AGENDA/TABLE OF CONTENTS ON PAGE 4

REGULAR MEETING

OF THE

BOARD OF DIRECTORS

February 3, 2026

9:30 AM

PERA Board Room

33 Plaza La Prensa, Santa Fe, NM 87507

Online: https://meet.goto.com/NMRHCA/boardmeeting

Telephone: 1-224-501-3412 / Access Code: 724-176-285

New Mexico Retire Health Care Authority

Regular Meeting

BOARD OF DIRECTORS

ROLL CALL

February 3, 2026

	Member in Attendance		
Dr. Lee Caruana, President			
Dr. Tomas Salazar, Vice President			
Lance Pyle, Secretary			
NM Treasurer Laura Montoya			
Raquel Alirez			
Dr. Gerry Washburn			
Donna Sandoval			
Therese Saunders			
Alex Castillo-Smith			
Renee Garcia			
Kate Brassington			

NMRHCA BOARD OF DIRECTORS

FEBRUARY 2026

Dr. Lee Caruana, MD Retired Public Employees of NM leecaruana13@gmail.com	Donna Sandoval NM Municipal League 100 Marquette Ave City/County Building Albuquerque, NM 87102 donnasandoval@cabq.gov 505-768-2975
Dr. Tomas E. Salazar, PhD, Vice President NM Assoc. of Educational Retirees PO Box 66 Las Vegas, NM 87701 salazarte@plateautel.net 505-429-2206	Therese Saunders, President NEA-NM, Classroom Teachers Assoc., & NM Federation of Educational Employees 5811 Brahma Dr. NW Albuquerque, NM 87120 tsaunders3@mac.com 505-934-3058
Lance Pyle, Secretary NM Association of Counties Curry County Administration 417 Gidding, Suite 100 Clovis, NM 88101 lpyle@currycounty.org 575-763-3656	Alex Castillo Smith Deputy Cabinet Secretary NM Health Care Authority PO Box 2348 Santa Fe, NM 87504 alex.castillosmith@hca.nm.gov 505-629-8652
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	Renee Garcia Alternate for ERB Executive Director Educational Retirement Board PO Box 26129 Santa Fe, NM 87502-0129 renee.garcia@erb.nm.gov 505-531-9885
Raquel Alirez Classified State Employee 401 Broadway NE Albuquerque, NM 87102 raquel.alirez@dws.nm.gov 505-365-3474	Kate Brassington Alternate for PERA Executive Director Public Employees Retirement Association 33 Plaza La Prensa Santa Fe, NM 87507 kate.brassington@pera.nm.gov 505-309-1088
Dr. Gerry Washburn. Ed. D. Superintendents' Association of NM 408 N Canyon Carlsbad, NM 88220 gerry.washburn@carlsbadschools.net	

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

February 3, 2026
9:30 AM

PERA Board Room
33 Plaza La Prensa, Santa Fe, NM 87507
Online: https://meet.goto.com/NMRHCA/boardmeeting
Telephone: 1-224-501-3412 / Access Code: 724-176-285

AGENDA

			PAGE
1.	Call to Order	Dr. Caruana, President	
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder	
3.	Pledge of Allegiance & Salute to New Mexico State Flag	Dr. Caruana, President	
4.	Approval of Agenda	Dr. Caruana, President	4
5.	Approval of Regular Meeting Minutes January 6, 2026	Dr. Caruana, President	5
6.	Public Forum and Introductions	Dr. Caruana, President	
7.	Committee Reports	Dr. Caruana, President	
8.	Staff Updates		
	a. 2026 Interagency Benefits Advisory Committee (IBAC) Plan Comparison	Ms. Atencio, Deputy Director	11
	b. FY26 Second Quarter Budget Report	Mrs. Ayanniyi, Chief Financial Officer	13
	c. November 30, 2025, updated & December 31, 2025, SIC Report		19 20
	d. Legislative	Mr. Kueffer, Executive Director	21
9.	Other Business	Dr. Caruana, President	
10.	Executive Session Pursuant to NMSA 1978, Section 10-15-1(H)(6) Contents of Competitive Sealed Proposals Solicited Pursuant to the Procurement Code – Discussion of RFP# 342-2026-01 for Pharmaceutical Benefit Management Services	Dr. Caruana, President	
11.	Pharmaceutical Benefit Management Services RFP (Action Item)	Mr. Kueffer, Executive Director	61
12.	Date & Location of Next Board Meeting March 3, 2026 – 9:30AM CNM Workforce Training Center 5600 Eagle Rock Ave NE, Albuquerque, NM 87113	Dr. Caruana, President	
13.	Adjourn		

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

January 6, 2026

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:
Dr. Lee Caruana, President
Dr. Tomas Salazar, Vice President
Mr. Lance Pyle, Secretary [online]
Hon. Laura M. Montoya, NM State Treasurer
Ms. Raquel Alirez [online]
Dr. Gerry Washburn [online]
Ms. Therese Saunders
Ms. Alex Castillo-Smith [online]
Ms. Renee Garcia
Ms. Kate Brassington

Members Excused:
Ms. Donna Sandoval

Staff Present:
Mr. Neil Kueffer, Executive Director
Ms. Linda Atencio, Deputy Director Ayanniyi
Ms. Sheri Ayanniyi, Chief Financial Officer
Mr. Raymond Long, IT Director
Mr. Alexander George, Network Administrator
Ms. Judith Beatty, Recorder

3. PLEDGE OF ALLEGIANCE

Ms. Saunders led the Pledge.

4. APPROVAL OF AGENDA

Treasurer Montoya moved approval of the agenda. Dr. Salazar seconded the motion, which passed unanimously.

5. APPROVAL OF MEETING MINUTES: December 2, 2025

Ms. Saunders moved approval of the minutes of the December 2, 2025, meeting. Ms. Brassington seconded the motion, which passed, with Ms. Garcia in abstention.

6. PUBLIC FORUM AND INTRODUCTIONS

Attendees introduced themselves.

7. COMMITTEE REPORTS

- Chairman Caruana reported that the Executive Committee met on December 29 and approved today's agenda and travel request to be heard today.

8. STAFF UPDATES

a. 2026 Exchange Rates and Plan Comparison

Ms. Atencio reported that there has been a significant increase in the BeWell New Mexico rates for 2026. The average increase is 35.7%. In addition, the federal subsidies expired December 31, 2025, resulting in a substantial increase for all members. During the special session in October, the legislature approved funds to help shield residents from huge health insurance premium hikes by replacing expiring federal subsidies for ACA plans.

Ms. Atencio referred to charts in the board book reflecting increases in the Gold, Silver and Bronze plans through the various health plan providers in Albuquerque, Santa Fe, Las Cruces, Roswell and Las Vegas.

Ms. Atencio added that the subsidies for New Mexico are temporary, with no end date, and there is no guarantee they will continue. She said this will be a big discussion in the upcoming legislative session.

Treasurer Montoya suggested that one way the NMRHCA can be active with respect to the federal issue is for the board to write letters to the federal delegation

describing its impact for the members. She expressed concern about $6,000 out-of-pocket maximums listed for some of the health plan providers, pointing out that the annual income for Las Vegas residents is $40,000 and the per capita income is $25,000. She also expressed concern about the lack of doctors in the state because NMRHCA members are being directly affected.

b. 2025 Switch Enrollment Results

Mr. Biggs reviewed charts reflecting medical plan changes, including new enrollments and cancellations, made by Pre-Medicare and Medicare members. In addition, he reviewed new and canceled members in dental plans and Davis Vision plans.

c. November 30, 2025, SIC Report

Ms. Ayanniyi reported a market value on November 30 of $1.93 billion, an increase of approximately $37 million over the previous month's balance was $1.89 billion.

d. BCBS of New Mexico Data Breach

Mr. Kueffer reported that NMRHCA continues to work through this issue. Notification has been provided to many news outlets around the country, including in New Mexico. He added that there have not been many phone calls from the membership and was not sure why. NMRHCA will continue to report on this until everything is addressed and closed out.

On an unrelated matter, Treasurer Montoya noted that the NMRHCA received an email, which has been provided to all board members, from a person indicating that they were a retired lawyer with concerns about a third-party contractor of BCBS. The individual was denied coverage for a medical procedure addressing a pulmonary issue that should have been covered by insurance. She said she was glad to know that NMRHCA and BCBS took care of this, but the bigger picture is that in New Mexico there is a tendency in all different spectrums to use third party vendors that sometimes lack the necessary training or skillset. The letter from the retired lawyer reminded her of how frustrating it is to be sick and be denied services. When she worked as a constituent services representative for former U.S. Sen. Jeff Bingaman, veterans were routinely denied for different services. She commented that it is a game with people's lives, where they are repeatedly denied until they give up or die. She said she didn't want that to be the case with third party vendors used by the health plan providers under NMRHCA.

Treasurer Montoya recommended that an analysis be conducted of all the insurance companies and that it be determined how many denials are issued by third

party vendors and whether they are justifiable. If an audit is already underway, she would like to see the paperwork.

Mr. Kueffer responded that denials do happen, and members are advised to talk to their plan provider, see what the issue is and see if it can be resolved. If not, they are advised to contact NMRHCA for help. Denials are issued when procedures are investigatory or experimental or haven't received prior authorization, for instance.

Regarding the complaint received by NMRHCA, Ms. Atencio clarified that the denial came from BCBS itself and not from a third-party vendor. It was a step therapy situation. BCBS initially determined that the doctor could have gone to a lower end procedure than the one used but reversed its decision after the doctor provided additional information.

Dr. Salazar commented that prior authorizations (PAs) are big items, and many states have statutes governing them. He said third party vendors can put people into precarious situations where they are appealing to an untrained person with a company that makes decisions based on numbers. He said some states do not allow the use of AI in making some determinations.

Dr. Salazar stated that Health and Human Services did discuss PAs last fall. He said the NMRHCA board might want to discuss this matter at a future meeting.

Ms. Saunders said she really appreciated Treasurer Montoya's point about third-party vendors and the impact that their decisions have on people. She noted that this agenda item is about a data breach, which also involved a third-party vendor but on a very large scale that ultimately affected several states and thousands of people. She said maybe there is another issue to look at with third party vendors, not just with prior authorizations or involving individuals, but on a large scale.

e. <u>Legislative</u>

Mr. Kueffer stated that the legislative session begins on January 20. Two senate bills are healthcare related, the first about interstate medical compacts, where physicians outside of the state would have the ability to practice in New Mexico. The second is the "Right to Try Individualized Treatments Act."

Mr. Kueffer said the Executive budget was released and matches the NMRHCA's request. The LFC is scheduled to discuss the Executive and Legislative budgets on January 15.

Lobbyist Robert Romero said the medical malpractice issue may be a high priority in the legislature this year.

Mr. Kueffer reported that HCA was awarded $211 million through the CMS rural Health Transformation (RHT) Program to support implementation of the state's RHT initiatives.

9. FY 2025 FINANCIAL AUDIT REPORT: KORY HOGGAN, PRINCIPAL; AARON HAMILTON, SENIOR MANAGER, BAKER TILLY

Mr. Hoggan and Mr. Hamilton reported on highlights from the audit. There were no material weaknesses or significant deficiencies reported.

10. TRAVEL REQUEST

Ms. Atencio requested approval to attend the National Conference of the State and Local Government Benefits Association (SALBGA), to be held May 4-7, in Providence, Rhode Island. Staff members attending would be Mr. Kueffer, Mr. Biggs, and herself. NMRHCA is a member of SALGBA and has been attending their annual conferences for a few years.

President Caruana stated that the Executive Committee recommended approval of this request.

Treasurer Montoya suggested that Mr. Kueffer provide a list of conferences that would be helpful for staff to attend.

The May NMRHCA board meeting was rescheduled from May 3 to May 12 so that Mr. Kueffer and Ms. Atencio could be present.

Treasurer Montoya moved for approval of this travel request, with the three staff members attending. Mr. Pyle seconded the motion, which passed unanimously.

11. OTHER BUSINESS

None.

