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REGULAR MEETING
OF THE
BOARD OF DIRECTORS

April 10, 2023
9:30 AM

CNM Workforce Training Center, Room 207
5600 Eagle Rock Ave. NE, Alb. NM 87113
Online: https://meet.goto.com/NMRHCA/boardmtgapril2023
Telephone: 1-224-501-3412 / Access Code: 361-514-069

New Mexico Retiree Health Care Authority
Regular Meeting

BOARD OF DIRECTORS

ROLL CALL

April 10, 2023

	Member in Attendance		
Mr. Crandall, President			
Ms. Saunders, Vice President			
Ms. Larranaga-Ruffy, Secretary			
Mr. Scroggins			
Mr. Salazar			
Ms. Montoya			
Mr. Widner			
Mr. Bhakta			
Mr. Pyle			
Ms. Alirez			

NMRHCA BOARD OF DIRECTORS

April 2023

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

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

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

Mr. Sanjay Bhakta
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City/County Building
Albuquerque, NM 87102
sbhakta@cabq.gov

Mr. Jamie Widner
Superintendents' Association of NM
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Melrose, NM 88124
jwidner@yucca.net
575-799-3348

The Honorable Ms. Laura M. Montoya
NM State Treasurer
2055 South Pacheco Street
Suite 100 & 200
Santa Fe, NM 87505
laura.montoya@sto.nm.gov
505-955-1120

Mr. Rick Scroggins
Alternate for ERB Executive Director
Educational Retirement Board
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505-476-6152

Mr. Lance Pyle
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Mr. Tomas E. Salazar, PhD
NM Assoc. of Educational Retirees
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salazarte@plateautel.net
505-429-2206

Ms. Raquel Alirez
Classified State Employee
401 Broadway NE
Albuquerque, NM 87102
raquel.alirez@state.nm.us
505-365-3474

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

April 10, 2023
9:30 AM
CNM Workforce Training Center
5600 Eagle Rock Ave NE, Alb. NM 87113
Online: https://meet.goto.com/NMRHCA/boardmtgapril2023
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AGENDA

1.	Call to Order	Mr. Crandall, President	Page
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder	
3.	Pledge of Allegiance	Mr. Crandall, President	
4.	Approval of Agenda	Mr. Crandall, President	4
5.	Approval of Regular Meeting Minutes March 7, 2023	Mr. Crandall, President	5
6.	Public Forum and Introductions	Mr. Crandall, President	
7.	Committee Reports	Mr. Crandall, President	
8.	Executive Director's Updates	Mr. Kueffer, Executive Director	
	a. Human Resources		
	b. Operations		
	c. Wellness Virtual Fair Update		
	d. Consultant RFP Big Bid		12
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	i. Investment Performance Report – December 2022		55
9.	FY23 Contract Amendments	Mr. Kueffer, Executive Director	58
10.	FY24 Operating Budget (Action Item)	Mr. Kueffer, Executive Director	59
11.	FY24 Contracts Amendments/New	Mr. Kueffer, Executive Director	62
12.	Other Business	Mr. Crandall, President	
13.	Executive Session	Mr. Crandall, President	

Pursuant to NMSA 1978, Section 10-15-1(H)(2) To Discuss Limited Personnel Matters; NMSA 1978, Section 10-15-1(H)(7) Pertaining to Threatened or Pending Litigation

14. Date & Location of Next Board Meeting — Mr. Crandall, President

May 2, 2023 – 9:30AM
CNM Workforce Training Center
5600 Eagle Rock Ave NE, Alb. NM 87113

15. Adjourn

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

March 7, 2023

1. CALL TO ORDER

A Regular Meeting of the Board of Directors of the New Mexico Retiree Health Care Authority was called to order on this date at 9:30 a.m. in Room 207. CNM Workforce Training Center, 5600 Eagle Rock Avenue, NE, Albuquerque, New Mexico.

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 [left at 11:00 a.m.]
The Hon. Laura Montoya, NM State Treasurer
Mr. Sanjay Bhakta
Mr. Lance Pyle {telephonically]
Dr. Tomas Salazar
Mr. Rick Scroggins

Members Excused:
Ms. Rachel Alirez
Mr. Jamie Widner

Staff Present:
Mr. Neil Kueffer, Executive Director
Mr. Keith Witt, Deputy Director
Ms. Sheri Ayanniyi, Chief Financial Officer
Mr. Jess Biggs, Director of Communication & Member Engagement
Mr. Trinity Angelino, Network Administrator
Mr. Raymond Long, Chief Information Officer
Ms. Judith Beatty, Recorder

3. PLEDGE OF ALLEGIANCE

Mr. Biggs led the Pledge.

4. APPROVAL OF AGENDA

Treasurer Montoya moved for approval of the agenda, as published. Ms. Larrañaga-Ruffy seconded the motion, which passed unanimously.

5. APPROVAL OF REGULAR MEETING MINUTES: February 7, 2023

Treasurer Montoya moved for approval of the February 7, 2023, minutes. Ms. Larrañaga-Ruffy seconded the motion, which passed unanimously.

6. PUBLIC FORUM AND INTRODUCTIONS

Attendees and board members introduced themselves.

7. COMMITTEE REPORTS

- The Executive Committee met last week to approve today's agenda. The Finance/Investment Committee also met to discuss today's action items. [Mr. Crandall]

8. EXECUTIVE DIRECTOR'S UPDATES

a. Human Resources

- Mr. Kueffer presented updates.

- Ads placed in the *Albuquerque Journal* and *New Mexican* for the General Counsel position yielded no response. NMRHCA is working with HR to place ads in other publications, including the State Bar Bulletin.

b. Wellness Updates

- Hinge program update: As of February 24, 66 retirees were enrolled in the Chronic program and 12 were enrolled in the Acute program. This is triple the number enrolled on January 31. The campaign to get the word out among the members appears to be succeeding.

- The Wellness Committee is scheduled to meet on April 19, when it will review the wellness scorecard and hear a report from Hinge Health.

- The Virtual Health Fair is scheduled on May 23. This is still in the planning stages.

c. Humana Business Update

- Humana is exiting the Employer Group Commercial Medical Products business for their pre-Medicare population. The NMRHCA will not be affected by this move.

d. Presbyterian Business Update

- Presbyterian Health Services has announced that it is exploring the formation of a parent organization with Iowa-based UnityPoint Health to consolidate administrative functions and ease cost burdens on both systems. Because this is in the exploratory stages, any impact on NMRHCA members or to Presbyterian is not known.

e. End of COVID-19 Public Health Emergency

- The Department of Health and Human Services is planning to end the COVID-19 Public Health Emergency effective May 11, 2023. Some of the items contained within the health orders included coverage vaccines, testing, and treatments as well as expanded telehealth services to provide more access. NMRHCA will be working with its health plan providers on these items as it returns to the pre-pandemic stage.

Mr. Kueffer commented that the one area he hopes will stay in place is the behavioral telehealth component, because a lot of NMRHCA members continue to take advantage of it. There is some coverage through Medicare that will continue in place for some of the other services. NMRHCA will continue to work with its health plan to make sure it is educating the members of any changes and how they can still access care.

f. Public Entity Participation Inquiries Update

- Public entities potentially interested in joining the NMRHCA are Taos Soil and Water Conservation District; Southeast New Mexico College, Carlsbad; City of Grants; and the Town of Red River. All public entities interested in joining the NMRHCA must meet with the actuaries (Segal) to determine the buy-in amount. The public entity makes direct payment to Segal for those services and NMRHCA bears no cost.

g. Legislative Updates

Mr. Kueffer reviewed pending legislation:

Senate Bill 14: [Amends and enacts sections of the Pharmacy Benefits Manager Regulation Act.] This would have a substantial financial impact on the NMRHCA plan and its membership. The NMRHCA offers the SaveOn program through Express Scripts, and gets network discounts through Express Scripts. A lot of those amounts would be passed on to the NMRHCA. This would

mean the NMRHCA would have to pass the cost back to the membership through premiums, or else eliminate the SaveOn program altogether, which would mean the $0 copays on prescriptions could not be offer members for participating in the program. The FIR reflects an estimated $16.6 million impact on the NMRHCA.

Senate Bill 453/Senate Bill 484 (merged into substitute bill): [Amending the Health Care Purchasing Act.] Looks at how the NMRHCA would do its procurement process, stipulating healthcare benefits, specifying pre-Medicare plans. The NMRHCA would lock into these contracts for one year, allowing time for the creation of the new health care authority.

Mr. Kueffer stated that this bill is moving very rapidly, ostensibly because the NMRHCA is preparing to go into the RFP process for a consultant for medical, dental and vision in the Medicare plans and would normally go for a four-year bid with one-year renewals. It takes about 18 months to go through the proposal process, get a consultant in place, and then enter into contracts on the back end, so doing this annually is going to impact the NMRHCA. It would have to do some streamlining and cut back in certain areas, which would be tough.

Mr. Scroggins noted that SB 484 requires publicly funded health care agencies to enter into a joint powers agreement with somebody. Because MOUs, JPAs and the like require negotiation and agreement, he wondered if the NMRHCA could just say no and not sign the JPA.

Chairman Crandall agreed that the NMRHCA doesn't have to agree. He noted that Rodey, the NMRHCA's legal advisor, is looking into this issue. If a law passes that affects what the NMRHCA board does, then it definitely needs to make a formal statement that it would not sign the JPA because its statutory authority would be usurped.

Mr. Kueffer stated that, in discussion with Rodey, he was told that if there are some later statutes or laws that are passed, they have precedence over the earlier statutes and laws.

Senate Bill 16: [Renaming Human Services Department as Health Care Authority Department, providing for transition, changing powers and duties.] This bill is moving very fast, and the NMRHCA did not have enough time to discuss it with the sponsor. Although the NMRHCA was given the authority to administer its program through state statute, it appears administrative authority is being transitioned to the new Health Care Authority agency. As written, this bill would have no impact on the NMRHCA.

House Bill 150: [NMRHCA]. Tabled because appropriations were not included in House Bill 2.

Senate Bill 193: [NMRHCA]. Still awaiting a hearing at the Senate Finance Committee.

h. January 31, 2023, SIC Reports

- The fund gained $37 million in January for a new high of $1.166 billion.

Treasurer Montoya noted that the 30-day rate for the LGIP is now at 4.655%. This might be something the NMRHCA might consider investing in.

9. FY23 NEW SMALL CONTRACTS

Web Portal Application Services

Mr. Kueffer stated that this relates to a prior dollar amount allocated to the NMRHCA to put a web portal in place for members that would give retirees the ability to upload their scanned documents, review benefits, enroll, and request changes to personal information. The portal was designed and developed by the current website host and vendor, Real Time Solutions. The NMRHCA moved to the second phase, which started the build-out and allowed the NMRHCA to make fixes within the portal; however, its functionality continues to evolve due to changes in process, new requirements (CMS – Race/Ethnicity), errors/bugs found and eliminated, and some previously undetected design flaws. Additional work and funds are needed to complete the process. The cost estimate for these services is $13,307.13.

Mr. Kueffer said the scope of work summary was on page 85.

Mr. Kueffer requested permission to enter into a new small purchasing contract with Real Time Solutions to provide the specified scope of work.

Chairman Crandall said the Finance Committee reviewed this item and recommended approval.

Ms. Larrañaga-Ruffy moved for approval. Chairman Crandall seconded the motion.

Responding to Mr. Scroggins, Mr. Kueffer said the NMRHCA doesn't have a system in place to accept digital signatures at the current time.

Mr. Scroggins said that, based on the NMERB's experience with DocuSign, he would caution the NMRHCA very strongly to examine all digital signature opportunities.

The motion passed unanimously.

