council.

The council includes membership from eleven state agencies and other governmental entities. The council will be required to convene its first meeting before December 1, 2017 and meet quarterly thereafter, and a majority of the voting members of the council constitutes a quorum.

Finally, SB 354 requires that LFC review and validate the council's progress on an annual basis.

FISCAL IMPLICATIONS

SB 354 does not require or guarantee cost savings as it pertains to pharmaceutical drug purchasing. It only creates a council to meet quarterly to continue cost-containment discussions and explore pooling opportunities, as resources allow. However, depending upon recommendations adopted by the council, the savings for the state could be significant. According to some reports, bulk savings alone are limited but real: about 2 to 5 percent of spend. According to LFC evaluation unit publications, in FY16, state agencies spent a combined total of about $680 million, up from $442 million in FY14, or an increase of 54 percent. Using these metrics, this suggests that the state could save between $13 million and $34 million annually.

NMRHCA reports it currently serves as a member of the interagency benefits advisory committee (IBAC) along with the State of New Mexico, NMPSIA and Albuquerque Public Schools. Combined, these 4 agencies are governed by the Health Care Purchasing Act (HCPA) which requires the collaboration of resources toward the procurement of medical, prescription drugs, and pharmacy benefits management (PBM) and other services as described in the bill.

This year, IBAC will issue its 3rd request for proposals (RFP) for a pharmacy benefits manager for the next 4 year cycle. The IBAC's first RFP saved $50 million over the term of the contract.

Express Scripts, the current pharmacy benefits manager for the entire IBAC, combines the purchasing power of its 95 million members with that of the IBAC's 200 thousand members. This has contributed to the IBAC agencies gaining access to aggressive pricing strategies.

NMDOH provided the following comments:

> SB345 would require NMDOH to utilize the same contracts and suppliers. This could result in significant cost savings or it could increase costs. A contract award to a supplier specializing in hospital goods and services may not have the same drugs on contract that are needed by a clinic or nursing home. NMDOH has hospitals, long term care facilities, custodial care facilities, outpatient clinics, and rehab facilities that have varied needs.
>
> NMDOH have GPOs (group purchasing organization) on contract for access to drug and supply pricing. The Public Health Division has 340B registrations in place for the Tuberculosis, Sexually Transmitted Disease and Family Planning programs, as well as the Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) GPO for non-340B qualifying services. MMCAP is a free, voluntary group purchasing organization for government facilities. GSD coordinates, oversees and facilitates the contracting process for the purchase of reduced price pharmaceuticals for state entities through MMCAP.
>
> One challenge is that MMCAP does not serve Medicaid or public employee programs. According to NCSL, a National Medicaid Pooling Initiative (NMPI), one of the first group purchasing organizations, was created in 2003 to address the need for lower priced pharmaceuticals for Medicaid programs. (http://www.ncsl.org/research/health/bulk-purchasing-of-prescription-pharmaceuticals.aspx) Ten states participated. Since then, other group purchasing organizations addressing Medicaid needs have been created. New Mexico is not a member of the NMPI or other Medicaid Pharmaceutical Purchasing Pools, and may benefit from becoming a member.

Multi-State Purchasing Alliances are proposed for WV, LA, MS, MO, NM and SC; GA, MA and TX have proposed intrastate pharmaceutical purchasing initiatives; FL, LA, KY and OR developed preferred drug lists for Medicaid beneficiaries; ME, MA, and WA require mandatory generic substitution for Medicaid programs; GA and KY have proposed cost sharing for Medicaid members by charging copayments; and VT has a multistate prescription drug purchasing coalition.
(https://www.nga.org/files/live/sites/NGA/files/pdf/PHARMSTRATEGIES.pdf
http://law.justia.com/codes/iowa/2016/title-iv/chapter-135/section-135.132)

SIGNIFICANT ISSUES

As resources allow, the council will explore strategies such as benchmarking pricing to Medicaid and/or Veterans' Affairs pricing, establishing a common formulary, a single purchase agreement for all pharmaceuticals and pharmacy benefits management services, and exploring opportunities for consolidating purchasing with other large entities, populations, or states.

