Report
to
The LEGISLATIVE FINANCE COMMITTEE

New Mexico Health Insurance Exchange
Status of New Mexico Health Insurance Exchange Performance and Operations
October 28, 2015

Report #15-11

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David Abbey
Director

October 28, 2015

Mr. James R. Damron, M.D., Chairman
New Mexico Health Insurance Exchange
6301 Indian School Road NE, Suite 100
Albuquerque, NM 87110

Dear Chairman Damron:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the program evaluation of New Mexico Health Insurance Exchange (NMHIX). The evaluation assessed the status of NMHIX performance and operations; reviewed budget allocation and expenditures; and assessed the status of implementation, including planning, project management and oversight, and security components.

The report will be presented to the Committee and public on October 28, 2015. An exit conference was held on October 19, 2015, with NMHIX representatives to discuss the contents of this report. The Committee would like a plan to address recommendations in this report within 30 days of the release of the report.

I believe this report addresses issues the Committee asked us to review and hope your organization will benefit from our efforts. We appreciate the cooperation and assistance we received from your staff.

Sincerely,

David Abbey, Director

Cc: Senator John Arthur Smith, Chairman, Legislative Finance Committee
Representative Jimmie C. Hall, Vice-Chairman, Legislative Finance Committee
Timothy Keller, State Auditor
Dr. Tom Clifford, Secretary, Department of Finance and Administration
Keith Gardner, Chief of Staff, Office of the Governor
Brent Earnest, Secretary, New Mexico Human Services Department
John Franchini, Superintendent of Insurance
Amy Dowd, Chief Executive Officer, New Mexico Health Insurance Exchange

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An estimated 430 thousand New Mexicans did not have health insurance in 2012, almost one in five New Mexicans. The state sought to increase coverage, thereby improving the collective health and well-being of New Mexicans, by expanding the Medicaid program and establishing a state-based marketplace for buying health insurance under the 2010 federal Affordable Care Act (ACA). Enabling legislation to set up the entity responsible for developing and operating this private marketplace, or exchange, did not occur until 2013, impacting its implementation.

This evaluation assessed the status of the New Mexico Health Insurance Exchange (NMHIX) operations compared with key objectives and statutory requirements; reviewed budget allocation and expenditures; and examined the information technology (IT) planning, project management, oversight, and security components.

NMHIX has spent $78 million with limited benefits to taxpayers. Marketing was costly with low resulting enrollment, and the investments in IT did not result in a full implementation of the individual exchange.

Although NMHIX helped accelerate Medicaid expansion, enrollment in the exchange remains below estimates. The latest count sits at 44 thousand out of an estimated pool of 180 thousand qualifying residents and roughly 150 thousand eligible for subsidies. The state's penetration rate of 28 percent compares with the national average of 36 percent.

New Mexico is the only state-based exchange that did not initially implement its own marketplace and remains on the federal platform, HealthCare.gov. Three other states have moved or are considering moving from their dysfunctional platforms to this "federally-supported" model. NMHIX did implement its small business marketplace, enrolling 877 people as of March 2015 at a high cost of $21 thousand per person.

Governance structure holds risks for conflicts of interest and lack of transparency. Exemptions from most statutory and regulatory requirements likely led to procurement issues, noncompliance with federal rules, and higher costs. As remaining grant funding is spent, federal oversight has the potential to decline, leaving the NMHIX with little official review. Most notable, the NMHIX is not subject to the Audit Act.

Based on evaluation results, the report includes a series of recommendations to improve business processes, transparency, and outcomes. These include enhanced website content, comprehensive procurement procedures, added coordination with stakeholders for heightened outreach, revised IT oversight, and revised performance measures tied to enrollment. Costing an estimated $15 million a year to operate, options to restructure the NMHIX to reduce overhead might be needed if enrollment remains low.

The Legislature should consider amending statute to make NMHIX subject to the state Audit Act.

Percent Uninsured New Mexicans

Year	%
1999*	24.0%
2006*	22.7%
2012*	21.4%
2013** (Baseline)	20.2%
2014**	15.3%
2015 (June 30)**	13.1%

*Source: U.S. Census Bureau
**Source: Gallup-Healthways Well-Being Index

New Mexico Federal ACA Funding 2010-2015

Type	Amount
Planning Grant	$1,000,000
1st Level One Establishment Grant	$34,279,483
2nd Level One Establishment Grant	$18,600,000
3rd Level One Establishment Grant	$69,402,117
Total	**$123,281,600**
8/2015 Grant Reduction	($15,601,358)

Source: Grant Notices of Award

A final grant request of $98 million submitted November 2014 was denied.

The NMHIX did not complete the development of the individual marketplace and will remain on the federal IT platform.

KEY FINDINGS

While accelerating Medicaid expansion, New Mexico Health Insurance Exchange (NMHIX) enrollment for individuals remains low. New Mexico has historically had a high proportion of uninsured citizens, with the percentage trending down slightly due to population growth. To improve the collective well-being and health of citizens, the state chose to implement both pathways to coverage offered by the federal Affordable Care Act (ACA) enacted in 2010: expand Medicaid to 138 percent of the federal poverty level (FPL) and implement a state-based exchange for the private marketplace where people could comparatively shop for insurance.

A February 2015 Gallup-Healthways Well-Being Index indicates the ACA is working to reduce the number of uninsured. Medicaid expansion has enrolled 214 thousand people as of March 2015, surpassing the original estimate of 170 thousand while NMHIX enrollment remains below projections and might stall below a 65 percent to 75 percent benchmark. Hitting a high of 52 thousand at the end of the last enrollment period, subsequent attrition reduced that number to 44 thousand, 28 percent of an estimated 156 thousand population pool. New Mexico enrollment continues to trail national averages of comparable exchanges. Most experts signal a slowdown in ACA enrollment going forward, reducing the chances the NMHIX will catch up. Continued low enrollment might require restructuring the NMHIX to reduce costs.

Marketing and outreach efforts were costly with mixed results. The NMHIX spent $25 million on consumer assistance contractual services, with almost half spent on marketing, media, and advertising with uncertain value. Little evidence supports a continued reliance on this strategy to improve enrollment. At the height of a revised campaign designed for the first enrollment period, enrollment actually dropped. Furthermore, year-over-year new enrollment declined by 16 percent, although federal projections indicated it should double.

After five years and spending $85 million, New Mexico has marginally met key objectives for implementing its individual exchange and uncertanties remain. External factors, combined with NMHIX decisions, impacted outcomes. New Mexico implemented ACA requirements over five years, two administrations, three lead organizations, and four Executive Directors – two under the current NMHIX. Three crucial years passed from the Affordable Care Act in 2010 to the New Mexico Health Insurance Act (Act) in 2013, a mere six months before the first enrollment period. This delay was one factor in the NMHIX failure to implement its own individual exchange, although two other states with exchanges established the same year were more successful.

Grant requirements and inconsistent federal agency guidance also impacted board options. NMHIX based its 2015 budget on obtaining a final grant that was denied and did not have a revised 2015 budget until late August. While the ACA required state-based exchanges be self-sufficient by January 1, 2015, the Exchange has been working under the

Leasing the federal IT platform will cost NMHIX an estimated $5 million starting in 2017.

Summary of IT Services Contracts
(in thousands)

Vendor	Contract Amount	Total Paid*
GetInsured	$34,117.6	$27,495.7
Software Engineering Services	$746.9	$621.8
Public Consulting Group	$4,667.9	$4,552.1
NM Human Services Dept.	$17,968.0	$15,836.0
Total	**$57,500.4**	**$48,505.6**

Source: NMHIX
*as of March 31, 2015

NMHIX needs $1.5 million in annual funding for the SHOP exchange starting in 2015.

NMHIX estimated it will cost an additional $6 million to wind down effort for the individual exchange. According to NMHIX, these costs will be reduced.

assumed date of January 1, 2016. Whether New Mexico will have to repay any of the funding received is unknown.

Despite an investment of over $48 million, NMHIX abandoned implementing the individual exchange and small business enrollment remains low. Between the Alliance and NMHIX, the $48 million information technology (IT) investment in establishing the health exchange began in May 2013 and continues with system enhancements and maintenance. As of March 31, 2015, information technology services contracts total $57.5 million, with GetInsured's contract representing 59 percent or $34.1 million. GetInsured is the design, development and implementation (DDI) vendor. NMHIX reimbursed GetInsured $27.5 million for completing the implementation of the Small Business Health Options Plan (SHOP) and partial completion of the individual state-based exchange.

NMHIX spent $18 million to enroll 877 people in the Small Business Health Options Plan, with a cost per enrollee of $21 thousand. By March 18, 2015, the state-run SHOP exchange had enrolled 524 people, including 345 employees and 179 of their dependents. Nearly 1,500 small businesses initiated applications in the SHOP exchange by the end of 2013, and several thousand employee names had been entered into the system. However, by December 2014, total enrollment was around 800 people, increasing to 877 as of March 31, 2015. Considering open enrollment for SHOP continues on a rolling basis throughout the year, and the basic functionality of SHOP works, enrollment for small business remains low.

At a high cost of $21 thousand per enrollee, NMHIX planned to spend an additional $5.7 million on SHOP enhancements; however, CMS did not approve the request.

NMHIX spent $9 million for the implementation of the individual state-based exchange, with limited long term benefits to taxpayers. The board's July 2014 decision to delay the New Mexico individual state-based exchange implementation impacted GetInsured deliverables. In December 2014, GetInsured submitted a change request to revise the contract deliverables based on the board's decision to delay the implementation of the state-based exchange and remain on the federal exchange in 2015. NMHIX approved the change request without processing a contract amendment to reflect the changes. The Change Management Plan states parties will execute a formal contract amendment for any change order that increases or decreases the maximum amount or the maximum deliverable cost. NMHIX legal counsel stated a change request in affect amends the contract.

While New Mexico did not succeed in implementing its state-based exchange, three states that implemented state exchanges, moved to the federal exchange due to IT issues and financial problems. Initially, Nevada and Oregon implemented state-based exchanges but due to issues with IT vendor performance the federal exchange became more viable. In addition, due to non-compliance with ACA, including unresolved IT

issues, a non-integrated eligibility enrollment system, and lack of financial sustainability, Hawaii's health exchange will transition to become a federally supported state-based marketplace similar to Nevada, New Mexico, and Oregon.

GetInsured implemented health exchanges in other states while working on New Mexico's exchange. Initially NMHIX anticipated the state-based exchange to be implemented in eight to ten months. Although several NMHIX project documents point to leveraging other states' efforts, such as Mississippi and Idaho, LFC staff could not determine to what extent such leveraging was used. GetInsured completed exchanges for Idaho and Mississippi while under contract with New Mexico.

NMHIX did not require completion of some deliverables, typically critical to successful project management.

The lack of adequate IT project oversight provides incomplete reporting to the NMHIX board, hinders decision making, and increases project risk. Board meeting minutes indicate NMHIX provides limited information to the board on the status of IT. While there is indication an executive project dashboard is provided to the board, it does not reflect complete details on the status of the IT project. For example, independent validation and verification (IV&V) information is not included, and the dashboard does not provide how the project is tracking scope, schedule, cost, staffing, and quality, making the project reporting incomplete and not in line with best practices.

NMHIX did not follow best practices for independent verification and validation, increasing project risk and likely being ineffective. The IV&V vendor, Software Engineering Services (SES), began work in April 2014 after SHOP implementation in October 2013. NMHIX considers the SHOP implementation as Phase I and development and implementation of the Individual Exchange as Phase II. The NMHIX awarded a competitive contract for IV&V services in March 2014, nine months after the project management vendor and seven months after the IT and design, development, and implementation (DDI) services vendor. While SES IV&V processes follow best practices, IV&V information is not included in project status reporting to the NMHIX Board.

NMHIX has developed some IT policies and procedures and implemented well defined technical domain controls.

Without IV&V, application development for SHOP was not reviewed by a third-party and has the potential to result in deficiencies over time. Planning and obtaining IV&V services should begin early in the project's life. IV&V is most effective when integrated into the entire project life cycle, conducted in parallel with the project development activities.

NMHIX information security processes need improvement to ensure systems security and compliance with federal requirements and industry best practices. The Information Security Maturity and Compliance Assessment of NMHIX identified various gaps and lack of maturity in some of the internal management, operational, and security controls. The assessment evaluated the effectiveness and maturity of internal security policies and processes and mapped them to international information security standards and industry best practices. Information security processes need improvement to achieve a more secure information systems environment, a good level of compliance with industry best

NMHIX has not performed IT security risk assessments.

practices, and improve the level of security program maturity. LFC's IT consultant determined NMHIX's overall security program maturity level is 2.4 out of a possible score of 5, with a desired level of 3. The Gartner scale Level 3 is considered to be compliant with regulatory and best practices.