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12. DATE AND LOCATION OF NEXT BOARD MEETING

February 3, 2026 – 9:30 AM
PERA Board Room
33 Plaza La Prensa, Santa Fe, NM 87507

13. ADJOURN: 11:05 a.m.

Accepted by:

Lee Caruana, President

Plan Comparison

NM Retiree Health Care Authority, State of New Mexico HCA, NM Public School Insurance Authority and Albuquerque Public Schools Effective 1/1/2026

Medical Plans: BCBS: Blue Cross Blue Sheild & PHP: Presbyterian Health Plan PPO: Preferred Provider Organziation, HMO: Health Maintenance Organization, & EPO: Exclusive Provider Organziation

Plan Premiums for individual member per month with employer subsidy of 64%	**NMRHCA Premier PPO - BCBS and PHP** $352.81	**NMRHCA Value Plan HMO - BCBS and PHP** $275.60	**SONM PPO - BCBS** $326.90	**SONM HMO - BCBS and PHP** $281.08	**NMPSIA High Option - BCBS and PHP** $401.75, $324.88	**NMPSIA Low Option - BCBS and PHP** $278.54 , $225.28	**APS EPO BCBS** $289.28	**APS EPO PHP** $303.73
Annual Deductible	$500 to $800/Individual	$1,500/Individual	$250 or $350/Individual	$212.50,$175 to $250 individual	$825/Individual	$2,200/Individual	$1,000/Individual	$500/Individual
Annual Out-of-Pocket Limit	$3,750 to 4,500/Individual	$5,500/Individual	$2,000 or $2,800/Individual	$2,000, $1875 to $2,125 individual	$4,500/Individual	$5,500/Individual	$5,000/Individual	$4,000/Individual
Office Services	Primary - $20 or $30 Specialist - $35 to $45	Primary -$35 Specialist - $55	Primary -$40 or $50 Specialist - $60 or $70	Primary -$35, $25, $40 Specialist - $50, $45 $75	Primary -$30 Specialist - $55	Primary -$35 Specialist - $70	Primary -$30 Specialist - $60	Primary -$20 Specialist - $50
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Related testing (includes routine Pap test, mammograms, colonoscopy, physicals, etc.) & immunization (deductible waived)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Lab, X-Ray, and Pathology	Plan pays 100%	Plan pays 100%	30% or 40%	25%, $20, $100	$30 freestanding lab/ radiology or actual allowed or $60 hospital outpatient	$35 freestanding lab/ radiology or actual allowed or $70 hospital outpatientd	$30	$20
Emergency Room	$250	$350	$325	$300, 20%	$550	$550	$450	$350
Urgent Care Facility	$45	$55	$65 or $75	$60, $100	$55	$70	$75	$50
Ambulance Services	25%	30%	20%	$30 Ground/$100 Air, 20%	$55	30%	20%	20%
High-Tech Radiology (MRI, PET & CT)	10%, 25% or $100 office/ freestanding radiology	30% or $125 office/ freestanding radiology	25% or 35% up to $300	25% to max $250 per test per day	$600 copay per day	$700 copay per day	$120 copay per day freestanding facility, 20% outpatient hospital	$120 copay per day freestanding facility, 20% outpatient hospital
Rehabilitation Inpatient or Outpatient (Occupational, Physical, and Speech)	10% or 25% / $20 or $30 - Physical therapy outpatient alternative to surgery 4 copay max	30% / $35 - Physical therapy outpatient alternative to surgery 4 copay max	$1,250 - $1,750 Inpatient/ $40-$50 Outpatient	$700 Inpatient, 20% / $35, $25 or $40 Outpatient	Outpatient visits: $30 copay/visit to max $300 per year; Inpatient rehab. admit: 25%	Outpatient visits: $35 copay; Inpatient rehab. admit: 30%	20% Inpatient, $30 to max $480 per year and 60 visit max per condition	20% Inpatient, $20 to max $320 per year and 60 visit max per condition
Alternative (chiropractic, acupuncture, etc.)	$30,10%,25% $1,500 combined annual max	$35, 30% $1,500 combined annual max	$60-$70, max 25 combined visits a year	$60, $55 max 25 combined visits a year	$25, $50 combined max 30 visits	25% - $30 combined max 30 visits	$30, max 25 visits a calendar year	$20, max 25 visits a calendar year
Hospitalization - Inpatient	10% or 25%	30%	$1,250 or $1,750	$700 per admit, 20%	25%	30%	20% coinsurance	20% coinsurance
Surgery - Outpatient	10% or 25%	30%	25% to max $500 or 35% to max $700	25%, $500 per admit	25%	30%	20% coinsurance	20% coinsurance
Majority of Other Covered Services	10% or 25%	30%	Vary	25%, 20%	25%	30%	20%	20%

Plan Comparison

NM Retiree Health Care Authority, State of New Mexico HCA, NM Public School Insurance Authority and Albuquerque Public Schools Effective 1/1/2026

Prescription Plans:

	NMRHCA Premier PPO		NMRHCA Value Plan HMO		SONM PPO		SONM HMO		NMPSIA High Option		NMPSIA Low Option		APS EPO BCBS		APS EPO Presbyterian	
Copay (Retail)	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*
Generic	$10	$30	$10	$30	$6		$6		$0	$10	$0	$15	20%	$10	20%	$10
Preferred Brand	$45	$100	$45	$100	$35	$95	$35	$95	$30	$75	$45	$112	$50	$100	$50	$100
Non-Formulary	$75	$200	$75	$200	$60	$130	$60	$130	70%		70%		$100	$175	$100	$175
Specialty					$60 generic, $85 preferred brand, $125 non-preferred				$55 Generic; $80 Preferred Brand; $130 Non-preferred Brand (CVS - Mail Order)		$55 Generic; $120 Preferred Brand; $170 Non-preferred Brand (CVS - Mail Order)		$100, $125, $200 based on tier (Accredo - Mail Order)		$100, $125, $200 based on tier (Accredo - Mail Order)	
Up to 30 or 34 day supply					$25 ind/$50 family brand-name deductible applies to OOP											
Copay (Mail Order)	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*
Generic	$24	$70	$24	$70	$17				$22		$35		$20		$20	
Preferred Brand	$90	$200	$90	$200	$120				$150		$175		$150		$150	
Non-Formulary	$150	$400	$150	$250	$155				70%				$300		$300	
Specialty																
90 day supply																

New Mexico Retiree Health Care Authority
Fiscal Year 2026 Second Quarter Budget Review

Healthcare Benefits Fund

Between July 1, 2025, and December 31, 2025, the Healthcare Benefits Administration Program expended $199.9 million and collected $250.6 million in revenue. The resulting $50.7 million surplus is higher than the $35.1 million surplus for the same period in FY25.

Second Quarter FY26 expenditure is $11.5 million higher than expenditure in Second Quarter FY25, for an increase of 6.1%. Current projections indicate a $123.9 million surplus at the end of FY26.

Major Upward Cost Pressures:

1. Claims costs typically increase during the third and fourth quarters of the plan year (calendar year) because members are meeting their annual deductible and reaching maximum out-of-pocket expenses.
2. Prescriptions drug costs are higher this quarter due to the new $2,000 cap on the EGWP plan, which shifts a greater share of prescription costs from members to the plan.
3. Medicare Advantage Prescription Drug (MAPD) plan costs reflect the premium increases effective for the 2025 calendar year.

Major Downward Cost Pressures:

Overall plan participation (medical and voluntary coverages) decreased by 0.4% between December 2024 and December 2025, a reduction of 284 members. This decline is lower than the 1.0% reduction in the previous fiscal year, which saw a loss of 693 members.

1. Pre-Medicare Plan Participation
    - Premier Plans: -569 members (-7.5%)
    - Value Plans: -176 members (-6.0%)
    - Net: -745 members (-7.0%)

2. Medicare Plan Participation
    - Medicare Supplement: -574 members (-2.9%)
    - *BCBS MA Plans: +2,053 members (57.8%)
    - Humana MA Plans: -107 members (5.2%)
    - Presbyterian MA Plans: -289 members (-3.2%)
    - UnitedHealthcare MA Plans: -1,176 members (-19.5%)

3. A 3.3% decline in dependent child participation in medical plans from 993 in December 2024 to 960 in December 2025.

*Default Plans --- All PHP and BCBS Pre-Medicare Plan Participants to BCBS MAPD PPO Plan effective January 1, 2025.

Below is an annual summary of the cash contributions made to the State Investment Council (SIC) between fiscal years 2016 – 2025, as well as contribution(s) made in FY26:

Ten-Year Summary of Cash Contributions to Long Term Investments - SIC		
FY16 Total	$	35,000,000
FY17 Total	$	33,000,000
FY18 Total	$	20,000,000
FY19 Total	$	45,000,000
FY20 Total	$	56,000,000
FY21 Total	$	75,000,000
FY22 Total	$	60,000,000
FY23 Total	$	100,000,000
FY24 Total	$	140,000,000
FY25 Total	$	140,000,000
Transfer Effective		Amount Transferred
November 1, 2025	$	30,000,000
FY26 Total	$	30,000,000
Total Transfers	**$**	**734,000,000**

New Mexico Retiree Health Care Authority

FY26 2nd Quarter Budget Review

Comparison of Projected vs. Actual

(in thousands)

Healthcare Benefit Fund

FY26/FY25 Comparison

	FY26 Approved Q2 Budget	FY26 Q2 Actual	FY25 Q2 Actual	Dollar Change	Percent Change
Sources:					
Employer/Employee Contributions	$ 70,551.50	$ 105,170.8	$ 104,088.9	$ 1,081.9	1.0%
Retiree Contributions	$ 86,450.7	$ 94,562.5	$ 82,311.3	$ 12,251.2	14.9%
Taxation & Revenue Fund	$ 29,016.45	$ 19,348.0	$ 17,275.0	$ 2,073.0	12.0%
Other Miscellaneous Revenue	$ 19,508.20	$ 30,740.4	$ 19,080.6	$ 11,659.8	61.1%
Interest Income	$ 50.0	$ 942.5	$ 914.3	$ 28.2	3.1%
Refunds	$ -	$ (134.5)	$ (160.9)	$ 26.4	-16.4%
Total Sources	$ 205,576.9	$ 250,629.7	$ 223,509.2	$ 27,120.5	12.1%
Uses:					
Medical Contractual Services	$ 203,318.4	$ 195,456.0	$ 184,297.6	$ 11,158.4	6.1%
ACA Fees (PCORI)	$ 45.0	$ 38.6	$ 39.8	$ (1.2)	-3.0%
Other Financing Uses	$ 2,213.5	$ 4,427.0	$ 4,125.2	$ 301.8	7.3%
Total Uses	$ 205,576.9	$ 199,883.0	$ 188,422.8	$ 11,460.2	6.1%
Sources Over Uses	**NA**	**$ 50,746.7**	**$ 35,086.4**	**NA**	**NA**

FY26 Budget Compared to Actual

	FY26 Approved Budget	FY26 Actuals	Remaing Balance	Percent Expended/ Collected	FY26 Projected Total
Sources:					
Employer/Employee Contributions	$ 141,103.0	$ 105,170.8	$ 35,932.2	74.5%	$ 210,000.0
Retiree Contributions	$ 172,901.4	$ 94,562.5	$ 78,338.9	54.7%	$ 189,000.0
Taxation & Revenue Fund	$ 58,032.9	$ 19,348.0	$ 38,684.9	33.3%	$ 58,000.0
Other Miscellaneous Revenue	$ 38,971.4	$ 30,740.4	$ 8,231.0	78.9%	$ 61,000.0
Interest Income	$ 100.0	$ 942.5	$ (842.5)	NA	$ 1,900.0
Refunds	$ -	$ (134.5)	$ -	NA	$ (270.0)
Total Sources	$ 411,108.7	$ 250,629.7	$ 160,344.5	61.0%	$ 519,630.0
Uses:					
Medical Contractual Services	$ 406,636.7	$ 195,417.4	$ 211,219.3	48.1%	$ 391,420.0
ACA Fees (PCORI)	$ 45.0	$ 38.6	$ 6.4	85.8%	$ 38.6
Other Financing Uses	$ 4,427.0	$ 4,427.0	$ -	100.0%	$ 4,283.9
Total Uses	$ 411,108.7	$ 199,883.0	$ 211,225.7	48.6%	$ 395,742.5
Sources Over Uses	**NA**	**$ 50,746.7**	**NA**	**NA**	**$ 123,887.5**

New Mexico Retiree Health Care Authority
2nd Quarter Healthcare Benefit Fund Detail
Fiscal Year 2026
(in thousands)

	FY26 Q2 Actuals	FY25 Q2 Actuals	FY26 - FY25 Difference
REVENUE:			
Employer/Employee Contributions	$ 105,170.8	$ 104,088.9	$ 1,081.9
Retiree Contributions	$ 94,562.5	$ 82,311.3	$ 12,251.2
Taxation and Revenue Suspense Fund	$ 19,348.0	$ 17,275.0	$ 2,073.0
Other Miscellaneous Revenue	$ 30,740.4	$ 19,080.6	$ 11,659.8
Interest Income	$ 942.5	$ 914.3	$ 28.2
Refunds	$ (134.5)	$ (160.9)	$ 26.4
TOTAL REVENUE:	**$ 250,629.7**	**$ 223,509.2**	**$ 27,120.5**
EXPENDITURES:			
Prescriptions			
Express Scripts	$ 78,688.6	$ 67,115.0	$ 11,573.6
Total Prescriptions	$ 78,688.6	$ 67,115.0	$ 11,573.6
Non-Medicare			
Blue Cross Blue Shield	$ 28,626.6	$ 33,259.1	$ (4,632.5)
BCBS Administrative Costs	$ 856.9	$ 791.0	$ 65.9
Presbyterian	$ 21,347.8	$ 23,083.2	$ (1,735.4)
Presbyterian Administrative Costs	$ 840.4	$ 1,070.3	$ (229.9)
PCORI Fee	$ 38.6	$ 39.8	$ (1.2)
Total Non-Medicare	$ 51,710.3	$ 58,243.4	$ (6,533.1)
Medicare			
Blue Cross Blue Shield	$ 25,698.3	$ 24,105.6	$ 1,592.7
BCBS Administrative Costs	$ 2,306.8	$ 2,297.4	$ 9.4
Presbyterian MA	$ 10,393.9	$ 9,650.0	$ 743.9
UnitedHealthcare MA	$ 4,119.5	$ 2,615.9	$ 1,503.6
Humana MA	$ 854.6	$ 485.5	$ 369.1
BCBS MA	$ 605.7	$ -	$ 605.7
Total Medicare	$ 43,978.8	$ 39,154.4	$ 4,824.4
Other Benefits			
Davis Vision	$ 1,344.4	$ 1,259.6	$ 84.8
BCBS Dental	$ 458.3	$ -	$ 458.3
Delta Dental	$ 12,399.7	$ 11,669.4	$ 730.3
Standard Life Insurance	$ 6,875.9	$ 6,855.8	$ 20.1
Total Other Benefits	$ 21,078.3	$ 19,784.8	$ 1,293.5
Other Expenses			
Program Support	$ 4,427.0	$ 4,125.2	$ 301.8
Total Other Expenses	$ 4,427.0	$ 4,125.2	$ 301.8
TOTAL EXPENDITURES:	***$ 199,883.0***	**$ 188,422.8**	**$ 11,460.2**
Total Revenue over Total Expenditures	***$ 50,746.7***	**$ 35,086.4**	**$ 15,660.3**

New Mexico Retiree Health Care Authority
FY26 2nd QTR Budget Review
Comparison of Budget vs. Actual
(in thousands)

