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REGULAR MEETING
OF THE
BOARD OF DIRECTORS

February 1, 2022
9:00 AM

Online: https://global.gotomeeting.com/join/582742069
Telephone: 1-312-757-3121/ Access Code: 582-742-069

New Mexico Retiree Health Care Authority
Regular Meeting

BOARD OF DIRECTORS

ROLL CALL

February 1, 2022

	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

FEBRUARY 2022

Mr. Greg Trujillo
Executive Director
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33 Plaza La Prensa
Santa Fe, NM 87507
greg.trujillo@state.nm.us
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Governor's Appointee
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Mr. Tomas E. Salazar, PhD
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Mr. Lance Pyle
NM Association of Counties
Curry County Administration
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lpyle@currycounty.org
575-763-3656

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

The Honorable Mr. Tim Eichenberg
NM State Treasurer
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Ms. Therese Saunders, Vice President
NEA-NM, Classroom Teachers Assoc., & NM Federation of Educational Employees
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tsaunders3@mac.com
505-934-3058

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Ms. Leane Madrid
Classified State Employee
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Ms. Leanne Larranaga-Ruffy, Secretary
Alternate for PERA Executive Director
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Regular Meeting of the
NEW MEXICO RETIREE HEALTH CARE AUTHORITY
BOARD OF DIRECTORS

February 1, 2022
9:00 AM

Online: https://global.gotomeeting.com/join/582742069
Telephone: 1-312-757-3121 / Access Code: 582-742-069

AGENDA

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1.	Call to Order	Mr. Crandall, President	
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder	
3.	Pledge of Allegiance	Mr. Crandall, President	
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5.	Approval of Regular Meeting Minutes January 4, 2022	Mr. Crandall, President	5
6.	Public Forum and Introductions	Mr. Crandall, President	
7.	Committee Reports	Mr. Crandall, President	
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13.	Other Business	Mr. Crandall, President	
14.	Executive Session Pursuant to NMSA 1978, Section 10-15-1(H)(6) Contents of Competitive Sealed Proposals Solicited Pursuant to the Procurement Code	Mr. Crandall, President	
15.	Pharmacy Benefit Manager RFP (Action Item)	Mr. Kueffer, Interim Executive Director	
16.	Date & Location of Next Board Meeting March 1, 2022 - 9:00 AM TBD	Mr. Crandall, President	
17.	Adjourn		

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

VIA TELECONFERENCE

January 4, 2022

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 9:00 a.m. via teleconference.

2. ROLL CALL TO ASCERTAIN A QUORUM

A quorum was present.

Members Present:
Mr. Doug Crandall, President
Ms. Therese Saunders, Vice President
Ms. LeAnne Larrañaga-Ruffy, Secretary
The Hon. Tim Eichenberg, NM State Treasurer
Mr. Sanjay Bhakta
Mr. Loren Cushman [joined at 10:00 a.m.]
Ms. Leane Madrid
Mr. Lance Pyle
Dr. Tomas Salazar
Mr. Rick Scroggins

Members Excused:
Mr. Terry Linton

Staff Present:
Mr. Dave Archuleta, Executive Director
Mr. Neil Kueffer, Deputy Director [appointed as Interim Executive Director during meeting]
Ms. Sheri Ayanniyi, Chief Financial Officer
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. Archuleta led the pledge.

4. APPROVAL OF AGENDA

Chairman Crandall asked that Item 14 (Appointment of Interim Executive Director) be moved up to follow Item 7 (Committee Reports).

Chairman Crandall moved approval of the agenda, as published. Ms. Saunders seconded the motion, which passed unanimously by roll call vote.

5. <u>APPROVAL OF REGULAR ANNUAL MEETING MINUTES</u>: December 7, 2021

Mr. Scroggins moved approval of the December 7 meeting minutes, as submitted. Ms. Saunders seconded the motion, which passed unanimously by roll call vote.

6. <u>PUBLIC FORUM AND INTRODUCTIONS</u>

None.

7. <u>COMMITTEE REPORTS</u>

- Chairman Crandall reported that the Executive Committee met to discuss today's agenda.
- Chairman Crandall reported that the Finance and Investment Committee met to discuss related items on today's agenda.
- Dr. Salazar said the Legislative Committee met to discuss the 2022 legislative proposal (Item 10).

14. <u>APPOINTMENT OF INTERIM EXECUTIVE DIRECTOR</u>

Chairman Crandall noted that Neil Kueffer is the Deputy Director, and so the Executive Committee felt it would not be necessary at this point to hold an executive session to determine who would be the Interim Executive Director or Acting Executive Director until such time as the board hires someone.

There was no objection to the Executive Committee's recommendation.

Ms. Larrañaga-Ruffy moved that Neil Kueffer be appointed as Interim Executive Director at the conclusion of this meeting. Ms. Saunders seconded the motion, which passed unanimously by roll call vote.

8. <u>EXECUTIVE DIRECTOR'S UPDATES</u>

a. <u>Human Resources</u>

- Mr. Archuleta, Mr. Kueffer, and board members congratulated and thanked Tomas Rodriguez, who would be retiring at the end of January, for his more than 15 years of service to the NMRHCA.

- Mr. Archuleta provided other HR updates.

b. <u>Operations</u>

- In cooperation with the other IBAC entities, the NMRHCA finalized the list of drugs to be covered at zero dollar cost sharing starting January 1. Express Scripts is also working on developing a report that the NMRHCA uses to perform an ongoing reconciliation for those members who are taking drugs on the list for purposes other than behavioral or mental health resources.

c. <u>Legislative</u>

- NMRHCA is required to make a presentation before the House Appropriations and Finance Committee next Thursday at 1:30 p.m. This will be the opportunity for Mr. Kueffer to advocate for the higher of the two recommendations between the Executive and the Legislative. The NMRHCA will know more in the next day or so what the recommendations are and whether there was any support from either side for those special appropriations.

- On January 24, the NMRHCA will make a presentation before the Senate Finance Committee. The presentation will be focused on GASB, solvency and strategies to help contain costs moving forward.

d. <u>Fall Switch/Open Enrollment Results</u>

- Based on a January 2022 report on switch enrollments and new and canceled members, the United Healthcare MA Plan 1 seemed to fare the best, with 116 new additions. United Healthcare MA Plans 1 and II led the pack in terms of switches. The Medicare Supplement plan continues to shrink with a net loss of 140 members.

- Every year, the NMRHCA sends out 55,000 packets to the members, and the hope is that this number will be substantially reduced when the web portal is up and running.

e. <u>Winter Newsletter</u>

- Mr. Archuleta reviewed the Winter Newsletter, which has been updated with a new format, and commended Jess Biggs on doing a great job.

Ms. Saunders commented that many of the older retirees, including her, like receiving their newsletter in the mail rather than reading it digitally. She said she appreciated the Helpful Tip section, about the increase in the number of members who sign up for a Medicare Advantage Plan outside of the NMRHCA, only to find they have been dis-enrolled from the NMRHCA plan. She said the large amount of mail older people receive about medical plans, etc., can be overwhelming and confusing, and people need to have something concrete in their hands with information like that in the newsletter, and she will be advocating for that.

f. <u>PBM RFP</u>

- NMRHCA staff is in the process of evaluating the proposals that were received. Mr. Archuleta will help NMRHCA get through the final process, evaluation, and recommendation; however, as a potential future board member representing the NMRHCA, he will not vote on the vendor selection.

g. **FEMA Grant**

- Mr. Biggs has submitted the application for $9.2 million for the testing, treatment and vaccination of retirees on the self-insured plans. The NMRHCA has responded to various requests for information updates, and Mike Madalena has provided supplemental information and data, as well.

h. **November 30, 2021, SIC Report**

- The fund has reached the $1.1 billion mark, a new high.

i. **Investment Performance Report – September 30, 2021**

- CYTD net return was 10.72 percent, and the 1-year net return was 20.43 percent.

j. **Lopez v. NMRHCA, N.M. Ct. App. No. A-1-CA-39121**

- The NMRHCA received notice from the Rodey firm on December 22 that the Court of Appeals had issued a memorandum opinion affirming the District Court's determination that the NMRHCA did not violate Ms. Lopez's constitutional rights in terminating her coverage. Ms. Lopez has the option of either filing a motion for a rehearing by January 6, which the Rodey firm indicates is seldom filed or granted; or else filing a petition for a certiorari review from the Supreme Court of Appeals by January 21, which the Rodey firm indicates is seldom granted.

Mr. Bebeau said he will continue to check the docket, but as of today, Ms. Lopez has not exercised either option.

9. FY21 FINANCIAL AUDIT

[Moss-Adams representatives Kory Hoggan and Aaron Hamilton were not available to make this scheduled presentation.]

Mr. Archuleta reported that there were three audit findings this year:

1. Relatively low funded status level. This finding has been reported for a number of years. Even though there has been an improvement over the last couple of years, funded status is at about 25.4 percent. Moss Adams recommends that the NMRHCA work with legislators and other funding sources to develop and adopt a funding policy to position the fund for long-term financial sustainability.

Chairman Crandall asked if they take into account the NMRHCA's solvency as opposed to its OPEB liability. Mr. Archuleta responded that, while solvency is more of a strategic planning tool for the board and staff, the more important item is the GASB report, which is more conservative. Solvency assumes a 7 percent rate of return for the life of the fund, whereas theirs is a graded approach, combining both the GASB and lower end long-term municipal bond ratings.

Chairman Crandall stated that if they are annually making recommendations around the NMRHCA's low funded status, it seems like there should be some recommendation about what they feel is okay, since otherwise their recommendation feels like a throwaway.

Dr. Salazar commented that Chairman Crandall's remark was appropriate, given that the legislature does consider issues regarding unfunded liabilities with respect to the state's financial positions, which is probably above and beyond what the board is responsible for.

2. Someone independent of the preparer does not review monthly reconciliations for key accounts. The cause cited was turnover in the NMRHCA's accounting staff, including departure of the former Chief Financial Officer and Controller prior to completion of the annual financial closing process. With the recent hiring of CFO Sheri Ayanniyi, this issue can be addressed immediately.

3. Financial close and reporting process. There was not a timely accounting of the monies or investments earned in Share. This was not a significant finding, and with the recent hiring of a new CFO, this should not be an issue going forward.

10. 2022 LEGISLATIVE PROPOSAL

[Mr. Cushman joined the meeting during this discussion.]

Mr. Archuleta noted that the FY22 consensus forecast is projected to reach $8.1 billion, with FY23 reaching $9 billion supported by higher-than-expected oil and gas production and prices. Prior to the introduction of HB 45 during the 2020 legislative session, the NMRHCA decided to pursue a 1/2 percent increase in employee (.17 percent) and employer (.33 percent) contributions based on an economic forecast of $8.3 billion. Although the proposal passed the House and Senate, the Governor vetoed it.

Mr. Archuleta said the NMRHCA has made several inquiries to staff in the Governor's Office, as well as to certain legislators, about whether or not this might be the right year to introduce some legislation. The feeling is that if the NMRHCA doesn't ask for the money now, in two years the financial situation might not be this positive and questions would arise about why the NMRHCA didn't ask when the state was having a good year.

Mr. Archuleta said staff started discussing this same proposal in November 2021. While it hadn't been presented to the Interim Investments and Pensions Oversight Committee for their endorsement, the Legislative Finance Committee voted to approve it. The NMRHCA would therefore pursue the additional 1/2 percent increase in the upcoming legislative session for FY23. Staff feels this is a reasonable sum that provides a meaningful difference to the NMRHCA's financial situation. It will push it past the 50 percent-funded ratio and moves solvency from the projected $10 billion in 2052 to about $13 billion. Rep. Figueroa and Sen. Gonzales have agreed to carry this legislation forward; however, it is unknown if the Governor's Office would sign the legislation if it passed.

Dr. Salazar noted that Mr. Cushman had indicated at the Legislative Committee meeting that this would be an appropriate time for the NMRHCA to proffer this request given the state's healthy financial picture. Mr. Pyle said he thought the NMRHCA should consult with the counties in terms of what impact this might have on county employees.

Dr. Salazar moved that the NMRHCA pursue the same increase that it sought in 2020, which was a 1/2 percent increase in contributions, with an employee contribution of .17 percent and in an employer contribution of .33 percent, with no additional direct appropriation. Mr. Eichenberg seconded the motion.