Internal Audit Services

Mr. Kueffer stated that the NMRHCA continues to look at ways of creating more efficiencies within the agency and has identified services that can improve operations by evaluating current business practices, processes and procedures. This is an increasingly common practice among agencies, and NMRHCA is seeking quotes from the vendor currently used by PERA and NMERB along with two additional quotes. The NMRHCA does not have the budget to issue an RFP for these services and take on a larger scope of work. With the budget it does have, it is looking at a small purchasing contract for internal audit services to review the NMRHCA's accounting and finance policies and procedures as well as its information technology policies and procedures.

Mr. Kueffer requested approval to contract with an audit firm to provide internal audit services for the scope of work references, not to exceed $40,000, to improve internal processes and operations within the agency.

Mr. Kueffer said firms the NMRHCA is seeking quotes from include Moss Adams, REDW, and CliftonLarsonAllen.

Treasurer Montoya so moved. Ms. Saunders seconded the motion.

Responding to Mr. Bhakta, Mr. Kueffer said the NMRHCA's contract with Moss Adams expires at the end of this fiscal year. With the rule change, however, changing the contractual period from six years to eight years, Moss Adams could still do an additional two years if they were to submit for an RFP. This may preclude them from submitting a quote for the internal audit services.

Mr. Bhakta commented that, generally speaking, Moss Adams is required to tell the NMRHCA if they find any inefficiencies in the internal controls; so if they had something to tell Mr. Kueffer or the board, they might have already. The NMRHCA would get a bigger bang for the buck if it were to hire someone else who can take a look with fresh eyes.

Mr. Scroggins said the NMERB is going through the RFP process right now for internal audit services, and makes it a practice to not use a firm that also does the financial audit.

Treasurer Montoya said she would like it specified that the internal audit will not be done by the same auditing firm that does the external audit. She would like the NMRHCA to seek quotes from three firms, not to include Moss Adams.

Treasurer Montoya moved this amendment. Mr. Bhakta seconded.

The motion, as amended, passed unanimously. [Ms. Larrañaga-Ruffy was not present.]

10. FY23 FINANCIAL AUDIT RFP

Mr. Kueffer state that the NMRHCA is authorized to enter into one-year agreements for up to three years prior to initiating the procurement process for Independent Public Accountant (IPA). The financial audits for FY22 represent the limit of NMRHCA's agreement with Moss Adams for audit services, as this will complete the third year of the contract. Additionally, the Audit Rule and State Procurement Code require the agency to seek approval from the Office of the State Auditor (OSA) prior to beginning the process of procurement IPA services. The State Auditor will be releasing and approving directions and guidelines regarding the 2023 Audit Rule and procurement parameters, and staff is seeking board approval to initiate the IPA procurement process.

Mr. Kueffer requested approval to seek the OSA's authorization to issue an RFP for professional financial audit services.

Chairman Crandall said the Finance Committee reviewed and approved this item, and recommended approval.

Mr. Scroggins moved for approval. Dr. Salazar seconded the motion, which passed unanimously. [Ms. Larrañaga-Ruffy was not present.]

11. IBAC BENEFIT PLAN COMPARISONS 2023

Mr. Kueffer stated that the IBAC Benefit Plan Comparisons were on pages 89-90. The NMRHCA is fairly in line with its partner agencies.

12. OTHER BUSINESS

Mr. Kueffer said the annual board meeting is tentatively scheduled for July 19-21 in Angel Fire.

13 EXECUTIVE SESSION

None.

14. DATE AND LOCATION OF NEXT BOARD MEETING

April 10, 2023 – 9:30 a.m.
CNM Workforce Training Center
5600 Eagle Rock Ave NE, Albuquerque NM 87113

15. ADJOURN 11:15 a.m.

Accepted by:

_____

Doug Crandall, President

ALBUQUERQUE PUBLIC SCHOOLS
REQUEST FOR PROPOSAL

RFP #23-066 NLM

RFP TITLE Consultant for IBAC Medical, Dental & Vision Plan

NIGP Commodity Code: 918-69

RFP Schedule

Action	Date & Time
RFP Issued	03/04/2023
READ ALL DOCUMENTS: Offerors must familiarize themselves with all documents contained herein; it is mandatory that all submitted offers be in compliance with all the provisions contained in the Request for Proposal. Offerors should promptly notify the Buyer of any ambiguity, inconsistency, error, or missing attachments which they may discover upon examination of the RFP.	
Deadline for Questions	03/10/2023 @ 5:00pm (local time)
RFP Due Date and Time	03/29/2023 @ 3:00pm (local time)
Proposals must be received by the due date and time. No late proposals will be accepted. The only acceptable evidence to establish the time of receipt is the date/time stamp from electronic bidding system (Vendor Registry).	
Evaluation of Proposals	TBD
Contract Negotiations	TBD

The RFP Buyer will make every effort to adhere to the RFP Schedule as shown above. The schedule is subject to change by addendum. The evaluation committee **MAY** interview the Offeror(s) of the top rated proposals; however, contracts may be awarded without such interviews and based solely on written offers. Finalists will be contacted to schedule interviews if required. If an interview is requested, evaluation scores will be re-scored to reflect written response and interview response. Please be prepared to present if requested on April 17 and 18, 2023 via Zoom or other agreed to platform.

RFP Buyer Contact Information

Name: Nathaniel L. Molinar	
Phone Number: 505-878-6118	
E-Mail: nathaniel.molinar@aps.edu	
Any inquiries or requests regarding clarification of this RFP document shall be submitted to the buyer in writing. Offerors may contact ONLY the buyer regarding the terminology stated in the procurement documents. Any other communication will be considered unofficial and non-binding.	

RFP Submittal

Proposals must be submitted electronically via electronic bidding system (Vendor Registry) by required date and time as noted on RFP document.

https://vrapp.vendorregistry.com/Vendor/Register/Index/albuquerque-public-schools-nm-vendor-registration

Offerors understand and agree that technical support may not be readily available the day of and or the hours/minutes prior to due date and time. Offerors also understand and agree that internet access, browsers, and operating systems are not supported by the District and/or its agents. **Offerors are strongly encouraged to review, create, and submit all electronic RFP responses several days in advance of the due date and time.**

RFP Term

Albuquerque Public Schools reserves the right to enter into an 18-24 month contract with the awarded Offeror. Contract length is dependent on contract negotiations between consultant and insurance providers but will not exceed 24 months.

The Interagency Benefits Advisory Committee (IBAC) is a joint purchasing collective established by state statute which consists of the State of New Mexico Risk Management Division, New Mexico Public Schools Insurance Authority, New Mexico Retiree Health Care Authority, Albuquerque Public Schools and the membership of each of these agencies.

The Health Care Purchasing Act of 1997, which became effective on July 1, 1997, is an act related to publicly funded health care programs to provide for consolidated negotiation and purchasing of insurance. This act requires the four agencies listed above to complete a single process for the procurement of employee benefits by these publicly funded agencies. However, the four agencies are not required to select the same provider/carrier. This act also requires that all requests for proposals issued as part of the consolidated purchasing shall include at least one distinct service area consisting of the Albuquerque metropolitan area. Proposals on a distinct service area shall be evaluated separately.

Legislation proposed during the 2023 State of New Mexico Legislative Session may amend or change provisions of the Health Care Purchasing Act, or how the IBAC operates.

OVERVIEW

The IBAC is a joint purchasing collective established by state statute which consists of the following entities (and their membership):
State of New Mexico Risk Management Division
New Mexico Public Schools Insurance Authority
New Mexico Retiree Health Care Authority
Albuquerque Public Schools

All IBAC entities currently provide comprehensive medical, dental, and vision benefits to their members (employees and eligible dependents, and retirees and eligible dependents). A majority of these benefits are self-insured; though, there are some fully insured offerings as well. Plan designs and carriers differ. Please reference each entities' web site for additional information.
State of New Mexico Risk Management Division - https://www.mybenefitsnm.com/
New Mexico Public Schools Insurance Authority - https://nmpsia.com/index.html
New Mexico Retiree Health Care Authority - http://nmrhca.org/
Albuquerque Public Schools - https://www.aps.edu/human-resources/benefits

A focus of this RFP will be the pursuit of specific objectives related to cost saving measures including value-based purchasing and other innovative approaches. The IBAC is looking for a consultant who can provide us with ideas and solutions which will place emphasis on cost saving throughout the totality of this procurement cycle. This approach should consider but not be limited to:

A. Value-Based Plan Design

B. Enhanced and Standardized Reporting

C. Value-Based Provider Reimbursement – Consideration will be given to opportunities both with and without medical plan administrator participation

D. Innovative approach to Performance Guarantees that will result in cost savings to the IBAC agencies and value to our employees.

RFP SCHEDULE

The RFP Buyer will make every effort to adhere to the RFP Schedule as noted on front cover of this RFP. The schedule is subject to change by addendum. The evaluation committee **MAY** interview the Offeror(s) of the top rated proposals; however, contracts may be awarded without such interviews and based solely on written offers. Finalists will be contacted to schedule interviews if required. If an interview is requested, evaluation scores will be re-scored to reflect written response and interview response.

PURPOSE OF THIS REQUEST FOR PROPOSAL

The purpose of the Request for Proposal (RFP) is to solicit sealed proposals, to establish a contract through competitive negotiations for the procurement of consulting/project management services to assist in the procurement of dental, vision and medical plans (including Medicare Advantage and Medicare Supplement) for The Interagency Benefits Advisory Committee (IBAC) and its approximately 138,000 eligible employees/retirees and approximately 176,000 medical plan enrolled members.

The scope of this procurement is limited to consulting and project management services associated with the development and evaluation of a comprehensive RFP for dental, vision and medical services/administrators

(including Medicare Advantage and Medicare Supplement plans), along with wellness services, point solutions, and Employee Assistance Program (EAP) for some of the IBAC agencies. The awarded contractor will work with the IBAC in all phases of the development and evaluation of the RFP, to include timeline, questionnaires for each type of service, data-gathering, evaluation criteria (including scoring template), assistance with response to bidder's questions, assistance in the evaluation of the RFP responses, to include both detailed and summary evaluation reports (including analyst of technical and financial responses, finalist presentations and best and final offers), and assistance in reviewing the resulting contracts to be certain all agreed-upon provisions from the RFP are captured in the final contracts.

Any inquiries or requests regarding this procurement should be submitted to the RFP Buyer in writing. See Cover Page of RFP. Offerors may contact ONLY the RFP Buyer regarding the procurement. Other APS or IBAC agency employees do not have the authority to respond to questions related to this RFP.

SCOPE OF SERVICES

APS is seeking a consultant to handle the procurement of IBAC medical, dental, vision, wellness services, point solutions, and EAP services effective July 1, 2024 for State of New Mexico Risk Management Division, New Mexico Public Schools Insurance Authority, and New Mexico Retiree Health Care Authority and effective January 1, 2025 for Albuquerque Public Schools. It is the IBAC's goal that this comprehensive RFP be released the first week in July, 2023. The consultant will act as project manager for the following services:

1. Based on input and direction from the APS RFP Buyer and the IBAC agencies, develop an IBAC-specific Request for Proposal (RFP) for dental, vision and medical services/administrators (including Medicare Advantage and Medicare Supplement plans), wellness services, point solutions, and EAP, while adhering to state-mandated purchasing guidelines and to the Health Care Purchasing Act; assume responsibility for state-mandated publication of the RFP. The RFP will ask for proposals for both self-funded and fully insured dental and vision plans, and shall include at least one distinct service area consisting of the Albuquerque metropolitan area. Proposals on a distinct service area shall be evaluated separately.

2. Collect all experience and eligibility/enrollment information needed for this RFP from each IBAC agency and/or the existing plan administrators/vendors. (This is generally time-consuming, and the Project Manager needs to ensure the data is reviewed for reasonableness and consistency.)

3. Include in the RFP desired services requested by each IBAC agency including any changes to be considered for the new contracts (i.e., a change in funding type). After collaboration with the IBAC agencies include in the RFP the agreed upon cost savings approaches and performance guarantees by type of service that will drive plan savings for the agencies and value for our members.