The 2014 HHS OIG audit of NMHIX identified vulnerabilities placing the confidentiality, integrity, and availability of NMHIX information at risk and could have allowed unauthorized access to sensitive consumer data. Vulnerabilities included data encryption, remote access, patch management, and USB port and device. The web application vulnerability scan revealed 64 vulnerabilities. In addition, the database vulnerability scan of the NMHIX database, which stores all sensitive user data, revealed 74 vulnerabilities. NMHIX provided corrective actions and implemented the OIG recommendations.

Although NMIX implemented some security controls, policies and procedures to prevent vulnerabilities in its web site, database and supporting information systems, its policies and procedures do not always conform to Federal IT requirements and National Institute of Standards and Technology (NIST) recommendations to secure sensitive information stored and processed by the NMHIX.

NMHIX does not have a formal documented comprehensive IT disaster recovery strategy or plan. NMHIX does not have a policy to direct the development, implementation, and testing of the disaster recovery (DR) plan for its local infrastructure. A disaster recovery policy establishes the framework for the management, development, and implementation, training, and maintenance of a disaster recovery program, ensuring a disaster recovery plan is developed, tested, and kept up-to-date. NMHIX stated developing a DR plan will be covered in the scope of work as part of the upcoming Project Management Services request for proposals (RFP) approved during the May 2015 board meeting.

NMHIX estimates an annual budget that will require carrier assessments of $10 million in 2016 and $15 million beginning in 2017.

The current governance structure lacks oversight, and transparency could be improved. New Mexico's law creating the NMHIX raises the risk of conflicts of interest for board members. While complying with the ACA by limiting the number of industry-affiliated board members, seven of the 16 state-based exchange states excluded personnel affiliated with the health insurance industry from participating on a governing board entirely. The Act does require board compliance with the Governmental Conduct Act but does not address potential issues arising from board members acting on behalf of their employers that might not benefit NMHIX.

Exemptions from most statutory and regulatory requirements likely contributed to procurement issues, noncompliance with federal rules, and higher costs. As grant funding subsides, federal oversight will decline, leaving the NMHIX with little official review. Most notable, the NMHIX is not subject to the Audit Act.

Going forward, the NMHIX sustainability plan assesses carriers for the cost of operations. In effect, it will act as a taxing authority with no

legislative or executive oversight except for board member appointments. Ultimately, the consumer will bear the cost of the NMHIX as the health insurance companies recoup this outlay through the premium setting process.

KEY RECOMMENDATIONS

The Legislature should consider amending the Act to:

- Improve oversight through requiring Office of the State Auditor review and approval of the annual audit;
- Improve transparency by requiring NMHIX reporting subject to the Accountability in Government Act and Sunshine Portal;
- Monitor enrollment and adopt alternate format for exchange administration if enrollment remains below a number justifying its current cost; and
- Provide more authority for the state's enterprise oversight of the New Mexico Health Insurance Exchange information technology projects. This would provide more authority to the state CIO's office and would equip New Mexico Health Insurance Exchange with the structure to ensure IT projects are carried out more effectively and economically in the future.

The New Mexico Health Insurance Exchange should:

- Establish quantifiable performance measures and targets, consistently monitoring and adjusting efforts as needed for a results-based approach to operations;
- Perform a risk assessment to identify key opportunities, such as regional or cooperative operations, as well as threats;
- Reduce costs;
- Reconsider marketing expenditures in favor of expanded hours or locations for walk-in centers and outreach efforts;
- Add health insurance literacy campaigns year-round;
- Improve transparency by revamping its website, adding content, and keeping it up to date;
- Develop administrative policies and procedures to detail the procurement process, from planning to product or service delivery, and train responsible parties;
- Develop a formal disaster recovery plan policy to include its local infrastructure; and
- Conduct a business impact analysis and risk assessment to determine the requirements for the disaster recovery plan.

Health Insurance Exchanges. Enacted March 2010, the federal Affordable Care Act (ACA) aims to extend health insurance coverage to about 32 million uninsured Americans by expanding both private and public insurance. Provisions in the ACA seek to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand health workforce, and curb rising health care costs.

The ACA requires most U.S. citizens and legal residents to have health insurance or pay penalties. The law provided two primary mechanisms for increasing insurance coverage: expanding Medicaid eligibility to include individuals within 138 percent of the federal poverty level and creating state-based insurance exchanges, or marketplaces, where individuals can purchase coverage. To make health insurance more affordable, the ACA offered premium and cost-sharing credits to individuals and families with certain incomes up to 400 percent of the federal poverty level (FPL). States were required to have exchanges for small businesses.

The ACA directed the U.S. Department of Health and Human Services (HHS) to establish a federally-facilitated marketplace (FFM) in any state that did not elect to establish a state-based exchange and in any state where it is determined by January 1, 2013, there will not be an operational state-based exchange by January 1, 2014. A state may also operate in partnership with HHS as a State Partnership Exchange, which provides states with the option to administer and operate exchange activities associated with plan management activities, some consumer-assistance activities, or both. States were required to have their health insurance exchanges up and running by the open enrollment period in October 2013.

States have either implemented a state-run health insurance exchange or let the federal government run the health insurance exchange for them. Some states have taken a variation on the approach by partnering with another state or the federal government. Currently there are 14 state-based exchanges with seven state-partnership exchanges and three federally-supported state exchanges, with the remaining states relying on the federal-facilitated market place. Mississippi and Utah have state-based Small Business Health Options Plan (SHOP) exchanges, using the federal exchange for individuals. Twenty-four out of 50 states have elected to have some form of a state exchange, including New Mexico. The rest rely on the federal exchange, HealthCare.gov.

Table 1. State Health Insurance Exchange Types 2015

State-based Exchange	Federally Supported State-based Exchange	State-Partnership Exchange
California	Nevada	Arkansas
Colorado	New Mexico	Delaware
Connecticut	Oregon	Illinois
District of Columbia		Iowa
Hawaii		Michigan
Idaho		New Hampshire
Kentucky		West Virginia
Maryland		
Massachusetts		
Minnesota		
New York		
Rhode Island		
Vermont		
Washington		

Source: Kaiser Family Foundation (as of June 30, 2015)

Current Snapshot of New Mexico Health Insurance Exchange. The New Mexico Health Insurance Exchange (NMHIX) Act created the NMHIX as a nonprofit public corporation, governed by a 13-member board of directors, consisting of voting members as follows:

- State Superintendent of Insurance or designee;
- Six members appointed by the Governor, including the Cabinet Secretary of the Human Services Department or designee, a health insurance issuer and a consumer advocate; and

- Six members appointed by the state legislature, including one health care provider and one health insurance issuer.

Currently, the NMHIX has 15 employees out of 17 staff positions. NMHIX staff and board are subject to the provisions of the Governmental Conduct Act, Inspection of Public Records Act, Financial Disclosure Act and Open Meetings Act, but as a quasi-state agency, are not subject to the Procurement Code or the Personnel Act. Statute requires the board to report quarterly to the legislature, governor and Superintendent of Insurance between July 1, 2013 and January 1, 2015—and report annually thereafter. The Act also requires the NMHIX to submit financial information annually to the Superintendent of Insurance and as required by federal law, and obtain an annual audit. NMHIX organizational information can be found online at www.nmhix.com.

NMHIX currently operates under the "Be Well NM" brand name, offering access to health plans on its www.bewellnm.com website for qualifying individuals through the federal exchange (HealthCare.gov) and small businesses with less than 50 employees under the ACA's Small Business Health Options Program (SHOP) since October 2013. A Spanish version of the individual website is available.

In New Mexico's SHOP marketplace, employers must cover a minimum of 50 percent of their employees' health care costs. If a business has less than 25 full-time employees, offers coverage to all full-time employees, has an average annual salary for all employees of less than $50 thousand and contributes at least 50 percent of premium costs for employee plans, the business may be eligible to receive a tax credit. Employers select a health plan metal level (bronze, silver, gold, or platinum) to offer employees, and select a reference plan on which to base their contribution for each employee. Employees can select any plan within the metal level offered by their employer, although they may have to pay more or less, based on the plan they choose compared to the reference plan.

HISTORY OF MAJOR EVENTS

2010	The federal Patient Protection and Affordable Care Act (P.L. 111-148) also known as the ACA signed into law. New Mexico Legislature created the Health Care Reform Working Group. Executive Order 2010-12 established the Health Care Reform Leadership Team. HHS Centers for Medicare and Medicaid Services (CMS) awards New Mexico $1 million planning grant.
2011	Governor Martinez vetoed legislation to establish a New Mexico state-based health insurance exchange. HHS- CMS awards New Mexico $34.3 million 1st Level One Establishment Grant.
2012	New Mexico Human Services Department submits Blueprint Evidence document to CMS.
2013	CMS grants New Mexico conditional approval to develop a state-based exchange. Laws 2013 established the New Mexico Health Insurance Exchange Act, repealing the New Mexico Health Insurance Alliance Act of 1994. The New Mexico Health Insurance Exchange (NMHIX) was created as a nonprofit public corporation, and established a board of directors with 13 voting members. HHS-CMS awards New Mexico $18.6 million 2nd Level One Establishment Grant.
2014	HHS-CMS awards New Mexico $69.4 million 3rd Level One Establishment Grant. NMHIX Board of Director's delay the implementation of the individual exchange until 2015. CMS notifies New Mexico its individual exchange was non-compliant, as it did not allow for a "single door design" and denies additional funding to implement technology design changes.
2015	NMHIX Board of Directors voted to remain on the federal-facilitated market place (HealthCare.gov) and forgo implementation of an individual state-based exchange. The U.S. Supreme Court ruling in the *King vs. Burwell* upholds health law subsidies.

Funding. HHS issued grants to states under ACA Section 1311 to establish health insurance exchanges. By the end of federal fiscal year 2014, HHS had awarded nearly $21.4 billion in grants to agencies and organizations across all states and the District of Columbia. As of January 2014, HHS Centers for Medicare and Medicaid Services (CMS) has awarded New Mexico $123.3 million, of which $23 million remains for use in 2015 after a grant reduction of almost $16 million executed in August. CMS awarded initial grants to the Human Services Department (HSD) prior to the enactment of the New Mexico Health Insurance Exchange Act. HSD did not fully expend the first planning grant of $1 million.

Table 2. Federal 1311 NMHIX Grant Funding 2010-2015

Grant	Year	Amount Awarded	Amount Expended HSD	Amount Expended NMHIX 3/31/2015	CMS Grant Reduction 8/2015	Amount Remaining
Planning Grant	2010	$1,000,000	($880,753)	N /A		$0
1st Level One Establishment Grant	2011	$34,279,483	($6,685,513)	($27,593,970)*		$0
2nd Level One Establishment Grant	2013	$18,600,000	N/A	($18,600,000)		$0
3rd Level One Establishment Grant	2014	$69,402,117	N/A	($31,052,270)	($15,601,358)	$22,748,489
Total		**$123,281,600**	**($7,566,266)**	**($77,246,240)**		**$22,748,489**

Sources: Grant Notices of Award; HSD Final Federal Report and grant transfer memo; NMHIX

*Includes $11.4 million initially awarded to HSD and transferred from HSD to the Alliance, the precursor to the NMHIX, and then to NMHIX

Generally, states will not be required to repay funds, provided funds are used for activities approved in the grant and cooperative agreement awards. By law, states operating exchanges in 2014 must ensure their exchanges are financially self-sustaining by January 1, 2015. The ACA provides that an exchange may charge an assessment or user fee to participating issuers, but also allows an exchange to find other ways to generate funds to sustain its operations. ACA grant funding by state is shown in **Appendix B.**

The Center for Consumer Information and Insurance Oversight (CCIIO) at CMS is responsible for implementing ACA's private health insurance reforms and administering the grant programs.

Expenditures. The NMHIX has expended 63 percent of the federal awards from inception to March 31, 2015, including payments to HSD. During this time the NMHIX established its Board of Directors and headquarters; hired staff; procured professional services; launched marketing, outreach and enrollment campaigns; set up its Native American and Stakeholder groups; implemented the small business marketplace (SHOP); and worked toward implementing the information technology platform for the individual marketplace. Non-grant funding is primarily associated with costs associated with running SHOP after January 1, 2015.

