The New Mexico State Senate

Study of the Efficient and Effective Procurement of Health Benefits Funded by the State for Public Employees and Their Beneficiaries

New Mexico Interagency Benefits Advisory Committee (IBAC)

Senator Martin Hickey

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Executive Summary

During the 2021 legislative session Senator Hickey secured funding to study current public employee health benefit purchasing for New Mexico's state, local government, and school employees. To support that effort a working group composed of selected state agency representatives was formed, and consultants hired to complete required research and analysis. The goal of the study has been to assess how benefits are purchased, statutory requirements associated with those activities, performance of existing processes, issues and concerns that may need to be addressed, and to understand innovations being implemented by other states. Senator Hickey was also asked to evaluate the Interagency Benefits Advisory Council (IBAC) by the 2021 Interim Legislative Finance Committee.

How Health Benefits are Purchased

As far back as 1997 the State understood the need to consolidate purchasing of health benefits to improve efficiency, passing the Healthcare Purchasing Act requiring consolidated purchasing of health benefits for specified state, local government, and school employees. Mandatory participants in this process include the state General Services Department (GSD), Albuquerque Public Schools (APS), the New Mexico Public Schools Insurance Authority (NMPSIA), and the New Mexico Retiree Healthcare Authority (NMHCRA). Other public entities may voluntarily participate. Additional New Mexico statutes such as those governing public employee compensation and the Public Schools Insurance Authority, and procurement statutes also effect various aspects of purchasing activities.

Through the Act, the participating government entities formed the IBAC which is an informal body that develops requests for proposals (RFPs) and manages the participant bidding process for purchase of benefits. Since its inception the IBAC has primarily acted as a collaborative for the joint issuance of RFPs only, combining resources to secure actuarial and consulting support for that activity, but without pooling its membership or entering into consolidated purchasing. The result has been continued increases in benefit costs in excess of national and regional trends, continually declining membership, decreased scope of benefits, and increasing lack of affordability.

Many of the challenges with the implementation of the programs envisioned by the Act rest with the Act itself, which is loosely worded and provides only limited guidance for IBAC formation, oversight, management, monitoring and reporting, performance expectations or other requirements. And surprisingly this limited language governs activities which relate to nearly $700 million in state expenditures in 2021 alone. (Note, that total excludes retiree health benefits and local governments and schools who choose not to participate, for an estimated total of approximately $1 billion in spending.) The Act also limits the number of mandatory participants, which when combined with statutes governing schools and local governments, results in only approximately one-half of public employees participating in the IBAC process.

Issues Identified Early

As early as 2010, the Legislative Finance Committee (LFC) had identified significant issues with the operation of IBAC, highlighting deficiencies in its design. Unfortunately, the Act provides no oversight authority to the state for any activities of the IBAC, requiring only reporting to the Legislature annually. Instead, the Act and other governing statutes place full responsibility in the hands of each of the participating entities.

This has resulted in many of those same deficiencies being identified in subsequent LFC oversight reports, with only limited action being taken to address those concerns. Over time, that list was expanded to include growing concerns about health benefit costs, the drivers of those costs, and increasing inequity in coverage provided to employees covered by each participant. The IBAC

participants responded to each of those reports, in some instances making minor programmatic changes.

New Mexico Joins a Growing List of States Seeking Reform

The State's experience with this area is not unique, and instead follows a pattern of similar challenges faced by other states. Among those states there has been mixed progress in consolidating purchasing to achieve the savings and employee benefits envisioned by the Act. One state has consolidated all purchasing and several others have significantly expanded the size of their purchasing pools. More importantly, the states have lived up to their description as **the laboratories of change** by implementing a broad range of reforms. Beyond increasing pool participation those reforms include changes to benefit design, provider reimbursement and contracting – including innovations such as implementation of Medicare-based reference pricing, centers of excellence and primary care reforms. They have also implemented changes to their bidding and procurement processes such as reverse auction bidding which has been used by the federal government in many areas. Each of these reforms, which are discussed in detail in this report, provide options for New Mexico reform.

A Foundation for Reform

Our detailed review of current law, programs, and practices, along with the years-long analyses provided by the LFC, have provided us with a strong set of recommendations for reform. The experience of other states which have pursued these efforts has also provided an important lesson – that these reforms will take time and must be implemented systematically to support required stakeholder engagement and to limit disruption for employees and their dependents. Recognizing these lessons, we have proposed a multi-phase effort which will include additional detailed comparative analyses of current benefits and programs, as well as completion of a claims recovery audit of current expenditures, which is standard practice among other large employers. We also propose that Phase I benefit procurements only be for one year to allow implementation of other changes which will require legislative action. Those Phase I legislative actions include proposed changes to the existing IBAC structure, processes, and oversight. We also propose specific actions to expand use and availability of the State's All-Payer Claims Database which will be essential for proposed procurement and oversight requirements and enhanced transparency. Finally, we propose a methodology to establish annual state health benefit spending targets (an innovation used in several other states) which will provide guidance for setting annual appropriations, expectations for contracted health plan vendors, and a data driven basis to understand target misses and suggested remedies.

In Phase II we propose legislation to establish a new consolidated state and local health benefit purchasing and oversight body based on best practice in other states; input from participating stakeholders, programs, and agencies; implementation of the proposed health benefit growth target process, standardization of modernized minimum benefit plans and cost sharing for all public employees, and changes to limit opportunities for entities to opt out of consolidated purchasing. We believe these recommended changes will help to modernize New Mexico public employee health benefit purchasing and support good stewardship of state taxpayer dollars. As important, these changes will lead to the potential for significant health status improvement of public employees. Finally, this oversight body can be used to analyze all healthcare costs for the state, public and private purchasers, as Massachusetts, Connecticut, Oregon, and California now do. This full analysis can include Medicaid and Medicare to provide a global picture of New Mexico Health Care costs and efficiencies, and health status improvement opportunities for each New Mexican.

Legislative Background

Highlights

- Legislation provided funding to complete detailed analysis of current employee health benefit purchasing practices in New Mexico
- Study also includes identifying and evaluating reforms and innovations implemented in other states
- Analysis will also include comparison of New Mexico benefit programs to those in other states
- Activities will be completed in two phases and will result in proposed legislative reforms

Junior Bills HB 548 and SB 536 Study Scope

During the 2021 legislative session Senator Hickey secured a Junior Bill Appropriation through SB 48, Sections 1 and 2, to contract for consultants "to assess improvements needed to health benefits procurement to ensure fairness, health improvement and cost-effectiveness." Specifically, the purpose is to study the health benefits process engaged in by any large state funded public entity. The study would assess:

- Recent procurements and cost trends of state funded health benefit programs, including the Interagency Benefits Advisory Committee (IBAC), universities, colleges, etc.,
- Disparities in benefits and beneficiary contributions statewide among entities,
- Drug and pharmaceutical costs, via pharmacies and medical administration, and potential efficiencies,
- Current and future health benefits needs and costs,
- Other state health benefits programs which are more cost effective, and fair. As an example, Oregon has a very large statewide public health benefits program that is fair to all, and only experiences around a 3% % annual increase vs. close to 6%+ for New Mexico., and
- Recommend appropriate solution options that generate:
  - Improved health status of covered beneficiaries,
  - Statewide beneficiary fairness in all state funded entities,
  - Efficiencies in drug and pharmaceutical costs,
  - Simplicity of administration and annual evaluation of costs and health outcomes,
  - Cost effectiveness and efficiencies for the State.

The Office of the Superintendent (OSI) and identified legislative experts was tasked to convene appropriate stakeholders (including IBAC agencies, LFC, OSI, GSD, etc.) to assist in procuring the consultant through the OSI, and then assisting the consultant to gather data and generate appropriate recommendations.

Study Rationale

Health insurance costs resulting from procurements by the IBAC for the State Risk Management Division, New Mexico Public School Insurance Authority (NMPSIA), Albuquerque Public Schools (APS), and New Mexico Retiree Healthcare Authority (NMRHCA) have increased year over year at unacceptable rates and larger than many other states. This is well documented in numerous LFC studies over more than 10 years. Specifically:

- Different IBAC agencies have different cost sharing and premium costs, leading to higher premium sharing and out of pocket costs for beneficiaries of some plans which is unfair to the employee and their family.
- Each agency pursuing its own contract violates the fundamental insurance actuarial benefits of large purchasing pools leading to higher unnecessary costs.
- Currently, public employee health benefits purchasing is largely done through a self-insured model, using third party administrators (TPAs) which have limited accountability or incentive to improve health status or act efficiently in regard to unnecessary costs to the state. This seems to be a generally uniform pattern in states which self-insure[1].
- Engaging all state funded institutions as well as the IBAC agencies will take advantage of the law of large numbers to lower insurance costs for the state.
- A potential solution is to follow the example of the Federal Health Employee Benefits program that establishes national benefits for all Federal Employees, allows multiple health plans (on a state-by-state basis) to uniformly price those benefits (PPO and HMO) for each federal employee (and their beneficiaries) in the state. The Federal program also enjoys most favored nation status which requires each health plan to not offer a plan to another large employer in a state at lower rates.

The appropriation for this study was deemed appropriate for the OSI as the study will be made across several public agencies (some state based, and some local government based) and the recommendations will have to be placed into legislation.

Based on these requirements and expectations, Senator Hickey formed a working group with representatives of key state agencies, including the New Mexico General Services Department (GSD), and its Risk Management Division (RMD), the Office of the Superintendent of Insurance (OSI) and the LFC. Representatives of those departments included GSD Secretary John Garcia, RMD Director Randall Cherry, and Lakisha Holley, RMD Deputy Director (now former). Representatives from the OSI included Superintendent Russel Toal and Colin Baillio, OSI Director of Coverage Affordability and Expansion. Working with the OSI, two consultants, Anne Sapon and DMoller and Associates Healthcare Consultants, were selected to support the initial phases of the study. Additional support and analyses were provided by Aon, who is the current GSD actuarial consultant and also supported the IBAC with its most recent health plan procurement Request for Proposal (RFP). Additional legal, legislative, and regulatory analysis was provided Amy Jaeger, Esq., and the Legislative Finance Council (LFC) staff.

The initial phase of this study, which is the subject of this report, was focused on understanding and documenting the following:

- Existing New Mexico legal and regulatory mechanisms governing the purchase of public employee health insurance
- Current New Mexico public employee health insurance purchasing and financing practices
- Historical performance of the existing public employee health insurance purchasing programs
- Programs and practices currently in place for purchase of public employee health insurance in other states, and
- Preliminary recommendations for legislative and regulatory reform.

[1] "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability", Georgetown University Health Policy Institute, Center on Health Insurance Reforms, June 2021, Pg. 25

The second phase of this project will separately focus on outreach and engagement of key governmental stakeholder groups (institutions of higher education, and county, municipal, and city governments as well as IBAC agencies). Further, Milliman, a nationally renowned health actuarial analysist and consultant, will be engaged to perform a detailed national and state-by-state comparative actuarial analysis of New Mexico public employee benefit program designs, key contracting strategies, mechanisms to support improved health outcomes and program results, and strategies to improve coverage and affordability. Outcomes from of the project will be the development of recommendations for legislative, regulatory, and programmatic improvements to enhance coverage, affordability, and outcomes for New Mexico public employees.

Existing Law Governing Health Purchasing

Highlights

- Current law provides for consolidated purchasing of public employee health benefits, and approximately one-half of public employees participate in that process
- However, existing law is loosely defined, allowing significant flexibility how the governing statutes have been implemented and which entities are required to participate
- Additionally, other statutes govern much of purchasing oversight and management at the individual participating entity level, leaving the state with limited program visibility or oversight
- Statutes and regulations at the individual participating entity level also provide significant flexibility to participants who may wish to opt out, resulting in a continually shrinking consolidated purchasing pool

According to the U.S. Bureau of Labor Statistics[2] there are approximately one hundred and eighty-one thousand (181,000) public employees in New Mexico, with approximately thirty-three thousand (33,000) federal employees[3] and an estimated 148,000 state and local employees. In combination this constitutes approximately 23% of New Mexico's employed workforce and is the third highest percentage of public employees for any state. With dependents, the public employee workforce constitutes the single largest commercial health insurance purchaser (estimated at 250,000 to 300,000 total employees and dependents) in the state. It includes:

- Approximately eighteen thousand (18,000) state employees
- Approximately one-hundred and thirty thousand (130,000) school, local government, college, and university employees.

State and local retirees are additional, with approximately 64,500 retirees and their dependents purchasing coverage through the NMRHCA, for a total of **approximately 360,000 state and local employees, retirees, and their dependents** (17% of the New Mexico population and more than 30% of the state's commercial insurance market).

Overview of New Mexico Public Employee Health Purchasing

Health benefits purchasing for New Mexico public employees and their dependents takes place through two basic mechanisms, including:

Current mandatory and voluntary participants in the IBAC

- **GSD Risk Management Joint Purchasing Pool:** includes mandatory state government employees, and voluntarily participating local government entities
  - 57,000 members (employees and dependents)
  - State employees, 108 voluntarily participating municipalities, schools, and counties
- **New Mexico Public Schools Insurance Authority (NMPSIA):** Includes non-Albuquerque school district employees and dependents from throughout the state. NMPSIA is a mandatory participant in the IBAC, with provisions to allow district opt-out.

[2] United States Bureau of Labor Statistics, Economy at a Glance, New Mexico, November 2022.
[3] United States Office of Personnel Management, New Mexico Federal Executive Board, November 2022.

