

**MINUTES  
of the  
FIRST MEETING  
of the  
PUBLIC EMPLOYEE BENEFITS OVERSIGHT SUBCOMMITTEE  
of the  
LEGISLATIVE COUNCIL**

**July 12, 2005  
State Capitol, Room 317  
Santa Fe, New Mexico**

The first meeting in 2005 of the Public Employee Benefits Oversight Subcommittee of the Legislative Council was called to order by Representative Ben Lujan, chair, on Tuesday, July 12, 2005, at 10:13 a.m. in Santa Fe in Room 317 of the State Capitol.

**PRESENT**

Rep. Ben Lujan, Chair  
Sen. Dianna J. Duran  
Sen. John T.L. Grubestic  
Rep. Ted Hobbs

**ABSENT**

Sen. Lidio G. Rainaldi  
Rep. Sheryl Williams Stapleton

**Advisory Members**

Rep. Ernest H. Chavez  
Rep. James Roger Madalena  
Rep. Teresa A. Zanetti

Sen. Sue Wilson Beffort  
Sen. Leonard Lee Rawson  
Sen. James G. Taylor

**Staff**

Pamela Ray  
Tim Crawford

**Tuesday, July 12**

**Work Plan, Schedule and Budget Review**

The Public Employee Benefits Oversight Subcommittee reviewed its work plan presented by Pam Ray, staff attorney, Legislative Council Service, and adopted the following provisions unanimously:

The subcommittee shall receive public testimony and review:

- (1) the statutes, constitutional provisions, regulations and court decisions governing the benefit plans provided by the New Mexico Retiree Health Care Authority (NMRHCA), the Public School Insurance Authority, the Albuquerque Public Schools benefits program and the state group benefits program;
- (2) the present and future costs of maintaining the programs;
- (3) present enrollment, trends in enrollment over the last five years and projected

future enrollment;

(4) comparative premium burden with similar benefits programs;

(5) benefits coverage changes;

(6) cost shifting used to maintain lower premiums, such as higher deductibles and increased co-pays;

(7) balancing enrollment of younger and older members to ensure continued fund health;

health;

(8) actuarial soundness and performance of program funds and terms of actuarial analyses;

analyses;

(9) investment of reserves and premium funds and a five-year comparison of return on the investment of the reserves and premium funds;

return on the investment of the reserves and premium funds;

(10) extent and effect of participation required by statute or lack of statutory requirement to participate in benefits programs;

requirement to participate in benefits programs;

(11) contractual relationships with third-party providers, administrators and agents;

agents;

(12) participation by counties and municipalities, arguments for and against;

(13) current board members, consultants and conflicts of interest;

(14) report on the small employers' participation program administered by the General Services Department (GSD);

General Services Department (GSD);

(15) extent and purpose of expenditures by health plans that are not related directly to benefit coverage;

directly to benefit coverage;

(16) size of reserve funds and source of indemnification if reserves prove inadequate;

inadequate;

(17) legislative proposals affecting benefits programs; and

(18) any other pertinent area of inquiry that arises during the course of reviewing information presented to the subcommittee.

information presented to the subcommittee.

The subcommittee will meet for four additional meetings in 2005. All meetings will begin at 10:00 a.m. and will be held in Room 317 of the State Capitol in Santa Fe. The meeting dates are:

Monday, August 8, 2005

Thursday, September 1, 2005

Wednesday, October 19, 2005

Monday, November 14, 2005.

### **General Services Department — Group Benefits Programs**

Ed Lopez, secretary of general services, presented information about the group benefits programs administered by the Risk Management Division (RMD) of the GSD. Manuel Tijerina, acting director, RMD, GSD, and Don Gonzales, deputy director, RMD, were also present to answer questions as needed. The package of materials provided to the subcommittee is available in the meeting file.

Secretary Lopez identified the participants in the group benefits programs as employees of local public bodies, 72 of which are members of RMD programs. These include state

employees, counties, incorporated municipalities and others such as housing authorities, soil and water conservation districts and regional educational cooperatives. Small businesses will soon be included in the programs also.

Benefits plans offered include:

- medical insurance, administered by Cigna, Blue Cross/Blue Shield and Presbyterian;
- prescription drug coverage by Express Scripts;
- dental coverage provided by Delta Dental;
- legal coverage;
- group life insurance (basic, supplemental and dependent, both term and whole life);
- vision insurance;
- flexible spending (a new transportation benefit);
- employee assistance;
- disability; and
- long-term care insurance.