4. Provide a detailed timeline, methodology, and strategy as to how the management of the RFP will be accomplished and evaluated by the IBAC. Develop a scoring template for IBAC agency use in the evaluation of each proposal.

5. Work closely with the assigned APS RFP Buyer and IBAC agencies to respond to offeror's questions and develop any needed addendums to the RFP.

6. Prepare and present to the IBAC any necessary or requested reports on all components of the RFP (mandatory specifications, desirable specifications, questionnaire(s), costs, etc.). Complete a comprehensive evaluation of the medical proposals (including Medicare Advantage and Medicare Supplement) and dental, vision, wellness services, point solutions and EAP proposals for each applicable IBAC agency and provide related

reporting including a side-by-side comparison of responses. Also to include but not be limited to analysis such as network disruption and geo-access reporting.

7. Assist with finalist interviews and with establishing and calculating the evaluation point summary, cost ranking, and total awarded points to include a best and final analysis.

8. Complete a comprehensive analysis of cost projections and assist the IBAC agencies in the evaluation of the cost of each offeror's proposal. Ensure the cost analysis for medical, dental, vision, wellness services and point solutions shows each agency on a solo basis, as well as the entire IBAC jointly. (In the past, there were quoted Administive Service Only (ASO) fees/other costs that varied by the number of IBAC agencies that awarded their business to that plan administrator/vendor. This requires the project manager to evaluate the impact of the various combinations.)

9. Provide guidance to the evaluation committee to make an informed decision after completion of finalist interviews, including best and final offers (BAFO).

10. Collaborate with the IBAC agencies to prepare the evaluation report required by the APS Procurement Department.

11. Assist and advise IBAC agencies with negotiations and implementation guidance. Work with each IBAC agency during the contracting phase with the awarded offerors to be certain all agreed-upon provisions in the RFP are captured in the final contracts.

12. Collaborate and cooperate with the IBAC Procurement offices (CPO or designee) in preparing any protest determination.

Note: Your proposal needs to outline the total cost for these services for the four IBAC agencies. However, also provide a breakdown of the cost by agency based on their requested services:

SONM – medical, dental, vision, wellness services, point solutions and EAP
NMPSIA – medical, dental, vision, wellness services, and point solutions
NMRHCA – medical, Medicare Advantage, Medicare Supplement, dental, vision, wellness services, and point solutions
APS – medical, dental, vision, and point solutions

The contract between APS and a contractor will follow the format specified by APS and contain the terms and conditions set forth in the Draft Contract Exhibit A, included in the Forms and Attachments Section of this RFP. Should an Offeror object to any of the terms and conditions as set forth in the RFP Draft Contract, the Offeror must propose specific alternative language in tracked changes/redline format on the Draft Contract, and provide that redlined document as part of the RFP response. Complete substitution of the contractor's standard contract for the Draft Contract is not acceptable to APS. If the Offeror agrees with all terms and conditions in the Draft Contract, that should be indicated as a comment on the Draft Contract, and the Draft Contract returned to APS as part of the RFP response.

Note: Performance Guarantees related to the Offeror's adherence to the timeline agreed upon between the awarded Offeror and the IBAC agencies will be included as part of the contract resulting from this RFP.

EVALUATION CRITERIA

Proposals must address each of the following criteria. Each proposal may be awarded points up to the numeric value listed. Points will be awarded in compliance with NMSA 1978, §13-1-21, for New Mexico In-State Resident Business, Native American Resident Business, New Mexico Resident Veteran Business or Native American Resident Veteran Business. If proposal is a Joint Venture, Offeror shall state in submitted proposal the percentage of work that will be performed by each business. Obtain more information:
http://tax.newmexico.gov/Businesses/in-state-veteran-preference-certification.aspx **and**
https://www.generalservices.state.nm.us/statepurchasing/vendorpreferencelist.aspx
Please Note: An Offeror cannot be awarded both a resident business preference and a resident veteran business preference or a Native American resident preference and a Native American resident veteran contractor preference.
The Preference(s) does not apply if APS is utilizing federal funds.
The Offeror should contact Buyer for clarification of evaluation criteria or terminology

	Possible Points	Points This RFP
Corporate Experience and Qualifications – Traditional Provider Network Valuations (20 Points): Offerors must submit a statement of relevant corporate experience within the last five (5) years, including the experience of major subcontractors, if any. The narrative in response to this factor must thoroughly describe the Offeror's experience with providing consulting services related to medical (including Medicare Advantage and Medicare Supplement), dental and vision benefits-related purchases and services using a traditional valuation of provider network unit cost comparisons. Also include your corporate experience with providing consulting services related to the evaluation and purchase of wellness services, point solutions and Employee Assistance Programs (EAP). In this Section, the Offeror shall provide the following information (referencing the subsections in sequence) to evidence the Offeror's experience in delivering services such as those sought under this RFP: a. A brief statement of how long the Offeror has been performing the services sought under this RFP. b. A description of the experience level, technical and application knowledge, and public sector experience of the corporate resources that may be used for the services under this contract. c. A description of the service provided. d. A statement of why the Offeror believes these services constitutes relevant corporate experience to this procurement. e. A list, if any, of all current contractual relationships with the State of New Mexico (including any of the IBAC agencies) or those contracts completed in the past five years. The listing should include the contract term, and procuring State Agency for each reference.	20	

. **Corporate Experience and Qualifications – Innovative approaches for solutions and evaluation of cost saving measures including Value Based Purchasing (28 Points):** Offerors must submit a statement of relevant corporate experience including the experience of major subcontractors, if any. The narrative in response to this factor must thoroughly describe the Offeror's experience with providing consulting services related to medical (including Medicare Advantage and Medicare Supplement), dental and vision benefits-related purchases and services specifically related to developing and evaluating cost saving measures (refer to Overview on page 23 of this RFP). In this Section, the Offeror shall provide the following information (referencing the subsections in sequence) to evidence the Offeror's experience in delivering services such as those sought under this RFP: a. A brief statement of how long the Offeror has been performing the services sought under this RFP. b. A description of the experience level, technical and application knowledge, and public sector experience of the corporate resources that may be used for the services under this contract. c. A description of the service provided. d. A statement of why the Offeror believes these services constitutes relevant corporate experience to this procurement. e. A list, if any of all current contractual relationships with the State of New Mexico (including any of the IBAC agencies) or those contracts completed in the past five years. The listing should include the contract term, and procuring State Agency for each reference.	28	
3. **Account Management (24 Points):** Offerors must submit resumes of all proposed professional staff members who will be performing services under the contract. Experience narratives shall be attached that describe the specific relevant experience of the staff members in relation to the role that member will perform for this contract. The narrative(s) must include the name of the individual(s) proposed and should include a thorough description of the education, knowledge, and relevant experience as well as certifications or other professional credentials that clearly shows how they are qualified to provide the required services to the IBAC. Your response to this RFP should also include a detailed timeline, including indication of IBAC responsibilities. This timeline should be based on the IBAC's goal of releasing the RFP for the services (medical, Medicare Advantage, Medicare Supplement, dental, vision, wellness, point solutions and EAP) the first week in July, 2023.	24	
Corporate References (3 Points): Offerors shall submit three (3) external references using Exhibit B from clients who have received similar services to those proposed by the Offeror for this contract, especially those projects in the public sector that have occurred within the past five (5) years. APS reserves the right to follow up on these and any other references in addition to the references given on Exhibit B.	3	

Cost (25 Points): Offeror's must complete the Cost Proposal Form in the Forms and Attachments Section of this RFP showing the cost associated with the services to be performed under this proposal. The lowest costing Offeror's quote will be used as the basis for all other calculations and receive the full 25 points. All other Offerors will be awarded points based on their relationship to the "basis" offer. Please ensure all proposals include and itemize appropriate GRT or other applicable taxes. (Note: Taxes are applicable to these services.) Include the total cost for these services for the four IBAC agencies and provide a breakdown of cost per agency based on their requested services: SONM – medical, dental, vision, wellness services, point solutions and EAP NMPSIA – medical, dental, vision, wellness services, and point solutions NMRHCA – medical, Medicare Advantage, Medicare Supplement, dental, vision, wellness services, and point solutions APS – medical, dental, vision and point solutions	25	
Total Possible Points	**100**	
Oral Presentation (50 Points): If selected as a finalist, the Offeror shall provide the Evaluation Committee the opportunity to interview all proposed core staff during an oral presentation via a virtual meeting platform at a date, time, and place set by the RFP Buyer. The individuals who will be performing services under the contract shall present the Offeror's proposal to the Evaluation Committee. Oral Presentations are tentatively planned for April 17 – 18, 2023.	**50**	
New Mexico Resident Business or Native American Resident Business Preference: Eight percent of the total possible points to a resident business. Offeror shall include a copy of their In-State Certificate issued by State of New Mexico Taxation & Revenue Department.	8	
Veteran New Mexico Resident Business or Native American Resident Veteran Business Preference: Ten percent of the total possible points to a resident veteran business or native American resident veteran business preference • Ten percent of the total possible points to a resident veteran business. • •10 points for Resident Veteran Business/Contractor with annual revenues of $3 million or less as verified by State of NM Tax & Revenue.	10	
Total Possible Awarded Points	**100-160**	

STATE OF NEW MEXICO

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

REQUEST FOR PROPOSALS (RFP)

FINANCIAL AND COMPLIANCE AUDIT SERVICES

RFP#
24-343-0380-00002

RFP Release Date: March 27, 2023

Proposal Due Date: April 18, 2023

II. CONDITIONS GOVERNING THE PROCUREMENT

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

A. SEQUENCE OF EVENTS

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

Action	Responsible Party	Due Dates
1. Issue RFP	Authority	March 27, 2023
2. Acknowledgement of Receipt Form	Potential Offerors	April 4, 2023
3. Deadline to submit Written Questions	Potential Offerors	April 7, 2023
4. Response to Written Questions	Procurement Manager	April 12, 2023
5. Submission of Proposal	***Potential Offerors***	***April 18, 2023***
6.* Proposal Evaluation	Evaluation Committee	April 19, 2023 – April 25, 2023
7.* Selection of Finalists	Evaluation Committee	April 26, 2023
8. * Oral Presentation(s)	Finalist Offerors	April 28, 2023 (Optional)
9.* Best and Final Offers	Finalist Offerors	April 28, 2023 (Optional)
10.* Submission NMRHCA Recommendation to State Auditor	Authority	May 2, 2023
11.* Finalize Contractual Agreements	Authority/Finalist Offerors	May 12, 2023
12.* Contract Awards	Authority/ Finalist Offerors	Final Signature of Approval
13.* Protest Deadline	SPD	+15 days from Contract Award

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

B. EXPLANATION OF EVENTS

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

1. Issue RFP

This RFP is being issued on behalf of the State of New Mexico Retiree Health Care Authority on the date indicated in Section II.A, Sequence of Events. It will be available on that date from the NMRHCA Internet website http://www.nmrhca.org/ by selecting the "Request for Proposals" link.

IV. SPECIFICATIONS

A. DETAILED SCOPE OF WORK

SCOPE OF WORK SUMMARY

1. Audit Services

The audits shall be conducted in accordance with government auditing standards including compliance with pertinent State Statutes, Rules and Regulations, and the New Mexico State Auditor's Rule codified at 2.2.2 NMAC. Such as but not limited to Financial and Compliance Audit, Financial Statement Audit, Financial Statement Preparation and Notes as included in Section 2.2.2.10 NMAC.

The contract shall begin on the approval date issued by the State Purchasing Department, Contract Review Bureau and end on June 30, 2024. The Term of the contract shall be for one year with the option to extend for three successive one-year terms, terms and conditions as was stated in the original multi-year proposal. Exercising such option to extend must be by mutual agreement of the parties to the contract and with the approval of the State Auditor and the State Purchasing Department, Contract Review Bureau (SPD/CRB).