Table 3. New Mexico Health Insurance Exchange Expenses

April 28, 2013 through March 31, 2015

Operating Expenses	2013 (Restated)	2014	2015 (Unaudited)
Salaries and benefits	$409,139	$1,666,426	$441,396
Professional and board	$270,378	$422,143	$88,339
Operations	$283,909	$465,034	$135,828
Technology and project management	$16,738,930	$28,628,498[1]	$2,109,741
Marketing and consumer assistance	$4,628,453	$15,542,544	$5,385,825
Plan management		$275,000	
Other		$15,000	
Total operating expenses	**$22,330,809**	**$47,014,645**	**$8,161,129[2]**

Source: NMHIX

[1] NMHIX includes transfers to Human Services Department for IT and federal HUB

[2] $260 thousand non-grant funding

WHILE ACCELERATING MEDICAID EXPANSION, NEW MEXICO HEALTH INSURANCE EXCHANGE ENROLLMENT FOR INDIVIDUALS REMAINS LOW

New Mexico has historically had a high proportion of uninsured citizens. Almost a quarter of New Mexicans were without health insurance in 1999, with the percentage trending slightly downward over a 14-year period due to population growth.

Table 4. New Mexico Uninsured Population
(in thousands)

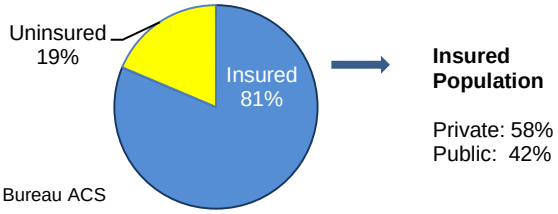
Year	All People	Not Covered	
		Number	Percent
2012	2,067	453	21.9
2011	2,039	399	19.6
2010	2,034	435	21.4
2009	1,978	414	20.9
2008	1,978	451	22.8
2007	1,946	424	21.8
2006	1,943	442	22.7
2005	1,938	391	20.2
2004	1,902	368	19.3
2003	1,871	398	21.3
2002	1,840	368	20.0
2001	1,804	354	19.6
2000	1,799	415	23.0
1999	1,835	440	24.0

Source: U.S. Census Bureau, American Community Survey (ACS)

The Affordable Care Act (ACA) sought to expand coverage by establishing marketplaces, or an exchange, in each state where individuals could shop for health insurance. States could choose to establish a state operated exchange or default to the federal marketplace. States could also opt to expand the public program, Medicaid. While some states did both under one umbrella organization, New Mexico eventually chose to administer the private and public markets through separate entities. While Medicaid expansion remained within the Human Services Department (HSD), the state created the New Mexico Health Insurance Exchange (NMHIX) to enroll eligible people in health insurance offered through its exchange, thereby improving the collective health and well-being of New Mexicans.

The percent of New Mexicans without health insurance has improved but many remain without coverage. During early ACA implementation, the Human Services Department (HSD) established its ACA uninsured baseline at 430 thousand, or roughly one in five New Mexicans. By 2013, the year prior to the effective date of January 1, 2014, for the ACA, the U.S. Census Bureau's American Community Survey (ACS) estimated 18.6 percent of New Mexicans lacked health coverage at any time during the year compared with the national average of 14.5 percent, and 21.6 percent under age 65. This equated to 382 thousand people. Based on this ACA data, the Small Area Health Insurance Estimates (SAHIE) interactive tool breaks the total pre-ACA baseline number down by county.

Chart 1. New Mexico Total Population
Uninsured/Insured - 2013

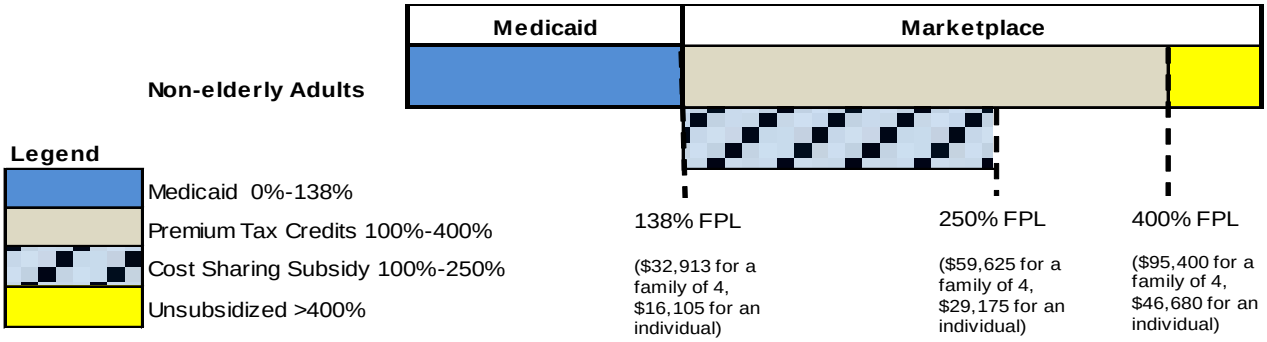


Source: U.S. Census Bureau ACS

Appendix C shows Los Alamos County with the lowest rate of uninsured at 5.3 percent and McKinley County topping the range at 30 percent.

The ACA offered two primary mechanisms to help people gain health insurance coverage. States could choose to expand the public program, Medicaid, by increasing the income eligibility up to 138 percent of the federal poverty level (FPL) for childless adults. New Mexico was one of 28 states (29 including the District of Columbia) that opted for expanding coverage for this low-income segment of the population. In addition, through marketplace enrollment, people with incomes above the 138 percent threshold but below the 400 percent FPL could be eligible for subsidies to offset premium or medical costs. Figure 1 shows how these two pathways to coverage aligned.

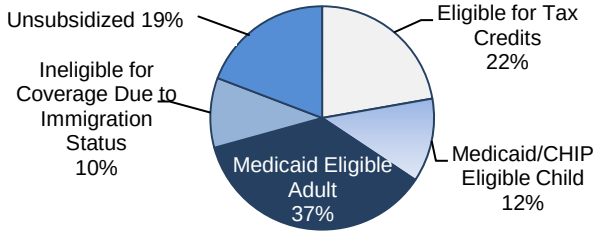
Figure 1. Pathways to Coverage Under the ACA for States with Medicaid Expansion



Source: ASPE

Both programs started January 1, 2014, making 2013 the benchmark year for measuring any changes in uninsured rates. Based on its estimate of 422 thousand uninsured non-elderly residents, the Henry J. Kaiser Family Foundation (KFF) analysis found over 70 percent were likely eligible for public plans or subsidies, as shown in Chart 2. The remaining 122 thousand residents fell into one of two categories. About 19 percent could enroll through the NMHIX but would not qualify for subsidies, either because of income or availability of employer-sponsored coverage. KFF estimated 10 percent of New Mexicans would be ineligible due to unauthorized residency.

Chart 2. Estimated ACA Eligibility for Uninsured New Mexicans

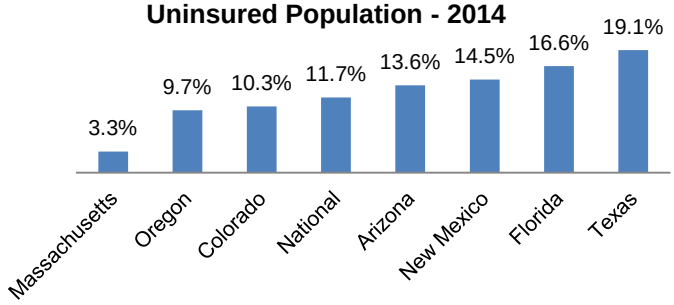


Source: Kaiser Family Foundation based on 2014 Mediad eligiblity levels and 2012-2013 Current Population Survey

While using different estimates, various reports indicate the ACA is working to reduce the number of uninsured. A February 2015 Gallup-Healthways Well-Being Index shows the number of New Mexicans without coverage declined by 4.9 percentage points from 2013 to 2014, placing the state in the top 10 states for uninsured reduction. This outcome falls in line with the survey's 4.8 percent average for the 28 states that chose to both expand Medicaid and operate their own exchange or in a partnership with the federal marketplace. The remaining 22 states that implemented only one or none of these measures saw a lower 2.7-point drop. Montana, tying New Mexico at 10th, was the exception to this observation. Gallup reported additional declines in the uninsured for the first half of 2015, with New Mexico showing a reduced rate to 13.1 percent.

The U.S. Census American Community Survey (ACS) also reported a decline, from the 18.6 percent surveyed in 2013 to 14.5 percent for 2014. However, as shown in **Appendix D**, New Mexico still ranks in the last quartile of all states for the percentage of uninsured, with Texas hitting the high at 19.1 percent. Massachusetts anchors the list with the lowest rate of 3.3 percent. New Mexico also remains above the national average of 11.7 percent but appears to have narrowed the gap from 2013. Chart 3 provides a comparative view of select states.

Chart 3. Estimated Percent of Select State Uninsured Population - 2014



Source: U.S. Census American Community Survey

New Mexico has already surpassed the original HSD enrollment estimate for Medicaid expansion of about 170 thousand. Including Children's Health Insurance Program (CHIP), the federal Assistant Secretary for Planning and Evaluation (ASPE) Office of Health Policy reports a net change of 239 thousand in New Mexico's Medicaid coverage since October 2013 through March 2015 due to expansion, of which HSD reports 215 thousand are adults. These include newly eligible adults and those considered previously eligible but newly covered. Of these, Native Americans accounted for about 27 thousand, bringing the total Native Americans to 112 thousand in the Medicaid program.

The NMHIX was instrumental in increasing Medicaid enrollment as a side-effect of its activities. As shown in Table 5, NMHIX activities ignited Medicaid enrollment primarily in the first year, with a more sustained pattern for the Native American population that has year-round enrollment privileges. Assuming 100 percent conversion rate of the referrals from the federal facilitated marketplace (FFM) and no repeat applicants, data suggests the NMHIX precipitated roughly 40 percent of Medicaid's new enrollment over the two-year period. This calculation excludes indirect contributions to Medicaid enrollment resulting from indirect conduits such as call center referrals or website eligibility queries due to lack of data.

Table 5. NMHIX Estimated Direct Impact on Medicaid Enrollment

Reporting Entities	Enrollment Period 1 (10-1-2013 to 4-19-2014)	Enrollment Period 2 (Reported 11-15-2014 through 2-22-2015)
ASPE: Determined or Assessed Eligible for Medicaid/CHIP by the Marketplace - Referrals	30,147	15,522
New Mexico Primary Care Association (NAPCA) Medicaid Enrollment	32,063	7,202
Native American Professional Parent Resources (NAPPR) Medicaid Enrollment Note: Year-round Enrollment	2,534 Oct 2013-April 2014	3,446 May 2014-April 2015

Sources: ASPE; NMPCA; NAPPR

A 5 percent drop in the uninsured rate equates to approximately 105 thousand people based on a New Mexico population of 2.1 million. While enrollment data does not include whether a person was insured or not prior to enrollment, given the high number of Medicaid enrollees since 2013, it is reasonable to assume expansion was the main contributor to increased health insurance coverage for uninsured New Mexicans. However, various estimates produce a range between 280 thousand and 320 thousand New Mexicans remaining without health insurance at the end of 2014, with the latest U.S. Census American Community Survey (ACS) data reporting 298 thousand uninsured at the end of 2014.

NMHIX enrollment remains below targets and appears to lag national averages and trends. Early enrollment estimates, based on surveys and differing methodologies, provided varied projections for New Mexico's exchange. From 2011 to 2014 the potential pool of eligible participants ranged from 162 thousand to 222 thousand, with the median value of about 177 thousand.

More recently, the estimated range has narrowed near the median to around 180 thousand, as shown in Table 6. The NMHIX currently uses the 166,587 in Table 6 as its target based on the U.S. Census Small Area Health Insurance Estimates (SAHIE) data – with the caveat the estimate overstates those eligible for the NMHIX because it does not make any adjustment for immigration status. The State Health Access Data Assistance Center (SHADAC), located at the University of Minnesota, School of Public Health, has provided analyses for the NMHIX since 2014. Both estimates offer a baseline prior to January 1, 2014 start of ACA coverage.