- 47,000 members (employees and dependents)
    - 88 school districts, 97 charter schools, 27 other educational institutions, and selected retirees
- **New Mexico Retiree Healthcare Authority (NMRHCA):** includes mandatory state and local government retirees
    - 15,500 retirees and dependents under 65
    - 40,000 retirees and dependents over 65
    - 9,000 voluntary participants
- **Albuquerque Public Schools (APS)**
    - 12,000 members (employees and dependents)

Independent agency purchasing (not required to purchase through IBAC, but may voluntarily participate)

- 180,000 members (estimated employees and dependents) which includes 8,000 University of New Mexico (UNM), and various schools, colleges, municipalities, and counties

The GSD Risk Management Division, NMPSIA, APS, and NMHCRA are required to participate in the IBAC. However, public school districts **may opt out** of participation in NMPSIA procurement under specified conditions, effectively rendering NMPSIA participation voluntary. Local governments also **may opt out** of participation in GSD Risk Management Division purchasing. UNM, state colleges, non-participating NMPSIA schools and local governments **may voluntarily opt into** the IBAC. In fact, in 2020 the IBAC issued a single, consolidated RFP for pharmacy benefit management (PBM) services, and which included voluntary bid participation of UNM.

The IBAC procurement process includes development and issuance of a joint requests for proposals (RFPs) for services to administer (third party administrator or TPA) the various participants self-insured health benefits as well as selected fully insured health insurance products (e.g., vision, dental, Medicare Advantage, etc.). The IBAC participating entities do not offer common benefits or programs, however. Instead, each participant establishes its own benefit program and administrative requirements and enters into separate purchasing agreements with vendors selected through the bidding process. In addition to TPA services, the specific types of health benefits purchased through this process include:

- General medical
- Vision
- Dental
- Employee assistance program
- Pharmacy benefit management
- Medicare advantage
- Medicare supplemental insurance

With the exception of selected ancillary and Medicare health benefit programs, the programs are self-insured. Each participating entity establishes its specific requirements for administration of its benefits programs including features such as outcome and cost management programs (e.g., wellness, disease management, utilization management, value-based reimbursement), member premiums and cost sharing, TPA data sharing and reporting, and claims auditing and other performance reviews.

All agency participants in joint purchasing through the GSD Risk Management Division are covered by the same benefit plans, with the state billing the participating agencies for health insurance premiums based on their number of covered members. Each of the participating school districts in NMPSIA (120) are billed for insurance premiums and costs based on each agency's participant experience.

Governing Law

Purchasing and managing health care benefits for New Mexico public employees is governed by a series of overlapping laws that have been developed over several decades. In combination, these laws allow for a shared procurement process, but require only limited further coordination on pooling of members, benefit design, performance and outcomes management programs, administrative consolidation, or other areas that are generally seen to drive value and cost management in the health insurance industry. Though there is greater oversight at the level of the individual participating agency (GSD, APS, NMPSIA, and NMRHCA), the IBAC itself is an RFP qualifying collaborative, **NOT** a true unified **PURCHASING** entity, rather than a formal public body. As such, there are only limited administrative capabilities that are made available through the participating entities and limited and non-binding oversight at the state level.

The various statutes governing public employee health benefit purchasing include:

- NM Health Care Purchasing Act
- NMPSIA governing legislation
- APS governing legislation
- State Procurement Act
- Retiree program governing legislation

Each is briefly discussed below.

NM Health Care Purchasing Act

The current methods for procuring health benefits for State, and certain local public employees through the IBAC was established through the passage of the **1997 New Mexico Health Care Purchasing Act** (1978 NMSA Sections 13-7-1 to Sections 13-7-27), which was part of a package of healthcare reforms introduced during this period.

The 1997 New Mexico Purchasing Act calls for "consolidated purchasing", which it described as a **single process** for procurement of all health care benefits. The Act also required that offerings **shall** include **both self-funded and fully insured options**. Mandatory participants were to include state employees, the Retiree Healthcare Authority (NMRHCA), public school insurance authority (NMPSIA), and any school district with enrollment in excess of six thousand (60,000) – the Albuquerque Public School (APS) District. Counties, municipalities, state educational institutions and other political subdivisions could also **voluntarily participate**.

Requires Consolidated Bidding

Specifically, the language of the Act states:

"Section 13-7-2 - Purpose of act

The purpose of the Health Care Purchasing Act is to **ensure** public employees, public school employees and retirees of public employment and the public school's access to more affordable and enhanced quality of health insurance through **cost containment and savings** effected by procedures for consolidating the purchasing of publicly financed health insurance.

NMSA § 13-7-2

Laws 1997, ch. 74, § 2.

Section 13-7-3 - Definitions

As used in the Health Care Purchasing Act:

A. "consolidated purchasing" means a single process for the procurement of all health care benefits by the publicly funded insurance agencies in compliance with the Procurement Code [13-1-28 to 13-1-199 NMSA 1978] and includes associated activities related to the procurement such as actuarial, cost containment, benefits consultation and analysis; and **B.** "publicly funded health care agency" means the: **(1)** risk management division and the group benefits committee of the general services department; **(2)** retiree health care authority; **(3)** public school insurance authority; and **(4)** publicly funded health care program of any public school district with a student enrollment in excess of sixty thousand students.

NMSA § 13-7-3

Laws 1997, ch. 74, § 3.

Section 13-7-4 - Mandatory consolidated purchasing **A.** The agencies shall enter into a cooperative consolidated purchasing effort to provide plans of health care benefits for the benefit of eligible participants of the respective agencies. The request for proposal shall set forth one or more plans of health care benefits and shall include accommodation of fully funded arrangements as well as varying degrees of self-funded pool options. **B.** A consolidated purchasing request for proposals for all health care benefits by the publicly funded health care agencies shall be issued on or before July 1, 1999, and any contracts for health care benefits renewed or issued on or after July 1, 2000, shall be the result of consolidated purchasing. **C.** All requests for proposals issued as part of the consolidated purchasing shall include at least one distinct service area consisting of the Albuquerque metropolitan area. Proposals on a distinct service area shall be evaluated separately."

Though the law calls for consolidated purchasing, it leaves the requirements for how that consolidated purchasing should take place somewhat loose and includes provisions allowing each participant to effectively continue to act as quasi-independent agencies for purposes of purchasing benefits.

IBAC Structure Suggested, But Not Required

Specifically, it allows that (emphasis added below):

"Section 13-7-7 - Consolidated administrative functions; benefit **A.** The publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act **may enter into a joint powers agreement pursuant to the Joint Powers Agreements Act [11-1-1 to 11-1-7 NMSA 1978**] with the publicly funded health care agencies and political subdivisions to determine assessments or provisions of resources to consolidate, standardize and administer the consolidated purchasing single process and subsequent activities pursuant to the Health Care Purchasing Act. The publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act may enter into contracts with nonpublic persons to provide the service of determining assessments or provision of resources for consolidation, standardization, and administrative activities.

Benefit Program Design Remains with Agencies

"B. Each agency shall retain its responsibility to determine policy direction of the benefit plans, plan development, training, and coordination with respect to participants and its benefits staff, as well as to respond to benefits eligibility inquiries and establish and enforce eligibility rules. (emphasis added)"

NMSA § 13-7-7

Laws 2001, ch. 351, § 3; 2005, ch. 157, § 1; 2019, ch. 48, § 14"

Implementation of the Healthcare Purchasing Act resulted in the establishment of a joint procurement process, a loosely defined procurement body (the IBAC), and development of a consolidated bidding process. Participating entities also achieve some savings by pooling resources to procure actuarial and consulting services for the development of single RFPs for healthcare benefits.

However, by not requiring the pooling of all participants under a single set of benefits and programs it fails to exploit the contracting power and underwriting benefits of the largest possible pool of members. This issue is exacerbated by elements of this law, and NMPSIA statutes which allow many entities to opt out of participation, which has over the life of the program, led to fewer and fewer participating entities and a shrinking purchasing pool.

Finally, although the IBAC procurement does include some fully insured ancillary products (vision, dental and Medicare Advantage) the general health benefit programs include only self-insured programs, resulting in the shifting of risk almost entirely to participating agencies, which do not maintain stop-loss coverage or other risk mitigation vehicles for the general benefit programs to offset or manage extraordinary program costs.

Interagency Benefits Advisory Committee Structure

The Health Care Purchasing Act contemplates a joint powers agreement to coordinate procurement and collaboration of health care benefits for all public employees. (1978 NMSA §13-7-7.) A NMPSIA document we were able to locate, did mention that the IBAC participants had entered into a joint powers' agreement in 1999. (*See* 1978 NMSA §13-7-3(B).) After a review of current audits of NMRHCA, GSD/Risk Management, NMPSIA, and APS, only NMPSIA's audit mentions their participation in the Joint Powers Agreement contemplated under the Act.

"An agreement exists among NMPSIA, New Mexico Retiree Health Care Authority, Albuquerque Public Schools, and the State's Risk Management Division of the General Services Department (collectively, the Interagency Benefits Advisory Committee). The purpose is to authorize the parties to exercise their common powers to provide and administer health care insurance program, and to implement the purposes of the Health Care Purchasing Act. Each agency acts as its own fiscal agent for cost purposes. The agreement was effective March 15, 1999 and continues in force until terminated by any party upon 90 days written notice to the other parties." ANNUAL FINANCIAL REPORT AND INDEPENDENT AUDITORS' REPORT for Year ended June 30, 2021, page 26

However, we were unable to find any evidence that any joint powers agreement had ever been established. The statute also requires that each agency determine its own benefit plan and eligibility requirements (1978 NMSA §13-7-7(B).)

The leadership of IBAC rotates annually, and NMRHCA is the current chair. However, there are no statutory membership requirements, duties, power, oversight, reporting requirements or recognition of accountability. Agencies report that IBAC serves to coordinate the *procurement process* for public bidding on various health contracts. At this time, DFA or participating agencies were unable to provide a copy of the joint powers agreement or other documents that confirm any duties, evaluation, reporting or oversight of IBAC. We have requested a copy from State Archives, but no copy has been located.

Public School Insurance Authority (NMPSIA)

NMPSIA purchasing of employee and dependent health benefits is governed by statute which created the NM Public School Insurance Authority (New Mexico Statue, Article 29, 1978 §22-29-1 to §22-29-12). The law establishes the Authority with responsibility to group health insurance and other types of

coverage. Unlike the Healthcare Purchasing Act, these statutes include the creation of a board, with defined membership and responsibilities, and the authority to hire staff and procure resources. It also creates the Public-School Insurance Fund, defines an appropriation process and requirements for management and disbursements from the Fund. Oversight for the fund is provided by the Board, the Public Education Department, the State Budget Division of the Department of Finance and Administration, and the Legislative Finance Committee.

All school districts and charter schools, other than APS, are required to participate in the Authority. However, districts and schools may request a waiver, allowing them to purchase coverage through other means. The Board is required to establish minimum benefit and financial standards for the coverage that must be met through the alternate method of procurement. Once a waiver is granted the district or school is then locked out of coverage through NMPSIA for a specified time frame. The law also specifies minimum employer contribution amounts based on employee salaries which follows requirements established in state statute government public employee compensation and working conditions (60% of costs covered for employees with salaries of $25,000 or more, up to 75% of costs covered for employees with salaries of $15,000 or less).

Albuquerque Public Schools

Health benefits purchasing for APS is governed by the Purchasing and Procurement Procedural Directives established by the Albuquerque Public Schools Board and overseen by APS Procurement Department. The Directives also require that all purchasing must follow applicable state and federal statutes, including the state Procurement Code, the Governmental Conduct Act and Federal Uniform Guidance.

Public Employee Compensation Statutes

The Health Purchasing Act is interwoven with the structure and requirements of the following related health care benefit statutes:

- Public Officers and Employees chapter, Compensation and Working Conditions, specifically
    - Group Insurance (1978 NMSA §10-7-1 to §10-7-22)
    - Group Benefits (1978 NMSA §10-7B-1 to §10-7B-8 passed 1998)
    - Retiree Health Benefits (1978 NMSA §10-7C-1 to §10-7C-15), and

These different statutory provisions for public employee health benefit purchasing create different boards, duties, and even authorities. The Authorities, in the case of retirees and public-school employees, have agency status. While the statutory consideration is for each entity to provide health benefits for their constituency, the statutory mandate allows each agency to procure, negotiate and administer health care coverage independently while being advised by separate Boards or Committees. (*E.g., see* 1978 NMSA §10-7C-7 (E) and (F) for retirees, 1978 NMSA §22-29-7 for public school employees, and 1978 NMSA §10-7B-4 for employees under GSD.) On the one hand, this structure allows (and maybe encourages) entities to disregard market purchasing power that could secure better and lower cost health benefits. On the other hand, it allows entities to meet the unique health needs of the public employees of that agency.

It does appear that the current statutes noted above (Group Insurance, Group Benefits, Retiree Health Benefits) conflict with the 1997 Health Care Purchasing Act which calls for consolidated purchasing. The 1997 Law should have amended all statutory provisions to assure conformity. This is not an uncommon issue in New Mexico Statutes, but any new consolidating law should assure full alignment of all health benefit statutes.

Additional requirements are detailed in **NM 10-7-4 (2021), related to compensation and working conditions for public officers and employees**. The law, which is required to ensure compliance with ACA mandates for employee-employer contributions and costs for healthcare benefits, includes provisions for reporting on plan performance. It is through this provision that the Legislature, through the Legislative Finance Council (LFC), has been able to exercise some oversight of the consolidated purchasing of health benefit plans. It **includes a requirement that group insurance plans offered pursuant to the provisions of the law shall include effective cost containment measures to control the growth of health care costs, and that they must report annually to the Legislature by September 1**. Specifically, it states:

"NM Stat § 10-7-4 (2021)#Section J. Any group medical insurance plan offered pursuant to this section shall include **effective** cost-containment measures to control the growth of health care costs. The responsible public body that administers a plan offered pursuant to this section shall report annually by September 1 to appropriate interim legislative committees on the effectiveness of the cost-containment measures required by this subsection."