Program Support

FY26/FY25 Comparison

	FY26 Approved Q2 Budget	FY26 Actuals	FY25 Actuals	Dollar Change	Percent Change
Sources:					
Other Transfers	$ 2,243.8	$ 4,487.6	$ 3,913.4	$ 574.2	14.7%
Total Sources	**$ 2,243.8**	**$ 4,487.6**	**$ 3,913.4**	**$ 574.2**	**14.7%**
Uses:					
Personal Services and Benefits	$ 1,557.1	$ 1,430.3	$ 1,284.0	$ 146.2	11.4%
Contractual Services	$ 374.2	$ 267.8	$ 244.5	$ 23.3	9.5%
Other Costs	$ 312.6	$ 317.9	$ 289.2	$ 28.6	9.9%
Total Uses	**$ 2,243.8**	**$ 2,015.9**	**$ 1,817.8**	**$ 198.1**	**10.9%**

New Mexico Retiree Health Care Authority
FY26 2nd QTR Budget Review
Comparison of Budget vs. Actual
(in thousands)

Program Support

FY26 Budget Compared to Actual

	Approved Operating Budget	FY26 Actuals	Remaining Balance	Percent Expended	FY26 Projected
Sources:					
Other Transfers	$ 4,487.6	$ 2,243.8	$ 2,243.8	50%	$ 4,283.9
Total Sources	**$ 4,487.6**	**$ 2,243.8**	**$ 2,243.8**	**50%**	**$ 4,283.9**
Uses:					
Personal Services and Benefits	$ 3,114.1	$ 1,430.3	$ 1,683.8	46%	$ 2,951.3
Contractual Services	$ 748.3	$ 267.8	$ 480.5	36%	$ 710.7
Other Costs	$ 625.2	$ 317.9	$ 307.3	51%	$ 621.9
Total Uses	**$ 4,487.6**	**$ 2,015.9**	**$ 2,471.7**	**45%**	**$ 4,283.9**

Program Support

Expenditure Summary (in thousands)

		A	B	C	D	E
Acct #	Account Description	Approved Budget	Expended Budget	Remaing Balance	Projected	Balance
200	Personal Services/ Employee Benefits	3,114.1	1,430.3	1,683.8	1,521.0	162.8
300	Contractual Services	748.3	267.8	480.5	442.9	37.6
400	Other Costs	625.2	317.9	307.3	304.0	3.3
	TOTAL	**4,487.6**	**2,015.9**	**2,471.7**	**2,268.0**	**203.7**

Expenditure Detail (in thousands)

Personal Services / Employee Benefits

Acct #	Account Description	Approved Budget	Expended Budget	Remaining Balance	Projected	Balance
520100	Exempt Positions	527.4	217.6	309.8	250.4	59.4
520300	Classified Perm. Positions	1,685.9	774.0	911.9	812.7	99.2
520700	Overtime & Other Premium Pay	0.0	5.8	(5.8)	0.0	(5.8)
520800	Annual, Sick & Comp Paid	0.0	0.3	(0.3)	0.0	(0.3)
521100	Group Insurance Premium	251.6	139.8	111.8	150.7	(38.9)
521200	Retirement Contributions	427.9	191.9	236.0	204.6	31.4
521300	FICA	169.2	74.0	95.2	81.3	13.8
521400	Workers Comp	0.3	0.1	0.2	0.0	0.2
521410	GSD Work Comp Ins	1.7	1.7	0.0	0.0	0.0
521500	Unemployment Comp	0.0	0.0	0.0	0.0	0.0
521600	Employee Liability Insurance	5.1	5.1	0.0	0.0	0.0
521700	Retiree Health Care	45.0	19.9	25.1	21.3	3.8
	TOTAL	**3,114.1**	**1,430.3**	**1,683.8**	**1,521.0**	**162.8**

Contractual Services

Acct #	Account Description					
535200	Professional Services	437.5	200.0	237.5	233.0	4.5
535300	Other Services	25.5	5.3	20.2	14.0	6.2
535309	Other Services InterA	30.4	0.0	30.4	31.6	(1.2)
535400	Audit Services	129.9	33.0	96.9	76.0	20.9
535500	Attorney Services	25.0	7.8	17.2	10.0	7.2
535600	Information Technology Services	100.0	21.6	78.4	78.3	0.1
	TOTAL	**748.3**	**267.8**	**480.5**	**442.9**	**37.6**

Other Costs

Acct #	Account Description					
542100	Employee In-State Mileage & Fares	2.5	0.8	1.7	1.0	0.7
542200	Employee In-State Meals & Lodging	6.0	3.9	2.1	1.0	1.1
542300	Board & Commission - In-State Meals & Lodging	5.5	4.7	0.8	1.2	(0.4)
542310	Board & Commission - In-State Mileage & Fares	6.0	3.8	2.2	3.9	(1.7)
542500	Transportation-Fuel & Oil	2.2	0.3	1.9	0.6	1.3
542600	Transportation	0.6	1.1	(0.5)	0.5	(1.0)
542700	Transportation - Insurance	0.2	0.0	0.2	0.2	0.0
542800	State Transportation Pool Charges	8.1	5.8	2.3	2.1	0.2
543200	Maintenance - Furniture, Fixtures & Equipment	6.0	0.0	6.0	6.0	0.0
543300	Maintenance - Building & Structure	6.0	0.0	6.0	0.0	6.0
543400	Maintenance - Property Insurance	0.1	0.0	0.1	0.1	0.0
543830	IT HW/SW Agreements	24.0	12.1	11.9	11.8	0.1
544000	Supply Inventory IT	20.0	0.3	19.7	19.5	0.2
544100	Supplies - Office Supplies	13.0	2.8	10.2	7.0	3.2
544200	Supplies - Medical, Lab, Personal	0.0	0.1	(0.1)	0.0	(0.1)
544900	Supplies - Inventory Exempt	5.0	0.1	4.9	4.8	0.1
545600	Rep/Recording	0.2	0.0	0.2	0.0	0.2
545700	DoIT - ISD Services	21.5	9.2	12.3	10.0	2.3
545701	DoIT - HCM Fees	9.8	9.8	0.0	0.0	0.0
545900	Printing & Photo. Services	70.0	58.5	11.5	15.0	(3.5)
546100	Postage & Mail Services	90.0	60.0	30.0	29.0	1.0
546400	Rent of Land & Buildings	134.7	67.6	67.1	67.1	(0.0)
546409	Rent - Interagency	19.9	9.9	10.0	10.0	0.0
546500	Rent of Equipment	37.1	16.6	20.5	20.5	0.0
546600	Telecomm	6.0	1.4	4.6	4.0	0.6
546610	DOIT Telecomm	58.5	37.0	21.5	37.0	(15.5)
546700	Subscriptions & Dues	7.0	2.8	4.2	2.5	1.7
546709	Subscriptions & Dues - Interagency	0.2	0.0	0.2	0.1	0.1
546800	Employee Training & Education	9.0	4.4	4.6	3.0	1.6
546801	Board Member Training	5.5	0.0	5.5	3.0	2.5
546900	Advertising	1.8	0.0	1.8	1.0	0.8
547900	Miscellaneous Expense	2.3	0.7	1.6	0.9	0.7
547999	Request to Pay Prior Year	0.0	0.0	0.0	0.0	0.0
548300	Information Technology Equipment	27.5	0.0	27.5	27.5	0.0
549600	Employee Out-Of-State Mileage & Fares	6.0	1.3	4.7	3.5	1.2
549700	Employee Out-Of-State Meals & Lodging	6.5	2.8	3.7	3.7	0.0
549800	B&C-Out-Of-State Mileage & Fares	3.5	0.0	3.5	3.5	0.0
549900	B&C- Out-Of-State Meals & Lodging	3.0	0.0	3.0	3.0	0.0
	TOTAL	**625.2**	**317.9**	**307.3**	**304.0**	**3.3**

New Mexico Retiree Health Care Authority (CP)
Change in Market Value
From Nov 2025 To Nov 2025
(Report as of January 20, 2026)

Investment Name	Prior Ending Market Value	Contributions	Distributions	Fees	Income	Gains - Realized	Gains - Unrealized	Gains - Realized & Unrealized	Market Value
Core Bonds Pool	375,133,495.76	6,000,000.00	-	(95,355.36)	923,350.39	596,560.38	987,857.29	1,584,417.67	383,545,908.46
Credit Plus Pool	92,561,003.61	1,500,000.00	-	(47,815.51)	436,745.58	40,478.34	54,287.80	94,766.14	94,544,699.82
NM Retiree Health Care Authority Cash Account	-	-	-	-	-	-	-	-	-
Non-US Developed Markets Index Pool	-	-	-	-	-	-	-	-	-
Non-US Emerging Markets Active Pool	-	-	-	-	-	-	-	-	-
Non-US Large Cap Active Pool	95,687,026.77	1,500,000.00	-	(70,274.89)	125,691.41	519,762.03	(277,492.99)	242,269.04	97,484,712.33
Non-US Large Cap Passive Pool	133,791,612.56	2,100,000.00	-	(8,004.74)	187,856.93	(95,701.70)	(71,805.23)	(167,506.93)	135,903,957.82
Non-US SMID Cap Active Pool	22,469,433.49	300,000.00	-	(22,255.12)	17,549.19	15,473.56	75,697.60	91,171.16	22,855,898.72
Non-US SMID Cap Passive Pool	35,869,533.82	600,000.00	-	(6,013.36)	31,344.44	401,432.02	(48,668.88)	352,763.14	36,847,628.04
Private Debt Market Pool	226,798,199.69	3,600,000.00	-	-	1,057,458.61	(5,412.57)	(704,081.53)	(709,494.10)	230,746,164.20
Private Equity Pool	208,883,400.33	3,300,000.00	-	-	252,079.61	485,732.51	(606,747.82)	(121,015.31)	212,314,464.63
Real Estate Pool	184,179,803.45	3,000,000.00	-	-	259,871.76	247,006.35	(387,683.38)	(140,677.03)	187,298,998.18
Real Return Pool	93,622,090.98	1,500,000.00	-	(17,267.49)	65,149.55	229,240.09	205,158.70	434,398.79	95,604,371.83
US Large Cap Index Pool	368,491,780.01	5,700,000.00	-	(8,241.19)	429,030.12	(2,447.98)	489,405.64	486,957.66	375,099,526.60
US SMID Cap Alternative Weighted Index Pool	56,470,460.91	900,000.00	-	(4,565.22)	78,393.78	1,164,060.60	275,727.61	1,439,788.21	58,884,077.68
Sub - Total New Mexico Retiree Health Care	1,893,957,841.38	30,000,000.00	-	(279,792.88)	3,864,521.37	3,596,183.63	(8,345.19)	3,587,838.44	1,931,130,408.31
Total New Mexico Retiree Health Care A	**1,893,957,841.38**	**30,000,000.00**	**-**	**(279,792.88)**	**3,864,521.37**	**3,596,183.63**	**(8,345.19)**	**3,587,838.44**	**1,931,130,408.31**

New Mexico Retiree Health Care Authority (CP)

Change in Market Value

For the Month of Dec 2025

(Report as of January 20, 2026)

Investment Name	Prior Ending Market Value	Contributions	Distributions	Fees	Income	Gains - Realized	Gains - Unrealized	Gains - Realized & Unrealized	Market Value
Core Bonds Pool	383,545,908.46	-	-	-	4,037,988.26	145,647.35	(5,106,150.49)	(4,960,503.14)	382,623,393.58
Credit Plus Pool	94,544,699.82	-	-	-	422,910.50	24,252.86	(250,981.33)	(226,728.47)	94,740,881.85
NM Retiree Health Care Authority Cash Account	-	-	-	-	-	-	-	-	-
Non-US Large Cap Active Pool	97,484,712.33	-	-	-	149,470.93	247,226.15	2,509,886.52	2,757,112.67	100,391,295.93
Non-US Large Cap Passive Pool	135,903,957.82	-	-	-	233,328.02	4,858.33	3,649,026.28	3,653,884.61	139,791,170.45
Non-US SMID Cap Active Pool	22,855,898.72	-	-	-	54,949.75	92,173.40	471,173.56	563,346.96	23,474,195.43
Non-US SMID Cap Passive Pool	36,847,628.04	-	-	-	74,168.55	149,318.65	497,259.18	646,577.83	37,568,374.42
Private Debt Market Pool	230,746,164.20	-	-	-	391,490.08	(6,253.94)	4,156,324.83	4,150,070.89	235,287,725.17
Private Equity Pool	212,314,464.63	-	-	-	105,034.80	475,496.73	6,798,333.17	7,273,829.90	219,693,329.33
Real Estate Pool	187,298,998.18	-	-	-	496,065.80	263,765.51	632,617.35	896,382.86	188,691,446.84
Real Return Pool	95,604,371.83	-	-	-	516,833.77	237,283.91	1,317,224.30	1,554,508.21	97,675,713.81
US Large Cap Index Pool	375,099,526.60	-	-	-	436,845.54	524,233.32	(934,517.80)	(410,284.48)	375,126,087.66
US SMID Cap Alternative Weighted Index Pool	58,884,077.68	-	-	-	125,183.11	714,233.29	(869,148.03)	(154,914.74)	58,854,346.05
Sub - Total New Mexico Retiree Health Care Auth	1,931,130,408.31	-	-	-	7,044,269.11	2,872,235.56	12,871,047.54	15,743,283.10	1,953,917,960.52
Total New Mexico Retiree Health Care Auth	**1,931,130,408.31**	**-**	**-**	**-**	**7,044,269.11**	**2,872,235.56**	**12,871,047.54**	**15,743,283.10**	**1,953,917,960.52**

House Appropriations & Finance Committee

Nathan P. Small, Chair
Meredith A. Dixon, Vice Chair

FY27 Appropriation Recommendations & Updates

January 15, 2026

Dr. Lee Caruana, President
Dr. Tomas Salazar, Vice President
Neil Kueffer, Executive Director

BOARD OF DIRECTORS

Broad representation from retired
and active membership

Dr. Lee Caruana, President

Retired Public Employees of New Mexico

Dr. Tomas Salazar, Vice President

New Mexico Association of Educational Retirees

Mr. Lance Pyle, Secretary

New Mexico Association of Counties

Ms. Alex Castillo-Smith
New Mexico Health Care Authority

Ms. Renee Garcia
Educational Retirement Board

Ms. Laura Montoya
New Mexico State Treasurer

Ms. Donna Sandoval
New Mexico Municipal League

Ms. Kate Brassington
Public Employees Retirement of New Mexico

Ms. Raquel Alirez
Classified State Employee

Dr. Gerry Washburn
New Mexico Superintendent Association

Ms. Therese Saunders
NEA NM, Classroom Teachers Association
Federation of Educational Employees

AGENCY BACKGROUND

The New Mexico Retiree Health Care Authority fosters quality of life and peace of mind by responsibly administering affordable, secure health care benefits for public retirees and their families.