Other services shall include: Financial Reporting for Postemployment Benefits Other Than Pension Plans, GASB 74 required by Section 2.2.2.10C. NMAC 1978. Also, Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions, GASB 75. This Statement establishes standards for recognizing and measuring liabilities, deferred outflows of resources, deferred inflows of resources and expense/expenditures. For benefit OPEB, this Statement identifies the methods and assumptions that are required to be used to project benefit payments, discount projected benefit payments to their actuarial present value, and attribute that present value to periods of employee service. The services shall include the Preparation of Employer Allocation Tables and the OPEB Reporting Guide.

2. Time Frame

The audit needs to be completed and the required number of copies of the audit report delivered to the Office of the State Auditor by November 22, 2023, in accordance with New Mexico Office of the State Auditor Rule 2.2.2.9 NMAC. For the fiscal year ended June 30, 2023, the Authority plans to present the draft of the final audit report to the Audit Committee Board Members at a designated scheduled meeting in November. A final presentation upon approval from the Office of the State Auditor will be conducted at the following regularly scheduled Board meeting.

V. EVALUATION

A. EVALUATION POINT SUMMARY

The following is a summary of evaluation factors with point values assigned to each. These weighted factors will be used in the evaluation of individual potential Offeror proposals by sub-category.

Evaluation Factors *(**C**orrespond to Sections IV.B and IV.C)*	**Points Available**
Technical Specifications (600 Total Points)	
B. 1. Organizational Experience	300
B. 2. Organizational References	150
B. 3. Mandatory Specification	300
Business Specifications (400 Total Points)	
C.1. Financial Stability	Pass/Fail
C.2. Letter Of Transmittal	Pass/Fail
C.3. Campaign Contribution Disclosure Form	Pass/Fail
C.4. Oral Presentations	100
C.5. Cost	150
TOTAL POINTS AVAILABLE	**1,000**
C.6. New Mexico / Native American Resident Preference	**80**
C.6. New Mexico / Native American Resident Veteran Preference Points per Section IV C.7	**100**

Table 1: Evaluation Point Summary

B. EVALUATION FACTORS

1. B.1 Organizational Experience (See Table 1)

Points will be awarded based on the thoroughness and clarity of Offeror's response in this Section. The Evaluation Committee will also weigh the relevancy and extent of Offeror's experience, expertise and knowledge; and of personnel education, experience and certifications/licenses. In addition, points will be awarded based on Offeror's candid and well-thought-out response to successes and failures, as well as the ability of the Offeror to learn from its failures and grow from its successes.

2. B.2 Organizational References (See Table 1)

Item		General Fund	Other State Funds	Intrnl Svc Funds/Inter-Agency Trnsf	Federal Funds	Total/Target
(f)	Leasehold community assistance	180.0				180.0
(g)	Acequia and community ditch education program	498.2				498.2
(h)	New Mexico acequia commission	88.1				88.1
(i)	Land grant council	626.9				626.9
(j)	Membership and dues	148.0				148.0
(k)	County detention of prisoners	5,000.0				5,000.0

The department of finance and administration shall not distribute a general fund appropriation made in items (a) through (i) and item (k) to a New Mexico agency or local public body that is not current on its audit or financial reporting or otherwise not in compliance with the Audit Act.

	Subtotal	[53,407.2]	[129,316.4]	[16,250.0]	[21,755.2]	220,728.8

PUBLIC SCHOOL INSURANCE AUTHORITY:

(1) Benefits:

The purpose of the benefits program is to provide an effective health insurance package to educational employees and their eligible family members so they can be protected against catastrophic financial losses due to medical problems, disability or death.

Appropriations:

(a)	Contractual services		370,984.4			370,984.4
(b)	Other financing uses		791.0			791.0

The other state funds appropriation to the benefits program of the public school insurance authority is contingent on the authority contracting with an independent third-party consultant to conduct a claims payment integrity review for claims filed in fiscal year 2022 and fiscal year 2023 by all health systems and hospitals.

Item	General Fund	Other State Funds	Intrnl Svc Funds/Inter-Agency Trnsf	Federal Funds	Total/Target
Performance measures:					
(a) Outcome: Percent change in per-member health claim costs					4.6%
(b) Outcome: Percent change in medical premium as compared with industry average					4.5%
(2) Risk:					
The purpose of the risk program is to provide economical and comprehensive property, liability and workers' compensation programs to educational entities so they are protected against injury and loss.					
Appropriations:					
(a) Contractual services		100,043.3			100,043.3
(b) Other financing uses		790.1			790.1
Performance measures:					
(a) Explanatory: Total dollar amount of excess insurance claims for property, in thousands					
(b) Explanatory: Total dollar amount of excess insurance claims for liability, in thousands					
(c) Explanatory: Total dollar amount of excess insurance claims for workers' compensation, in thousands					
(3) Program support:					
The purpose of program support is to provide administrative support for the benefits and risk programs and to assist the agency in delivering services to its constituents.					
Appropriations:					
(a) Personal services and employee benefits			1,305.4		1,305.4
(b) Contractual services			90.4		90.4
(c) Other			185.3		185.3

Item	General Fund	Other State Funds	Intrnl Svc Funds/Inter-Agency Trnsf	Federal Funds	Total/Target

Any unexpended balances in program support of the public school insurance authority remaining at the end of fiscal year 2024 shall revert in equal amounts to the benefits program and risk program.

	Subtotal		[472,608.8]	[1,581.1]	474,189.9

RETIREE HEALTH CARE AUTHORITY:

(1) Healthcare benefits administration:

The purpose of the healthcare benefits administration program is to provide fiscally solvent core group and optional healthcare benefits and life insurance to current and future eligible retirees and their dependents so they may access covered and available core group and optional healthcare benefits and life insurance benefits when they need them.

Appropriations:

(a)	Contractual services		390,376.7		390,376.7
(b)	Other		45.0		45.0
(c)	Other financing uses		3,781.3		3,781.3

The other state funds appropriations to the healthcare benefits administration program of the retiree health care authority is contingent on the authority contracting with an independent third-party consultant to conduct a claims payment integrity review for claims filed in fiscal year 2022 and fiscal year 2023 by all health systems and hospitals for pre-medicare health plans.

Performance measures:

(a) Output: Minimum number of years of positive fund balance 30

(2) Program support:

The purpose of program support is to provide administrative support for the healthcare benefits administration program to assist the agency in delivering its services to its constituents.

Appropriations:

(a)	Personal services and employee benefits			2,453.8	2,453.8

Item	General Fund	Other State Funds	Intrnl Svc Funds/Inter-Agency Trnsf	Federal Funds	Total/Target
(b) Contractual services			702.3		702.3
(c) Other			625.2		625.2

Any unexpended balances in program support of the retiree health care authority remaining at the end of fiscal year 2024 shall revert to the healthcare benefits administration program.

Subtotal		[394,203.0]	[3,781.3]	397,984.3

GENERAL SERVICES DEPARTMENT:

(1) Employee group health benefits:

The purpose of the employee group health benefits program is to effectively administer comprehensive health-benefit plans to state and local government employees.

Appropriations:

(a) Contractual services		30,703.3		30,703.3
(b) Other		332,438.9		332,438.9

Performance measures:

(a) Outcome:	Percent change in state employee medical premium	5%
(b) Outcome:	Percent change in the average per-member per-month total healthcare cost	5%
(c) Efficiency:	Annual loss ratio for the health benefits fund	98%
(d) Explanatory:	Projected year-end fund balance of the health benefits fund, in thousands	

(2) Risk management:

The purpose of the risk management program is to protect the state's assets against property, public liability, workers' compensation, state unemployment compensation, local public bodies unemployment compensation and surety bond losses so agencies can perform their missions in an efficient and responsive manner.

Appropriations:

SENATE TAX, BUSINESS AND TRANSPORTATION COMMITTEE SUBSTITUTE FOR SENATE BILL 51

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

This document may incorporate amendments proposed by a committee, but not yet adopted, as well as amendments that have been adopted during the current legislative session. The document is a tool to show amendments in context and cannot be used for the purpose of adding amendments to legislation.

AN ACT

RELATING TO HEALTH CARE COVERAGE; CALCULATING COST-SHARING CONTRIBUTIONS FOR PRESCRIPTION DRUG COVERAGE HHHC➜~~Sfll➜;~~ ~~REQUIRING PRESCRIPTION DRUG PRICE REDUCTIONS TO BE PROVIDED TO ALL CUSTOMERS FOR THE ENTIRETY OF THE PLAN OR CALENDAR YEAR←Sfll~~←HHHC HHHC➜ENACTING A NEW SECTION OF THE NEW MEXICO INSURANCE CODE TO PROHIBIT DISCRIMINATION AGAINST ENTITIES PARTICIPATING IN THE FEDERAL 340B DRUG PRICING PROGRAM←HHHC .

.225901.1AIC March 17, 2023 (12:12pm)

underscored material = new
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Amendments: new = ➜bold, blue, highlight←
~~delete~~ = ➜bold, red, highlight, strikethrough←

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

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] CALCULATING AN ENROLLEE'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an enrollee's cost-sharing obligation for covered prescription drugs, pursuant to group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act, the insurer shall credit the enrollee for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum amount;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 2. A new section of Chapter 59A, Article 16 NMSA 1978 is enacted to read:

"[NEW MATERIAL] HEALTH BENEFITS PLAN DISCLOSURE.--Each producer, plan administrator or pharmacy benefits manager licensed in this state shall not produce a health benefits plan for sale or pharmacy benefits services for contract without prior disclosure to the purchaser of the plan or services of the option to contract for pharmaceutical drug cost-sharing protections."

SECTION 3. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] CALCULATING AN INSURED'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health insurance policy, health care plan

or certificate of health insurance that is delivered, issued for delivery or renewed in this state, the insurer shall credit the insured for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer,

including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has

been met, unless otherwise allowed pursuant to federal law."

SECTION 4. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] CALCULATING AN INSURED'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to a group health plan other than a small group health plan or a blanket health insurance policy or contract that is delivered, issued for delivery or renewed in this state, the insurer shall credit the insured for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 5. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] CALCULATING AN ENROLLEE'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating an enrollee's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state, the insurer shall credit the enrollee for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at

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Amendments: new = →bold, blue, highlight←
delete = →~~bold, red, highlight, strikethrough~~←

different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-

pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

SECTION 6. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] CALCULATING A SUBSCRIBER'S COST-SHARING OBLIGATION FOR PRESCRIPTION DRUG COVERAGE.--

A. When calculating a subscriber's cost-sharing obligation for covered prescription drugs, pursuant to an individual or group health insurance policy, health care plan or certificate of health insurance issued for delivery or renewed in this state, the insurer shall credit the subscriber

for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

B. Beginning on or after January 1, 2024, an insurer shall not charge a different cost-sharing amount for:

(1) prescription drugs or pharmacy services obtained at a non-affiliated pharmacy; or

(2) administration of prescription drugs at different infusion sites; provided that an insurer may communicate with an insured regarding lower-cost sites of service.

C. Beginning on or after January 1, 2024, an insurer shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the insurer, including the cost-sharing amount paid by an insurer; or

(4) value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for

the prescribed drug.

D. Beginning on or after January 1, 2024, if a prescription drug rebate is more than the amount needed to reduce the insured's copayment to zero on a particular drug, the remainder shall be credited to the insurer.

E. Beginning on or after January 1, 2024, any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

F. For purposes of this section, "cost sharing" means any:

(1) copayment;

(2) coinsurance;

(3) deductible;

(4) out-of-pocket maximum;

(5) other financial obligation, other than a premium or share of a premium; or

(6) combination thereof.

G. The provisions of this section do not apply to excepted benefit plans as provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax favored plans or high-deductible health plans with health savings accounts until an eligible insured's deductible has been met, unless otherwise allowed pursuant to federal law."