In a 2015 LFC program evaluation of the Centennial Care Medicaid managed care program, staff lauded the IBAC's ability to negotiate a cost-effective option for Hepatitis C treatment for its plans. Staff recommended HSD should negotiate a lower rate for pharmaceutical drugs related to high cost treatments such as Hepatitis C as done by IBAC for New Mexico public employees, and should require actuaries to incorporate pharmaceutical discounts into the rate setting process.

In a subsequent 2016 LFC Health Note addressing maximizing state purchasing power related to prescription drug costs, staff highlighted various cost control mechanisms including use of formularies, prior authorization, cost sharing, dispensing limits, drug utilization reviews and medication adherence programs, bulk purchasing, and the use of PBM's. The document goes on to discuss HSD's use of a risk corridor for Hepatitis C drugs, where the state and the contractor share additional costs or enjoy shared savings should they materialize. Lastly, the Health Note advised that states can increase price transparency through legislation and increase negotiation power through collaborative purchase as is used by the IBAC, or joining purchasing pools.

PERFORMANCE IMPLICATIONS

According to NMDOH, this proposal is related to its strategic plan and could result in greater purchasing power, improved treatment, and improved health outcomes.

ADMINISTRATIVE IMPLICATIONS

Participating entities will be required to use existing staff and resources to participate.

NMPSIA is concerned that the purchasing process for drugs for sub-groups (employee groups, public assistance groups, 340B eligible populations, correctional detainees, etc.) are different, and the combined volume may not have the impact anticipated in a contract with a single vendor. Compromises necessary to reach consensus for a diverse purchasing authority may not be in the best interest of NMPSIA. In some states, agencies that combine employer sponsored health plans and public assistance plans maintain separate PBM contracts to recognize the critical differences.

AHO/jle

SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 354

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

AN ACT

RELATING TO PROCUREMENT; ESTABLISHING THE INTERAGENCY PHARMACEUTICALS PURCHASING COUNCIL; PROVIDING FOR COORDINATED PROCUREMENT OF PHARMACEUTICALS AND PHARMACEUTICAL BENEFITS AMONG CERTAIN STATE AGENCIES AND OTHER GOVERNMENTAL ENTITIES AND FOR REPORTING.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] INTERAGENCY PHARMACEUTICALS PURCHASING COUNCIL--CREATION--MEMBERSHIP--DUTIES.--

A. The "interagency pharmaceuticals purchasing council" is created and is administratively attached to the general services department. The council shall utilize existing constituent agency resources to review and coordinate cost-containment strategies for the procurement of pharmaceuticals and pharmacy benefits and the pooling of risk

underscored material = new
[bracketed material] = delete

for pharmacy services by the constituent agencies. Pursuant to its review of these strategies and related data, the council shall decide by vote which cost-containment strategies it will recommend. Constituent agencies shall make their own procurement decisions. The secretary of general services shall serve as director of the council and shall be responsible for the coordination of the day-to-day activities of the council.

B. The interagency pharmaceuticals purchasing council shall be composed of the following eleven members serving as voting, ex-officio members:

(1) the secretary of human services or the secretary's designee;

(2) the secretary of health or the secretary's designee;

(3) the secretary of children, youth and families or the secretary's designee;

(4) the secretary of corrections or the secretary's designee;

(5) the director of the risk management division of the general services department or the director's designee;

(6) the executive director of the retiree health care authority or the executive director's designee;

(7) the executive director of the public school insurance authority or the executive director's

underscored material = new
[bracketed material] = delete

designee;

(8) the superintendent of the Albuquerque public school district or the superintendent's designee;

(9) the president of the university of New Mexico or the president's designee; and

(10) two members, appointed by the governor, who are officers of, or representative of organizations that represent, county, municipal or local government entities that participate in consolidated purchasing of pharmaceuticals or pharmacy benefits with other constituent agencies.