Established July 1990

1. Retiree Health Care Act
2. First full benefits paid to 16k members in Jan '91
3. Board of directors has authority to set plan parameters
4. Legislature has authority over employer/employee contributions
5. Current solvency – Beyond 2056

Purpose & Composition

1. Provide comprehensive health insurance for those who've retired from public service in NM
2. Active employees - Over 93k
3. Public Employer Groups – 304
   a. 50% schools
   b. 25% State agencies
   c. 25% local govt
4. Member participation – 65,485 (1/1/26)

a. Retirees – 48,288
   Pre-Medicare – 7,007
   Medicare – 32,398
   Voluntary – 8,883
b. Spouses/DP – 15,313
   Pre-Medicare – 1,795
   Medicare – 8,051
   Voluntary – 5,467
c. Dependent Children – 1,884
d. Retiree Average Age – 70.5
e. Average age upon retirement – 61.7
f. Retirees Under Age 55 – 1,040

BENEFITS OFFERED 2026

Pre-Medicare (pre-65/non-disabled)

Medical

- 2 - Value HMO Plans
  - Choice between Presbyterian Health Plan and Blue Cross Blue Shield
- 2 - PPO Plans
  - Choice between Presbyterian Health Plan and Blue Cross Blue Shield

Medicare (65+/disabled)

Medical

- 1 – Supplement Plan – Blue Cross Blue Shield
- 5 – Medicare Advantage Plans
  - Choice United HealthCare, Humana, Presbyterian Health Plan, and Blue Cross Blue Shield HMO and Blue Cross Blue Shield PPO

Voluntary Benefits

Dental – Delta & Blue Cross Blue Shield

- Basic
- Comprehensive

Vision – Davis

Supplemental Term Life Insurance – Standard Insurance Company

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

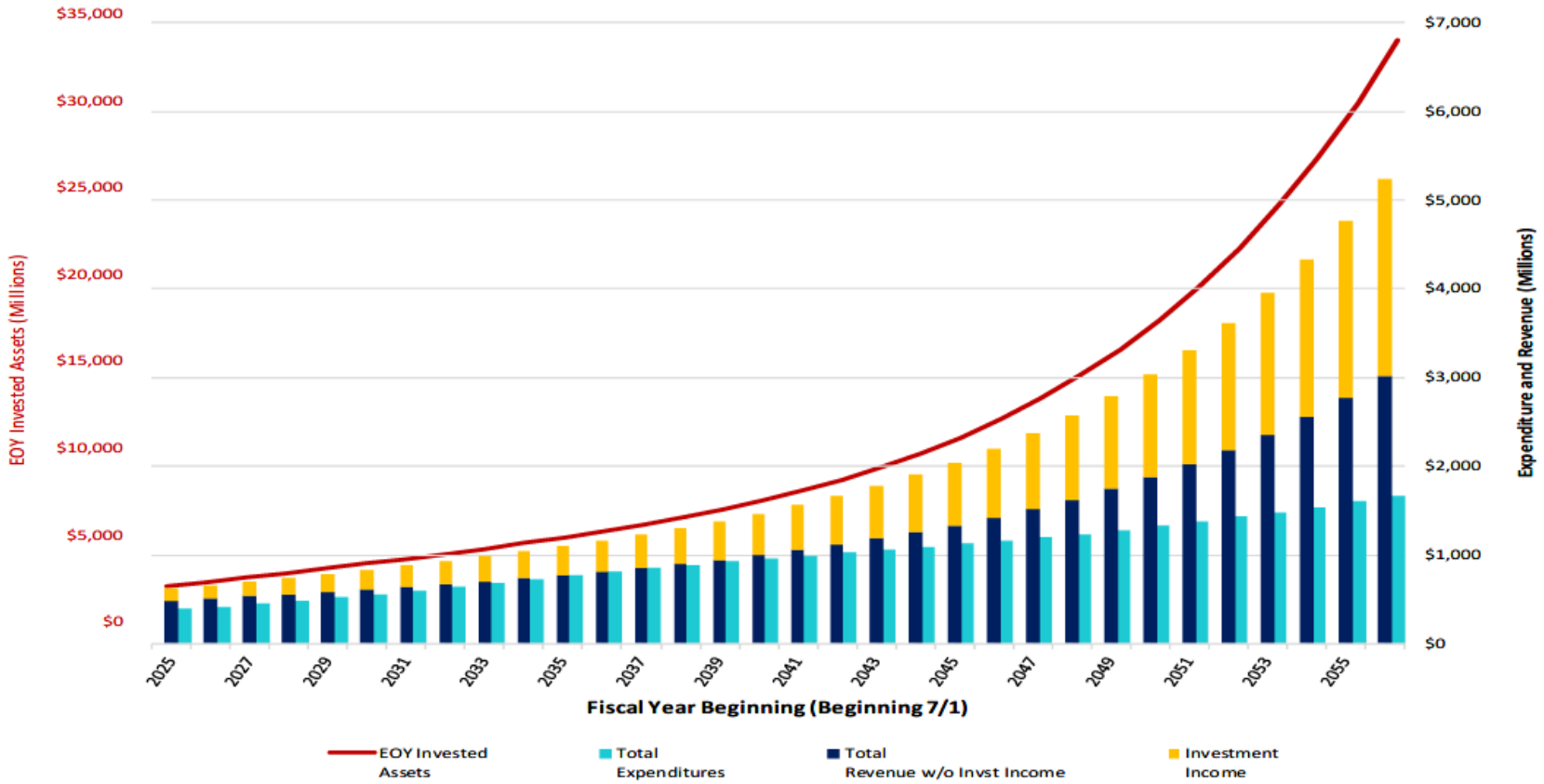
SOLVENCY UPDATES

Projected solvency = past 30 years

Period of time when expenditures exceed revenue

2025 Solvency Scenario – Board Approved Rate Action with SB51 Impact

2% Non-Medicare retiree and spouse, 3% Non-Medicare dependent, 0% Med Supp Rate Increases, CY2026 Non-Medicare Rx Copay Changes and EGWP Plan Changes*



* No annual Medicare Supplement rate increases throughout the projection period.

Segal

FY27 APPROPRIATION REQUEST & RECOMMENDATIONS

($ shown in thousands)	FY26 Approved Operating	FY27 NMRHCA Request	LFC Recommendation	LFC Growth	DFA Recommendation	DFA Growth
Healthcare Benefits Administration						
Contractual Services	$ 406,636.7	$ 418,236.7	$ 418,236.7	2.9%	$ 418,236.7	2.9%
Other	$ 45.0	$ 45.0	$ 45.0	0.0%	$ 45.0	0.0%
Other Financing Uses	$ 4,427.0	$ 4,967.6	$ 4,656.6	5.2%	$ 4,967.6	12.2%
Subtotal	**$ 411,108.7**	**$ 423,249.3**	**$ 422,938.3**	2.9%	**$ 423,249.3**	3.0%
Program Support						
Personal Services & Employee Benefits	$ 3,053.5	$ 3,497.7	$ 3,243.0	6.2%	$ 3,497.7	14.5%
Contractual Services	$ 748.3	$ 815.3	$ 763.2	2.0%	$ 815.3	9.0%
Other Financing Uses	$ 625.2	$ 654.6	$ 650.4	4.0%	$ 654.6	4.7%
Subtotal	**$ 4,427.0**	**$ 4,967.6**	**$ 4,656.6**	5.2%	**$ 4,967.6**	12.2%
Total	**$ 415,535.7**	**$ 428,216.9**	**$ 427,594.9**	2.9%	**$ 428,216.9**	3.1%
FTE	**28**	**32**	**29**	**1**	**32**	**4**

FY27 Request:

NMRHCA Request of about $12.7 Million or 3.1% increase in Spending Authority for FY27

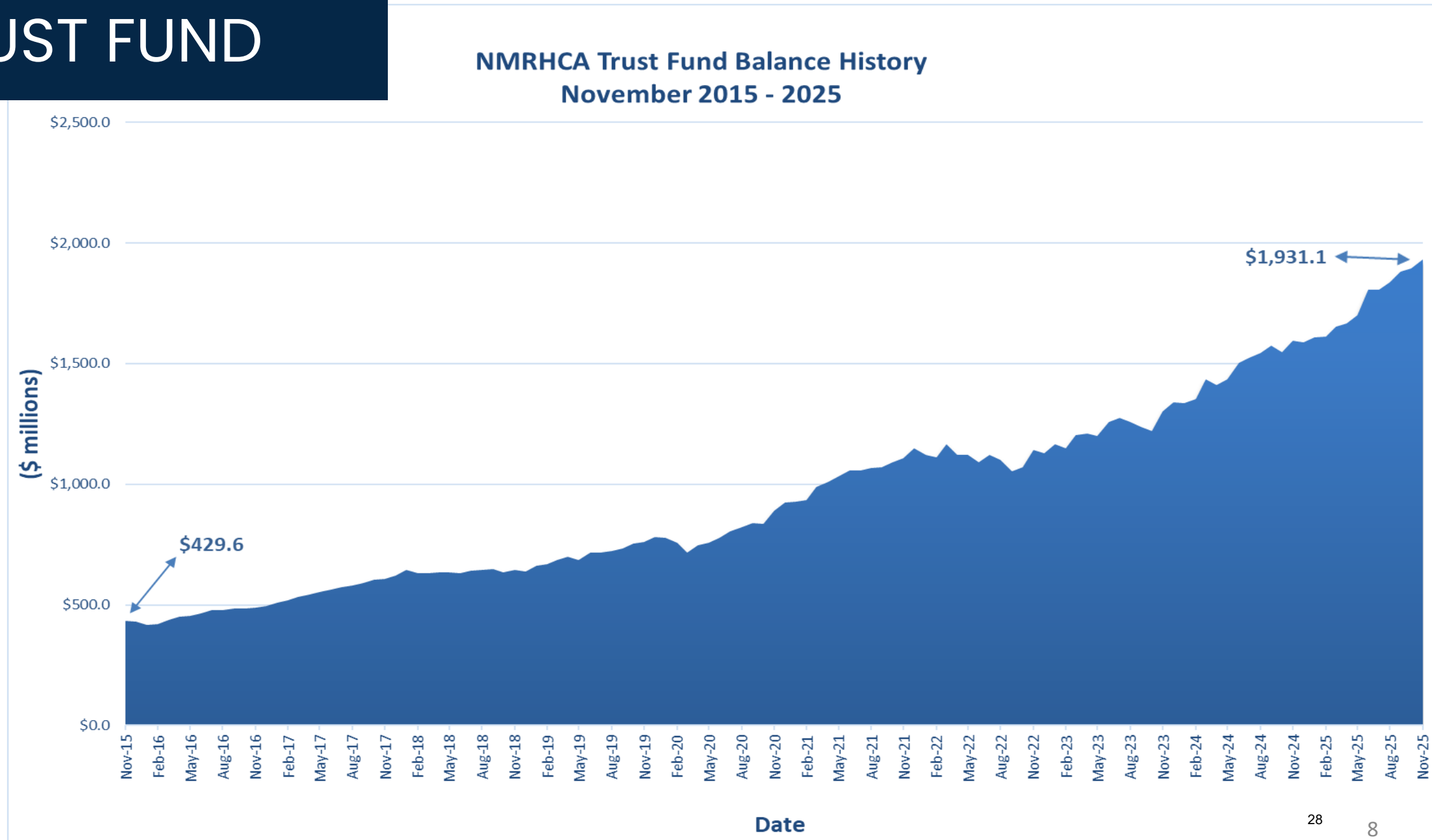
- Healthcare Benefits Administration $418.2 million equates to 99% total budget
- Personal Services and Employee Benefits Includes $540.6 Thousand (12.2%) Increase, above FY26
  - Program support includes 4 new FTE to support members
- Unspent funds revert to Trust Fund

GASB 74

GASB Statement No. 74 – Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans as of June 30, 2025

- Total OPEB Liability: $3,422,408,572 (2025)
  - $3,366,766,868 (2024) / $3,049,662,302 (2023) / $3,467,298,517 (2022) / $4,409,849,335 (2021)
- Net OPEB Liabilities (NOL): $1,556,676,574 (2025)
  - $1,784,800,039 (2024) / $1,702,935,655 (2023) / $2,311,603,052 (2022) / $3,290,349,790 (2021)
- NOL decreased by $173 million from previous year, due to the following:
  - There were various calculations that led to the decrease of demographic savings, higher rate of return for FY25, and changes in Medicare Advantage Prescription Drug plans.
  - Blended Discount rate – 7.25% compared to 7% in 2024, decrease to liabilities
- Funded Status: 54.52% (2025)
  - 46.99% (2024) / 44.16% (2023) / 33.33% (2022) / 25.39% (2021)