Table 6. Comparative NMHIX Potential Pool Estimates

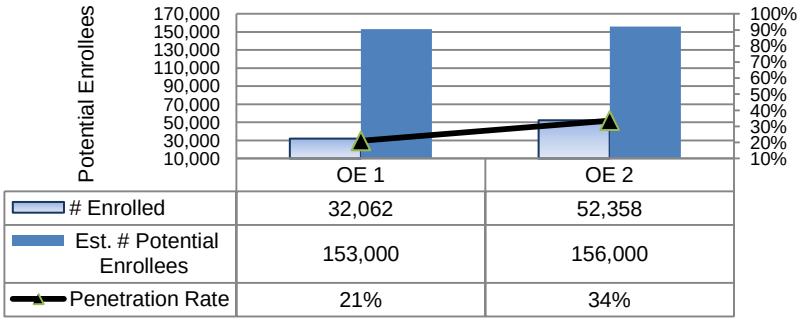
Sources:	Medicaid <138% FPL	Subsidies Between 138% FPL and 400% FPL	No Subsidies >400% FPL	Adjustment*	Total Potential NMHIX
SAHIE	177,867	166,587	37,433	(20,402)	183,618
SHADAC		124,761	55,146	N/A	179,907

In addition to listing total estimated uninsured population by county, **Appendix C** also provides a snapshot of those eligible for subsidies. Averaging 44 percent statewide, four counties account for over 50 percent of the NMHIX targeted population of 166 thousand: Bernalillo, Dona Ana, San Juan and Santa Fe. Again, the SAHIE data does not account for immigration status so the actual number of residents qualified to use the exchange would be about 10 percent less.

While improving from the first-year penetration rate of 21 percent, the NMHIX remains below the national average. In addition to monitoring the reduction in a state's uninsured rate to gauge program effectiveness, viewing the penetration rate of the potential pool of enrollees has become the most important metric for assessing state exchange performance. It basically answers the question, "Of those qualified to use the exchange, what percent likely did?" Industry experts, Wakely Consulting Group, set 65 to 75 percent of eligible residents as a reasonable long term target.

KFF has provided consistent analyses for both enrollment periods. Using the ASPE data and its own conservative pool estimates, the organization reported New Mexico had enrolled about a third of its targeted pool by February 28, 2015, up from a 21 percent penetration rate the prior year.

Chart 4. New Mexico Health Insurance Exchange Enrollees as a Percent of Estimated Potential Enrollees 2013-2015



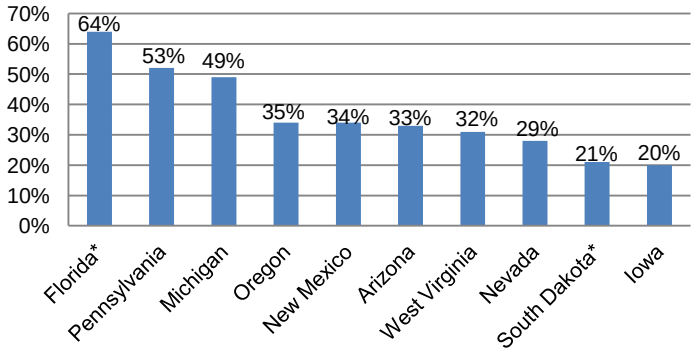
Source: Kaiser Family Foundation

This increase fits the enrollment pattern for states using the federal platform. Rebounding from the prior year, when the well-publicized technical issues with the federal website delayed enrollment two months, most states

reliant on the federal platform saw penetration improvement for 2015. Pennsylvania nearly doubled its enrollments, and six states improved enrollment by more than 20 percentage points. New Mexico's gain comes in at a smaller 13 percentage points.

New Mexico's penetration rate of 34 percent is eight percentage points lower than the national average for states using the FFM. The national penetration rate at the close of the regular open enrollment period averaged 42 percent, reduced to 38 percent excluding states using the federal platform without Medicaid expansion. New Mexico's penetration of 34 percent (as of February 22, 2015) places the state in the third quartile of all states plus the District of Columbia as listed in **Appendix E**.

Chart 5. 2015 Percent of Potential Marketplace Population Enrolled - Select States Using FFM

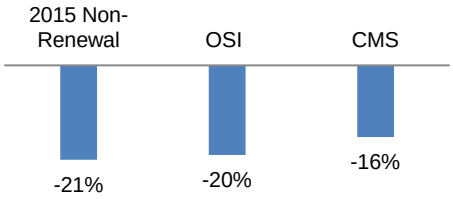


Source: Kaiser Family Foundation as of February 22, 2015
* Did not expand Medicaid.

New Mexico enrollment missed most projections or markers. As shown in **Appendix E**, enrollment met one out of five targets over the two-year period. The widely publicized 80 thousand to 83 thousand target for the first enrollment period, discussed more fully in the Marketing and Outreach section, included enrollment estimates for both the individual market and the small business market, or SHOP. For year two health insurance issuers estimated a more conservative range from 50 thousand to 55 thousand, which was met.

While the NMHIX retention rate of 79 percent compares favorably to other states, the "drop-off" rate is high. In addition to uninsured reductions and the penetration rate of the potential pool of clients, the number of enrollees actually remaining in the system – or retention rate – follows as a third key performance measure for exchanges. Based on the March ASPE Issue Brief reported through February 22, 2015, New Mexico retained almost 80 percent of its 2014 NMHIX clientele, primarily through the FFM automatic re-enrollment process. State-based marketplaces and states using the federal platform reported 63 percent and 76 percent, respectively.

Chart 6. Drop-off Rates



Sources: ASPE March 10, 2015 Issue Brief; CMS; LFC files

However, while New Mexico's retention rate of 2014 enrollees compares favorably with national averages, it also means the NMHIX lost 21 percent of its enrollees from 2014, or just under 7 thousand people.

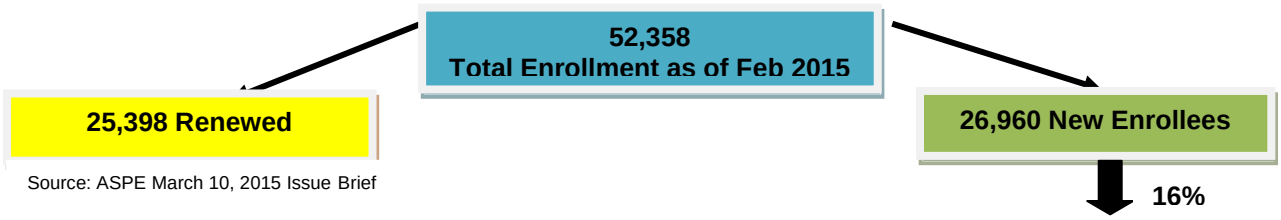
This pattern appears to be holding for 2015, with 16 percent of new enrollees lost within five weeks due to various possible factors, such as dropping coverage, non-payment of premiums, lack of documentation to substantiate immigration status or income, or gaining coverage elsewhere. In its March 31, 2015, Effectuated Enrollment Snapshot (effectuated means active policy in place) published in June, the Centers for Medicare and Medicaid Services (CMS) reported a loss of over 8,000 enrollees in its revised count of 44,085 NMHIX enrollees with active policies in place for New Mexico. As a result, the same KFF analysis generating the penetration rate for the state at

34 percent at the end of the enrollment period in February now calculates the state's rate at 28 percent at the end of March, tying Mississippi, West Virginia, and Wyoming. The national average had also slipped, to 36 percent.

Barring a net gain of enrollees over the next few months due to qualifying events, enrollment could start the third open enrollment period in November with only a net 10 to 12 thousand added over 2014's initial 32 thousand.

The 2015 enrollment result is likely signaling a slow-down in exchange growth. Accounting for insurance renewals, the KFF analysis is likely reflecting the increasing difficulty in attracting new enrollees into the system. The penetration rate of 34 percent includes enrollees retained from the first enrollment as well as new applicants added for 2015 coverage. Using ASPE Office of Health Policy data to separate total enrollment into these two segments, new enrollment dropped by almost 7 thousand people from the prior year, or 16 percent.

Figure 2. New Mexico Enrollment Breakdown by New Enrollees and Renewals



Source: ASPE March 10, 2015 Issue Brief

This slow-down in the pace of enrollment reflects a recent New York Times article suggesting those who wanted health insurance already obtained it and those remaining uninsured will be increasingly difficult to locate and enroll. The article, *Now the Hard Part; The Rate of Health Care Enrollment is Set to Slow*, cautions marketplace momentum might be losing steam. The author points to state-based exchanges (SBE), which out-performed states using the well-publicized disastrous federal platform (FFM) in the first year, fell behind FFM production of new enrollees in the second year by a wide margin. Table 7 supports this claim, showing a 10 percent disparity.

Table 7. Breakdown of Enrollment for 2nd Enrollment Period

Marketplace Type	% New Enrollees	% Reenrolled
State-based Marketplaces Using Own Platform	43%	57%
States Using Federal Platform (FFM)	53%	47%
New Mexico	51%	49%

Source: ASPE March 10, 2015 Issue Brief as of February 22, 2015

Some SBE states saw minimal growth despite large investments in outreach efforts, such as California, New York and Washington. Experts have become concerned over this slowdown in states that did well last year, predicting a similar slowdown for FFM states next enrollment period. Modeling is being revised accordingly, with more conservative estimates and a longer take-up period to reach peak enrollment.

Other studies support the growing view that enrolling the remaining uninsured will prove more difficult. The Congressional Budget Office (CBO) estimates about 45 percent of these remaining people would be eligible to purchase insurance through their employer or an exchange but will chose not to. An earlier poll released by Enroll America suggests reasons vary from choosing alternative means of obtaining health care to concerns regarding affordability. However, the poll revealed only 1 in 5 of those who assumed they couldn't afford insurance knew of the ACA subsidies to reduce costs, pointing to an avenue of opportunity through improved educational efforts.

A slower growth rate in enrollment would make it difficult for New Mexico to reach a 65 percent to 75 percent long-term target. In recent years the Congressional Budget Office (CBO) has consistently projected national enrollment would likely double in 2015 from 2014 and nearly double again in 2016 before leveling off in subsequent years.

The NMHIX is not on track with those growth projections. The relatively low enrollment rate for year one, coupled with the slowdown in new enrollees for year two, has created a wedge to future performance. To catch up, enrollment would need to increase from 60 thousand to 76 thousand net enrollees in 2016, or more than double.

Table 8. NMHIX Enrollment Under CBO Projections
(in thousands)

	2014	2015	2016	2017
CBO Trendline Projection 1	32*	69	128	133
CBO Trendline Projection 2	32*	64	112	133
CBO Trendline Projection 3	32*	59	112	128
Actual	32*	52*		

Source: LFC Analysis based on CBO Projections and NMHIX 2014 Initial Enrollment
*Actual enrollment

As noted earlier, industry experts (the Wakely Consulting Group) have suggested a reasonable long-term target for the percent of potential pool enrolled ranges from 65 percent to 75 percent. Interestingly, the projected 133 thousand enrollee number developed using CBO trend lines would meet the Wakely low objective of 65 percent for both low and high pool estimates, as shown in Table 9, and almost reach the 75 percent at the high end.

Table 9. Enrollment Under Target Penetration Rates

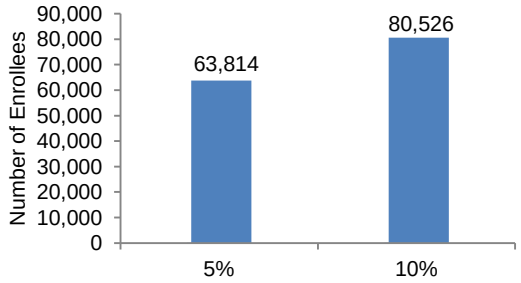
Rate	Description of Pool Estimate	Est. Pool	65% Penetration Rate	75% Penetration Rate
LOW	NMHIX target of subsidy-eligible uninsured based on the SAHIE estimate of 166,587 reduced by 10% for immigration status	150,000	97,500	112,500
HIGH	Subsidy and non-subsidy	180,000	117,000	135,000

Source: LFC Analysis based on SAHIE and SHADOC Table 8 Data and Wakely Consulting Group Long Term Targets

However, to reach even the least aggressive goal of 65 percent for the SAHIE eligible pool would require an annual growth rate of almost 15 percent over five years. A 22 percent annual rate would be required to attain the higher objective of 135 thousand enrollees by 2020 with an assumed starting base of 50 thousand enrollees.

Given the nationwide pattern of slowing growth, such optimistic rates appear unlikely. Using 5 percent and 10 percent annual rates for five years suggests the NMHIX penetration rate might stall below 50 percent, assuming a starting base of 50 thousand. NMHIX staff used a 10 percent growth rate for enrollment in its March 2015 budget projections.