C. The interagency pharmaceuticals purchasing council shall convene its first meeting with a quorum of its members present by September 1, 2017 at the call of the secretary of general services. After the initial meeting of the council, a quorum of its members shall meet at least once quarterly at the call of the secretary of general services. Meetings of the council shall be subject to the Open Meetings Act. In addition to notice provided pursuant to that act, the secretary of general services shall provide written notice of each scheduled meeting of the council to the director of the legislative finance committee at least ten days before each meeting.

D. The presence of a majority of voting members of the interagency pharmaceuticals purchasing council constitutes a quorum. The affirmative vote of a majority of a quorum

underscored material = new
[bracketed material] = delete

present shall be necessary for an action to be taken by the council.

E. The interagency pharmaceuticals purchasing council shall utilize existing constituent agency resources to review and coordinate cost-containment strategies for the procurement of pharmaceuticals and pharmacy benefits and the pooling of risk for pharmacy services by the constituent agencies. As resources allow, the cost-containment strategies that the council shall examine are:

(1) the benchmarking of pricing for pharmaceuticals and pharmacy benefits to:

(a) the pricing that the state's medical assistance plans achieve for pharmaceuticals and pharmacy benefits; and

(b) the pricing that the United States department of veterans affairs achieves for pharmaceuticals and pharmacy benefits;

(2) active medical management to optimize health outcomes and reduce costs;

(3) the establishment of a common formulary for all pharmaceuticals and pharmacy benefits plans offered by constituent agencies;

(4) a single purchase agreement for all constituent agencies' pharmaceuticals and pharmacy benefits;

(5) common procurement of expert services,

underscored material = new
[bracketed material] = delete

including, at minimum, pharmacy benefits management, pharmacy benefits management oversight services, medical direction and actuarial services;

(6) identifying any opportunities to consolidate purchasing among two or more constituent agencies;

(7) identifying any opportunities for pooling risk among two or more constituent agencies or populations the constituent agencies serve;

(8) identifying any opportunities for consolidating purchasing with other entities and states of the United States;

(9) ensuring that all agencies, programs, clinics, hospitals and other health-related centers and entities, including those identified by the human services department pursuant to Paragraph (3) of Subsection A of Section 27-2-12.13 NMSA 1978, that are eligible for pharmaceutical discounts pursuant to Section 340B of the federal Public Health Service Act participate in that Section 340B federal pharmaceutical price discount program;

(10) identifying any opportunities for maximizing the use of generic pharmaceuticals where safe and cost-effective to do so;

(11) negotiating advantageous pricing and incentives with insurers, pharmacy benefits managers, pharmacies, manufacturers, distributors and vendors of

underscored material = new
[~~bracketed material~~] = delete

pharmaceuticals and other third-party entities involved in supplying pharmaceuticals, pharmacy benefits and management services to the council's constituent entities; and

(12) identifying any other opportunities for maximizing efficiency and a high standard of health care quality.

F. The legislative finance committee shall annually review and validate the council's progress. It shall incorporate this information into its budget and policy analysis and recommendations.

G. As used in this section, "constituent agency" means:

(1) the human services department, including any medical assistance program it administers;

(2) the department of health;

(3) the children, youth and families department;

(4) the corrections department;

(5) the risk management division of the general services department;

(6) the retiree health care authority;

(7) the public school insurance authority;

(8) the publicly funded health care program of the Albuquerque public school district;

(9) the university of New Mexico health

benefits program for university employees and retirees;

(10) the university of New Mexico hospitals; or

(11) any local, county or municipal government that opts to participate in consolidated pharmaceuticals or pharmacy benefit purchasing.

underscored material = new
[bracketed material] = delete

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

SPONSOR Dodge **ORIGINAL DATE** 2/27/17 **LAST UPDATED** **HB** 452

SHORT TITLE FY2017 Fund Transfers **SB**

ANALYST Armstrong

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY17	FY18	FY19		
$1,867.6			Nonrecurring	General Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY17	FY18		
$1,867.6		Nonrecurring	Various Other State Funds appropriated to the General Fund (see "Fiscal Implications")

(Parenthesis ( ) Indicate Revenue Decreases)

Relates to HB6, SB113

SOURCES OF INFORMATION
LFC Files

Responses Received From
Retiree Healthcare Authority (RHCA)
Regulation and Licensing Department (RLD)
Office of the Superintendent of Insurance (OSI)
NM Environment Department (NMED)
Public Education Department (PED)

Responses Not Received From
Department of Finance and Administration (DFA)
General Services Department (GSD)
Board of Nursing (BON)
Higher Education Department (HED)

SUMMARY

Synopsis of Bill

House Bill 452 (HB452) bill transfers cash balances in certain funds to the general fund.