TRUST FUND


NMRHCA Trust Fund Balance History
November 2015 - 2025
$2,500.0
$2,000.0
$1,500.0
$1,000.0
$500.0
$0.0
($ millions)
$1,931.1
$429.6
Nov-15
Feb-16
May-16
Aug-16
Nov-16
Feb-17
May-17
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Feb-18
May-18
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Nov-18
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Nov-24
Feb-25
May-25
Aug-25
Nov-25
Date

NEW MEXICO RETIREE HEALTH CARE AUTHORITY

Neil Kueffer, Executive Director
505-222-6408
neil.kueffer@rhca.nm.gov

Please call 800-233-2576 / 505-222-6400
Or visit us at: www.nmrhca.org or www.facebook/nmrhca
Business Hours: 8:00AM – 5:00PM (Monday through Friday)

Albuquerque Office Location
6300 Jefferson Street NE, Suite 150

Santa Fe Office Location
33 Plaza La Prensa

LFC Requester:	Harry Romel

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
AgencyAnalysis.nmlegis.gov and email to **billanalysis@dfa.nm.gov**
(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: *01/28/2027*
Bill Number: *SB20*

Check all that apply:
Original *X* Correction __
Amendment __ Substitute __

Sponsor: Elizabeth "Liz" Stefanics, Martin Hickey, Linda M. López, Reena Szczepanski, Elizabeth Thomson

Agency Name and Code Number: New Mexico Retiree Health Care Authority 34300

Short Title: PRIOR AUTHORIZATION & PRESCRIPTION DRUGS

Person Writing Linda Atencio
Phone: 505-490-0519 **Email** Linda.atencio@rhca.nm.gov

SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	FY27		

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	FY27	FY28		

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27*	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	$0	$1,800-$2,600	$0	$1,800-$2,600	Nonrecurring	RHCA Benefit Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to:
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis:

Senate Bill 20 amends the Prior Authorization Act to explicitly apply its requirements to pharmacy benefit managers (PBMs) and modifies prior authorization and step therapy rules for prescription drugs. The bill adds medications prescribed to treat serious mental illness to the list of conditions for which prior authorization and step therapy are prohibited, except when a generic, biosimilar, or interchangeable biologic is available. The bill further limits the ability of a health insurer or PBM to require reauthorization of chronic maintenance medications to no more than once every three years.

The bill applies to health benefit plans issued pursuant to the Health Care Purchasing Act, under which the New Mexico Retiree Health Care Authority administers benefits.

FISCAL IMPLICATIONS

The fiscal impact of Senate Bill 20 on the RHCA is measurable but not material when evaluated in the context of RHCA's total annual pharmacy and medical claims expenditures. While the estimated impact represents a relatively small percentage of total claims costs, it contributes to upward cost pressure within the self-funded non-Medicare plans. Additional analysis and implementation experience would be required to more precisely quantify any resulting cost increases associated with these changes.

Limiting prior authorization for chronic maintenance medications to once every three years materially reduces RHCA's ability to confirm ongoing medical necessity, adjusting therapy based on changes in a member's health status, and preventing avoidable utilization.

From a member perspective, reduced prior authorization frequency may lessen administrative burden and delays in accessing prescribed medications, which could improve continuity of care and treatment adherence for affected members.

Increased pharmacy costs associated with SB 20 would ultimately be borne by members through higher premiums and cost-sharing, particularly impacting non-Medicare retirees whose coverage is fully self-funded by RHCA.

In addition to lost savings, implementation of SB 20 would require custom pharmacy benefit configuration and ongoing system maintenance outside standard PBM operations. These non-standard configurations increase administrative costs, operational complexity, and compliance risk. Based on pharmacy benefit manager analysis, this provision is estimated to result in an initial loss of $1.8 million to $2.6 million in pharmacy savings.

While the immediate rebate and utilization impact associated with adding serious mental illness medications to step therapy and prior authorization prohibitions is limited, step therapy is a foundational tool used by PBMs to negotiate manufacturer rebates. Further statutory expansion of step therapy prohibitions could significantly increase net pharmacy costs over time.

Pharmacy Benefit Managers (PBMs) operate under a defined set of criteria and regulatory expectations for prior authorizations, medical-necessity determinations, and safety-related dispensing controls. In addition, PBMs use prior authorization to ensure that medications are clinically appropriate, cost effective, and aligned with plan rules. These include both clinical and regulatory requirements, such as diagnosis must match FDA approved or evidence-based indications. In addition, auto approval of medical necessity within seven days may not be

appropriate without documentation from the provider.

The National Committee for Quality Assurance (NCQA), which evaluates health plans through its Health Plan Accreditation program, supports policies that ensure step therapy protocols are transparent and evidence-based and include a straightforward process for exceptions when medically necessary. It advocates patient protection and timely access to appropriate medications.

SIGNIFICANT ISSUES
Mandated limitations on pharmacy utilization management tools reduce RHCA's ability to control rising drug costs and initial reconfiguration costs will both place additional pressure on member premiums.

PERFORMANCE IMPLICATIONS
None

ADMINISTRATIVE IMPLICATIONS
The bill would require custom pharmacy benefit configuration and require post review of multi-year authorization periods to ensure compliance with statutory requirements versus current rules in place.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
None identified

TECHNICAL ISSUES
None

OTHER SUBSTANTIVE ISSUES
SB20 conflicts with the statutory authority granted to the New Mexico Retiree Health Care Authority Board of Directors under Sections 10-7C-5 and 10-7C-6 NMSA 1978, which vest the Board with responsibility for plan design, benefit administration, and premium determination. Mandated benefit administration requirements may limit the Board's ability to manage pharmacy benefits in a fiscally responsible manner.

ALTERNATIVES
None

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
None

AMENDMENTS
None

FISCAL IMPACT REPORT

BILL NUMBER: Senate Bill 130
SHORT TITLE: No Cost-Sharing of Certain Drugs

SPONSOR: Hickey
LAST UPDATE: **ORIGINAL DATE:** 01/28/2026 **ANALYST:** Chilton

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Public School Insurance Authority	0	**$200.0-$460.0**	**$450.0-$1,000.0**	**$650.0-$1,460.0**	Recurring	**Other state funds**
Medicaid	0	**$34.8**	**$34.8**	**$69.6**	Recurring	**Medicaid funding**
State Health Benefits	0	**$16.3**	**$32.5**	**$48.8**	Recurring	**Other state funds**
Retiree Health Care Authority	0	**$135.0-$270.0**	**$295.0-$585.0**	**$430.0-$855.0**	Recurring	**RHCA Benefit Fund**
Total	**0**	**$386.1-$781.1**	**$812.3-$1,652.3**	**$1,198.4-$2,433.4**	Recurring	Choose an item.

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Health Care Authority
Office of the Superintendent of Insurance
New Mexico Public School Insurance Authority
Retiree Health Care Authority

SUMMARY

Synopsis of Senate Bill 130.

Senate Bill 130 (SB130) is concerned with eliminating copays on tests used for estimating risk of coronary artery disease and medications used to treat disorders of blood lipids, including cholesterol.

There are two repeated sections, making the same requirements of each form of insurance:

Coverage of coronary artery screening and blood cholesterol tests. Screening for coronary artery disease and measurement of cholesterol and other lipid levels are to be provided without cost sharing for patients over the age of 49, except for patients at increased risk of coronary artery disease, as determined by symptoms suggestive of or family history of coronary artery disease.

Co-payment free cholesterol lowering drugs. Generic medications used to lower cholesterol levels are to be provided free of cost sharing; if those are insufficient to achieve a specified cholesterol level or are not tolerated by the patient, second-level cholesterol-lowering drugs are to be provided without co-pay.

Section of Bill	Section of NMSA 1978	Subject of section	Type of Insurance Covered
1	13-7-24	Coverage of coronary artery screening and blood cholesterol tests	Group health coverage, self-insurance, including Health Care Purchasing Act policies
2	New	Co-payment free cholesterol lowering drugs	Group health coverage, self-insurance, including Health Care Purchasing Act policies*
3	27-2-12.31	Coverage of coronary artery screening and blood cholesterol tests	Medical assistance coverage
4	New	Co-payment free cholesterol lowering drugs	Individual or group health insurance policy, health care plan or certificate of health insurance*
5	59A-23-7.16	Coverage of coronary artery screening and blood cholesterol tests	Individual or group health insurance policy, health care plan or certificate of health insurance
6	New (part of 59A-23)	Co-payment free cholesterol lowering drugs	Group or blanket health insurance policy, health care plan or certificate of health insurance*
7	59A-46-50.5	Coverage of coronary artery screening and blood cholesterol tests	Group or blanket health insurance policy, health care plan or certificate of health insurance
8	New (part of Health Maintenance Organization Law)	Co-payment free cholesterol lowering drugs	Individual or group health maintenance organization contract*
9	59A-47-45.7	Coverage of coronary artery screening and blood cholesterol tests	Group health care plan, other than a small group health care plan
10	New (part of Nonprofit Health Care Plan Law	Co-payment free cholesterol lowering drugs	Individual or group health care plan*

*Policies for short-term travel, accidents only and catastrophic plans are exempted from the requirements.

Section 11 of the bill amends Section 61-11-6 NMSA 1978, which deals with the powers and duties of the Board of Pharmacy. A twenty-first duty is added requiring the board to promulgate rules for assessing cardiovascular risk and prescribing lipid-lowering therapy or cardiovascular plaque-reducing drugs.

The effective date of this bill is January 1, 2027.

FISCAL IMPLICATIONS

There is no appropriation in Senate Bill 130. HCA estimates additional costs to the Medicaid program and to state health benefits, as do the Public School Insurance Authority (PSIA) and the Retiree Health Care Authority (RHCA) due primarily to increased utilization of these tests and medications if there is no cost sharing for them. In addition, RHCA points out that second-tier medications for hypertension are likely to be used more often if cost sharing for these expensive medications is no longer assessed. The figures included in the table represent these agencies' estimates of the increased costs.

SIGNIFICANT ISSUES

According to the American Heart Association, a "A coronary artery calcium (CAC) test is a kind of heart scan. X-rays take detailed images of the arteries that supply blood to the heart muscle. The images show any calcium deposits in your coronary arteries. Higher amounts of calcium in the arteries suggest more severe disease."

The Cleveland Clinic indicates that

> A calcium scoring test can assist healthcare providers in making treatment decisions for people with borderline risk of heart disease. Calcium score testing results could help you if you're between ages 40 and 70 and at increased risk for heart disease but don't have symptoms.
>
> People at increased risk include those who:
>
> - Have a family history of heart disease.
> - Use tobacco products now or in the past.
> - Have a history of high cholesterol, diabetes or high blood pressure.
> - Have overweight (a body mass index, or BMI, higher than 25) or obesity (a BMI higher than 30).
> - Have an inactive lifestyle.
> - Have other, non-traditional risk factors.
>
> If you're younger than 40 years old and high cholesterol runs in your family (familial hypercholesterolemia), you might consider calcium score testing… Anything above zero means there's some evidence of coronary artery disease (CAD)… Higher scores indicate that you could be at risk for a heart attack.

According to the Centers for Disease Control, coronary artery disease killed 371,506 people in the United States in 2022. Coronary artery disease and other forms of heart disease are the leading cause of death for most ethnic groups in the United States: 919,032 for all forms of heart disease in 2022.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Related to 2020 House Bill 126, which required coronary artery screening for at-risk individuals aged 45 to 65 years. Its provisions were included in the Health Care Purchasing Act as Section 59A-23-7.16 NMSA 1978.

TECHNICAL ISSUES

HCA points out that "strong family history" is not defined. Nationally, efforts to increase health screen accessibility more commonly use family history to expand, not limit, eligibility for cost-free screenings." Similarly, the bill appears to restrict cost-sharing-free coronary artery screening from those at high risk due to previous coronary artery screening resulting in a non-zero calcium score or a family history of coronary artery disease. It would seem as if the intention was to extend cost-free screening to these high-risk patients before they reach the age of 49.

Section 11 would appear to ask pharmacists to assess cardiovascular risk and prescribe medications intended to reduce that risk, which may exceed the practical capacity of many pharmacists given existing workload constraints.

The sections on cholesterol-lowering drugs fail to differentiate between "good cholesterol" (high-density lipoproteins or HDL) and "bad cholesterol" (low-density lipoproteins, or LDL). Total cholesterol is almost never below 60 mg/dl, and the American Heart Association recommends concern only when the LDL level is greater than 70 mg/dl.

OSI recommends as following: "Use language that aligns with the intent of the bill while allowing for individualized treatment decisions. For example, 'a recommended LDL of 60 mg/dl, unless otherwise specified by the patient's clinician who is managing the individual's cholesterol levels.'"

AMENDMENTS

Section 11-A19 of the bill requires the Board of Pharmacy, in conjunction with the medical board, to promulgate rules authorizing pharmacists to prescribe "dangerous drug therapy, including vaccines and immunizations," and to notify a physician when such therapy is provided. Vaccines and immunizations are not typically classified as dangerous drugs by medical providers, and pharmacists may not view physician notification as necessary following routine vaccination, making the requirement impractical in many pharmacy settings.