However, there is no further, specific guidance on the nature and manner of reporting, and no remedy offered should the agency(ies) fail to "include effective cost containment measures to control the growth of health care costs". With that limitation in mind, It should be noted that as far back as 2010, the LFC had identified systemic issues with implementation of consolidated purchasing and significant concerns with program performance. The LFC requested corrective action in multiple years. However, since neither the Healthcare Purchasing Act nor compensation statutes provide any mechanisms for enforcement it is unclear what changes have been made. Further, the only "cost effectiveness" measures have been to lower benefits and/or increase the cost sharing of the beneficiaries. These actions have led to many groups and individuals to abandon agency health benefits for less expensive options or have no health insurance coverage at all.

The primary mechanisms for oversight and enforcement rest with the additional provisions for oversight and management of the benefit programs for each of the individual IBAC participants, are defined within the benefit programs, enabling legislation, and regulatory requirements for each individual agency, as well as collective bargaining agreements, where they apply.

All self-insured programs are also regulated through Federal ERISA laws/regulations governing employee benefit programs and retiree benefit programs.

New Mexico Procurement Act

All health benefit procurements conducted under the statutes noted above are also governed by New Mexico public procurement statutes outlined in Chapter 13, Public Purchases and Property. As applied to the purchase of health benefits, the law primarily affects requirements around competitive bidding, pricing, conflicts of interest and similar issues.

Health Purchasing Governance and Oversight

Highlights

- The primary vehicle for consolidated purchasing of public employee health benefits, the IBAC, is only informally defined as to structure, processes, responsibilities, and other key areas
- That informality has led to limited transparency and oversight
- The implementation of the IBAC has followed only the most minimal requirements of consolidated purchasing originally envisioned by the Act
- That implementation has resulted in consolidated bidding, but not purchasing and continues to support processes and programs that are duplicative and inefficient
- Budgeting and appropriations for health benefits also differs between each participating entity leading to variability in state expenditures on a per-employee basis

As noted earlier, the Health Care Purchasing Act establishes the requirement that specific public agencies enter into consolidated purchasing of health care benefits. However, the law, as currently written provides only limited details for how that is to occur or how the results of those processes should be monitored and reported, except as detailed in statute and regulations governing individual participating entities. Additionally, although State law related to public employees' compensation and benefits requires reporting to the Legislature annually, the law does not specify the scope of that reporting and provides no direct remedies, other than through the budgeting process, to address issues and concerns related to the implementation of the law.

Additionally, as noted in the prior section, though the Health Care Purchasing Act prescribes the participation of specified entities, the laws which govern both the participants in the GSD Risk Management procurement process and the NMPSIA procurement process both allow for certain participants in those entities to opt out of participation in consolidated purchasing. Only State employees, APS, and retirees have no authority to opt out. By default, then, the law sets a floor on participation in the consolidated purchasing process at a number well below 50% of total public employees. The net result has been a continued loss in the number of participants since the Act first took effect, significantly diminishing its effectiveness in accomplishing the goals originally set for the Act.

We specifically highlight the following key weaknesses in current statewide public employee health benefit purchasing as executed through existing IBAC programs.

Structure and Process

Loosely Defined Structure: Though the Health Care Purchasing Act allows for the formation of a joint power's authority among participants under the Act, it does not require its formation. Additionally, existing law does not establish any requirements for who should serve on that body, roles, and responsibilities, reporting or other oversight of the activities mandated by the Act. However, the IBAC entities have informally agreed to a practice of rolling IBAC chairmanship, with each of the four mandated participants serving in that role for a period of one year during the four-year contracting cycle. The entity serving as chair is responsible for developing requests for proposal (RFP) and managing the procurement process for any health benefit procurements that are scheduled during that timeframe. All other standards and requirements for the procurement of benefits are governed by statute and regulations governing each participating entity.

Consolidated Bidding: The law does not define what consolidated purchasing is expected to include. Other parts of state law also establish that each the individual participating entities have full authority to define their own benefit packages, with the only limitation being on requirements for employee cost sharing, as required for compliance with the ACA. The combined effect of each of those requirements has been to define a process for **consolidated bidding, rather than consolidated purchasing** with each entity setting its own premiums, defining programmatic and other requirements for participating vendors, and monitoring and managing performance within its individual pool of members. In the case of NMPSIA, reporting and monitoring is performed for each separate school district, further limiting the ability to pool actuarial risk or gain contracting leverage even across NMPSIA. The result across the entire IBAC is a series of smaller underwriting pools, rather than one large pool across all participants. This process also allows for variability in the actuarial value of benefits across different groups of employees and different regions of the state and has resulted in higher costs for some employee groups encouraging some local government entities and schools to opt out of the program and procure benefits separately.

Administrative Consolidation: Additionally, although the Health Care Purchasing Act specifies that “ "consolidated purchasing" means a single process for the procurement of all health care benefits by the publicly funded insurance agencies in compliance with the Procurement Code [13-1-28 to 13-1-199 NMSA 1978] and includes associated activities related to the procurement such as actuarial, cost containment, benefits consultation and analysis…” this has been implemented primarily through the participants regular rotation of the IBAC chairmanship. Collectively, the IBAC participating entities also select the actuarial consultant who will prepare joint RFP issued by the group. However, each entity also still retains its own actuarial and benefits consultant, and develops, manages, and monitors its own cost and outcomes containment programs. There is no pooling of any of those administrative activities. The same occurs with procurement of pharmacy benefits now conducted through separate contracts with different Pharmacy Benefits Management firms.

Governance

Joint Powers Authority: As noted earlier, governance of consolidated public health benefit purchasing is only loosely defined by statute. Though there is some evidence that the IBAC was formed under a Joint Powers Agreement, that Act includes only limited requirements for public oversight, primarily through reporting to the Secretary of Finance and Administration upon the original formation of the JPA. Specifically, the Act requires that (emphasis added):

> **“2006 New Mexico Statutes - Section 11-1-1 — Short title.**
>
> **11-1-1. Short title.**
>
> This act [11-1-1 to 11-1-7 NMSA 1978] may be cited as the "Joint Powers Agreements Act."
>
> **2006 New Mexico Statutes - Section 11-1-2 — Definitions.**
>
> **2006 New Mexico Statutes - Section 11-1-3 — Authority to enter into agreements; approval of the secretary of finance and administration required.**
>
> **11-1-3. Authority to enter into agreements; approval of the secretary of finance and administration required.**
>
> …nothing contained in this Joint Powers Agreements Act [11-1-1 NMSA 1978] shall authorize any state officer, board, commission, department or any other state agency, institution or authority, or any county, municipality, public corporation or public district to make any agreement without the **approval of the secretary of finance and administration as to the terms and conditions thereof**.

Joint powers agreements approved by the secretary of finance and administration **shall be reported to the state board of finance at its next regularly scheduled public meeting. A list of the approved agreements shall be filed with the office of the state board of finance and made a part of the minutes**.

2006 New Mexico Statutes - Section 11-1-4 — Terms and conditions of joint agreements.

11-1-4. Terms and conditions of joint agreements.

A. Every agreement executed by one or more public agencies shall clearly specify the purpose of the agreement or for any power which is to be exercised. **The agreement shall provide for the method by which the purpose will be accomplished and the manner in which any power will be exercised under such agreement**."

Beyond those requirements identified above, and which are primarily tied to the initial formation of the JPA, there appear to be no regular reporting and monitoring requirements for the IBAC and no other mechanisms for oversight except as defined in that original agreement which we have not been able to locate, or through loosely defined annual reporting to the Legislature.

Agency Oversight: Instead, oversight for the day-to-day activities of the IBAC falls primarily to each participating entity. This includes:

- NMPSIA
- APS
- State Risk Management Division
- Retiree Healthcare Authority

Legislative Finance Council: Through the authority granted by the benefit and compensation statutes, the Legislative Finance Council (LFC) conducts an annual review of the overall performance of the IBAC as well as the benefit programs offered by each of the participating entities as required by their governing statutes. As part of that review, the LFC has made multiple requests for modifications to programs and program results. However, the LFC has no enforcement authority, except through legislative action. In several instances, the IBAC participants have responded regarding recommended or requested changes, although except as stated in the IBAC rebuttals, it is unclear what, if any program modifications have been made. A theme in these rebuttals and annual reports is to have TPAs increase "care management" activities by the contracted systems. However, no measurement or impact is required or documented in terms of achieved cost efficiencies or continued outcomes improvement. Aspirations are noted, but results are not made accountable.

Reporting and Transparency

Nearly all monitoring and reporting for the consolidated purchasing process takes place at the level of each participating entity. Each also defines its own requirements for data sharing and performance reporting by the health benefit vendors with which it contracts, limiting the ability to identify and assess results, trends, or issues across all purchasers.

Although the IBAC has publicly posted its RFPs and related documents, as required by State purchasing law and regulation, we could not find any other evidence of posted minutes or other activities of the IBAC. Additionally, we were unable to find any reporting to the Department of Finance as required under the Joint Powers Authority Act.

Currently the only state-mandated reporting requirement on the results of the consolidated purchasing process are related to budgeting requests. The State has only limited visibility into any underlying

factors driving health benefit purchasing performance. The NMPSIA vendor contracts require that each vendor must submit health plan claims data to its actuarial consultant. However, none of the other contracts have those requirements. NMPSIA does conduct some form of audits of claims payment accuracy, but only on one of the three vendors for each year; NOT all the TPA vendors for each year!

At the State level, monitoring of vendor performance primarily consists of auditing for claims accuracy, fraud, waste, and abuse. The State's actuarial vendor also provides periodic projections for claims costs relative to budget and premium collections. Similar to other states we reviewed, the contracted vendors provide little access underlying claims and utilization data, reimbursement rates and terms of contracts with healthcare provides are generally treated as confidential, with no access to that information.

Health Benefit Budgeting and Funds Flow

Total annual State expenditures for public employee health benefit purchases are difficult to determine through current budgeting and reporting. Though payment for these expenditures flows both directly and indirectly through the annual state budgeting process there is no single line item that can be looked at across all participating entities. Detail of health care premiums, member claims costs, key trends, etc. must be obtained through each entity's separate funding mechanisms and annual appropriations requests. The result is mixed visibility into health benefit trends and costs across all public purchasers.

Participants in the GSD pool are required to provide information on the numbers of enrollees they will have in the following year. The Risk Management Division then recommends annual premium rates which are approved by the Legislature and applied to that membership. Expected claims costs for those benefits are budgeted separately, with high-level projections for anticipated costs being developed by the GSD actuarial consultant based on:

- Gross medical and pharmaceutical claims paid from the most recent 12-month claims experience period
- Conversion of net claims to per employee per month costs
- Trending of claims using annual trend rates from the actuarial consultants' national trend survey
- Reduction of trended claims for guaranteed minimum pharmaceutical rebates
- Application of adjustment factors for changes to trend
- Estimated fixed costs for benefit plan administration
- Allocation of total claims expense to tiered rates based on most recent employee enrollment

Health benefit costs for both APS and NMPSIA are developed separately and included in their annual appropriations requests, with line-item detail maintained at the level of each participating agency, or in the case of NMPSIA through accounting for the Public-School Insurance Fund.

Expenditures that exceed the budgeted amounts are handled differently for each of the IBAC participants. NMPSIA health benefits are funded through annual appropriations to the NMPSIA Benefits Fund which must maintain balanced funding and expenditures. Retiree benefits are paid following a similar mechanism except that the state retiree program maintains a trust fund that is not tied to annual appropriations. APS, as noted above, separately manages its benefits expenditures through its annual appropriations. The outlier in this process is GSD managed benefit pool. As noted earlier, funding for the program is set through the annual appropriation process. However, shortfalls in the program are offset by deficiency appropriations from the state general fund, with the program having tapped that funding source in the majority of the last ten years, demonstrating poor actuarial accounting for the following year's claim expenses. Appendix A includes diagrams of the funds flows for the agencies.

Current IBAC Purchasing

Highlights

- Each of the IBAC participants operates largely independently, although the chair does rotate regularly
- Though the participating entities do combine resources to issue a consolidated bid, all other aspects including benefit design, projected overall claims costs, program administration and related activities remain separate
- Benefits and employee-employer contributions also vary, leaving significant differences in coverage between participating entities
- Though the Act requires use of both fully-insured and self-insured products, only self-insured programs are used for basic benefit programs – although some fully-insured products are procured for ancillary benefits and retirees

As mentioned previously the IBAC is comprised of four mandatory public entity participants and voluntary participants which include local governments, schools, and state educational institutions. The Health Care Purchasing Act requires member agencies to jointly go through an RFP for services, however the agencies are not required, and do not jointly contract for healthcare services under one Agreement. Additionally, there are no requirements that IBAC agencies collectively focus on controlling health care costs and monitor quality outcomes for public employees. Instead of focusing on cost saving measures and opportunities to manage the quality of the care the agencies have shifted costs onto employees through increased premiums and cost-sharing arrangements. The exception to that trend has been health benefits purchased through the GSD procurement pool. For the past 3 years the State of New Mexico (SONM) has subsidized all additional costs associated with health insurance as employee contributions have remained the same even though there have been year-over-year increases in health care costs for services rendered as well as LPB employees. As a result, that program is currently facing a significant deficiency. Neither of the above approaches are sustainable and actions must be taken for the state to be a responsible fiduciary.

State and Local Agency Participation

The IBAC leadership team is comprised of representatives from each of the four mandatory IBAC participants. Each year the designated chairperson for the IBAC switches and the responsibility transfers to a new designated chair representing another entity, allowing each entity to lead the IBAC once every four years. Each month the IBAC leadership team holds a meeting with all the benefit vendors. Typically, the chair requests that a formal presentation be done by one of the vendors during the monthly meeting and then each of the vendors does a short update on their operations. IBAC meeting minutes were not located online or posted for the public.

The State of New Mexico (SONM) through the General Services Division (GSD) provides insurance for all active employees of the SONM and includes some 108 municipalities, schools and counties known as local public bodies (LPB). The SONM currently covers approximately 57,000 members under its self-insured medical plans. Enrollment in the SONM sponsored plan declined by 4.3% between FY17 and FY21, primarily driven by the New Mexico Municipal League discontinuing its insurance program. During

this same time period, 800 local government workers and their dependents were added to the state program.