Secretary Lopez further noted that more than 60,000 people are served by the group benefits programs of the RMD and the programs are self-insured. The contracts include "most favored nation" provisions that require that services be provided by the administrators at the lowest rate provided by the contractor to any other organization purchasing services from it. GSD sets its own rates, hires outside auditors to perform program audits and provides enrollment administration for all of the local public bodies. This number includes both employees and their eligible dependents. He discussed the rising costs of health care and noted that the national rate of increase in health benefit programs is 10 percent to 14 percent per year. The increase in the cost of health benefit programs in fiscal year 2005 and projections for fiscal years 2006 and 2007 are as follows:

<u>FISCAL YEAR</u>	<u>PERCENT INCREASE</u>
2005	11%
2006 (budgeted)	5%
2007 (projected)	7%.

GSD is required by the Health Care Purchasing Act to cooperate through the Interagency Benefits Advisory Committee (IBAC) with the NMRHCA, the Public School Insurance Authority and the Albuquerque Public Schools benefits programs to purchase administration of their benefits programs. GSD has an independent RFP for benefits not common to IBAC programs. The contract with the administrators is for a four-year period. Copies can be supplied to the subcommittee upon request.

The RMD is required to keep all funds actuarially sound, even though they are backed by the state general fund. Money in the fund comes from contributions from employees and employers and from earnings on the fund. This is an enterprise-funded activity of GSD; no general fund money is appropriated to operate the benefits programs. The benefits programs have not run into financial difficulties because they can raise contribution levels as required to

meet the program costs and GSD can also reach out and increase the number of members and reduce overall costs by taking in new member local public bodies. Local public bodies sign on with the state to:

- reduce premium rates;
- shift administration to GSD and its third-party administrators; and
- provide more and better benefit programs than they can purchase individually.

GSD has also been able to make the plan more attractive by reducing deductibles for primary care while increasing deductibles for emergency room care. This shifts people into seeing their primary care physicians for preventative care while reducing emergency care due to failure to seek preventative care. The ability of GSD to hold down premium increases is also very attractive to local public bodies that are offering benefits through third-party insurers.

Some counties and municipalities have chosen not to participate. Larger municipalities and counties are many times self-insured and do not participate in the state programs. Savings are more likely realized when a municipality or county must contract with a third-party insurer. Seventeen new public bodies joined the GSD program in 2004. The definition of "local public body" excludes nonprofit organizations and tribal governments. GSD has been actively promoting membership in the state benefits programs to spread the risk and reduce costs. The New Mexico Municipal League offers risk insurance such as liability and property damage for municipalities, but it does not offer medical and ancillary health programs. Legislators may participate in the GSD benefits programs but are required to pay 100 percent of the premium cost. Fewer than 20 legislators have chosen to participate in the plan. The Public Regulation Commission does not regulate the benefits programs of GSD because GSD is not an insurance carrier. The benefits programs are self-insured.

The small employers' benefits program is in the process of determining how it will capitalize the plan. In addition, eligible employers have to be identified. They must not have had insurance coverage for one year or more prior to applying to the state plan.

The speaker asked for more information in the future on the rate stabilization reserve.

### **Retiree Health Care Authority Benefits Programs**

Milton Sanchez, director, and Dr. Christine L. Tessmann, deputy director, both of the NMRHCA, presented information about the NMRHCA benefits programs. Mr. Sanchez described the benefit program of the NMRHCA. Materials provided to the subcommittee members are in the meeting file. The NMRHCA Board has 11 members. The New Mexico Association of Counties was recently added as a member to the board. There are approximately 36,000 members served by the program. About 12 of the members are retired legislators. Enrollment is not mandatory. Of the 36,000 members served, 2,500 are enrolled in ancillary plans only, not in the medical plan. Since 1996, 18 or 19 employers have been added to the membership. The NMRHCA also offers a senior prescription drug program and is currently determining how it will interface with the Medicare Part D proposal from the federal government

that will go into effect soon. The coverage will follow members and serve them in their communities or wherever they travel.

The total projected income for NMRHCA for fiscal year 2006 is \$142.4 million. Twenty-eight percent of the total projected revenue is expected to come from participating employers, or \$40.12 million. Full-time employees will contribute approximately 14 percent of total revenue, or \$20.06 million. A distribution from the Tax Administration Suspense Fund provides an estimated six percent of NMRHCA total revenues, or \$8.5 million, which was initiated in the 1990s when the state retiree tax exemption was terminated due to a court decision that found the exemption was unconstitutional unless it was given to all retirees. Retirees who are enrolled participants pay 48 percent of the total revenue of NMRHCA, which is approximately \$68.6 million. The total percentage of medical, pharmacy and basic life insurance paid by retirees is 41 percent and retirees pay 100 percent of the premiums of voluntary plans (dental, vision, supplemental life insurance and long-term care).