LAC/ct/dw/ct

FISCAL IMPACT REPORT

BILL NUMBER: Senate Bill 21
SHORT TITLE: Medicare Supplement Open Enrollment
SPONSOR: Sens. Stefanics, Campos, Hickey and Wilson/Rep. Szczepanski
LAST UPDATE: **ORIGINAL DATE:** 1/28/2026 **ANALYST:** Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
OSI Total		No fiscal impact	No fiscal impact		Recurring	General Fund

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Health Care Authority
Office of Superintendent of Insurance
Public Schools Insurance Authority
Retiree Health Care Authority

Agency or Agencies That Declined to Respond
New Mexico Health Insurance Exchange dba BeWellNM

SUMMARY

Synopsis of Senate Bill 21

Senate Bill 21 (SB21) amends New Mexico's Medicare Supplement Act to require issuers of Medicare supplement ("medigap") policies to offer an annual open enrollment period for eligible policyholders 65 and older. The bill establishes a guaranteed 60-day open enrollment window beginning the first day of the month of an individual's birthday month, during which policyholders may switch to a Medicare supplement policy of equal or lesser value without medical underwriting or premium discrimination based on health status. It also prohibits new preexisting condition exclusions for coverage previously held and requires issuers to provide advance written notice of the open enrollment period, policyholder rights, and any premium or policy changes, subject to approval by the Office of Superintendent of Insurance

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns, which is May 20, 2026.

FISCAL IMPLICATIONS

The Office of Superintendent of Insurance (OSI) notes it can implement the provisions of the bill within its current workload and would incur no additional costs.

OSI reports insurer premiums may increase moderately in the first couple of years after implementation due to the guaranteed issue nature of open enrollment. The actual impact will vary by insurer, depending on the demographics and health status of its policyholders.

OSI states the bill also addresses the concern that some Medicare supplement insurers may have about adverse selection that may result in increased rates if policyholders decide to switch to plans with richer benefits during the annual open enrollment period. This is addressed in section 2.A(1), which allows policyholders to switch plans only if the new plan is of equal or lesser value compared to their current plan.

OSI notes the impact on premiums would be muted because policyholders are already rated based on their current age, and most of the policies sold in New Mexico are based on the policyholder's current (attained) age rather than the age at which the policy was first issued (issue age). It is important to note that several other states have successfully implemented the “birthday rule” to allow additional protections for Medicare supplement policyholders.

SIGNIFICANT ISSUES

The Health Care Authority (HCA) notes the bill does not require insurers to reopen discontinued or grandfathered medigap plans. Policyholders may retain existing grandfathered coverage if they choose, but the annual open enrollment applies only to plans actively offered in the market. The bill also preserves existing preexisting-condition protections by prohibiting new exclusions for conditions already covered under the prior medigap policy.

HCA reports SB21 expands consumer protections within the Medicare supplement insurance market while remaining consistent with federal standards. By limiting guaranteed issue to existing medigap enrollees and to equal or lesser value plans currently offered, the bill improves plan portability and affordability without disrupting federal rules or requiring insurers to make unavailable products broadly accessible.

ADMINISTRATIVE IMPLICATIONS

SB21 requires OSI to review and approve policyholder notifications before issuance, but OSI notes the work is manageable within current staffing levels.

OTHER SUBSTANTIVE ISSUES

The New Mexico Retiree Health Care Authority (RHCA) administers a self-insured medigap plan that covers costs not paid by Medicare Parts A and B and includes Medicare Part D coverage through a carved-out Employer Group Waiver Plan (EGWP). As a public plan sponsor and benefit administrator, RHCA does not underwrite, medically rate, or deny coverage based on health status.

Enrollment and eligibility for RHCA coverage are governed by [state law and the administrative code] and the Health Care Purchasing Act. RHCA allows annual switch enrollment for current members across Medicare Advantage Prescription Drug (MAPD) and Medicare Supplement offerings; biennial open enrollment for nonenrolled retirees during January of odd-numbered years; advance notice to members approaching Medicare eligibility at age 65; and mid-year changes for federal Centers for Medicare and Medicaid Services qualifying events.

RAE/sgs/hg/sgs

LFC Requester:	RubyAnn Esquibel

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
AgencyAnalysis.nmlegis.gov and email to **billanalysis@dfa.nm.gov**
(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: *1/30/26*
Bill Number: *HB209*

Check all that apply:
Original *X* Correction __
Amendment __ Substitute __

Sponsor: Joshua N. Hernandez, Harlan Vincent and Andrea Reeb
Short Title: FIREFIGHTER NO-COST CANCER SCREENING

Agency Name and Code Number: New Mexico Retiree Health Care Authority 34300
Person Writing Linda Atencio
Phone: 505-222-6416 **Email** Linda.Atencio@rhca.nm.gov

SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	**FY27**		

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	**FY27**	**FY28**		

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	Indeterminate	Indeterminate	Indeterminate	Indeterminate		

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to:
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis:

House Bill 209 amends the Health Care Purchasing Act to require group health coverage plans, including self-insured plans, to provide no-cost preventive cancer screenings for firefighters. Covered screenings must follow the most recent cancer screening guidelines issued by the International Association of Fire Fighters and may not include cost sharing such as deductibles, copayments, or coinsurance. The bill applies to firefighters who are members of fire departments that are part of or administered by the state or a political subdivision.

FISCAL IMPLICATIONS

The fiscal impact of House Bill 209 depends in part on how the term "firefighter" is interpreted under the Health Care Purchasing Act. The bill defines a firefighter as any member of a fire department that is part of or administered by the state or a political subdivision. The statutory language does not expressly refer to retired firefighters, former members, or retiree health plans. Based on the plain-language definition and its use of the present-tense term "member," the bill is reasonably interpreted to apply to active firefighters currently serving in a fire department. While the New Mexico Retiree Health Care Authority participates in the Health Care Purchasing Act, the bill does not clearly state legislative intent to extend this benefit to retired firefighters enrolled in retiree health plans administered under the Act. Absent clarifying statutory language or implementing guidance, application of this requirement to retired firefighters remains ambiguous and could require further interpretation or legislative clarification.

If clarified and determined to apply to retired firefighters, additional time would be required to identify the affected retiree population, assess utilization of cancer screenings, and evaluate the potential downstream impact of diagnoses and treatment costs that may be incurred by group health plans.

SIGNIFICANT ISSUES

House Bill 209 may raise implementation and coordination considerations related to the treatment of cancers identified through required screenings. While preventive cancer screenings would be covered under group health plans, subsequent diagnostic services and treatment would ordinarily be paid through the health plan unless a separate workers' compensation claim is filed and accepted establishing the condition as a compensable occupational disease. Determining whether and when costs should transition from group health coverage to workers' compensation would require additional administrative coordination among health plans, employers, and workers' compensation carriers. To the extent treatment costs are initially borne by self-insured group health plans, particularly pre-Medicare retiree plans funded by member premiums, such costs would be shared across the broader covered population. If occupational cancer claims are not promptly or consistently shifted to workers' compensation, this could contribute to increased claims experience and upward pressure on premiums for all members participating in self-insured plans.

PERFORMANCE IMPLICATIONS

If House Bill 209 were interpreted to apply to retired firefighters, the operational and fiscal implications would differ by retiree plan type. For pre-Medicare retirees enrolled in self-funded group health plans administered by the New Mexico Retiree Health Care Authority under the

Health Care Purchasing Act, the requirement to provide no-cost cancer screenings would directly affect plan design and claims expenditures. In contrast, Medicare-eligible retirees receive primary coverage through Medicare Parts A and B, with supplemental coverage administered by the Authority to cover remaining eligible costs. Preventive cancer screenings for Medicare retirees are generally governed by federal Medicare coverage rules, which may already include certain screenings and cost-sharing limitations. As a result, the applicability and fiscal impact of House Bill 209 on Medicare retiree plans would likely be limited or indirect, depending on whether the screenings are covered by Medicare or would otherwise fall to the supplemental or prescription drug components of retiree coverage.

ADMINISTRATIVE IMPLICATIONS
Implementation may require system configuration changes, updates to eligibility and coding processes, and coordination with carriers and administrators to properly identify covered firefighters and apply no-cost screening requirements in accordance with the bill.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
None identified at this time.

TECHNICAL ISSUES
The bill references cancer screening guidelines issued by the International Association of Fire Fighters but does not specify how updates to those guidelines will be adopted, communicated, or operationalized by plan administrators.

OTHER SUBSTANTIVE ISSUES
The bill does not address coordination between group health coverage and workers' compensation when cancers identified through screening may qualify as occupational diseases.

ALTERNATIVES
None identified

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
Current preventive cancer screening coverage and cost-sharing requirements for firefighters would remain unchanged.

AMENDMENTS
None

FISCAL IMPACT REPORT

BILL NUMBER: Senate Bill 15
SHORT TITLE: Health Care Purchasing Act Amendments

SPONSOR: Trujillo/Wirth
LAST UPDATE: **ORIGINAL DATE:** 1/20/2026 **ANALYST:** Rommel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
OSI	No fiscal impact	Indeterminate but minimal	No fiscal impact		Nonrecurring	Other state funds

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Office of the Superintendent of Insurance (OSI)

Because of the short timeframe between the introduction of this bill and its first hearing, LFC has yet to receive analysis from other state, education, or judicial agencies. This analysis could be updated if that analysis is received.

SUMMARY

Synopsis of Senate Bill 15

Senate Bill 15 relates to insurance and nondiscrimination in the healthcare workforce. It enacts new sections of the Health Care Purchasing Act, the New Mexico Insurance Code, the Health Maintenance Organization Law, and Nonprofit Health Care Plan Law. The bill directs that health coverage carriers shall cover all types of healthcare providers working within their legal scope of practice.

The legislation also repeals existing Insurance Code provisions concerning discrimination (sections 59A-46-35, 59A-46-36, 59A-47-28.2, and 59A-47-28.3).

FISCAL IMPLICATIONS

Senate Bill 15 contains no appropriation. There will be an indeterminate but minimal impact to the Office of Superintendent of Insurance (OSI) related to updating the Insurance Code to reflect the changes within the legislation.

SIGNIFICANT ISSUES

This legislation creates a uniform requirement across New Mexico's insurance laws to ensure that any licensed healthcare provider acting within their legal scope of practice must be eligible to participate in health insurance networks. It applies broadly to individual and group health insurance policies, HMOs, nonprofit health plans, and state-purchased coverage. The bill does not require insurers to contract with every provider, but it prohibits insurers from excluding entire categories of providers solely because of their profession.

Health plans may still set their own participation standards, negotiate contracts, and establish different reimbursement rates based on quality or performance measures.

OSI notes the following:

> Sections 1-5 of the bill create parallel healthcare provider inclusion provisions in the Health Care Purchasing Act and in the Insurance Code that are applicable to individual, group, HMO, and nonprofit plans. Subsection A of these sections requires that health plans include providers that are acting within the scope of their license to practice in the state. However, Subsection B states, "This section shall not require that a group health plan contract with any health care provider willing to abide by the terms and conditions for participation established by the group health plan."
>
> Subsection C allows a group health plan to establish varying reimbursement rates for providers based on quality or performance measures. These sections also include a broad definition of healthcare provider in Subsection D: "As used in this section, 'health care provider' means a person who is licensed, certified, or otherwise authorized to provide services relating to physical or behavioral health care in the ordinary course of business in the state."
>
> While the bill seeks to prevent categorical exclusion of provider types, it explicitly preserves carriers' discretion not to contract with every willing provider. This creates a potential conflict between Subsection A, which suggests inclusion, and Subsection B, which allows carriers to decline contracts.
>
> The language also refers to health care providers who are "acting within the scope of that provider's license, certification or *other legal authority* to practice in the state." It is unclear what "other legal authority to practice in the state" is referencing.

ADMINISTRATIVE IMPLICATIONS

OSI notes it is unclear if there are any expectations from the superintendent's office regarding enforcement.

OTHER SUBSTANTIVE ISSUES

OSI comments the repeal of Sections 59A-46-35 (Provider Discrimination Prohibited), 59A-46-36 (Doctor of Oriental Medicine; Discrimination Prohibited), 59A-47-28.2 (Doctor of Oriental Medicine Discrimination Prohibited), and 59A-47-28.3 (Provider Discrimination Prohibited) may remove important protections without fully incorporating them into the new language. This could

result in gaps in enforcement and interpretation.

The repealed sections, which prohibit discrimination against providers and doctors of oriental medicine, appear to provide stronger nondiscrimination provisions than the new language in the bill. If this legislation is intended to include an additional type of provider into the non-discrimination provisions, it is recommended that this provider type be added directly into existing statute.

HLR/rl/hg/rl

FISCAL IMPACT REPORT

BILL NUMBER: House Bill 38
SHORT TITLE: Wheelchair Insurance Coverage

SPONSOR: Cates
LAST UPDATE: **ORIGINAL DATE:** 1/29/2026 **ANALYST:** Esquibel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Medicaid		$103.3	$103.3	$206.6	**Recurring**	**General Fund**
Medicaid		$258.8	$258.8	$517.6	Recurring	Medicaid Federal Funds
Medicaid Admin		$12.2	$12.2	$24.4	Recurring	General Fund, Federal Funds
State Health Benefits (Member+State)		$39.0	$84.4	$123.4	Recurring	SHB (Member+State)
TOTAL		$413.3	$458.7	$872.0	Recurring	Multiple

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Aging and Long-Term Services Department
Developmental Disabilities Council
Governor's Commission on Disability
Health Care Authority
Office of Superintendent of Insurance

SUMMARY

Synopsis of House Bill 38

House Bill 38 (HB38) amends the Health Care Purchasing Act to require health insurance carriers to cover wheelchairs and activity chairs if the item is for a permanent physical condition including limb loss, paralysis, or conditions that significantly limit a person's ability to independently and safely engage in necessary physical activity.

"Activity chair" is defined as a device designed specifically to enable a person with mobility

impairment to participate in physical activities by providing better speed, safety, stability, maneuverability, and balance than a standard wheelchair designed for activities of daily living.

HB38 describes conditions under which wheelchairs and activity chairs should be replaced. The bill also narrows insurers mandated coverage for all these devices by limiting the prohibition or denials to "a person with documented permanent physical conditions" and then lists examples of conditions presumptively considered to qualify as permanent physical conditions.

The effective date of this bill is January 1, 2027.