Dr. Salazar noted Chairman Crandall's comments at the last meeting that the NMRHCA is not constitutionally protected and therefore can be eliminated. Dr. Salazar suggested that the board look into considering the idea of making the NMRHCA a constitutionally protected agency in order to protect the property rights of the membership. If the NMRHCA needs to be protected in terms of property right, it would require a constitutional amendment. The board would have to decide which legislation it wanted to bring forward in the upcoming session.

Dr. Salazar said that, while HB 45 had a relatively easy time getting through both the House and Senate, the Governor's Office said she should have been told after it passed one of the chambers that this was legislation she would have to be considering.

Dr. Salazar said the NMRHCA wouldn't be changing HB 45, and legislators are therefore familiar with it. He also stated that he did not think bypassing the IPOC review, as it had this time around, would hinder the proposal from moving forward through committees.

Chairman Crandall said he was more inclined to move ahead with the proposal to increase contributions given the state's financial picture, and to pursue the constitutional amendment in the future.

Mr. Cushman said he just left the statewide superintendents meeting. Overwhelmingly, the superintendents are in support of proposing this legislation now.

Mr. Pyle recommended that Interim Executive Director Kueffer hold a meeting with the Executive Director of the New Mexico Association of Counties and seek their support. If the NMRHCA works to educate people and explain why this legislation is needed, he did not believe there would be any objection. He said the counties should especially be reminded that they are otherwise going to continue carrying the NMRHCA's unfunded liability on their books.

The motion passed unanimously by roll call vote.

11. VILLAGE OF PECOS PARTICIPATION SUSPENSION

Mr. Archuleta stated that NMRHCA staff was requesting authorization to temporarily suspend the Village of Pecos's participation in the New Mexico Retiree Health Care Act for non-payment, effective immediately. The NMRHCA has not received employer contributions from the Village since December 2020, and the NMRHCA has basically run the gauntlet since then in terms of excuses from the Village about why they haven't been in compliance. On December 6 and again on December 12, 2021, he sent a letter to the Mayor asking that the Village contact the NMRHCA and warning that he would otherwise suspend participation in the program. There was no response to either letter.

Mr. Archuleta requested approval to suspend the Village of Pecos's participation in the New Mexico Retiree Health Care Act for non-payment until such time as it brings its account current.

Chairman Crandall stated that the Executive Committee concurs with Mr. Archuleta's recommendation.

Ms. Saunders moved Mr. Archuleta's recommendation. Chairman Crandall seconded the motion, which passed unanimously by roll call vote.

12. MESSAGE FROM EXECUTIVE DIRECTOR

Mr. Archuleta thanked board members and staff for their support for these past five years. He commented that the NMRHCA is an incredible organization that does a lot of good things, including the opportunity to help people, and it has been a pleasure to be a part of it.

Board members Tomas Salazar, Rick Scroggins, Tim Eichenberg, Loren Cushman, Therese Saunders, Sanjay Bhakta, and Doug Crandall each shared their thoughts with Mr. Archuleta and wished him the best. Others who spoke were Neil Kueffer, Tomas Rodriguez, Greg Archuleta, Lori Bell, and Sam Garcia.

13. OTHER BUSINESS

None.

15. EXECUTIVE SESSION

None.

16. DATE AND LOCATION OF NEXT BOARD MEETING

February 1, 2022 – 9:00 a.m.
Virtually via GoToMeeting

17. ADJOURN: 10:30 a.m.

Accepted by:

____
Doug Crandall, President

Job Description

◀ Previous Job | **Chief Information Officer (NMRHCA #00023554)** | Next Job ▶

Apply for Job

Job ID	121829	**Full/Part Time**	Full-Time
Location	Albuquerque	**Regular/Tem…**	Regular - PERM for State
Posting End Date		**Job Posting Type**	Standard Requisition
Agency	Retiree Health Care Authority		

For more Job Requirements & Classification Description: Click Here

☆ Add to Favorite Jobs

✉ Email this Job

Salary

$29.01 - $48.45 Hourly

$60,351 - $100,786 Annually

This position is a Pay Band IF

Purpose of Position

THIS POSTING WILL BE USED FOR ON-GOING RECRUITMENT AND WILL REMAIN OPEN UNTIL FILLED.

Why does the job exist?

The Chief Information Officer (CIO) provides leadership, vision, and strategic planning in the management of personnel, annual budgets, cost effectiveness, contracts, IT projects and programs for all areas of information systems and technology in support of New Mexico Retiree Health Care Authority mission and business services. The CIO oversees all areas of information systems and technology, including innovation, policy, planning, design, integration, delivery, evaluation, privacy, security, compliance to include Healthcare Insurance Portability Accountability Act (HIPAA), incident response and continuity.

How does it get done?

Conducts the day-to-day oversight of IT technical functions with New Mexico Retiree Health Care Authority (NMRHCA). Provides technical guidance to NMRHCA IT staff and brings highly specialized knowledge and expertise to high level administrative managers, particularly in the areas of business and technical integration.

Who are the customers?

Internal and External

Ideal Candidate

The Chief Information Officer (CIO) will drive innovation, strategy, planning, architecture, system coordination, technology standards and the application of best practices. They will be dedicated to excellence in

operations by managing information technology, computer systems, electronic data operations and ensure security of data to include backup systems. In addition, excellent knowledge of technical management, information analysis and of computer hardware/software systems. Excellent communication skills with the ability to simply explain modern technology in a business-friendly way are a must. Act in alignment with user needs and system functionality to contribute to organizational policy. Incumbent will engage in senior level business discussions and need to have a passion for identifying and solving difficult business problems with creative application of technology. Finally, the ideal candidate will have improved skills, proven professional experience, and be a person of integrity who builds business relationships based upon trust. Manage IT staff to include training, coaching, effectively communicate job expectations, and evaluating their performance. Lastly, hands-on experience with computer networks, network administration and network installation.

Minimum Qualification

Bachelor's degree in Computer Science, Management Information Systems (MIS), Information Technology, Engineering or similar technical degree four (4) years of experience in at least two of the following areas: Applications Development, IT Architecture, Data Management, Network Administration, Project Management, IT Security/Compliance, or Systems Administration. Substitutions Apply. See Substitution Table below.

Substitution Table

These combinations of education and experience qualify you for the position:

	Education		**Experience**		**Education**		**Experience**
1	High School Diploma or Equivalent	**AND**	8 years of experience		High School Diploma or Equivalent	**AND**	8 years of experience
2	Associate's degree in the field(s) specified in the minimum qualification	**AND**	6 years of experience		Associate's degree or higher in any field	**AND**	8 years of experience
3	Bachelor's degree in the field(s) specified in the minimum qualification	**AND**	4 years of experience	**OR**			
4	Master's degree in the field(s) specified in the minimum qualification	**AND**	2 years of experience				
5	PhD degree in the field(s) specified in the minimum qualification	**AND**	0 years of experience				

• Education and years of experience must be related to the purpose of the position.

• If Minimum Qualification requires a specific number of "semester hours" in a field (e.g. 6 semester hours in Accounting), applicants MUST have those semester hours in order to meet the minimum qualifications. No substitutions apply for semester hours.

Employment Requirements

Must possess and maintain a valid Driver's License. Must possess and maintain a current Defensive Driving Course Certificate from the State of New Mexico or must pass and receive Defensive Driving Course Certification as a condition of continued employment.

Working Conditions

Executive Order 2021-066 requires all employees with the State of New Mexico to provide either proof of COVID-19 vaccination (including proof of a booster dose of vaccine by January 17, 2022, or within four weeks of becoming eligible for a booster dose) or proof of a COVID-19 viral test every week.

The Public Health Order (on Vaccination) dated December 2, 2021, requires Congregate Care Facility Workers and Hospital Workers to have received a primary series of vaccination by October 6, 2021, and a booster dose of vaccine by January 17, 2022, or within four weeks of becoming eligible for a booster.

Links to the referenced Executive Order and Public Health Order can be found on the State Personnel Office website homepage: www.spo.state.nm.us

Work is performed in an office setting with exposure to Visual/Video Display Terminal (VDT) and extensive personal computer and phone usage. Some sitting, standing, bending and reaching may be required. Some travel may be required. Occasionally work extra hours, on weekends and holidays.

Supplemental Information

Benefits:

Do you know what Total Compensation is? Click here

Agency Contact Information: Samantha Olivas 505-412-8458Email

For information on Statutory Requirements for this position, click the Classification Description link on the job advertisement.

Bargaining Unit Position

This position is not covered by a collective bargaining agreement.

SB 112 – FUND RETIREE HEALTH CARE

If you believe our public employees deserve affordable health care upon retirement, then believe in and support SB 112

KEY POINTS

- Passage of bill has a modest increase of 0.5% overall; 0.33% employer increase and 0.17% employee increase
- 10% of New Mexico's adult population – 157,000 Retirees/Active Employees participate now or will access the program in the future
- Approximately 2/3 of bankruptcies nationally are due to rising health care costs
- Public employees worked and earned the ability to retire with affordable health care options as promised by State of NM in 1990

OUTCOMES

- Minimize required increases to retiree's while continuing to provide access to quality, affordable health care
- Reduce liabilities for all participating employers by increasing funding status and lowering Net OPEB Liabilities
- Stabilize the financial condition of the program's solvency
- 30-yr funded status exceeds 50% solvency
- Reduce deficit spending by 3 years
- Helps participating public employers in recruiting and retaining talent

TOUGH ACTIONS TAKEN

- Lowered subsidies to retirees and spouse/partners
- Eliminated subsidies for dependent children
- Established minimum eligible age to 55
- Increased years of service from 20 to 25 for non-enhanced employees
- Increased rates, co-pays and deductibles
- Converted 100% agency paid basic life insurance to 100% member paid
- Forced tough actions will eventually make plans unaffordable

SUPPORT SB 112

- If you believe retired public employees deserve affordable health care upon retirement
- If you believe securing retiree healthcare benefits well into the future
- If you believe the commitment by the State of NM to public retirees should be honored

Support those, who worked and served in our communities during their many years of public service!

In 1990 the Legislature made a commitment to its dedicated public servants by establishing the Retiree Health Care Authority to provide those employees with access to affordable health care. Benefits started six months later January 1, 1991, with NMRHCA paying benefits to retirees of participating entities without any prefunding.

This Second Session of the 55th Legislature provides itself an opportunity to continue to act on the intent of why the Retiree Health Care Act was enacted. Passage of **SB 112** has a modest increase of 0.5% with employer increase 0.33% and employee increase of 0.17%. The positive impact of this change assures public sector employees who have been working towards a retirement with benefits, peace of mind knowing both their families and themselves will have healthcare options now (current retiree) or at retirement and far into their retirement years.

With healthcare continuing to rise and members needing support more than ever, there is no better time than now. Help those who served our communities by helping raise and educate our children, maintain our roads and keep us safe during their careers.

Impact of Passed Bill:

- Further stabilizes the financial condition of the program's solvency by pre-funding future benefits
- Reduces liability reporting for all participating employers by increasing funding status and lowering Net OPEB Liabilities of more than $3.2 billion
- Minimizes required increases to retirees for rising prescriptions & health care cost
- Strengthens the commitment made by the State of New Mexico in 1990
- Protects participating entities against credit rating downgrades
- 30-year funded status exceeds 50 percent solvency
- Ensures continued access to quality, affordable and comprehensive healthcare
- Helps the 300 participating public employers recruit and retain talent

The Board of Directors over the last 10 years have made tough decisions and changes that have improved the trust fund balance to $1.1 billion and raised the funded status to 25.39% per 2021 GASB.

Changes Made To Date:

- Lowered retiree and spouse/domestic partner subsidy levels
- Increased pre-Medicare and Medicare Supplement rates every year
- Implemented Minimum age of 55 (non-enhanced)
- Changed minimum years of service for full subsidy from 20 to 25 years (non-enhanced)
- Eliminated dependent child subsidies
- Implement Open Enrollment period every other year
- Gradually converted 100% agency paid basic life to 100% member paid
- Increased copays and deductibles to plans

10% of the adult population in New Mexico currently participates in or will have access to these programs which serves as a deferred form of compensation and an important component of overall compensation. Help the over 65,000 retirees and 92,000 active members who contribute to this program with the expectation of this benefit being there when they need it.

