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

REGULAR MEETING
OF THE
BOARD OF DIRECTORS

December 7, 2021
9:30 AM

Online: https://global.gotomeeting.com/join/136274197
Telephone: 1-408-650-3123/ Access Code: 136-274-197

New Mexico Retiree Health Care Authority
Regular Meeting

BOARD OF DIRECTORS

ROLL CALL

December 7, 2021

	Member in Attendance		
Mr. Crandall, President			
Ms. Saunders, Vice President			
Ms. Larranaga-Ruffy, Secretary			
Mr. Scroggins			
Mr. Linton			
Mr. Salazar			
Mr. Eichenberg			
Mr. Cushman			
Mr. Bhakta			
Mr. Pyle			
Ms. Madrid			

NMRHCA BOARD OF DIRECTORS

DECEMBER 2021

Mr. Greg Trujillo
Executive Director
Public Employees Retirement Association
33 Plaza La Prensa
Santa Fe, NM 87507
greg.trujillo@state.nm.us
505-476-9301

Mr. Sanjay Bhakta
NM Municipal League
100 Marquette Ave, 11th Floor
City/County Building
Albuquerque, NM 87102
sbhakta@cabq.gov

Mr. Rick Scroggins
Interim Executive Director
Educational Retirement Board
PO Box 26129
Santa Fe, NM 87502-0129
rick.scroggins@state.nm.us
505-476-6152

Mr. Terry Linton
Governor's Appointee
PO Box 25485
Albuquerque, NM 87125
terry.linton@hubinternational.com
505-250-4070

Mr. Tomas E. Salazar, PhD
NM Assoc. of Educational Retirees
PO Box 66
Las Vegas, NM 87701
salazarte@plateautel.net
505-429-2206

Mr. Lance Pyle
NM Association of Counties
Curry County Administration
417 Gidding, Suite 100
Clovis, NM 88101
lpyle@currycounty.org
575-763-3656

Mr. Doug Crandall, President
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
505-955-1120

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

Mr. Loren Cushman
Superintendents' Association of NM
#1 Panther Boulevard
Animas, NM 88020
lrcushman@animask12.net
575-548-2299

Ms. Leane Madrid
Classified State Employee
2600 Cerrillos Rd.
Santa Fe, NM 87505
leane.madrid@state.nm.us
505-629-3365

Ms. Leanne Larranaga-Ruffy, Secretary
Alternate for PERA Executive Director
33 Plaza La Prensa
Santa Fe, NM 87507
leanne.larranaga@state.nm.us
505-476-9332

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

December 7, 2021
9:30 AM
Online: https://global.gotomeeting.com/join/136274197
Telephone: 1-408-650-3123 / Access Code: 136-274-197

AGENDA

1.	Call to Order	Mr. Crandall, President	Page
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder	
3.	Pledge of Allegiance	Mr. Crandall, President	
4.	Approval of Agenda	Mr. Crandall, President	4
5.	Approval of Regular Meeting Minutes October 5, 2021	Mr. Crandall, President	5
6.	Public Forum and Introductions	Mr. Crandall, President	
7.	Committee Reports	Mr. Crandall, President	
8.	Executive Director's Updates	Mr. Archuleta, Executive Director	
	a. Human Resources		
	b. Operations		10
	c. FY21 Audit		16
	d. PBM RFP		20
	e. FEMA Grant		
	f. September 30, 2021/October 31, 2021 SIC Reports		24
	g. Federal Legislation – Build Back Better EGWP Implications		26
9.	GASB Statement 74 Actuarial Valuation & Review	Ms. Krumholz, FSA, MAAA Senior Health Consultant, Actuary	41
10.	FY22 Q1 Budget Review	Mr. Archuleta, Executive Director	88
11.	2022 Legislative Proposal	Mr. Archuleta, Executive Director	93
12.	Notice of Proposed Rule Making (Action Item)	Mr. Bebeau, General Counsel	110
13.	Other Business	Mr. Crandall, President	
14.	Executive Session Pursuant to NMSA 1978, Section 10-15-1(H)(7) Pertaining to Threatened or Pending Litigation	Mr. Crandall, President	
15.	Date & Location of Next Board Meeting	Mr. Crandall, President	

January 4, 2022 – 9:30AM
GoToMeeting: https://global.gotomeeting.com/join/428866429
Telephone: 1-646-749-3122 / Access Code: 428-866-429

16. Adjourn

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING/VIA TELECONFERENCE

October 5, 2021

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. via teleconference.

2. ROLL CALL TO ASCERTAIN A QUORUM

A quorum was present.

Members Present:
Mr. Doug Crandall, President
Ms. LeAnne Larrañaga-Ruffy, Secretary
Ms. Julie Filatoff, designee of Hon. Tim Eichenberg, NM State Treasurer
Mr. Sanjay Bhakta
Mr. Loren Cushman [joining at 10:05 a.m.]
Mr. Terry Linton
Ms. Leane Madrid
Mr. Lance Pyle
Dr. Tomas Salazar
Mr. Rick Scroggins

Members Excused:
Ms. Therese Saunders, Vice President

Staff Present:
Mr. Dave Archuleta, Executive Director
Mr. Neil Kueffer, Deputy Director
Mr. Jess Biggs, Director of Communication & Member Engagement
Mr. Michael R. Bebeau, General Counsel
Ms. Judith S. Beatty, Board Recorder

3. PLEDGE OF ALLEGIANCE

Mr. Linton led the pledge.

4. APPROVAL OF AGENDA

Mr. Pyle moved approval of the agenda, as published. Dr. Salazar seconded the motion, which passed unanimously by roll call vote.

5. APPROVAL OF REGULAR ANNUAL MEETING MINUTES: August 31, 2021

Dr. Salazar moved approval of the August 31 meeting minutes, as submitted. Mr. Pyle seconded the motion, which passed by roll call vote, with Ms. Filatoff in abstention.

6. PUBLIC FORUM AND INTRODUCTIONS

None.

7. COMMITTEE REPORTS

- Chairman Crandall stated that the Executive Committee did not meet; however, he discussed today's agenda with Mr. Archuleta.

- Dr. Salazar reported that the Legislative Committee met, and the matters discussed are on today's agenda (Item 10).

8. COMMITTEE ASSIGNMENTS

[None.]

9. EXECUTIVE DIRECTOR'S UPDATES

a. Human Resources

- Mr. Archuleta reviewed HR updates. He introduced Jess Biggs, the agency's new Director of Communication & Member Engagement. Mr. Archuleta additionally noted that 12 highly qualified individuals have applied for the CFO position, and interviews are scheduled for October 15.

b. Operations

- The annual audit is well underway, and is due on November 24. Mr. Archuleta commented that things are a little behind schedule, partly because there has not been a CFO on board, but he does not anticipate missing the deadline.

c. PBM RFP

- Mr. Archuleta discussed the timeline for the PBM RFP and scoring criteria. Best and final interviews are anticipated in late January or early February. Board approval will be required to enter into best and final contract negotiations, and may require a special meeting.

- UNM has joined the other IBAC entities in this procurement.

d. Wise and Well Event

- Mr. Archuleta thanked the NMRHCA's health plan partners for helping organize this event, which took place last week. Although not all of the 200 people who registered for the event ultimately attended, the NMRHCA received positive feedback from those who did attend.

- The fall switch enrollment meetings have begun, with the first yesterday and nine more scheduled throughout October and the beginning of November.

e. FEMA Grant

- DFA and the Department of Homeland Security have indicated that NMRHCA is eligible for grant money through FEMA's Safe Opening and Operation Work Eligible for Public Assistance interim policy. The NMRHCA has spent $1,500-$2,000 cleaning its office, purchasing PPE equipment, and sanitizing work stations, but the bulk of its expenses are in testing and related treatment, which is about $10 million. The NMRHCA has notified DFA of its intent to pursue any money that might be available for expenses incurred up to this point.

f. Legislative

- NMRHCA presented its FY23 appropriation request to the Legislative Finance Committee on September 23. Among the questions posed by the committee was what would happen if the NMRHCA raised the minimum age requirement from 55 to 60. There were no major questions or concerns about the agency's overall appropriation request.

g. Case No. A-1-CA-39-39121 v. Lopez v. NMRHCA

- Victoria Lopez, the plaintiff in this case, filed the appellate memorandum in opposition to the Court's opposed disposition finding in the NMRHCA's favor.

Mr. Bebeau stated that the NMRHCA will have to wait for the Court of Appeals to decide whether or not there are other pleadings that the NMRHCA will need to submit, or whether or not the Court will go with the proposed disposition that it previously gave to the NMRHCA and the plaintiff. He said Ms. Lopez can decide whether or not she wants to file an appeal to the New Mexico Supreme Court. While it is too early to predict what will happen, the NMRHCA is likely on a multi-month waiting period.

Responding to Chairman Crandall, Mr. Archuleta said there is sufficient money set aside for this fiscal year to cover legal expenses associated with this lawsuit.

h. August 31, 2021, SIC Report

- The trust fund reached all-time high of $1,066,210,297 in August.

[Mr. Cushman joined the proceedings.]

10. FY 23 SPECIAL APPROPRIATION REQUEST

Mr. Archuleta stated that this is a threefold request:

-- BAR authority: Each agency is allowed an additional 5 percent increase if they generate their revenues from internal service funds, interagency transfers, or other state funds, as is the case with the NMRHCA. He said a 5 percent appropriation translates to roughly $18 million. If the claims exceed that, the NMRHCA would exercise this BAR authority.

-- The second request is for a special appropriation of $9,237,866.13, plus the cost of September's claims (an additional $1 million to $1.5 million), to cover expenses related to COVID-19 testing and treatment on the self-insured side.

-- The third request is for $15 million to cover projected costs associated with the elimination of cost sharing related to Senate Bill 317 between January 1, 2022 and December 31, 2026.

Dr. Salazar stated that he had served on the House Appropriations & Finance Committee. He commented that Rep. Raymundo Lara, a member of that committee, has been very supportive of the NMRHCA. He added that Rep. Christine Trujillo is also a member. He said he was very pleased to read an NEA New Mexico newsletter that supported the idea of providing funds to ensure the long-term solvency of the NMRHCA. On the Senate side, he suggested Mr. Archuleta get in touch with Sen. Roberto Gonzales, and added that Sen. George Muñoz and Sen. Stuart Engle are extremely supportive of the NMRHCA and have been very complimentary toward Mr. Archuleta.

Mr. Scroggins moved for approval of Mr. Archuleta's request. The motion was seconded by Ms. Larrañaga-Ruffy, which passed unanimously by roll call vote. [Mr. Linton was not present for the vote.]

11. RULE CHANGE

Mr. Kueffer stated that he served as hearing officer for the proposed rule change hearing, which took place on September 24. There was no verbal or written comment, and no member of the public attended the hearing. The purpose of the rule change is to align the NMRHCA's definition of salary with that of PERA.

Mr. Kueffer requested approval to accept the proposed rulemaking change, which is to align the NMRHCA's salary definition with PERA's.

Dr. Salazar moved for approval. Mr. Pyle seconded the motion, which passed unanimously by roll call vote. [Mr. Linton was not present for the vote.]

12. FY22 MA CONTRACT AMENDMENTS

Mr. Kueffer stated that the contracts in question are Medicare Advantage contracts, which run on a calendar year basis, whereas the NMRHCA's rates and plan design changes occur during the July-August timeframe. He requested approval to amend the UnitedHealthcare, Presbyterian Health Plan, Blue Cross Blue Shield and Humana Medicare Advantage contracts to reflect the monthly charges, plan summaries, performance guarantees, and gain share agreements applicable to the 2022 calendar year.

Ms. Larrañaga-Ruffy moved for approval. Dr. Salazar seconded the motion, which passed unanimously by roll call vote. [Mr. Linton and Mr. Bhakta were not present for the vote.]

13. OTHER BUSINESS

Chairman Crandall congratulated Greg Trujillo on his becoming the permanent executive director of PERA. He said the board is very happy with Ms. Larrañaga-Ruffy, and the agency and board would benefit if she were to remain as a member.

14. EXECUTIVE SESSION

None.

15. DATE AND LOCATION OF NEXT BOARD MEETING

November 2, 2021 – 9:30 A.M.
CNM Workforce Training Center/GoToMeeting
5600 Eagle Rock Avenue NE, Room 101
Albuquerque NM 87113

16. ADJOURN

Meeting adjourned at 10:15 a.m.

Accepted by:

_____

Doug Crandall, President

STATE OF NEW MEXICO
OFFICE OF SUPERINTENDENT OF INSURANCE

SUPERINTENDENT OF INSURANCE
Russell Toal

DEPUTY SUPERINTENDENT
Jennifer A. Catechis

BULLETIN 2021-009

June 14, 2021

TO: ALL INSURERS LICENSED TO SELL HEALTH INSURANCE IN NEW MEXICO

RE: SENATE BILL 317: APPLYING COST-SHARING WAIVERS TO BEHAVIORAL HEALTH SERVICES

Senate Bill 317, titled "No Behavioral Health Cost Sharing", was signed into law by Governor Michelle Lujan Grisham on April 8, 2021, will become effective January 1, 2022 and is scheduled to expire on December 31, 2026. Among other advancements, SB317 prohibits cost sharing, including imposition of a deductible, for behavioral health ("BH") services covered by any health care plan "delivered, issued for delivery or renewed in New Mexico". To ensure that all New Mexicans receive equal treatment with respect to health plan coverage for BH services, the application of the prohibition on cost-sharing for BH services must be standardized across all subject health plans on January 1, 2022. To that end, the New Mexico Office of Superintendent of Insurance ("OSI") directs every subject health plan to use the following criteria to identify BH services that are not subject to cost sharing, listed by service type.

Professional Services

- Professional services rendered by a BH provider, except when delivered in an emergency room or urgent-care center.
- Services rendered by a primary care provider when a BH diagnosis is the 1st or 2nd code on the claim (see definition of BH diagnoses below.)

Outpatient Facility Services

- Outpatient services, including professional services, delivered in a BH facility.
- Outpatient services, including professional services, delivered in a non-BH facility if the attending provider is a BH provider.
- Non-emergency room and non-urgent care center outpatient services, including professional services, delivered in a non-BH facility, by a non-BH provider, when a BH diagnosis is the 1st or 2nd code on the claim.
- Transcranial magnetic stimulation treatment services and electroconvulsive therapy services, including professional services.

Inpatient Facility Services

- Inpatient services, including professional services, delivered in a BH hospital or in the BH department of a general acute care hospital.
- Inpatient services, including professional services, delivered in a residential treatment center.
- Inpatient services, including professional services, delivered in a general, acute care hospital when the attending provider is a BH provider.
- Detoxification services, including professional services, delivered in a BH hospital, a general acute care hospital, or a residential treatment center.
- Transcranial magnetic stimulation treatment services and electroconvulsive therapy services, including professional services.

Ancillary Services

- Clinical laboratory services, radiology services and other imaging services when the ordering provider is a BH provider.
- Clinical laboratory services, radiology services and other imaging services when the ordering provider is not a BH provider, or when the ordering provider information is not present on the claim, but a BH diagnosis code is 1st or 2nd on the claim.

Prescription Drugs

- A prescription drug covered on the plan's drug formulary or authorized by the plan when the drug is in a USP therapeutic category and class combination as specified on the attached list. While examples of drugs in a class are provided, the lists are not all inclusive and the carrier shall ensure its Pharmacy Benefits Manager is able to identify all drugs included in the listed categories and class combinations.
- Special considerations apply for the off-label use of drugs for the treatment of BH conditions. To that end, the attached list includes some non-BH USP therapeutic categories and classes of drugs that might be used off-label for BH conditions. If the prescriber is a BH provider, the drug is to be considered a BH drug.
    - A BH provider might prescribe drugs from other therapeutic categories and classes that are not on the attached list. It is up to the carrier to determine whether the drug should be treated as a BH drug for cost-sharing purposes.
    - Cost-sharing may be applied to these non-BH drugs if the prescriber is not a BH provider. However, at least monthly, a carrier shall analyze utilization of these drugs to identify members who likely filled these prescriptions for treatment of a BH condition. When confirmed with the prescriber, carriers will reimburse these identified members their cost-sharing expenditures for these drugs and take appropriate steps to remove the cost sharing requirement for the member when prescriptions for the specified drug(s) are filled in the future.

These directives apply to cost-sharing policies. Carriers may continue to apply their plans' drug formulary policies, prior authorization and utilization management policies, and other drug coverage policies. For example, if a carrier's formulary covers the generic version of a brand drug, there is nothing in the bill or in this guidance that would require the carrier to pay for the brand name product.

If a member receives BH services subject to this guidance from an out-of-network provider, the plan may impose cost-sharing for those services unless:

1. Reimbursement for the service is governed by the Surprise Billing Act; or
2. The plan specifically authorized the out-of-network provider to deliver the service(s).

If a plan is required to reimburse a member for cost sharing pursuant to this guidance, the plan may recoup the reimbursement amount from the contracted provider that accepted the cost sharing from the member, if authorized under the terms of the provider agreement.

BH Diagnosis Codes

The International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) contains a set of diagnosis codes that begin with "F" that includes behavioral health conditions subject to SB317. Carriers are directed to use the presence of an ICD-10-CM "F-code" in the 1st or 2nd diagnosis as needed to identify a BH service, except for the following code sets:

- F01.x – F09.9x - Mental disorders due to known physiological conditions
- F70.x – F79.9x - Mild intellectual disabilities
- F80.x – F83.9x - Pervasive and specific developmental disorders
- F85.x – F89.9x - Pervasive and specific developmental disorders
- F91.x – F98.9x - Behavioral and emotional disorders with onset usually occurring in childhood and adolescence

The OSI will, at times, reevaluate these directives based on carrier and other stakeholder input and on claims data.

As always, OSI thanks carriers for their partnership and cooperation.

ISSUED this 14th day of June, 2021.

RUSSELL TOAL
Superintendent of Insurance

Behavioral Health Prescription Medications Not Subject to Cost-Sharing

U.S. Pharmacopeia (USP) Therapeutic Category	U.S. Pharmacopeia (USP) Class (Carriers must cross-reference to their comparable therapeutic classes)	***EXAMPLES*** OF MEDICATIONS IN THE CLASS (Not intended to be all-inclusive)
Anti-addiction/Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	Acamprosate Calcium, Disulfiram, Naltrexone, Naltrexone Hydrochloride
	Opioid Dependence	Buprenorphine, Buprenorphine/Naloxone Hydrochloride, Lofexidine, Naltrexone
	Opioid Reversal Agents	Naloxone Hydrochloride
	Smoking Cessation Agents	Bupropion Hydrochloride, Nicotine Polacrilex, Varenicline Tartrate
Anticonvulsants	Gamma-aminobutyric Acid (GABA) Augmenting Agents	Gabapentin, Pregabalin
	Sodium Channel Agents	Carbamazepine, Oxcarbazepine
	Anticonvulsants, Other	Divalproex sodium, Lamotrigine, Topiramate, Valproic Acid
Antidepressants	Monoamine Oxidase Inhibitors	Isocarboxazid, Phenelzine Sulfate, Selegiline, Tranylcypromine Sulfate
	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	Citalopram Hydrobromide, Desvenlafaxine, Duloxetine Hydrochloride, Escitalopram Oxalate, Fluoxetine Hydrochloride, Fluvoxamine Maleate, Nefazodone Hydrochloride, Paroxetine Hydrochloride, Sertraline Hydrochloride, Trazodone Hydrochloride, Venlafaxine Hydrochloride
	Tricyclics	Amitriptyline Hydrochloride, Amoxapine, Clomipramine Hydrochloride, Desipramine Hydrochloride, Doxepin Hydrochloride, Imipramine Hydrochloride, Imipramine Pamoate, Nortriptyline Hydrochloride, Protriptyline Hydrochloride Trimipramine Maleate
	Antidepressants, Other	Maprotiline Hydrochloride, Bupropion Hydrobromide, Bupropion Hydrochloride, Mirtazapine,

Behavioral Health Prescription Medications Not Subject to Cost-Sharing

U.S. Pharmacopeia (USP) Therapeutic Category	U.S. Pharmacopeia (USP) Class (Carriers must cross-reference to their comparable therapeutic classes)	***EXAMPLES*** OF MEDICATIONS IN THE CLASS (Not intended to be all-inclusive)
		Aripiprazole, Quetiapine Fumarate, Esketamine Hydrochloride, Chlordiazepoxide/ Amitriptyline Hydrochloride, Olanzapine/ Fluoxetine, Perphenazine/ Amitriptyline Hydrochloride
Antiparkinson Agents	Anticholinergics	Benztropine Mesylate, Diphenhydramine Hydrochloride, Trihexyphenidyl Hydrochloride
	Dopamine Agonists	Pramipexole Dihydrochloride (for augmentation in severe depression)
Antipsychotics	1st Generation/Typical[1]	Chlorpromazine, Fluphenazine, Haloperidol, Loxapine, Perphenazine, Pimozide, Prochlorperazine, Thioridazine, Thiothixene, Trifluoperazine
	2nd Generation/Atypical[2]	Aripiprazole, Asenapine, Brexpiprazole, Cariprazine Hydrochloride, Iloperidone, Lurasidone Hydrochloride, Olanzapine, Pimavanserin Tartrate, Quetiapine Fumarate, Paliperidone, Risperidone, Ziprasidone
	Treatment-Resistant	Clozapine
Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inhibitors/ Serotonin and Norepinephrine Reuptake Inhibitors)	Duloxetine Hydrochloride, Escitalopram Oxalate, Paroxetine Hydrochloride, Sertraline Hydrochloride, Venlafaxine Hydrochloride
	Benzodiazepines	Alprazolam, Chlordiazepoxide, Clonazepam, Clorazepate Dipotassium, Diazepam, Midazolam, Lorazepam, Oxazepam
	Anxiolytics, Other	Buspirone Hydrochloride, Doxepin Hydrochloride, Hydroxyzine Hydrochloride, Hydroxyzine Pamoate, Meprobamate

[1] Includes long-acting injectables
[2] Includes long-acting injectables

Behavioral Health Prescription Medications Not Subject to Cost-Sharing

U.S. Pharmacopeia (USP) Therapeutic Category	U.S. Pharmacopeia (USP) Class (Carriers must cross-reference to their comparable therapeutic classes)	***EXAMPLES*** OF MEDICATIONS IN THE CLASS (Not intended to be all-inclusive)
Bipolar Agents	Mood Stabilizers	Carbamazepine, Divalproex Sodium, Lamotrigine, Lithium Carbonate, Lithium Citrate
	Bipolar Agents, Other	Aripiprazole, Asenapine, Lurasidone, Olanzapine, Olanzapine Pamoate, Quetiapine Fumarate, Risperidone, Ziprasidone Hydrochloride
Cardiovascular Agents	Alpha-adrenergic Blocking Agents	Prazosin Hydrochloride (for treatment of PTSD)
Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agents, Amphetamines	Amphetamine, Dextroamphetamine Sulfate, Dextroamphetamine Saccharate/ Amphetamine Aspartate/ Dextroamphetamine Sulfate/ Amphetamine Sulfate, Lisdexamfetamine Dimesylate, Methamphetamine Hydrochloride
	Attention Deficit Hyperactivity Disorder Agents, Non-amphetamines	Atomoxetine Hydrochloride, Clonidine Hydrochloride, Dexmethylphenidate Hydrochloride, Guanfacine Hydrochloride, Methylphenidate Hydrochloride
	Central Nervous System Agents, Other	Valbenazine, Deutetrabenazine
Hormonal Agents, Stimulant/Replacement/ Modifying (Thyroid)	Not applicable – no class assigned by USP	Liothyronine (for augmentation in severe depression)
Sleep Disorder Agents	Sleep Promoting Agents	Eszopiclone, Zolpidem (IR, ER, CR), Suvorexant, Zaleplon, Estazolam, Flurazepam, Quazepam, Temazepam, Triazolam

NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

BOARD OF DIRECTORS:

DOUG CRANDALL
PRESIDENT

THERESE SAUNDERS
VICE PRESIDENT

LEANNE LARRAÑAGA-RUFFY
SECRETARY

DAVID ARCHULETA
EXECUTIVE DIRECTOR

November 19, 2021

Moss Adams LLP
6565 Americas Parkway, Suite 600
Albuquerque, NM 87110

We are providing this letter in connection with your audit of the financial statements of New Mexico Retiree Health Care Authority (RHCA), which comprise the statement of fiduciary net position as of June 30, 2021, the statement of changes in fiduciary net position for the year then ended, and the notes to the financial statements for the purpose of expressing an opinion as to whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States (U.S. GAAP).