FISCAL IMPLICATIONS

The Health Care Authority (HCA) reports the bill would have fiscal implications for both the Medicaid program and the State Health Benefits program. HCA estimates to fund the additional wheelchair and activity chair benefit it would cost the Medicaid program a total of $748.6 thousand in state and federal funds, and $123.4 thousand for the State Health Benefits program in both member and state costs.

SIGNIFICANT ISSUES

The Health Care Authority notes the bill does not amend Chapter 27 which pertains to Medicaid, so it is unclear if the bill is intended to apply to Medicaid. Coverage of wheelchairs, seating systems, prosthetic devices, and custom orthotics are part of an existing benefit described in NMAC 8.324.5. Currently, Medicaid covers one wheelchair and activity chair every three years unless there is a change in medical necessity.

ADMINISTRATIVE IMPLICATIONS

Carriers may need to expand contracts with DME suppliers and specialty providers.

TECHNICAL ISSUES

The Office of Superintendent of Insurance (OSI) suggests the following:

Specify a dollar amount for cost containment and operational purposes. For example, "for the full cost of one activity chair per member up to five thousand dollars ($5,000) no more than frequently than every thirty-six months."

Insert a comma, after wheelchair or change language to read "a wheelchair and activity chair" to clarify that members are subject to more than one device.

Update the definition of "activity chair" to "mean a device that is used to support physical activity to maintaining or improving whole body health and designed specifically to enable a person with mobility impairment to participate in physical activities by providing better speed, safety, stability, maneuverability and balance than a standard wheelchair that is designed for activities of daily living."

RAE/ct/cf

LFC Requester:	

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
AgencyAnalysis.nmlegis.gov and email to **billanalysis@dfa.nm.gov**
(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: *1/28/26* *Check all that apply:*
Bill Number: *HB 38* Original *X* Correction __
Amendment __ Substitute __

Sponsor: Kathleen Cates
Short Title: WHEELCHAIR INSURANCE COVERAGE

Agency Name and Code Number: New Mexico Retiree Health Care Authority 34300
Person Writing Linda Atencio
Phone: 505-222-6416 **Email** Linda.atencio@rhca.nm.gov

SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	FY27		
$0	$0	$0	

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	FY27	FY28		
$0	**$0**	**$0**	**$0**	

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	$0	$10,000-$50,000	$25,000 - $105,000	$35,000 - $155,00	Recurring	RHCA Benefits Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to:
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis:
This legislation expands health insurance coverage requirements in New Mexico by explicitly requiring coverage for prosthetic devices, custom orthotic devices, wheelchairs and activity chairs under the Health Care Purchasing Act and the New Mexico Insurance Code. The bill requires coverage for individuals with permanent physical disabilities to be provided on a nondiscriminatory basis, with benefits that are no less favorable than those provided for medical and surgical services and at least equivalent to Medicare coverage standards.

HB38 further requires coverage of the most appropriate device determined to be medically necessary by a treating physician and associated providers, including devices that support activities of daily living, employment-related functions, and physical activity that promotes whole-body health. The bill includes provisions addressing replacement, repair, and access to in-state and out-of-network providers, and establishes notice and appeals requirements related to coverage determinations.

FISCAL IMPLICATIONS

House Bill 38 is expected to have an increased fiscal impact on the New Mexico Retiree Health Care Authority (NMRHCA) benefit program, particularly for the non-Medicare eligible population for which NMRHCA is the primary payer. While NMRHCA currently provides coverage for medically necessary wheelchairs, HB38 expands both the scope and standards of coverage, including the addition of activity chairs and broader medical-necessity and replacement requirements.

The magnitude of the fiscal impact depends on utilization patterns, member eligibility, device pricing, maintenance costs, and vendor variability. National prevalence data was used to estimate potential utilization due to the absence of New Mexico-specific prevalence data for NMRHCA's non-Medicare population. Costs were modeled using estimated acquisition costs for wheelchairs and activity chairs, ongoing maintenance expenses, and assumed plan cost-sharing.

Wheelchair costs vary widely depending on medical need, ranging from several hundred dollars for basic manual chairs to tens of thousands of dollars for advanced power mobility devices. Based on available market data, activity chairs typically range from approximately $1,500 to $6,000 per device, exclusive of maintenance, repairs, and replacement costs. For individuals with degenerative or progressive conditions, utilization and replacement frequency may increase over time.

Based on actuarial modeling, the estimated plan-paid cost impact to NMRHCA is projected to range from approximately $10,000 to $50,000 in FY27 and $25,000 to $105,000 in FY28, with an estimated three-year total impact of $35,000 to $155,000. Actual experience may vary significantly depending on uptake rates, clinical determinations of medical necessity, and access to contracted providers.

SIGNIFICANT ISSUES

NMRHCA notes significant uncertainty related to the implementation of HB38. While current plan designs already cover medically necessary wheelchairs, the bill introduces several new coverage standards that may increase utilization and administrative complexity. These include coverage for activity chairs used to support physical activity and whole-body health, expanded replacement provisions that limit the application of useful lifetime standards, and requirements to provide access to multiple in-state providers or out-of-network referrals when necessary.

The bill's reliance on treating-provider determinations of medical necessity and its requirement that coverage be at least equivalent to Medicare standards may increase appeals and disputes where plan utilization-management criteria differ from provider recommendations. Additionally, the requirement to reimburse out-of-network providers at mutually agreed-upon rates when adequate in-network access is unavailable, introducing cost and administrative uncertainty.

PERFORMANCE IMPLICATIONS

NMRHCA and its contracted carriers will need to ensure sufficient supplier and provider capacity to support the expanded benefit, including access to vendors capable of furnishing activity chairs and specialized mobility equipment. Compliance with network adequacy standards, medical-necessity determinations, and replacement criteria will require ongoing monitoring to ensure consistent application and to mitigate member appeals and grievances.

ADMINISTRATIVE IMPLICATIONS

Implementation of HB38 will require updates to benefit plan documents, evidence of coverage materials, prior authorization criteria, medical-necessity guidelines, and claims processing systems. Carriers may need to revise fee schedules, credential additional durable medical equipment suppliers, and update member and provider communications to reflect the expanded coverage requirements.

The bill also requires that benefit denials include specific notice of appeal rights, which may necessitate revisions to standard denial templates and internal review processes. Administrative oversight will be necessary to ensure consistent interpretation across carriers and to minimize the risk of external reviews and litigation.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

None identified

TECHNICAL ISSUES

Carriers will be required to reconfigure claims adjudication systems and internal policies to reflect the expanded statutory coverage requirements. This may include mapping new billing codes, aligning coverage criteria with Medicare-equivalent standards, and managing replacement and repair thresholds. Additional coordination may be needed to support out-of-network reimbursement arrangements when in-state provider capacity is insufficient.

OTHER SUBSTANTIVE ISSUES

NMRHCA will continue its ongoing evaluation of benefit plan design to mitigate potential increases in premiums or claims costs associated with expanded coverage mandates. Ongoing actuarial monitoring will be necessary to assess utilization trends and fiscal impact if this benefit is implemented.

ALTERNATIVES

Continue reliance on existing medically necessary durable medical equipment coverage consistent with Medicare standards. Clarify that coverage is limited to devices required for functional mobility and activities of daily living. Establish clearer statutory guidance regarding replacement frequency, documentation standards, and the distinction between repair and replacement.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

NMRHCA will continue to provide coverage using industry standard definition for administration of benefit plans.

AMENDMENTS

Establish reasonable limits and clearer standards for replacement frequency of activity chairs and custom orthotic devices while preserving clinical exceptions. Clarify network adequacy and out-of-network reimbursement requirements to reduce administrative burden and cost uncertainty. Further define “activity chair” to support consistent interpretation and claims administration.

FISCAL IMPACT REPORT

BILL NUMBER: House Bill 99
SHORT TITLE: Medical Malpractice Changes
SPONSOR: Chandler/Armstrong/Hochman-Vigil/Silva/Gallegos
LAST UPDATE: 1/29/2026 **ORIGINAL DATE:** 1/28/2026 **ANALYST:** Hernandez/Rodriguez

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
	No fiscal impact	No fiscal impact	No fiscal impact			

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Conflicts with House Bills 107 and 143

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Office of Superintendent of Insurance
University of New Mexico Health Sciences
New Mexico Medical Board
New Mexico Hospital Association

Agency or Agencies That Were Asked for Analysis but did not Respond
Miner's Colfax Medical Center

SUMMARY

Synopsis of House Bill 99

House Bill 99 (HB99) does the following:

Section 1 amends the definition of a medical malpractice "occurrence" to an injury or set of injuries to a patient caused by acts or omissions in the course of medical treatment that combine to create malpractice claims—thereby limiting the number of claims an individual can file per distinct injury to one. This section also clarifies that the costs recoverable by a plaintiff in a medical malpractice suit is limited to the costs that were actually incurred for the patient's treatment.

Section 2 extends hospital and hospital-controlled outpatient facilities participation in the patient compensation fund (PCF) to January 1, 2030. Once hospitals are no longer participating in the PCF, they will not have to establish financial liability with the Office of Superintendent of Insurance but will continue to receive the benefits of the other

provisions of the Medical Malpractice Act. Similarly, section 3 also extends until January 1, 2030, PCF coverage of judgments or settlements below $750 thousand. After January 1, 2030, amounts due from a judgment or settlement are not paid by the PCF. Section 3 also strikes a section clarifying that separate acts or omissions causing multiple injuries are each eligible for the full statutory maximum. This amendment is consistent with the amendments in Section 1.

Section 4 prohibits lump sum payments for the estimated costs of a plaintiff's future medical care and instead requires that payments are made by the PCF for expenses incurred. Furthermore, HB99 repeals an existing provision allowing parties to negotiate a settlement whereby a plaintiff's right to receive future medical care is limited by the settlement agreement. Section 4 also strikes language clarifying that punitive damages against a health care provider are personal liabilities against the provider and cannot be paid from the PCF.

Section 5 is a new section of the Medical Malpractice Act that focuses on punitive damages. This section amends the process of punitive damages so that an individual must first file a claim without punitive damages on the table, then discovery takes place to determine if there is a triable issue of medical malpractice, a plaintiff can then amend the pleadings to include punitive damages, and the court determines if the suit includes punitive damages. Punitive damages may only be awarded if the plaintiff provides clear and convincing evidence that the acts of the health care provider were malicious, willful, wonton, reckless, fraudulent, or in bad faith.

Section 7 clarifies the provisions of this act apply to all claims of medical malpractice that arrive on or after the effective date of this act.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns, which is May 20, 2026.

FISCAL IMPLICATIONS

The Office of Superintendent of Insurance (OSI) "anticipates that medical malpractice premiums will be reduced" if HB99 is passed. OSI's actuary estimates that medical malpractice premiums and surcharges could potentially decrease by 3 percent. Additionally, OSI points out that medical expenses have accounted for 32 percent of the PCF portion of settlements over the past three years, while paid medical bills are estimated to be somewhere between 20 and 50 percent lower than billed amounts—although this is not always the case. According to OSI, the changes related to billed versus paid amounts in settlements should result in a 6 percent decrease in premiums and 6 percent decrease in PCF surcharges—as seen in the table below.

Independent Provider Specialty	Current Medical Malpractice Premium (PCF plus Primary Layer)	Post Bill Medical Malpractice Premium (PCF plus Primary Layer)
Internal Medicine	$21,110	$17,200
General Surgery	$101,521	$82,719
OB/GYN	$107,961	$87,967
Average	$76,864	$62,629

SIGNIFICANT ISSUES

Workforce Shortages. New Mexico continues to face a critical, chronic shortage of health professionals across the disciplines, particularly in rural areas. Thirty-two of 33 New Mexico counties are designated as health professional shortage areas (HPSAs) in primary care, behavioral health, dental health, or a combination of the three. On average, New Mexico needs at least an additional 5,000 healthcare workers to address current shortages. In December 2025, according to the Workforce Solutions Department, 69 percent of online job postings were for health and personal care and 15 percent of those were postings for physicians.

Medical Malpractice Research. According to the New Mexico Medical Society, New Mexico has some of the highest numbers of medical malpractice lawsuits in the country and medical malpractice premiums are significantly higher in New Mexico compared with other states. The New Mexico Hospital Association previously stated that hospitals across the state have seen increases in malpractice plan premiums in the past four years and punitive damages have grown, potentially affecting fiscal solvency for smaller hospitals. In response to a proposed bill during the 2025 session, the Department of Health noted many states have changed their medical malpractice laws to reduce the cost of malpractice insurance. Malpractice insurance rate increases and lack of access to medical malpractice insurance may disproportionately impact smaller, independent medical providers who often serve in rural, underserved communities.

New Mexico's medical malpractice cap limitations are higher than two out of three neighboring states. Research is mixed on the impact of tort reform on physician supply, with many articles showing a correlation between high medical malpractice and reduced physician supply. However, studies of states that implemented tort reform have seen varied impacts on physician supply. New Mexico recently changed its medical malpractice laws, allowing for claims up to $4 million against hospitals and outpatient facilities. This cap will increase to $6 million in 2026. Meanwhile Colorado, Texas, and other states have lower caps on medical malpractice, while Arizona has no limitations.

LFC staff conducted a survey between December 4, 2025, and December 18, 2025. In total, 17,897 potential participants were identified if they were physicians with current licenses in New Mexico, and 1,215 respondents participated. With the response rate, the survey is considered to have a representative sample, with a 3.5 percent margin of error and a confidence level of 99—indicating high confidence in the results. The survey found that 65 percent of New Mexico physicians surveyed are currently considering leaving the state to practice elsewhere. Of New Mexican physicians who are considering leaving the state, 83 percent reported the cause as punitive damages associated with medical malpractice—the most picked option.