For more information about NMRHCA and its long-term outlook, please contact Neil Kueffer, Interim Executive Director at 505-222-6408 or visit our website at the following link: NMRHCA.org

1 SENATE BILL 112
2 **55TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2022**
3 INTRODUCED BY
4 Roberto "Bobby" J. Gonzales
5
6
7
8
9
10 AN ACT
11 RELATING TO RETIREE HEALTH CARE; INCREASING EMPLOYEE AND
12 EMPLOYER CONTRIBUTION RATES TO THE RETIREE HEALTH CARE FUND.
13
14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:
15 **SECTION 1.** Section 10-7C-15 NMSA 1978 (being Laws 1990,
16 Chapter 6, Section 15, as amended by Laws 2009, Chapter 287,
17 Section 2 and by Laws 2009, Chapter 288, Section 3) is amended
18 to read:
19 "10-7C-15. RETIREE HEALTH CARE FUND CONTRIBUTIONS.--
20 A. Following completion of the preliminary
21 contribution period, each participating employer shall make
22 contributions to the fund pursuant to the following provisions:
23 (1) for participating employees who are not
24 members of an enhanced retirement plan, the employer's
25 contribution shall equal

.221896.2

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

[~~(a) one and three-tenths percent of each participating employee's salary for the period from July 1, 2002 through June 30, 2010;~~

~~(b) one and six hundred sixty-six thousandths percent of each participating employee's salary for the period from July 1, 2010 through June 30, 2011;~~

~~(c) one and eight hundred thirty-four thousandths percent of each participating employee's salary for the period from July 1, 2011 through June 30, 2012; and~~

~~(d)~~] two and thirty-three hundredths percent of each participating employee's salary [~~beginning July 1, 2012~~];

(2) for participating employees who are members of an enhanced retirement plan, the employer's contribution shall equal

[~~(a) one and three-tenths percent of each participating employee's salary for the period from July 1, 2002 through June 30, 2010;~~

~~(b) two and eighty-four thousandths percent of each participating employee's salary for the period from July 1, 2010 through June 30, 2011;~~

~~(c) two and two hundred ninety-two thousandths percent of each participating employee's salary for the period from July 1, 2011 through June 30, 2012; and~~

~~(d)~~] two and [~~one-half~~] ninety-three

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hundredths percent of each participating employee's salary [~~beginning July 1, 2012~~]; 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

[~~(a) sixty-five hundredths of one percent of the employee's salary for the period from July 1, 2002 through June 30, 2010;~~

~~(b) eight hundred thirty-three thousandths of one percent of the employee's salary for the period from July 1, 2010 through June 30, 2011;~~

~~(c) nine hundred seventeen thousandths of one percent of the employee's salary for the period from July 1, 2011 through June 30, 2012; and~~

~~(d)~~] one and seventeen-hundredths percent of the employee's salary [~~beginning July 1, 2012~~];

(2) for a participating employee who is a

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member of an enhanced retirement plan, the employee's contribution shall equal

[~~(a) sixty-five hundredths of one percent of the employee's salary for the period from July 1, 2002 through June 30, 2010;~~

~~(b) one and forty-two thousandths percent of the employee's salary for the period from July 1, 2010 through June 30, 2011;~~

~~(c) one and one hundred forty-six thousandths percent of the employee's salary for the period from July 1, 2011 through June 30, 2012; and~~

~~(d)~~] one and [~~one-fourth~~] forty-seven hundredths percent of the employee's salary [~~beginning July 1, 2012~~]; 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. [~~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)

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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.

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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 [~~7-1-6.1~~] 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 and probation and parole 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

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1 provisions of this act is July 1, 2022.
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Fiscal impact reports (FIRs) are prepared by the Legislative Finance Committee (LFC) for standing finance committees of the New Mexico Legislature. LFC does not assume responsibility for the accuracy of these reports if they are used for other purposes.

Current and previously issued FIRs are available on the New Mexico Legislative Website (www.nmlegis.gov).

FISCAL IMPACT REPORT

SPONSOR	Gonzales	**ORIGINAL DATE** **LAST UPDATED**	1/27/22	**HB**	
SHORT TITLE	Retiree Health Care Fund Contributions			**SB**	112
				ANALYST	Jorgensen

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY22	**FY23**	**FY24**		
	24,600.0	24,600.0	Recurring	Retiree Health

(Parenthesis ( ) Indicate Revenue Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY22	FY23	FY24	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$8,200.0	$8,200.0	$16,400.0	Recurring	Various

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION

Responses Received From
Retiree Health Care Authority (RHCA)
State Personnel Office (SPO)

SUMMARY

Synopsis of Bill

Senate Bill 112 (SB112) increases employee and employer contributions as shown in the table below:

	Current Rates	Proposed Rates
Non-Enhanced Retirement Plan		
Employer	2.00%	2.33%
Employee	1.00%	1.17%
Enhanced Retirement Plan	**Current Rates**	**Proposed Rates**
Employer	2.50%	2.93%
Employee	1.25%	1.47%

FISCAL IMPLICATIONS

The Retiree Health Care Authority estimates SB112 will generate $24.6 million in annual revenue to the fund. Of this amount, $16.4 million will come from employers and must be absorbed in the existing operating budgets as there is no appropriation to pay for the increased costs. The amount of the increased employer cost is included in the estimated additional operating budget impact table.

SIGNIFICANT ISSUES

In addition to employee and employer contributions and participant premiums, RHCA receives a direct distribution from the tax suspense fund. In FY23, the distribution will be $41.3 million. Statute mandates the distribution from the tax suspense fund increases at a rate of 12 percent per year, roughly doubling every six years. Monies distributed to RHCA from the tax suspense fund would otherwise go to the general fund.

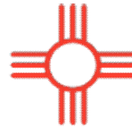
At the end of FY21, the RHCA trust fund balance was $1 billion, compared with $190 million a decade ago. However, on an actuarial basis, funding is only sufficient to cover about 16.5 percent of the estimated $4.2 billion in current and future healthcare liabilities. The program is projected to maintain a positive fund balance through 2052.

RHCA membership includes 14.4 thousand pre-Medicare retirees with an average age of 54 years and 40.6 thousand Medicare eligible retirees with an average age of 74. Depending on years of service, pre-Medicare retirees receive a subsidy up to 64 percent of plan cost while Medicare-eligible participants may receive a subsidy up to 50 percent. RHCA also provides spousal subsidies up to 25 percent for Medicare-eligible spouses and 36 percent for pre-Medicare spouses depending on the retiree's years of service. Premiums for dependent coverage are 100 percent paid by the retiree, as are premiums for dental, vision, and life insurance. In FY21, RHCA paid $173.4 million for coverage of pre-Medicare participants, $12 thousand per member on average, and $103.4 million for Medicare-eligible participants, or $2,600 per member on average.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

SB112 is identical to House Bill 74.

CJ/acv



NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

House Appropriations & Finance Committee

Patricia A. Lundstrom, Chair
Nathan P. Small, Vice Chair

FY23 Appropriation Recommendations, Updates & Proposed Legislation

January 13, 2022

Doug Crandall, President
Therese Saunders, Vice President
LeAnne Larrañaga-Ruffy, Secretary
Neil Kueffer, Interim Executive Director

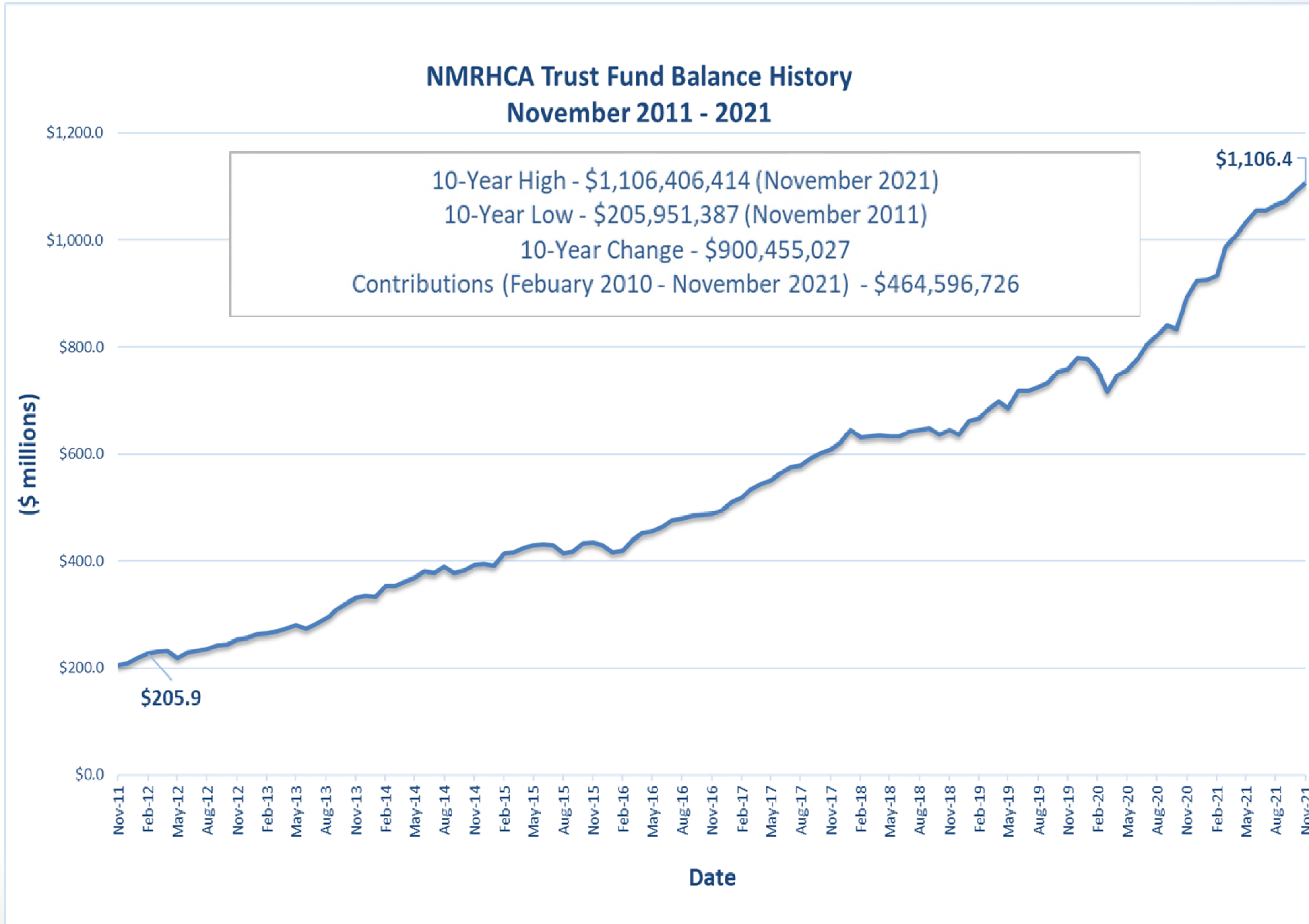
Background

- New Mexico Retiree Health Care Authority (NMRHCA) was established in 1990 to provide health insurance to retirees of state agencies and eligible participating public entities
- The Authority is governed by an 11-member Board of Directors
- Purpose is to provide Medicare and Non-Medicare eligible retirees medical, dental, vision and life insurance
- All participating entities and their employees while actively working make contributions into this program through payroll deduction
- At time of retirement the employee is eligible for the benefits as long as they have worked the minimum of 5 years and they continue to pay premiums based on years of service

Agency Updates

- Interim Executive Director Appointment
- COVID-19 Operations
  - Combination of office/telework
  - In-person appointments
  - Monthly Board/Committee meetings held via/GoToMeetings
  - Assistance provided by telephone and email
- Web-Portal Development
  - Spring 2022
- Pharmacy Benefit Manager Request of Proposal – July 1, 2022
  - Collaboration w/State of New Mexico, Public Schools Insurance Authority, Albuquerque Public Schools and the University of New Mexico
- Life Insurance Request for Proposal – Fall 2022
- Continued participation with the Interagency Pharmaceuticals Purchasing Council (SB 131, 2019)