Certain representations in this letter are described as being limited to matters that are material. Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

We confirm that, to the best of our knowledge and belief, having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves as of the date of this letter.

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit engagement letter dated August 9, 2021, for the preparation and fair presentation of the financial statements in accordance with U.S. GAAP.
2. We acknowledge our responsibility for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.
3. We have asked you to assist us in the preparation of the financial statements. However, we acknowledge that the financial statements are management's responsibility. We have appointed David Archuleta, Executive Director, to oversee the non-attest function of assistance with the drafting of our financial statements. He has the appropriate skills, knowledge and experience to make management decisions related to the financial statements and accept responsibility for the assistance that you provided in drafting our financial statements.
4. We acknowledge our responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.
5. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.
6. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

7. All events subsequent to the date of the financial statements and for which U.S. GAAP requires adjustment or disclosure have been adjusted or disclosed.

8. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

9. Guarantees, whether written or oral, under which the NMRHCA is contingently liable, have been properly recorded or disclosed in accordance with U.S. GAAP.

10. We acknowledge our responsibility for presenting the management's discussion and analysis, schedule of changes in the net OPEB liability, schedule of employers' contributions, and schedule of annual money-weighted rate of return (required supplementary information) in accordance with U.S. GAAP and we believe the required supplementary information, including its form and content, is fairly presented in accordance with such accounting principles. is measured and presented in accordance with the prescribed guidelines. The methods of measurement and presentation of the required supplementary information have not changed from those used in the prior periods, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the required supplementary information.

11. With respect to the combining schedule of fiduciary net position by functional activity, schedule of changes in fiduciary net position by functional activity, and schedule of investment fees (collectively, the supplementary information):

    a. We acknowledge our responsibility for presenting the supplementary information in accordance with accounting principles generally accepted in the United States of America, and we believe the supplementary information. The methods of measurement and presentation of the supplementary information have not changed from those used in the prior period, and we have disclosed to you any significant assumptions or interpretations underlying the measurement and presentation of the supplementary information.

    b. If the supplementary information is not presented with the audited financial statements, we will make the audited financial statements readily available to the intended users of the supplementary information and other supplementary information no later than the date we issue the supplementary information and the auditor's report thereon.

Information Provided

12. We have provided you with:

    a. Access to all information, of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation and other matters;

    b. Minutes of the meetings of the board of directors and summaries of actions of recent meetings for which minutes have not yet been prepared;

    c. Additional information that you have requested from us for the purpose of the audit;

    d. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence.

13. All transactions have been properly recorded in the accounting records and are reflected in the financial statements.

14. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

15. We have no knowledge of any fraud or suspected fraud that affects RHCA and involves—

    e. Management,

    f. Employees who have significant roles in internal control, or

    g. Others when the fraud could have a material effect on the financial statements.

16. We have no knowledge of any disclosed to you all information that we are aware of regarding allegations of fraud or suspected fraud, affecting RHCA's financial statements communicated by employees, former employees, analysts, regulators or others.

17. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

18. We are not aware of any pending or threatened litigation, claims, and assessments whose effects should be considered when preparing the financial statements and we have not consulted legal counsel concerning litigation, claims, or assessments.

19. We have disclosed to you the identity of RHCA's related parties and all the related party relationships and transactions of which we are aware.

20. We have made available to you all financial records and related data and all audit or relevant monitoring reports, if any, received from funding sources.

21. There have been no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices.

22. RHCA has no plans or intentions that may materially affect the carrying value or classification of assets, liabilities, or net position.

23. We are responsible for compliance with the laws, regulations, and provisions of contracts and grant agreements applicable to us, including tax or debt limits and debt contracts; and we have identified and disclosed to you all laws, regulations and provisions of contracts and grant agreements that we believe have a direct and material effect on the determination of financial statement amounts or other financial data significant to the audit objectives, including legal and contractual provisions for reporting specific activities.

24. There are no violations or possible violations of budget ordinances, laws and regulations (including those pertaining to adopting, approving, and amending budgets), provisions of contracts and grant agreements, and tax or debt limits, whose effects should be considered for disclosure in the financial statements, or as a basis for recording a loss contingency, or for reporting on noncompliance.

25. RHCA has satisfactory title to all owned assets, and there are no liens or encumbrances on such assets nor has any asset been pledged as collateral

26. RHCA has complied with all aspects of contractual agreements that would have a material effect on the financial statements in the event of noncompliance.

27. We have followed all applicable laws and regulations in adopting, approving, and amending budgets.

28. The financial statements properly classify all funds and activities.

29. Investments are properly reported at fair value at year end.

30. Actuarial information provided from our agency to the RHCA's independent actuary is accurate and agrees to our internal records and is representative of our data.

31. We have reviewed and understand the significant assumptions underlying the total OPEB liability prepared by our actuary This blended discount rate assumption utilized for purpose of determining the 2021 total OPEB liability is reasonable.

32. We agree with the assumptions used by the RHCA's independent actuary to calculate and prepare the Governmental Accounting Standards Board (GASB) No. 74 *Financial Reporting for Postemployment Benefits Other Than Pensions* reporting and disclosure information and the total OPEB liability the amounts and disclosures used in the financial statements and underlying accounting records. We did not give or cause any instructions to be given to the actuary with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the actuary.

33. The schedule of legislative changes provided to you is an accurate and complete representation of all changes during the fiscal year.

34. To our knowledge, the census data supplied to our actuary for purposes of determining the total OPEB liability as of June 30, 2021 is complete and accurate in all material respects.

Mr. David Archuleta, Executive Director

Issued By:

The Interagency Benefits Advisory Committee (IBAC) consisting of:

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

REQUEST FOR PROPOSALS (RFP)

Pharmaceutical Benefits Management Services

RFP#342-2021-03

Amendment # 1

Release Date: October 18, 2021

Proposal Due Date: ~~November 15, 2021~~ November 18, 2021

ELECTRONIC-ONLY PROPOSAL SUBMISSION

Amendment # 1

2 CONDITIONS GOVERNING THE PROCUREMENT

2.1 This section of the RFP contains the schedule of events, the descriptions of each event, and the conditions governing this procurement.

SEQUENCE OF EVENTS

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

Action	Responsible Party	Due Dates
1. Issue RFP	NMPSIA on behalf of the IBAC/UNM	October 18, 2021
2. Acknowledgement of Receipt Form	Potential Offerors	3:00 PM MST October 25, 2021
3. Deadline to submit Written Questions	Potential Offerors	3:00 PM MST October 29, 2021
4. Response to Written Questions	Procurement Manager	November 5, 2021
5. Organizational Reference Questionnaire	Organizational References	3:00 PM MST November 12, 2021
6. Submission of Proposal	***Potential Offerors***	***3:00 PM MST ~~November 15, 2021~~ November 18, 2021***
*7. Proposal Evaluation	Evaluation Committee	~~November 16, 2021 to January 7, 2022~~ November 19, 2021-January 14, 2022
*8. Selection of Finalists	Evaluation Committee	~~January 7, 2022~~ January 14, 2022
*9. Best and Final Offers	Finalist Offerors	January 21, 2022
*10. Oral Presentation(s)	Finalist Offerors	January 21, 2022
*11. Finalize Contractual Agreements	Agency/Finalist Offerors	February 9, 2022 to March 31, 2022 (December 31, 2022 for APS)
*12. Contract Awards	Agency/ Finalist Offerors	July 1, 2022 (January 1, 2023 for APS)
*13. Protest Deadline	NMPSIA on behalf of the IBAC/UNM	+15 days

*Dates indicated in Events 7 through 13 are estimates only, and may be subject to change without necessitating an amendment to the RFP.

2.2 **EXPLANATION OF EVENTS**

The following paragraphs describe the activities listed in the Sequence of Events shown in Section 2.1., above.

1. Issue RFP

This RFP is being issued on behalf of the State of New Mexico IBAC and UNM on the date indicated in Section 2.1, Sequence of Events.

Issued By:

The Interagency Benefits Advisory Committee (IBAC) consisting of:

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

REQUEST FOR PROPOSALS (RFP)

Pharmaceutical Benefits Management Services

RFP#342-2021-03

Amendment # 2

Release Date: October 18, 2021

Proposal Due Date: ~~November 15, 2021~~ November 18, 2021

ELECTRONIC-ONLY PROPOSAL SUBMISSION

Amendment # 2

2 CONDITIONS GOVERNING THE PROCUREMENT

2.1 This section of the RFP contains the schedule of events, the descriptions of each event, and the conditions governing this procurement.

SEQUENCE OF EVENTS

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

Action	Responsible Party	Due Dates
1. Issue RFP	NMPSIA on behalf of the IBAC/UNM	October 18, 2021
2. Acknowledgement of Receipt Form	Potential Offerors	3:00 PM MST October 25, 2021
3. Deadline to submit Written Questions	Potential Offerors	3:00 PM MST October 29, 2021
4. Response to Written Questions	Procurement Manager	~~November 5, 2021~~ November 10, 2021
5. Organizational Reference Questionnaire	Organizational References	3:00 PM MST November 12, 2021
6. Submission of Proposal	***Potential Offerors***	***3:00 PM MST ~~November 15, 2021~~ November 18, 2021***
7.* Proposal Evaluation	Evaluation Committee	~~November 16, 2021 to January 7, 2022~~ November 19, 2021-January 14, 2022
8.* Selection of Finalists	Evaluation Committee	~~January 7, 2022~~ January 14, 2022
9.* Best and Final Offers	Finalist Offerors	January 21, 2022
10.* Oral Presentation(s)	Finalist Offerors	January 21, 2022
11.* Finalize Contractual Agreements	Agency/Finalist Offerors	February 9, 2022 to March 31, 2022 (December 31, 2022 for APS)
12.* Contract Awards	Agency/ Finalist Offerors	July 1, 2022 (January 1, 2023 for APS)
13.* Protest Deadline	NMPSIA on behalf of the IBAC/UNM	+15 days

*Dates indicated in Events 7 through 13 are estimates only, and may be subject to change without necessitating an amendment to the RFP.

2.2 **EXPLANATION OF EVENTS**

The following paragraphs describe the activities listed in the Sequence of Events shown in Section 2.1., above.

1. Issue RFP

This RFP is being issued on behalf of the State of New Mexico IBAC and UNM on the date indicated in Section 2.1, Sequence of Events.

New Mexico Retiree Health Care Authority (CP)
Change in Market Value
For the Month of Sep 2021
(Report as of October 18, 2021)

Investment Name	Prior Ending Market Value	Contributions	Distributions	Fees	Income	Gains - Realized & Unrealized	Market Value
Core Bonds Pool	192,954,451.04	-	-	-	420,347.29	(2,640,445.38)	190,734,352.95
Credit & Structured Finance	144,326,597.32	-	-	-	382,853.62	2,321,042.88	147,030,493.82
NM Retiree Health Care Authority Cash Account	-	-	-	-	-	-	-
Non-US Developed Markets Index Pool	149,839,920.08	-	-	-	431,467.38	(4,650,647.33)	145,620,740.13
Non-US Emerging Markets Active Pool	105,655,913.73	-	-	-	236,120.64	(4,332,105.27)	101,559,929.10
Private Equity Pool	129,866,131.26	-	-	-	180,901.99	16,940,937.03	146,987,970.28
Real Estate Pool	91,189,661.83	-	-	-	310,968.82	4,156,205.74	95,656,836.39
Real Return Pool	41,721,575.34	-	-	-	159,769.19	1,135,871.95	43,017,216.48
US Large Cap Index Pool	185,647,467.51	-	-	-	198,560.60	(8,724,367.55)	177,121,660.56
US SMID Cap Alternative Weighted Index Pool	25,008,579.50	-	-	-	32,109.04	(642,705.71)	24,397,982.83
Sub - Total New Mexico Retiree Health Care	1,066,210,297.61	-	-	-	2,353,098.57	3,563,786.36	1,072,127,182.54
Total New Mexico Retiree Health Care A	**1,066,210,297.61**	**-**	**-**	**-**	**2,353,098.57**	**3,563,786.36**	**1,072,127,182.54**

New Mexico Retiree Health Care Authority (CP)
Change in Market Value
For the Month of Oct 2021
(Report as of November 16, 2021)

Investment Name	Prior Ending Market Value	Contributions	Distributions	Fees	Income	Gains - Realized & Unrealized	Market Value
Core Bonds Pool	190,734,352.95	-	-	-	431,818.30	(530,783.04)	190,635,388.21
Credit & Structured Finance	147,030,493.82	-	-	-	133,327.27	848,925.45	148,012,746.54
NM Retiree Health Care Authority Cash Account	-	-	-	-	-	-	-
Non-US Developed Markets Index Pool	145,620,740.13	-	-	-	144,689.00	3,933,986.95	149,699,416.08
Non-US Emerging Markets Active Pool	101,559,929.10	-	-	-	46,795.57	1,125,087.59	102,731,812.26
Private Equity Pool	146,987,970.28	-	-	-	94,695.55	(123,109.48)	146,959,556.35
Real Estate Pool	95,656,836.39	-	-	-	246,843.08	(247,003.87)	95,656,675.60
Real Return Pool	43,017,216.48	-	-	-	129,925.15	413,669.39	43,560,811.02
US Large Cap Index Pool	177,121,660.56	-	-	-	150,837.36	12,132,184.19	189,404,682.11
US SMID Cap Alternative Weighted Index Pool	24,397,982.83	-	-	-	18,888.82	819,071.44	25,235,943.10
Sub - Total New Mexico Retiree Health Care	1,072,127,182.54	-	-	-	1,397,820.10	18,372,028.62	1,091,897,031.27
Total New Mexico Retiree Health Care A	**1,072,127,182.54**	**-**	**-**	**-**	**1,397,820.10**	**18,372,028.62**	**1,091,897,031.27**

Dow industrials down 250 points after Moderna CEO's remarks on new virus variant →

U.S. consumer confidence falls to lowest level in nine months →

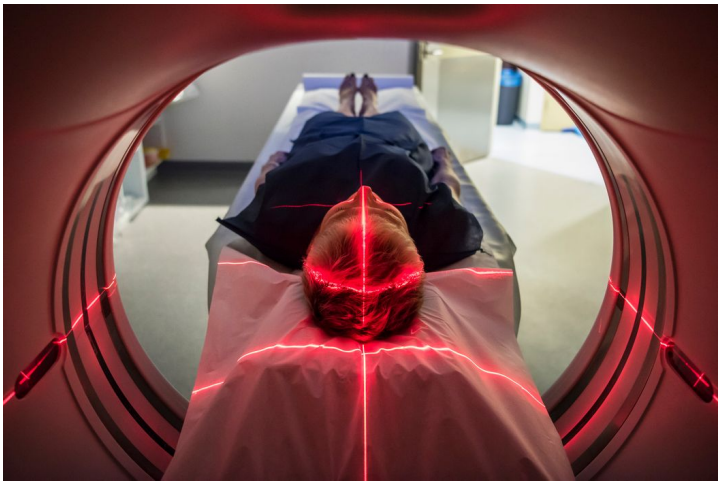
NerdWallet

Premiums, deductibles and copays will be higher—Medicare changes for 2022

Last Updated: Nov. 30, 2021 at 9:15 a.m. ET
First Published: Nov. 30, 2021 at 5:02 a.m. ET

By Kate Ashford

The good news? The Medicare Advantage plan got higher ratings.



ISTOCK

Listen to article
7 minutes

This article is reprinted by permission from NerdWallet.

Open enrollment for Medicare goes from Oct. 15 to Dec. 7 each year, when Medicare beneficiaries choose their coverage for the next plan year. As Medicare enrollees contemplate their choices for 2022, here are overall Medicare changes to keep in mind.

Original Medicare costs are going up

Original Medicare includes Part A and Part B. A separate Medicare drug plan, called Part D, is also available. Here's how deductibles, premiums and coinsurances are changing in 2022:

Medicare Part A (hospital insurance)

Although most Medicare beneficiaries don't pay a premium for Medicare Part A, those who do will see higher costs, paying $499 a month in 2022, up from $471 a month in 2021. This premium applies to you if you worked and paid Medicare taxes for less than 30 quarters. If you worked and paid Medicare taxes for 30 to 39 quarters, you'll pay $274 a month for Part A in 2022, up from $259 in 2021. If you paid Medicare taxes for 40 quarters or more, you won't owe a premium.

The Part A inpatient hospital deductible is increasing to $1,556 in 2022 for each benefit period, up from $1,484 in 2021. Coinsurance is also rising as follows:

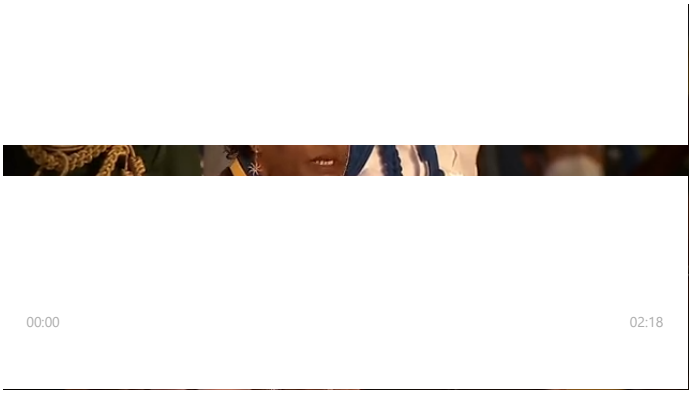
- **Hospitalization days 1 to 60:** Members pay $0 coinsurance for each benefit period.
- **Hospitalization days 61 to 90:** Members pay $389 coinsurance per day for each benefit period, up from $371 in 2021.

Dow industrials down 250 points after Moderna CEO's remarks on new virus variant →

U.S. consumer confidence falls to lowest level in nine months →

Coinsurance for skilled nursing facility care will remain at $0 for days 1 to 20 for each benefit period, and will be $194.50 per day for days 21 to 100 of each benefit period in 2022, up from $185.50 per day in 2021.

NOW PLAYING:
Rihanna, Prince Charles Mark Barbados Ceremony as It Becomes Republic



Visit our Video Center

Medicare Part B (medical insurance)

All Medicare members pay a Part B premium, and that is increasing to $170.10 per month in 2022, up from $148.50 in 2021. You may pay a higher premium, depending on your income. For example, those who file taxes individually with a modified adjusted gross income of more than $91,000 (or those who file joint tax returns with a modified adjusted gross income of more than $182,000) will pay an additional $68 to $408.20 per month on top of the Medicare Part B premium.

The Part B deductible is increasing to $233 in 2022, up from $203 in 2021. Once you meet your deductible, you generally will pay 20% of Medicare-approved costs for Part B services.

Also read: You might save money with Medigap Plan N—here's how it works

Medicare Part D (prescription drug coverage)

The average Medicare Part D premium in 2022 will be $33 per month, versus $31.47 in 2021. Those with higher incomes will pay more: Those who file taxes individually with a modified adjusted gross income of more than $91,000 (or those who file joint tax returns with a modified adjusted gross income of more than $182,000) will pay an additional $12.40 to $77.90 per month on top of their Part D premium.

Financial News You Can Truly, Actually, Really Use

Understand how today's business practices, market dynamics, tax policies and more impact you with real-time news and analysis from MarketWatch.

CYBER MONDAY SALE: 50% OFF 1 YEAR

Medicare Advantage plan ratings are higher

Medicare Advantage is a bundled alternative to Original Medicare that includes all the coverages of Medicare Part A, Part B and usually Part D. Medicare Advantage plans, also called Medicare Part C, often include additional benefits, such as some cost help with dental, vision and hearing care, fitness memberships, over-the-counter allowances and meal delivery.

Each year, the Centers for Medicare & Medicaid Services assigns every Medicare

Dow industrials down 250 points after Moderna CEO's remarks on new virus variant →

U.S. consumer confidence falls to lowest level in nine months →

In 2022, the average star rating for Medicare Advantage Prescription Drug plans is 4.37, compared to 4.06 in 2021. In fact, 68% of Medicare Advantage plans that include prescription drug coverage have received an overall rating of 4 stars or higher for 2022, compared to 49% in 2021, according to the CMS.

Don't miss: Social Security redesigned your statement, here's why you should take a long, hard look at it

Medicare Advantage premiums are lower

The average premium in 2022 for Medicare Advantage plans will be $19 per month, versus $21.22 in 2021. (Note: Medicare Advantage members are still responsible for the Medicare Part B monthly premium, which is $170.10 in 2022.)

More people are projected to enroll in Medicare Advantage in 2022 as well: The CMS estimates 29.5 million people will sign up, compared to 26.9 million in 2021.

There are 3,834 Medicare Advantage plans available in 2022, up 8% from 2021. Of the 2022 plans, 59% are health maintenance organization, or HMO, plans, and 37% are preferred provider organization, or PPO, plans.

Making plan changes

Changes you make during Medicare open enrollment will take effect on Jan. 1. During this open enrollment period from Oct. 15 to Dec. 7, you can switch from Original Medicare to Medicare Advantage, or vice versa, or switch from one Medicare Advantage plan to another one.

Read next: 90% of people want to grow old in their own home — what's the real cost of doing so?

If you discover that you've erred in your plan choice after the enrollment period ends, there's a Medicare Advantage open enrollment period from Jan. 1 to March 31. During this time, you can do the following:

- Switch Medicare Advantage plans.
- Return to an Original Medicare plan, with the option to join a Part D prescription drug plan.