FISCAL IMPLICATIONS

HB452 transfers nearly $1.9 million to the general fund from the following funds:

Agency	Fund Name	Amount
RHCA	Discount Prescription Drug Program Fund	$16.9
GSD	Property Control Reserve Fund	$808.0
RLD	Landscape Architects Fund	$100.0
RLD	Pharmacy Fund	$100.0
RLD	Board of Dental Health Care Fund	$50.0
RLD	Construction Industries Publications Fund	$43.2
RLD	Interior Design Board Fund	$17.5
OSI	Insurance Examination Fund	$1.4
BON	Board of Nursing Fund	$8.0
NMED	Radiologic Technology Fund	$180.2
NMED	Solid Waste Facility Grant Fund	$170.8
NMED	Voluntary Remediation Fund	$77.0
PED	Teacher Professional Development Fund	$78.9
PED	Incentives for School Improvement Fund	$46.3
PED	Charter Schools Stimulus Fund	$14.2
PED	Educational Technology Fund	$14.2
PED	Family and Youth Resource Fund	$1.1
HED	Program Development Enhancement Fund	$139.9
	Total	**$1,867.6**

SIGNIFICANT ISSUES

Prior to the start of the 2017 legislative session, the Department of Finance and Administration (DFA) and Legislative Finance Committee (LFC) staff worked to identify fund balances available to transfer to the general fund that were not budgeted and would not impact agency operations. To do this, staff relied on agency projected FY17 ending fund balances and the amounts recommended for FY18 operating budgets.

Senate Bill 113 (SB113) transferred fund balances identified by DFA and LFC in excess of $200 thousand, and HB452 includes smaller amounts identified; except the $808 thousand from the property control reserve fund that was agreed on by DFA and LFC staff following the passage of SB113.

RELATIONSHIP

As noted above, SB113, enacted earlier in the 2017 session, transferred $47.2 million from various other state funds to the general fund.

JA/jle

HOUSE BILL 452

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

George Dodge, Jr.

AN ACT

RELATING TO STATE EXPENDITURES; TRANSFERRING MONEY FROM FUNDS AND ACCOUNTS TO THE FISCAL YEAR 2017 APPROPRIATION ACCOUNT OF THE GENERAL FUND; MAKING APPROPRIATIONS; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. FUND AND OTHER ACCOUNT TRANSFERS AND REVERSIONS TO GENERAL FUND--FISCAL YEAR 2017.--Notwithstanding any restriction on the use of money from the source, the following amounts are appropriated from the following funds or accounts and are transferred to the fiscal year 2017 appropriation account of the general fund:

A. sixteen thousand nine hundred dollars ($16,900) from the discount prescription drug program fund;

B. eight hundred eight thousand dollars ($808,000)

underscored material = new
[bracketed material] = delete

from the property control reserve fund;