Financial Updates



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GASB Updates

- GASB 74 – Actuarial Valuation Review of Other Postemployment Benefits (OPEB) as of June 30, 2021
  - Completed December 6, 2021
  - Total OPEB Liability: $4,409,849,335 (2021) /$5,028,579,923 (2020)
  - Net OPEB Liabilities (NOL) decreased $894.2 million, due to the following:
    - An increase in the blended discount rate
    - Updated per capita health care costs
    - Discount rate – 3.62% compared to 2.86% in 2020
      - Blend rate = 7.00% assumed investment return + 20-year tax exempt general obligation municipal bonds with an average rate of AA/Aa or higher (2.16% as of June 30, 2021)
  - NOL: $3,290,349,790 (2021) / $4,198,908,018 (2020)
    - 1% Decrease in Discount Rate - $4,134,247,608
    - 1% Increase in Discount Rate - $2,633,889,896
    - 1% Decrease in Health Care Cost Trend - $2,646,501,227
    - 1% Increase in Health Care Cost Trend - $3,808,841,141
  - Funded Status: 25.39% (2021) / 16.50% (2020)

5

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**

6

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.**

7

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.**

8

Legislative Proposal

Duplicate (Senate/House) amending the Retiree Health Care Act

- Increases employee contributions from 1 percent to 1.17 percent of salary
- Increases employer contributions from 2 percent to 2.33 percent of salary

Example: Employee earing $40,000 annually

Employee Impact:

- Contributions would increase by $68 per year

Employer Impact:

- Contributions would increase by $126 per year

NMRHCA Impact

- Minimizes use of investment earnings to support benefits
- Further extends solvency beyond 30-year projection period
- Increase funded status over 50%
- Lowers reported GASB OPEB Liabilities

New Mexico Retiree Health Care Authority

Neil Kueffer, Interim Executive Director

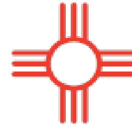
505-222-6408

neil.kueffer@state.nm.us

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

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

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



NEW MEXICO
RETIREE
HEALTH CARE
AUTHORITY

Senate Finance Committee

George K. Muñoz, Chair
Nancy Rodriguez, Vice Chair

Agency Updates and Information

January 24, 2022

Doug Crandall, President
Therese Saunders, Vice President
LeAnne Larrañaga-Ruffy, Secretary
Neil Kueffer, Interim Executive Director

Background

- New Mexico Retiree Health Care Authority (NMRHCA) was established in 1990 to provide health insurance to retirees of state agencies and eligible participating public entities

- The Authority is governed by an 11-member Board of Directors

- Purpose is to provide Medicare and Non-Medicare eligible retirees medical, dental, vision and life insurance

- All participating entities and their employees while actively working make contributions into this program through payroll deduction

- At time of retirement the employee is eligible for the benefits as long as they have worked the minimum of 5 years and they continue to pay premiums based on years of service

Program Composition and Operating Budget

Active participation – 92,484 (6/30/21)

- Public Employer Groups - 300
  - Schools – 50%
  - State agencies – 25%
  - Local government – 25%

Retiree participation – 65,288 (1/1/22)

- Retirees – 41,986
  - Pre-Medicare – 9,810
  - Medicare – 32,176
  - Average age – 70
- Spouses/DP – 11,365
  - Pre-Medicare – 2,766
  - Medicare – 8,599
  - Average age – 69
- Dependent Children – 1,551
  - Pre-Medicare – 1,524
  - Medicare - 27
  - Average age – 20
- 2021 Average age upon retirement - 60

Funding Sources

- Employee/Employer Contributions
- Retiree Contributions
- Tax Suspense Fund
- Miscellaneous
- Interest Earnings

FY23 Appropriation Request

- Benefits - $376.9 million
- Program Support - $3.5 million (26 FTE)

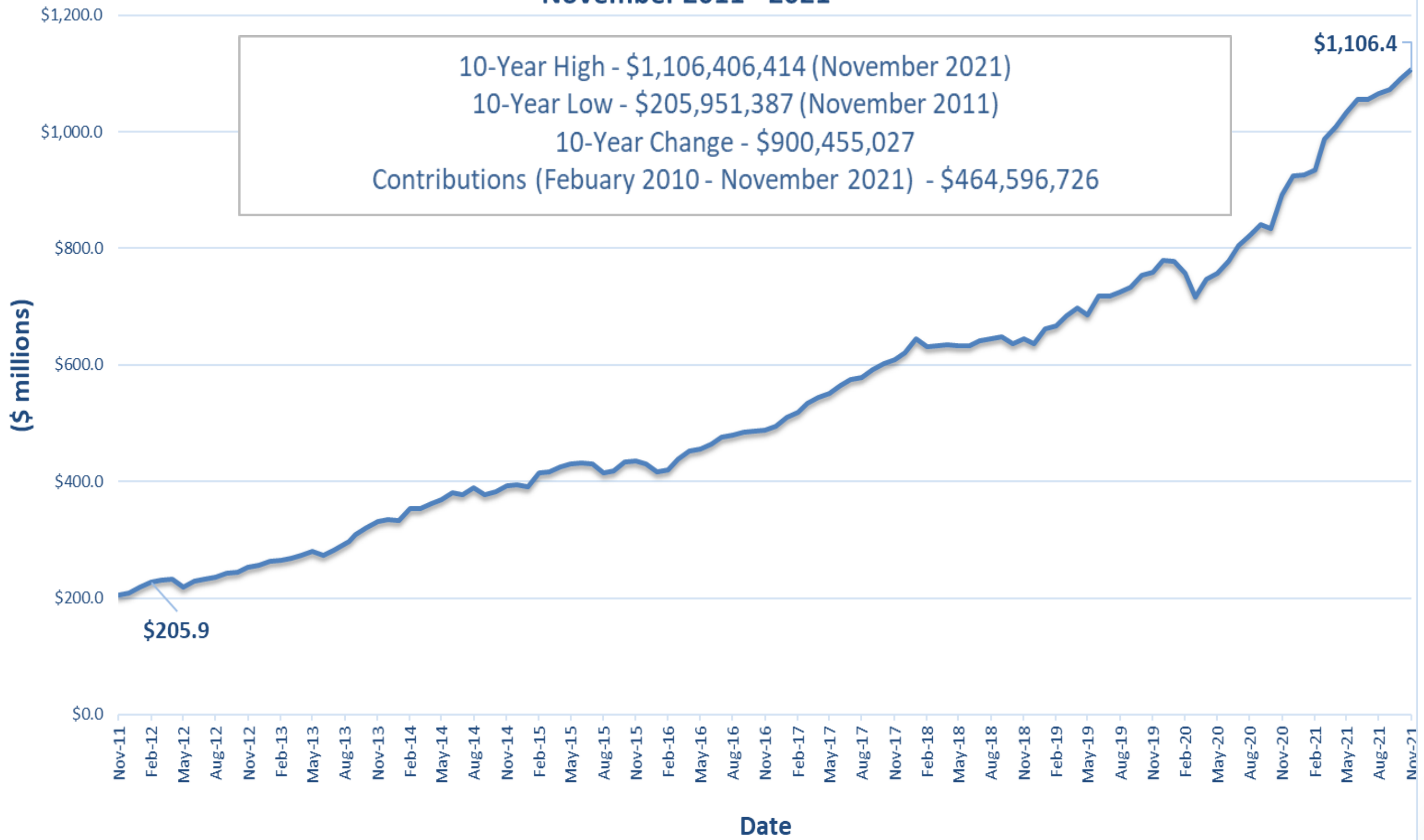
Investments

- Managed by the State Investment Council
- Biennial Asset Allocation Performed by Wilshire
- Asset Allocation Updated January 1, 2021
  - Transferred all assets in the Non-US Emerging Index Pool to Non-US Emerging Active pool
  - Transferred all assets in the US Small/Mid Cap Active Pool to US Small/Mid Cap Alternative Weighted Index Pool

Agency Updates

- Interim Executive Director
- COVID-19 Operations
  - Combination of office/telework
  - In-person appointments
  - Monthly Board/Committee meetings held via GoToMeetings
  - Assistance provided by telephone and email
- Medical, dental, vision and Medicare Advantage contracts (July 2020 – June 2024)
- Plan rates:
  - 2022 pre-Medicare plan rates: 6% increase
  - 2022 Medicare Supplement plan rates: 4% increase
  - 2022 Medicare Advantage plan rates: *Range from -100% to +10%*
  - 2022 Dental and Vison plan rates: No change
- Pharmacy Benefit Manager Request of Proposal – July 1, 2022
- Life Insurance Request for Proposal – Fall 2022
- Continued participation with the Interagency Pharmaceuticals Purchasing Council (SB 131, 2019)

Financial Updates



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Investment Performance

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

As of September 30, 2021

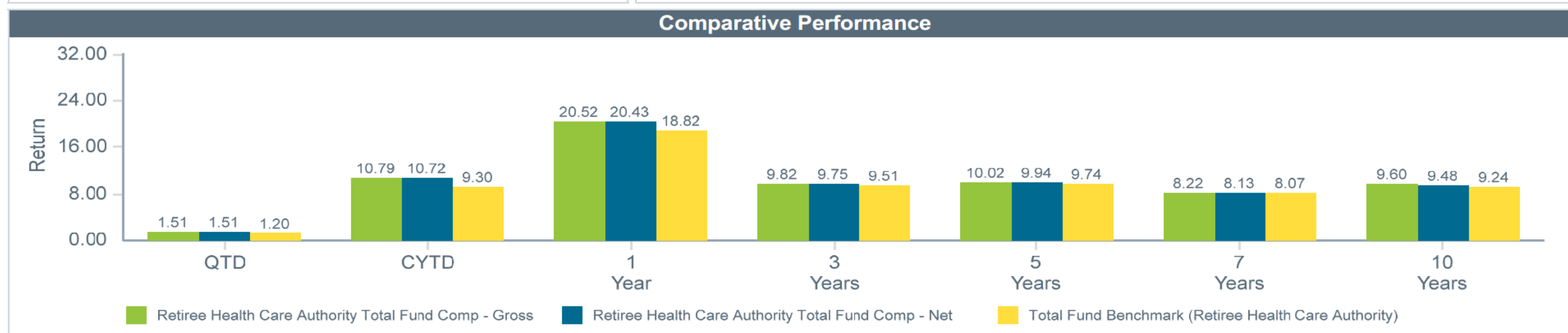
Overview

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	177,121,658	16.52	14.00	2.52
Small/Mid Cap US Equity Index	24,397,982	2.28	2.00	0.28
Non-US Developed Markets Index	145,620,745	13.58	14.00	-0.42
Non-US Emerging Markets Active	101,559,931	9.47	10.00	-0.53
US Core Bonds	190,734,349	17.79	20.00	-2.21
Credit & Structured Finance	147,030,492	13.71	15.00	-1.29
Private Equity	146,987,969	13.71	10.00	3.71
Real Estate	95,656,836	8.92	10.00	-1.08
Real Return	43,017,217	4.01	5.00	-0.99
Total Fund	1,072,127,177	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	**1.51**	**10.79**	**20.52**	**9.82**	**10.02**	**8.22**	**9.60**	**9.88**	**13.27**	**-1.24**
Total Fund Benchmark (Retiree Health Care Authority)	*1.20*	*9.30*	*18.82*	*9.51*	*9.74*	*8.07*	*9.24*	*10.23*	*14.34*	*-1.86*
Difference	0.31	1.49	1.70	0.31	0.28	0.15	0.36	-0.35	-1.07	0.62
Retiree Health Care Authority Total Fund Comp - Net	**1.51**	**10.72**	**20.43**	**9.75**	**9.94**	**8.13**	**9.48**	**9.83**	**13.21**	**-1.32**
Total Fund Benchmark (Retiree Health Care Authority)	*1.20*	*9.30*	*18.82*	*9.51*	*9.74*	*8.07*	*9.24*	*10.23*	*14.34*	*-1.86*
Difference	0.31	1.42	1.61	0.24	0.20	0.06	0.24	-0.40	-1.13	0.54