During Medicare Advantage open enrollment, you can't switch to a Medicare Advantage plan if you're enrolled in Original Medicare. Additionally, if you return to Original Medicare, you might not be able to buy a Medigap policy. Your coverage will begin on the first day of the month after you request a plan change.

More From NerdWallet

- Medicare Open Enrollment 2021
- Best Medicare Advantage Plans in 2021
- 6 Things You Should Know About Signing Up for Medicare

Kate Ashford writes for NerdWallet. Email: kashford@nerdwallet.com. Twitter: @kateashford.

Confused about whether to get a COVID booster? Here's what to know

Doctors want to convey some key facts about boosters: Yes, they are safe, yes, you

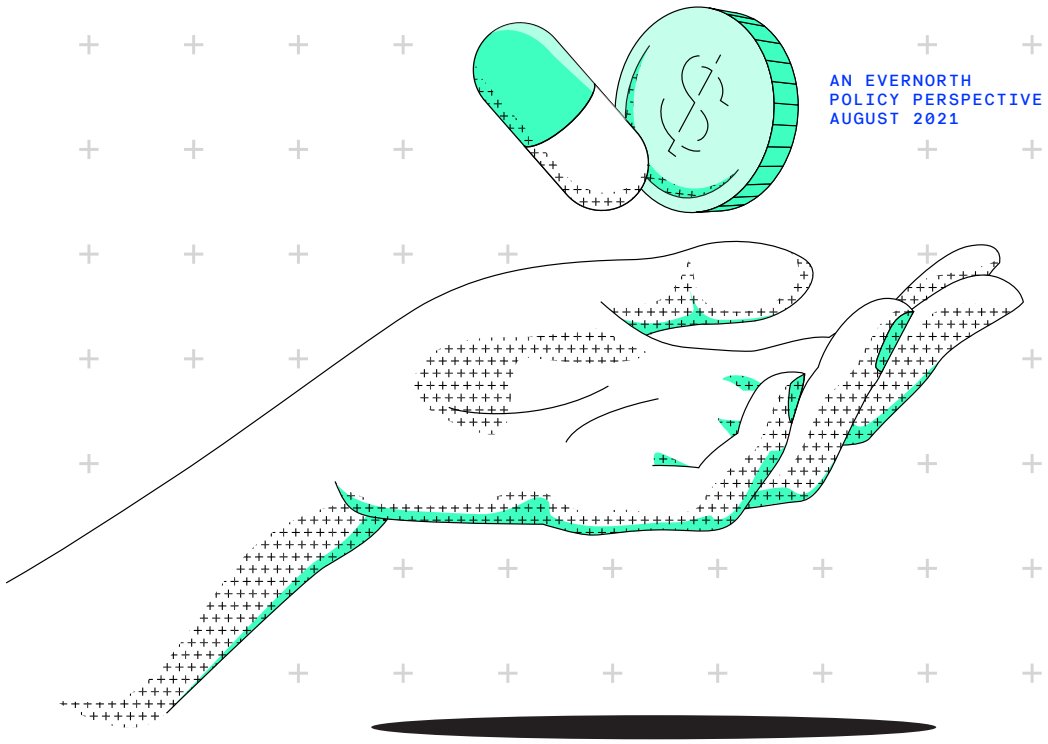
When Should You Claim Social Security?

Age

See How Claiming Earlier or Later Affects

EMPLOYER GROUP WAIVER PLANS (EGWPs)
ARE AT RISK

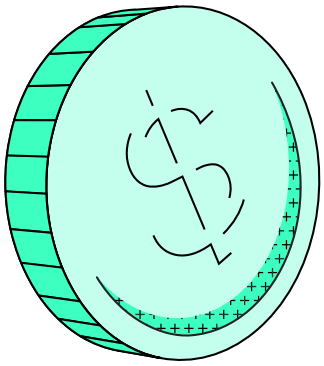
+ HELP RETIREES KEEP THEIR COVERAGE



AN EVERNORTH
POLICY PERSPECTIVE
AUGUST 2021

EVERNORTH℠

PROTECT HIGH-QUALITY, AFFORDABLE MEDICARE COVERAGE



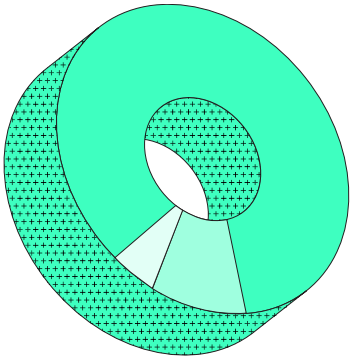
Drug pricing reforms currently under consideration will have unintended consequences—threatening EGWPs in Part D and creating a windfall for drug manufacturers

Many employers and unions provide Medicare Part D coverage to eligible retirees through dedicated plans known as Employer Group Waiver Plans (EGWPs). EGWPs offer tremendous value to retirees, employers, retirement systems and unions—as well as to Medicare—by improving access and affordability for patients at a low cost to the federal government. These plans must provide benefits that are at least the same as those offered by other Medicare plans. In addition, they provide flexibilities that allow coverage customized to support each employer's retiree benefit commitments.

As policymakers focus on lowering drug prices and reforming the Part D program, many of the reforms under consideration will have unintended consequences that both threaten EGWPs in Part D and create a windfall for drug manufacturers.

What to know about EGWPs

Under the Part D program, Medicare beneficiaries can purchase prescription drug coverage offered by private health or prescription drug plans in their area. Employers, retirement systems and unions can also provide Medicare Advantage and Part D coverage to their Medicare-eligible retirees through dedicated plans known as Employer Group Waiver Plans (EGWPs).



There are currently 7.4M retirees enrolled in EGWPs, representing 15% of the nearly 49M Part D beneficiaries

Since the enactment of the Affordable Care Act (ACA), more employers have been offering drug benefits to retirees through EGWPs, largely due to the ACA's creation of the Coverage Gap Discount Program (CGDP) and the elimination of the tax deduction for employers receiving the Retiree Drug Subsidy (RDS).

Prior to the passage of the ACA, employers were able to deduct the subsidies reimbursed by the federal government through the RDS program from their taxable incomes. However, starting in 2013, plan sponsors were no longer permitted to deduct health benefit costs reimbursed by the RDS program, eliminating its once tax-free status and making EGWPs more desirable to retiree benefit providers. In addition, under Governmental Accounting Standards Board accounting, future subsidies cannot be used to offset liabilities for future benefits. As such, the RDS program does not impact liability and, therefore, does not allow for state and local governments to recognize the value of these subsidies in the Other Post-Employment Benefits (OPEB) actuarial funding calculations. For example, Teachers' Retirement System of the State of Kentucky has been able to reduce their OPEB liability by $1.9 billion due to enrolling retirees in EGWPs for Part D and Medicare Advantage.

The elimination of the tax-favored treatment of the RDS plan, combined with the increase in manufacturer contribution through the CGDP, made EGWPs a more attractive option for many employers, retirement systems and trusts. As a result, the number of enrollees in RDS plans has declined considerably, from 6.8M in 2010 to 1.4M in 2019, while enrollment in EGWPs has increased from 2.4M to 7M over the same period.[1] There are currently 7.4M retirees enrolled in EGWPs, representing 15% of the nearly 49M Part D beneficiaries. The majority (4.5M) of EGWPs are stand-alone Prescription Drug Plans (PDP), while 2.8M are Medicare Advantage Prescription Drug (MA-PD) plans. California, New York, Michigan, Texas and Pennsylvania are the top five states for employer retiree coverage, representing 40% of total EGWP enrollment.[2]

Many of the 7.4M EGWP enrollees are retirees from state and local governments, including first responders, teachers and other public workers. In addition, many labor unions have fought for better retiree health benefits—including EGWP drug coverage—through collective bargaining with employers. For all of these retirees, EGWPs provide health and retirement security that has been well-earned through a lifetime of hard work and service to our communities.

Why EGWPs are worth protecting

EGWPs are granted flexibilities from the Centers for Medicare & Medicaid Services (CMS) that allow them to offer benefits that maintain a level of coverage specified by commitments to retirees. As these flexibilities are paid for by the employer/retirement system as a life-long retirement benefit, they enable employers to pay for drug benefits that are much more comprehensive and cost-effective for their retirees.

Lower out-of-pocket (OOP) costs help EGWPs receive greater contributions from drug manufacturers—through the Coverage Gap Discount Program—and reduce costs in the Part D catastrophic benefit phase.

Employers pay for drug benefits that are much more comprehensive and cost-effective for their retirees

Enhanced Drug Benefits: While EGWPs must meet the same standard for actuarial value as other Part D plans, employers have more flexibility to enhance the standard Part D benefit cost sharing in different phases of the benefit. This buy-up, which is funded by the employer, retirement system or union, builds upon the standard Part D benefit and is sometimes known as an "Employer Wrap."

In practice, EGWP coverage is far more robust than what is offered by other Part D plans. Though there is a lot of variation across employers, EGWPs typically have lower or no deductibles and charge enrollees fixed copayments for their prescriptions (see Member Cost Sharing in Table 1). In addition, they typically offer broader formularies and allow enrollees better access to medicines. As an example, 92% of Express Scripts EGWP members are in an open formulary. And 98% of the Express Scripts EGWPs have an enhanced formulary and cover non-Part D drugs.

Higher Discounts from Manufacturers: Part D beneficiaries move through the coverage gap and into the catastrophic coverage phase based on their true out-of-pocket (TrOOP) costs. TrOOP costs include both the OOP costs paid by the enrollee and the discounts paid by drug manufacturers in the coverage gap. Since EGWP enrollees have lower OOP costs, they move through the Part D benefit phases more slowly than other beneficiaries—even if the cost of the drug is the same. Lower OOP costs for EGWP enrollees prolongs the time they spend in the coverage gap compared to non-EGWP enrollees. For this reason, drug manufacturers pay more coverage gap discounts to EGWPs than other Part D plans (see Table 1), which EGWPs reinvest to offset the costs of the more generous coverage or higher premiums.

TABLE 1:

Stakeholder costs for hypothetical patient taking a $1,000-a-month brand drug, Standard Plan vs. EGWP, 2021

STANDARD PLAN	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Manufacturer Discount	$0	$0	$0	$0	$0	$609	$700	$700	$700	$411	$0	$0	**$3,820**
Member Cost Sharing	$584	$250	$250	$250	$250	$250	$250	$250	$250	$167	$50	$50	**$2,851**
Plan Liability	$416	$750	$750	$750	$141	$50	$50	$50	$50	$91	$150	$150	**$3,399**
Federal Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$331	$800	$800	**$1,931**

EGWP	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Manufacturer Discount	$0	$0	$0	$0	$609	$700	$700	$700	$700	$700	$700	$700	**$5,509**
Member Cost Sharing	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	$50	**$600**
Plan Liability	$750	$750	$750	$750	$141	$50	$50	$50	$50	$50	$50	$50	**$3,491**
Employer Wrap	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	$200	**$2,400**
Federal Reinsurance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	**$0**

Assumes standard benefit design for Standard Plan and no deductible and $50 brand copayment for EGWP.

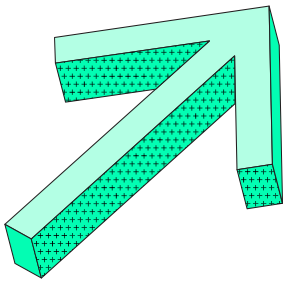
Plan Liability and Employer Wrap are both paid for by the employer.

If EGWP providers cease offering coverage to retirees, it is estimated to increase annual federal reinsurance liabilities by $2.5B to $3B

Improved Employer, Retirement System and Union Finances: Medicare subsidies (through the direct subsidy and reinsurance payments) combined with coverage gap discounts discounts allow employers to maximize their resources through EGWPs versus other retiree drug coverage options such as RDS. If these subsidies and discounts diminish, employers, retirement systems and unions would need to find other funds to meet their obligations to their workers or reduce their benefits. The alternative is placing all EGWP beneficiaries on the individual Part D open market. This would greatly increase Medicare's liability during the reinsurance phase (see Table 1). If EGWP providers cease offering coverage to retirees, it is estimated to increase annual federal reinsurance liabilities by $2.5B to $3B.[3]

Signficant Value for Medicare: EGWP enrollees have lower OOP costs, which result in fewer EGWP beneficiaries reaching the catastrophic phase of the benefit where Medicare pays 80% of drug costs. In a March 2020 report, MedPAC cited that only 5% of EGWP enrollees reached the catastrophic phase compared to almost twice the share of non-EGWP enrollees.[4] Also, the comprehensive drug coverage offered by EGWPs can improve access to prescription drugs, thereby increasing medication adherence. Successful adherence to medications can improve health outcomes and lead to lower medical costs, which may decrease Medicare spending on services covered by Parts A and B.[5]

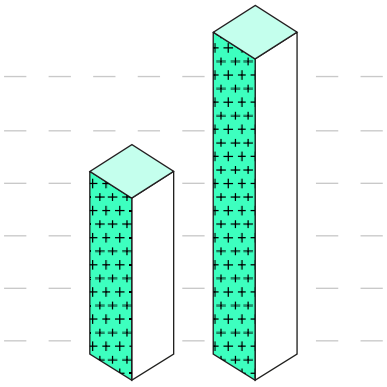
PROPOSED CHANGES THREATEN EGWPs—BUT IT'S NOT TOO LATE



Several independent analyses found the Rebate Rule would raise federal spending and increase seniors' premiums by as much as 25-40%

Policymakers are currently considering several changes to Medicare Part D that would have a substantial impact on the ability of employers to continue to offer high-quality drug coverage through EGWPs. Proposals to redesign the Part D benefit have been put forth by bipartisan, bicameral leaders in Congress aimed at reducing OOP costs for a subset of seniors who reach the catastrophic phase and decrease Medicare's spending on reinsurance. While these are worthy goals, the problems of high OOP costs and large reinsurance payments do not exist in the EGWP market, so policymakers should be careful to avoid creating disruption.

In addition, the final Rebate Rule from the previous Administration, set to take effect in 2023, will result in higher costs for patients, taxpayers and plan sponsors.[6] In fact, several independent analyses, including one by the Congressional Budget Office[7] (CBO) and by CMS' own actuaries,[8] found the Rebate Rule would raise federal spending and increase seniors' premiums by as much as 25-40%, while providing only limited relief on OOP costs for select beneficiaries. Because patients in EGWPs almost always pay fixed copayments that are not based on the price of the drug, the Rebate Rule will increase premiums for employers and unions without reducing drug list prices at all.



Many EGWPs would not benefit from the proposed changes to the Medicare Part D program

Current Part D Redesign Proposals

One Senate proposal, the Prescription Drug Price Reduction Act (PDPRA), and two House proposals, the Elijah E. Cummings Lower Drug Costs Now Act (H.R. 3) and the Lower Costs, More Cures Act (H.R. 19), would completely reform the Part D benefit. While there are many differences, key elements are similar across these proposals: 1) patient OOP costs would be capped at the catastrophic threshold, 2) the manufacturer coverage gap discounts would be replaced by a new discount program both above and below the catastrophic phase, and 3) government reinsurance costs would be shifted predominantly onto plans. For all proposals, only OOP costs (not manufacturer discounts) would count towards a patient's OOP cap and manufacturer discounts would be higher above the cap than below it.

Many of these reforms to standard Part D plans are intended to address rising drug costs for both beneficiaries and the federal government. However, very few EGWP beneficiaries will experience those benefits, as the reforms are attempting to correct problems not applicable in the EGWP market. In fact, both proposals cause the drug benefits that workers have fought for to be in jeopardy. Due to their employer subsidies, very few EGWP beneficiaries have high-enough OOP costs to enter the newly proposed catastrophic phase, where their plan could access higher discounts and federal reinsurance. That means that many EGWPs would not benefit from the proposed changes to the manufacturers' discount. In fact, the discount paid by manufacturers for retirees enrolled in EGWPs will be substantially lower than what is paid today. If policymakers hope to increase manufacturers' liability in the Part D program to disincentivize high prices, applying these reforms to impact EGWPs will have the opposite result.

Given this financial reality, employers, unions and state and local governments will be forced to make difficult decisions, either shouldering sharp premium hikes, increasing OOP costs for patients, or not offering drug coverage for their retirees at all and placing them on the individual Part D open market where more costs will shift to the federal government.

Congress can reform Part D and still retain the value of EGWPs

Reforms are essential to keep drug prices affordable and to protect patients from high OOP costs. However, Part D reforms must also protect the EGWP drug benefits that millions of retirees depend on. Recognizing that applying a separate set of rules for EGWPs may not be administratively feasible nor efficient, we propose a solution (on the following page) that policymakers can incorporate into current Part D redesign proposals to protect EGWP beneficiaries and plan sponsors.

This change would result in the least amount of disruption for retirees by making it easier for EGWPs to maintain their current coverage

Treat EGWPs as defined standard plans with respect to catastrophic coverage

Today, EGWP sponsors follow the rules that apply for defined standard benefit plans, regardless of the benefit structure of the Other Health Insurance benefit. To avoid penalizing employers, retirement systems and unions for honoring their commitments to retirees and paying for more valuable coverage, we propose a technical fix to Part D redesign proposals. For EGWPs only, allow the cost-sharing amount dictated under the standard benefit design to count towards the beneficiary's OOP cap. This would be similar to how manufacturer discounts are calculated, based off the defined standard benefits for EGWPs today—easing any challenges CMS may have in implementing this change.

Another way to think about this recommendation is to leverage the total gross spend accumulator, which will be determined as part of the new defined standard spend amount, for entry into the catastrophic stage. This change would result in the least amount of disruption for retirees by making it easier for EGWPs to maintain their current coverage, preventing drug manufacturers from paying lower manufacturer discounts, and maintaining the ability to have EGWPs operate as a "wrap" while still achieving policymakers' goals of Part D benefit redesign proposals.

As shown in Table 2 and Figure 1, counting only the employee contribution based on the defined standard would lower the members' copay while maintaining program stability.

TABLE 2:

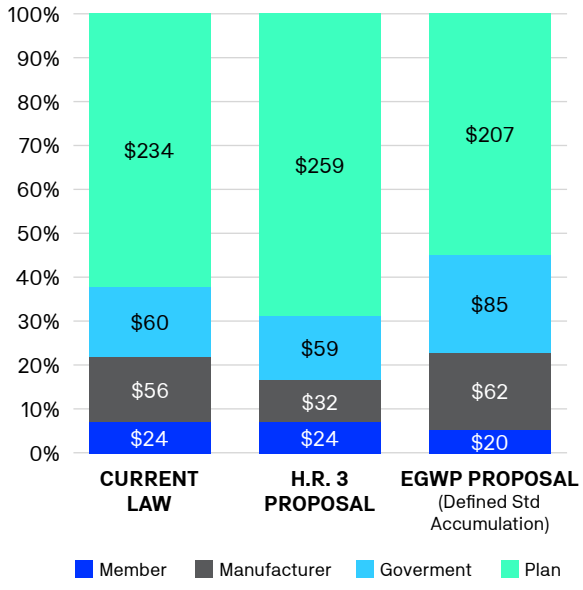
Estimated stakeholder costs for plan* under three policy options, 2022 PMPM

	CURRENT LAW	H.R. 3 PROPOSAL	EGWP PROPOSAL (Defined Std Accumulation)
Drug Cost	**$374**	**$374**	**$374**
Member Cost Sharing	$24	$24	$20
Manufacturer Discount	$56	$32	$62
Federal Reinsurance	$60	$1	$27
Net Claim Cost	**$234**	**$317**	**$265**
CMS Direct Subsidy	$0	$58	$58
Plan Liability	**$234**	**$259**	**$207**

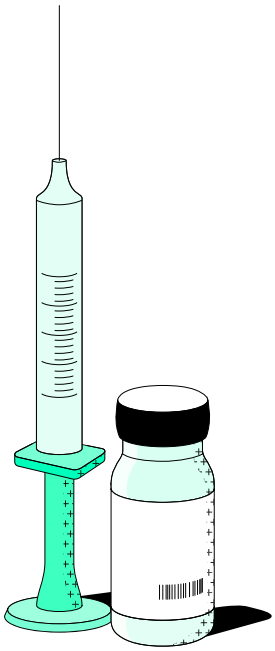
* Three-tier copay plan ($5/$20/$50)

FIGURE 1:

Contribution by stakeholder



We strongly encourage the Administration or Congress to repeal the Rebate Rule



Eliminating the use of rebates in Part D creates winners and losers among seniors and would be especially harmful for EGWPs

In 2020, the Trump Administration finalized the Rebate Rule, which eliminates the safe harbor for rebates from drug manufacturers to Part D plan sponsors, thus requiring that all discounts from manufacturers be offered to the patient at the point-of-sale. Eliminating the use of rebates in Part D creates winners and losers among seniors and would be especially harmful for EGWPs.

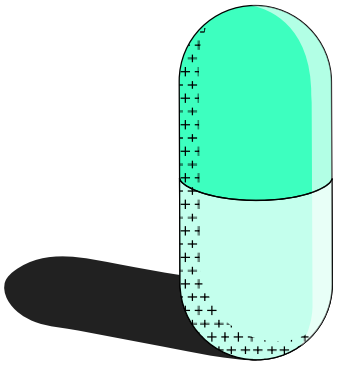
Harmful Effects of the Rebate Rule

+ **Higher premiums for retirees.** As noted earlier, several independent analyses found that the Rebate Rule would increase seniors' premiums by as much as 25-40%. Employers, retirement systems and unions, which subsidize EGWP premiums, would feel the brunt of a premium hike, making retiree drug coverage less affordable to provide. For states and local governments, it would reduce OPEB actuarial savings.

+ **Profits for drug manufacturers.** Pharmaceutical manufacturers benefit the most from the Rebate Rule. Independent analysts show that point-of-sale discounts would be lower than manufacturer rebates, allowing drug manufacturers to realize billions in revenue currently used to subsidize EGWPs. Also, the Rebate Rule would decrease the total amount of CGDP discounts paid by manufacturers in Part D.[9]

+ **Higher costs for the federal government.** CMS and CBO agree the Rebate Rule would cost the government substantially, resulting in almost $200 billion in higher federal spending over the next decade.[10]

+ **Little gain for EGWP beneficiaries.** While some beneficiaries may pay less if their prescriptions carry rebates (such as during the deductible phase) or if their cost-sharing is based on co-insurance rather than copays, the majority of beneficiaries would not.[11] Retirees in EGWPs typically pay fixed copayments for their prescriptions, so these beneficiaries would gain little from the Rebate Rule. For example, 80% of Express Scripts EGWPs have a flat copay for preferred brand drugs.



The proposals currently under consideration would make it harder, not easier, for employers and unions to continue providing comprehensive drug coverage

Bottom Line: Policymakers can reform *and* protect

Despite skyrocketing drug prices, EGWPs in Part D have made drugs affordable for beneficiaries—and coverage affordable for the government, employers and unions. While drug pricing reform is essential, the proposals currently under consideration would make it harder, not easier, for employers and unions to continue providing comprehensive drug coverage for their retirees. Thankfully, by considering the policy options described above, policymakers can do both—enact meaningful reforms and protect employer drug benefits for millions of retirees covered under EGWPs.