New Mexico Public School Authority (NMPSIA) is the entity responsible for procuring benefits for statewide public school active employees, except for Albuquerque Public Schools. NMPSIA currently provides benefit and risk coverage to 88 school districts 40 Charter Schools and 15 educational entities**. NMPSIA enrollment has declined by 10% from FY17 to FY21. This significant decrease is attributed to Central New Mexico Community College and Santa Fe Community college exiting the NMPSIA plan and creating their own medical benefit program.** Most of the participating school districts within NMPSIA are in rural New Mexico, and as a result experience higher health care costs. Higher health care cost is attributed to a lack of competition in the rural community's allowing hospitals and providers to maximize reimbursement from commercial payers like NMPSIA. To address the higher cost of health care NMPSIA historically modifies employee cost-sharing and premium contributions semi-annually. The play between income and health care costs (even with coverage) leads many employees to drop coverage or be covered by plans they can't afford to use due to prohibitive cost sharing requirements.

Albuquerque Public Schools (APS) is New Mexico's largest school district and provides coverage to approximately 15,000 beneficiaries in the metropolitan area of Albuquerque. Every year for the past 3 years, APS has evaluated its medical expenses, program costs and benefits, resulting in increased premiums, employee contribution and modifications to benefit cost-sharing for employees. Enrollment for APS fell 3.4% between FY17 and FY21. This decline can be attributed to staffing levels within APS.

The Retiree Health Care Authority is unique to the other three entities and manages their benefit program according to retiree program requirements. Segal (Arizona) is the consulting actuary for RHCA. Given the unique nature and requirements for retiree programs we have not included an evaluation of that program or its participation in the IBAC as part of this assessment.

RFP and Bid Development

In early 2019, the IBAC retained AON (New Mexico) to develop an RFP and required tools to analyze bids and select vendors to provide medical, dental, vision, employee assistance program (EAP) and Medicare Advantage/Medicare Supplemental insurance programs. The IBAC identified a selection committee with representation from each of the entities, who reviewed the RFP and tools and approved their release on October 28, 2019. The RFP process was overseen and managed by the Albuquerque Public Schools Procurement department in conjunction with AON. Bidder submissions were due on December 10, 2019, at which point the qualitative responses to the RFP were disseminated to the selection committee who independently scored, rated, and ranked each response. Once complete, the responses were submitted to AON for overall scoring. AON was responsible for scoring each of the bidders, ranking them, identifying the finalists, and incorporating the quantitative portion of the bidder's response for final scores. Finalists were selected and presentations were held with the selection committee and appropriate key stakeholders. The bidders selected were Presbyterian, Blue Cross Blue Shield, CIGNA Healthcare and True Health New Mexico (specifically for APS). Following the selection each of the entities independently selected their choices among the approved bidders and proceeded with building product offerings, administrative models and TPA contracting.

Plans and Benefit Offerings

The State of New Mexico (SONM) offers three third-party administrators (TPA's) who provide unique provider networks, plan designs and medical management philosophies to its members. The three vendors selected through the 2019 RFP selection process are Presbyterian Health Plan, Blue Cross Blue Shield and CIGNA Healthcare. All carriers offer a statewide network allowing all employees to be eligible

to enroll in all plan offerings. Presbyterian Health Plan and Blue Cross Blue Shield offer Dual Option Plans that enable employees to select at the time of seeking services if they want to access services in narrow networks at a lower cost share or select a non-preferred provider requiring higher cost-sharing. The plan's benefits vary slightly based on carrier technology administrative capabilities and medical management capabilities. CIGNA Healthcare offers SONM employees a traditional PPO Plan. Employee premium contribution is the same for all 3 Plans.

NMPSIA offers the same three TPAS's with a different approach to product selection. Each TPA offers a high option and low option PPO and only Blue Cross Blue Shield offers an Exclusive Provider Option (EPO, which is similar to an HMO). Employees of NMPSIA contribute different amounts for each of the TPA's, plan selection based on the percent of employer covered costs as defined in the Public-School Insurance Authority statutes. As noted earlier, the statute specifies a sliding scale based on income. The lowest contribution is for employees who earn less the $15,000 a year pay, paying 25% of the premium equivalent, while employees who earn $25,000 or more are responsible for 40% of the premium equivalent.

In 2023 APS will offer the same three TPA's as the other entities. (Through the RFP process, APS selected True Health New Mexico which provided coverage in 2020-2022. However, in 2023 True Health New Mexico is no longer offering coverage to New Mexicans.) APS offers two PPO's and one EPO to its employees, and like NMPSIA employee, costs are based on a sliding scale for premium contributions based on income. An employee earning $42,500 or less contributes 20% of the premium equivalent, while employees at the highest income tier, $55,00 pay 40% of the premium equivalent.

IBAC Programs and Infrastructure

All entities except the Retiree Health Care Authority contract to self-fund all health care cost incurred under the contractual agreements. Although self-funding is a common strategy in many states this strategy means that all financial risks for coverage of healthcare benefits rests with the public entity. Many states also have formal infrastructure in place to effectively manage the oversight of their programs, which is lacking at the IBAC and agency level. Almost all large private self-insured employers also purchase stop-loss coverage which can be used to offset unanticipated high-cost claims. We were able to determine that the SONM does not purchase stop-loss coverage, although some of the other IBAC participants do have some stop-loss coverage for selective programs. Some of the additional capabilities present in other states and private employer self-funded programs include actuarial analysis throughout the year to be used in decision-making regarding plan designs, cost-sharing approaches, and management of TPA services (NMPSIA does do a version of this, usually resulting in an increase in cost sharing and/or reduction of benefits, often mid-year). Additionally, in most states the oversight bodies manage performance data to assure the plans are performing within cost-growth targets.

Capabilities for Managing Outcomes and Risks

Currently, all the IBAC entities have outsourced healthcare decision making expertise to the consulting firms of AON and Segal which provide industry and program advisory services, some ongoing analytical capabilities, and act as a strategic partner providing input and guidance regarding contracting and performance of the three TPA's. The IBAC and even some of the benefit departments of the individual participating entities do not include in-house, highly experienced subject matter experts on employee healthcare benefits to provide ongoing oversight and strategic program direction. Given the independent nature of each of the IBAC entities, limited opportunities exist for collective evaluation and actionable steps to be taken to address critical medical cost trends and quality health overall.

IBAC Program Results

Highlights

- Issues were identified more than a decade ago and remain largely unaddressed to this day.
- Challenges identified span the spectrum from IBAC design and functioning, budgeting, and financial management mechanisms, to benefit design and benefit equity.
- The results of these issues and challenges are apparent through the performance of the IBAC structure and processes in providing coverage to public employees, seen through continued declines in participation and coverage.

Multiple years of LFC analyses also show that during this period total benefit costs for the program have also consistently exceeded national trend on an absolute basis, with an even larger differential on a unit cost basis, as both enrollment and utilization have declined. This suggests higher than expected provider reimbursement rate increases, leading to higher member costs.

Performance

2010 Evaluation – Structural Weaknesses in Program Design

As far back as 2010 The Legislative Finance Committee analyses of the IBAC performance have identified the deficiencies in the programs for each entity and have expressed their concerns regarding the different plan designs, premiums, and employer/employee contribution rates[4]. In its 2010 report assessing performance of GSD and NMPSIA, the Committee concluded:

"Neither agency has provided the administrative oversight necessary to impact the pricing for medical services or to ensure that enrollees are receiving quality services. Programs expenses have continued to climb in spite of decreasing enrollment and utilization.

Overall, the state has not maximized the purchasing power for health benefits nor taken advantage of comprehensive quality improvement initiatives that would better contain costs. There is little focus on the price of medical care or the outcomes the care provides. Utilization and provider rates are the key components of medical costs. With utilization remaining flat or decreasing, it appears as if provider rates are the primary cost driver."

The report went on to identify many of the same issues we have identified in this report, specifically highlighting:

- Joint RFP, but not consolidated purchasing
- Contracting for administrative fees rather than provider rates
- No monitoring or controls over provider reimbursement rate increases
- Separate administrative structures, with duplicative and redundant functions
- Disparate benefit plans
- Differing cost structures
- Lack of standardized report

[4] "Report to the Legislative Finance Committee: General Services Department and the Public Schools Insurance Authority Program Evaluation of Public Employee Health Benefits" November 18, 2010

- No central repository for claims data to support monitoring and analysis
- No regular comprehensive claims and recovery auditing

The report also highlighted the trend of participating agencies to shift costs to employee out-of-pocket spending rather than taking steps to impact the consistent increases in provider reimbursement rates. The report noted that between 2008 and 2010 premiums had increased between 7 and 17 percent, resulting in premiums totaling as much as 99 percent of some lower wage employees' income. Additionally, the report highlighted the likely benefits of true consolidated purchasing, highlighting IBAC's move toward consolidated purchasing for pharmaceutical benefits which, at that time, was estimated to save taxpayers $51.5 million over a four-year period.

The report concluded with the recommendation that:

"The state should centralize all insurance functions of NMPSIA and RMD under a single entity to leverage the state's purchasing power, remove duplicative government functions, and improve the efficiency of government operations."

The report further details specific recommendations for the creation of a New Mexico Healthcare Finance Authority with specific responsibilities for program management. All participating IBAC agencies submitted written responses to the Report, indicating their support for some recommendations, but with significant pushback from RMD.

2013 Evaluation – Recognition of Financial Risks in Current Practices

The Legislative Finance Committee's IBAC report issued in 2013[5] identified the same issues, and noted an additional issue related to the financial risks associated with the IBAC agencies continuing practice of offering self-funded plans which shifts all risks for providing coverage to the taxpayers instead of the financial risks being borne by the health plan vendors under fully insured contracting. The report noted that although that option affords additional flexibility, it requires monitoring and management which the agencies lacked. The report also highlighted continuing cost shifting to employees through premium increases that exceed national trends. Finally, the report noted that no action had been taken by IBAC to implement recommendations in the 2010 report.

2016 Evaluation – Identifying the Sources of Higher Program Costs

The Legislative Finance Committee conducted an even more comprehensive review of the IBAC in 2016, assessing performance and trends from 2012 to 2016. Once again, the findings were similar to those noted in prior reports, although there was additional extensive analysis of the provider reimbursement rates paid by the IBAC participants. Specifically, the report noted[6]:

"…the IBAC agencies are paying higher average rates than Medicare, which in turn pays higher rates than Medicaid. The primary tools IBAC agencies have used to attempt to contain rising costs are increased premiums and out-of-pocket costs like deductibles and copayments, but this approach simply shifts more costs to members – and the state – and does not address the root cause."

The report goes on to state:

"In addition to the previous LFC recommendations…there are further opportunities for state savings through greater IBAC agency participation in negotiating provider rates rather than continued and

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[5] "Report to the Legislative Finance Committee: Interagency Benefits Advisory Committee Oversight of Public Employee Health Benefit Plans" November 22, 2013

[6] "Health Notes: Program Evaluation of Legislative Finance Committee: IBAC Cost and Utilization Trends, 2012-2016", August 18, 2017

potentially unsustainable cost-shifting to members. True consolidation of the IBAC agencies could likely facilitate could likely facilitate greater influence over rates, as may a shift away from straight fee-for-service payments."

The report goes on to include detailed analyses of benefit design, spending and performance trends, identifying specific areas in which the programs are outliers. That included a finding that the IBAC agencies experienced a higher percentage of high-cost claims relative to that experienced by other large employers. The report noted the potential value of disease management programs to address this issue but did not highlight the use of stop-loss insurance or negotiated single-case-agreements which are commonly used risk mitigation tool to address this issue in the health insurance industry. A rebuttal memorandum to the report issued by the IBAC[7] (collectively) did note that both APS and NMPSIA had added stop-loss coverage to address this issue, although it is not clear whether that coverage extends to all products. The memorandum included additional detail of actions taken by the IBAC to address issues through the bidding process and encouragement of care management activities, but no subsequent measurement of impact, but was largely silent on actions taken to implement additional changes recommended by the LFC in previous years.

2021 Assessment – An Emerging Issue of Equity

Once again in 2021 the LFC identified similar ongoing issues. However, their analysis in that year highlighted an additional issue that had emerged related to equity in plan design, coverage, and costs across IBAC participants. Specifically, the report noted:

"...In the case of APS and NMPSIA, health benefit rates are set by their respective boards while ultimate discretion for GSD rates resides with the Governor…The trifurcated system of providing health benefits has led to different plan designs, premiums, and employer and employee contribution rates…. While the insurance plans are similar, the premiums are dramatically different…. The disparity in employer and employee contribution rates is largely due to statutory constraint and agency policy. Statute mandates higher employee cost sharing rates for NMPSIA than for GSD and is silent on rates for APS employees. Additionally, the NMPSIA and APS boards have made the policy decision to consistently increase rates to pay program costs and build a reserve while GSD rate increases have not kept pace with healthcare cost increases."

The report goes on to highlight additional differences in New Mexico employee-employer contribution requirements, noting that surrounding states do not tie contributions to income levels. The report also highlights differences between IBAC participants in who is eligible for coverage (APS requires 30-hours/week, GSD requires 20-hours, and NMPSIA has an effective 15-hour minimum). It also highlights the fact that IBAC participants offer fewer and less robust insurance options.

Finally, the report highlights differences between IBAC participating entities in the method of how health benefit purchasing is budgeted, noting that:

"GSD rates are built into base budget requests of agencies prior to the appropriations process while NMPSIA requests funding to be included in the public-school support (PSS) budget for distribution to the districts. The NMPSIA board is empowered to set insurance rates assessed to districts assessed to districts regardless of whether funding was included in the PSS budget. APS receives 25 percent of the state equalization guarantee funding available for insurance in the PSS budget regardless of claims experience."