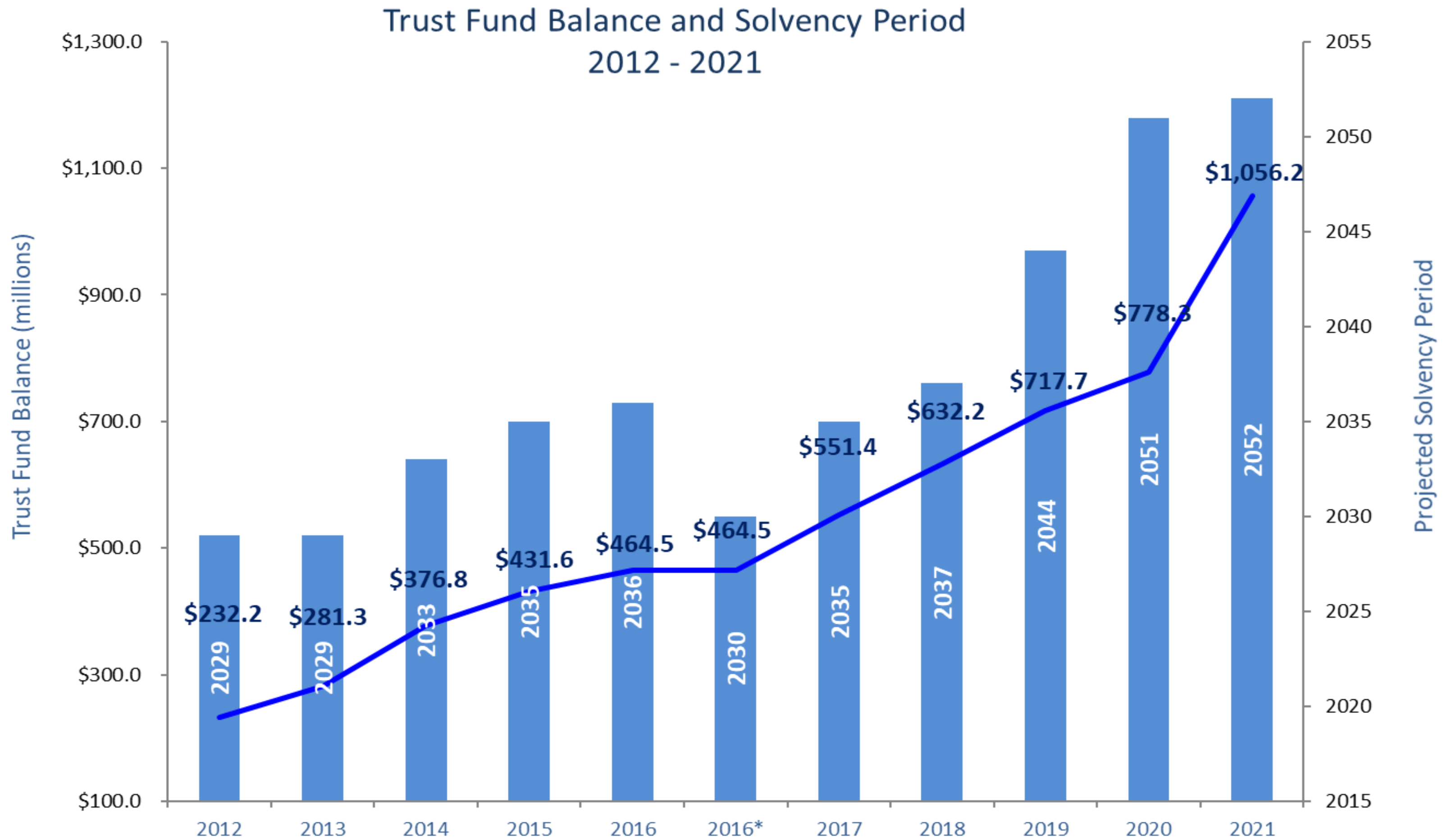
Schedule of Investable Assets

Periods Ending	Beginning Market Value ($)	Net Cash Flow ($)	Gain/Loss ($)	Ending Market Value ($)	% Return
CYTD	**924,474,338**	**45,000,000**	**102,652,839**	**1,072,127,177**	**10.72**

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.

RVK

Solvency Analysis



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    - Updated per capita health care costs
    - Discount rate – 3.62% compared to 2.86% in 2020
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    - 1% Increase in Discount Rate - $2,633,889,896
    - 1% Decrease in Health Care Cost Trend - $2,646,501,227
    - 1% Increase in Health Care Cost Trend - $3,808,841,141
  - Funded Status: 25.39% (2021) / 16.50% (2020)

Special Appropriations

- SB315 Public Safety Officer Retirement – Laws 2021, Chapter 36
  - 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

- 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 totaling $15 million over 5 years.
  - NMRHCA respectfully requests a Special Appropriation totaling $15 million to offset the impact to the Trust Fund and or increases to retiree monthly charges.

- 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
  - 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.

Legislative Proposal

Senate Bill 112 – Retiree Health Care Fund Contributions

- Amends the Retiree Health Care Act
- Increases employee contributions from 1 percent to 1.17 percent of salary
- Increases employer contributions from 2 percent to 2.33 percent of salary

Example: Employee earing $40,000 annually

Employee Impact:

- Contributions would increase by $68 per year

Employer Impact:

- Contributions would increase by $132 per year

NMRHCA Impact

- Minimizes use of investment earnings to support benefits
- Further extends solvency beyond 30-year projection period
- Increase funded status over 50%
- Lowers reported GASB OPEB Liabilities

New Mexico Retiree Health Care Authority

Neil Kueffer, Interim Executive Director

505-222-6408

neil.kueffer@state.nm.us

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

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

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

FY23 LFC/Executive Recommendation Comparison

Overall, the FY23 appropriation recommendations proposed by the Legislative Finance Committee (LFC) and the Executive do not vary significantly. The DFA recommendation supported our request in full and the LFC recommended a lower increase in personal services and employee benefits. Table 1 highlights the FY22 approved operating budget, FY23 appropriation request and corresponding recommendations made by the LFC and Executive.

Table 1 ($ shown in thousands)	FY22 Approved/Adjusted Operating	FY23 Request	LFC Recommendation	Exec Recommendation
Personal Services & Employee Benefits	$ 2,110.7	$ 2,240.5	$ 2,150.9	$ 2,240.5
Contractual Services	$ 354,123.1	$ 377,601.6	$ 377,601.6	$ 377,601.6
Other	$ 592.5	$ 632.0	$ 632.0	$ 632.0
Other Financing Uses	$ 3,280.7	$ 3,502.4	$ 3,412.8	$ 3,502.4
Total	**$ 360,107.0**	**$ 383,976.5**	**$ 383,797.3**	**$ 383,976.5**
Healthcare Benefits Administration				
Contractual Services	$ 353,501.7	$ 376,926.7	$ 376,926.7	$ 376,926.7
Other	$ 43.9	$ 45.0	$ 45.0	$ 45.0
Other Financing Uses	$ 3,280.7	$ 3,502.4	$ 3,412.8	$ 3,502.4
Subtotal	**$ 356,826.3**	**$ 380,474.1**	**$ 380,384.5**	**$ 380,474.1**
Program Support				
Personal Services & Employee Benefits	$ 2,110.7	$ 2,240.5	$ 2,150.9	$ 2,240.5
Contractual Services	$ 621.4	$ 674.9	$ 674.9	$ 674.9
Other	$ 548.6	$ 587.0	$ 587.0	$ 587.0
Subtotal	**$ 3,280.7**	**$ 3,502.4**	**$ 3,412.8**	**$ 3,502.4**
Total	**$ 360,107.0**	**$ 383,976.5**	**$ 383,797.3**	**$ 383,976.5**
FTE	**26**	**26**	**26**	**26**

Table 2 provides a comparison of the incremental growth requested and recommended for each program compared to the approved FY22 operating budget. The LFC recommendation is $179,200 lower than the Executive recommendation and agency request. The difference is reflected in the personal services and employee benefits ($89,600) and other financing uses category of the Healthcare Benefits Administration program.

Table 2 ($ shown in thousands)	FY22 Approved/Adjusted Operating	FY23 Requested Growth	LFC Recommended Growth	Exec Recommended Growth
Healthcare Benefits Administration				
Contractual Services	$ 353,501.7	$ 23,425.0	$ 23,425.0	$ 23,425.0
Other	$ 43.9	$ 1.1	$ 1.1	$ 1.1
Other Financing Uses	$ 3,280.7	$ 221.7	$ 132.1	$ 221.7
Subtotal	**$ 356,826.3**	**$ 23,647.8**	**$ 23,558.2**	**$ 23,647.8**
Program Support				
Personal Services & Employee Benefits	$ 2,110.7	$ 129.8	$ 40.2	$ 129.8
Contractual Services	$ 621.4	$ 53.5	$ 53.5	$ 53.5
Other Financing Uses	$ 548.6	$ 38.4	$ 38.4	$ 38.4
Subtotal	**$ 3,280.7**	**$ 221.7**	**$ 132.1**	**$ 221.7**
Total	**$ 360,107.0**	**$ 23,869.5**	**$ 23,690.3**	**$ 23,869.5**
FTE	**26**	**0**	**0**	**0**

Table 3 highlights the FY22 operating budget along with the FY23 requested and recommended growth expressed in terms of a percentage.

Table 3 ($ shown in thousands)	FY22 Approved/Adjusted Operating	FY23 Requested Growth	LFC Recommended Growth	Exec Recommended Growth
Healthcare Benefits Administration				
Contractual Services	$ 353,501.7	6.6%	6.6%	6.6%
Other	$ 43.9	2.5%	2.5%	2.5%
Other Financing Uses	$ 3,280.7	6.8%	4.0%	6.8%
Subtotal	**$ 356,826.3**	**6.6%**	**6.6%**	**6.6%**
Program Support				
Personal Services & Employee Benefits	$ 2,110.7	6.1%	1.9%	6.1%
Contractual Services	$ 621.4	8.6%	8.6%	8.6%
Other Financing Uses	$ 548.6	7.0%	7.0%	7.0%
Subtotal	**$ 3,280.7**	**6.8%**	**4.0%**	**6.8%**
Total	**$ 360,107.0**	**6.6%**	**6.6%**	**6.6%**
FTE	**26**	**0%**	**0%**	**0%**

NMRHCA staff respectfully requested support for the spending levels supported by the Executive recommendation on Thursday, January 13 before the House Appropriations and Finance Committee (HAFC). Following adoption by HAFC, staff does not anticipate the Senate will take action to adjust the budget amounts adopted by the House. Budget deficiencies in the personal services and employee benefits category can be accommodated through vacancy savings or budget adjustment authority. In addition, the Executive recommendation includes support for one of the three requested Special Appropriations -- a request totaling $145,300 for the full actuarial value associated with Laws 2021, Chapter 36, Senate Bill 315 from the 2021 legislative session which converted motor transportation officers from general plan 3 to the state police retirement plan. Final adoption of special appropriations and BAR language is scheduled to occur later this week.

DIAGNOSTICS, PAYERS

Why Medicare does not cover rapid at-home Covid tests

It turns out that the laws governing traditional Medicare don't provide for coverage of self-administered diagnostic tests. Medicare patients are left to seek free tests other ways, including through the administration's new website, covidtests.gov, and at community centers.

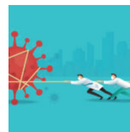
By MICHELLE ANDREWS, KAISER HEALTH NEWS

Post a comment / Jan 24, 2022 at 6:41 PM

What group is especially vulnerable to the ravages of covid-19 even if fully vaccinated and boosted? Seniors. And who will have an especially tough time getting free at-home covid tests under the Biden administration's plan? Yes, seniors.

3 strategies for how physicians can care for seniors in 2022

Clinical trials startup comes out of stealth by announcing $27.5M funding round


In highly-vaccinated Vermont, Covid strikes but packs far less punch

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It turns out that the laws governing traditional Medicare don't provide for coverage of self-administered diagnostic tests, which is precisely what the rapid antigen tests are and why they are an important tool for containing the pandemic.

"While at this time original Medicare cannot pay for at-home tests, testing remains a critical tool to help mitigate the spread of covid," a statement from the federal Centers for Medicare & Medicaid Services said. Medicaid and CHIP cover at-home covid tests, with no cost to beneficiaries, based on a 2021 Biden administration mandate.

Medicare patients are left to seek free tests other ways, including through the administration's new website, covidtests.gov, and at community centers. The Medicare program does cover rapid antigen or PCR testing done by a lab without charging beneficiaries, but there's a hitch: It's limited to one test per year unless someone has a doctor's order.

More needs to be done, advocates say.

The administration has changed some Medicare rules during the pandemic, including improving access to telehealth services and nursing home care, said David Lipschutz, associate director and senior policy attorney at the Center for Medicare Advocacy.