REFERENCES

1. Centers for Medicare and Medicaid Services, 2020 Medicare Trustees Report, available at: *https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf.*

2. Centers for Medicare & Medicaid Services, Medicare Advantage/Part D Contract and Enrollment Data, May 2021, available at: *https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData.*

3. Estimated increase in CMS federal reinsurance payments if EGWPs are covered under the defined standard benefit, comparable to what is common in the individual market.

4. 4 Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy,* March 2020, available at: *http://medpac.gov/docs/default-source/reports/mar20_entirereport_sec.pdf.*

5. 5 Congressional Budget Office, *Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services*, November 2012, available at: *https://www.cbo.gov/publication/43741.*

6. Fraud and abuse; removal of safe harbor protection for rebates involving prescription pharmaceuticals and creation of new safe harbor protection for certain point-of-sale reductions in price on prescription pharmaceuticals and certain pharmacy benefit manager service fees. Federal Register. *https://www.federalregister.gov/documents/2020/11/30/2020-25841/fraud-and-abuse-removal-of-safe-harbor-protection-for-rebates-involving-prescription-pharmaceuticals.* Published Nov. 30, 2020. Accessed June 24, 2021.

7. Incorporating effects of the proposed rule on safe harbors for pharmaceutical rebates in CBO's budget projections—supplemental material for updated budget projections: 2019 to 2029. Congressional Budget Office. *https://www.cbo.gov/publication/55151.* Published May 2, 2019. Accessed June 24, 2021.

8. Pelzer B, Spitalnic P. Proposed safe harbor rule. CMS Office of the Actuary. *https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/ProposedSafeHarborRegulationImpact.pdf.* Published Aug. 30, 2018. Accessed June 24, 2021.

9. Centers for Medicare and Medicaid Services, Office of the Actuary, Memorandum on Proposed Safe Harbor Regulation, August 2018, available at: *https://www.regulations.gov/document/HHSIG-2019-0001-0004.*

10. Congressional Budget Office, Incorporating the Effects of the Proposed Rule on Safe Harbors for Pharmaceutical Rebates in CBO's Budget Projections—Supplemental Material for Updated Budget Projections: 2019 to 2029, May 2019, available at: *https://www.cbo.gov/system/files/2019-05/55151-SupplementalMaterial.pdf.*

11. Milliman, Impact of Potential Changes to the Treatment of Manufacturer Rebates, January 2019, available at: *https://www.regulations.gov/document/HHSIG-2019-0001-0002.*

MORE INSIGHTS

EVERNORTH.COM

CLICK TO SHARE

EVERNORTH℠

Health services built on the recognition that health makes progress possible.
We deliver flexible and focused solutions for every business, for every person, for all.

© 2021 Evernorth. All rights reserved. All products and services are provided by or through operating subsidiaries or affiliates of Evernorth.

New Mexico Retiree Healthcare Authority

Governmental Accounting Standards Board (GASB) Statement 74 Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of June 30, 2021

DRAFT

This report has been prepared at the request of the NMRHCA Board to assist in administering the Plan. This valuation report may not otherwise be copied or reproduced in any form without the consent of the NMRHCA Board and may only be provided to other parties in its entirety. The measurements shown in this actuarial valuation may not be applicable for other purposes.

Copyright © 2021 by The Segal Group, Inc. All rights reserved.

Segal

1501 W Fountainhead Parkway, Suite 370
Tempe, AZ 85282
segalco.com
T 415.263.8200

November 16, 2021

Board of Trustees
New Mexico Retiree Healthcare Authority
6300 Jefferson St NE, Suite 150
Albuquerque, NM 87109

Dear Board Members:

We are pleased to submit this Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of June 30, 2021 under Governmental Accounting Standards Board Statement No. 74. The report summarizes the actuarial data used in the valuation, discloses the Net OPEB Liability (NOL), and analyzes the preceding year's experience. The non-retired census information was provided by New Mexico ERB and PERA. The retiree census and medical data information was provided by NMRHCA. The updated financial information was provided by NMRHCA on October 25, 2021. We have based our calculations on the information provided by these parties and the assistance is gratefully acknowledged.

The measurements shown in this actuarial valuation may not be applicable for other purposes. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; and changes in plan provisions or applicable law.

The actuarial valuation has been completed in accordance with generally accepted actuarial principles and practices. To the best of our knowledge, the information supplied in this actuarial valuation is complete and accurate. Further, in our opinion, the assumptions used in this valuation and described in Section 4, Exhibit II are reasonably related to the experience of and the expectations for the Plan. The actuarial projections are based on these assumptions and the plan of benefits as summarized in Section 3, Exhibit III.

Sincerely,

Segal

Mary Kirby, FCA, FSA, MAAA
Senior Vice President & Consulting Actuary

Melissa A. Krumholz, FSA, MAAA
Senior Health Consultant & Actuary

DRAFT

Table of Contents

DRAFT

Section 1: Actuarial Valuation Summary

Purpose and basis

This report presents the results of our actuarial valuation of NMRHCA (the "Plan") OPEB plan as of June 30, 2021, required by Governmental Accounting Standards Board (GASB) Statement No. 74, *Financial Reporting for Postemployment Benefit Plans Other than Pension Plans*. The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. This valuation is based on:

- The benefit provisions of NMRHCA OPEB Plan, as administered by the Board;
- The characteristics of covered active members, terminated vested members, and retired members and beneficiaries as of June 30, 2021 (captured as of January 1, 2021), provided by NMRHCA;
- The assets of the Plan as of June 30, 2021, provided by NMRHCA;
- Economic assumptions regarding future salary increases and investment earnings adopted by the Board for the June 30, 2021 valuation; and
- Other (health and non-health) actuarial assumptions, regarding employee terminations, retirement, death, health care trend and enrollment, etc.

Highlights of the valuation

Accounting and Financial Reporting

1. For GASB 74 reporting as of June 30, 2021, the NOL was measured as of June 30, 2021. The Plan's Fiduciary Net Position (plan assets) and the TOL were valued as of the measurement date.
2. Valuation assumption changes decreased the NOL by $894.2 million. This was mainly due to (1) an increase in the blended discount rate and (2) updated per capita costs; offset somewhat by (3) updating the future trends on per capita health costs, and (4) updating the ERB decrement rates based on the GRS actuarial valuation report as of June 30, 2020. Details regarding the assumption changes can be found in Exhibit II, Section 3.
3. The discount rates used to determine the TOL and NOL as of June 30, 2021 and 2020 were 3.62% and 2.86%, respectively. The detailed calculations used in the derivation of the "cross-over date" to determine the discount rate of 3.62% used in the calculation of the TOL and NOL as of June 30, 2021 can be found in Appendix A of Section 3. Various other information that is required to be disclosed can be found in Section 2.

DRAFT

Section 1: Actuarial Valuation Summary

4. The discount rate used in the valuation for financial disclosure purposes as of June 30, 2021 is a blend of the assumed investment return on Plan assets (e.g. 7.00% for the June 30, 2021 valuation) and the rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (e.g. 2.16% as of June 30, 2021 compared to 2.21% as of June 30, 2020). Because NMRHCA is not fully prefunding benefits, Plan assets, when projected in accordance with the method prescribed by GASB 74, are expected to be sufficient to make benefit payment through June 30, 2052 (the projected beginning balance at July 1, 2052 is less than the projected benefit payments for the 2052/2053 year, before including projected contributions for the year). Projected benefit payments are discounted by the Plan investment return assumption of 7.00% until June 30, 2052. Benefit payments after June 30, 2052 are then discounted by the municipal bond rate of 2.16 %. The 3.62% is the blended discount rate reflecting benefits discounted by the Plan investment return assumption rate and the bond rate.
5. The Net OPEB Liability (NOL) as of June 30, 2021 is $3.290 billion, a decrease of $0.909 billion, from the prior valuation NOL of $4.199 billion. The decrease was the net effect of the higher discount rate and updated per capita costs, offset by demographic assumption updates for ERB members and experience gains and losses.
6. Plan changes increased the Net OPEB Liability by $0.8 million. Adopted April 5, 2021, Senate Bill 315 grants employees who were employed with the Department of Public Safety (DPS) prior to July 1, 2015 and that were reported under the State General Plan 3 ('Non-Enhanced') retroactive eligibility in the State Police and Adult Correctional Officer Plan ('Enhanced') for purposes of retirement and health care benefits. This measure represents the impact of reclassifying those members to the Enhanced Plan for retiree healthcare subsidies based upon GASB 74 valuation assumptions and methods. The current plan of benefits is summarized in Exhibit III of Section 3.
7. As of June 30, 2021, the ratio of assets to the Total OPEB Liability (the funded ratio) is 25.39%. This is based on the market value of assets at this point in time. The funded ratio as of June 30, 2020 was 16.50%.

Funding (with funding policy)

8. The funding policy for the Plan does not rely upon an actuarially determined contribution. Retiree benefits are funded from a combination of employer contributions as a percentage (2.50% for Public Safety, and 2.00% for Other Occupations) of compensation and member contributions as a percentage (1.25% for Public Safety and 1.00% for Other Occupation) of compensation to fund the cost of the subsidy, with the remaining cost funded by retiree contributions, RHCA Statutory Distribution, investment income and pharmacy plan subsidies from Centers for Medicare and Medicaid Services (CMS).

DRAFT

Section 1: Actuarial Valuation Summary

9. The Coronavirus (COVID-19) pandemic is rapidly evolving and has had a significant impact on the US economy in 2020, including most retiree health plans, and will likely continue to have an impact in the future. Our results do not include the impact of the following:
   - Direct or indirect effects of COVID-19 on long-term health plan costs
   - Changes in the market value of plan assets since June 30, 2021
   - Changes in interest rates since June 30, 2021
   - Short-term or long-term impacts on mortality of the covered population
   - The potential for federal or state fiscal relief

   Each of the above factors could significantly impact these results. We will keep you updated on emerging developments.

DRAFT

Summary of key valuation results

Measurement Date		June 30, 2021	June 30, 2020
Disclosure elements for fiscal year ending June 30:	• Total OPEB Liability	$4,409,849,335	$5,028,579,923
	• Plan Fiduciary Net Position (Assets)	1,119,499,545	829,671,905
	• Net OPEB Liability	3,290,349,790	4,198,908,018
	• Plan Fiduciary Net Position as a percentage of Total OPEB Liability	25.39%	16.50%
	• Service Cost at Beginning of Year[1]	171,993,017	123,904,973
	• Covered Payroll	4,614,243,876	4,298,116,494
Schedule of contributions for fiscal year ending June 30:	• Statutory contributions	$178,635,582	$161,578,422
	• Actual contributions	177,813,458	174,162,723
	• Contribution deficiency / (excess)	822,124	-12,584,301
	• Benefit Payments	102,376,381	109,583,678

DRAFT

[1] The service cost is always based on the previous year's valuation, meaning the June 30, 2021 and 2020 values are based on the valuations as of June 30, 2020 and June 30, 2019 respectively. The key assumptions used in the June 30, 2019 valuation are as follows:

Discount rate	4.16%
Health care premium trend rates	
Non-Medicare	8.0% in 2019/2020 graded down to 4.5% over 14 years
Medicare	7.5% in 2019/2020 graded down to 4.5% over 12 years

Important information about actuarial valuations

An actuarial valuation is a budgeting tool with respect to defining future uncertain obligations of a postretirement health plan. As such, it will never forecast the precise future stream of benefit payments. It is an estimated forecast – the actual cost of the plan will be determined by the benefits and expenses paid, not by the actuarial valuation.

In order to prepare a valuation, Segal relies on a number of input items. These include:

Plan of benefits	Plan provisions define the rules that will be used to determine benefit payments, and those rules, or the interpretation of them, may change over time. Even where they appear precise, outside factors may change how they operate. For example, a plan may provide health benefits to post-65 retirees that coordinates with Medicare. If so, changes in the Medicare law or administration may change the plan's costs without any change in the terms of the plan itself. It is important for the NMRHCA to keep Segal informed with respect to plan provisions and administrative procedures, and to review the plan summary included in our report to confirm that Segal has correctly interpreted the plan of benefits.
Participant data	An actuarial valuation for a plan is based on data provided to the actuary by the plan. Segal does not audit such data for completeness or accuracy, other than reviewing it for obvious inconsistencies compared to prior data and other information that appears unreasonable. It is not necessary to have perfect data for an actuarial valuation: the valuation is an estimated forecast, not a prediction. The uncertainties in other factors are such that even perfect data does not produce a "perfect" result. Notwithstanding the above, it is important for Segal to receive the best possible data and to be informed about any known incomplete or inaccurate data.
Assets	The valuation is based on the market value of assets as of the valuation date, as provided by the NMRHCA on October 25, 2021.
Actuarial assumptions	In preparing an actuarial valuation, Segal starts by developing a forecast of the benefits to be paid to existing plan participants for the rest of their lives and the lives of their beneficiaries. To determine the future costs of benefits, Segal collects claims, premiums, and enrollment data in order to establish a baseline cost for the valuation measurement, and then develops short- and long-term health care cost trend rates to project increases in costs in future years. This forecast also requires actuarial assumptions as to the probability of death, disability, withdrawal, and retirement of each participant for each year, as well as forecasts of the plan's benefits for each of those events. The forecasted benefits are then discounted to a present value, typically based on an estimate of the rate of return that will be achieved on the plan's assets or, if there are no assets, a rate of return based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). All of these factors are uncertain and unknowable. Thus, there will be a range of reasonable assumptions, and the results may vary materially based on which assumptions the actuary selects within that range. That is, there is no right answer (except with hindsight). It is important for any user of an actuarial valuation to understand and accept this constraint. The actuarial model necessarily uses approximations and estimates that may lead to significant changes in our results but will have no impact on the actual cost of the plan. In addition, the actuarial assumptions may change over time, and while this can have a significant impact on the reported results, it does not mean that the previous assumptions or results were unreasonable or wrong.

DRAFT

Section 1: Actuarial Valuation Summary

Models	Segal accounting results are based on proprietary actuarial modeling software. The accounting valuation models generate a comprehensive set of liability and cost calculations that are presented to meet accounting standards and client requirements. Our Actuarial Technology and Systems unit, comprising both actuaries and programmers, is responsible for the initial development and maintenance of these models. The models have a modular structure that allows for a high degree of accuracy, flexibility and user control. The client team programs the assumptions and the plan provisions, validates the models, and reviews test lives and results, under the supervision of the responsible actuary. The blended discount rate used for calculating total pension liability is based on a model developed by our Actuarial Technology and Systems unit, comprised of both actuaries and programmers. The model allows the client team, under the supervision of the responsible actuary, control over the entry of future expected contribution income, benefit payments and administrative expenses. The projection of fiduciary net position and the discounting of benefits is part of the model. Our claims costs assumptions are based on proprietary modeling software as well as models that were developed by others. These models generate per capita claims cost calculations that are used in our valuation software. Our Health Technical Services Unit, comprised of actuaries and programmers, is responsible for the initial development and maintenance of our health models. They are also responsible for testing models that we purchase from other vendors for reasonableness. The client team inputs the paid claims, enrollments, plan provisions and assumptions into these models and reviews the results for reasonableness, under the supervision of the responsible actuary.

DRAFT

Section 1: Actuarial Valuation Summary

The user of Segal's actuarial valuation (or other actuarial calculations) should keep the following in mind:

The actuarial valuation is prepared for use by the NMHRCA Finance Department. It includes information for compliance with accounting standards and for the plan's auditor. Segal is not responsible for the use or misuse of its report, particularly by any other party.
If the NMRHCA is aware of any event or trend that was not considered in this valuation that may materially change the results of the valuation, Segal should be advised, so that we can evaluate it.
An actuarial valuation is a measurement at a specific date – it is not a prediction of a plan's future financial condition. Accordingly, Segal did not perform an analysis of the potential range of financial measurements, except where otherwise noted. The actual long-term cost of the plan will be determined by the actual benefits and expenses paid and the actual investment experience of the plan.
Sections of this report include actuarial results that are not rounded, but that does not imply precision.
Critical events for a plan include, but are not limited to, decisions about changes in benefits and contributions. The basis for such decisions needs to consider many factors such as the risk of changes in plan enrollment, emerging claims experience, health care trend, and investment losses, not just the current valuation results.
Segal does not provide investment, legal, accounting, or tax advice. Segal's valuation is based on our understanding of applicable guidance in these areas and of the plan's provisions, but they may be subject to alternative interpretations. The NMRHCA should look to their other advisors for expertise in these areas.
While Segal maintains extensive quality assurance procedures, an actuarial valuation involves complex computer models and numerous inputs. In the event that an inaccuracy is discovered after presentation of Segal's valuation, Segal may revise that valuation or make an appropriate adjustment in the next valuation.
Segal's report shall be deemed to be final and accepted by the NMRHCA upon delivery and review. NMRHCA should notify Segal immediately of any questions or concerns about the final content.

As Segal has no discretionary authority with respect to the management or assets of the Plan, it is not a fiduciary in its capacity as actuaries and consultants with respect to the Plan.

DRAFT

Section 1: Actuarial Valuation Summary

Actuarial Certification ***November 16, 2021***

This is to certify that Segal has conducted an actuarial valuation of certain benefit obligations of New Mexico Retiree Healthcare Authority's other postemployment benefit programs as of June 30, 2021, in accordance with generally accepted actuarial principles and practices. The actuarial calculations presented in this report have been made on a basis consistent with our understanding of GASB Statement 74 for the determination of the liability for postemployment benefits other than pensions.

The actuarial valuation is based on the plan of benefits verified by the Plan and reliance on participant, premium, claims and expense data provided by the Plan or from vendors employed by the Plan. Segal does not audit the data provided. The accuracy and comprehensiveness of the data is the responsibility of those supplying the data. Segal, however, does review the data for reasonableness and consistency.

The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. Accordingly, additional determinations may be needed for other purposes, such as judging benefit security at termination of the plan, or determining short-term cash flow requirements.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: retiree group benefits program experience or rates of return on assets differing from that anticipated by the assumptions; changes in assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and changes in retiree group benefits program provisions or applicable law. Retiree group benefits models necessarily rely on the use of approximations and estimates, and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. The scope of the assignment did not include performing an analysis of the potential change of such future measurements except where noted.

To the best of our knowledge, this report is complete and accurate and in our opinion presents the information necessary to comply with GASB Statement 74 with respect to the benefit obligations addressed. The signing actuaries are members of the Society of Actuaries, the American Academy of Actuaries, and other professional actuarial organizations and collectively meet the "General Qualification Standards for Statements of Actuarial Opinions" to render the actuarial opinion contained herein.

Mary Kirby, FCA, FSA, MAAA
Senior Vice President & Consulting Actuary

Melissa A. Krumholz, FSA, MAAA
Senior Health Consultant & Actuary

DRAFT

Section 2: GASB 74 Information

General information about the OPEB plan

Plan Description

Plan administration. The NMRHCA administers the OPEB Plan - a multiple employer cost sharing OPEB plan that is used to provide postemployment benefits other than pensions (OPEB) for retirees who were an employee of an employer participating in NMRHCA and eligible to receive a pension from either the New Mexico Public Employees Retirement Association (PERA) or Educational Retirement Board (ERB). For employers who "buy-in" to the plan, retirees are eligible for benefits six months after the effective date of employer participation.

At the July 11, 2014 meeting, the Board of Directors of the NMRHCA approved a change to its subsidy eligibility requirements such that retirees not in a PERA enhanced (Fire, Police, Corrections) pension plan who commence benefits on or after January 1, 2020 will not receive any subsidy from NMRHCA before age 55. Amended November 29, 2018, the subsidy eligibility requirement of age 55 was deferred one year (from 2020) such that retirees not in a PERA enhanced pension plan who commence benefits after January 1, 2021 will not receive a subsidy from NMRHCA before age 55. On June 2, 2020, the Board approved amending the effective date of minimum years of service and age requirements to receive the maximum subsidy provided by the program from January 1, 2021 to July 31, 2021 in order to align with the school year-end and subsequent potential teacher retirements.

Adopted April 5, 2021, Senate Bill 315 grants employees who were employed with the Department of Public Safety (DPS) prior to July 1, 2015 and that were reported under the State General Plan 3 ('Non-Enhanced') retroactive eligibility in the State Police and Adult Correctional Officer Plan ('Enhanced') for purposes of retirement and health care benefits. This measure represents the impact of reclassifying those members to the Enhanced Plan for retiree healthcare subsidies based upon GASB 74 valuation assumptions and methods.

Plan membership. At June 30, 2021 (captured as of January 1, 2021 with service for active members increased by half year from census date to valuation date), OPEB Plan membership consisted of the following:

Retired members, beneficiaries and married dependents currently receiving benefits	53,092
Vested terminated members entitled to but not yet receiving benefits	11,754
Active members	92,484
Total	157,330

DRAFT

Section 2: GASB 74 Information

Benefits provided. Retirees and spouses are eligible for medical and prescription drug benefits. Dental vision, and life insurance benefits are also available, but were not included in this valuation, since they are 100% retiree-paid. Employees and dependents are valued for life. A description of these benefits may be found at www.nmrhca.org by clicking on Retirees.

DRAFT

Net OPEB liability

Measurement Date	June 30, 2021	June 30, 2020
Components of the Net OPEB Liability		
Total OPEB Liability	$4,409,849,335	$5,028,579,923
Plan Fiduciary Net Position	1,119,499,545	829,671,905
Net OPEB Liability	3,290,349,790	4,198,908,018
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	25.39%	16.50%

The Net OPEB Liability (NOL) was measured as of June 30, 2021 and 2020. Plan Fiduciary Net Position (plan assets) was valued as of the measurement dates and the Total OPEB Liability was determined from actuarial valuations using data as of June 30, 2021 and 2019 (captured as of January 1 2021 and 2019), respectively.

- Discount rate has been calculated as a blend of the investment return on plan assets and municipal bond rate in accordance with GASB 74 and Illustration B2 of *Implementation Guide No. 2017-2, Financial Reporting Postemployment Benefit Plans Other Than Pension Plans*.

Plan provisions. The plan provisions used in the measurement of the Total OPEB Liability (TOL) as of June 30, 2021 are outlined in Exhibit II of Section 3:

- Amended November 29, 2018 and subsequently approved, the subsidy eligibility requirement of age 55 and the lower NMRHCA subsidy percentages were deferred one year (from 2020) and will be effective for eligible retirees not in a PERA enhanced retirement plan who commence benefits on or after January 1, 2021.
- On June 2, 2020, the Board approved amending the effective date of minimum years of service and age requirements to receive the maximum subsidy provided by the program from January 1, 2021 to July 31, 2021 (defer 7 months) in order to align with the school year.
- On June 2, 2020, the Board approved the reaffirmation of intent to modify plan designs to remain under the threshold that would have been in effect based on the PPACA “Cadillac” tax provisions that were in place immediately prior to its repeal on December 20, 2019.
- Adopted April 5, 2021, Senate Bill 315 grants employees who were employed with the Department of Public Safety (DPS) prior to July 1, 2015 and that were reported under the State General Plan 3 (‘Non-Enhanced’) retroactive eligibility in the State Police and Adult Correctional Officer Plan (‘Enhanced’) for purposes of retirement and health care benefits. This measure represents the impact of reclassifying those members to the Enhanced Plan for retiree healthcare subsidies based upon GASB 74 valuation assumptions and methods.

