FISCAL IMPACT REPORT

SPONSOR	Stefanics/Muñoz	**LAST UPDATED**	
		ORIGINAL DATE	2/18/2025
SHORT TITLE	State Employee Health Benefit Contributions	**BILL NUMBER**	Senate Bill 376
		ANALYST	Chenier

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Salary Tiers/Deficit Reduction/Reference-Based Pricing		$68,300.0	$74,100.0	$142,100.0	Recurring	General Fund
Employee under 250 FPL/National Guard		$10,200.0	$11,093.8	$21,293.8	Recurring	HCAF

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

Relates to a supplemental appropriation of $85 million in General Appropriation Act

Sources of Information

LFC Files

Agency Analysis Received From
Health Care Authority (HCA)
State Personnel Office (SPO)
New Mexico Public School Insurance Authority (NMPSIA)

SUMMARY

Synopsis of Senate Bill 376

Senate Bill 376 (SB376) would eliminate existing tiered salary thresholds for employer premium contributions by requiring the employer contribution of the state or any of its executive, judicial, or legislative departments to be 80 percent. The bill also authorizes the Health Care Authority (HCA) to establish a reference-based pricing program for in-network or out-of-network hospital services while also prohibiting hospitals from charging additional amounts to employees above the reference-based price.

The bill requires HCA to submit its budget request so that it reflects actuarily sound rates.

Lastly, the bill would authorize HCA to use the health care affordability fund to subsidize the employee contribution for health benefits for employees up to 250 percent of the federal poverty level and cover benefits for members of the New Mexico National Guard who qualify for a federal TRICARE reserve select policy.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns if enacted, or June 20, 2025.

FISCAL IMPLICATIONS

SB376 Costs (millions)		
	General Fund	OSF
Eliminate Salary Tiers 80/20 Contribution	$48.3	
Eliminate Structural Deficit	$37.0	
Hospital Reference-Based Pricing	($17.0)	
HCAF Employee Under 250 FPL		$9.7
HCAF National Guard		$0.5
Total	**$68.3**	**$10.2**

HCA states the state health benefits plan provides coverage to state and local government employees and their families. As of January 31, 2025, 60,360 people were enrolled in the state health benefits plan, 36,433 of whom are affiliated with the state of New Mexico and 23,954 of whom are affiliated with a local public body. The state contributes a portion of premiums for state employees and local governments participating in the plan to establish their own contribution levels. In recent years, the fund has faced a significant deficit, in large part because the state has not established adequate rates to cover expenses. At the same time, the state covers just 65 percent of premiums on average, the lowest level in the nation, resulting in higher premiums for state employees.

HCA states cost savings to state employees under the bill would total about $36.3 million and employee premiums would be reduced by about 46.2 percent on average.

Likewise, the local public body's costs would be about $19.9 million in total, including a cost of $36 million to eliminate the structural deficit and a reduction in costs from reference-based pricing of $16.4 million.

SIGNIFICANT ISSUES

Several factors lead to the current situation in the State Health Benefits Program (SHB):

- New Mexico has continued to experience total health benefit program costs exceeding employee premium revenues since 2021 when the state first suspended employee premium increases.
- Financial deficiencies continued to grow during the two succeeding years (2022 and 2023) when the state once again suspended employee premium increases.
- The state once again implemented employee premium increases in FY24, taking the first steps toward reducing ongoing, annual deficits.
- However, at current trend, annual program deficits are expected to continue due to **both**:
    - The cumulative effects of three years of zero employee premium increases, and
    - Program medical cost trends that appear to exceed national trends.

Analysis of Benefit Program Shortfalls Due to Excess Medical Costs and Not Increasing Rates Annually (millions)						
	FY20	FY21	FY22	FY23	FY24	FY25
Revenue Increase		$0.0	$0.0	$0.0	$42.0	$35.2
National Medical Cost Trend		5%	8%	4%	7%	7%
Estimated Needed Revenue Increase at National Trend		$19.6	$29.2	$15.1	$30.4	$28.9
Annual Deficit Due to National Trend and Not Raising Rates		-$18.4	-$29.2	-$15.1	$11.6	$6.3
Cumulative Deficit Due to Not Raising Rates			**-$47.6**	**-$62.7**	**-$51.1**	**-$44.8**
Deficit Due to Excess Medical Costs			**-$40.7**	**-$40.7**	**-$92.8**	**-$79.4**
Total Deficit	**-$10.4**	**-$18.4**	**-$88.3**	**-$103.4**	**-$143.3**	**-$124.2**

- Plan medical costs reset at higher levels exceeding national trend in 2022 and then again in 2024 and 2025. Although the pandemic likely contributed to initially higher costs, it is unclear what has caused this permanent reset at higher levels. Typically, this could result from any of the following:
    - Specific high-cost claims for a limited number of beneficiaries, and with no mechanism to mitigate those unanticipated excess costs (stop-loss/reinsurance, mechanisms to negotiate single case agreements, benefit limits).
    - Program design or administration changes including benefit design, administrator contracts, reimbursement methods/levels, provider network design, utilization and care management practices, claims payment and management including adjudication and COB/TPL (coordination of benefits/third party liability) practices.