[7] "Interagency Benefits Advisory Committee, Memorandum to Dr. Jenny Felmley, PhD, Program Evaluator, Legislative Finance Committee", August 14, 2017

It should also be noted that many of these same issues were identified in HB59, School Group Insurance Contributions (2022), which looked to address the identified inequities and increasing unaffordability of health benefits coverage for NMPSIA covered employees. Specifically, the bill analysis issued by the Legislative Education Study Committee[8] noted:

"Under current law, there is significant inequity between public school employees in the employer funding of health insurance benefits."

The bill, which did not pass, sought to bypass current funding mechanisms to allow the Public Education Department to allocate additional funds to certain schools to pay for additional employer contributions to equalize funding with other public employees.

Key LFC Themes

As noted above, many of the LFC analyses highlight the same issues in multiple years. It is important to note those issues which speak to some of the most significant issues that the Legislature should address to build the foundation needed to support the benefit programs needed for our valuable public employee work force. These key issues include:

- Continued disenrollment of groups and beneficiaries due to continuous increase in premiums, cost sharing, benefit reductions, and increasing unaffordability
- Inequality of benefits and costs borne by the beneficiaries in the different agencies
- Lack of action by the agencies with regard to LFC recommendations to contain costs in any impactful manner
- Consistently noted increases in costs due to health system/provider pricing; and not due to an increase in utilization

LFC Findings Validated by Consultant Review: Finally, and most importantly, through our research we noted that the TPA contracts with health systems and hospitals are not based on a reference to Medicare pricing, which is likely contributing to the cost increases noted above and the resulting shifting of expense to employees. Rather it appears that these contracts are a percentage of full billed charges based on each system/hospital's "Charge Master." It is standard in such contracts that these charges can be increased as needed at any time for any diagnosis. While there are often restrictions to annual increases, there are always loopholes in the contracts to significantly raise charges and thus significantly raise revenues to the system/hospital. The IBAC agencies should have required full review (confidentially) of contracts and methodologies of billing. We believe that this percent of full billed charges is the key driver of health care costs for the state year after year. However, because of the lack of transparency in public agency benefits contracting, we were unable to fully validate this observation.

Agency Participation and Enrollment Trends

During the last eleven years (2010 – 2021) for which we were able to obtain data, IBAC participation has consistently decreased, from approximately 152 thousand members in 2010 to 118 thousand in 2021 (a 22% decrease). Much of that loss of membership has come from GSD and NMPSIA, while APS membership has been more stable. As noted above, lack of affordability – particularly for lower paid employees – has been a significant driver of these losses.

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[8] "Legislative Education Study Committee Bill Analysis, 55th Legislature, 2nd Session, 2022. HB59 – School Group Insurance Contributions" January 25, 2022.

In spite of these significant enrollment losses, program expenditures have continued to grow at rates that exceed national averages. **The most recent LFC analysis notes[9] that total state expenditures had increased 6.9 percent, to $686.8 million between 2017 and 2021. However, just during that period enrollment shrank by 6.5 percent, resulting in a per member increase in costs of 14.3 percent during that period.**

The state continues to insure fewer and fewer people, at higher and higher costs – the definition of an actuarial death spiral in the insurance industry. We've seen nothing in our analysis of IBAC design, functioning, or performance which would suggest likely improvement without significant reform.

[9] "LFC Hearing Brief: Funding Health and Risk Insurance Premiums for Public Employees", August 25, 2021

Health Benefit Purchasing Reform in Other States

Highlights

- Public employee benefit costs across the country are higher due to differences in the underlying employee population, its health, and compensation practices
- This has resulted in states seeking innovative ways to control higher costs while still providing important benefits to their valued employees
- Though many states have tried to consolidate purchasing for all employees, only a small number have accomplished that goal
- Instead, states have implemented a broad range of innovations from changing the way benefits are purchased, reforms to provider and vendor/insurer reimbursement, enhancements to benefit programs, and finally changes to state budgeting processes

Across the nation approximately 5% of Americans receive their health benefits coverage through state and local government purchasing programs. (As noted earlier in this report, these percentages are much higher in New Mexico due to the higher overall percentage of public employees.) The Centers for Medicare and Medicaid Services (CMS) estimates that total healthcare spending for those employee healthcare benefits, and other state and local health programs accounted for approximately fourteen percent (14%) of total US health spending in 2020, just behind the total of all spending by all private parties.

Public Employee Health Benefit Purchasing Trends and Issues

Healthcare Costs Continue to Outpace Inflation: Although the pace of healthcare spending has been slower since the passage of the Affordable Care Act (ACA) it still remains greater than general inflation. Without considering recent significant increases in general inflation, CMS has projected national health spending growth averaging 5.4 percent annually for 2019-28, reaching $6.2 trillion by 2028. Because national health expenditures are projected to grow 1.1 percentage points faster than gross domestic product per year on average over 2019–28, the health share of the economy is projected to rise from 17.7 percent in 2018 to 19.7 percent in 2028.

Public Employee Health Benefits are Richer: The challenges these continued increases pose for public employee health benefit programs is even more significant. The Georgetown University Health Policy Institute Center on Health Insurance Reforms[10] states that "in general, public-sector employees earn less than their private sector peers, but receive more generous health and pension benefits. In spite of rising health care costs, 28 of the 47 SEHPs [State Employee Health Plans] that responded to [their] survey reported that the generosity of their health plans had either shifted higher or stayed the same over the last 10 years. SEHPs also tend to contribute relatively more to employee premiums than their private sector counterparts. While private employers pay on average 70 percent of the cost of premiums, 40 states in our survey reported paying between 80 and 100 percent, and only 6 reported contributing less than 80 percent."

[10] "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability", Georgetown University Health Policy Institute, Center on Health Insurance Reforms, June 2021

Public Employees are Older and Sicker: Additionally, the age and gender mix of public sector employees presents additional challenges. According to a recent analysis by the Pew Charitable Trust and MacArthur Foundation[11] "on average, the public employee insured populations are older and are composed of a greater percentage of females than in the private sector. According to Truven Health Analytics, a health care data management and consulting firm, state and local governments insured a higher proportion of older workers and dependents (age 50 or above) and a greater proportion of females than did private sector employers in 2010. Thirty-six percent of public sector health plan workers and dependents were ages 50-64, compared with 26 percent among private firms…. Similarly, females were more predominant in the insured population of public employers (57 percent) than that of private employers (51 percent)."

The same study highlights the cost and outcomes implications of those differences in the typical public employee risk pool. Their research notes that "according to a study of commercial insurance costs sponsored by the Society of Actuaries, health care during the first year of life is very expensive and then drops dramatically until age 8, when it levels off throughout adolescence. Average costs for males remain stable throughout their 20s and then begin to increase steadily after age 30 through age 65 … For females, however, average costs rise dramatically during their childbearing years, at which point average costs are more than double those for men of the same age. Average costs for females level off from their early 30s until their early 40s and then rise again to the age of Medicare eligibility."

This same study notes that analyses by the Congressional Research Service found similar results. "In 2011, 52 percent of full-time state government workers were between the ages of 45 and 64, compared with 43 percent of full-time private sector workers. With respect to gender, women held a much greater share of full-time jobs in state government (59 percent) than in the private sector (42 percent)."

The study also noted that public sector employees have higher rates of chronic illnesses, which also significantly increases benefit costs. Specifically, "people covered by public sector employers had a higher prevalence in 2010 of every chronic condition tracked by Truven Health Analytics than people covered by private sector employers. For example, diabetes and hypertension were 48 percent and 59 percent more prevalent within the public sector population, respectively. Even after adjusting for age and gender, which are correlated with chronic conditions, Truven found that public employees and their dependents had a greater prevalence of chronic conditions."

Public Employee Health Benefit Purchasing Reforms

Each of the key factors noted above impact the costs for providing health benefits for public employees and their dependents. Similarly, these trends are driving increased state focus on opportunities for reforms and innovation. With state and local governments representing such a large pool of healthcare purchasers and health benefit purchasing making up an increasingly large share of public sector budgets, states and local governments are pursuing varied solutions to influence health outcomes and costs of care. Reforms that have been implemented or are under consideration across the country include:

- Purchasing consolidation
- Changes to bidding methods
- Changes to benefit design
- Consumer directed health and right to shop
- Provider reimbursement methodologies and network design
- Healthcare cost growth benchmarking

[11] "State Employee Health Plan Spending: An Examination of Premiums, Cost Drivers and Policy Approaches", The Pew Charitable Trust and the MacArthur Foundation, August 2014.

- Administrative efficiencies

We briefly discuss actions in these areas below.

Purchasing Consolidation

The organization, management, oversight, and scope of responsibilities for purchasing vary widely from state to state. Significantly, most states are not following private sector practices of strategic sourcing by creating large, consolidated pools that can exercise more leverage in purchasing benefits. Instead, research has shown that, most public employee health benefit purchasing is highly fragmented into smaller, separate employee purchasing pools for teachers, local government, and state employees. This results in limited purchasing market share of 5% or less and reduces contracting leverage. Many public employee purchasers also further dilute their purchasing power by offering several health plan options, following a model similar to that in New Mexico[12].

A comprehensive national survey conducted by Georgetown University showed that most state public employee health plan purchasing pools are available only to active state agency employees, retirees, legislators, and state university system employees (faculty and staff). Only about one-half of states allow for participation by school district employees (teachers and staff) and local, municipal, or county employees. Even then, in all but a small number of states, that participation is optional. More typically, local school districts and municipalities either have their own purchasing pools and programs or individual districts separately purchase health coverage.

According to the National Academy for State Health Policy[13] fewer than ten states have pursued consolidation across all public employer types. However, states that have established these larger pools (approximately twelve states) through consolidation or other mechanisms exercise greater purchasing power with market shares of 11-20 percent versus an average 2-5 percent in other states.

Washington State Reforms: Only Washington state has achieved full participation by all public employees. Through a multi-year effort, the state created the Washington State Healthcare Authority. The Authority administers both Medicaid and the public employees' healthcare plan. In 2020 the School Employees' Benefits Board (SEBB), the consolidated school district employees' health benefits purchasing program required all school districts to participate in SEBB and the SEBB was added to the State Healthcare Authority purchasing pool. Previously, the state allocated funding to each individual school district that negotiated health benefits separately.

Oregon State Reforms: The state created the Oregon Health Authority (OHA) which combined the administration of public benefit programs for public employees, educators, and Medicaid into a single agency. The OHA currently purchases health benefits for approximately one-third of the state's residents.

North Carolina Reforms: According to the National Academy for State Health Policy (NASHP), North Carolina has made some of the most far-reaching progress in consolidating public health benefit purchasing. The state created the North Carolina State Health Plan which covers nearly one million individuals and includes state, school, fire department, medical transportation services and some local government employees. It even covers charter school employees under specified conditions. The plan pools all covered lives and also provides a single, standard preferred drug list across all its offerings.

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[12] "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability", Georgetown University Health Policy Institute, Center on Health Insurance Reforms, June 2021

[13] "Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power", National Academy for State Health Policy, April 2019

California Reforms: California has also recently expanded its CalPERS purchasing pool to include local agencies and schools who opt into the state plan (similar to New Mexico's General Services Department pool which includes voluntary local government participants). California's research estimates that CalPERS has saved $40 million in premiums costs each year due to local governments participating in the state health plan through increased purchasing leverage, and the benefits of streamlined purchasing, administration, and operations. Most school districts participate in CalPERS, or one of several large consortiums of school districts, such as Self-Insured Schools of California (SISC) and California's Valued Trust (CVT).

Connecticut Reforms: Connecticut has also pursued a multi-year effort to consolidate purchasing across larger public employee pools. Its Connecticut Partnership Plan was started in 2012 allowing local governments and schools to participate in the state's employee health insurance pool. Entities that joined received the same benefits offered to state employees with pricing dependent on each group applying for coverage. Initially, only a small number of entities joined, and the plan eventually suffered from an actuarial imbalance (similar to that experienced by NMPSIA). This led to higher health insurance premiums for participants and discouraged new local government agencies with better claims experience from joining the plan.

In 2016 Connecticut modified the program, making it easier and more cost effective for local governments to join the pool. The state also modified program oversight and management, with the new program being administered by a separate, dedicated, and experienced team. The state also implemented specific annual financial reporting by the state comptroller, including a plan to ensure fiscal adequacy of premiums.

Additionally, the claims experience for all state and local participants are now pooled together, with all participating groups paying the same rates, and all entities have the same plan design and insurance carriers. This new approach allows for a more stable pool and reduced risk of adverse selection. Entities must join as a unit (i.e., an entire town, city, etc.) and must participate in the program for three years, with penalties to the entity if they leave the pool earlier. More than 30 new groups have joined since these reforms were implemented. In 2019 Connecticut added additional pooling programs for non-state employers, allowing the offering of special programs for pharmacy and surgical insurance.

Covering Dependents in the Children's Health Insurance Program: The Children's Health Insurance Program (CHIP) was created in 1997 to provide health coverage for children in families with incomes that are too high to qualify for Medicaid. According to the Peter G. Peterson Foundation income eligibility differs by state with a low of 170 percent of the federal poverty level (FPL) in North Dakota, to a high of 400 percent of FPL in New York. According to Peterson[14] CHIP's premiums and cost-sharing requirements are routinely lower than those of state employee health plans for dependent coverage, while the comprehensiveness of its coverage is comparable and often better as in New Mexico. Additionally, premiums are prohibited for families below 150 percent of the poverty level. According to the Peterson Institute a study conducted in 2015 showed that the average plan cost per child enrolled in CHIP was $158 versus $891 for employer plans.

The additional benefit of CHIP is administered by states, but the program is jointly funded with the federal government, which contributes at least 65 percent of the cost of the program. The average federal matching rate for CHIP was 93 percent in 2019 (most recently available data). Federal matching differs from that for Medicaid. Under the CHIP program, federal funds are capped nationwide, and each state operates under an allotment.