DRAFT

Section 2: GASB 74 Information

Actuarial assumptions. See Exhibit II in Section 3 for complete description. The mortality, retirement, disability, turnover and salary increase assumptions are based on the Public Employees Retirement Association (PERA) of New Mexico Annual Actuarial Valuation as of June 30, 2018 and the New Mexico Educational Retirement Board (ERB) Actuarial Valuation Report as of June 30, 2020. In summary, the following actuarial assumptions were applied to all periods included in the June 30, 2021 measurement:

Inflation	2.30% for ERB, 2.50% for PERA
Salary increases	ERB: Ranges from 3.00% to 10.00% based on years of service, including inflation. PERA: Ranges from 3.25% to 13.00% based on years of service, including inflation
Investment rate of return	7.00%, net of OPEB plan investment expense and margin for adverse deviation including inflation
Discount rate	3.62%
Healthcare cost trend rates	
Non-Medicare Medical	8.0% in 2021/2022 graded down to 4.5% over 14 years
Medicare Supplement	7.5% in 2021/2022 graded down to 4.5% over 12 years
Medicare Advantage	Trends reflect actual premium increase in 2021/2022, then 7.00% in 2022/2023, graded down to 4.50% over 10 years
Other assumptions	Same as those shown in Exhibit II of Section 3

Detailed information regarding all actuarial assumptions can be found in Section 3, Exhibit II.

DRAFT

Determination of discount rate and investment rates of return

The long-term expected rate of return on OPEB plan investments was determined using a building block method in which best estimate ranges of expected future rates of return (expected returns, net of investment expense and inflation) are developed for each major asset class. These returns are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation and subtracting expected investment expenses and a risk margin. The target allocation and projected arithmetic real rates of return for each major asset class, after deducting inflation, but before investment expenses, used in the derivation of the long-term expected investment rate of return assumption are summarized in the following table:

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return
Large Cap U.S. Equity	20.00%	6.55%
Mid/Small Cap U.S. Equity	3.00%	6.55%
Developed Non-US Equity	12.00%	7.30%
Emerging Markets Equity	15.00%	9.20%
U.S. Core Fixed Income	20.00%	0.40%
Private Equity	10.00%	10.55%
Credit & Structured Finance	10.00%	3.10%
Absolute Return	5.00%	2.45%
Real Estate	5.00%	3.65%
Total	100.00%	

Rate of return. For the year ended June 30, 2021, the annual money-weighted rate of return on investments, net of investment expense and margin for adverse deviation, was assumed to be 7.00%. The money-weighted rate of return expresses investment performance, net of investment expense, adjusted for the changing amounts actually invested.

Municipal Bond Rate. 2.16% and 2.21% based on the 20-year municipal bond rate for the Bond Buyer GO Index as of June 30, 2021 and June 30, 2020, respectively.

DRAFT

Section 2: GASB 74 Information

Discount rate. The discount rates used to measure the Total OPEB Liability (TOL) were 3.62% and 2.86% as of June 30, 2021 and June 30, 2020, respectively. The projection of cash flows used to determine the discount rate assumed employer and plan member contributions will be made at the current contribution rate. For this purpose, only employer contributions that are intended to fund benefits for current plan members and their beneficiaries are included. Projected employer contributions that are intended to fund the service costs for future plan members and their beneficiaries, as well as projected contributions from future plan members, are not included. Based on those assumptions, the OPEB Plan's assets was projected to be sufficient to make projected future benefit payments for current plan members through June 30, 2052 (the projected beginning balance at July 1, 2052 is less than the projected benefit payments for the 2052/2053 year, before including projected contributions for the year). Payments after that date would be funded by employer assets. Therefore, the long-term expected rate of return on OPEB Plan investments (7.00%) was applied to periods of projected benefit payments through June 30, 2052, and the 20-year municipal bond rate (2.16%) was applied to periods after June 30, 2052 to determine the TOL.

Funding Policy. Retiree benefits are funded from a combination of employer contributions as a percentage (2.50% for Public Safety, and 2.00% for Other Occupations) of compensation and member contributions as a percentage (1.25% for Public Safety and 1.00% for Other Occupation) of compensation to fund the cost of the subsidy, with the remaining cost funded by retiree contributions, RHCA Statutory Distribution, investment income and pharmacy plan subsidies from CMS

DRAFT

Sensitivity

The following presents the NOL of NMHRCA as well as what the NMRHCA's NOL would be if it were calculated using a discount rate that is 1-percentage-point lower (2.62%) or 1-percentage-point higher (4.62%) than the current rate. Also, shown is the NOL as if it were calculated using healthcare cost trend rates that were 1-percentage-point lower or 1-percentage-point higher than the current healthcare trend rates.

	1% Decrease (2.62%)	Current Discount Rate (3.62%)	1% Increase (4.62%)
Net OPEB Liability (Asset)	$4,134,247,608	$3,290,349,790	$2,633,889,896

	1% Decrease in Health Care Cost Trend Rates	Current Health Care Cost Trend Rates	1% Increase in Health Care Cost Trend Rates
Net OPEB Liability (Asset)	$2,646,501,227	$3,290,349,790	$3,808,841,141

DRAFT

Schedule of changes in Net OPEB Liability – Last two fiscal years

Measurement Date	June 30, 2021	June 30, 2020
Total OPEB Liability		
Service cost	$171,993,017	$123,904,973
Interest	147,282,724	169,239,236
Change of benefit terms	802,116	6,623,960
Differences between expected and actual experience	57,769,743	-150,535,215
Changes of assumptions	-894,201,807	989,792,910
Benefit payments[1]	-102,376,381	-109,583,678
Net change in Total OPEB Liability	-$618,730,588	$1,029,442,186
Total OPEB Liability – beginning	5,028,579,923	3,999,137,737
Total OPEB Liability – ending	$4,409,849,335	$5,028,579,923
Plan Fiduciary Net Position[2]		
Contributions – employer	$96,585,103	$96,503,837
Contributions – employee	48,292,552	48,251,919
Net investment income	217,737,204	10,836,882
Benefit payments[1]	-102,376,381	-109,583,678
Administrative expense	-3,049,460	-3,072,619
Other[3]	32,638,622	29,986,573
Net change in Plan Fiduciary Net Position	$289,827,640	$72,922,914
Plan Fiduciary Net Position – beginning	829,671,905	756,748,991
Plan Fiduciary Net Position – ending	$1,119,499,545	$829,671,905
Net OPEB Liability – ending	$3,290,349,790	$4,198,908,018
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	25.39%	16.50%
Covered payroll[4]	$4,614,243,876	$4,298,116,494
Plan Net OPEB Liability as percentage of covered payroll	71.31%	97.69%

See next page for footnotes.

DRAFT

Section 2: GASB 74 Information

Notes to Schedule:

[1] For measurement date June 30, 2021, this category equals Premium and claims paid ($315,956,002) offset by the sum of Retiree contributions ($177,054,535) and Medicare Part D subrogation and rebates ($36,525,086). For measurement date June 30, 2020, this category equals Premium and claims paid ($318,068,212) offset by the sum of Retiree contributions ($178,132,212) and Medicare Part D subrogation and rebates ($30,352,322).

[2] The Plan Fiduciary Net Position values are based on financial statements provided by NMRHCA on October 25, 2021.

[3] For measurement date June 30, 2021, this category equals sum of Employer buy-ins interest portion ($57,807) and tax administration suspense fund revenue ($32,935,803) offset by the sum of Refunds to retirees ($317,658) and Depreciation expense ($37,330). For measurement date June 30, 2020, this category equals sum of Employer buy-ins interest portion ($61,809) and tax administration suspense fund revenue ($29,406,967) offset by the sum of Losses and loss adjustment accrual increase (-$1,132,145), Refunds to retirees ($579,270), and Depreciation expense ($35,078).

[4] Covered payroll as of June 30, 2020 measurement was rolled forward from June 30, 2019 ($4,172,928,635) at 3.00% assumed payroll increases for PERA and ERB.

DRAFT

Schedule of contributions – Last ten fiscal years

Year Ended June 30	Statutory Contributions[1,2]	Contributions in Relation to the Statutory Contributions	Contribution Deficiency / (Excess)	Covered Payroll	Contributions as a Percentage of Covered Payroll
2012	340,074,787	142,053,551	198,021,236	N/A	N/A
2013	353,657,828	135,388,449	218,269,379	3,876,220,608	3.49%
2014	367,804,141	149,277,185	218,526,956	N/A	N/A
2015	292,656,765	156,670,251	135,986,514	3,941,587,760	3.97%
2016	303,631,394	159,862,801	143,768,593	N/A	N/A
2017	317,546,941	159,379,195	158,167,747	4,165,647,340	3.83%
2018[3,4]	156,266,741	154,358,714	1,908,027	4,290,616,760	3.60%
2019[4]	160,077,200	159,030,773	1,046,427	4,172,928,635	3.81%
2020[4,5]	161,578,422	174,162,723	-12,584,301	4,298,116,494	4.05%
2021[4]	178,635,582	177,813,458	822,124	4,614,243,876	3.85%

DRAFT

1 All "Statutory Contributions" through June 30, 2017 were determined as the "Annual Required Contribution" under GASB 43 and 45.
2 Includes an interest adjustment to the end of the year though fiscal year end June 30, 2017.
3 Covered payroll was rolled forward from the June 30, 2017 at 3.00% assumed payroll increases using a member-weighted average of PERA and ERB payroll growth rates rounded to the nearest 0.25%.
4 The funding policy for the Plan does not rely upon an actuarially determined contribution. For illustration purposes, for fiscal years ended after June 30, 2017, we have applied the statutory contributions as described in the funding policy to payroll as of the beginning of the period.
5 Covered payroll was projected forward from June 30, 2019 valuation at 3.00% assumed payroll increases for PERA and ERB.

Section 3: Supporting Information

Exhibit I: Summary of Participant Data

	As of June 30, 2021
Number of retirees	39,471
Average age of retirees	71.18
Number of spouses	11,266
Average age of spouses	70.74
Number of surviving spouses	2,355
Average age	79.58
Number inactive vested	11,754
Average age	52.84
Number of actives	92,484
Average age	45.47
Average service	10.13

DRAFT

Exhibit II: Actuarial Assumptions and Actuarial Cost Method

Data	Detailed census data and financial data for postemployment benefits were provided by: The non-retired census information was provided by New Mexico ERB and PERA. The retiree census and medical data information was provided by NMRHCA. The financial information was provided by NMRHCA on October 25, 2021.
Demographic Assumptions	Mortality, Retirement, Disability, Turnover, Inflation Rate and Salary Scale assumptions are based on: › For PERA, the Public Employees Retirement Association (PERA) of New Mexico Annual Actuarial Valuation as of June 30, 2018. › For ERB, the New Mexico Educational Retirement Board (ERB) Actuarial Valuation Report as of June 30, 2020.
Actuarial Cost Method	Entry Age Actuarial Cost Method. Entry Age is the age at the member's hire date. Actuarial Accrued Liability is calculated on an individual basis and is based on costs allocated as a level percentage of compensation.
Asset Valuation Method	Market Value. The assets as of June 30, 2021 were based on financial statements provided by NMRHCA on October 25, 2021.
Measurement Date	June 30, 2021
Actuarial Valuation Date	June 30, 2021
Census Date	January 1, 2021
Discount Rate	3.62%
Payroll Increase	3.00%, assumed payroll increases for PERA. 2.60%, assumed payroll increases for ERB.

DRAFT

Section 3: Supporting Information

PERA Salary Increases

Salary increases occur in recognition of (i) individual merit and longevity, (ii) inflation-related depreciation of the purchasing power of salaries, and (iii) other factors such as productivity gains and competition from other employers for personnel. Sample rates follow:

	Annual Rates (%) of Salary Increase for Sample Years of Service				
Attributable to:	**1**	**5**	**10**	**15**	**20**
General Increase in Wage Level Due to					
Inflation	2.50	2.50	2.50	2.50	2.50
Other factors	0.75	0.75	0.75	0.75	0.75
Increase Due to Merit/Longevity					
State General	5.00	1.25	0.50	0.00	0.00
State Police and Corrections[1]	9.75	3.50	2.00	1.50	1.50
Municipal General	2.50	1.50	0.50	0.00	0.00
Municipal Police	7.75	2.75	1.50	0.75	0.75
Municipal Fire	7.75	2.75	1.50	1.25	1.25

[1] Police and Corrections were not identified separately in the census data. We have used the Corrections assumption because the subgroup comprises about 70% of the combined group total.

ERB Salary Scale

General Increase in Wage level Due to:

Inflation: 2.30%

Productivity increase rate: 0.70%

Salary increases occur in recognition of (i) individual merit and longevity, (ii) plus step-rate/promotional as shown:

Years of Service	Annual Step Rate (%) / Promotional Components Rates of Increase	Total Annual Rate (%) of Increase
0	7.00	10.00
1	3.50	6.50
2	2.75	5.75
3	2.25	5.25
4	1.75	4.75
5	1.50	4.50
6	1.25	4.25
7	1.00	4.00
8	0.75	3.75
9	0.50	3.50
10-14	0.25	3.25
15 or more	0.00	3.00

DRAFT

Section 3: Supporting Information

PERA Post-Retirement Mortality Rates

Healthy: Headcount-Weighted RP-2014 Blue Collar Annuitant Mortality, set forward one year for females, projected generationally with Scale MP-2017 times 60%.

Disabled: Headcount-Weighted RP-2014 Blue Collar Annuitant Mortality, set forward one year for females, projected generationally with Scale MP-2017 times 60%.

The tables shown above were determined so as to reasonably reflect future mortality improvement, based on the June 30, 2018 PERA pension valuation.

PERA Pre-Retirement Mortality Rates

Headcount-Weighted RP-2014 Blue Collar Employee Mortality, set forward one year for females, projected generationally with Scale MP-2017 times 60%.

PERA Termination Rates before Retirement

	Rates (%) of Active Members Terminating During Year				
	State General Males Sample Service (Yr.)				
Age	2	4	6	8	10+
20	18.76	10.86	8.21	7.78	5.11
25	17.72	11.06	8.10	7.07	4.65
30	16.45	11.27	7.97	6.18	4.13
35	15.31	10.81	7.59	5.58	3.89
40	14.30	9.97	7.08	5.40	3.86
45	13.55	9.06	6.63	5.40	3.86
50	13.26	8.45	6.49	5.40	3.86
55	13.26	8.37	6.49	5.40	3.86
60	13.26	8.37	6.49	5.40	3.86

	Rates (%) of Active Members Terminating During Year				
	State General Females Sample Service (Yr.)				
Age	2	4	6	8	10+
20	18.13	11.95	8.22	6.05	4.83
25	17.76	11.95	8.02	5.81	4.25
30	17.28	11.89	7.81	5.54	3.55
35	16.34	11.23	7.45	5.28	3.46
40	15.22	10.24	6.99	5.06	3.46
45	14.19	9.20	6.58	4.95	3.46
50	13.52	8.55	6.45	4.80	3.46
55	13.37	8.50	6.45	4.70	3.46
60	13.37	8.50	6.45	4.70	3.46

DRAFT

PERA Termination Rates before Retirement (continued)

	Rates (%) of Active Members Terminating During Year				
	Municipal General Males Sample Service (Yr.)				
Age	2	4	6	8	10+
20	21.70	14.59	11.29	8.93	8.54
25	20.00	13.52	10.26	8.05	7.32
30	17.73	12.04	8.96	6.94	5.69
35	15.77	10.65	8.01	6.20	4.61
40	14.06	9.37	7.29	5.73	3.92
45	12.80	8.39	6.87	5.58	3.65
50	12.20	8.01	6.79	5.58	3.65
55	12.18	8.01	6.79	5.58	3.65
60	12.18	8.01	6.79	5.58	3.65

	Rates (%) of Active Members Terminating During Year				
	Municipal General Females Sample Service (Yr.)				
Age	2	4	6	8	10+
20	24.40	17.77	14.41	11.94	7.51
25	21.96	16.06	12.80	10.32	6.38
30	18.85	13.77	10.63	8.16	4.94
35	16.69	11.96	9.08	6.70	4.09
40	15.16	10.49	7.84	5.74	3.67
45	14.28	9.49	6.50	5.31	3.62
50	14.01	9.14	6.50	5.30	3.62
55	14.01	9.14	6.50	5.30	3.62
60	14.01	9.14	6.50	5.30	3.62

	Service Based Rates (%) of Active Members Terminating During Year				
	Sample Service (Yr.)				
Age	1	3	5	7	10+
State Police & Corrections[1]	20.00	16.00	9.00	8.00	5.75
Municipal Detention	22.00	16.00	10.00	10.00	6.00
Municipal Police	14.00	9.50	6.80	5.15	3.50
Municipal Fire	10.00	7.50	5.00	3.30	2.75

[1] Police and Corrections were not identified separately in the census data. We have used the Corrections assumption because the subgroup comprises about 70% of the combined group total.

DRAFT

PERA Termination Rates before Retirement (continued)

	Disability Incidence Rates (%)						
	State General		State Police and	Municipal General		Municipal	Municipal
Age	Male	Female	Corrections[1]	Male	Female	Police	Fire
25	0.02	0.02	0.14	0.03	0.04	0.01	0.02
30	0.04	0.03	0.16	0.06	0.04	0.01	0.02
35	0.08	0.06	0.21	0.09	0.04	0.05	0.02
40	0.13	0.12	0.27	0.13	0.06	0.11	0.08
45	0.24	0.20	0.46	0.18	0.14	0.18	0.08
50	0.41	0.39	0.90	0.30	0.25	0.28	0.33
55	0.57	0.61	1.40	0.49	0.39	0.46	0.33
60	0.74	0.73	1.88	0.60	0.51	0.74	1.17
65	0.75	0.73	1.88	0.62	0.59	1.08	1.17

[1] Police and Corrections were not identified separately in the census data. We have used the Corrections assumption because the subgroup comprises about 70% of the combined group total.

PERA Actives' Retirement Rates

	Retirement Rates (%)						
	State General		State Police and	Municipal General		Municipal	Municipal
Age	Male	Female	Corrections[1]	Male	Female	Police[2]	Fire[2]
40	25	25	40	20	25	30	30
45	25	25	40	20	25	30	25
50	25	25	40	20	25	30	20
55	25	25	40	20	25	30	25
60	30	25	35	15	25	30	20
65	25	25	35	15	25	30	20
70	25	20	100	20	15	100	100
75	25	20		20	15		
80	100	100		100	100		

[1] Police and Corrections were not identified separately in the census data. We have used the Corrections assumption because the subgroup comprises about 70% of the combined group total.

[2] Plan 1-5 were not identified separately in the census data. We have used the Plan 3-5 assumptions because this subgroup comprises over 95% of the combined group total for Municipal Police and Fire.

DRAFT

Section 3: Supporting Information

ERB Post-Retirement Mortality Rates

Healthy:

Males: 2000 GRS Southwest Region Teacher Mortality Table, set back one year and scaled at 95%. Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2020.

Females: 2020 GRS Southwest Region Teacher Mortality Table, set back one year. Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2020.

Disabled:

Males: 2020 GRS Southwest Region Teacher Mortality Table, set forward three years with minimum rates at all ages of 4.0%. Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2020.

Females: 2020 GRS Southwest Region Teacher Mortality Table, set forward three years with minimum rates at all ages of 2.0%. Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2020.

The tables shown above were determined so as to reasonably reflect future mortality improvement, based on the June 30, 2020 ERB pension valuation.

ERB Pre-Retirement Mortality Rates

Pub-2010 Teachers Active Employee Mortality table. Generational mortality improvements in accordance with the Ultimate MP scales are projected from the year 2010..

ERB Disability Rates Before Retirement

	Disability Incidence Rates (%)	
Years of Service	**Males**	**Females**
25	0.007	0.010
30	0.007	0.010
35	0.042	0.020
40	0.091	0.050
45	0.133	0.080
50	0.168	0.120
55	0.182	0.168

DRAFT

Section 3: Supporting Information

ERB Termination Rates before Retirement

Completed Service	Active Members Terminating During Year Rates (%) Males	Females
0	30.0	24.0
1	24.0	20.0
2	19.0	16.5
3	14.0	13.5
4	11.5	11.5
5	10.0	10.0
6	9.0	9.0
7	7.5	7.5
8	6.5	7.0
9	6.0	6.0
10	5.3	5.5
11	4.6	4.7
12	4.1	4.2
13	3.4	3.6
14	3.1	3.2
15	2.8	2.8
16	2.5	2.5
17	2.2	2.2
18	1.9	1.9
19 and over	0.0	0.0

ERB Retirement Rates

Age	Members Hired Before July 1, 2010 and Normal Retirement for Members Hired On Or After July 1, 2020 Male Retirement Rates (%) Years of Service 0-4	5-9	10-14	15-19	20-24	25	26+
45	0	0	0	0	0	25	15
50	0	0	0	0	0	25	18
55	0	0	0	0	5	20	18
60	0	0	0	15	20	25	25
62	0	0	30	30	30	25	25
65	0	40	35	30	30	25	25
67	0	25	25	25	30	25	25
70	100	100	100	100	100	100	100

DRAFT

Section 3: Supporting Information

ERB Retirement Rates (continued)

Members Hired Before July 1, 2010 and Normal Retirement for Members Hired On Or After July 1, 2020

Female Retirement Rates (%)

	Years of Service						
Age	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**25**	**26+**
45	0	0	0	0	0	25	15
50	0	0	0	0	0	25	18
55	0	0	0	0	6	25	23
60	0	0	0	20	15	25	25
62	0	0	40	30	30	30	30
65	0	35	40	40	40	40	40
67	0	25	25	25	30	30	30
70	100	100	100	100	100	100	100

Members Hired On Or After July 1, 2010

Male Retirement Rates (%)

	Years of Service		
Age	**15-19**	**20-24**	**25-29**
55	0	0	5
60	0	20	20
62	30	30	30
65	30	30	30

Members Hired On Or After July 1, 2010

Female Retirement Rates (%)

	Years of Service		
Age	**15-19**	**20-24**	**25-29**
55	0	0	6
60	0	15	15
62	30	30	30
65	40	40	40

DRAFT

Section 3: Supporting Information

Administrative Expenses

Non-Medicare: $373/year
Medicare Supplement: $460/year
Medicare Advantage: $60/year

The administrative expenses were assumed to increase by 2.5% in 2021/2022 and thereafter.

Per Capita Cost Development

The assumed costs on a composite basis (and other demographic factors such as sex and family status) are the future costs of providing postretirement health care benefits at each age. To determine the assumed costs on a composite basis, historical claims costs are reviewed, and adjusted for increases in the cost of health care services.