C. one hundred thousand dollars ($100,000) from the landscape architects fund;

D. one hundred thousand dollars ($100,000) from the pharmacy fund;

E. fifty thousand dollars ($50,000) from the board of dental health care fund;

F. forty-three thousand two hundred dollars ($43,200) from the construction industries publications fund;

G. seventeen thousand five hundred dollars ($17,500) from the interior design board fund;

H. one thousand four hundred dollars ($1,400) from the insurance examination fund;

I. eight thousand dollars ($8,000) from the board of nursing fund;

J. one hundred eighty thousand two hundred dollars ($180,200) from the radiologic technology fund;

K. one hundred seventy thousand eight hundred dollars ($170,800) from the solid waste facility grant fund;

L. seventy-seven thousand dollars ($77,000) from the voluntary remediation fund;

M. seventy-eight thousand nine hundred dollars ($78,900) from the teacher professional development fund;

N. forty-six thousand three hundred dollars ($46,300) from the incentives for school improvement fund;

underscored material = new
[bracketed material] = delete

O. fourteen thousand two hundred dollars ($14,200) from the charter schools stimulus fund;

P. fourteen thousand two hundred dollars ($14,200) from the educational technology fund;

Q. one thousand one hundred dollars ($1,100) from the family and youth resource fund; and

R. one hundred thirty-nine thousand nine hundred dollars ($139,900) from the higher education program development enhancement fund.

SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

underscored material = new
[~~bracketed material~~] = delete

HB2 House Appropriations and Finance Committee Update

The FY18 appropriation recommendations proposed by the Legislative Finance Committee (LFC) and Executive provide for a range of growth between 4.8 and negative 3.7 percent for the Healthcare Benefits Administration Program with the LFC recommendation being greater. The request assumed a 3 percent growth in participation, 6 percent growth in medical trend. Table 1 compares the FY17 operating budget along with the FY18 request and corresponding recommendations made by the LFC, Executive and House Appropriation and Finance Committee (HAFC) action. Overall, final HAFC action includes a $7 million increase to Healthcare Benefits Administration Program (2.2 percent) and $181 thousand reduction to Program Support (minus 5.8 percent).

Table 1 ($ shown in thousands)	FY17 Approved Operating	FY18 Request	LFC Recommendation	Exec Recommendation	**HAFC**
Personal Services & Employee Benefits	$ 1,949.8	$ 1,997.3	$ 1,997.3	$ 1,858.8	$ 1,858.8
Contractual Services	$ 310,507.8	$ 339,515.2	$ 325,575.8	$ 299,275.7	$ 317,636.0
Other	$ 592.1	$ 618.5	$ 607.7	$ 571.0	$ 571.0
Other Financing Uses	$ 3,118.3	$ 3,118.3	$ 3,118.3	$ 2,807.7	$ 2,936.8
Total	**$ 316,168.0**	**$ 345,249.3**	**$ 331,299.1**	**$ 304,513.2**	**$ 323,002.6**
Healthcare Benefits Administration					
Contractual Services	$ 309,883.4	$ 338,970.4	$ 325,051.8	$ 298,860.0	$ 317,091.2
Other	$ 48.0	$ 42.3	$ 41.5	$ 37.8	$ 37.8
Other Financing Uses	$ 3,118.3	$ 3,118.3	$ 3,118.3	$ 2,807.7	$ 2,936.8
Subtotal	**$ 313,049.7**	**$ 342,131.0**	**$ 328,211.6**	**$ 301,705.5**	**$ 320,065.8**
Program Support					
Personal Services & Employee Benefits	$ 1,949.8	$ 1,997.3	$ 1,997.3	$ 1,858.8	$ 1,858.8
Contractual Services	$ 624.4	$ 544.8	$ 524.0	$ 415.7	$ 544.8
Other	$ 544.1	$ 576.2	$ 566.2	$ 533.2	$ 533.2
Subtotal	**$ 3,118.3**	**$ 3,118.3**	**$ 3,087.5**	**$ 2,807.7**	**$ 2,936.8**
Total	**$ 316,168.0**	**$ 345,249.3**	**$ 331,299.1**	**$ 304,513.2**	**$ 323,002.60**
FTE	**27**	**27**	**27**	**27**	**27**

Table 2 provides a comparison of the incremental growth requested, recommended and adopted for each program compared to the approved FY17 operating budget.