HHHC➔~~Sfll➔SECTION 7. [NEW MATERIAL] PRESCRIPTION DRUG PRICE REDUCTIONS.--~~

~~A. A manufacturer that offers a reduction in the price, including any discounts, rebates or coupons, for a prescription drug product shall make the reduction in price available to all customers for the entirety of the plan year or the calendar year, whichever is longer.~~

~~B. For the purposes of this section:~~

~~(1) "manufacturer" means an entity that:~~

~~(a) engages in the manufacture of a prescription drug product;~~

~~(b) enters into a lease with another manufacturer to market and distribute a prescription drug product under the entity's own name; or~~

~~(c) sets or changes the wholesale acquisition cost of the prescription drug product it manufactures or markets; and~~

~~(2) "prescription drug product" means a brand name drug, generic drug, biologic or biosimilar.~~ ~~Sfll~~ HHHC

HHHC→SECTION 7. A new section of the New Mexico Insurance Code is enacted to read:

"[NEW MATERIAL] PROHIBITION ON DISCRIMINATION AGAINST A COVERED ENTITY.--

A. As used in this section:

(1) "340B drug" means a drug that is purchased at a discount in accordance with the 340B program requirements;

(2) "340B program" means the federal drug

underscored material = new
[~~bracketed material~~] = delete
Amendments: new = →bold, blue, highlight←
delete = →~~bold, red, highlight, strikethrough~~←

pricing program created pursuant to 42 U.S.C. Section 256b;

(3) "covered entity" means an entity participating in the 340B program; and

(4) "pharmacy benefits manager" means an entity that provides pharmacy benefits management services.

B. A pharmacy benefits manager or a third party shall not discriminate against a covered entity on the basis of its participation in the 340B program by:

(1) reimbursing a covered entity for a 340B drug at a rate lower than that paid for the same drug to pharmacies, similar in prescription volume, that are non-covered entities;

(2) assessing a fee, chargeback or other adjustment to the covered entity that is not assessed to non-covered entities;

(3) imposing a provision that prevents or interferes with a person's choice to receive 340B drugs from a covered entity; or

(4) imposing terms or conditions that differ from terms or conditions imposed on a non-covered entity, including:

(a) restricting or requiring participation in a pharmacy network;

(b) requiring more frequent auditing or a broader scope of audit for inventory management systems using

generally accepted accounting principles;

(c) requiring a covered entity to reverse, resubmit or clarify a claim after the initial adjudication, unless these actions are in the normal course of pharmacy business and not related to the 340B program; or

(d) charging an additional fee or provision that prevents or interferes with an individual's choice to receive a 340B drug from a covered entity."←HHHC

underscored material = new
[~~bracketed material~~] = delete
Amendments: new = →bold, blue, highlight←
delete = →~~bold, red, highlight, strikethrough~~←

Fiscal impact reports (FIRs) are prepared by the Legislative Finance Committee (LFC) for standing finance committees of the Legislature. LFC does not assume responsibility for the accuracy of these reports if they are used for other purposes.

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

SPONSOR STBTC

LAST UPDATED 03/17/2023
ORIGINAL DATE 03/10/2023

SHORT TITLE Cost-Sharing Contributions for Prescriptions

BILL NUMBER CS/Senate Bill 51/STBTCS/aSFl /aHHHC

ANALYST Chilton/Toal

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

	FY23	FY24	FY25	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
GSD Risk Management Division		$3,600.0	$3,600.0	$7,200.0	Recurring	General Fund
NMPSIA added benefit, no cost share		$2,150.0	$2,150.0	$4,300.0	Recurring	Health Care Benefits Administration Fund
RHCA added benefit, no cost share		$1,539.43	$3,078.86	$4,618.29	Recurring	Healthcare Benefits Administration Fund
OSI actuarial analyses		Indeterminate but possibly substantial	Indeterminate but possibly substantial	Indeterminate but possibly substantial	Recurring	Health Care Affordability Fund (HCAF) or General Fund
Health Insurance Exchange added benefit, no cost share		Indeterminate but possibly substantial	Indeterminate but possibly substantial	Indeterminate but possibly substantial	Recurring	HCAF or health insurance premium tax
Total		$7,289.4-$10,000.0	$8,828.6-$10,000.0	$16,118.0-$20,000.0	Recurring	Multiple funds

Note that the estimates in this table were made prior to committee adoption of the substitute bill and do not include some added costs from the new provision in the substitute that cost-sharing amounts be the same regardless of which in-network or nonparticipating pharmacy will fill a patient's prescription.

Relates to House Bill 132 and House Bill 51

Sources of Information
LFC Files

Responses Received Regarding the Original and the Substitute Bills
General Services Department (GSD)
Office of the Superintendent of Insurance (OSI)
Office of the Attorney General (NMAG)
Retiree Health Care Authority (RHCA)

Responses Received Regarding the Original Bill
Department of Health (DOH)
Human Services Department (HSD)
Public School Insurance Authority (PSIA)

No Response Received
Albuquerque Public Schools (APS)

SUMMARY

Synopsis of HHHC Amendment to Senate Bill 51

The HHHC amendment begins by removing all parts of the Senate Floor amendment. It adds to the title of the bill a description of a new section of the bill which would prohibit discrimination against entities participating in the federal 340B drug pricing program. The new subsection 7A defines terms used in subsection 7B, which states that pharmacy benefit managers and third parties cannot discriminate against entities that participate in the 340B program by:

- Reimbursing a covered entity less than it would an entity not covered by the 340B program,
- Assessing covered entities fees or other assessments different from non-covered entities,
- preventing or interfering with a patient's right to use a 340B program drug from a covered entity,
- Imposing different requirements for covered vs. non-covered entities, including:
    - requiring use of a pharmacy network,
    - requiring use of different audit procedures,
    - requiring claim procedures that would not be required of non-covered entities, or
    - charging additional fees or other provisions that would interfere with a patient's right to receive a 340B drug from a covered entity.

Synopsis of SFI#1 to Senate Bill 51

Removed by HHHC amendment above
The Senate floor amendment to Senate Bill 51 adds a new section 7 at the end of the bill that requires drug manufacturers make any rebates, discounts, coupons, or other price reductions available to all customers throughout the longer of a plan year or a calendar year. "Manufacturer" is defined as the maker of a prescription drug product of any kind, the licensor of manufacturing of a drug product, or an entity that changes the wholesale price of a drug it manufactures or markets. The addition is also represented in the title of the bill.

Synopsis of STBTC Substitute for Senate Bill 51

The STBTC substitute for Senate Bill 51 joins provisions of an earlier version of Senate Bill 51 with a provision of House Bill 132, applying the combination to each of the types of insurance products. The main purpose of the earlier version of Senate Bill 51 was to assure that discounts provided to pharmacies, pharmacy benefit managers (PBMs), or wholesalers would be passed on to the patient, reducing the patient's cost-sharing amount. House Bill 132 aimed to be certain that insurers would allow access to any willing local pharmacy or mail-order pharmacy on the same basis, with the same patient cost-sharing for any prescription filled at any of these willing

pharmacies; the bill would require that insurers provide the same cost-sharing at nonaffiliated as at affiliated pharmacies.

Section 1A of the bill would create a new section within the Health Care Purchasing Law (Section 13-7 NMSA 1978), which states the full value of discounts or payments received by the insurer would be credited against any cost-sharing (defined in Section 1F) that would be the patient's obligation.

Section 1B states cost-sharing to the patient must be the same at affiliated and nonaffiliated pharmacies; the same would be true of locations where infusions of medications are given.

Section 1C requires insurers to required insured patients to pay only the least of the following at the point of sale:

- The applicable cost-sharing amount,
- The amount that would be paid without the patient having any coverage for the prescription,
- The total of what the insurer would pay plus the patient's cost-share amount,
- The value of the manufacturer's rebate to the insurer or PBM.

If the prescription drug rebate is greater than the patient's cost-share, the remainder is retained by the insurer. These provisions do not apply to excepted benefit plans, which include those covered by the Short-Term Health Plan and Excepted Benefit Act, catastrophic plans, tax-favored or high deductible plans until a patient's deductible has been met.

Section 2 requires insurers and PBMs to disclose to buyers the option to contract for drug cost-sharing protections.

Section 3 applies the same requirements as in Section 1 to individual and group health insurance policies covered under Section 59A-22 NMSA 1978, with the same exceptions.
Section 4 applies the same requirements as in Section 1 to group health plans (other than small group health plans) or blanket health plans covered under Section 59A-23 NMSA 1978, with the same exceptions.

Section 5 applies the same requirements as in Section 1 to individual or group health maintenance organization contracts covered under Health Maintenance Organization Law, Section 59A-46 NMSA 1978, with the same exceptions.

Section 6 applies the same requirements as Section 1 to nonprofit health plans covered under the Nonprofit Health Plan Law, Section 59A-47 NMSA 1978, with the same exceptions.

This bill does not contain an effective date and, as a result, would go into effect June 16, 2023, (90 days after the Legislature adjourns) if signed into law; however, most of the provisions of the act have their onset on January 1, 2024.

FISCAL IMPLICATIONS

There is no appropriation in Senate Bill 51.

The fiscal impact of this bill is difficult to calculate and depends on which group—pharmacy benefit managers, state insurance programs, or consumers—will benefit from or feel the pain of the provisions in this bill. NMPSIA estimated a recurring cost to that agency of $2.150 million per year, RHCA sees a full-year cost of $3.079 million, and GSD estimates an annual cost of $3.6 million. APS has not given an estimate yet. The amounts entered into the table above are, therefore, highly speculative and do not include additional costs related to the substitute bill's new provision that cost-sharing for patients must be the same at any community or mail-order pharmacy. In addition, OSI has not indicated a cost to that office for enforcing the provision of the act. And as stated in the note below the table, the added costs of allowing patients to use any local or mail-order pharmacy have not been added to the estimates given.

There is no appropriation in Senate Bill 51.

SIGNIFICANT ISSUES

New Mexico and the other states in the United States suffer from very high drug costs relative to the rest of the developed world. As noted by DOH, "A U.S. Health and Human Services Department (HHS) funded study in 2018 found that U.S. drug prices are more than 2.5 times more expensive than other high-income countries. Additionally, a small survey of 1,170 New Mexico residents found that 33 percent cut pills in half, skipped doses of medicine, or did not fill a prescription due to cost."
Thus, any strategy that decreases costs of drugs to consumers would be welcome. This bill may decrease costs to consumers if rebates to insurance companies and pharmacy benefit managers (PBMs) are passed on to those consumers and if PBMs absorb the cost of these rebates or the insurance companies and state health insurance entities who may see compensatory higher costs from PBMs do not pass those additional costs on to their consumers.

In addition, the survival of community pharmacies is vital to New Mexicans, especially those in rural areas. The provision that cost-sharing must be the same regardless of which pharmacy fills a prescription would help assure that patients would use local pharmacies, although that provision comes at a price, as noted in the "Fiscal Impacts" section.

Each of the three Health Purchasing Act entities that have responded with analysis of this bill (GSD, RHCA, and PSIA) mention concern that incentives and discounts provided through their prescription benefit managers (PBMs) may be significantly reduced if this bill were passed, thereby increasing the net cost to the plans and ultimately to the consumer.

DOH explains some of the complexities of drug pricing as follows, with the accompanying table:

> Pharmacy benefit managers (PBMs) and insurance companies incentivize the use of lower cost drug options through a variety of tools. One method is patient cost sharing. Patients must meet a deductible or out-of-pocket maximum amount prior to additional benefit payments. Some patients utilize funds from patient assistance grants (charitable donations) or manufacturer copay programs to help cover their medication copays. Patient assistance grants often have a maximum payment per patient. Once the patient has received their maximum payment from the grant or manufacturer copay card, the patient is responsible for their full insurance copay going forward.
>
> In New Mexico, over 67 percent of plans have copay accumulator adjustment policies. These policies implemented by PBMs or plans prevent payments by patient assistance

grants or manufacturer copay programs from counting toward the patient's deductible or out-of-pocket maximum. Plans with copay accumulator adjustment policies can impact the ability of patients on fixed incomes to afford their medication copays. The following graphic from the AIDS institute helps to explain the impact on patients and insurers of copay accumulator programs.