Per Capita Costs

Annual medical and drug claims costs for the 2021/2022 plan year, excluding assumed expenses were developed actuarially for retirees and spouses at select ages and are shown in the table below. These costs are net of deductibles and other benefit plan cost sharing provisions.

	Premier Non-Medicare				Value Non-Medicare			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
50	$9,690	$11,037	$6,768	$8,862	$6,719	$7,653	$4,693	$6,145
55	11,508	11,881	9,057	10,258	7,979	8,238	6,280	7,113
60	13,667	12,806	12,125	11,897	9,476	8,879	8,407	8,249
64	15,679	13,585	15,306	13,391	10,871	9,420	10,613	9,285

	Non-Medicare Drug Rebates			
	Retiree		Spouse	
Age	Male	Female	Male	Female
50	-$370	-$421	-$258	-$338
55	-439	-453	-345	-391
60	-521	-488	-462	-454
64	-598	-518	-584	-511

DRAFT

Section 3: Supporting Information

Per Capita Costs (continued)

	United Healthcare Medicare Advantage				BCBS Supplemental			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$576	$490	$576	$490	$6,290	$5,347	$6,290	$5,347
70	668	528	668	528	7,290	5,762	7,290	5,762
75	719	568	719	568	7,856	6,202	7,856	6,202
80	775	612	775	612	8,460	6,686	8,460	6,686

	BCBS (Medicare Advantage)				Presbyterian Medicare Advantage			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	$475	$404	$475	$404	$1,258	$1,069	$1,258	$1,069
70	551	435	551	435	1,458	1,152	1,458	1,152
75	593	468	593	468	1,571	1,240	1,571	1,240
80	639	505	639	505	1,692	1,337	1,692	1,337

	Medicare Drug Rebates & Other CMS Subsidies				Medicare Direct Drug Subsidy			
	Retiree		Spouse		Retiree		Spouse	
Age	Male	Female	Male	Female	Male	Female	Male	Female
65	-$2,807	-$2,386	-$2,807	-$2,386	$18	$15	$18	$15
70	-3,253	-2,571	-3,253	-2,571	21	16	21	16
75	-3,506	-2,768	-3,506	-2,768	22	18	22	18
80	-3,775	-2,984	-3,775	-2,984	24	19	24	19

	Humana Medicare Advantage			
	Retiree		Spouse	
Age	Male	Female	Male	Female
65	$575	$489	$575	$489
70	666	527	666	527
75	718	567	718	567
80	773	611	773	611

DRAFT

Section 3: Supporting Information

Drug Rebate and Other Subsidy Increase Assumptions	The 2021/2022 annual drug rebate for non-Medicare retirees was assumed to have no projected future increases. The 2021/2022 annual drug rebate for Medicare retirees with BCBS Medicare Supplement plan was assumed to have no projected future increases. Medicare Part D subsidies for low income reinsurance and coverage gap discounts are assumed to have no projected future increases.
Medicare Part D Direct Subsidy Assumption	These calculations include an offset for retiree prescription drug plan federal subsidies that the Plan is eligible to receive because the Plan has been determined to be a Medicare PDP. The subsidy shown above per eligible retiree or spouse for 2021/2022, was assumed to increase by 100% to $0 in the first year and 0% thereafter.
Unknown Data for Participants	Same as those exhibited by members with similar known characteristics. If not specified, members are assumed to be male. For active participants with unknown dates of birth, we assumed their age at entry was that of the average for actives with date of birth.
Spouse Coverage	35% male, 30% female
Age of Spouse	Wives are 2 years younger than their husbands.
Future Benefit Accruals	1.0 year of service per year.
Participation and Election	60% of the active participants are assumed to continue coverage at retirement. 25% of employees terminating prior to retiring, and eligible, are assumed to elect NMRHCA benefits at retirement. Future retirees are assumed to elect medical carriers in the same proportion as current retirees:

Non-Medicare Plan	Medical Election Rate (%)
Premier	75
Value Plan	25
Medicare Plan	**Medical Election Rate (%)**
BCBS Medicare Supplement	56
BCBS Senior Plan I or II	9
Presbyterian Senior Plan I or II	21
United Healthcare Plan I or II	11
Humana Plan I or II	3

Former Vested Retirement Age	Former vested members are assumed to begin receiving retiree health benefits at the later of age 60 and early retirement eligibility.

DRAFT

Section 3: Supporting Information

Health Care Cost Trend Rates

Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are "net" and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that is applied to that year's cost to yield the next year's projected cost. For example, the projected per capita cost for a male retiree age 64 covered under the Premier Plan in the year July 1, 2022 through June 30, 2023 would be determined with the following formula:
[$15,679 x (1 + 8.0%)] = $16,933.

	Rate (%)					
Year Ending June 30	All Non-Medicare Plans	Medicare Supplement Plan	UHC Medicare Advantage[1]	BCBS Medicare Advantage[1]	Humana Medicare Advantage[1]	Presbyterian Medicare Advantage[1]
2021	8.00	7.50	0.00	-14.00	2.00	5.00
2022	7.75	7.25	7.00	7.00	7.00	7.00
2023	7.50	7.00	6.75	6.75	6.75	6.75
2024	7.25	6.75	6.50	6.50	6.50	6.50
2025	7.00	6.50	6.25	6.25	6.25	6.25
2026	6.75	6.25	6.00	6.00	6.00	6.00
2027	6.50	6.00	5.75	5.75	5.75	5.75
2028	6.25	5.75	5.50	5.50	5.50	5.50
2029	6.00	5.50	5.25	5.25	5.25	5.25
2030	5.75	5.25	5.00	5.00	5.00	5.00
2031	5.50	5.00	4.75	4.75	4.75	4.75
2032	5.25	4.75	4.50	4.50	4.50	4.50
2033	5.00	4.50	4.50	4.50	4.50	4.50
2034	4.75	4.50	4.50	4.50	4.50	4.50
2035 & Later	4.50	4.50	4.50	4.50	4.50	4.50

[1] The first year Medicare Advantage rates reflect actual calendar year 2022 premiums.

The trend rate assumptions were developed using Segal's internal guidelines, which are established each year using data sources such as the Segal Health Trend Survey, internal client results, and trends from other published surveys prepared by the S&P Dow Jones Indices, consulting firms and brokers, and CPI statistics published by the Bureau of Labor Statistics

DRAFT

Section 3: Supporting Information

Funding Policy	Retiree benefits are funded from a combination of employer contributions as a percentage (2.50% for Public Safety, and 2.00% for Other Occupations) of compensation and member contributions as a percentage (1.25% for Public Safety and 1.00% for Other Occupation) of compensation to fund the cost of the subsidy, with the remaining cost funded by retiree contributions, RHCA Statutory Distribution, investment income and pharmacy subsidies from CMS.
Plan Design	Development of plan liabilities was based on the substantive plan of benefits in effect as described in Exhibit III.
Assumption Changes	The discount rate was updated from 2.86% to 3.62%. Medical carrier election assumptions were updated based on recent enrollment. Per capita health costs were recalculated based on more recent data. Future trend rates were updated. The 2021/2022 trends for Medicare Advantage plans were updated to reflect actual calendar year 2022 premiums. Mortality, salary scale, disability, retirement, and turnover rates were updated for ERB members. The assumed spouse age difference for future retirees was lowered from 3 years to 2 years.

DRAFT

Exhibit III: Summary of Plan

This exhibit summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plans as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility	A retiree who was an employee of either New Mexico PERA or an ERB eligible to receive a pension, is eligible for retiree health benefits. For employers who "buy-in" to the plan, retirees are eligible for benefits six months after the effective date of employer participation. • Amended June 2, 2020, the Board of Directors of the NMRHCA approved a change to its subsidy eligibility requirements such that retirees not in a PERA enhanced (Fire, Police, Corrections) pension plan who commence benefits on or after July 31, 2021 will not receive any subsidy from NMRHCA before age 55. • Adopted April 5, 2021, Senate Bill 315 grants employees who were employed with the Department of Public Safety (DPS) prior to July 1, 2015 and that were reported under the State General Plan 3 (`Non-Enhanced') retroactive eligibility in the State Police and Adult Correctional Officer Plan (`Enhanced') for purposes of retirement and health care benefits. This measure represents the impact of reclassifying those members to the Enhanced Plan for retiree healthcare subsidies based upon GASB 74 valuation assumptions and methods.
Benefit Types	Retirees and spouses are eligible for medical and prescription drug benefits. For Calendar years 2017 and prior there was a NMRHCA-paid Basic Life benefit of $6000 for all retirees who commenced benefits on or before December 31, 2012. The $6000 benefit decreases $1500 per year commencing January 1, 2018 until January 1, 2021 at which time retirees must pay 100% of the premium cost. Dental and vision benefits are also available, but were not included in this valuation, since they are 100% retiree-paid. A description of these benefits may be found at www.nmrhca.state.nm.us by clicking on Retirees.
Duration of Coverage	Employees and dependents are valued for life.

DRAFT

Section 3: Supporting Information

Retiree Contributions

The retiree contribution is derived on a service based schedule implemented effective July 1, 2001 and updated annually. The table below shows the anticipated retiree paid portion of claims.

	FY 2021 And Later
Non-Medicare Retiree	36.0%
Non-Medicare Spouse	64.0
Medicare Retiree	50.0
Medicare Spouse	75.0

Amended on June 2, 2020, the Board of Directors of the NMRHCA approved a change to its subsidy eligibility requirements for retirements on or after July 31, 2020 (deferred 7 months from January 1, 2021) and not in a Public Safety pension plan:

Years of Service	Retired Before July 31, 2021 or in Public Safety Pension Plan Percent of Full Subsidy Based on Service (%)	Retired on or after July 31, 2021 and Not in Public Safety Pension Plan Percent of Full Subsidy Based on Service (%)
5	6.25	4.76
6	12.50	9.52
7	18.75	14.29
8	25.00	19.05
9	31.25	23.81
10	37.50	28.57
11	43.75	33.33
12	50.00	38.10
13	56.25	42.86
14	62.50	47.62
15	68.75	52.38
16	75.00	57.14
17	81.25	61.90
18	87.50	66.67
19	93.75	71.43
20	100.00	76.19
21	100.00	80.95
22	100.00	85.71
23	100.00	90.48
24	100.00	95.24
25+	100.00	100.00

DRAFT

Section 3: Supporting Information

Dental Eligibility	This benefit was not included in the valuation because retirees pay 100% of the cost.
Vision Eligibility	This benefit was not included in the valuation because retirees pay 100% of the cost
Life Insurance Death Benefit Eligibility	For Calendar years 2017 and prior there was a NMRHCA-paid Basic Life benefit of $6000 for all retirees who commenced benefits on or before December 31, 2012. The $6000 benefit decreases $1500 per year commencing January 1, 2018 until January 1, 2021 at which time retirees must pay 100% of the premium cost.
Excise Tax on High Cost Health Plans Imposed by The Affordable Care Act (ACA "Cadillac Tax")	In 2013, NMRHCA's Board of Directors approved its intent to modify plan designs as necessary to preclude the payment of any excise tax established by the ACA. Therefore, we have only valued benefits up to the tax threshold levels. On June 2, 2020, the Board approved the reaffirmation of intent to modify plan designs to remain under the threshold that would have been in effect based on the PPACA "Cadillac" tax provisions that were in place immediately prior to its repeal on December 20, 2019.
Plan Changes	Adopted April 5, 2021, Senate Bill 315 grants employees who were employed with the Department of Public Safety (DPS) prior to July 1, 2015 and that were reported under the State General Plan 3 (`Non-Enhanced') retroactive eligibility in the State Police and Adult Correctional Officer Plan (`Enhanced') for purposes of retirement and health care benefits. This measure represents the impact of reclassifying those members to the Enhanced Plan for retiree healthcare subsidies based upon GASB 74 valuation assumptions and methods.

DRAFT

Appendix A: Projection of OPEB Plan's Fiduciary Net Position for use in the Calculation of Discount Rate as of June 30, 2021

Year Beginning June 30	Projected Beginning Plan Fiduciary Net Position (a)	Projected Total Contributions (b)	Projected Benefit Payments (c)	Projected Administrative Expenses (d)	Projected Investment Earnings (e)	Projected Beginning Plan Fiduciary Net Position (f) = (a) + (b) – (c) – (d) + (e)
2021	$1,119,499,545	$178,635,582	$136,379,875	$0	$79,843,918	$1,241,599,170
2022	1,241,599,170	169,080,157	139,142,031	0	87,959,776	1,359,497,071
2023	1,359,497,071	161,698,468	145,201,306	0	95,742,196	1,471,736,430
2024	1,471,736,430	155,095,142	151,006,066	0	103,164,668	1,578,990,174
2025	1,578,990,174	149,013,381	157,288,701	0	110,239,676	1,680,954,530
2026	1,680,954,530	143,295,677	163,903,462	0	116,945,545	1,777,292,291
2027	1,777,292,291	137,802,678	171,716,500	0	123,223,477	1,866,601,946
2028	1,866,601,946	132,430,641	180,363,698	0	128,984,479	1,947,653,368
2029	1,947,653,368	127,105,113	189,467,527	0	134,153,051	2,019,444,005
2030	2,019,444,005	121,887,876	198,686,429	0	138,673,131	2,081,318,583
2031	2,081,318,583	116,772,759	208,740,946	0	142,473,414	2,131,823,810
2032	2,131,823,810	111,701,111	218,409,703	0	145,492,866	2,170,608,084
2033	2,170,608,084	106,737,189	227,735,787	0	147,707,615	2,197,317,101
2034	2,197,317,101	101,879,496	235,913,952	0	149,120,991	2,212,403,636
2035	2,212,403,636	97,390,295	242,926,137	0	149,774,500	2,216,642,294
2036	2,216,642,294	93,366,999	249,311,121	0	149,706,916	2,210,405,088
2037	2,210,405,088	89,750,274	255,795,238	0	148,916,782	2,193,276,905
2038	2,193,276,905	86,427,470	262,325,113	0	147,372,966	2,164,752,229
2039	2,164,752,229	83,268,099	269,222,656	0	145,024,247	2,123,821,919

DRAFT

2040	2,123,821,919	80,028,839	276,155,804	0	141,803,091	2,069,498,045
2041	2,069,498,045	76,762,689	283,427,597	0	137,631,591	2,000,464,728
2042	2,000,464,728	73,168,972	290,864,937	0	132,413,172	1,915,181,935
2043	1,915,181,935	69,395,458	298,570,366	0	126,041,614	1,812,048,641
2044	1,812,048,641	65,419,187	$305,731,798	0	118,432,463	1,690,168,493
2045	1,690,168,493	61,502,830	$312,365,208	0	109,531,611	1,548,837,726
2046	1,548,837,726	57,640,243	$318,326,066	0	99,294,637	1,387,446,540
2047	1,387,446,540	54,194,033	$323,354,230	0	87,700,651	1,205,986,994
2048	1,205,986,994	51,128,263	$327,842,400	0	74,734,095	1,004,006,952
2049	1,004,006,952	48,340,019	$332,008,909	0	60,352,075	780,690,136
2050	780,690,136	45,838,163	$335,502,069	0	44,510,073	535,536,303
2051	535,536,303	43,621,374	$337,842,174	0	27,189,813	268,505,316
2052	268,505,316	41,905,370	$338,805,124	0	8,403,881	0

Notes

1. Amounts may not total exactly due to rounding.
2. Years beyond 2052/2053 have been omitted from this table as the Fiduciary Net Position is zero.
3. Column (b): Projected total contributions are calculated as fixed percentages of payroll plus the Pension Tax Revenue. Contributions are assumed to occur halfway through the year on average.
4. Column (c): Projected benefit payments have been determined in accordance with paragraphs 43-47 of GASB Statement No. 74 and are based on the closed group of active, retired members and beneficiaries as of June 30, 2021.
5. Column (d): Projected administrative expenses have been reflected in benefit payments.
6. Column (e): Projected investment earnings are based on the assumed investment rate of return of 7.00% per annum and reflect the assumed timing of benefit payments made at the beginning of each month.
7. The Plan's Fiduciary Net Position is projected to be exhausted by June 30, 2053.

DRAFT

Appendix B: Definition of Terms

Definitions of certain terms as they are used in Statement 75. The terms may have different meanings in other contexts.

Actuarially Determined Contribution:	A target or recommended contribution to an OPEB plan for the reporting period based on the most recent measurement available.
Assumptions or Actuarial Assumptions:	The estimates on which the cost of the Plan is calculated including: a) Investment return — the rate of investment yield that the Plan will earn over the long-term future; b) Mortality rates — the death rates of employees and pensioners; life expectancy is based on these rates; c) Retirement rates — the rate or probability of retirement at a given age; d) Turnover rates — the rates at which employees of various ages are expected to leave employment for reasons other than death, disability, or retirement.
Covered Payroll:	The payroll of the employees that are provided OPEB benefits
Discount Rate:	The single rate of return, that when applied to all projected benefit payments results in an actuarial present value that is the sum of the following: 1) the actuarial present value of projected benefit payments projected to be funded by plan assets using a long term rate of return, and 2) the actuarial present value of projected benefit payments that are not included in (1) using a yield or index rate for 20 year tax exempt general obligation municipal bonds with an average rating of AA/Aa or higher
Entry Age Actuarial Cost Method:	An actuarial cost method where the present value of the projected benefits for an individual is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit age
Healthcare Cost Trend Rates:	The rate of change in per capita health costs over time
Net OPEB Liability:	The Total OPEB Liability less the Plan Fiduciary Net Position
Plan Fiduciary Net Position:	Market Value of Assets
Real Rate of Return:	The rate of return on an investment after removing inflation
Service Cost:	The amount of contributions required to fund the benefit allocated to the current year of service.

DRAFT

Section 3: Supporting Information

Total OPEB Liability:	Present value of all future benefit payments for current retirees and active employees taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions.
Valuation Date:	The date at which the actuarial valuation is performed

DRAFT

Appendix D: Accounting Requirements

The Governmental Accounting Standards Board (GASB) issued Statement Number 74 – Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans, and Statement Number 75 – Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions. Under these statements, all state and local government entities that provide other post-employment benefits are required to report the cost of these benefits on their financial statements. The accounting standards supplement cash accounting, under which the expense for postemployment benefits is equal to benefit and administrative costs paid on behalf of retirees and their dependents (i.e., a pay-as-you-go basis).

The statements cover postemployment benefits of medical, prescription drugs, dental, vision and life insurance coverage for retirees; long-term care coverage, life insurance and death benefits that are *not* offered as part of a pension plan; and long-term disability insurance for employees. The benefits valued in this report are limited to those described in Exhibit III of Section 4, which are based on those provided under the terms of the substantive plan in effect at the time of the valuation and on the pattern of sharing costs between the employer and plan members. The projection of benefits is not limited by legal or contractual limits on funding the plan unless those limits clearly translate into benefit limits on the substantive plan being valued.

The new standards prescribe an accrual-basis accounting requirement, thereby recognizing the employer cost of postemployment benefits over an employee's career. The standards also prescribe a consistent accounting requirement for both pension and non-pension benefits.

The total cost of providing postemployment benefits is projected, taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions. These assumptions are summarized in Exhibit II of Section 4. This amount is then discounted to determine the Total OPEB Liability. The Net OPEB Liability (NOL) is the difference between the Total OPEB Liability and market value of assets in the Plan, called the Plan Fiduciary Net Position.

Once the NOL is determined, the Annual OPEB Expense is determined as the change in NOL from the prior year with deferred recognition of certain elements. In addition, Required Supplementary Information (RSI) must be reported, including historical information about the Net OPEB Liability and the contributions made to the Plan. Appendices C and E of Section 4 contain a definition of terms as well as more information about GASB 74/75 concepts.

The calculation of an accounting obligation does not, in and of itself, imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Employer is required to implement a funding policy to satisfy the projected expense.

Actuarial calculations reflect a long-term perspective, and the methods and assumptions use techniques designed to reduce short-term volatility in accrued liabilities and the actuarial value of assets, if any.

DRAFT

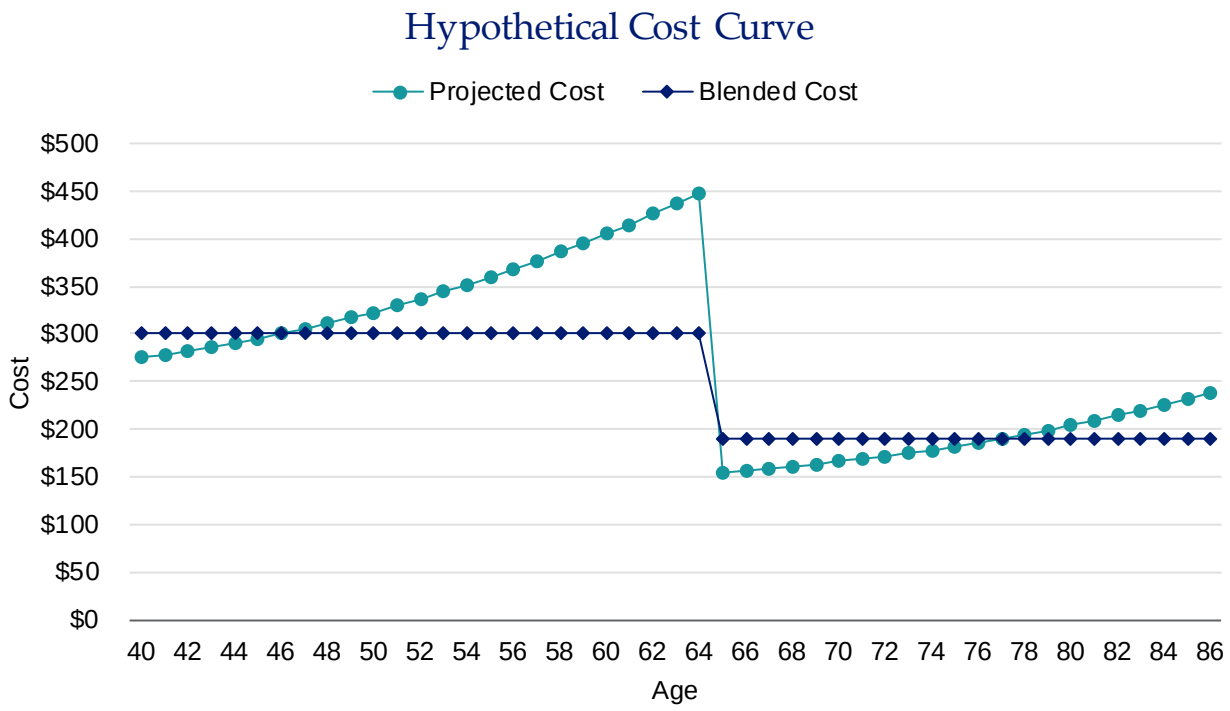
Section 3: Supporting Information

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events far into the future, and the actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

DRAFT

Appendix E: GASB 74/75 Concepts

The following graph illustrates why a significant accounting obligation may exist even though the retiree contributes most or all of the blended premium cost of the plan. The average cost for retirees is likely to exceed the average cost for the whole group, leading to an implicit subsidy for these retirees. The accounting standard requires the employer to identify and account for this implicit subsidy as well as any explicit subsidies the employer may provide.