As of July 1, 2005, contribution rates have increased. Employers will be contributing 1.3 percent of their payroll. Employees pay 0.65 percent of their salaries. The distribution from the Tax Administration Suspense Fund is increased by 12 percent annually.

The average annual contribution of an employee is \$208. The average employer and employee contribution is \$624 annually, per employee.

Deficits that occur in the program can be covered by the money in the program's trust fund, administered and invested by the State Investment Council. The current balance in the fund is \$138,635,829. This is within \$1 million of the projected balance for this year. It now looks like the fund will outperform expectations for the year.

When the NMRHCA was created in 1990, the program was expected to be insolvent by 1999. Changes were implemented that were predicted to keep the program solvent through 2006. In 1996, the program was again altered to provide solvency for a 25-year period. The performance measures for NMRHCA only require that actuarial soundness be projected for 15 years. Some projected assumptions regarding the Medicare population were not realized and now the projected solvency is for 24 years if modifications are made. However, an actuarial study in 1999 found the program to have an expectation of solvency only through 2012. The current changes were suggested and, due to their implementation and a better than expected return on investment of the funds, the current solvency projection exceeds 25 years.

Implementation of Medicare Part D (prescription drug benefits) will help to increase the soundness of the programs. This may occur in two ways. Some members may choose to use the federal prescription programs, which reduce the drug benefits costs to NMRHCA, and benefits for those who choose the NMRHCA drug plan may be redirected to the NMRHCA.

The self-insured programs are administered by Blue Cross/Blue Shield-New Mexico (BC/BSNM) or Presbyterian for the non-Medicare members. The programs are preferred

provider organizations (PPO). Deductibles and coinsurance payments are required for either administrator. The deductibles are for visits to in-network physicians who do not provide basic care and range from \$100 to \$800 depending on the level of contribution provided by the member. After the deductible is exhausted, then a percentage of 10 percent to 25 percent is paid for each visit as coinsurance, again with higher coinsurance amounts to obtain a lower member contribution. For the most frequently accessed services (doctors, urgent care and emergency room visits) a flat co-pay fee is retained. Medicare members also receive services administered by Lovelace Senior. Sixty percent of the NMRHCA members are Medicare eligible. The change to PPO plans caused some drop in satisfaction with the programs.

The average increase in plan costs to NMRHCA has been about 9.5 percent each year for the last three years. Increases in health care program costs nationally run 15 percent. For enhanced medical plans, NMRHCA did not increase the cost in fiscal year 2005 and some members will see their medical plan contributions decrease by an average of \$122. A four percent increase in membership is expected in fiscal year 2006.

NMRHCA is a member of the IBAC, as is the risk management benefits programs. The IBAC serves to allow cooperative purchasing of administrative services. NMRHCA chose to only engage two administrators, rather than three. BC/BSNM and Cigna use the same provider network, so NMRHCA felt it was not necessary to engage both BC/BSNM and Cigna. Claims now constitute the greatest expense of the program, averaging \$4,200 per member.

Employers that did not join NMRHCA in 1990 (the city of Santa Fe is a new member) are now required to buy into the program. Santa Fe is contributing \$2.5 million to join now. The required payment to buy in to the system may be paid over a 13-year period. Retirees of a member employer may enroll in the program as long as they are receiving pension benefits. If the retiree enrolls at retirement, no health statement is required. In addition, if the retiree returns to work and is covered by a health plan, then retires from that employment or has coverage involuntarily terminated, the retiree can also enroll with no health statement. Also, a retiree who is insured on a spouse's plan and then is involuntarily terminated from that plan may enroll without a health statement. Finally, if the retiree involuntarily loses individual coverage that the retiree purchased after retirement, the retiree will not be required to submit a health statement. However, if the retiree chooses to wait before enrolling and has no coverage or cancels coverage, a health statement will be required. Approximately 78 percent of retired PERA members enroll in the NMRHCA program. The remainder may choose not to participate because they are insured through a working spouse's program. Some people do not wish to expend the funds and rely on Medicare. Occasionally, a retiree returns to work and is covered by another medical program.

### **Adjournment**

The subcommittee adjourned at 12:35 p.m.