- Plan deductible: $4,600
- Annual out-of-pocket maximum: $8,550
- Cost-sharing for specialty tier prescription: 50% after deductible is met
- Monthly medication cost: $1,680
- Copay assistance total: $7,200

Scenario 1: Plan *Without* a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,240	$840	$840	$840	$80	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$2,920	$1,240	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$8,550
Consumer Pays	$0	$0	$0	$0	$0	$0	$760	$590	$0	$0	$0	$0	$1,350	

Deductible is met — Copay assistance limit is met — Out-of-Pocket maximum is met

Scenario 2: Plan *With* a Copay Accumulator Program

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Insurer collects
Copay Assistance	$1,680	$1,680	$1,680	$1,680	$480	$0	$0	$0	$0	$0	$0	$0	$7,200	
Remaining Deductible	$4,600	$4,600	$4,600	$4,600	$3,400	$1,720	$40	$0	$0	$0	$0	$0		$15,160
Consumer Pays	$0	$0	$0	$0	$1,200	$1,680	$1,680	$40	$840	$840	$840	$840	$7,960	

Deductible is met — Copay assistance limit is met — Out-of-Pocket maximum is met

https://aidsinstitute.net/documents/final_TAI_2022-Report-Update_020122.pdf

A concern regarding co-pay assistance programs is that they shift patient spending toward higher cost branded medications. This concern has largely been discredited as copay assistance programs help patients afford their coinsurance or co-payment. The medication must have already been approved by the insurance. Prior to branded medications being approved by insurance, patients must go through a step therapy or prior authorization process to prove the need for the branded product over less expensive generic alternatives. Additionally, a study conducted by IQVIA of claims data from 2013-2017 shows that 99.6 percent of co-pay assistance was used for treatments without generic alternatives. https://www.iqvia.com/locations/united-states/library/fact-sheets/evaluation-of-co-pay-card-utilization

RELATIONSHIP

Relates to House Bill 51, which would establish a Prescription Cost Affordability Board, and House Bill 132, which requires parity between cost-sharing amounts experienced by patients using any willing local or mail-order pharmacy.

TECHNICAL ISSUES

The provision in Section 1A (and other subsections A) means that every insurer licensed in the state under the various code sections will have to "credit the enrollee for the full value of discounts provided or payments made by third parties at the time of the prescription drug claim." This means, for example, that coupons provided by a pharmaceutical manufacturer (typically for high priced drugs) will have to be honored by the insurer. The bill does not indicate whether this must be done for all drugs or only those that are an insurer's formulary, or if they must honor the coupon if the insurer covers other therapeutically equivalent drugs at lower cost. "Third parties" are not defined.

Section 1C (and other subsections C) requires that the maximum amount of cost sharing be the least of four possibilities, the last of which is "the value of the rebate from the manufacturer provided to the insurer or its pharmacy benefits manager for the prescribed drug." This will be difficult for an insurer or PBM to calculate given the myriad of ways manufacturer rebates are paid.

Section 1E (and other subsections E) states that after January 1, 2024, any rebate amount shall be counted toward the insured's out of pocket prescription drug costs. It is not clear what "any rebate" means.

In Section 7 as added in the HHHC amendment, neither "entity" nor "third party" are defined.

The bill does not direct the OSI to issue regulations, though regulations are likely appropriate.

NMAG makes the following comments:

- Absent clearly defined terms in pharmacy benefits legislation, a company can make a "reasonable interpretation" of the law, even if it is the wrong interpretation, and not be penalized. See United States et al ex rel Schutte v. SuperValu Inc., U.S. Supreme Court Docket No. 21-1326 (oral argument set for April 18, 2023).
- Section 1(B)(2), Section 3(B)(2), Section 4(B)(2), Section 5(B)(2), Section 6(B)(2)—the term "infusion site" is not defined.
- Section 1(B)(2), Section 3(B)(2), Section 4(B)(2), Section 5(B)(2), Section 6(B)(2)—the phrase "provided that an insurer may communicate" is unclear. Does "provided" mean if the insurer makes this communication, then it is exempt from (B)(2)?
- Section 1(G), Section 3(G), Section 4(G), Section 5(G), and Section 6(G)—the terms "catastrophic plan" and "tax-favored plans" are not defined.
- Section 2—the term "pharmaceutical drug cost-sharing protections" is not defined.

Finally, GSD makes the following point:

> The sponsor may consider amending Subsection G in each Section to clarify that only the provisions of Subsection A do not apply, as it appears that the provisions of Subsections

B through E might have general application, regardless of whether the plan is provided pursuant to the Short-Term Health Plan and Excepted Benefit Act, is a catastrophic plan, tax-favored plan, or high-deductible health plan with a health savings account.

LAC/RBT/al/hg/rl/ne

underscored material = new
[~~bracketed material~~] = delete
Amendments: new = →bold, blue, highlight←
delete = →bold, red, highlight, ~~strikethrough~~←

SENATE FINANCE COMMITTEE SUBSTITUTE FOR
SENATE BILL 521

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

This document may incorporate amendments proposed by a committee, but not yet adopted, as well as amendments that have been adopted during the current legislative session. The document is a tool to show amendments in context and cannot be used for the purpose of adding amendments to legislation.

AN ACT

RELATING TO THE PUBLIC PEACE, HEALTH, SAFETY AND WELFARE; PROVIDING A SUPPLEMENTAL SALARY INCREASE FOR STATE, HIGHER EDUCATION AND PUBLIC SCHOOL EMPLOYEES TO OFFSET INFLATION, INCLUDING INSURANCE PREMIUM INCREASES **SFC→**~~; MAKING AN APPROPRIATION~~**←SFC** .

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

SECTION 1. SUPPLEMENTAL SALARY INCREASE--INFLATION

OFFSET.--In addition to any salary increases provided in the General Appropriation Act of 2023, the legislature shall provide a supplemental one percent salary increase for those state employees, higher education employees and public school employees who are eligible to receive a salary increase in that act from the general fund, other state funds or federal funds to offset inflation, including increases in insurance premiums.

SFC→~~SECTION 2. APPROPRIATION.--~~

~~A. Forty-seven million five hundred thousand dollars ($47,500,000) is appropriated from the general fund to the department of finance and administration for expenditure in fiscal year 2024 to provide a supplemental one percent salary increase for state employees, higher education employees and public school employees who are eligible to receive a salary increase in the General Appropriation Act of 2023 to offset inflation, including increases in insurance premiums. Any unexpended or unencumbered balance remaining at the end of fiscal year 2024 shall revert to the general fund.~~

~~B. For those state employees whose salaries are referenced in or received as a result of nongeneral fund appropriations in the General Appropriation Act of 2023, the department of finance and administration shall transfer from the appropriate fund to the appropriate agency the amount required for the supplemental salary increase equivalent to the increase provided for in this section. Such amounts are~~

~~appropriated for expenditure in fiscal year 2024, and any unexpended or unencumbered balances remaining at the end of fiscal year 2024 shall revert to the appropriate fund.~~ SFC

New Mexico Retiree Health Care Authority (CP)
Change in Market Value
For the Month of Feb 2023
(Report as of March 15, 2023)

Investment Name	Prior Ending Market Value	Contributions	Distributions	Fees	Income	Gains - Realized	Gains - Unrealized	Gains - Realized & Unrealized	Market Value
Core Bonds Pool	186,851,723.92	-	-	(41,938.85)	502,330.08	(383,394.02)	(4,556,841.61)	(4,940,235.63)	182,371,879.52
Credit & Structured Finance	168,409,128.32	-	-	-	495,109.41	145,724.31	758,533.67	904,257.98	169,808,495.71
NM Retiree Health Care Authority Cash Account	-	-	-	-	-	-	-	-	-
Non-US Developed Markets Index Pool	150,073,074.75	-	-	(14,253.80)	183,714.73	(7,265.50)	(3,867,956.36)	(3,875,221.86)	146,367,313.82
Non-US Emerging Markets Active Pool	92,034,950.70	-	-	(112,199.98)	27,346.72	16,322.52	(5,981,033.84)	(5,964,711.32)	85,985,386.12
Private Equity Pool	172,271,574.63	-	-	-	223,311.26	362,891.54	(1,035,396.36)	(672,504.82)	171,822,381.07
Real Estate Pool	135,069,717.79	-	-	-	17,019.10	2,249.55	(164,323.78)	(162,074.23)	134,924,662.66
Real Return Pool	56,194,948.83	-	-	(11,978.94)	138,618.88	117,981.71	(266,393.26)	(148,411.55)	56,173,177.22
US Large Cap Index Pool	180,046,116.00	-	-	(3,817.53)	312,252.16	(40,027.53)	(4,549,387.84)	(4,589,415.37)	175,765,135.26
US SMID Cap Alternative Weighted Index Pool	25,391,933.42	-	-	(2,259.70)	32,279.07	100,061.85	(445,014.27)	(344,952.42)	25,077,000.37
Sub - Total New Mexico Retiree Health Care	1,166,343,168.36	-	-	(186,448.80)	1,931,981.41	314,544.43	(20,107,813.65)	(19,793,269.22)	1,148,295,431.75
Total New Mexico Retiree Health Care A	**1,166,343,168.36**	**-**	**-**	**(186,448.80)**	**1,931,981.41**	**314,544.43**	**(20,107,813.65)**	**(19,793,269.22)**	**1,148,295,431.75**

Retiree Health Care Authority

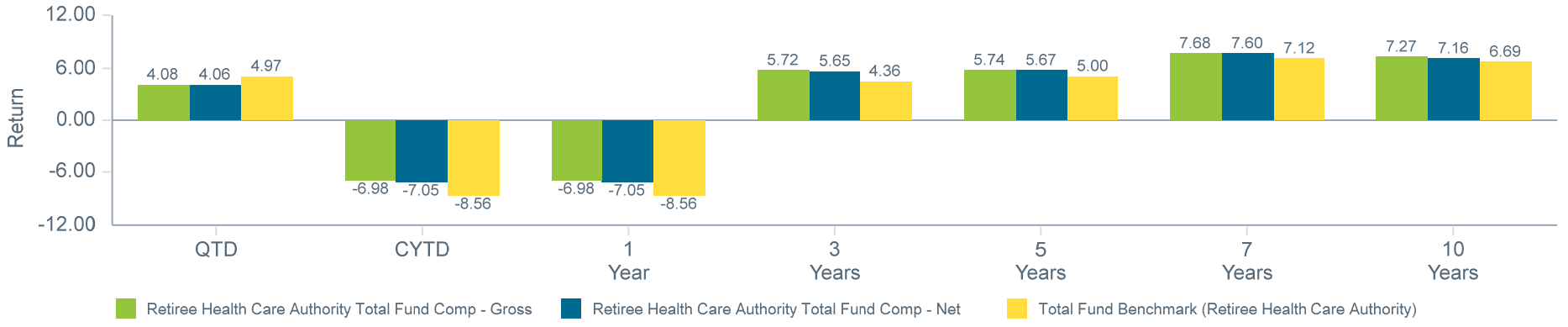
Overview

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

Asset Allocation vs. Target Allocation

	Market Value ($)	Allocation (%)	Target (%)	Difference (%)
US Large Cap Index	168,669,998	14.96	14.00	0.96
US Small/Mid Cap Alt Wtd Index	23,190,854	2.06	2.00	0.06
Non-US Developed Markets Index	139,207,020	12.34	14.00	-1.66
Non-US Emerging Markets Active	85,039,034	7.54	10.00	-2.46
US Core Bonds	181,116,692	16.06	20.00	-3.94
Credit & Structured Finance	167,797,203	14.88	15.00	-0.12
Real Return	55,898,545	4.96	5.00	-0.04
Real Estate	134,932,661	11.96	10.00	1.96
Private Equity	171,909,488	15.24	10.00	5.24
Total Fund	1,127,761,495	100.00	100.00	0.00