Data Section

GASBStringBookmarks	
PlanNameLongGASB	New Mexico Retiree Healthcare Authority
PlanNameShortGASB	NMRHCA
ClientShortGASB	NMHRCA
FundOfficeContactGASB	Board of Directors
OfficeAddr1GASB	4308 Carlisle Blvd NE, Suite 104
OfficeAddr2GASB	Albuguergue, NM 87107
ActuaryNameGASB	Mary Kirby
ActuaryTitleGASB	Senior Vice President & Consulting Actuary
ActuaryCredentialsGASB	FCA, FSA, MAAA
ActuaryNameGASB2	@
ActuaryTitleGASB2	@
ActuaryCredentialsGASB2	@
AnalystGASB	JAC
ReviewerGASB	VZP
ConsultantNameGASB	Melissa A. Krumholz
ConsultantTitleGASB	Senior Health Consultant & Actuary
SegalOfficeGASB	San Francisco
ValDateGASB	"6/30/2021"
ValDateGASB1	"6/30/2019"
ReportDate75Next	"6/30/2023"
ReportDate75	"6/30/2022"
ReportDate751	"6/30/2021"
ReportDate752	"6/30/2020"
ReportDate753	"6/30/2019"
MeasureDate	"6/30/2021"
MeasureDate1	"6/30/2020"
MeasureDate2	"6/30/2019"
MeasureDate3	"6/30/2018"
MeasureDateBeg	"7/1/2021"
MeasureDate1Beg	"7/1/2020"
MeasureDate2Beg	"7/1/2019"
SegalAddr1	180 Howard Street, Suite 1100
SegalAddr2	San Francisco, CA 94105-6147
SegalPhone	415.263.8200
SegalFax	415.376.1167
AllocationBasis	Payroll
AllocationBasis1	Payroll

IntDisc	3.62%	“#.00%”
IntDisc1	2.86%	“#.00%”
InflRate	2.50%	“#.00%”
SalRate	4.50%	“#.00%”

DRAFT

RORRate751	3.00%	“#.00%”
ColaRate	7.25%	“#.00%”
FYrsGASB	5.98	“##.#0”

NOL	$3,290,364,322	“#,###”
NOL1	$4,198,908,018	“#,###”
Diff_NOL	-$908,543,696	“#,###”
GL_NOL_EXP	-$97,202,970	“#,###”
GL_NOL_CA	-$893,385,159	“#,###”
GL_NOL_CP	- -	“#,###”
Ratio	0.2539	“#.00%”
OPEBexp	-$504,413,723	“#,###”
OPEBexp1	-$195,226,619	“#,###”

Proportionate Share Sections Deleted? False

Results of last import: Last Import reported ERRORS!
Type of import: Import All!
Spreadsheet imported from: J:\NMRHCA.CLI\Val2021\Report For GAS 74\GASB7475.xlsm
Date and time of import: 10/25/2021 4:00:27 PM

DRAFT

New Mexico Retiree Health Care Authority
Fiscal Year 2022 First Quarter Budget Review

Healthcare Benefits Fund

Between July 1, 2021 and September 30, 2021, the Healthcare Benefits Administration Program expended $85.8 million and collected $95.9 million in revenue. The resulting $10.1 million surplus is greater than the $10.2 million surplus for the same period in FY21.

First Quarter FY22 expenditures are $4.5 million greater than expenditures in First Quarter FY21, for a growth of 5.6%. Current projections indicate a $50 million surplus at the end of FY22.

Major Upward Cost Pressures:

1. Overall plan participation (medical and voluntary coverages) grew by 1.5% between October 2020 and October 2021, adding 960 members, compared to a 0.6% growth rate during the previous fiscal year when the plan only added 381.

2. Claim costs typically increase during the Third Quarter and Fourth Quarter of the plan year (calendar year) because members begin meeting their annual deductible and reaching maximum out-of-pocket expenses.

Major Downward Cost Pressures:

1. Pre-Medicare Plan Participation
    - Premier Plans: -224 members (-2.0%) / -756 members (FY21)
    - Value Plans: +115 members (3.2%) / -28 members (FY21)
    - Net: -109 members (-0.7%) / -784 members (FY21)

2. Medicare Plan Participation
    - Medicare Supplement: -655 members (-2.9%) / -396 members (FY21)
    - BCBS MA Plans: +25 members (0.7%) / -61 members (FY21)
    - Humana MA Plans: +160 members (13.5%) / +271 members (FY21)
    - Presbyterian MA Plans: +287 members (3.4%) / +446 members (FY21)
    - *UnitedHealthcare MA Plans: +682 members (16.5%) / +147 members (FY21)

3. A 6.6% decline in dependent child participation in medical plans from 1,724 in October 2020 to 1,611 in October 2021.

*Default Plans --- All Pre-Medicare Plan Participants to UnitedHealthcare effective January 1, 2021.

Additional Analysis:

A major trend in First Quarter FY22 costs is continuing growth in prescription drug expenses, which was partially offset by reductions in the number of self-insured plan participants (Pre-Medicare and Medicare Supplement) and an increase in

the number of Medicare Advantage Plan participants (1,154 in total) who have elected to participate in less costly capitated arrangements.

Some New Mexico health care providers are enacting Crisis Standards of Care (CSC) in response to new COVID-19 cases and staffing issues. While it the scope and duration of CSC implementation is unclear, claim costs may become more volatile and uncertain in the immediate future. Certain health care costs may decrease as hospitals and facilities suspend non-medically necessary procedures, but most, if not all, the cost savings will likely go towards capacity building investments. NMRHCA anticipates that facilities may take steps to increase bed availability, create alternative sites for care, transfer patients to other facilities, hire traveling nurses, and provide financial incentives for staff members to work additional shifts in the short-term, depending on how events develop.

Sufficient budget authority exists within each category of Program Support to fund agency operations through the remainder of FY22.

Below is an annual summary of the cash contributions made to the State Investment Council (SIC) between fiscal years 2011 – 2021, as well as monthly contribution(s) made in FY22:

FY11 Total	$	21,879,651
FY12 Total	$	21,060,000
FY13 Total	$	15,315,000
FY14 Total	$	57,500,000
FY15 Total	$	42,500,000
FY16 Total	$	35,000,000
FY17 Total	$	33,000,000
FY18 Total	$	20,000,000
FY19 Total	$	45,000,000
FY20 Total	$	56,000,000
FY21 Total	$	75,000,000
Transfer Effective		Amount Transferred
November 1, 2021	$	30,000,000
	$	-
FY22 Total	$	30,000,000
Total Transfers	**$**	**452,254,651**

New Mexico Retiree Health Care Authority
1st Quarter Healthcare Benefit Fund Detail
Fiscal Year 2022
(in thousands)

	FY22 Q1 Actuals	FY21 Q1 Actuals	FY22 - FY21 Difference
REVENUE:			
Employer/Employee Contributions	$ 37,862.9	$ 34,982.2	$ 2,880.7
Retiree Contributions	$ 43,338.8	$ 44,978.5	$ (1,639.7)
Taxation and Revenue Suspense Fund	$ 9,222.0	$ 5,489.3	$ 3,732.7
Other Miscellaneous Revenue	$ 5,504.5	$ 6,080.6	$ (576.1)
Interest Income	$ 62.3	$ 63.5	$ (1.2)
Refunds	$ (65.9)	$ (63.7)	$ (2.2)
TOTAL REVENUE:	**$ 95,924.6**	**$ 91,530.4**	**$ 4,394.2**
EXPENDITURES:			
Prescriptions			
Express Scripts	$ 30,240.5	$ 23,615.5	$ 6,625.0
Total Prescriptions	$ 30,240.5	$ 23,615.5	$ 6,625.0
Non-Medicare			
Blue Cross Blue Shield	$ 15,764.3	$ 15,052.0	$ 712.3
BCBS Administrative Costs	$ 485.8	$ 492.4	$ (6.6)
Presbyterian	$ 10,270.5	$ 11,484.2	$ (1,213.7)
Presbyterian Administrative Costs	$ 549.8	$ 554.1	$ (4.3)
PCORI Fee	$ 39.1	$ 35.9	$ 3.2
Total Non-Medicare	$ 27,109.5	$ 27,618.6	$ (509.1)
Medicare			
Blue Cross Blue Shield	$ 10,468.9	$ 8,787.4	$ 1,681.5
BCBS Administrative Costs	$ 1,375.8	$ 1,420.6	$ (44.8)
Presbyterian MA	$ 2,818.1	$ 4,474.8	$ (1,656.7)
UnitedHealthcare MA	$ 709.4	$ 1,663.9	$ (954.5)
Humana MA	$ 186.0	$ 335.9	$ (149.9)
BCBS MA	$ 474.4	$ 1,109.1	$ (634.7)
Total Medicare	$ 16,032.6	$ 17,791.7	$ (1,759.1)
Other Benefits			
Davis Vision	$ 618.9	$ 599.3	$ 19.6
Delta Dental	$ 5,340.5	$ 5,204.5	$ 136.0
Standard Life Insurance	$ 3,186.0	$ 3,138.0	$ 48.0
Total Other Benefits	$ 9,145.4	$ 8,941.8	$ 203.6
Other Expenses			
Program Support	$ 3,280.7	$ 3,306.7	$ (26.0)
Total Other Expenses	$ 3,280.7	$ 3,306.7	$ (26.0)
TOTAL EXPENDITURES:	***$ 85,808.7***	**$ 81,274.3**	**$ 4,534.4**
Total Revenue over Total Expenditures	***$ 10,115.9***	**$ 10,256.1**	**$ (140.2)**

New Mexico Retiree Health Care Authority
FY22 1st QTR Budget Review
Comparison of Budget vs. Actual
(in thousands)

Program Support

FY22/FY21 Comparison

	FY22 Approved Q1 Budget	FY22 Actuals	FY21 Actuals	Dollar Change	Percent Change
Sources:					
Other Transfers	$ 820.2	$ 3,280.7	$ 3,306.7	$ (26.0)	-0.8%
Total Sources	**$ 820.2**	**$ 3,280.7**	**$ 3,306.7**	**$ (26.0)**	**-0.8%**
Uses:					
Personal Services and Benefits	$ 527.7	$ 484.5	$ 478.7	$ 5.8	1.2%
Contractual Services	$ 155.4	$ 146.9	$ 52.6	$ 94.3	179.3%
Other Costs	$ 137.2	$ 178.7	$ 139.7	$ 39.0	27.9%
Total Uses	**$ 820.2**	**$ 810.1**	**$ 671.0**	**$ 139.1**	**20.7%**

New Mexico Retiree Health Care Authority
FY22 1st QTR Budget Review
Comparison of Budget vs. Actual
(in thousands)

Program Support

FY22 Budget Compared to Actual

	Approved Operating Budget	FY22 Actuals	Remaining Balance	Percent Expended	FY22 Projected
Sources:					
Other Transfers	$ 3,280.7	$ 3,280.7	$ -	100%	$ 1,468.4
Total Sources	**$ 3,280.7**	**$ 3,280.7**	**$ -**	**100%**	**$ 1,468.4**
Uses:					
Personal Services and Benefits	$ 2,110.7	$ 484.5	$ 1,626.2	23%	$ 1,566.6
Contractual Services	$ 621.4	$ 146.9	$ 474.5	24%	$ 437.8
Other Costs	$ 548.6	$ 178.7	$ 369.9	33%	$ 345.4
Total Uses	**$ 3,280.7**	**$ 810.1**	**$ 2,470.6**	**25%**	**$ 2,349.8**

Program Support

Expenditure Summary (in thousands)

Acct #	Account Description	A Approved Budget	B Expended Budget	C Remaing Balance	D Projected	E Balance
200	Personal Services/ Employee Benefits	2,110.7	484.5	1,626.2	1,566.6	59.6
300	Contractual Services	621.4	146.9	474.5	437.8	36.7
400	Other Costs	548.6	178.7	369.9	345.4	24.5
	TOTAL	**3,280.7**	**810.1**	**2,470.6**	**2,349.8**	**120.8**

Expenditure Detail (in thousands)

Personal Services / Employee Benefits

Acct #	Account Description	Approved Budget	Expended Budget	Remaining Balance	Projected	Balance
520100	Exempt Positions	285.9	76.9	209.0	297.0	(88.0)
520300	Classified Perm. Positions	1,215.6	263.3	952.3	823.1	129.2
520800	Annual, Sick & Comp Paid	0.0	5.7	(5.7)	0.0	(5.7)
521100	Group Insurance Premium	202.2	40.9	161.3	147.2	14.1
521200	Retirement Contributions	258.8	61.8	197.0	185.0	12.0
521300	FICA	114.2	25.3	88.9	82.1	6.8
521400	Workers Comp	0.2	0.1	0.1	0.1	0.0
521410	GSD Work Comp Ins	1.0	0.9	0.1	1.2	(1.1)
521500	Unemployment Comp	0.0	0.0	0.0	0.0	0.0
521600	Employee Liability Insurance	2.9	2.8	0.1	9.5	(9.4)
521700	Retiree Health Care	29.9	6.8	23.1	21.4	1.7
523000	COVID Related Admin Leave	0.0	0.0	0.0	0.0	0.0
	TOTAL	**2,110.7**	**484.5**	**1,626.2**	**1,566.6**	**59.6**

Contractual Services

Acct #	Account Description					
535200	Professional Services	358.9	72.9	286.0	280.0	6.0
535300	Other Services	12.5	0.0	12.5	6.5	6.0
535309	Other Services InterA	15.8	3.1	12.7	20.0	(7.3)
535400	Audit Services	84.2	41.9	42.3	42.3	0.0
535500	Attorney Services	60.0	8.2	51.8	20.0	31.8
535600	Information Technology Services	90.0	20.8	69.2	69.0	0.2
	TOTAL	**621.4**	**146.9**	**474.5**	**437.8**	**36.7**

Other Costs

Acct #	Account Description					
542100	Employee In-State Mileage & Fares	1.5	0.0	1.5	0.0	1.5
542200	Employee In-State Meals & Lodging	2.5	0.7	1.8	0.0	1.8
542300	Board & Commission - In-State	13.5	3.4	10.1	0.0	10.1
542500	Transportation-Fuel & Oil	1.0	0.1	0.9	0.0	0.9
542600	Transportation	0.1	0.0	0.1	0.0	0.1
542700	Transportation - Insurance	0.2	0.1	0.1	0.0	0.1
542800	State Transportation Pool Charges	4.5	5.5	(1.0)	0.0	(1.0)
543200	Maintenance - Furniture, Fixtures & Equipment	6.0	0.0	6.0	0.0	6.0
543300	Maintenance - Building & Structure	4.5	0.0	4.5	0.0	4.5
543400	Maintenance - Property Insurance	0.0	0.0	0.0	0.0	0.0
543830	IT HW/SW Agreements	7.5	16.6	(9.1)	0.0	(9.1)
544000	Supply Inventory IT	23.0	4.2	18.8	23.0	(4.2)
544100	Supplies - Office Supplies	8.5	0.7	7.8	9.6	(1.8)
544900	Supplies - Inventory Exempt	5.0	0.0	5.0	10.0	(5.0)
545600	Rep/Recording	0.0	0.0	0.0	0.0	0.0
545700	DoIT - ISD Services	4.2	2.9	1.3	2.8	(1.5)
545701	DoIT - HCM Fees	9.5	9.5	0.0	0.0	0.0
545900	Printing & Photo. Services	56.0	7.6	48.4	48.0	0.4
546100	Postage & Mail Services	120.0	56.8	63.2	45.0	18.2
546400	Rent of Land & Buildings	115.8	48.9	66.9	66.9	0.0
546409	Rent - Interagency	8.6	1.4	7.2	4.4	2.8
546500	Rent of Equipment	43.3	0.5	42.8	44.0	(1.2)
546600	Telecomm	21.0	19.2	1.8	5.0	(3.2)
546610	DOIT Telecomm	56.1	0.0	56.1	56.0	0.1
546700	Subscriptions & Dues	7.0	0.0	7.0	5.0	2.0
546800	Employee Training & Education	5.0	0.0	5.0	5.0	0.0
546801	Board Member Training	10.0	0.0	10.0	5.0	5.0
546900	Advertising	1.0	0.0	1.0	1.0	0.0
547900	Miscellaneous Expense	1.3	0.6	0.7	0.7	0.0
547999	Request to Pay Prior Year	0.0	0.0	0.0	0.0	0.0
548300	Information Technology Equipment	5.0	0.0	5.0	5.0	0.0
549600	Employee Out-Of-State Mileage & Fares	1.0	0.0	1.0	2.0	(1.0)
549700	Employee Out-Of-State Meals & Lodging	1.0	0.0	1.0	2.0	(1.0)
549800	B&C-Out-Of-State Mileage & Fares	3.5	0.0	3.5	3.5	0.0
549900	B&C- Out-Of-State Meals & Lodging	1.5	0.0	1.5	1.5	0.0
	TOTAL	**548.6**	**178.7**	**369.9**	**345.4**	**24.5**

NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

Investments & Pensions Oversight Committee

Representative Patricia Roybal Caballero, Chair
Senator Roberto "Bobby" J. Gonzales, Vice Chair

Final Update
November 12, 2021

Doug Crandall, President
Therese Saunders, Vice President
LeAnne Larrañaga-Ruffy, Secretary
David Archuleta, Executive Director

Current Agency Operations

- **Two Office Locations**

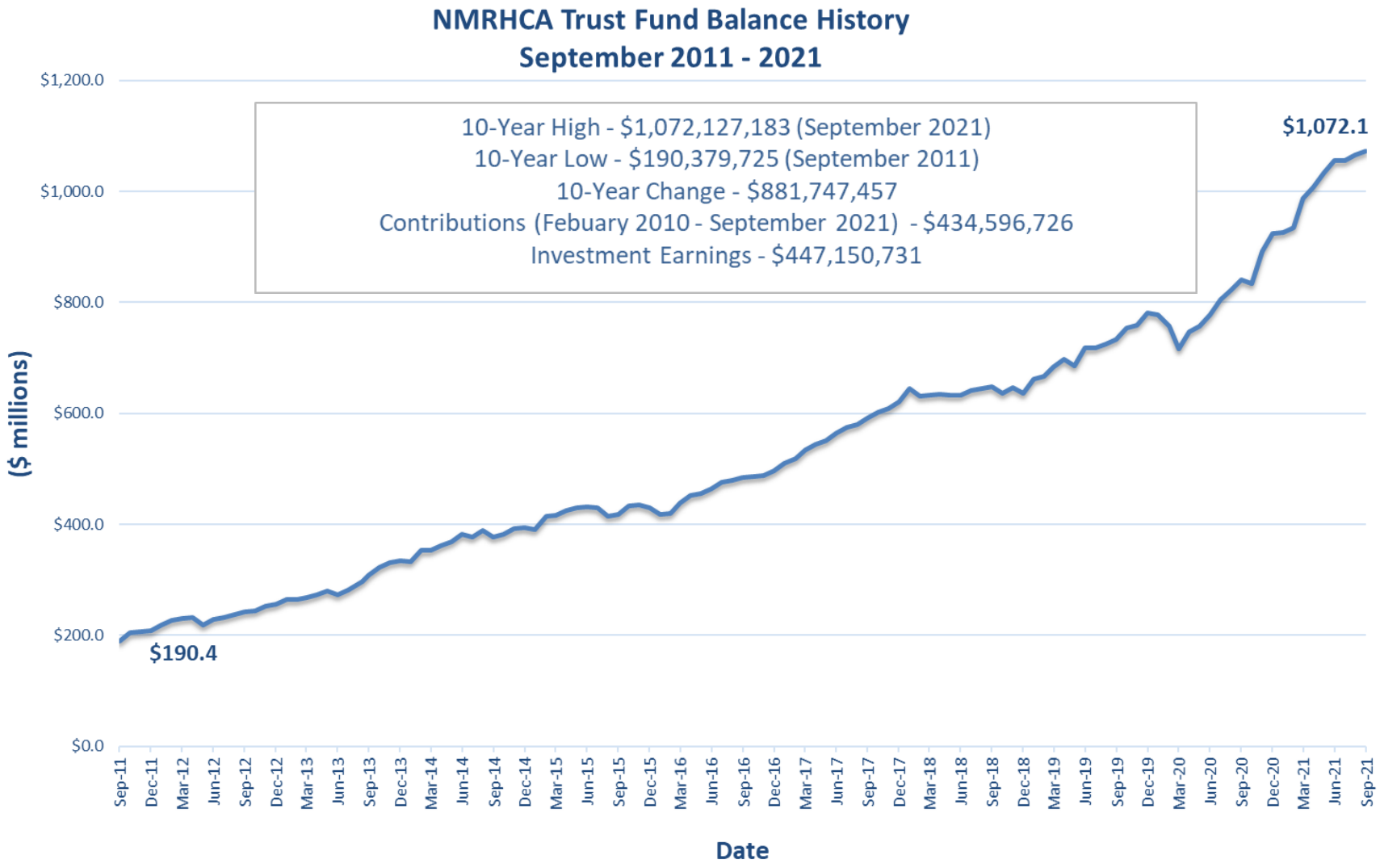
  6300 Jefferson Street NE, Suite 150
  Albuquerque, NM 87109

  33 Plaza La Prensa
  Santa Fe, NM 87505

- **COVID-19 Update**
  - Employees working in-office and remote
  - Currently making appointments for in-person meetings with customers
  - Monthly Board and Committee meetings held via GoToMeeting

- **Current Priorities**
  - Pharmacy Benefit Manager RFP 2022
    - Purpose: Provide continued prescription medication coverage for participants.
    - RFP includes other public purchasers – State of New Mexico, Public Schools Insurance Authority, Albuquerque Public Schools and the University of New Mexico.
  - Generic Drug Litigation
    - Purpose: Attempt to recoup funds from alleged price fixing in the generic drug industry.
    - Currently developing RFP and draft contract.
  - Develop Web Portal
    - Purpose: Improve customer service and automate some manual processes.
    - Allows members to access their account, billing information, and enable direct communications.