Patient's Compensation Fund. Established under the New Mexico Medical Malpractice Act, the patient's compensation fund (PCF) provides a second layer of malpractice coverage and caps the amount of certain damages awarded against member healthcare providers. The program is funded by surcharges on providers who are members. As of August 2025, 14 hospitals, 417 independent provider groups, and 5,013 individual providers were participating in the program. OSI is responsible for approving surcharge increases—in 2026, OSI approved a 10 percent assessment increase for independent providers and 25.6 percent assessment increase for hospitals. As it stands, the PCF does not cover punitive damages. PCF only covers monetary damages and medical care and related benefits.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Conflicts with House Bill 107 (HB107) and House Bill 143 (HB143), which modify the same section of law.

TECHNICAL CHANGES

According to Section 2 of the HB99, subsection D adds language removing the qualification requirements under subsection A of Section 2 for hospitals and hospital-controlled outpatient health care facilities. This makes it unclear if hospitals and hospital-controlled outpatient healthcare facilities are no longer required to (1) establish financial responsibility with the Office of Superintendent of Insurance using any form of malpractice insurance and (2) pay the surcharge assessed on healthcare providers by the office. The language should be clarified to state if the amendment aims to remove the requirements listed under subsection A(1), subsection A(2), or both. If the amendment applies to subsection A(1), hospitals and hospital-controlled outpatient healthcare facilities would no longer be required to establish financial responsibility through any form of malpractice liability insurance to qualify under the provisions of the Medical Malpractice Act.

AH/JR/sgs/hg/sgs/dw

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.

FISCAL IMPACT REPORT

BILL NUMBER: House Bill 47/aHEC
SHORT TITLE: School Employee Insurance Programs

SPONSOR: Reps. Lara, Mirabal Moya, Baca/Sens. Figueroa, Stewart
LAST UPDATE: 1/28/26 **ORIGINAL DATE:** 1/25/26 **ANALYST:** Liu/Simon

APPROPRIATION*
(dollars in thousands)

FY26	FY27	Recurring or Nonrecurring	Fund Affected
	$73,153.9	Recurring	General Fund

*Amounts reflect most recent analysis of this legislation.

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
School Transportation Distribution		$1,343.6	$1,343.6	$2,687.2	Recurring	General Fund
RECs		$275.0	$275.0	$550.0	Recurring	General Fund
PED		$125.0	$125.0	$250.0	Recurring	General Fund
Total		**$1,743.6**	**$1,743.6**	**$3,487.2**	Recurring	**General Fund**

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Duplicates appropriation in the General Appropriation Act
Conflicts with Senate Bill 125

Sources of Information

LFC Files
Legislative Education Study Committee Files
Kaiser Family Foundation

Agency or Agencies Providing Analysis
Public Education Department
Regional Education Cooperatives
Higher Education Department
Public School Insurance Authority

Agency or Agencies That Were Asked for Analysis but did not Respond
Albuquerque Public Schools

Because of the short timeframe between the introduction of this bill and its first hearing, LFC has yet to receive some analysis from state, education, or judicial agencies. This analysis could be updated if that analysis is received.

SUMMARY

Synopsis of HEC Amendment

The House Education Committee amendment to House Bill 47 inserts language referring to the LESC endorsement of the bill.

Synopsis of House Bill 47

House Bill 47 (HB47) appropriates $73.2 million from the general fund to the state equalization guarantee (SEG) distribution for the purpose of increasing the employer group insurance contribution for school districts and charter schools participating in the New Mexico Public School Insurance Authority (NMPSIA) program to 80 percent for all school employees' insurance plans. The bill also includes a temporary provision requiring the Legislative Education Study Committee (LESC), in collaboration with LFC, NMPSIA, Albuquerque Public Schools (APS), the Public Education Department (PED), and the Health Care Authority (HCA), to study the sustainability of insurance programs for public school employees. This bill is endorsed by LESC.

The effective date of this bill is July 1, 2026.

FISCAL IMPLICATIONS

The appropriation of $73.2 million contained in this bill is a recurring expense to the general fund. Any unexpended or unencumbered balance remaining at the end of FY27 shall revert to the general fund. The bill duplicates LFC and LESC budget recommendations that already include a $73.2 million appropriation to the SEG distribution and $1.3 million appropriation to the school transportation distribution for the costs of transitioning to 80 percent coverage for all public school employees.

The bill would increase personnel costs for school districts and charter schools by requiring them to cover a larger share of health insurance costs for public school employees. However, the additional costs to school districts and charter schools would be offset by reduced costs to employees that choose to participate in school insurance programs, leading to increased take-home pay for employees.

According to NMPSIA, the estimated cost difference between meeting minimum statutory employer contributions and providing 80 percent coverage for all school employees is $63 million. Including a distribution in the SEG for APS, which does not participate in NMPSIA's program but constitutes about 22 percent of the student population, would bring the estimated cost difference to $80.3 million. PED estimates the costs of implementation to range between $62.6 million to $87.7 million.

The fiscal impact of shifting to a minimum of 80 percent of health insurance premiums is

estimated at $74.5 million in FY27, based on current plan enrollment and current health insurance rates, and the current level of subsidies provided by school districts and charter schools, with a 10 percent projected rate increase for FY27. According to NMPSIA and APS, 67 school districts and 92 charter schools currently are covering insurance premiums for school employees in line with current statutory minimums.

The remaining districts and charters provide a higher employer contribution rate than required by law, including 13 districts and six charter schools that provide at least 80 percent coverage for all employees as contemplated by this bill. These 19 local educational agencies (LEA) would, therefore, receive a windfall from any appropriation added to the SEG—the pool of money distributed to schools through a formula—to support the bill's implementation statewide. Because 30 LEAs currently provide more than the minimum statutory employer contribution rate, the total statewide fiscal impact is lower than $80.3 million. Fiscal impacts by LEA will depend on the share of SEG generated and enrollment in NMPSIA's plans.

	Employer Contribution Rates		
	Current Statutory Minimum • 80% for <$50,000 • 70% for $50,000 to $59,999 • 60% for >$60,000	**Above Statutory Minimum**	**80% or More for All Employees**
School Districts	67	9	13
Charter Schools	92	2	6
Higher Education	3	2	5
Other	8	2	8
TOTAL	**170**	**15**	**32**

Source: NMPSIA, APS

School districts and charter schools could see additional costs due to changes in employee behavior. For example, some employees could choose to opt into plans that offer a higher benefit. These plans feature lower out-of-pocket costs to the member but charge higher premiums because plan costs are higher. Similarly, some employees currently not participating in school insurance programs could choose to pick up the plan at the next open enrollment period, leading to increased costs for school districts and charter schools.

For FY26, NMPSIA provides single coverage health, dental, and vision plans with a total cost that varies between $1,155.22 per month and $646.70 per month and family coverage plans that vary between $2,947.20 per month and $1,809.68 per month. Under the current system, public school employees earning more than $60 thousand would need to pay $2,440 more per year for high option single coverage or $5,460 per year for high option family coverage. Under the bill, those costs would be cut in half, which could induce some members currently in low option plans to select high option coverage. However, with a greater share of the costs shifted to the employer, NMPSIA may wish to explore plan design changes to simplify their plan offerings. One reason NMPSIA has many plan options is historically even low-paid school employees have paid a large share of health insurance premiums and found high option coverage unaffordable. Until FY24, most employees earning more than $25 thousand paid 60 percent of the total premium.

Additionally, the bill would likely impact program support costs for NMPSIA due to the consolidation of APS into the authority's plan. Because of the size of the school district, APS may need to add between 3 FTE and 5 FTE to its current staff of 12, with an estimated cost of

$500 thousand to $1 million. NMPSIA's support costs are paid from premiums for health, property, liability, and workers' compensation insurance.

While the bill excludes other participants in NMPSIA's plans from meeting the new 80 percent contribution requirement, The Higher Education Department (HED) notes changes to the contribution structure for public schools could affect benefit parity with higher education institutions. Regional Education Cooperatives (REC) are also exempted from the 80 percent requirement but are likely to raise contribution rates to remain competitive, which could result in $275 thousand of additional operating costs collectively for cooperatives providing a lower contribution rate.

SIGNIFICANT ISSUES

New Mexico, like most other states, operates several self-insured health plans, providing participating public employees with medical, dental, vision, and prescription drug coverage. Self-funded plans, typically favored by large employers that have the scale to spread risk with a larger insured population, cover the cost of medical care, contracting with external entities for access to their coverage networks and for third-party administrative services, such as claims processing. New Mexico's public employee plans place health premiums into a fund, which are then used to pay medical claims.

Current state law requires public schools to pay at least 80 percent of the premium for employees earning less than $50 thousand per year, 70 percent for employees earning between $50 thousand and $60 thousand, and 40 percent for employees earning more than $60 thousand. At higher salary levels, this subsidy is well below what employers nationally typically pay for coverage. According to the Kaiser Family Foundation, a nonprofit health policy research organization, in 2025, employers typically contributed 85 percent of premiums for single coverage, or on average $7,884 annually, and 75 percent of the premium for family coverage, or on average $20,143 annually.

NMPSIA currently has multiple plan options each with a different cost, although most employees are currently enrolled in more expensive "high option" plans, such as the agency's preferred provider organization (PPO) plan offered by Blue Cross and Blue Shield of New Mexico. For this plan, the 60 percent subsidy for single coverage costs $8,305 and family coverage costs $20.5 thousand slightly above the national average. However, the employee share of $5,356 and $13.6 thousand, respectively, is well above the nation average of $1,440 for single coverage and $6,850 for family coverage, posing affordability challenges for New Mexico educators.

ADMINISTRATIVE IMPLICATIONS

Provisions of this bill require LESC, in collaboration with LFC, NMPSIA, APS, PED, and HCA, to study the sustainability and future needs of insurance programs for public school employees. The study must assess the impacts of consolidating public school employee insurance programs with other existing public group health insurance programs and identify the agency and legislative actions needed to integrate the plans of NMPSIA, HCA, and APS by June 30, 2029. The final study must be completed by October 1, 2026, and must be provided to the governor, LFC, and PED.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

The bill duplicates LFC and LESC budget recommendations that already include a $73.2 million appropriation to the SEG distribution and $1.3 million appropriation to the school transportation distribution for the costs of transitioning to 80 percent coverage for all public school employees.

The bill conflicts with Senate Bill 125, which also raises the group insurance contribution rate for school districts and charter schools to 80 percent. Senate Bill 125 further requires APS to participate in NMPSIA's program by FY28, and requires state agencies, including NMPSIA, to establish a reference-based pricing program for hospital services.

OTHER SUBSTANTIVE ISSUES

Historically, APS has been exempt from the requirement that all school districts and charter schools participate in NMPSIA or receive a waiver from the authority allowing the school district to purchase alternative coverage. The reasons for this go back to the creation of the authority in the mid-1980s. At that time, small rural school districts in New Mexico were finding it difficult to purchase insurance coverage. The small size of these schools, and the smaller income they would generate, made them unattractive to some insurers. Additionally, smaller school districts also had limited capacity to administer plans. NMPSIA allowed school districts to combine their collective purchasing power and spread risk among schools statewide.

However, because of its size, APS did not face the same challenges as smaller school districts, and the Legislature included an exemption for any school district with an enrollment of more than 60 thousand students. Currently, APS has about 61 thousand students, slightly over the statutory cap. However, with the overall downward trend in school enrollment, APS may soon fall under this floor. Because provisions of this bill only apply to NMPSIA, APS is not required to contribute 80 percent for insurance; however, the district has historically aligned its coverage with NMPSIA minimum contribution rates.

Currently, NMPSIA provides health benefits plans to a number of higher education institutions as well as nonprofit organizations "dedicated to the improvement of public education and whose membership is composed exclusively of public school employees, public schools or school districts." While the bill would require school districts and charter schools to cover at least 80 percent of health benefits, these entities are left with flexibility to determine their own contributions. Unlike school districts and charter schools, higher education institutions currently have a wide array of choices for insurance coverage.

Some of these entities participate in state health benefits plans sponsored by HCA, such as New Mexico State University, and some currently participate in plans offered by NMPSIA, such as New Mexico Tech. Other institutions, such as the University of New Mexico, provide their own health plans to employees, independent of the state agencies offering health benefits for public employees. State law sets minimum contributions for higher education institutions in Section 10-7-4 NMSA 1978 that differ from the minimum contributions specified in the Public School Insurance Authority Act. HED notes higher education employers operate in the same statewide labor market, and enhanced contribution levels for school employees may influence expectations for benefit competitiveness at public colleges and universities.

SL/sgs/cf/sgs/cf/sgs

Pharmaceutical Benefits Management Services RFP - Action Item*

OVERVIEW

A Pharmacy Benefits Manager (PBM) administers the prescription drug benefits on behalf of a health plan by managing pharmacy networks, negotiating drug pricing and rebates with manufacturers, processing pharmacy claims, and supporting utilization management and clinical programs. Given the central role a PBM plays in controlling prescription drug costs and ensuring member access to medications, the IBAC agencies and UNM conducted a competitive procurement to select a PBM partner that aligns with its fiduciary responsibilities and service expectations.

PROCUREMENT PROCESS

The IBAC, inclusive of NMRHCA, NMPSIA, APS, and the State of New Mexico along with UNM, has followed all applicable state procurement requirements in issuing a formal Request for Proposals (RFP) for PBM services. Proposals were evaluated by a interprofessional review committee using the criteria outlined in the RFP, including cost, clinical programs, operational capabilities, compliance, transparency, and experience serving public sector retiree populations. Based on this structured evaluation process, one proposer received the highest overall score.

ACTION ITEM REQUEST

NMRHCA Staff respectfully requests authorization from the Board of Directors to proceed with contract negotiations with the highest-scoring proposer of RFP# 342-2026-01 for Pharmaceutical Benefits Management Services.