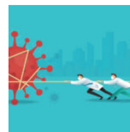
"We know that the Medicare program has significant flexibility relative to the public health emergency, and it has demonstrated it has the ability to alter the rules," Lipschutz said. "We think they should find the flexibility to offer the covid at-home tests for free."

Q: Why can't the Medicare program reimburse beneficiaries for the over-the-counter tests or pick up the tab at the pharmacy as commercial health plans will do?

The services the Medicare program pays for are spelled out in federal law.

3 strategies for how physicians can care for seniors in 2022

Clinical trials startup comes out of stealth by announcing $27.5M funding round


In highly-vaccinated Vermont, Covid strikes but packs far less punch

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and the administration could yet decide to expand coverage. Some lawmakers in Congress are urging the administration to cover the tests.

"Demanding Medicare recipients — nearly one-fifth the population of the United States — to foot the bill out-of-pocket for at-home tests is unfair, inefficient, and will cost lives," said Rep. Bill Pascrell Jr. (D-N.Y.), who has urged the Biden administration to expand Medicare coverage to include them.

It may not be a simple change, as these tests appear to fall into coverage gaps. Medicare Part A covers hospitalization, and Part B generally covers provider-based services like doctor visits and lab tests. Part D covers drugs.

"So there's a little bit of a question of where this type of benefit would fit," Schwarz said.

People in private plans sometimes pay upfront for services and then are reimbursed by their health plan. But that's not how Medicare works. The program pays providers, not beneficiaries. So that's another wrinkle that would have to be ironed out.

Q: So how can a Medicare beneficiary get free at-home covid tests?

There are a couple of options. This week, the Biden administration launched a website, covidtests.gov, where anyone, including Medicare beneficiaries, can order free at-home covid tests. One billion tests eventually will be available. Each residence initially can receive four tests.

Four tests is a far cry from the eight monthly tests that people with private insurance can be reimbursed for. But it's better than nothing, experts say, especially when preventing the spread of covid requires repeated testing over a period of days.

"Four tests is not a lot of tests," said Juliette Cubanski, deputy director of the program on Medicare policy at KFF. "This is one of the most at-risk populations, and to not have the opportunity to buy at-home tests and get reimbursed puts this whole population on their back foot."

About 4 in 10 Medicare beneficiaries are in Medicare Advantage managed-care plans. These private plans may offer free at-home tests to members, but it's not required. Enrollees should check with their plans to see whether that's an option.

Q: What other free covid testing options are available to Medicare beneficiaries?

In traditional Medicare, beneficiaries can get rapid antigen or PCR diagnostic tests without paying anything out-of-pocket if the test is ordered by a doctor or other health care provider and performed by a lab.

The federal government has set up more than 10,000 free pharmacy testing sites across the country that Medicare beneficiaries can visit as well.

With the recent extension of the public health emergency, the situation is fluid, and Medicare beneficiaries may yet get coverage for at-home covid tests that's comparable to what privately insured people now have.

"This is all a moving target," Lipschutz said.

KHN (Kaiser Health News) is a national newsroom that produces in-depth journalism about health issues. Together with Policy Analysis and Polling, KHN is one of the three major operating programs at KFF (Kaiser Family Foundation). KFF is an endowed nonprofit organization providing information on health issues to the nation.

This article is featured in the **Healthcare Docket** newsletter, a partnership between Breaking Media publications MedCity News and Above the Law.

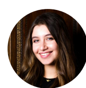
AREA OF FOCUS
Improving Health Care Quality

BLOG / JANUARY 19, 2022

Medicare's Decision to Cover the Alzheimer's Drug Aduhelm: What Will It Mean for Patients and the Program?

AUTHORS

Gretchen Jacobson
Vice President, Medicare, The Commonwealth Fund



Aimee Cicchiello
Program Assistant, Cost Control and Medicare Programs, The Commonwealth Fund

TOPLINES

At an annual per-patient price of $28,200, how would Medicare coverage of the controversial Alzheimer's drug Aduhelm affect Medicare beneficiaries and program costs?

Medicare has proposed covering Aduhelm, a controversial and costly drug for treating mild Alzheimer's disease, conditional on the drugmaker Biogen collecting additional safety and effectiveness data

On January 11, the Centers for Medicare and Medicaid Services (CMS) proposed that Medicare would cover Aduhelm, a drug for the treatment of mild Alzheimer's disease, conditional on the drug manufacturer Biogen collecting more data on effectiveness and safety. Medicare will cover the drug only for beneficiaries enrolled in a clinical trial approved by CMS or supported by the National Institutes of Health (NIH). The price has been set at $28,200 per year — before accounting for the costs of determining eligibility, monitoring, treating side effects, and drug administration. Aduhelm is not a curative therapy and patients could take the drug for multiple years.

Although Aduhelm is approved by the Food and Drug Administration (FDA), it been controversial in terms of its effectiveness, safety, and price. This blog post examines the decision to cover the drug, the impact on costs, and the overall effect on the Medicare program. It also may help to provide insight into how an impending pipeline of high-cost drugs may be covered by Medicare.

How many Medicare beneficiaries have Alzheimer's?

About 6 million people are estimated to have Alzheimer's disease. Most are age 65 or older and enrolled in Medicare. Approximately half of Alzheimer's cases are classified as mild. The CMS memorandum on the proposed coverage decision also notes that Alzheimer's disease is more prevalent among Black and Hispanic communities than in white communities. CMS is requiring that the racial and ethnic diversity of patients in Aduhelm clinical trials is representative of the national population diagnosed with Alzheimer's disease, unlike the population that participated in the drug's previous trials.

What does it mean for drugs to be covered conditional on evidence development?

CMS has the option to cover a new drug conditional on the development of additional evidence on safety and effectiveness, known as Coverage with Evidence Development (CED). There are currently 21 drugs and medical devices that were approved using CED and are waiting on final decisions or conducting evidence collection. CMS is requiring beneficiaries to be administered Aduhelm in a hospital outpatient setting and enrolled in a CMS-approved or NIH-supported clinical trial, which will limit the number of beneficiaries with access to the drug.

Is the drug expected to be widely available and used?

Many health systems, including Cleveland Clinic, Mass General Brigham, and Mount Sinai of New York City, have announced that they will not administer Aduhelm because of safety and effectiveness concerns. Combined with potentially restrictive eligibility criteria, Medicare beneficiaries may find it difficult to find a provider to administer Aduhelm.

How much will Medicare pay for the drug?

If covered by Medicare, the drug would be covered under Part B, which funds outpatient drugs that are typically administered under the supervision of a physician or nurse. Medicare pays 80 percent of the cost of the drug and the beneficiary (or supplemental insurance, if any) is responsible for paying the remaining 20 percent. Physicians and hospital outpatient departments are responsible for purchasing the drugs, and then are paid by Medicare and patients. For new drugs covered under Part B, once sufficient data on sales are available, the total payment by Medicare and the beneficiary is calculated by taking the Average Sales Price and adding a percentage to account for variations in acquisition costs (i.e., 6% add-on, minus required reductions known as sequestration). Physicians or hospitals retain the difference between the total payment and their actual acquisition costs. This can result in substantial gains or losses for providers, particularly with expensive drugs.

How much would Medicare beneficiaries pay for the drug?

Medicare beneficiaries would be responsible for 20 percent of the total cost. If the average sales price is $28,200 per year per patient, then the average Medicare beneficiary would pay about $5,640 per year. The vast majority of beneficiaries in traditional Medicare have some form of supplemental coverage that could help cover costs. In response to higher costs, supplemental insurers could increase premiums, which could further reduce the affordability of supplemental coverage.

Medicare Advantage plans have the flexibility to lower cost sharing but most Medicare Advantage plans require beneficiaries to pay 20 percent coinsurance for Part B drugs. While all Medicare Advantage plans have out-of-pocket limits for Part A and Part B services, the average limit is set at $5,153 in 2022. This means most Medicare Advantage enrollees who receive Aduhelm would pay for much of the costs out-of-pocket and exceed the out-of-pocket limit.

Could Medicare coverage of Aduhelm increase Part B premiums?

The standard Medicare Part B premiums are set to cover 25 percent of the expected Part B spending per person for a year. The Medicare Trustees projected in August 2021 that the standard Part B premium for 2022 would be $158.50, which did not account for the costs of Aduhelm. In November, CMS raised the Part B premium to $170.10, in anticipation of the increased spending from Aduhelm. Biogen halved its initial price in December; the lower price combined with fewer people using the drug as a result of a CED decision could lower projected Part B spending and cause Medicare to reexamine its projected premium increase, something Health and Human Services Secretary Becerra has already signaled it will do.

How could the Medicare coverage decision affect Medicaid?

Medicaid is responsible for covering the Medicare Part B premiums and cost sharing for people who are dually eligible for Medicare and Medicaid, potentially making state Medicaid programs liable for higher Part B premiums and 20 percent of the total Medicare payment for the drug. Even

with rebates and other policies that may reduce outlays, states and Medicaid programs may face substantial costs.

Would this affect the solvency of the Medicare Hospital Insurance trust fund?

Since the drug is covered by Part B, it would not have a direct effect on the trust fund. However, if the drug reduces the use of Part A covered services, such as hospitalizations, then it could help extend the solvency of the trust fund. Likewise, if side effects from the drug increased hospitalizations or the use of other Part A–covered services, then it could shorten the life of the trust fund. However, such savings would likely not materialize for some time, if at all.

What are the next steps for coverage?

The proposed coverage determination is open for comment for 30 days. The final decision will be announced by April 11.

PUBLICATION DETAILS

DATE

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AREA OF FOCUS

Improving Health Care Quality

TOPICS

Prescription Drugs,
Medicare

New Mexico Retiree Health Care Authority (CP)

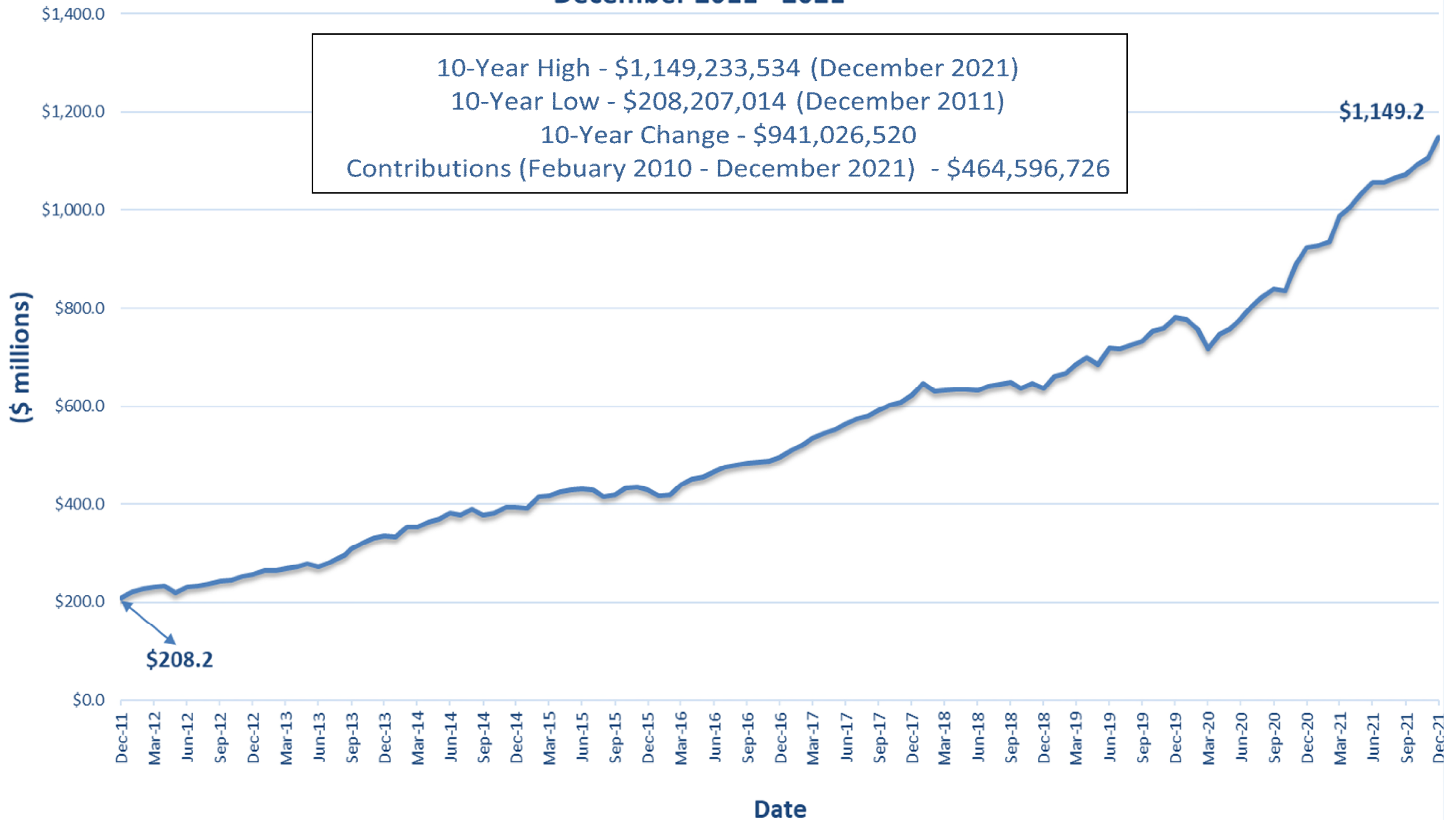
Change in Market Value

For the Month of Dec 2021

(Report as of January 18, 2022)