Table 2 ($ shown in thousands)	FY17 Approved Operating	FY18 Requested Growth	LFC Recommended Growth	Exec Recommended Growth	**HAFC**
Healthcare Benefits Administration					
Contractual Services	$ 309,883.4	$ 29,087.0	$ 15,168.4	$ (11,023.4)	$ 7,207.8
Other	$ 48.0	$ (5.7)	$ (6.5)	$ (10.2)	$ (10.2)
Other Financing Uses	$ 3,118.3	$ -	$ -	$ (310.6)	$ (181.5)
Subtotal	**$ 313,049.7**	**$ 29,081.3**	**$ 15,161.9**	**$ (11,344.2)**	$ 7,016.1
Program Support					
Personal Services & Employee Benefits	$ 1,949.8	$ 47.5	$ 47.5	$ (91.0)	$ (91.0)
Contractual Services	$ 624.4	$ (79.6)	$ (100.4)	$ (208.7)	$ (79.6)
Other Financing Uses	$ 544.1	$ 32.1	$ 22.1	$ (10.9)	$ (10.9)
Subtotal	**$ 3,118.3**	**$ -**	**$ (30.8)**	**$ (310.6)**	$ (181.5)
Total	**$ 316,168.0**	**$ 29,081.3**	**$ 15,131.1**	**$ (11,654.8)**	**$ 6,834.6**
FTE	**27**	**0**	**0**	**0**	**0**

Table 3 compares the FY17 operating budget along with the requested, recommended and adopted growth expressed in terms of a percentage.

Table 3 ($ shown in thousands)	FY17 Approved Operating	FY18 Requested Growth	LFC Recommended Growth	Exec Recommended Growth	HAFC
Healthcare Benefits Administration					
Contractual Services	$ 309,883.4	9.4%	4.9%	-3.6%	2.3%
Other	$ 48.0	-11.9%	-13.5%	-21.3%	-21.3%
Other Financing Uses	$ 3,118.3	0.0%	0.0%	-10.0%	-5.8%
Subtotal	**$ 313,049.7**	**9.3%**	**4.8%**	**-3.6%**	2.2%
Program Support					
Personal Services & Employee Benefits	$ 1,949.8	2.4%	2.4%	-4.7%	-4.7%
Contractual Services	$ 624.4	-12.7%	-16.1%	-33.4%	-12.7%
Other Financing Uses	$ 544.1	5.9%	4.1%	-2.0%	-2.0%
Subtotal	**$ 3,118.3**	**0.0%**	**-1.0%**	**-10.0%**	-5.8%
Total	**$ 316,168.0**	**9.2%**	**4.8%**	**-3.7%**	2.2%
FTE	**27**	**0**	**0**	**0%**	**0%**

Final HAFC action provides for a spending level much less than projected costs for FY18. However, HB2 includes the following budget adjustment request authority:

(19) program support of the retiree health care authority may request budget increases up to two hundred thousand dollars ($200,000) from other state funds and internal service funds/interagency transfers for information technology services and the healthcare benefits administration program may request budget increases from other state funds for claims;

With approve by the Board of Directors, this authority will enable staff to manage the operating budget according to the projected costs.

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

	Core Plus Bonds	Large Cap Index	Non US Dev Index	Non US Emg Index	Small Mid Cap	Credit and Structure	Absolute Return	Private Equity	Real Estate	Total
Market Value 12/31/2016	$99,025,368.52	$105,047,472.03	$54,100,459.49	$66,753,467.83	$14,653,096.69	$50,978,815.36	$23,690,389.63	$52,649,238.25	$28,732,139.98	$495,630,447.78
CONTRIBUTIONS	1,000,000.00	1,000,000.00	600,000.00	750,000.00	150,000.00	500,000.00	250,000.00	500,000.00	250,000.00	5,000,000.00
WITHDRAWALS	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FEES	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
INCOME EARNED	274,263.90	5.81	28,544.54	42,141.74	2,581.15	8,574.21	184.97	40,592.98	96,288.14	493,177.44
CAPITAL APPR/DEPR	473,264.94	2,130,548.50	1,558,391.48	3,583,557.06	221,472.76	395,331.61	255,941.82	79,272.22	(71,750.54)	8,626,029.85
Market Value 1/31/2017	$100,772,897.36	$108,178,026.34	$56,287,395.51	$71,129,166.63	$15,027,150.60	$51,882,721.18	$24,196,516.42	$53,269,103.45	$29,006,677.58	$509,749,655.07