Monthly Per Member Per Month 7-2023 through 7-2024				
Category	BCBS	Pres	Dif	% Dif
Covered Lives	26,758	30,987	4,229	15.80%
Medical Costs/Covered Life	$759.25	$760.03	$0.78	0.10%
Administrative Costs/Covered Life	$23.08	$25.68	$2.60	11.30%
Total Costs/Covered Life	$782.33	$785.71	($89.52)	-10.20%
Revenue/Covered Life	$639.59	$556.62	($82.97)	-13.00%
Deficit/Covered Life	($235.64)	($229.09)	($6.55)	-2.80%

HCA provides the following:

Medicare Reference-Based Pricing for Urban Hospitals and Balance Billing Protections
The HCA plans to implement Medicare Reference-Based Pricing with urban hospitals for the SHB in FY26. This is a strategy adopted in, or being considered by, many other states (including Montana, Oklahoma, Oregon, South Carolina, and Washington) to manage state employee health plan costs. (After implementing Medicare reference-based pricing for hospital services, Oregon did not experience hospital closures or network exits). HCA would focus these efforts on urban hospitals to ensure rural communities that face greater access challenges are not negatively impacted. SHB pays hospitals, on average, three times what Medicare pays for the same services. Hospitals cite low payments from public programs as a reason for these higher rates paid by private insurers. According to a

Congressional Budget Office (CBO) analysis of data from the American Hospital Association, hospitals were reimbursed 144.8 percent of the cost of providing care for privately insured patients in 2018.

New Mexico is especially well-positioned to establish fair prices for the SHB, given the major investments in Medicaid provider reimbursement rates, including historic increases in hospital reimbursement rates through the Health Care Access and Delivery Act (2024), which reimburses most hospitals at the average commercial reimbursement rate for Medicaid patients. On net, New Mexico hospitals will receive $1.59 billion in FY26 under the 2024 act. These historic investments fundamentally reshape the landscape for how much a large employer like the State of New Mexico should pay hospitals for services provided under the state health plan, since investments in Medicaid reimbursement now match average commercial reimbursement rates.

When public payment rates reach these levels, it is reasonable for employers to negotiate rates that more closely align with hospital costs while ensuring improved access to care through the state's investments in Medicaid rates. As noted above, many states, even those without the investments made in New Mexico's Medicaid program, have adopted or are considering adopting reference-based pricing programs.

A major barrier to this proven cost savings approach is the practice of "balance billing" patients for the amount that the provider wishes to be paid above the amount the state sets as a payment maximum. SB376 ensures state employees and members of other [Interagency Benefits Advisory Committee] plans will not be penalized if an agency adopts reference-based pricing policies. HCA projects savings between $37.6 million and $39.5 million in SHB costs with reference-based pricing. According to the health research organization KFF, "Health care debt can have significant financial consequences, including having bills going to collections, lowering credit scores, and for some can contribute to bankruptcy, home foreclosures or evictions… Health care debt can have significant financial consequences, including having bills going to collections, lowering credit scores, and for some can contribute to bankruptcy, home foreclosures or evictions." According to Business Insider, medical debt remains the top cause of bankruptcy in the United States. Providing balance billing protections is critical to ensure that state can implement cost containment initiatives without risking the financial well-being of the state and local government workforce.

NMPSIA provides the following:

The New Mexico Public School Insurance Authority currently follows the tiers outlined in NMSA 22-29-10. At least eighty percent of the cost of the insurance of an employee whose annual salary is less than fifty thousand dollars ($50,000); at least seventy percent of the cost of the insurance of an employee whose annual salary is fifty thousand dollars ($50,000) or more but less than sixty thousand dollars ($60,000); and at least sixty percent of the cost of the insurance of an employee whose annual salary is sixty thousand dollars ($60,000) or more; with an option for members to contribute up to 100% of the premium.

NMPSIA breaks down membership into three categories: 1) School Districts and Charter Schools, which pay for premiums through the State Equalization Guarantee (SEG); 2) higher educational institutions, which pay for premiums through Instruction and General

Funding (I&G); and 3) Other Educational Entities, which pay for premiums from other revenues.

The table below displays the cost of bringing all NMPSIA members to an 80% contribution percentage. The first column, labeled Tier Difference Per Statute, is the amount needed if all institutions followed the statutory tier contributions. The second column, labeled Tier Difference Per Current Contributions, is the amount needed with members' current contributions.

SB376 Contributions	Tier Difference Per Statute	Tier Difference Per Current Contributions	Difference
School Districts and Charter Schools	$ 59,317,963	$ 36,683,759	$ (22,634,204)
Higher Educational Institutions	$ 5,483,748	$ 2,038,695	$ (3,445,053)
Total Educational Contributions	$ 64,801,711	$ 38,722,454	$ (26,079,257)
Other Educational Entities	$ 753,175	$ 387,448	$ (365,727)
Total	$ 65,554,886	$ 39,109,902	$ (26,444,984)

ALTERNATIVES

PSIA requests the changes made to tiers specified in Section E of the proposed bill to also be reflected in **Section 10-7-4 NMSA 1978 Section 1.C** to be amended to read, "The group insurance contributions of school districts and charter schools shall be eighty percent of the cost of insurance."

Section 22-29-10 NMSA 1978 Section A would also then require amendment for consistency and shall read, "Group insurance contributions for school districts, charter schools and participating entities in the authority shall be eighty percent of the cost of insurance."

EC/hg/sgs