Investment Name	Prior Ending Market Value	Contributions	Distributions	Fees	Income	Gains - Realized & Unrealized	Market Value
Core Bonds Pool	197,501,146.50	-	-	-	434,458.50	(859,185.33)	197,076,419.67
Credit & Structured Finance	153,153,811.70	-	-	-	(105,177.82)	1,748,081.29	154,796,715.17
NM Retiree Health Care Authority Cash Account	-	-	-	-	-	-	-
Non-US Developed Markets Index Pool	146,564,089.27	-	-	-	173,583.68	7,195,414.51	153,933,087.46
Non-US Emerging Markets Active Pool	100,087,523.90	-	-	-	269,217.80	2,205,343.99	102,562,085.69
Private Equity Pool	149,408,544.86	-	-	-	284,561.58	12,184,605.67	161,877,712.11
Real Estate Pool	98,757,658.47	-	-	-	528,804.36	8,744,013.76	108,030,476.59
Real Return Pool	44,677,113.88	-	-	-	275,362.85	864,924.75	45,817,401.48
US Large Cap Index Pool	191,020,406.78	-	-	-	224,634.69	7,516,998.44	198,762,039.91
US SMID Cap Alternative Weighted Index Pool	25,236,119.10	-	-	-	45,998.33	1,095,478.49	26,377,595.92
Sub - Total New Mexico Retiree Health Care	1,106,406,414.46	-	-	-	2,131,443.97	40,695,675.57	1,149,233,534.00
Total New Mexico Retiree Health Care A	**1,106,406,414.46**	**-**	**-**	**-**	**2,131,443.97**	**40,695,675.57**	**1,149,233,534.00**

Investments



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

Healthcare Benefits Fund

Between July 1, 2021, and December 31, 2021, the Healthcare Benefits Administration Program expended $169.1 million and collected $187.3 million in revenue. Resulting in $18.2 million surplus, lower than the $22.6 million surplus for the same period in FY21.

Second Quarter FY22 expenditures are $841,600 less than expenditures in Second Quarter FY21, for a decrease of -0.5%. Current projections indicate a $44.8 million surplus at the end of FY22.

Major Upward Cost Pressures:

1. Overall plan participation (medical and voluntary coverages) grew by 1.25% between December 2020 and December 2021, adding 808 members, compared to a 0.8% growth rate during the previous fiscal year when the plan only added 516.

2. Claim costs typically increase during the Third 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: -344 members (-3.15%)
   - Value Plans: +73 members (2.03%)
   - Net: -271 members (-1.87%)

2. Medicare Plan Participation
   - Medicare Supplement: -685 members (-3.03%)
   - BCBS MA Plans: +42 members (1.12%)
   - Humana MA Plans: +117 members (9.46%)
   - Presbyterian MA Plans: +283 members (3.30%)
   - *UnitedHealthcare MA Plans: +726 members (17.39%)

3. A 8.8% decline in dependent child participation in medical plans from 1,731 in December 2020 to 1,578 in December 2021.

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

Additional Analysis:

A major trend in Second 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 (1,168 in total) who have elected to participate in less costly capitated arrangements.

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

FY22 2nd Quarter Budget Review

Comparison of Projected vs. Actual

(in thousands)

Healthcare Benefit Fund

FY22/FY21 Comparison

	FY22 Approved Q2 Budget	FY22 Q2 Actual	FY21 Q2 Actual	Dollar Change	Percent Change
Sources:					
Employer/Employee Contributions	$ 57,285.25	$ 76,246.4	$ 72,516.7	$ 3,729.7	5.1%
Retiree Contributions	$ 87,487.4	$ 86,773.9	$ 96,927.6	$ (10,153.7)	-10.5%
Taxation & Revenue Fund	$ 18,440.50	$ 12,296.0	$ 10,978.6	$ 1,317.4	12.0%
Other Miscellaneous Revenue	$ 15,000.00	$ 12,085.0	$ 12,302.6	$ (217.6)	-1.8%
Interest Income	$ 200.0	$ 62.3	$ 63.5	$ (1.2)	157.0%
Refunds	$ -	$ (126.3)	$ (200.7)	$ 74.4	-37.1%
Total Sources	$ 178,413.2	$ 187,337.3	$ 192,588.3	$ (5,251.0)	-2.7%
Uses:					
Medical Contractual Services	$ 176,721.0	$ 165,830.2	$ 166,645.8	$ (815.6)	-0.5%
ACA Fees (PCORI)	$ 45.0	$ 39.1	$ 35.9	$ 3.2	8.9%
Other Financing Uses	$ 1,640.4	$ 3,280.7	$ 3,306.7	$ (26.0)	-0.8%
Total Uses	$ 178,406.3	$ 169,110.9	$ 169,952.5	$ (838.4)	-0.5%
Sources Over Uses	**NA**	**$ 18,226.4**	**$ 22,635.8**	**NA**	**NA**

FY22 Budget Compared to Actual

	FY22 Approved Budget	FY22 Actuals	Remaing Balance	Percent Expended/ Collected	FY22 Projected Total
Sources:					
Employer/Employee Contributions	$ 114,570.5	$ 76,246.4	$ 38,324.1	66.5%	$ 152,492.7
Retiree Contributions	$ 174,974.8	$ 86,773.9	$ 88,200.9	49.6%	$ 176,047.8
Taxation & Revenue Fund	$ 36,881.0	$ 12,296.0	$ 24,585.0	33.3%	$ 36,888.1
Other Miscellaneous Revenue	$ 30,000.0	$ 12,085.0	$ 17,915.0	40.3%	$ 25,000.0
Interest Income	$ 400.0	$ 62.3	$ 337.7	15.6%	$ 124.6
Refunds	$ -	$ (126.3)	$ -	NA	$ (252.6)
Total Sources	$ 356,826.3	$ 187,337.3	$ 169,362.7	52.5%	$ 390,300.7
Uses:					
Medical Contractual Services	$ 353,501.7	$ 165,791.1	$ 187,710.6	46.9%	$ 342,184.9
ACA Fees (PCORI)	$ 45.0	$ 39.1	$ 5.9	86.9%	$ 39.1
Other Financing Uses	$ 3,280.7	$ 3,280.7	$ -	100.0%	$ 3,280.7
Total Uses	$ 356,827.4	$ 169,110.9	$ 187,716.5	47.4%	$ 345,504.7
Sources Over Uses	**NA**	**$ 18,226.4**	**NA**	**NA**	**$ 44,796.0**

New Mexico Retiree Health Care Authority
2nd Quarter Healthcare Benefit Fund Detail
Fiscal Year 2022
(in thousands)

	FY22 Q2 Actuals	FY21 Q2 Actuals	FY22 - FY21 Difference
REVENUE:			
Employer/Employee Contributions	$ 76,246.4	$ 72,516.7	$ 3,729.7
Retiree Contributions	$ 86,773.9	$ 96,927.6	$ (10,153.7)
Taxation and Revenue Suspense Fund	$ 12,296.0	$ 10,978.6	$ 1,317.4
Other Miscellaneous Revenue	$ 12,085.0	$ 12,302.6	$ (217.6)
Interest Income	$ 62.3	$ 63.5	$ (1.2)
Refunds	$ (126.3)	$ (200.7)	$ 74.4
TOTAL REVENUE:	**$ 187,337.3**	**$ 192,588.3**	**$ (5,251.0)**
EXPENDITURES:			
Prescriptions			
Express Scripts	$ 58,886.6	$ 55,945.4	$ 2,941.2
Total Prescriptions	$ 58,886.6	$ 55,945.4	$ 2,941.2
Non-Medicare			
Blue Cross Blue Shield	$ 31,386.3	$ 30,626.2	$ 760.1
BCBS Administrative Costs	$ 973.8	$ 986.0	$ (12.2)
Presbyterian	$ 23,152.7	$ 24,229.3	$ (1,076.6)
Presbyterian Administrative Costs	$ 1,091.1	$ 1,102.9	$ (11.8)
PCORI Fee	$ 39.1	$ 35.8	$ 3.3
Total Non-Medicare	$ 56,643.0	$ 56,980.2	$ (337.2)
Medicare			
Blue Cross Blue Shield	$ 20,797.4	$ 17,586.1	$ 3,211.3
BCBS Administrative Costs	$ 2,740.9	$ 2,834.7	$ (93.8)
Presbyterian MA	$ 5,668.4	$ 9,044.1	$ (3,375.7)
UnitedHealthcare MA	$ 1,447.9	$ 3,438.1	$ (1,990.2)
Humana MA	$ 377.6	$ 697.1	$ (319.5)
BCBS MA	$ 952.7	$ 2,219.1	$ (1,266.4)
Total Medicare	$ 31,984.9	$ 35,819.2	$ (3,834.3)
Other Benefits			
Davis Vision	$ 1,243.2	$ 1,205.0	$ 38.2
Delta Dental	$ 10,715.4	$ 10,429.2	$ 286.2
Standard Life Insurance	$ 6,357.1	$ 6,266.8	$ 90.3
Total Other Benefits	$ 18,315.7	$ 17,901.0	$ 414.7
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:	***$ 169,110.9***	**$ 169,952.5**	**$ (841.6)**
Total Revenue over Total Expenditures	***$ 18,226.4***	**$ 22,635.8**	**$ (4,409.4)**

New Mexico Retiree Health Care Authority
FY22 2nd QTR Budget Review
Comparison of Budget vs. Actual
(in thousands)

Program Support

FY22/FY21 Comparison

	FY22 Approved Q2 Budget	FY22 Actuals	FY21 Actuals	Dollar Change	Percent Change
Sources:					
Other Transfers	$ 1,640.4	$ 3,280.7	$ 3,306.7	$ (26.0)	-0.8%
Total Sources	**$ 1,640.4**	**$ 3,280.7**	**$ 3,306.7**	**$ (26.0)**	**-0.8%**
Uses:					
Personal Services and Benefits	$ 1,055.4	$ 999.4	$ 1,155.3	$ (155.9)	-13.5%
Contractual Services	$ 310.7	$ 222.4	$ 394.5	$ (172.1)	-43.6%
Other Costs	$ 274.3	$ 257.6	$ 314.3	$ (56.7)	-18.0%
Total Uses	**$ 1,640.4**	**$ 1,479.4**	**$ 1,864.1**	**$ (384.7)**	**-20.6%**

New Mexico Retiree Health Care Authority
FY22 2nd 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	$ 1,640.4	$ 1,640.4	50%	$ 1,468.4
Total Sources	**$ 3,280.7**	**$ 1,640.4**	**$ 1,640.4**	**50%**	**$ 1,468.4**
Uses:					
Personal Services and Benefits	$ 2,110.7	$ 999.4	$ 1,111.3	47%	$ 941.6
Contractual Services	$ 621.4	$ 222.4	$ 399.0	36%	$ 387.8
Other Costs	$ 548.6	$ 257.6	$ 291.0	47%	$ 277.8
Total Uses	**$ 3,280.7**	**$ 1,479.4**	**$ 1,801.3**	**45%**	**$ 1,607.2**