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[14] "Three Key Things to Know About CHIP", Peter G. Peterson Foundation

States have more flexibility under CHIP around benefits and cost-sharing. However, total premium and cost sharing can't exceed 5 percent of family income. States have the option to extend eligibility for CHIP to children of public employees if (a) the state's annual increase in per-employee expenditures for dependent health coverage is not less than the annual increase in medical inflation since 1997, or (b) the state demonstrates that the employee share of premiums and cost sharing for all state health plans would exceed 5 percent of the family's income. By adopting this option, states save money that currently goes to employees' health benefits while also giving their lower-income employees access to comprehensive, relatively low-cost health coverage. According to the Kaiser Family Foundation, as of 2016 (last available data) 15 of the 36 states with separate CHIP programs (not run through the Medicaid program) had done so.

Changes to Bidding Methods

Reverse Auctions: A reverse auction program requires bidders to compete through an anonymous bidding process through which the bidders can make successive modifications to their bids through a competitive process much like an auction. Bids are anonymously submitted through an online portal and the final lowest offer is awarded the contract. The federal Government Accountability Office (GAO) has developed extensive programs and best practice guidelines for reverse auction bidding processes for government procurements. The State of Minnesota, which uses a reverse auction process, has identified the following key elements for a well-designed reverse auction program:

- Development of a "best-in-class" benefit contract
- Development and deployment of a benefit program pricing analytics platform to evaluate bids
- Dynamic, online competition between bidders
- Digitized pricing and contract requirements that support automated program loading and ongoing monitoring

A number of states have implemented, or are planning to implement reverse auction procurement methods, although to-date those programs have only been applied to the purchase of pharmaceutical benefits programs. However, it's important to note that the Federal government has been using reverse auction programs for procurements in a number of programs, including for the Department of Defense. Some private employers have also used reverse auction programs to purchase employee health benefits.

The first state to implement a reverse auction program was New Jersey, which, according to research conducted by the State of Minnesota, has reduced its drug spending by 20 percent, saving the state an estimated $2.5 billion over the first five years of the program. Since the implementation of that program, Colorado, Louisiana, Maryland, and Minnesota have followed suit for their pharmaceutical benefit programs. In Louisiana, the reverse auction process may be extended to health plans offered through the Louisiana State University System, including any public four-year college or community college system, or to public school employees.

Reference Pricing: Some states have legislated that all TPAs and plans contracting for state/governmental entities require provider contracts to use a percentage of Medicare pricing for all services and products. In New Mexico, while specific data is not available from TPAs, it appears that the majority of contracting with health systems is based on a percent of billed charges as previously noted.

Changes to Benefit Design

The most common type of reform implemented by public employee health benefit programs to improve outcomes and costs are changes to benefit design. Although programs have been slower to implement innovations such as value-based reimbursement and outcomes driven tiered provider networks seen

among private sector employees, the solutions still include a significant number of innovations. These include:

- Consumer-directed health plans (CDHP's)
- Workplace wellness programs
- Benefit rating tier structure redesign
- Modifications of premium contribution arrangements
- Right-to-shop
- Targeted cost sharing

Each of these innovations is discussed briefly below.

Consumer Directed Health Plans (CDHPs): CDHP's have been in use throughout the private sector for several decades. They are high-deductible plans coupled with tax advantaged personal health savings accounts which can be used to pay for out-of-pocket health expenses, and which typically include matching employer contributions. The design of the programs is intended to increase consumer incentives for more careful utilization of healthcare services. However, after several decades of use the results for CDHP's are still considered mixed. Consumer research suggests that they are primarily considered an attractive health plan option by younger, higher-income and healthier employees who are attracted to the tax benefits of the health savings programs. Georgetown University's national survey identified thirty states offering CDHP's[15]. However, only slightly more than half of the states offering these plans also include health savings accounts with any matching contributions. States also report that uptake of the plans is typically limited, and only one state reported any cost savings associated with its HDHP.

Workplace Wellness Programs: Workplace wellness programs initially had significant uptake among private sector employers. However, after numerous studies that failed to demonstrate significant improvements in either costs or outcomes many programs have been abandoned or scaled back significantly. Research by Harvard University has demonstrated that some programs save money, although much of those savings were not tied to the cost of health benefits. Instead, the benefits of these programs were greatest when looking at the combination of medical costs and costs related to absenteeism, estimating a savings of approximately $3 for every dollar spent on targeted programs, although savings took a significant time to accumulate.

A number of other studies have raised important questions about the value of wellness programs. In particular, researchers who reviewed results of randomized controlled trials found that the financial incentives which are typically part of these programs are often ineffective for influencing behavior. Savings were determined to be primarily attributable to cost shifts between healthy and higher risk employees rather than improved health outcomes. Those programs that remain in use are typically carefully targeted at topics like smoking cessation, weight loss, or management of specific illnesses. Georgetown University's national survey[16] identified a little more than a dozen states (including New Mexico) which have active workplace wellness programs and two were able to document associated cost savings.

Changes to Rating Tiers: States can affect their benefit costs by using their benefit plan rating tier structures to influence the size and composition of the people covered by the health plan. The structure

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[15] "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability", Georgetown University Health Policy Institute, Center on Health Insurance Reforms, June 2021

[16] "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability", Georgetown University Health Policy Institute, Center on Health Insurance Reforms, June 2021

of rating tiers can also significantly impact average costs within each tier. As an example, under a two-tier structure (employee or employee with any dependents), an employee covering a spouse and an employee covering children but not a spouse would be charged the same monthly premium as an employee covering a spouse and children. Under a three or four-tier program design premiums are higher for employees covering a spouse and dependent children. Two-tiered rate structures create an incentive for larger households to enroll in their employer-sponsored insurance and a potential disincentive for smaller households to subscribe, thereby attracting more enrollees per employee. They also disincentivize employees from using coverage that may be available to their spouse through their spouse's employer. Recognizing these incentives and the impact they can have on enrollment and costs, Georgetown University's national survey found that a majority of states have now adopted at least a three-tier structure, while a smaller number are experimenting with four-tier structures. These changes are most valuable when coupled with innovations such as those allowing enrollment of children through the CHIP program.

Modifications of Premium Contribution Arrangements: Premium contribution arrangements can affect employers' total costs because they can have a significant impact on the employees' plan selection. For example, some states, such as North Carolina, base their contribution on the lowest-cost plan and require employees who select a higher-cost plan to pay the full difference in premiums. This can drive more employees to select the lower-cost plan.

The share of premiums that employers pay for dependent tiers also affect employee enrollment decisions and therefore state spending. For example, a state may encourage an employee with dependents to consider other options—a less expensive state plan, the spouse's employer-sponsored insurance, or the health insurance exchange—by requiring the employee to pay a greater percentage or the entire cost of dependent coverage. This strategy can reduce the number of persons covered—per employee and in total—and lower the state's total costs.

The most common arrangement for premium contributions by states is to vary the premiums paid across tiers by paying a larger dollar amount—though not necessarily a larger percentage—for dependent tiers than for the employee-only tier[17]. Alabama, Colorado, and Utah, as well as others, follow this strategy. Some states, such as North Dakota, Ohio, and Vermont, pay a fixed percentage of the premium for all coverage tiers. A small group of states place a significantly greater share of the premium on employees who wish to cover dependents than on those who choose employee-only coverage. Mississippi and North Carolina, for example, pay a fixed dollar amount for all employees, regardless of the coverage tier. In these states, the employer pays all or nearly all of the cost for employee-only coverage, while the employee is responsible for the additional cost of covering dependents. This arrangement creates a clear financial incentive for employees to seek alternative coverage for their dependents, but it also increases the risk that dependents could go uninsured.

Right to Shop: Right-to-shop programs provide financial incentives for patients to seek lower cost, high-quality providers, and health services. Through right-to-shop programs, insurers typically share a portion of their cost savings with enrollees to offset any pre-deductible or out-of-pocket expenses. A number of states have implemented Right to Shop programs for state employee health plans. New Hampshire, Kentucky and Utah have established Right to Shop programs. According to NASHP[18] New

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[17] "State Employee Health Plan Spending: An Examination of Premiums, Cost Drivers, and Policy Approaches", The Pew Charitable Trusts and MacArthur Foundation. August 2014

[18] "Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power", National Academy for State Health Policy, April 2019

Hampshire was the first state to establish a shared incentive program with 90 percent of enrollees using the Right to Shop program within the first three years of the program.

To support the growth of price transparency and right-to-shop program CMS released a final rule in 2019 requiring hospitals to provide "standard charges" for hospital items and services. These hospital price transparency requirements went into effect January 2021. CMS released another final rule in 2020 establishing similar price transparency requirements for health insurers. The final rule requires most private health insurance plans to provide patients out-of-pocket costs and negotiated rate information for health care items and services upon a patient's requests.

Targeted Cost Sharing: Cost sharing can be used to influence employees' behavior, encouraging them to reduce utilization of certain types of care, such as inappropriate use of emergency department services, or to explore less costly treatment options and care settings. Many employers also use tiered prescription drug formularies—the prescription drugs covered by a plan—to further the use of lower-cost generic drugs by charging employees less for these than for the medically equivalent but more expensive brand-name drug. Georgetown University's national survey showed that a majority of public employee health plans include relatively modest amounts of cost sharing, resulting in a higher overall actuarial value compared to private employers and providing few incentives to affect health plan utilization.

Provider Reimbursement and Network Design

Network Design Reforms: Some states have been experimenting with changes to provider reimbursement rates or provider network design to reduce the rate of increases in health plan unit costs. Typically, the targets of these reforms are high prices for hospital and specialty physician services. Twenty-three states have implemented Center of Excellence programs, with four additional states reporting they are in the process of developing one. Two states were able to document cost savings from these programs, although the primary stated goal of these programs has been to improve patient outcomes. Nineteen states have implemented a primary care-based initiative such as a patient-centered medical home (PCMH), direct primary care program, or worksite clinics (such as that implemented in New Mexico). Again, only two states were able to document cost savings from these programs.

States can also use narrow or tiered provider networks to highlight cost differences and to limit the impact of price variation by directing care toward more cost-efficient providers. While not directly affecting price differences, narrower health plans encourage members to receive care from lower-cost, high-quality providers, as well as impact health plan and provider contract negotiations.

Reference Pricing: Another policy option is the use of reference pricing, which has historically been used as part of the benefit management for prescription drugs and more recently has been extended to other medical services. Under a reference price model, a health plan sets a maximum amount that it is willing to pay (i.e., the reference price) for a prescription, service, or procedure. Employers typically strive to set a price that provides employees with qualified provider options within a reasonable distance from their homes. If enrollees receive care from a facility that charges more than the reference price, they are responsible for paying the additional amount out of pocket. This arrangement can save money by directing enrollees—who in the absence of such guidance may assume that cost and quality are invariably correlated—toward cost-efficient providers and motivating providers to charge at or below the price threshold.

In 2011, the California Public Employees' Retirement System implemented reference pricing for hip and knee replacements, and extended it to outpatient colonoscopies, cataract surgeries, and arthroscopies the following year. A recent evaluation of the initial results of the initiative reports cost savings for the

state and its employees, heightened awareness among employees of the cost differences among providers, and increased willingness of some hospitals to lower their rates. The program is estimated to have saved approximately $5 million over a two-year period.

Provider Reimbursement Reform: States have shown greater interest in pursuing changes to provider reimbursement methods, with nineteen states having implemented some sort of risk-sharing payment models. An additional fourteen states have engaged in direct negotiations with providers. Of these, four reported that they had generated cost savings by removing the middleman (the third-party administrator, or TPA) from the process. Twelve states offer employees a narrow or tiered network plan, and four of these report measurable cost savings from these plans.

Seven states have followed the state of Montana's lead by pursuing initiatives to set provider rates or peg them to a reference price, such as the Medicare rate. Although Montana has recently announced that it is abandoning its program to implement a broader range of new reimbursement models, it has previously reported $47.8 million in savings over three years and has been credited with restoring the state's health plan reserves. Oregon, which implemented a similar program is projected to save $81 million[19].

Before implementing its reference-based pricing program, Montana reported paying a range of 191 to 322 percent of Medicare for inpatient services, and a range of 239 to 611 percent of Medicare rates through its existing reimbursement programs based on a percent of charges. By implementing its program to set prices using Medicare rates as a reference (reference-based pricing), the health plan was able to establish a range of 220 to 225 percent and 230 to 250 percent for inpatient and outpatient hospital services, respectively. Medicare rates are based on a hospital's annual federal cost reports reflecting actual costs of care while reimbursement based on percent of charges is typically driven by a facility's chargemaster which is developed based on other factors.

Direct Provider Contracting: Georgetown University's nationwide survey noted[20] that fourteen states have implemented programs for direct contracting with providers, essentially eliminating the role of their third-party administrator (TPA) in these activities. Partly because of that disintermediation, some states have reported difficulties getting TPAs to work with them on these efforts. Four states indicated they achieved savings through this method, although they did not place a value on those savings. At least one state noted that it had used this approach to negotiate **"preferential government rates"** relative to commercial health benefit purchasers. It's important to note that the federal government follows a similar practice for many contracts, requiring that bidders agree to accept a "government rate" for products and services. However, many of the states surveyed noted that the effectiveness of this approach is largely dependent on the state's ability to pool large numbers of enrollees, thereby allowing it to exercise contracting leverage following established principles for strategic sourcing.

Healthcare Cost Growth Benchmarking

All-Payer Claims Databases (APCD): An innovation that has been implemented, or is being considered, is the implementation of healthcare cost growth targets coupled with infrastructure to capture health claims and services utilization data. Specifically, more than half of states have or are implementing All-Payer Claims Databases (APCDs) which provide states with greater visibility into health and health cost

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[19] "Estimating the Impact of Reference-Based Hospital Pricing in the Montana State Employee Plan: An Analysis Commissioned by the National Academy for State Health Policy with Support from Arnold Ventures"

[20] "Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability", Georgetown University Health Policy Institute, Center on Health Insurance Reforms, June 2021

trends for the populations they serve. They support the development of state population health improvement strategies, analysis and planning for Medicaid and Exchange programs, and are used by both health payers and providers for analysis and planning.