Chart 7. Projected 5 Year Enrollment at 5% and 10% Growth Rates

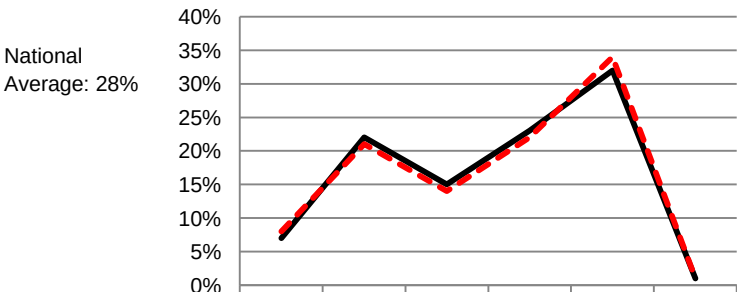


Source: LFC Analysis

Additional factors, such as New Mexico's demographic make-up, might also negatively impact future enrollment. A key demographic indicator for ACA success might be pointing to premium escalation over time faster in New Mexico than the national average, further eroding NMHIX participation. The ACA strove to manage healthcare costs by spreading risk over a larger pool of participants while adding healthier people. Thus, increasing the 18-34 year old population segment to the healthcare system became a critical indicator for ACA success, and industry analysts are carefully monitoring this important statistic.

One approach was extending the age under which children can remain covered by parent's policies to under 26. However, young adults age 26-34 became a targeted group with unique marketing challenges. Known as the "Young Invincibles," how well exchanges are able to attract or push these otherwise reluctant enrollees into buying health insurance provides a key marker for future healthcare – and premium – costs.

Chart 8. Percent of New Mexico Enrollees by Age



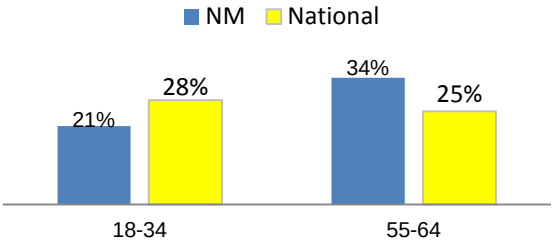
	<18	18-34	35-44	45-54	55-64	>+65
2013	7%	22%	15%	23%	32%	1%
2014	8%	21%	14%	22%	34%	1%

Source: ASPE Issue Brief, March 10, 2015

New Mexico is lagging the national average by seven percentage points for this key metric is concerning. Additionally, it sits nine points below the NMHIX stated goal of 30 percent. The group aged 26-34 has dropped from 15 percent to 14 percent over the two years compared with the national average holding steady at 17 percent.

Furthermore, this differential appears shifted to the older 55-64 age group when compared with national averages, as shown in Chart 9, suggesting higher costs could result from the state's enrollee demographic make-up. Higher claim costs result in premium escalation, potentially further eroding NMHIX participation. The Blue Cross Blue Shield request to increase premiums on average 51.6 percent for the NMHIX for 2016, and the company's subsequent withdrawal from the exchange, is the first sign this unraveling of the marketplace might already be taking place.

Chart 9. Key 2014 Enrollee Demographic Comparison By Age Group



Sources: ASPE Office of Health Policy, May 2014 and March 2015 Issues Briefs

The underlying demographics do not look promising. LFC Program Evaluation 2015-06, *Aging and Long-Term Services Department Adult Protective Services Spending, Investigation Management, and Client Outcomes*, reported New Mexico is one of the most rapidly aging states in the nation, predicted to move from 39th in the nation in percentage of its population over 65 in 2013 to fourth by 2030. While NMHIX clientele stops at age 65 for the most part due to Medicare coverage, the report notes those over 60 will account for a third of the state's population within 15 years. The younger age groups' representation will shrink accordingly.

If enrollment remains low, the NMHIX might not be cost effective as a stand-alone entity. Population determines cost per enrollee to a great extent, with the ability to spread costs over a larger pool of people favoring more populated states. Thus, New Mexico's relatively small population never pointed to a low average cost per enrollee for establishment expenditures, although the widely circulated 2013 Angoff analysis overstated the rate by a wide margin. The reported $6,181 per enrollee after the first open enrollment was six times the national average of $988.

However, the report was misleading at the time by assuming the entire amount of grant funding, or $123 million was spent but NMHIX and, most likely, other states had only used a portion of their funding. In addition, it allocated an equal amount of the federal platform costs across all states using the platform.

A more current snapshot uses the latest figures as of March 31, 2015, and focuses only on grant funding to New Mexico. Excluding costs associated with the business market (both development and operational) and those associated with developing the federal platform, average cost per enrollee during this start-up phase for the individual market falls just under $1,500. This is still $500 over the national estimate provided by Angoff.

Table 10. Point-in-Time Average Establishment Cost per Enrollee

Effectuated Enrollees as of March 31, 2015	Grant Expenditures to March 31, 2015*	Average Cost per Enrollee
44.085	$64 million	$1,448

Source: CMS June 2, 2015 Effectuated Enrollment Snapshot, NMHIX, LFC Analysis
*$83.7 million less estimated SHOP costs

The federal grants phase out by 2016. Going forward, the NMHIX will rely on assessing carriers to cover ongoing operational costs. Initial estimates peg these rising to $15 million starting in 2017 when lease payments for using the federal platform kick in, which will eventually percolate to consumer pocketbooks through the rate-setting process as issuers recoup these outlays.

Continued lackluster enrollment numbers would naturally raise the question of whether it is cost effective to maintain NMHIX functions as a separate entity with associated costs or find an alternative with lower overhead. Using the key performance measures presented in this section might offer a framework for such a determination, as presented in Table 11. Sample targets are not recommendations. A complete business case would also consider additional demographic characteristics and actual costs, topics covered in other chapters.

Table 11. Sample Framework for Decision Point
Continue NMHIX Operations or Recommend Alternative

Performance Metric	Minimum Sample Target
Number of Effectuated Enrollees by 20xx	100,000
Annual Growth Rate (20xx)	10%
Penetration Rate	65%*
Retention Rate	80%
National Comparison	2nd Quartile

*Base of 150,000 (NMHIX adjusted target of potential enrollees eligible for subsidies)

Recommendations

The New Mexico Health Insurance Exchange Board should:

- Consider determining the minimum number of enrollees in both the individual and business markets that justify retaining the NMHIX in the present format;
- Use actuarial analysis and other available sources of data and methodologies for modeling; and
- Continue to investigate the barriers to enrollment and identify those amenable to corrective actions.

The Legislature could consider reviewing operations at key junctures to reassess New Mexico's health insurance exchange structure and amend statute if necessary to adopt the most cost effective and efficient delivery of health insurance options to New Mexico citizens.

EXTENSIVE MARKETING AND OUTREACH EFFORTS WERE COSTLY WITH MIXED RESULTS

The New Mexico Health Inurance Exchange complied with statutory consumer assistance requirements by establishing a referral call center, a walk-in center, and enrollment counselor programs. Recognizing the complexity of the new health insurance paradigm, the Affordable Care Act (ACA) required state-based exchanges develop extensive consumer assistance and stakeholder frameworks. State law echoed many of the compulsory components but added mandates unique to New Mexico, such as requiring a Native American Service Center. The main objective of these requirements was to educate people on the ACA and enroll them as seamlessly as possible. **Appendix F** details compliance with federal regulations and state law.

The NMHIX spent $25 million on consumer assistance contractual services, with almost half spent on marketing, media, and advertising with uncertain value. To meet its consumer assistance obligations, the NMHIX adopted a three-pronged approach composed of outreach, education, and enrollment. Anticipating awareness of the ACA underpinned this approach, significant resources were dedicated to marketing, using media channels as diverse as traditional billboards to social media.

Table 12. Consumer Assistance Spending Categories

Inception - March 31, 2015		% of Total	Enrollment Period 1	Enrollment Period 2
Website Support	$435,368	2%	Duke City	Duke City/BlueSpire
HIX Call Center Vendor	$1,239,381	5%	Xerox	Xerox
Marketing, Advertising, Media	$11,297,903	46%	BVK	K2MD
Marketing Survey	$181,793	1%	Research & Polling	Research & Polling
HIX Consumer Assistance Training	$1,021,303	4%	PCG	NMPCA
Enrollment Entities/Healthcare Guides	$7,351,003	30%	NMPCA, NAPPR	NMPCA, NAPPR/Others
Outreach Entities	$1,841,993	7%	Multiple	Waite & Company/Others
Communications & Outreach Mgmt	$1,406,302	6%	BVK	The Garrity Group
Total	**$24,775,047**	**100%**		

Source: NMHIX

The NMHIX spent over $6 million for a marketing campaign in the first enrollment period that was later found to be largely ineffective. The NMHIX hired the Wisconsin firm, Birdsall Voss Associates (BVK), for the first enrollment period to handle all aspects of the promotion, from creative production and media buys to developing educational content and outreach campaigns. From September 2013 to the wind-down of the contract the following summer, NMHIX paid BVK over $7 million.

Issues with the federal platform disrupted BVK's initial launch, causing the firm to delay scheduled campaigns. By December, however, both the federal platform and BVK's marketing plan appeared on track. Television ads began December 2nd and BVK reported record activity. The call center hit 455 calls in one day with the average calls sitting at 383 at mid-month, almost a three-fold increase from the prior month. For the week ending December 10, 2013, BVK estimated 16 million people were exposed to an advertising schedule – more than September through November combined.

However, within two weeks calls and website visits dropped off. BVK wrote a memo in early January summarizing the situation as follows:

- Enrollment was lagging projections/goals;
- Early momentum was lost due to federal web site problems (and associated reduction in advertising) and partner availability; and
- Advertising was perceived as too "soft/sleepy" by key stakeholders.

As part of the planning process for ACA implementation, in 2011 the Human Services Department commissioned a state-specific study to gage exchange participation as well as Medicaid expansion. The NMHIX used these projections for first year enrollment. Breaking down total enrollments over time, Table 13 provides these initial

Leavitt Partners projections from the first open enrollment period starting in 2014 through 2020 for the private market, including both the individual and small business (SHOP) segments.

Table 13. Leavitt Partners Exchange Enrollment Projections as of November 23, 2012

Private Market	2014	2015	2016	2017	2018	2019	2020
Individual	73,876	102,605	128,637	153,389	173,855	172,779	177,574
SHOP	8,681	16,147	20,296	28,751	33,890	33,896	33,896

Source: *New Mexico Exchange Enrollment Analysis*, Leavitt Partners

The combined number of first year enrollees totaling 83 thousand became a generalized 80 thousand NMHIX target as the distinction between the two markets blurred. Now considered overly optimistic, the original estimate nevertheless had repercussions for decision making. Another first-year estimate of 54 thousand is referenced in NMHIX documents by January, presumably reflecting lowered expectations due to the federal platform technical malfunction.

The December enrollment of less than 8,000 people trailed both targets by wide margins, prompting additional spending on marketing that consumed 85 percent of the 18-month budget by March.

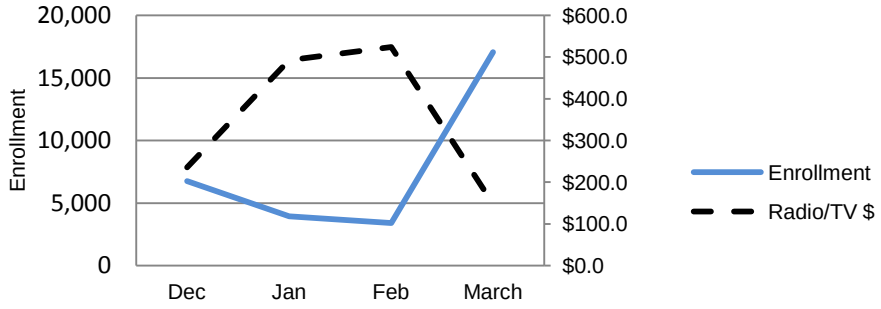
Table 14. Monthly Enrollment

November	934
December	6,754
January	3,932
February	3,392
March-April 19	17,050
Total	**32,062**

Source: NMHIX

Monthly enrollment continued to slide for two months despite the additional spending. As shown in Table 14, enrollment fell 40 percent into January, continuing to decline through February. Rebounding dramatically in March through the extended closing date of April 19, then interim CEO Mike Nunez pointed to the looming deadline as a key motivator as well as a "lot of work," including sending 10,000 electronic post cards, 3,700 emails and 28,000 phone calls to eligible enrollees. The NMHIX received national attention for its aggressive outreach effort. Chart 10 indicates enrollment and media spending are not positively correlated for this period.