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	999.4	1,117.0	941.6	169.7
300	Contractual Services	621.4	222.4	399.0	387.8	11.2
400	Other Costs	548.6	257.6	291.0	277.8	13.2
	TOTAL	**3,280.7**	**1,479.4**	**1,807.0**	**1,607.2**	**194.1**

Expenditure Detail (in thousands)

Personal Services / Employee Benefits

Acct #	Account Description	Approved Budget	Expended Budget	Remaining Balance	Projected	Balance
520100	Exempt Positions	285.9	182.1	103.8	144.9	(41.1)
520300	Classified Perm. Positions	1,215.6	529.3	686.3	506.5	179.8
520800	Annual, Sick & Comp Paid	0.0	5.7	0.0	0.0	(5.7)
521100	Group Insurance Premium	202.2	82.1	120.1	110.0	10.1
521200	Retirement Contributions	258.8	129.6	129.2	115.0	14.2
521300	FICA	114.2	52.5	61.7	50.0	11.7
521400	Workers Comp	0.2	0.1	0.1	0.1	0.0
521410	GSD Work Comp Ins	1.0	1.0	0.0	0.0	0.0
521500	Unemployment Comp	0.0	0.0	0.0	0.0	0.0
521600	Employee Liability Insurance	2.9	2.8	0.1	0.1	0.0
521700	Retiree Health Care	29.9	14.2	15.7	15.0	0.7
523000	COVID Related Admin Leave	0.0	0.0	0.0	0.0	0.0
	TOTAL	**2,110.7**	**999.4**	**1,117.0**	**941.6**	**169.7**

Contractual Services

Acct #	Account Description	Approved Budget	Expended Budget	Remaining Balance	Projected	Balance
535200	Professional Services	358.9	131.4	227.5	230.0	(2.5)
535300	Other Services	12.5	4.1	8.4	6.5	1.9
535309	Other Services InterA	15.8	1.3	14.5	20.0	(5.5)
535400	Audit Services	84.2	45.8	38.4	42.3	(3.9)
535500	Attorney Services	60.0	9.8	50.2	20.0	30.2
535600	Information Technology Services	90.0	30.0	60.0	69.0	(9.0)
	TOTAL	**621.4**	**222.4**	**399.0**	**387.8**	**11.2**

Other Costs

Acct #	Account Description	Approved Budget	Expended Budget	Remaining Balance	Projected	Balance
542100	Employee In-State Mileage & Fares	1.5	0.0	1.5	0.0	1.5
542200	Employee In-State Meals & Lodging	2.5	0.9	1.6	0.0	1.6
542300	Board & Commission - In-State	13.5	3.4	10.1	0.0	10.1
542500	Transportation-Fuel & Oil	1.0	0.0	1.0	0.0	1.0
542600	Transportation	0.1	0.0	0.1	0.0	0.1
542700	Transportation - Insurance	0.2	0.2	0.0	0.0	0.0
542800	State Transportation Pool Charges	4.5	5.7	(1.2)	0.0	(1.2)
543200	Maintenance - Furniture, Fixtures & Equipment	6.0	6.5	(0.5)	0.0	(0.5)
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	8.8	14.2	23.0	(8.8)
544100	Supplies - Office Supplies	8.5	6.1	2.4	9.6	(7.2)
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	14.5	(10.3)	2.8	(13.1)
545701	DoIT - HCM Fees	9.5	0.0	9.5	0.0	9.5
545900	Printing & Photo. Services	56.0	7.6	48.4	40.0	8.4
546100	Postage & Mail Services	120.0	62.9	57.1	40.0	17.1
546400	Rent of Land & Buildings	115.8	58.6	57.2	57.2	0.0
546409	Rent - Interagency	8.6	2.1	6.5	6.5	0.0
546500	Rent of Equipment	43.3	9.9	33.4	23.0	10.4
546600	Telecomm	21.0	1.4	19.6	5.0	14.6
546610	DOIT Telecomm	56.1	33.5	22.6	30.0	(7.4)
546700	Subscriptions & Dues	7.0	0.0	7.0	5.0	2.0
546800	Employee Training & Education	5.0	0.3	4.7	5.0	(0.3)
546801	Board Member Training	10.0	0.0	10.0	5.0	5.0
546900	Advertising	1.0	0.1	0.9	1.0	(0.1)
547900	Miscellaneous Expense	1.3	1.0	0.3	0.7	(0.4)
547999	Request to Pay Prior Year	0.0	10.8	(10.8)	0.0	(10.8)
548300	Information Technology Equipment	5.0	6.7	(1.7)	5.0	(6.7)
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**	**257.6**	**291.0**	**277.8**	**13.2**

2022 Market Comparison of Commercially Available Plans (Pre-Medicare)

New Mexico Health Care Exchange Plans	Retiree Premium	Spouse Premium	Ret + Spouse Premium	Plan Type	Plan Level	Deductible Individual	Out-of-Pocket Max Individual	First Dollar Coverage
Blue Cross Blue Shield (205) - Age: 60 - Albuquerque	$628	$628	$1,257	HMO	Gold	$750	$8,700	Y
True Health (500/30) - Age: 60 - Albuquerque	$793	$793	$1,586	HMO	Gold	$500	$8,700	Y
Ambetter from Western Sky Comm. Care (Secure Care 5)	$634	$634	$1,267	HMO	Gold	$1,450	$6,300	Y
Blue Cross Blue Shield (204) - Age: 60 - Albuquerque	$803	$803	$1,606	HMO	Silver	$2,200	$8,700	Y
True Health (2500/40) - Age: 60 - Albuquerque	$966	$966	$1,932	HMO	Silver	$2,500	$8,700	Y
Ambetter from Western Sky Comm. Care (Balanced Care 31)	$689	$689	$1,378	HMO	Silver	$5,450	$6,450	N
Presbyterian Health Plan, Inc. (Bronze 2) - Age: 60 - Albuquerque	$641	$641	$1,283	HMO	Bronze	$8,700	$8,700	N
True Health (Expanded bronze 6900/40) - Age: 60 - Albuquerque	$591	$591	$1,182	HMO	X-Bronze	$6,900	$8,700	Y
Friday health plans (Expanded bronze plus) - Age: 60 - Albuquerque	$507	$507	$1,014	HMO	X-Bronze	$8,700	$8,700	Y
Blue Cross Blue Shield (205) - Age: 60 - Santa Fe	$861	$861	$1,722	HMO	Gold	$750	$8,700	Y
True Health (500/30) - Age: 60 - Santa Fe	$781	$781	$1,562	HMO	Gold	$500	$8,700	Y
Ambetter from Western Sky Comm. Care (Secure Care 5)	$867	$867	$1,733	HMO	Gold	$1,450	$6,300	Y
Blue Cross Blue Shield (204) - Age: 60 - Santa Fe	$1,100	$1,100	$2,201	HMO	Silver	$2,200	$8,700	Y
True Health (2500/40) - Age: 60 - Santa Fe	$952	$952	$1,903	HMO	Silver	$2,500	$8,700	Y
Ambetter from Western Sky Comm. Care (Balanced Care 31)	$942	$942	$1,885	HMO	Silver	$5,450	$6,450	N
Presbyterian Health Plan, Inc. (Bronze 2) - Age: 60 - Albuquerque	$641	$641	$1,283	HMO	Bronze	$8,700	$8,700	N
True Health (Expanded bronze 6900/40) - Age: 60 - Albuquerque	$582	$582	$1,165	HMO	X-Bronze	$6,900	$8,700	Y
Friday health plans (Expanded bronze plus) - Age: 60 - Albuquerque	$557	$557	$1,115	HMO	X-Bronze	$8,700	$8,700	Y
Blue Cross Blue Shield (205) - Age: 60 - Las Cruces	$824	$824	$1,649	HMO	Gold	$750	$8,700	Y
True Health (500/30) Age: 60 - Las Cruces	$852	$852	$1,704	HMO	Gold	$500	$8,700	Y
Ambetter from Western Sky Comm. Care (Secure Care 5)	$817	$817	$1,634	HMO	Gold	$1,450	$6,300	Y
Blue Cross Blue Shield (204) - Age: 60 - Las Cruces	$1,053	$1,053	$2,107	HMO	Silver	$2,200	$8,700	Y
True Health (2500/40) - Age: 60 - Las Cruces	$1,038	$1,038	$2,075	HMO	Silver	$2,500	$8,700	Y
Ambetter from Western Sky Comm. Care (Balanced Care 31)	$889	$889	$1,777	HMO	Silver	$5,450	$6,450	N
Presbyterian Health Plan, Inc. - Age: 60 - Las Cruces	$898	$898	$1,796	HMO	Bronze	$8,700	$8,700	N
True Health (Expanded bronze 6900/40) - Age: 60 - Las Cruces	$635	$635	$1,270	HMO	Bronze	$6,900	$8,700	Y
Friday Health Plans (Expanded bronze plus) - Age 60 - Las Cruces	$606	$606	$1,213	HMO	Bronze	$8,700	$8,700	Y

Staff Recommendations for
NMRHCA 5-Year Strategic Plan
2018 – 2022
Approved November 2017

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

   PBM Contract 7/1/2018 – 6/30/2022 – Currently in 4th Year
   Introduction of SaveOn Program August 2019
   Introduction of Patient Assurance Program – Insulin Copay Caps
   Increase in min/max copays for Brand drug prescriptions
   Broad Performance Network (Medicare Supplement Rx)

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

   Development of 3-tier benefit plan through BCBS

3. Reduce pre-Medicare retiree subsidies*
   - Currently 64 percent
     No change

4. Reduce pre-Medicare spousal subsidies*
   - Currently 36 percent
     No change

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

   Introduction of Community Health Worker Program (Presbyterian pre-Medicare/MA) Introduction of Paramedicine Program (BCBS)

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

- Accountable-care organizations
- Bundled-payment arrangements
- Referenced-based reimbursements

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

    Failed attempt to partner w/Grand Rounds

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

      Addition of Livongo Diabetes Management Program
      Addition of Wondr Health (Naturally Slim Program)
      2019 Health Fair, 2021 two Virtual Health Fairs
      Addition of Hinge Health Pilot Program

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

    2018 – No legislation
    2019 – HB95 passed State Government, Elections & Indian Affairs Committee / tabled in House
    Appropriations and Finance Committee
    2020 – HB45 passed both chambers of the legislature vetoed by Governor
    2021 – No legislation
    2022 – Proposed Legislation HB74 and SB112 in progress

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

    Monthly Medicare seminar
    Entity pre-retirement seminars
    Employer group newsletters
    Annual HIPAA training for all employees

*Consensus carryover items from previous strategic plan.

BOARD OF DIRECTORS
DOUG CRANDALL
PRESIDENT
THERESE SAUNDERS
VICE PRESIDENT
LEANNE LARRAÑAGA-RUFFY
SECRETARY
NEIL KUEFFER
INTERIM EXECUTIVE DIRECTOR

NEW MEXICO RETIREE HEALTH CARE BOARD

PROCLAMATION

WHEREAS, The New Mexico Retiree Health Care Board relies on New Mexico Retiree Health Care Authority staff to carry out its statutory mission of providing affordable group insurance coverage to member Retirees and their dependents;

WHEREAS, Tomas Rodriguez, one of the New Mexico Retiree Health Care Authority's longest serving employees, retired today, the first day of February, two thousand twenty-two;

WHEREAS, Tomas Rodriguez devoted over twenty years of his career to ensuring that the New Mexico Retiree Health Care Authority provided impeccable service to current public employees, participating employer groups, Retirees, and their dependents;

WHEREAS, Tomas Rodriguez achieved success in positions of increasing responsibility, including serving as Interim Executive Director and Chief Information Officer, while administering the New Mexico Retiree Health Care Authority, modernizing and securing its technical infrastructure, and serving as leader and role model to others;

NOW THEREFORE, I, Doug Crandall, New Mexico Retiree Health Care Board President, on behalf of the New Mexico Retiree Health Care Board and the New Mexico Retiree Health Care Authority proclaim gratitude to Tomas Rodriguez for his years of dedicated public service and our wishes for the best of luck in retirement.

Done following a vote in open session of the New Mexico Retiree Health Care Board, this first day of February, two thousand twenty-two,

____

DOUG CRANDALL
PRESIDENT

Attestation,

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LEANNE LARRAÑAGA-RUFFY
SECRETARY