The availability of an APCD is also considered essential for the development of health benefit cost growth targets as well as the use of pricing transparency, consumer-facing price comparison tools and consumer-directed care solutions discussed earlier in this document. APCD's can be used to identify extreme price variation, analyze utilization trends and spending, and develop benefit design or programmatic solutions to target wasteful or low-value spending. According to the national APCD Council, twenty-five states (including New Mexico) have implemented or are in the process of implementing APCD's. However, there is significant variability in the types of data collected, and participation.

Healthcare Cost Growth Benchmarking: States are increasingly considering the setting of healthcare cost growth benchmarks for public purchasing programs, and in some instances, for the overall healthcare market. There is, in fact, a strong, long-running model for this approach to healthcare purchasing. Under federal law, Medicaid programs are required to set actuarially sound payer contracted rates for managed care contracts. Actuarial soundness is determined through detailed analysis of underlying population, utilization, and cost data. Projections can then be further modified based on assumptions about the positive and negative impacts of changes to benefits, program design and other cost factors. Though Medicaid program costs have increased significantly over the last decade, primarily as a result of growth of covered populations, unit cost growth has generally remained lower than that for other payer types, at least in part due to this data-driven approach to pricing.

Establishing data-driven health care cost growth benchmarking programs can provide a structure and process for increasing health system transparency and developing strategies for improving health outcomes and containing costs. According to Manatt[21] at least eight states have adopted benchmarking programs that bring stakeholders together to set cost growth targets for health care spending, collect data from payers to measure progress, and identify where policy or program action may be required.

Massachusetts established its expansive benchmarking program in 2012. It requires annual reporting and includes a detailed hearing process that engages stakeholders across the state's health care system to inform and shape potential policy recommendations. Delaware and Rhode Island quickly followed Massachusetts with less expansive programs and were followed by five additional states. The programs, which have been supported by the Peterson-Milbank Program for Sustainable Health Care Costs have since expanded to include Oregon, Connecticut, Washington, Nevada, and New Jersey, all of which have used these programs to provide data-driven analysis and program design for many of the reform efforts noted throughout this report.

The Peterson-Milbank Program has identified five common features of cost growth benchmarking programs, as well as some features, such as accountability, that are required for successful implementation and use to drive program innovation. These include:

- Defined strategy to engage stakeholders in program development, goal setting and problem solving
- Authority to collect and use data to monitor health system spending trends
- Growth targets that serve as a baseline to measure spending trends

[21] "State Benchmarking Models: Promising Practices to Understand and Address Healthcare Cost Growth", Manatt, June 2021

- Well-designed metrics, data collection and measurement methods to collect outcomes and expenditures
- Data and analytic infrastructure and organizational capabilities to support data analysis, reporting and use cases
- Defined approaches and processes for data use to drive policy and program analysis and decision-making

The Peterson-Milbank Program has also noted that there must be mechanisms put in place to hold payers and providers accountable for not exceeding benchmarks, which can pose policy challenges. Oregon recently adopting legislation to impose financial penalties when performance improvement plans do not achieve compliance. However, it's program is integrated into is ground-breaking comprehensive Medicaid redesign and Delivery System Reform and Improvement Plan (DSRIP) which was designed and implemented with broad stakeholder involvement over a multi-year timeframe. As part of program development, the state's Medicaid cost growth target was expanded to cover state employees and teachers as part of the creation of a cost growth benchmarking program to cover all state health care spending. The state is planning to leverage the program to improve health care transparency and cost containment.

Each of the states which have implemented these programs have built operational infrastructure to support their efforts. Massachusetts created two new agencies—the Center for Health Information and Analysis (CHIA) and the Health Policy Commission (HPC)—to monitor and respond to health care cost drivers. Delaware's program is run by a subcommittee of the Delaware Economic and Financial Advisory Council (DEFAC). Rhode Island's program is jointly operated by the state's Office of the Health Insurance Commissioner (OHIC) and Executive Office of Health and Human Services (EOHHS).

California's 2021 budget included provisions to establish a similar program in the state. The state's Office of Health Care Affordability will be charged with "increasing transparency on cost and quality, developing cost targets for the health care industry, enforcing compliance through financial penalties, and filling gaps in market oversight of transactions that may adversely impact market competition, prices, quality, access, and the total cost of care. The program is even more expansive than that implemented in some of the other states, serving as a cornerstone for the state's comprehensive health strategy.

Administrative Efficiencies

Targeted Cost-Containment Initiatives: Finally, states have implemented initiatives to improve efficiency, management, and oversight of public employee health benefit purchasing. Many states have implemented targeted programs for more effective management of chronic and high-cost diseases and behavioral health services. These include both disease management and complex case management programs as well as strengthened requirements for prior authorizations or referrals.

TPA Contractual Incentives: According to the Georgetown University Health Policy Institute Center on Health Insurance Reform nearly all of the states that responded to their nationwide survey noted that the common practice of contracting with third-party administrators (TPAs) and other vendors to perform a range of functions (also used in New Mexico) makes it difficult to reform program administration. With TPA's creating an additional layer between the state purchaser and providers, some states are now contractually incentivizing their TPAs to implement cost containment initiatives, including financial penalties if they fail to meet a savings target. However, numerous states also noted that many TPA contracts include barriers to accessing claims data from their TPAs making it difficult to monitor performance in these areas.

Claims Auditing: Georgetown University's nationwide survey identified thirty states that audit claims for inappropriate utilization or fraud. However, the scope of these programs varied, with only a small number of states implementing regular claims recovery audits as are standard practice in commercial health plans, private sector self-insured employers, and federal health programs, including both Medicare and Medicaid. We were able to identify at least one state, Nevada, which has conducted in-depth, independent performance and financial management audits as part of its oversight of the employee benefit program. New York has also performed claims recovery audits for its pharmacy benefit program.

Preliminary Reform Recommendations

Highlights

- We propose that program reforms be implemented through a phased, ongoing process
- Reforms should include changes to the structure, management, and oversight of public employee health benefit purchasing in the state
- Specific reforms should be implemented to provide key foundational elements required for the effective management and oversight of a modern employee benefit program
- Additional reforms should be made to support enhanced cost management and greater visibility for the Legislature and other decision makers into benefit cost trends and performance
- These Additional reforms can be applied to ALL entities, public (Medicaid, Medicare, and the Marketplace Exchange beWellNM as well) and all private commercial insurance to benefit all New Mexicans. There are four state models for this – Massachusetts, Connecticut, Oregon, and California – and more currently adopting.

One of the most significant conclusions of this analysis of existing New Mexico health benefit purchasing programs, as well as nationwide reforms efforts is that significant improvements should be implemented in a phased approach. This allows time for engagement of key stakeholders, implementation of key infrastructure and programs, and design of benefit programs that improve enrollee health and integrate industry best practices while supporting the state's goals to attract the best talent to serve the people of New Mexico. Modernizing health care purchasing, predictability of costs, building sophisticated health analysis, developing oversight capacity, and ensuring robust benefits at a fair and reasonable cost to both the state and employees would be a positive goal. With that approach and anticipated timing in mind, we recommend the following key enhancements to current public employee health benefit purchasing.

Participation

The Legislature should strengthen requirements for agency opt-out of joint purchasing. At present, only the state General Services Department, the state employee retirement program, and the Albuquerque Public Schools are required to participate in the IBAC, with no option to opt out. Although NMPSIA is a required participant, all of the individual participants in NMPSIA have the option to opt out under specified conditions, rendering NMPSIA's required participation essentially moot. The state government's purchasing pool is affected by a similar set of conditions, since all local government participants have the option to opt out under specified circumstances. The effect of these provisions has been pronounced, with a continued loss of participants in what was originally envisioned as a consolidated state and local government health benefit purchasing pool, and a resulting diminishment of IBAC's strategic sourcing leverage.

All of the IBAC entities, with some exceptions for RHCA, and all 29 institutions of higher learning should be consolidated into one large pool of beneficiaries to leverage the insurance law of large numbers. County, municipal, and city governments could voluntarily join, as many currently do. The cost, fairness, and attractiveness of such a large pool should induce them to enter. The legislature should also require commitment to remaining in the pool for a specified timeframe. Greater consistency in plan design

across all agencies could also ensure that all participants are receiving benefits of the same actuarial value regardless of the agency for which they work, or the area of the state in which they live.

The Legislature should modernize the structure, membership, and procurement processes of the IBAC or its replacement, consistent with best practices in use by other states. Specifically, we recommend formalizing the legal structure, agency representation, required reporting, transparency requirements, and state oversight. This will support greater visibility into the functioning of the entity and greater accountability to state decision makers regarding the expenditures of the public funds which are made available to its participants through annual appropriations.

As part of this restructuring, we recommend the inclusion of specific requirements for ongoing reporting (at least quarterly) of key health benefit utilization and cost trends to a responsible oversight body, development of annual health benefit cost projections, analysis of annual cost trends, consistency of health benefit actuarial value across all participants and regions, and recommendations for health benefit program enhancements to improve health outcomes and costs. This would formalize statutory requirements for annual reporting on health benefit plan performance to the Legislature. It would also support annual budgeting for health benefits expenditures in the appropriations process.

We also recommend creation and funding of operational infrastructure, with appropriate highly experienced staffing to support the requirements of a modernized consolidated purchasing entity. Currently, the IBAC functions by rotating the chairmanship of the committee between the four required participants. Staffing and support for all required activities is then entirely dependent on the available of trained and experienced staff within that organization, an arrangement which is unusual for a body that is responsible for hundreds of millions of taxpayer dollars annually. Similar entities in other states have defined highly experienced staff, competitive compensation, and resources to support their regular activities.

Required Activities

To support modernized and strengthened oversight of New Mexico public employee health benefit purchasing, the IBAC, or its successor entity should be tasked with ongoing monitoring and reporting of health benefit expenditures, regular analysis of health benefit program design against best practice and trends in other states, monitoring of program quality outcomes and costs, development of annual projections of anticipated costs, recommendations of changes to benefit and program design to improve the health of public employees, and development of a recommended annual benefit cost increase for the program.

In support of these activities, all public employee health benefit programs should be required to submit claims and utilization data to the state's All Payer Claims Database (APCD). IBAC staff, or its successor entity, as well as participating agencies should be provided access to the Database to support program analysis, reporting, and actuarially sound reimbursement rates.

The IBAC and its staff should also have responsibility for annual conduct of claims recovery audits for all its health benefit plans, both medical and pharmaceutical. Additionally, the Department of Finance or the OSI should be responsible for conducting a financial and operational performance audit of the IBAC and its activities at least bi-annually. The IBAC, or its successor entity, should also be responsible for the development of required requests for proposal (RFP) and conduct of the procurement process. All RFPs should include:

- Actuarially-sound reimbursement rates for all required services based on Medicare reference pricing and excluding all percent of billed charges pricing (except perhaps for what Medicare does not delineate).

- Vendor agreement to participate in and accept the results of required annual claims recovery audits
- Vendor agreement to provide claims, utilization and other data as required to support timely and accurate availability of data for the APCD
- Vendor agreement to participate in regular financial and operational performance audit
- Vendor participation in annual performance risk-sharing programs
- Benefit design features to support employee benefit cost transparency and incentivize member health improvement
- And other requirements as deemed appropriate to support best value for the state and public employee participants.

The IBAC and its staff should have responsibility for completing an analysis to benchmark benefit programs and program results against best practice in other states prior to each procurement cycle. Results of that analysis should support enhancements to existing health benefit programs and coverage.

Oversight

We recommend that the Legislature formalize requirements for regular and ongoing oversight of IBAC, or its successor agency, including clear definition of the state level body responsible for oversight, and remedies available to that oversight body in the event of unsatisfactory reporting or performance (similar to performance improvement plan processes in use for Medicaid and Medicare managed care participants). This should include specific authority to require changes in program design or functioning to ensure the program is financially sustainable for both public workers and New Mexico taxpayers. This would include defining an approach for the setting of an annual health benefit program cost growth target each year as part of the annual appropriation process. The IBAC, or its successor entity should be required to abide by all state transparency and open meeting requirements including posting of meeting minutes, decisions made, and actions taken.

Benefit Program Assessment

As a continuing part of this project, Senator Hickey and the working group will oversee a detailed analysis and benchmarking of existing state employee health benefit programs, with evaluation against best practices in other states. This will include an assessment of the state's current self-insured model for benefits procurement versus the use of fully insured benefit program alternatives. The review, which will be conducted under an existing OSI contract with the Milliman actuarial firm will specifically include a comparison of existing benefit programs to current and best practice for public employee benefit programs across the country. The analysis will be conducted using Miliman's multi-state benefit database. Early thinking on potential improvements to program design may include:

- Employee benefit rate tier design
- Value-based purchasing requirements
- Quality and outcomes incentive programs
- Integrated medical-behavioral-pharmaceutical care and care management
- Integration of digital tools and telehealth to expand access to care
- Member and provider incentive programs

Additionally, the GSD will continue working with its actuarial consultant to complete detailed analyses of current and projected future cost trends and work with its vendor partners to identify and implement program improvements under existing the existing contract.

The goal of both of these ongoing efforts will be to integrate best practices and new program features in a one year rebid of health benefit contracts in advance of the more comprehensive changes envisioned for the state's approach to health benefit purchasing.

Develop and Issue New RFP for a One-Year Benefit Program

Building on enhancements identified through the benefit program assessment noted above, legislative reforms and identified program enhancements, all IBAC participants will develop a new RFP which integrates best practices and supports stable financial performance for RFP procurement duration for one year.