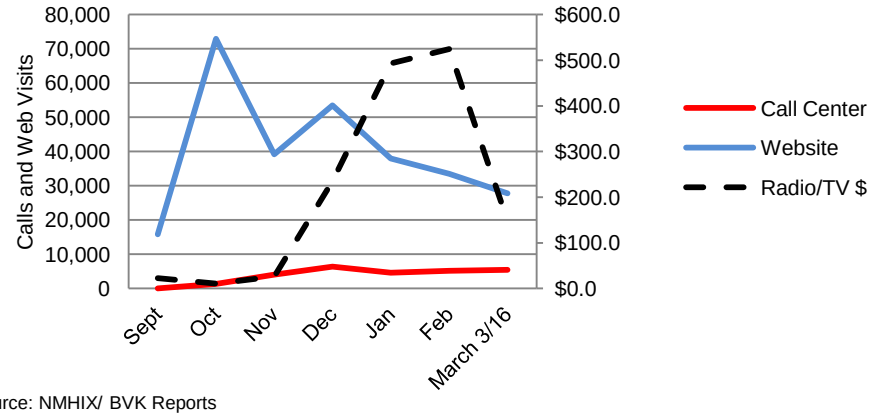
Chart 10. Media Spend for New Campaign Compared with Enrollment
(dollars in thousands)



Source: BVK Reports, NMHIX Dashboards

Metrics used to report performance yielded minimal insight into marketing effectiveness. BVK submitted weekly and monthly reports detailing advertising, media, public relations, outreach, and website activity. While triggering short term spikes in calls and website hits, the longer term impact on consumer activity is unsupported. Activity peaked in October at the lowest media spend and trailed off during the highest television and radio promotions as indicated in Chart 11.

Chart 11. Media Spend Compared with Website and Call Center Activity from September 2013 through March 16, 2014
(dollars in thousands)



Source: NMHIX/ BVK Reports

Furthermore, neither BVK nor the NMHIX connected these output measures and related consumer activity to enrollment as the Alliance, the NMHIX predecessor for the small business market, had previously reported. Delayed reporting of enrollment numbers from the federal website also might have contributed to the board's "favorable" response to the BVK revised campaign conveyed by the February 28, 2014 board minutes—after the two months of abysmal enrollment numbers. The first reference to January and February 2014 cumulative enrollment results appears in the March 7, 2014 dashboard posted to the NMHIX website. With less than $1 million remaining on the contract intended to cover the next enrollment period to December 2014, in July the Board voted to amend the BVK contract to $6.2 million and extend the length to June 2015. BVK continued executing its work plan, obtaining feedback, and progressing on revamping the campaign for the following October.

A subsequent third-party survey suggested the BVK outreach campaign had been ineffective in raising awareness of uninsured New Mexicans regarding the ACA, the exchange, and availability of subsidies. In April 2014 the Board agreed to engage a third-party polling firm to determine the effectiveness of BVK's campaigns. Research & Polling conducted interviews during June and July, reporting results in August. While acknowledging a more accurate reading of the campaign would have been obtained immediately following March, the study notes almost half of the respondents said they had never heard of the New Mexico Health Insurance Exchange and less than a third of the uninsured adults had heard of the brand name "Be Well New Mexico."

The report laid out additional key data points that convinced the Board to cancel the $6.2 million renewed contract with BVK and re-issue the Request for Proposals (RFP) for a "new marketing strategy and fresh approach." As reported to the Legislative Health and Human Services Committee the following September, NMHIX found the survey indicated the following:

- Insufficient numbers of New Mexicans knew about the exchange;
- Improved marketing was needed for Hispanic population;
- TV/radio promotions did not reach enough New Mexicans; and
- There remained significant confusion about requirement for coverage and options.

Measured by enrollment, the second year campaign could be considered even less productive, indicating improved awareness by itself does not necessary translate into desired outcomes. From a baseline measure of 39 percent recorded two months earlier, a December 2014 Research & Polling survey revealed awareness levels of the NMHIX for adults aged 18 to 64 years old had surged significantly to 54 percent. Most importantly, awareness levels increased for those eligible for subsidies. Advertising recall also faired better this time around, although survey timing was undoubtedly a factor in the poorer performance of the prior BVK campaign survey results. The January survey, conducted in the midst of the campaign, reported improved awareness metrics across the board.

Yet new enrollees counted as of February 22, 2015, dropped by 16 percent from the prior year, from 32 thousand to 27 thousand. Furthermore, comparing media spend to enrollment by county suggests a weak link between the two. Table 15 summarizes totals for each county with a media allocation. The budget data is used because NMHIX did not provide the final numbers from Kilmer, Kilmer, Marshall & Duran (K2MD), the vendor replacing BVK as lead marketing firm. However, a K2MD memo confirms actual spending fell within an overall $7 thousand to budget, although $350 thousand allocated for a sponsorship that was redirected to additional radio spots. Sandoval County is combined with Bernalillo County as the metro area.

Table 15. Counties with Media Budget
(dollars in thousands)

County	Total Media Budget	% of Total $
Bernalillo	$1,840	69%
Sandoval	$0	0%
Total Metro	$1,840	69%
Dona Ana	$405	15%
San Juan	$75	3%
Santa Fe	$69	3%
McKinley	$30	1%
Lea	$13	0.5%
Chaves	$100	4%
Otero	$16	1%
Eddy	$15	1%
Curry	$15	1%
Rio Arriba	$13	0.5%
Taos	$15	1%
Lincoln	$18	1%
San Miguel	$23	1%
Grant	$19	1%
Total Direct Counties	**$2,663**	

Source: NMHIX

Assuming media spend tracked closely to planned outlays, some counties with low or zero advertising outperformed those that did. The metro area received 69 percent of county-designated spend of $2.7 million, followed by Dona Ana and San Juan counties based on the rationale the most effective use of media dollars favors populated areas with strong media outlets. Geographic data indicating concentration of targeted population groups also directed planning efforts. Thus, K2MD did not allocate advertising dollars to 17 mostly rural counties.

Appendix G shows enrollment totals by county for those reporting 50 or more enrollees. Not surprisingly, Bernalillo County (including Albuquerque) reported the most enrollees with 17 thousand, or 36 percent of the total. But 21 counties placed ahead of Bernalillo County in improving enrollment from the first enrollment period, with Torrance, Otero, Lincoln, and McKinley counties more than doubling their numbers. Each of these counties received 1 percent or less of the budgeted media spend compared with the metro area's 69 percent, indicating a weak link between year-over-year improvement and marketing.

Furthermore, using an indicator of enrollees as a percentage of the targeted population 138 percent to 400 percent of the federal poverty level (FPL), **Appendix G** also shows four counties with substantially less planned media spend outperforming the metro area. While actual enrollees might not belong to this pool of potential enrollees, this penetration rate remains a useful measure of NMHIX performance. Five counties with planned media spend fall in the bottom half, well below a 25 percent rate.

Comparing the planned media spend against enrollment suggests marketing is neither a guarantee nor a good predictor of enrollment. Three of the top four counties averaged around $10 per enrollee, the lowest amount. The metro area—at nine times this value—ranked fifth in performance. Six counties without any marketing allocation outperformed McKinley County, with its $75 per enrollee, coming in last. Lincoln County performed well at $27 per enrollee while Rio Arriba County did not at a similar amount.

Table 16. Marketing $ per Enrollee

Rank*	County	# Enrollees	Media $	Media $/ Enrollee
14	Valencia	1,342	$0	$0.00
12	Luna	457	$0	$0.00
13	Roosevelt	356	$0	$0.00
11	Torrance	281	$0	$0.00
16	Socorro	219	$0	$0.00
21	Cibola	159	$0	$0.00
1	Santa Fe	7,366	$69,000	$9.37
2	Taos	1,501	$15,000	$9.99
15	Lea	1,178	$12,500	$10.61
4	Eddy	1,313	$14,500	$11.04
7	Curry	1,185	$15,000	$12.66
17	Otero	891	$16,000	$17.96
3	Lincoln	637	$17,500	$27.47
18	Rio Arriba	430	$12,500	$29.07
8	Grant	500	$18,500	$37.00
10	San Miguel	439	$22,500	$51.25
19	San Juan	1,328	$75,000	$56.48
9	Chaves	1,477	$100,000	$67.70
6	Don Ana	5,610	$405,000	$72.19
22	McKinley	401	$30,000	$74.81
5	Total Metro	20,272	$1,840,000	$90.77
	Average			$56.25

Source: LFC Analysis

*Based on Appendix G - Table 2 Penetration Rate for counties with >1,000 potential pool

This analysis points to other factors in addition to marketing, such as outreach and education, must play pivotal roles in generating enrollment.

Initial education and outreach efforts for the first open enrollment period likely contributed to the low "take-up" rate. Despite partnering with over 40 organizations, the effort apparently lacked cohesive and coordinated statewide planning and execution. The NMHIX conducted eight debriefing sessions across the state, reporting "there were clear gaps in local outreach organizations… as many of the 2013-2014 outreach activities were focused in the Albuquerque area." Additionally, the Native American Professional Parenting Resources (NAPPR) noted several challenges impacting its enrollment efforts, including the lack of culturally relevant and appropriate outreach and education materials as well as limited on-going training, technical assistance, and support – all issues repeated across the state for other brokers and enrollment entities. A consumer advocacy group report concluded "Inaccessibility of in-person assistance, especially in rural areas, underfunded outreach campaigns, confusing marketing, and un-affordability of plans account for much of the failure to reach enrollment targets."

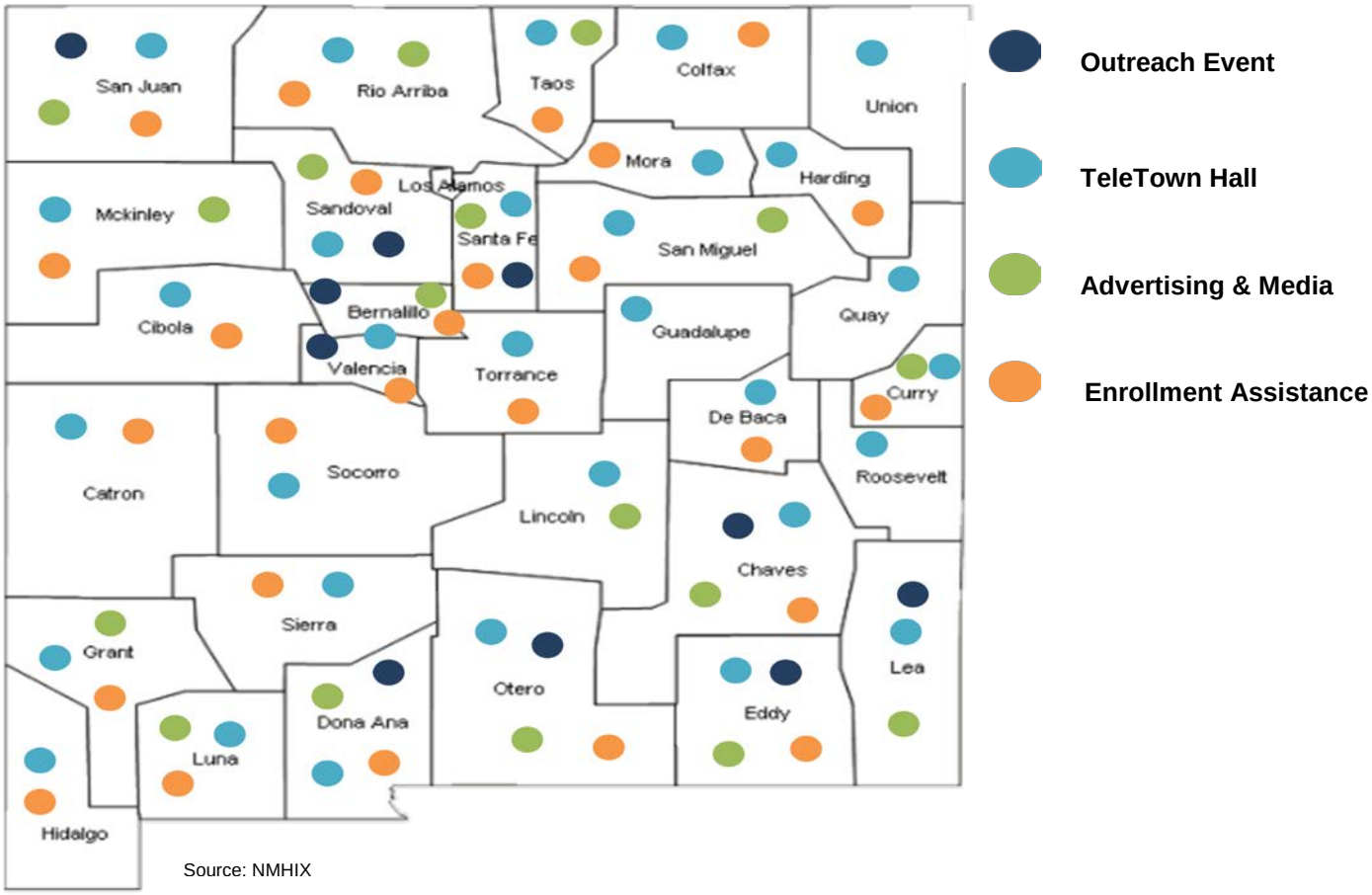
Besides the two-month delay caused by the federal platform malfunction, the report points to the NMHIX reliance on traditional insurance industry marketing practices over in-person outreach efforts as a main contributor to poor enrollment. The detail further explains, the advertising and marketing was not targeted to the specific, diverse, hard-to-reach populations.