Investments



Investment Performance

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

As of June 30, 2021

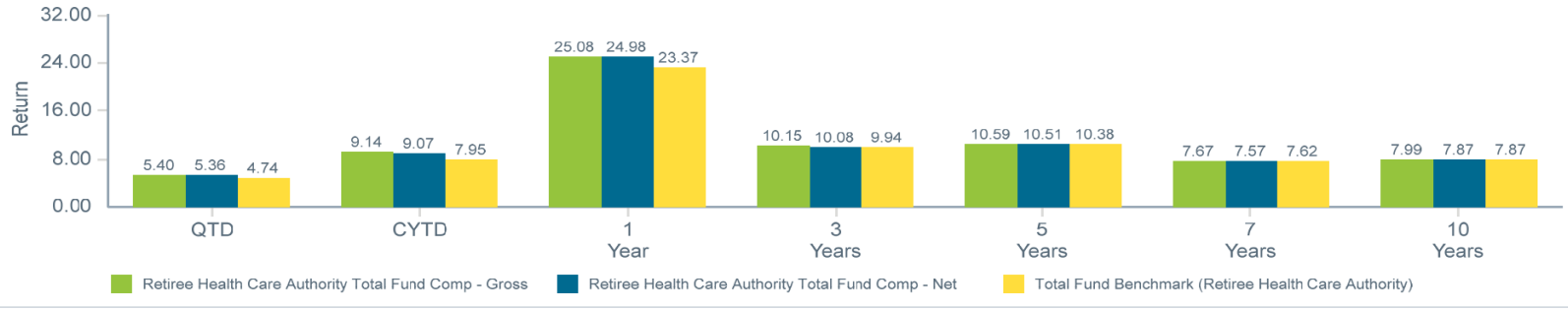
Overview

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

Asset Allocation vs. Target Allocation

	Market Value ($)	Allocation (%)	Target (%)	Difference (%)
Large Cap US Equity Index	176,755,158	16.74	14.00	2.74
Small/Mid Cap US Equity Index	25,118,981	2.38	2.00	0.38
Non-US Developed Markets Index	146,223,309	13.84	14.00	-0.16
Non-US Emerging Markets Active	111,487,412	10.56	10.00	0.56
US Core Bonds	190,451,533	18.03	20.00	-1.97
Credit & Structured Finance	142,946,052	13.53	15.00	-1.47
Private Equity	129,949,548	12.30	10.00	2.30
Real Estate	91,249,224	8.64	10.00	-1.36
Real Return	42,002,682	3.98	5.00	-1.02
Total Fund	1,056,183,900	100.00	100.00	0.00

Comparative Performance



Comparative Performance

	QTD	CYTD	1 Year	3 Years	5 Years	7 Years	10 Years	2020	2019	2018
Retiree Health Care Authority Total Fund Comp - Gross	**5.40**	**9.14**	**25.08**	**10.15**	**10.59**	**7.67**	**7.99**	**9.88**	**13.27**	**-1.24**
Total Fund Benchmark (Retiree Health Care Authority)	*4.74*	*7.95*	*23.37*	*9.94*	*10.38*	*7.62*	*7.87*	*10.21*	*14.34*	*-1.86*
Difference	0.66	1.19	1.71	0.21	0.21	0.05	0.12	-0.33	-1.07	0.62
Retiree Health Care Authority Total Fund Comp - Net	**5.36**	**9.07**	**24.98**	**10.08**	**10.51**	**7.57**	**7.87**	**9.83**	**13.21**	**-1.32**
Total Fund Benchmark (Retiree Health Care Authority)	*4.74*	*7.95*	*23.37*	*9.94*	*10.38*	*7.62*	*7.87*	*10.21*	*14.34*	*-1.86*
Difference	0.62	1.12	1.61	0.14	0.13	-0.05	0.00	-0.38	-1.13	0.54

Schedule of Investable Assets

Periods Ending	Beginning Market Value ($)	Net Cash Flow ($)	Gain/Loss ($)	Ending Market Value ($)	% Return
CYTD	**924,474,338**	**45,000,000**	**86,709,561**	**1,056,183,900**	**9.07**

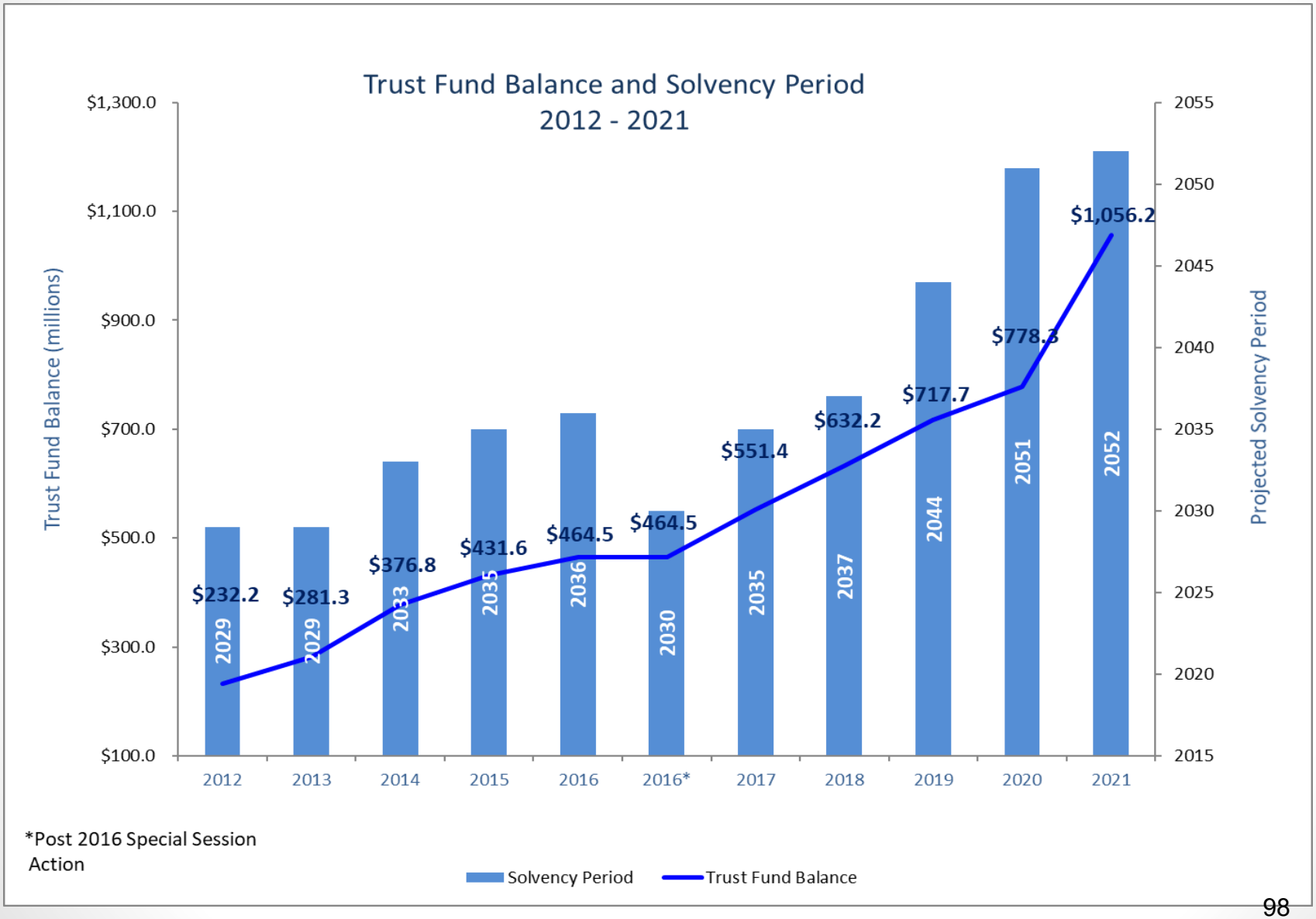
Allocations shown may not sum up to 100% exactly due to rounding. Performance shown is net of fees, except where noted otherwise. Performance includes receipt of additional units of the US Large Cap Index Pool effective July 1, 2020.

Solvency Study

Strategic Planning Tool

- **Projected Revenues**
  - Employee and Employer Contributions (Set by Statute).
  - Retiree Medical Premiums (Set by Board of Directors).
  - Retiree Ancillary Premiums (Not Subsidized/Pass-Through).
  - Tax Suspense Fund (Set by Statute).
  - Miscellaneous (Medicare Subsidies, Drug Rebates, Performance Guarantees) (Varies).
- **Projected Expenses**
  - Medical and Prescription.
  - Retiree Ancillary Premiums.
  - Administrative Fees.
  - Agency Operating Expenses.
- **Major Assumptions**
  - Payroll Growth: 2.75%
  - Discount Rate: 7.00%
  - Medical Trend: 8% pre-Medicare / 6% Medicare
  - Plan Selection: Migration to Lower Costing Plans.
  - Plan Design Changes: Increased Copays, Coinsurance and Deductibles.
  - Plan Rates: Continue to Grow in Accordance With Medical Trend.

Solvency Update



GASB Updates

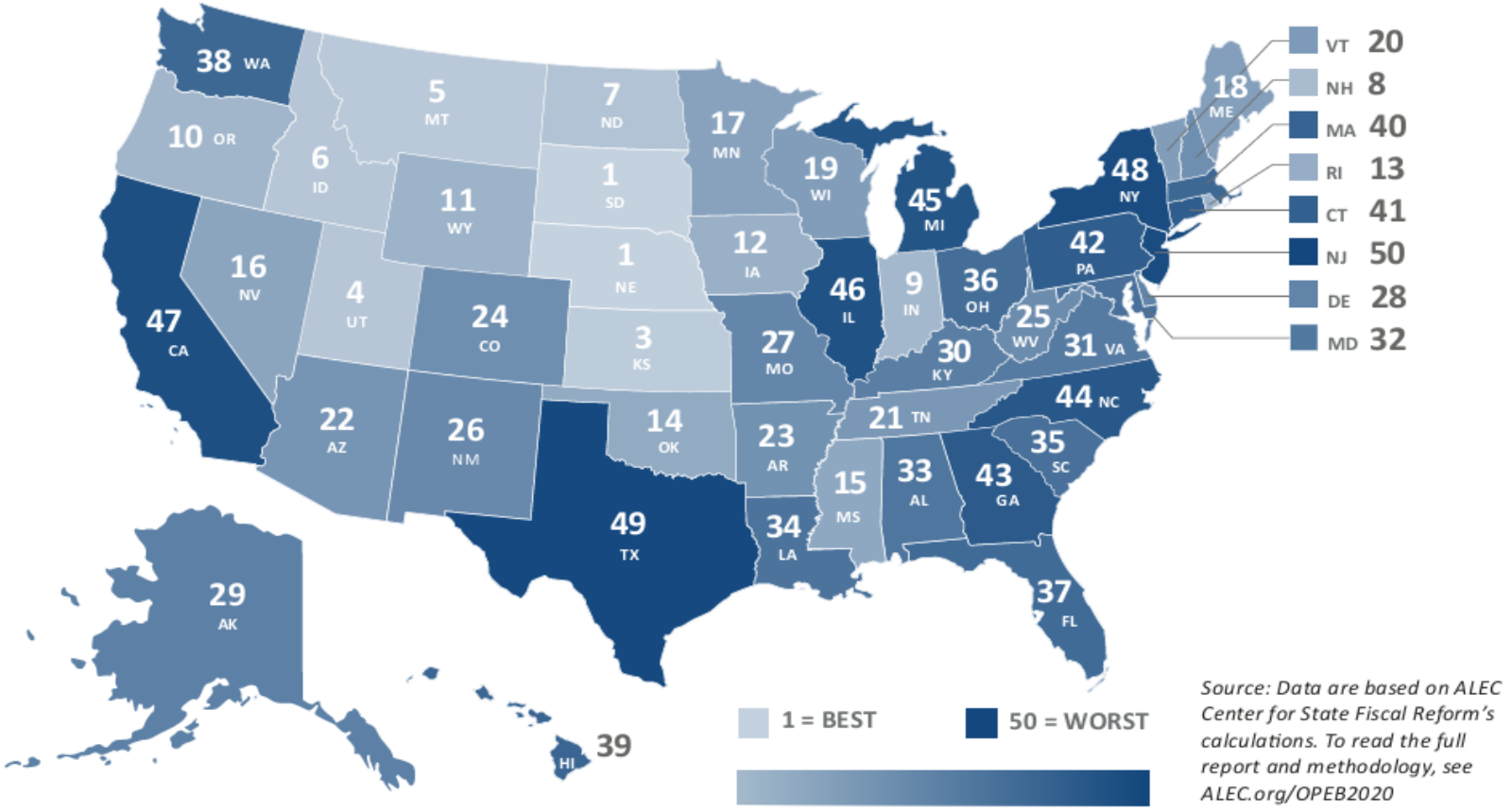
- GASB 74 – Actuarial Valuation Review of Other Postemployment Benefits (OPEB) as of June 31, 2021*
  - Pending Final Review
  - Total OPEB Liability: $4,409,849, 335 (2021) / $5,028,579,923 (2020) / $3,999,137,737 (2019)
  - Net OPEB Liabilities (NOL) decreased $618.7 million (driven by increased to the Fiduciary Net Position)
    - 3.26% in (2021) / 2.86% in (2020) / 4.16% in (2019)
    - Applicable discount rate = blend of assumed investment return on plan assets – 7.0% and the rate for 20-year, tax-exempt general obligation municipal bonds w/an average rate of AA/Aa or higher (e.g. 2.16% as of June 30, 2020 compared to 2.21 % as of June 30, 2020)
  - NOL: $3,290,349,790 (2021) / $4,198,908,018 (2020) / $3,242,388,746 (2019)
  - Funded Status: 25.39% (2021) / 16.50% (2020) / 18.92% (2019)
  - Plan Fiduciary Net Position: $1,119,499,545 (2021) / $829,671,908 (2020) / $756,748,991 (2019)
  - The Coronavirus (COVID-19) pandemic is rapidly evolving and may have a significant financial impact on future expenditures. The report does not attempt to measure the following:
    - Direct or indirect effects of COVID-19 on short-term health plan costs
    - Short-term or long-term impacts on mortality of the covered population
    - The potential for federal or state fiscal relief

*Pending Final Review

Other Postemployment Benefits Continued

FIGURE 1 TABLE 1
Total Unfunded OPEB Liabilities

This metric shows the total OPEB liabilities in each state. It is important to note that Nebraska and South Dakota implemented defined-contribution healthcare benefits, eliminating unfunded liabilities in these states.



Source: [2020-OPEB-FINAL.pdf (alec.org)]

Special Appropriation Requests

SB315 Public Safety Offer Retirement – Laws 2021, Chapter 36

- The law amended the definition of "state police member" to include officers who were previously excluded from coverage under State Police, Adult Correctional Officer and Probation and Parole Officer Plan 1. Officers excluded formerly assigned to the motor transportation division certified and commissioned prior to June 30, 2015.
- The law effectively increased the number of employees who are eligible to participate under an enhanced benefit plan and, as such, are not subject to NMRHCA's minimum age and increased years-of-service requirements to receive the maximum subsidy provided to retirees.
- Section 10-7C-15 Retiree Health Care Fund Contributions States the following:
  - C. On or after July 1, 2009, no person who has obtained service credit pursuant to Subsection B of Section 10-11-6 NMSA 1978, Section 10-11-7 NMSA 1978 or Paragraph (3) or (4) of Subsection A of Section 22-11-34 NMSA 1978 may enroll with the authority unless the person makes a contribution to the fund equal to the full actuarial present value of the amount of the increase in the person's health care benefit, as determined by the authority.
  - The full actuarial present value of this amount was estimated at $340,000 and the Special Appropriation directed to the Department of Public Safety totaled $194,700
  - **NMRHCA respectfully requests the difference, $145,300, be directly appropriated to NMRHCA**

Special Appropriation Requests Cont.

SB317 No Behavioral Health Cost Sharing – Laws 2021, Chapter 136

- The law requires NMRHCA to eliminate cost sharing (copays, deductibles and coinsurance) for mental and behavioral health services beginning January 2022 – December 2026. This requirement is projected to increase costs to NMRHCA as follows:

	2022	2023	2024	2025	2026	Total
Elimination of cost share on medical	$ 762,932.77	$ 793,450.08	$ 825,188.08	$ 858,195.61	$ 892,523.43	$ 4,132,289.97
Elimination of cost share on prescription drugs	$1,247,501.83	$1,334,826.96	$1,428,264.85	$1,528,243.38	$1,635,220.42	$ 7,174,057.44
Increased utilization on medical	$ 634,785.95	$ 660,177.39	$ 686,584.48	$ 714,047.86	$ 742,609.78	$ 3,438,205.46
Increased utilization on prescription drugs	$ 54,802.37	$ 58,638.54	$ 62,743.23	$ 67,135.26	$ 71,834.73	$ 315,154.13
Total	**$2,700,022.92**	**$2,847,092.97**	**$3,002,780.64**	**$3,167,622.11**	**$3,342,188.36**	**$15,059,707.00**

- This estimate was developed by NMRHCA's consulting actuaries based on the Health Insurance Experiment (HIE) which analyzes how cost sharing effects behavior and how people use health care as a function of how rich their benefits are.
- **NMRHCA respectfully requests a Special Appropriation totaling $15 million to offset the impact to the Trust Fund and or increases to retiree monthly charges.**

Special Appropriation Requests Cont.

- COVID-19 Testing and Treatment
- Between March 2020 and September 2021 the cost associated with the testing and treatment of COVID-19 for members participating in one of NMRHCA's self-insured plans has exceeded $9.2 million
- Costs are broken down by plan as follows:

Plan	Distinct Patients	Plan Paid
BCBS - PreMed	3,427	4,270,130.91
PHS - PreMed	2,988	3,419,228.45
Medicare Supplement	5,228	1,548,506.77
		9,237,866.13

- This request is being made to offset future increases and mitigate the impact to NMRHCA Trust Fund Balances.
- **NMRHCA respectfully requests a Special Appropriation totaling $9.2 million to offset the impact to the Trust Fund and or increases to retiree monthly charges.**

New Mexico Retiree Health Care Authority

David Archuleta, Executive Director

505-222-6416

david.archuleta@state.nm.us

NMRHCA Office: 800-233-2576 / 505-222-6400

8:00AM – 5:00PM (Monday - Friday)

www.nmrhca.org or www.facebook/nmrhca

Offices Remain Closed Except by Appointment

AN ACT

RELATING TO RETIREE HEALTH CARE; INCREASING EMPLOYEE AND EMPLOYER CONTRIBUTION RATES TO THE RETIREE HEALTH CARE FUND.

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

SECTION 1. Section 10-7C-15 NMSA 1978 (being Laws 1990, Chapter 6, Section 15, as amended by Laws 2009, Chapter 287, Section 2 and by Laws 2009, Chapter 288, Section 3) is amended to read:

"10-7C-15. RETIREE HEALTH CARE FUND CONTRIBUTIONS.--

A. Following completion of the preliminary contribution period, each participating employer shall make contributions to the fund pursuant to the following provisions:

(1) for participating employees who are not members of an enhanced retirement plan, the employer's contribution shall equal two and thirty-three hundredths percent of each participating employee's salary;

(2) for participating employees who are members of an enhanced retirement plan, the employer's contribution shall equal two and ninety-three hundredths percent of each participating employee's salary; and

(3) each employer that chooses to become a participating employer after January 1, 1998 shall make contributions to the fund in the amount determined to be

appropriate by the board.

B. Following completion of the preliminary contribution period, each participating employee, as a condition of employment, shall contribute to the fund pursuant to the following provisions:

(1) for a participating employee who is not a member of an enhanced retirement plan, the employee's contribution shall equal one and seventeen-hundredths percent of the employee's salary;

(2) for a participating employee who is a member of an enhanced retirement plan, the employee's contribution shall equal one and forty-seven hundredths percent of the employee's salary; and

(3) as a condition of employment, each participating employee of an employer that chooses to become a participating employer after January 1, 1998 shall contribute to the fund an amount that is determined to be appropriate by the board. Each month, participating employers shall deduct the contribution from the participating employee's salary and shall remit it to the board as provided by any procedures that the board may require.

C. No person who has obtained service credit pursuant to Subsection B of Section 10-11-6 NMSA 1978, Section 10-11-7 NMSA 1978 or Paragraph (3) or (4) of

Subsection A of Section 22-11-34 NMSA 1978 may enroll with the authority unless the person makes a contribution to the fund equal to the full actuarial present value of the amount of the increase in the person's health care benefit, as determined by the authority.

D. Except for contributions made pursuant to Subsection C of this section, a participating employer that fails to remit before the tenth day after the last day of the month all employer and employee deposits required by the Retiree Health Care Act to be remitted by the employer for the month shall pay to the fund, in addition to the deposits, interest on the unpaid amounts at the rate of six percent per year compounded monthly.

E. Except for contributions made pursuant to Subsection C of this section, the employer and employee contributions shall be paid in monthly installments based on the percent of payroll certified by the employer.

F. Except in the case of erroneously made contributions or as may be otherwise provided in Subsection D of Section 10-7C-9 NMSA 1978, contributions from participating employers and participating employees shall become the property of the fund on receipt by the board and shall not be refunded under any circumstances, including termination of employment or termination of the participating employer's operation or participation in the Retiree Health

Care Act.

G. Notwithstanding any other provision in the Retiree Health Care Act and at the first session of the legislature following July 1, 2013, the legislature shall review and adjust the distributions pursuant to Section 7-1-6.30 NMSA 1978 and the employer and employee contributions to the authority in order to ensure the actuarial soundness of the benefits provided under the Retiree Health Care Act.

H. As used in this section, "member of an enhanced retirement plan" means:

(1) a member of the public employees retirement association who, pursuant to the Public Employees Retirement Act, is included in:

(a) state police member and adult correctional officer member coverage plan 1;

(b) municipal police member coverage plan 3, 4 or 5;

(c) municipal fire member coverage plan 3, 4 or 5; or

(d) municipal detention officer member coverage plan 1; or

(2) a member pursuant to the provisions of the Judicial Retirement Act."

SECTION 2. EFFECTIVE DATE.--The effective date of the

provisions of this act is July 1, 2020.

Notice of Proposed Rule Making (Action Item)

Background

The Retiree Health Care Act states that, with the exception of "erroneous payments" and legacy payments before 1991, all payments collected become the property of the New Mexico Retiree Health Care Board and are not subject to refund under any circumstances. However, the term "erroneous payments" is not defined by the Retiree Health Care Act or by regulation and there is no formal procedure for requesting or administering refunds.

NMRHCA staff seek to codify the definition of "erroneous payments" through a NMAC rule and create a procedure for administering certain refunds for those erroneous payments to mitigate the distinction between individuals enrolled in self-insured plans and individuals enrolled in fully-insured plans.

If an individual who is enrolled in a self-insured plan made inadvertent overpayments, NMRHCA can refund the entire amount of the overpayment, less a small administrative fee charged by the carrier. However, if that same individual were enrolled in a fully-insured plan, NMRHCA could only recoup 90 days of payments from the carrier and can therefore only refund 90 days of overpayments to the member.

NMRHCA staff anticipates promulgating a rule that payments older than 90 days are presumed not to be erroneous payments, define a procedure for members to recoup those funds, and provide a mechanism for appealing that decision. This would establish a 90-day limit on refunds for both the self-insured plans and fully-insured plans with the option to request a review of the circumstances surrounding any particular case.

Requested Action

NMRHCA staff respectfully request authority to begin the rulemaking process to codify and formalize the process of administering refunds to members.