Evaluate Options for Pool Design and Increased Participation

The Legislature should evaluate options to enhance coverage and improve affordability for low-income employees and their dependents through the expansion of the CHIP program to allow participation for state and local employees up to 400 percent of the poverty level. This may require modifications to the Medicaid State Plan or waiver applications and should be evaluated relative to overall coverage for low-income families and children in the state.

While the Health Care Purchasing Act was originally intended to tap the program innovation and negotiating potential of the largest possible pool of state and local employees, that potential has failed to be realized. As part of program reforms developed through the work of Senator Hickey's IBAC working group, we recommend continuing to outreach and engage those government entities not currently participating in the program.

The stated purpose of the Health Care Purchasing Act (Act) is to ensure **access** to more affordable health insurance benefits for public employees and retirees. The Act *requires* consolidated "purchasing efforts". The affected agencies and public employee purchasing entities (e.g., public schools, counties, municipalities) have implemented this mandate by simply seeking **procurement** collaboratively, but not using both market dominance with its competitive benefits, and pooled health risk to obtain a single health benefit plan for all public employees.

What is lacking in the implementation of the Act is for the state to consolidate purchasing of health benefits for all New Mexico public employees with a single health benefit plan. If agencies and public entities combined their purchasing, and not just procurement, it would achieve the goal of the Act which is to ensure enhanced benefit plan at an affordable cost.

The Act is dynamic, and benefits have been amended in 2003, 2007, 2009, 2011, 2012, 2013, 2015, 2018, 2020, and 2021. But legislative review and recommendations by LFC regarding the structure and effectiveness of the Act, or analysis of the current policy allowing public employee groups to purchase separately and outside of the Act has **not** resulted in statutory changes to the structure, reporting or transparency requirements of the State's multi-billion dollar contracting expenditure.

The Act could be improved by requiring a single health benefit plan for all public employees and also providing a structure for oversight, accountability and transparency of group purchasing.

Timing of Legislation

Recognizing these goals, we propose the following elements and timing of legislative reform efforts.

Year One Legislation to Streamline and Modernize Benefit Program Administration

The IBAC working group, led by Senator Hickey will be developing legislation to identify and address issues and weaknesses in existing Consolidated Purchasing as defined in the Health Care Purchasing Act

and NM Stat 10-7-4 which, together govern health benefits procurement, compensation, and program oversight. Proposed year one reforms include:

- OSI to complete analysis of health benefits program benchmarking and development of recommendations for best practice benefit program design via the current consultants and existing Milliman contract
- Limitation of the new IBAC RFP due out in June 2023 to just one year. This will allow many of the above recommended reforms to be placed into a new far reaching public employee health benefits purchasing and oversight entity for FY 2025.
- Completion of claims recovery audit of GSD, NMPSIA and APS health benefit program claims (medical and pharmaceutical) and implementation of ongoing formal requirements for annual claims recovery audits for all agencies for medical and pharmaceutical claims. The claims recovery audits should cover a period of at least two prior contract years.
- Formalize requirements for GSD and any future healthcare authority to establish vendor health outcomes and costs performance targets in all future contracts
- Formalize management and oversight of the design and implementation of the state's all-payer claims database and ensure mechanisms to capture and analyze and report claims and utilization data for all state and local health benefit purchasing programs
- Each agency shall establish annual cost growth targets and generate quarterly assessments of target acquisition to be reported to the Legislature.
- **Complete analysis of the opportunity to provide coverage of child beneficiaries (up to age 19) currently in APS, NMPSIA and RM/GSD to the S-CHIP program as 15 other states have done. CHIP benefits are generally richer than current public employee benefit programs and could potentially generate a very favorable federal contribution to the state and potentially save the state substantial dollars for dependent coverage.**

Year Two Legislation to Enhance Existing Health Benefit Programs and Fiscal Management

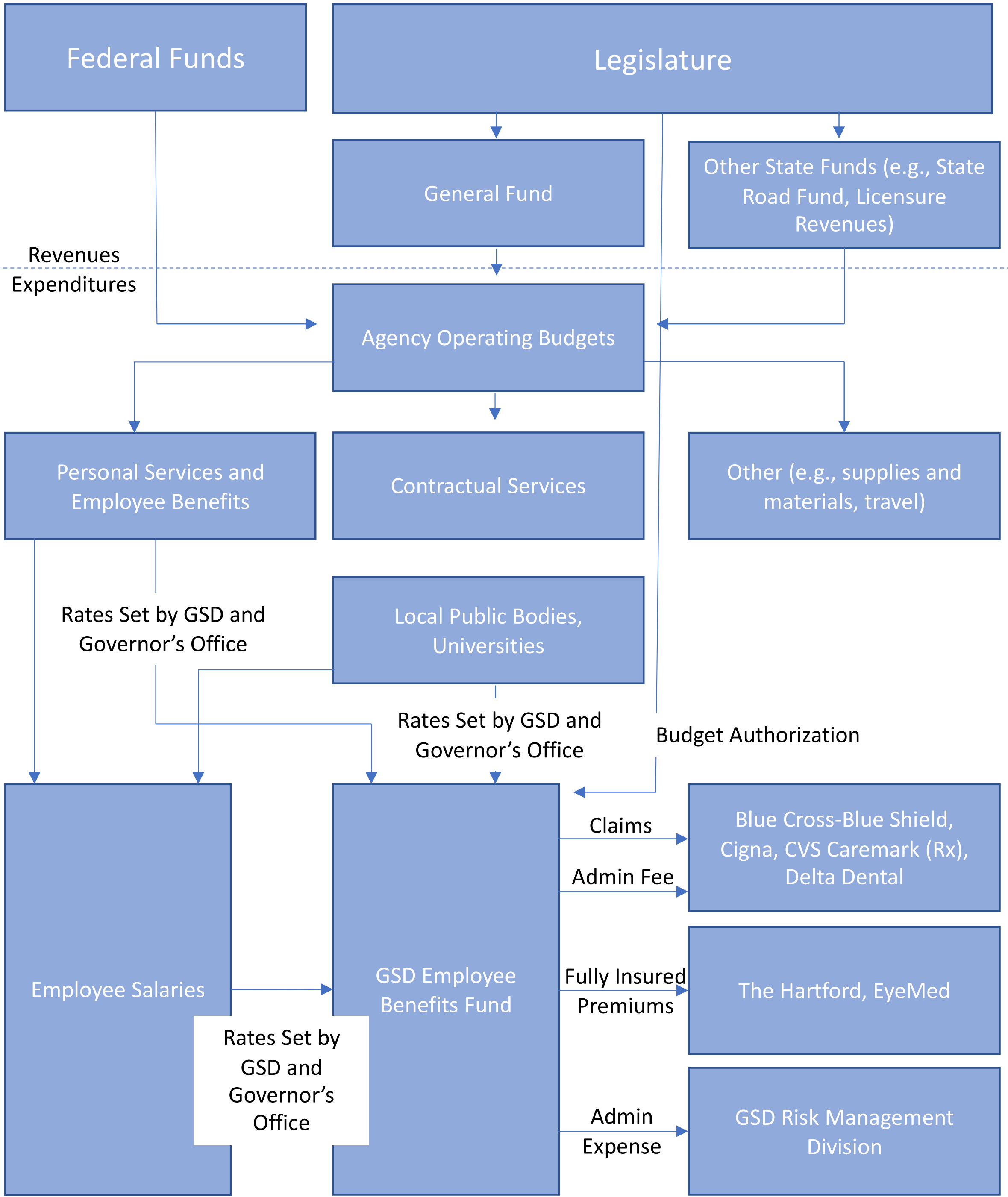
- Establish new consolidated state and local health benefit purchasing and oversight body based on best practice in other states
- Complete legislative analysis and reporting on current health benefit funding and budgeting process, employer/employee contributions, and actuarial value of benefits across all IBAC agency participating beneficiaries and regions of the state.
- Establish method and process for annual health benefit growth target and the setting of actuarially sound health benefit reimbursement rates
- Develop new standard benefit package that provides fair and uniform benefits across all agencies, regions, and beneficiaries
- Partner with local government entities to develop proposals that will encourage increased local government participation to increase pool size
- Clarify current program requirements to ensure use of consolidated purchasing pools, with participation of all agencies, as intended by original 1997 legislation
- Change procurement practices to increase benefits of consolidated purchasing and enable reverse auction contracting
- **Initiate creation of a State Health Authority to collect all healthcare cost/claims and healthcare status improvement data, analyze the data and apply findings to update state policy for maximized health status (individual and population based) improvement. Data and analyses should cover all public employees, all Medicaid recipients, all Medicare eligible, all beWell beneficiaries, and as possible uninsured.**

Appendices

Appendix A: Public Employee Health Benefits Funds Flow

Appendix A.1

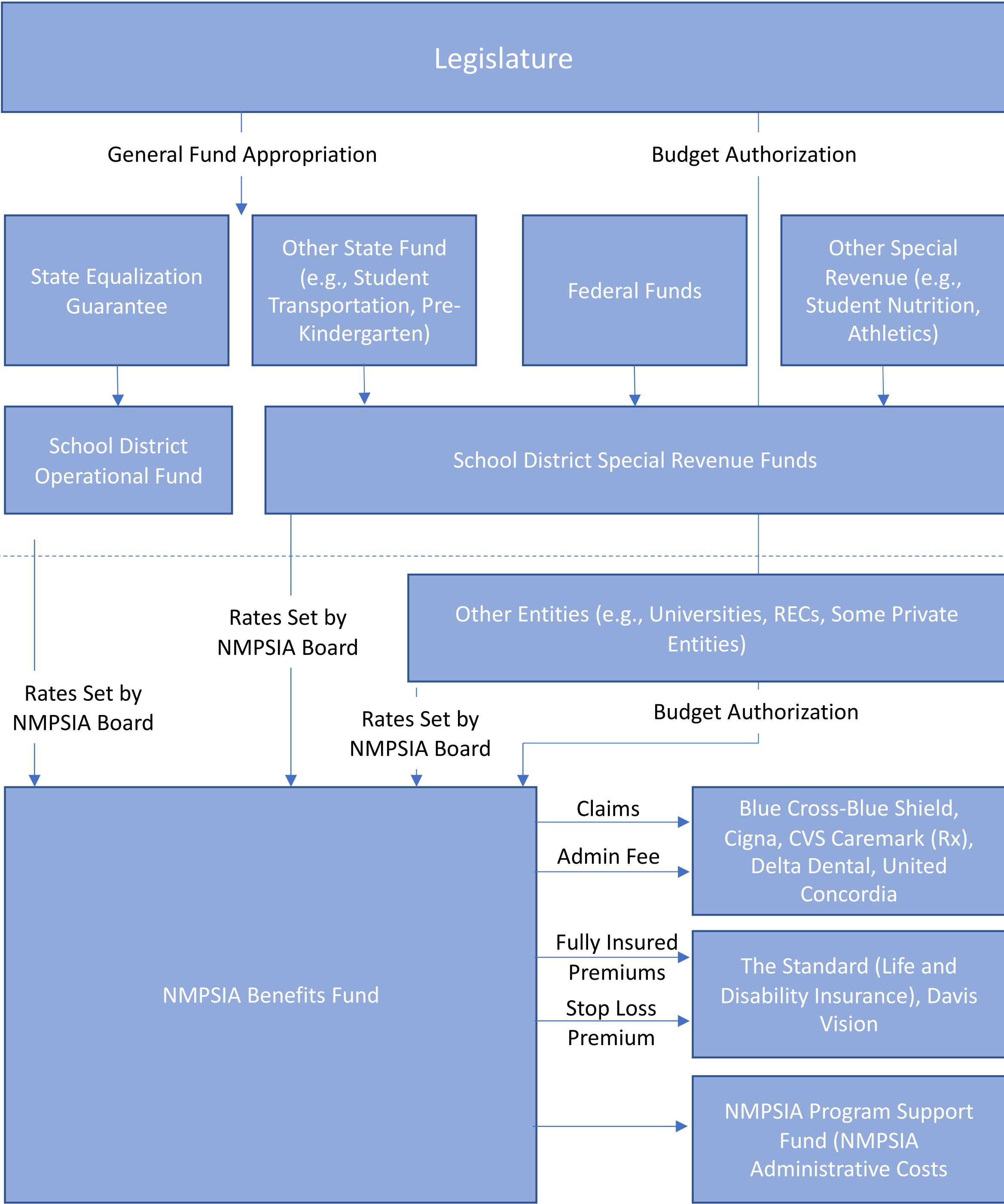
SONM Employee Health Benefits Funds Flow



Source: Legislative Finance Committee

Appendix A.2

NMPSIA Employee Health Benefits Funds Flow



Source: Legislative Finance Committee

Appendix B: Selected Background Research Reports

Appendix B Content Summary

Appendix A contains a compilation of selected background research reports, from academic institutions, foundations, and recognized experts, and which were used in the development of this report. We provide the following brief descriptions of each report. The reports themselves are being provided as a separate document.

1. Report 1: “Unleashing the Giant: Opportunities for State Employee Health Plans to Drive Improvements in Affordability”, Prepared by Georgetown University Health Policy Institute Center on Health Insurance Reforms, June 2021

   The report is a compilation of the results of a 47-state survey of public employee health benefit coverage, and discussion of the many enhancements and reforms that have been implemented in those states.

2. Report 2: “Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power”, National Academy for State Health Policy, April 2019

   The report summarizes recent innovations implemented by selected states to increase contracting leverage, reduce costs, and improve outcomes. The report specifically discusses formation of multi-state and multi-agency purchasing collaboratives and reforms to provider contracting.

3. Report 3: “State Benchmarking Models: Promising Practices to Understand and Address Health Care Cost Growth”, Manatt, June 2021

   The report summarizes current efforts to develop claims and costs transparency tools and infrastructure, as well as the use of those tools to benchmark and establish targets for state health care cost growth.