Despite improved outreach strategies for the second year, new enrollment declined. In addition to bringing in a new marketing firm, the NMHIX hired the Waite Company to provide outreach and education services specifically geared toward Bernalillo, Sandoval, San Juan, Dona Ana, Santa Fe, Valencia, Lea Chaves, Otero, and

Eddy counties. The organization also created a new Communications and Outreach conceptual framework for increased coordination, bringing the Garrity Group on board to assist with program management. Activities ranged from media relations to supporting outreach partner and events.

The outreach filled in where the marketing left off. For the second enrollment period, NMHIX reports seven outreach partners held almost 350 events with nearly 1,100 in-person attendees. Venues ranged from local businesses and churches to civic clubs. Outreach partners also worked with 300 local groups across 11 counties, and three TeleTownHalls were held with more than 5,000 participants statewide. Through 14 enrollment entities, more than 250 enrollment counselors were available in 25 counties, as depicted in Figure 3.

Figure 3. County Outreach Throughout New Mexico



Source: NMHIX

The NMHIX also retained the primary enrollment entities from the first enrollment period, including over 250 certified agents and brokers, the New Mexico Primary Care Association (NMPCA) and the Native American Professional Parenting Resources (NAPPR). Departing from the prior year, though, the NMHIX contracted directly with six other enrollment entities to target specific population segments, including Amigos y Amigas, Centro Savila, Internal Medicine Specialists, Miner's Colfax Medical Center, Southwest CARE Center, Taos Health Systems, and Youth Development, Inc.

Enrollment data supports the federal "best practice" approach for rural areas using one-on-one, or "boots on the ground" strategies. NAPPR adopted a "Results Based Accountability" approach to track performance against specific goals, allowing the organization to measure activity impact on outcomes. Noting "a clear connection between outreach, education and enrollment" during the first enrollment period, NAPPR set specific goals for these areas, as reproduced in Table 17.

Table 17. NAPPR "Results Based Accountability" Report as of December 31, 2014

Performance Measure	Goal	Actual
Outreach	90,000	85,655
One-on-One Education	27,000	44,072
Completed Appointments	13,190	7,572
Quality Health Plan (QHP) Enrollment	2,250	1,170*
Medicaid Enrollment	-	5,233

Source: Native American Professional Parenting Resources
*NAPPR added 405 enrollees to equal 1,575 QHP by March 31, 2015

Including Medicaid, 85 percent of appointments resulted in enrollment. While QHP enrollment stopped short of its goal, enabling Native Americans to gain coverage under a public plan serves the overarching goal of reducing the uninsured. While the 45 non-Native American enrollment entities had varied success in translating appointments into enrollment, including Medicaid enrollments, together they averaged an 88 percent conversion rate. These enrollment rates align with similar results reported by Enroll America for its test centers, which noted consumers who had in-person assistance were nearly 60 percent more likely to enroll compared with those who started the enrollment process by themselves online.

These numbers also coincide with a federal Office of Rural Health Policy "best practices" guide in rural outreach and enrollment for the Affordable Care Act. Using data based on 52 outreach grantees, the document concludes, "One-on-one counseling seemed the most effective at clarifying misunderstandings about the law." The NMHIX December 2014 survey conducted by Research & Polling reported "a majority of residents would prefer a more personal method such as a face-to-face meeting or a discussion over the telephone."

The NMHIX emphasized expensive marketing and advertising strategies despite their uncertain value through the second enrollment period but now signals a shift to increased outreach. From inception through March 31, 2015, NMHIX spent about 14 percent on direct outreach programs versus almost half of its consumer assistance expenditures on marketing and media. Because some enrollment entities and a BVK subcontractor also provided outreach and education activities, indirect costs would increase this outreach tally to some extent.

Table 18. New Mexico Health Insurance Exchange Expenditures Marketing, Outreach, and Enrollment - Inception through 3.31.15

Marketing, Media	$11,297,903	48.8%
Call Center	$1,239,381	5.4%
Enrollment – NAPPR	$3,903,857	16.9%
Enrollment – NMPCA	$3,447,146	14.9%
Outreach	$1,841,993	8%
Communications & Outreach Mgmt	$1,406,302	6.1%
Total - Consumer Assistance	**$23,136,582**	**100.0%**

Source: NMHIX

Initially, the NMHIX appeared committed to this model for the third enrollment period. Although realigning the budget slightly to include the Garrity Group contract for Stakeholder Communications and Public Relations category, the proposed 2015 budget sent to Center for Medicaid and Medicare (CMS) for approval retained its heavy reliance on advertising and media as indicated in Table 19. However, during negotiations with CMS, the NMHIX staff found CMS strongly supportive of outreach efforts to help grow membership. CMS subsequently approved the modified budget for 2015 increasing outreach by 259 percent, as shown in Table 19 under the modified budget column. Additional funding was also allocated toward enrollment and stakeholder categories as a result of this CMS guidance that deemed them to be allowable development costs.

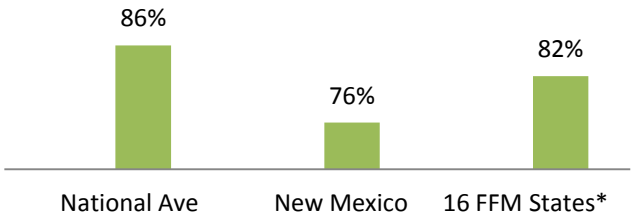
Table 19. New Mexico Health Insurance Exchange 2015 Request and Final Modified Budget

Category	NMHIX Budget Request	%	Final Modified Budget	%
Advertising, Media	$4,902,150	45%	$4,619,809	29%
Enrollment (Healthcare Guides/Navigators)	$2,674,463	11%	$3,354,373	21%
Outreach Partners Funding	$1,627,456	15%	$5,847,586	36%
Stakeholder Communications and Public Relations	$1,723,250	16%	$2,242,844	14%
Total 2015	$10,927,319	100%	$16,064,612	100%

Source: NMHIX

In line with factors noted nationally, the New Mexico health insurance marketplace presents challenges for enrolling the uninsured population that might not be bridged by NMHIX marketing and outreach efforts.
One measure of how well an exchange is reaching the targeted population eligible for subsidies is the percent of marketplace enrollees with financial assistance. So far New Mexico falls short of national averages. Even after excluding states that did not expand Medicaid, which would push eligible enrollees onto a state's exchange, New Mexico stands 6 percentage points lower at the end of the last enrollment period among comparable states.

Chart 12. Percent of Marketplace Enrollees with Financial Assistance



Sources: ASPE Issue Brief March 10, 2015 and LFC Analysis
*States expanding Medicaid using FFM

Affordability reigns as the number one barrier for enrollment, according to numerous surveys. While New Mexico ranks sixth against states adopting Medicaid expansion, the $127 monthly premium after the accelerated premium tax credit (APTC) still appears out of reach for many New Mexicans.

Table 20. Subsidy Comparisons by FFM State with Medicaid Expansion

States*	% w APTC	Pre APTC*	APTC	After APTC	% Reduction
Arkansas	88%	$389	$280	$109	72%
Iowa	85%	$371	$260	$111	70%
Nevada	89%	$361	$242	$119	67%
Indiana	87%	$438	$319	$120	73%
Arizona	75%	$278	$155	$123	56%
New Mexico	76%	$323	$196	$127	61%
Illinois	78%	$336	$208	$128	62%
Pennsylvania	80%	$355	$226	$129	64%
Michigan	88%	$366	$236	$130	64%
16 States AVE	**82%**	**$376**	**$245**	**$131**	**65%**
Oregon	77%	$334	$198	$136	59%
West Virginia	86%	$448	$311	$137	69%
Delaware	83%	$404	$264	$140	65%
New Hampshire	70%	$385	$244	$141	63%
N Dakota	86%	$369	$228	$141	62%
Ohio	84%	$389	$244	$145	63%
New Jersey	83%	$470	$306	$164	65%

Source: ASPE Issue Brief March 10, 2015 , LFC Analysis
*Average monthly premium before accelerated premium tax credit (APTC)

Additional analysis of this premium gap and policy alternatives could be explored, including the possible impact of free Medicaid coverage serving as a disincentive to obtaining work that would disqualify coverage or, upon obtaining work, losing coverage due to cost.

Recommendations

The New Mexico Health Insurance Exchange (NMHIX) should improve performance tracking and oversight by:

- Adopting a "results-based performance" program to better measure enrollment outcomes against specific efforts;
- Setting clear goals for all consumer assistance contractors and monitor performance;
- Requiring enrollment counselors use a centralized tracking system, such as the one developed by the New Mexico Primary Care Association for improved oversight and data collection;
- Using the information to realign contracts during enrollment to those that are performing well, where applicable and feasible;
- Identifying best practices and replicating them wherever applicable; Providing guidance and additional training if needed to struggling enrollment entities;
- Developing reporting that ties enrollment to specific activities; and
- Continuing to use surveys to track performance in lieu of real time enrollment numbers.

The NMHIX should strengthen its partnership network by:

- Developing additional coordination between enrollment counselors and brokers/agents, such as sharing referrals;
- Continuing efforts to increase outreach coordination across the state, using key partnerships that cross county lines—such as federally qualified health centers—to establish a wide net of enrollment counselors;
- Using longer term contracts for lead enrollment groups so they don't lose staff while contracts are pending;
- Considering working with stakeholders to adopt additional "boots on the ground" activities;
- Coordinating statewide campaigns leveraging appropriate state agencies, such as the Human Services Department, Department of Indian Affairs, and Department of Health; and
- Establishing a stakeholder presence on the NMHIX website to increase transparency and public participation.

The NMHIX should consider allocating additional funding toward outreach and enrollment efforts by:

- Adding additional walk-in centers for heightened one-on-one availability;
- Adding longer hours at peak periods such as during evening hours and weekends, especially for open enrollment periods;
- Exploring mobile units deployed to underserved areas;
- Identifying regional needs and adapting processes accordingly;
- Considering year-round education program to sustain momentum;
- Considering methods to improve retention in qualified health plans, such as implementing consumer education programs on health insurance literacy to maximize benefits;
- Improving enrollment by educating consumers on the advanced premium tax credit and cost sharing mechanisms to make silver plans more affordable; and
- Using lower cost methods to raise and sustain awareness.

AFTER FIVE YEARS AND SPENDING $85 MILLION, NEW MEXICO HAS MARGINALLY MET KEY OBJECTIVES FOR IMPLEMENTING ITS INDIVIDUAL EXCHANGE AND UNCERTAINTIES REMAIN

New Mexico is the only state out of the 17 state-based exchange (SBE) entities that never implemented its own state-run individual exchange. Timing is a key factor. Three crucial years passed from the passage of the federal Affordable Care Act (ACA) to the enactment of the New Mexico Health Insurance Exchange Act (Act). As shown in Table 21, 11 of the 16 SBE states were able to initiate design, development and implementation for their exchanges beginning in 2011 or earlier. However, the fact two other states starting in 2013, Idaho and Minnesota, did implement their individual exchanges points to other considerations in New Mexico's implementation.

Table 21. Exchange Establishment

Year Established	#	State-based Exchange States
2006	1	Massachusetts
2010	1	California
2011	9	Colorado, Connecticut, Nevada, Hawaii, Maryland, Oregon, Rhode Island, Vermont, Washington
2012	3	Kentucky, New York, District of Columbia
2013	3	Idaho, Minnesota, New Mexico

Sources: NCSL and State Statutes

External factors, combined with New Mexico Health Insurance Exchange (NMHIX) decisions, impacted outcomes. Complicating the already challenging effort to establish the state exchange within federal timelines, New Mexico faced a succession of ACA leadership spanning five years, two administrations, three lead organizations, and four Executive Directors – two under the current NMHIX – as depicted in **Appendix H.** Policy priorities changed, such as considering a "one door" portal for public or private health insurance to a "no wrong door" approach. Partnering with the Center for Medicaid and Medicare Services (CMS) to obtain funding also contributed unique challenges to meet grant requirements.