Comparative Performance



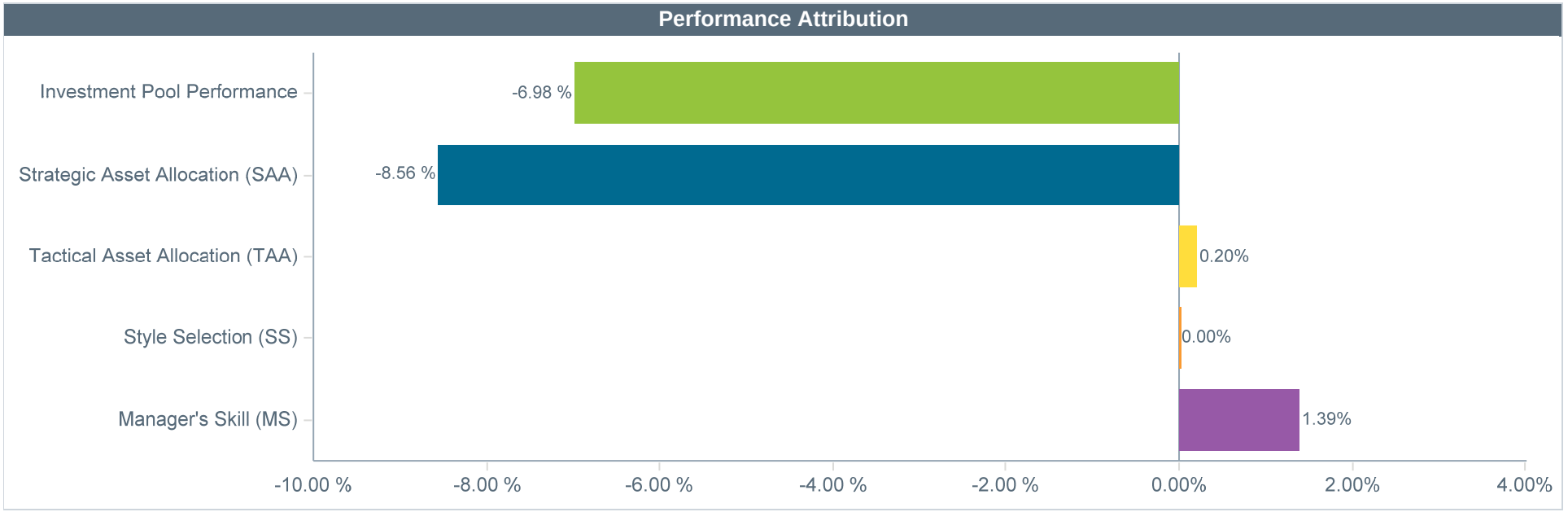
Comparative Performance

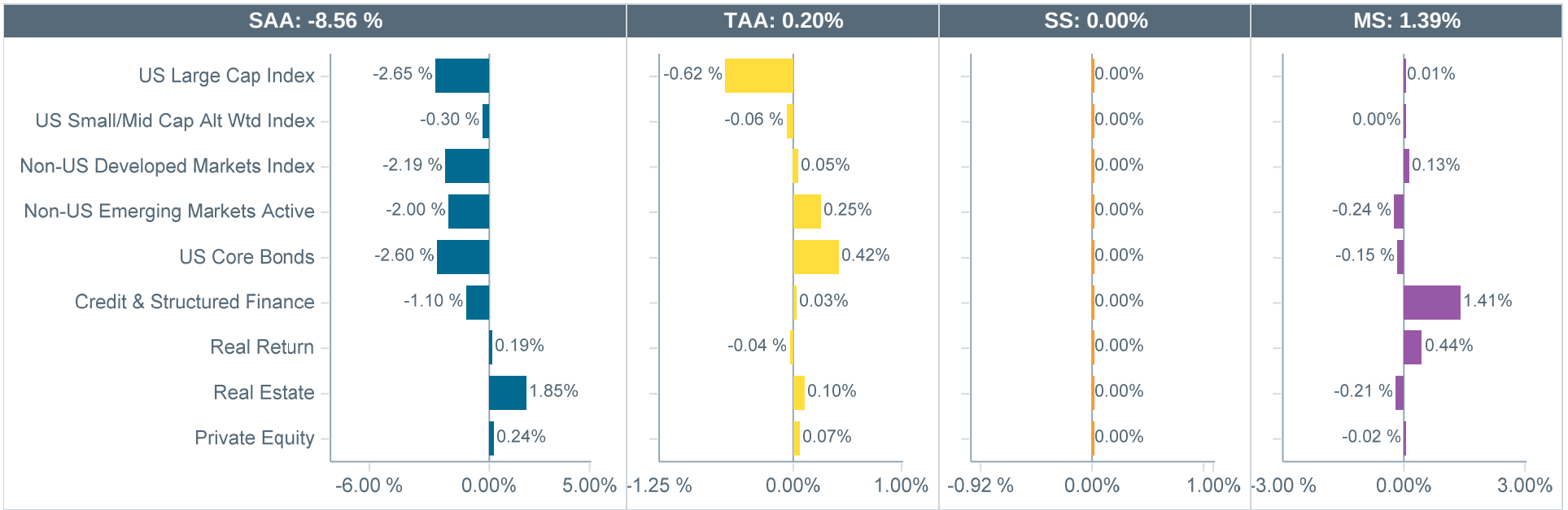
	QTD	CYTD	1 Year	3 Years	5 Years	7 Years	10 Years	2021	2020	2019
Retiree Health Care Authority Total Fund Comp - Gross	**4.08**	**-6.98**	**-6.98**	**5.72**	**5.74**	**7.68**	**7.27**	**15.61**	**9.88**	**13.27**
Total Fund Benchmark (Retiree Health Care Authority)	*4.97*	*-8.56*	*-8.56*	*4.36*	*5.00*	*7.12*	*6.69*	*12.78*	*10.21*	*14.35*
Difference	-0.89	1.58	1.58	1.36	0.74	0.56	0.58	2.83	-0.33	-1.08
Retiree Health Care Authority Total Fund Comp - Net	**4.06**	**-7.05**	**-7.05**	**5.65**	**5.67**	**7.60**	**7.16**	**15.51**	**9.83**	**13.21**
Total Fund Benchmark (Retiree Health Care Authority)	*4.97*	*-8.56*	*-8.56*	*4.36*	*5.00*	*7.12*	*6.69*	*12.78*	*10.21*	*14.35*
Difference	-0.91	1.51	1.51	1.29	0.67	0.48	0.47	2.73	-0.38	-1.14

Schedule of Investable Assets

Periods Ending	Beginning Market Value ($)	Net Cash Flow ($)	Gain/Loss ($)	Ending Market Value ($)	% Return
CYTD	**1,149,233,513**	**60,000,000**	**-81,472,017**	**1,127,761,495**	**-7.05**

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.





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

Healthcare Benefits Administration & Program Support
FY23 Contract Amendments

Background

NMRHCA staff will be amending the self-insured agreements in the Healthcare Benefits Administration with Presbyterian Health Plan and Express Scripts as shown below, based on projected expenditures through June 30, 2023. The proposed amendments will reduce Presbyterian Health Plan's budget and add this reduced amount with the unencumbered balance to accommodate the potential shortfall with the prescription benefit budget set through for the remainder of the fiscal year. In addition, staff will be amending the legal contract in Program Support with the Rodey Law Firm utilizing the remaining unencumbered balance for the projected expenditures through June 30, 2023.

Healthcare Benefits Administration Contractual Services Information for FY23

FY23 Approved/Adjusted Operating Budget	$376,926,700							
Contract	Amount Encumbered YTD	Expended 4.05.23	Contract Balance	Percent Remaining	Proposed Amendment	Revised Total	Projected	Shortfall/ Surplus
BCBS -- Self Insured	$122,500,000	$76,803,956	$45,696,044	37.3%	$0	$122,500,000	$118,100,000	$4,400,000
Presbyterian -- Self Insured	$56,750,000	$34,338,046	$22,411,954	39.5%	($3,000,000)	$53,750,000	$48,000,000	$5,750,000
Presbyterian MA	$14,000,000	$9,687,291	$4,312,710	30.8%	$0	$14,000,000	$13,250,000	$750,000
BCBS MA	$3,000,000	$1,185,900	$1,814,100	60.5%	$0	$3,000,000	$1,500,000	$1,500,000
Humana MA	$1,450,000	$654,452	$795,548	54.9%	$0	$1,450,000	$810,000	$640,000
UnitedHealthcare MA	$8,000,000	$3,023,679	$4,976,321	62.2%	$0	$8,000,000	$3,800,000	$4,200,000
Express Scripts	$122,000,000	$94,569,241	$27,430,759	22.5%	$12,331,700	$134,331,700	$133,500,000	$831,700
Delta	$23,400,000	$18,134,531	$5,265,469	22.5%	$0	$23,400,000	$22,350,000	$1,050,000
Standard	$13,700,000	$9,749,168	$3,950,832	28.8%	$0	$13,700,000	$13,400,000	$300,000
Davis Vision	$2,750,000	$2,095,376	$654,624	23.8%	$0	$2,750,000	$2,600,000	$150,000
PCORI Fee	$45,000	$40,065	$4,935	11.0%	$0	$45,000	$ 42,000.00	$3,000
Total	**$367,595,000**	**$250,281,705**	**$117,313,295**	**31.9%**	**$9,331,700**	**$376,926,700**	**$357,352,000**	**$19,574,700**
Unencumbered Balance	$9,331,700	$9,331,700	$9,331,700	100.0%	$0	$0	$0	$0

Program Support Contractual Services Information for FY23

FY23 Approved/Adjusted Operating Budget	$674,900					
Contract	Amount Encumbered YTD	Expended 4.05.23	Contract Balance	Percent Remaining	Proposed Amendment/ New	Revised Total
Segal	$345,000	$119,364	$225,636	65.4%	$0	$345,000
Judith Beatty	$7,000	$1,977	$5,023	71.8%	$0	$7,000
Moss Adams	$70,390	$48,757	$21,633	30.7%	$0	$70,390
Rodey	$40,000	$28,367	$11,633	29.1%	$7,750	$47,750
Work Quest	$4,095	$2,040	$2,054	50.2%	$0	$4,095
RESPEC	$55,016	$29,553	$25,463	46.3%	$0	$55,016
PERA (MOU)	$16,037	$0	$16,037	100.0%	$0	$16,037
Real Time Solutions (Webhost)	$1,316	$1,316	$0	0.0%	$0	$1,316
NMPSIA (MOU)	$8,500	$8,500	$0	0.0%	$0	$8,500
Albuquerque Computers	$642	$642	$0	0.0%	$0	$642
Wilshire	$35,000	$0	$35,000	100.0%	$0	$35,000
SHI International Group	$34,846	$0	$34,846	100.0%	$0	$34,846
REDW	$36,000	$0	$36,000	100.0%	$0	$36,000
Real Time Solutions	$13,307	$0	$13,307	100.0%	$0	$13,307
Total	**$667,150**	**$240,517**	**$426,633**	**63.9%**	**$7,750**	**$674,900**
Unencumbered Balance	$7,750	$7,750	NA	NA	$0	$0

NMRHCA staff will amend the contracts stated above for the remainder of fiscal year 2023 to meet projected expenditures.

FY24 Operating Budget – Action Item

Background: The State Budget Act (Section 6-3-7 NMSA 1978) mandates the completion and submission of the FY24 operating budget to the State Budget Division (SBD) by close of business Monday, May 1, 2023. The State Budget Act specifies that operating budgets require SBD approval, and expenditures cannot be made without such approval. In addition, the Retiree Health Care Act (Section 10-7C-16) includes a requirement that "expenditures for the administration of the Retiree Health Care Act shall be made as provided by an operating budget adopted by the board." In accordance with these requirements, the FY24 operating budget submitted by the agency will be consistent with the amounts contained in Laws 2023, Chapter XXX otherwise known as the General Appropriation Act of 2023.

Table I

($ shown in thousands)

Agency	FY23 Approved Operating	FY23 Adjusted Operating	FY24 Request	HB2/GAA	Comp/ Package (OPBUD2)	Total
Personal Services & Employee Benefits*	$ 2,296.3	$ 2,296.3	$ 2,673.6	$ 2,453.8	$ -	$ 2,453.8
Contractual Services	$ 377,601.6	$ 377,601.6	$ 391,112.5	$ 391,079.0	$ -	$ 391,079.0
Other	$ 632.0	$ 632.0	$ 670.2	$ 670.2	$ -	$ 670.2
Other Financing Uses*	$ 3,558.2	$ 3,558.2	$ 4,034.6	$ 3,781.3	$ -	$ 3,781.3
Total	**$ 384,088.1**	**$ 384,088.1**	**$ 398,490.9**	**$ 397,984.3**	**$ -**	**$ 397,984.3**
Healthcare Benefits Administration						
Contractual Services	$ 376,926.7	$ 376,926.7	$ 390,376.7	$ 390,376.7	$ -	$ 390,376.7
Other	$ 45.0	$ 45.0	$ 45.0	$ 45.0	$ -	$ 45.0
Other Financing Uses*	$ 3,558.2	$ 3,558.2	$ 4,034.6	$ 3,781.3	$ -	$ 3,781.3
Subtotal	**$ 380,529.9**	**$ 380,529.9**	**$ 394,456.3**	**$ 394,203.0**	**$ -**	**$ 394,203.0**
Program Support						
Personal Services & Employee Benefits*	$ 2,296.3	$ 2,296.3	$ 2,673.6	$ 2,453.8	$ -	$ 2,453.8
Contractual Services	$ 674.9	$ 674.9	$ 735.8	$ 702.3	$ -	$ 702.3
Other	$ 587.0	$ 587.0	$ 625.2	$ 625.2	$ -	$ 625.2
Subtotal	**$ 3,558.2**	**$ 3,558.2**	**$ 4,034.6**	**$ 3,781.3**	**$ -**	**$ 3,781.3**
Total	**$ 384,088.1**	**$ 384,088.1**	**$ 398,490.9**	**$ 397,984.3**	**$ -**	**$ 397,984.3**
FTE	26	26	29	27	27	27

*Subject to change based on Compensation Package

The sections highlights are subject to change pending DFA's allocation to support the pay increases authorized in Section 8 of the General Appropriation Act. These increases apply to all employee (classified and exempt) and will be reflected in the personal services and employee benefits category of Program Support and the other financing uses category of the Healthcare Benefits Administration Program.

Section 4: Performance Measure and Reversion.

Performance Measure:

(a) Output: Minimum number of years of positive fund balance – Target 30

Reversion Language:

Any unexpended balances in program support of the retiree health care authority remaining at the end of fiscal year 2024 shall revert to the healthcare benefits administration program.

Section 8. Compensation Appropriations.

Subsection A. Ninety-five million seven hundred forty-eight thousand nine hundred dollars ($95,748,900) is appropriated from the general fund to the department of finance and administration for fiscal year 2024 to pay all costs attributable to the general fund of providing an average salary increase of five percent to employees in budgeted positions who have completed their probationary period subject to satisfactory job performance. This appropriation includes sufficient funding to provide all affected employees an hourly salary of at least fifteen dollars ($15.00). Police officers of the department of public safety shall be exempt from the requirement to complete their probationary period. The salary increases shall be effective the first full pay period after July 1, 2023 and distributed as follows:

(3) thirty-five million two hundred seventy-three thousand nine hundred dollars ($35,273,900) for incumbents in agencies governed by the State Personnel Act, the New Mexico state police career pay system, attorney general employees, workers' compensation judges and executive exempt employees; and

Subsection B. Eight million four hundred seventy-two thousand nine hundred dollars ($8,472,900) is appropriated from the general fund to the department of finance and administration for fiscal year 2024 to increase medical insurance premiums paid by employers on behalf of state employees covered by health plans managed by the general services department by ten percent.

Subsection C. Eight million four hundred seventy-two thousand nine hundred dollars ($8,472,900) is appropriated from the general fund to the department of finance and administration for fiscal year 2024 for the general fund share of a ten percent medical insurance premium rate increase paid by employers on behalf of state employees covered by health plans managed by the general services department.

Subsection D. For those state employees whose salaries are referenced in or received as a result of nongeneral fund appropriations in the General Appropriation Act of 2022 or 2023, the department of finance and administration shall transfer from the appropriate fund to the appropriate agency the amount required for the salary increases equivalent to those provided for in this section. Such amounts are appropriated for expenditure in fiscal year 2024. Any unexpended balances remaining at the end of fiscal year 2024 shall revert to the appropriate fund.

Section 13. Certain Fiscal Year 2024 Budget Adjustment Authorized.

Subsection C. In addition to the specific category transfers authorized in Subsection E of this section and unless a conflicting category transfer is authorized in Subsection E of this section, all agencies, including legislative agencies, may request category transfers among personal services and employee benefits, contractual services and other.

Subsection D. Unless a conflicting budget increase is authorized in Subsection E of this section, a program with internal service funds/interagency transfers appropriations that collects money in excess of those appropriated may request budget increases in an amount not to exceed five percent of its internal service funds/interagency transfers, and a program with other state funds that collects money in excess of those appropriated may request budget increases in an amount not to exceed five percent of its other state funds contained in Section 4 of the General Appropriation Act of 2023. To track the five percent transfer limitation, agencies shall report cumulative budget adjustment request totals on each budget request submitted. The department of finance and administration shall certify agency reporting of these cumulative totals.

Subsection E. In addition to the budget authority otherwise provided in the General Appropriation Act of 2023, the following agencies may request specified budget adjustments:

(10) the healthcare benefits administration program of the retiree health care authority may request budget increases from other state funds for claims;

Other Substantive Information:

Subsection D authorizes budget adjustments by program as follows:

	GAA	5%	Total
Healthcare Benefits Administration	$394,203.0	$ 19,710.2	$413,913.2
Program Support	$ 3,781.3	$ 189.1	$ 3,970.4
	$397,984.3	$ 19,899.2	$417,883.5

Requested Action: The deadline for submission is prior to the next regularly scheduled board meeting, therefore, NMRHCA staff respectfully requests that the Board of Directors delegate final approval of the FY24 operating budget to the Finance Committee, upon review at its regularly scheduled meeting (to be scheduled last week of April). Final approval will include a 5 percent pay increase for all employees subject to the State Personnel Act and executive exempt employees including the executive director.

Healthcare Benefits Administration & Program Support
FY24 Contract Amendments/New Contracts

The charts below include a list of existing contracts to be amended for fiscal year 2024 required to meet our business obligations regarding the administration of both the Healthcare Benefits Administration Program and Program Support.

Healthcare Benefits Administration Program FY24 Proposed Contract Amendments

The proposed contracts administered through the Healthcare Benefits Administration Program are as follows:

	FY24 Approved Operating Budget	**$390,376,700**			
		Proposed			
		Contract	**Contract**		**Amendment**
	Vendor	**Amount**	**Term**		**Type**
1	Express Scripts	$129,500,000	July 1, 2022 - June 30, 2026		Term & Comp
2	Vendor A - Life Insurance	$14,500,000	July 1, 2023 - June 30, 2027		New
3	BCBS -- Self Insured	$122,500,000	July 1, 2020 - June 30, 2024		Term & Comp
4	Prebyterian -- Self Insured	$55,000,000	July 1, 2020 - June 30, 2024		Term & Comp
5	Presbyterian MA	$15,250,000	July 1, 2020 - June 30, 2024		Term & Comp
6	BCBS MA	$3,000,000	July 1, 2020 - June 30, 2024		Term & Comp
7	Humana MA	$1,500,000	July 1, 2020 - June 30, 2024		Term & Comp
8	UnitedHealthcare MA	$8,000,000	July 1, 2020 - June 30, 2024		Term & Comp
9	Delta	$24,400,000	July 1, 2020 - June 30, 2024		Term & Comp
10	Davis Vision	$2,850,000	July 1, 2020 - June 30, 2024		Term & Comp
	Total	**$376,500,000**	**NA**		**NA**
	Unencumbered Balance	**$13,876,700**	**Available for mid/end-year adjustments**		

The proposed amounts for FY24 are based on FY23 projected expenditures and assume the following variables:

1. Express Scripts - projected costs based on FY23 projected expenditures.
2. Vendor A (Life Insurance) – projected costs based on FY23 projected expenditures + growth in participation.
3. Blue Cross Blue Shield (Self-Insured) – projected costs based on FY23 projected expenditures + medical trend.
4. Presbyterian (Self-Insured) – projected costs based on FY23 projected expenditures + medical trend.
5. Presbyterian (Medicare Advantage) – projected costs based on FY23 projected expenditures + growth in participation.
6. Blue Cross Blue Shield (Medicare Advantage) – projected costs based on FY23 projected expenditures.
7. Humana (Medicare Advantage) - projected costs based on FY23 projected expenditures.
8. UnitedHealthcare (Medicare Advantage) - projected costs based on FY23 projected expenditures + growth in participation.
9. Delta (Dental) – projected costs based on FY23 projected expenditures + growth in participation + rate adjustment.
10. Davis (Vision) – projected costs based on FY23 projected expenditures.

Program Support FY24 Proposed Contract Amendments/New

The proposed contracts administered through Program Support are as follows:

	FY24 Approved Operating Budget	**$702,300**		
	Vendor	**Proposed Contract Amount**	**Contract Term**	**Type**
1	Vendor A - Benefit & Actuary Consultant	$320,000	July 1, 2023 - June 30, 2027	Term/Comp
2	Judith Beatty	$7,000	July 1, 2023 - June 30, 2024	New/Small
3	Vendor B - Audit Services	TBD	TBD	Term/Comp
4	Vendor C - Legal Services	$40,000	July 1, 2023 - June 30, 2024	New/Small
5	RESPEC	$58,551	July 1, 2023 - June 30, 2024	Price Agreement
6	PERA MOU - HR Services	$22,100	July 1, 2023 - June 30, 2024	MOU
7	Vendor D - Shredding Services	$4,500	July 1, 2023 - June 30, 2024	New/Small
8	Real Time Solutions (Webhost)	$1,400	July 1, 2023 - June 30, 2024	Price Agreement
9	Health Benefits RFP Consultant	TBD	July 1, 2023 - June 30, 2024	MOU
	Total	**$453,552**		
	Unencumbered Balance	**$248,748**	**Available for mid/end-year adjustments**	

The proposed contracts and amounts for FY24 assume the following:

1. Vendor A (Benefit & Actuary Consulting Services) – projected expenditures related to benefit consulting services, solvency projections, GASB employer allocation schedules and HIPAA compliance support.
2. Judith Beatty – projected expenditures based on prior year actuals.
3. Vendor B (Audit Services) – TBD based on RFP.
4. Vendor C (legal services) - for fees consistent with historical expenditures and contingencies.
5. RESPEC – projected amounts associated with ongoing maintenance related to CareView based on FY23.
6. PERA MOU – shared HR services.
7. Vendor D – document destruction services projected expenditures based on historical expenditures.
8. Real Time Solutions (Webhost) – projected expenditures based on historical expenditures.
9. Health Benefits RFP Consultant – TBD based on RFP.

NMRHCA staff will be setting up the contract amendments and new contracts as listed in the charts above for fiscal year 2024.