The decision to remain on the federal platform stretched over two years, driven to an extent by outside influences. The board committed to establishing a state-owned exchange per statute but, given the short six-month deadline for system implementation, voted to use the federal platform for the first enrollment period. The stated goal was to have the state's individual exchange ready for business the following year. In the meantime, the board supported plans already underway to build the small business system known as SHOP and operate as a hybrid state.

The federal platform malfunctioned its first year, delaying enrollment by two months. Not receiving assurances the state system would be 100 percent operational in time for the second year enrollment, the board voted in July 2014 to stay on the federal platform until 2015.

CMS took advantage of the delay to impose new system requirements, informing the NMHIX of the changes six days prior to the final Level II Establishment grant deadline to fund the remaining information technology (IT) system. NMHIX revised its request accordingly but the grant was denied. After considering all options, the NMHIX ultimately faced choosing between continuing along the path toward a state-based exchange with limited funding or remaining on the federal platform.

A projected cost comparison pegged leasing at $78.6 million over the 2015-2019 period compared with $127 million for continuing to build the New Mexico Exchange.
Source: NMHIX

Without additional federal funding, in March 2015 the NMHIX Board of Directors voted to remain on the federal-facilitated marketplace (FFM) indefinitely. Advantages noted included the following:

- Avoid the cost of building New Mexico's own IT platform;
- Avoid the uncertainty regarding future vender and system performance; and
- Avoid future potential costs for upgrades or federally-driven changes to the system.

The advantages of building New Mexico's own state-based exchange focused on unresolved issues concerning FFM lease costs, state autonomy, and data availability.

Thus, New Mexico has an individual state-based exchange but not as originally envisioned. Most akin to the original partnership model, the Office of the Superintendent retains plan management; NMHIX will focus on the SHOP and consumer assistance activities for the individual marketplace, while the federal government retains system functionality for the individual marketplace.

So far using the federal platform has limited data needed for effective decision making and planning, increasing risk. Reliant on HealthCare.gov for the individual exchange, NMHIX does not own the statistics being generated from the federal website. Nor was the interface installed capable of capturing some non-identifiable information prior to the consumer being sent to HealthCare.gov. Thus, using the federal platform has a secondary impact of providing limited and untimely data upon which to base decisions.

Data availability remains uncertain. The NMHIX is negotiating with CMS to phase in a data package. Additionally, the board had proposed new initiatives for conducting in-depth research and analytics and developing a robust database using grant funding. CMS approved the funding requested for the database at $1.7 million but reduced the research project from $2.1 to $1.2 million. However, the board will continue with limited insight into underlying demographics and dynamics for several months, as well as enrollment metrics, as the NMHIX executes these planned activities.

For the first eight months of 2015, NMHIX did not have firm budget, and future spending decisions to achieve revised priorities remained uncertain. The CMS grant denial not only derailed plans to build the state's own platform, it unraveled the 2015 NMHIX budget. The board approved a 2015 budget assuming the final Level II grant request would be forthcoming, as shown in Table 22.

Table 22. Original 2015 Budget Funding Assumptions
(in millions)

Grants Spent or To Be Spent:	2014 Projection	2015 Budget
HBEIE 140187	$13.5	
HBEIE 140185	$12.8	
HBEIE 140193	$18.9	$50.5
Additional Grant to be requested by 11/15/2014		***$65.7***
Total	**$45.2**	**$116.2**
Total Budgeted Expenditures	$45.2	$117.7
Shortfall		($1.5)

Source: NMHIX

NMHIX based over 55 percent of its 2015 budget on unconfirmed funding that did not materialize. Without it, the entity had to undertake a "re-budget" process to align activities with reduced resources. This process is lengthy, from staff development to board approval, with final approval for grant allocations required by CMS. Started in January, CMS approved the final grant allocations in August. In the meantime, planned activities for the upcoming enrollment period remained in flux, dependent on the outcome of the CMS ruling. This uncertainty impacted not only NMHIX but also its enrollment partners.

Inconsistent messaging from CMS has fueled uncertainty for what costs will be allowable, impacting NMHIX planning. The NMHIX has been operating under the understanding all costs associated with the individual exchange would be eligible for grant funding through 2015. However, in March 2015 staff learned CMS would no longer permit costs associated with consumer support – such as advertising, professional services or enrollment support – using establishment funds *after June 30th*. As a consequence, issuer assessments – the only alternative funding source currently available to NMHIX – were projected to rise from the $1.3 million originally calculated to support the operation and maintenance (O&M) costs of SHOP to between $4 million and $7 million to absorb the non-allowable costs for the second half of the year.

As a result of CMS decisions made since December, the revised 2015 proposed budget stood at $40 million, about a third of the budget originally envisioned last November. The largest reduction fell on the IT vendor (GetInsured) budget as a consequence of dropping the individual exchange but other areas also saw reductions. To reallocate previously earmarked funds for the individual exchange, the Board added IT enhancements for SHOP and increased research and analytics for improving a consumer database to drive more informed decision making going forward.

The revised budget broke expenditures into two funding sources, DD&I (Design, Develop and Implement or Establishment grant) and M&O (Maintenance and Operations or Carrier Assessments) to adhere to the new July 1 date for non-allowable grant costs, as shown in Table 23.

Table 23. NMHIX 2015 Revised Budget by Funding Source

Expenditure Categories	DD&I	M&O	Total
Governance & Administration	$2,383,919	$36,000	$2,419,919
Consumer Support	$12,803,482	$3,540,110	$16,343,592
SHOP	$7,996,852	$1,169,029	$9,165,881
Information Technology	$11,328,802	$0	$11,328,802
Office of Superintendent (OSI) Plan Management	$825,000	$0	$825,000
Total	**$35,338,055**	**$4,745,139**	**$40,083,194**

Source: NMHIX

However, NMHIX acknowledged CMS might not approve some of the expenses listed in the DD&I column, considering them M&O costs at this point. Staff cautioned the Board, "*If CMS does not approve some or all of the request, M&O expenses (and carrier assessments) may be impacted and the Board will re-visit the budget.*"

CMS denied some costs and de-funded the final $69 million establishment grant by $16 million. During negotiations with CMS, NMHIX staff found themselves dealing directly with a senior CMS representative who guided them through the re-budget process. Contrary to the CMS guidance received earlier in the year that consumer-related activities would not be supported after July 1, CMS approved a final $30.7 million grant budget that significantly increased outreach, from $1.6 million to $5.8 million, and reduced or denied funding for IT proposals.

Table 24. Remaining 1311 Grant Funding

Grant HBEIE 140193	$69,402,117
Spent in 2014	($23,143,692)
Balance Remaining at 1/1/2015	$46,258,425
CMS "De-obligation" 8/2015	($15,601,358)
Balance Remaining for 2015	$30.657,068
Final 2015 Budget Using Grant $	$30.657,068
Remaining Grant Balance	**$0**

Source: NMHIX

Appendix I compares the proposed budget to the final budget the board approved on August 21, 2015.

There is a potential risk NMHIX might have to repay federal funding due to inconsistent CMS guidance. The ACA required state-based exchanges be self-sufficient by January 1, 2015, with a clear prohibition against using federal establishment grant funds (1311 funding) for supporting operations after that date (45 CFR Part 155-160). To implement these provisions, CMS issued guidance in March 2014 identifying non-allowable costs for operating and maintenance costs after that date, including "rent, software maintenance, telecommunications, utilities, and base operational personnel and contractors." NMHIX complied with this requirement for its small business program, or SHOP.

However, the NMHIX has consistently been using January 1, 2016, as its deadline for ending reliance on the federal funding for operating the individual exchange. CMS appears to have agreed until reversing itself in March, approving a November 2014 request to extend grant use for operations through 2015. Furthermore, the CMS approval included items it had proscribed only seven months earlier, such as rent. Of the $726.5 thousand allocated in the "Other" category, $241 thousand fell within those defined prohibitions, with another $1.8 million set aside for personnel costs. Yet the extension was approved.

CMS actions seem in conflict with the U.S. Office of Inspector General (OIG) and might lead to unintended consequences for the NMHIX. The OIG recently alerted CMS of concerns regarding state-based marketplace (SBM) violations of this 1311 grant restriction and self-sustainability deadline, encouraging the department publish "clear guidance on what constitutes (1) operational costs and (2) design, development, and implementation costs to minimize the marketplace's improper use of establishment grant funding for operational expenses after January 1, 2015." The letter reiterated the purpose of grant extensions was to "allow SBMs to complete the design, development, and implementation activities of a marketplace but do not authorize the SBMs to use these funds for operational purposes."

Whether future congressional or agency action will require repayment of operating costs incurred after the statutory January 1, 2015, date or obligate repayment of costs associated with failed information technology initiatives paid for with federal grants, is uncertain.

Future NMHIX operations will be financed by issuer assessments, essentially creating an unregulated taxing authority. Per Section 1311(d)(5)(A) of the ACA, NMHIX adopted a financial sustainability plan in December 2014 (Article XIII, Plan of Operation). The plan pegs issuer assessments to the actual budget by assessing issuers (including Medicaid carriers) an amount equal to their market share of the prior year premium base times the NMHIX operating budget adopted annually. Thus, NMHIX avoids the uncertainty imposed by charging a per member fee or administrative percentage that depends on enrollment and premiums hitting projections to produce the required funding. Additionally, NMHIX will assess a reserve sufficient for six months of operating costs, which appears excessive given the funding formula that assures financing as long as issuers pay promptly.

These assessments will funnel down into premiums paid by consumers statewide. The 2017 projected per member per month (PMPM) equivalent is $23.42, based on a $15 million operating budget and 10 percent annual enrollee growth in both the individual and SHOP marketplaces. This amount compares to an NMHIX goal of $3.50 PMPM. Most state-based exchanges are reevaluating PMPM rates they currently charge in light of fluctuations in costs, appropriations, enrollment, and premium generation. Current rates run from Oregon's $9.66 PMPM to $13.95 PMPM in California. Other states charge a percentage of premiums, ranging from 1 percent in Kentucky across all plans to 3.5 percent in Minnesota. Vermont is fully state-funded. How the NMHIX assessment will impact statewide premiums as issuers pass it along is uncertain.

Recommendations

The New Mexico Health Insurance Exchange Board should:

- Base operating budgets on confirmed revenue sources;
- Continue working with CMS to define allowable and non-allowable costs and revise the 2015 remaining expenditures accordingly;
- Prioritize key outlays in outreach and education for targeted groups;
- Augment the current Goals and Objectives with a robust array of outcome performance measures and a monitoring plan based on available data, adjusted as more data becomes available;
- Continue developing relevant data sources through completed negotiations with CMS and funded research studies as well as developing a data warehouse;
- Perform risk assessments and mitigation strategies more consistently and effectively;
- Consider conducting a SWOT analysis (Strengths, Weaknesses, Threats and Opportunities);
- Monitor NMHIX performance more often that once a year; and
- Post results to the website for heightened transparency.

DESPITE AN INVESTMENT OF OVER $48 MILLION, NMHIX ABANDONED IMPLEMENTING THE INDIVIDUAL EXCHANGE AND SMALL BUSINESS ENROLLMENT REMAINS LOW

Between the Alliance and NMHIX, the $48 million information technology (IT) investment in establishing the health exchange began in May 2013 and continues with system enhancements and maintenance. Initial IT procurements were processed by the Alliance and later responsibility shifted to the NMHIX. Contract amounts and associated payments through March 31, 2015 are shown in Table 25 and Table 26.

Table 25. New Mexico Health Insurance Exchange
Summary of Information Technology Services Contracts
(in thousands)

Vendor	Contract Amount	Total Paid	Contract Balance
GetInsured	$34,117.6	$27,495.7	$6,621.9
Software Engineering Services	$746.9	$621.8	$125.1
Public Consulting Group*	$4,667.9	$4,552.1	$115.8
NM Human Services Dept	$17,968.0	$15,836.0	$2,132.0
Total	**$57,500.4**	**$48,505.6**	**$8,994.8**

Source: NMHIX Contracts, 2014 Financial Audit and 2015 accounting data.
* Public Consulting Group contract includes IT project management services and consulting services.

Table 26. New Mexico Health Exchange
Summary of Information Technology Contract Payments
2013 – 2015
(in thousands)

Service and Vendor	2013 Actual	2014	2015 through 3/31/15	Total
IT Vendor - GetInsured *	$15,952.2	$11,321.0	$222.5	$27,495.7
Independent Validation & Verification - Software Engineering Services	$0.0	$512.9	$108.9	$621.8
Project Management Vendor - Public Consulting Group**	$1,330.96	$3,087.7	$133.4	$4,552.1
NM Human Services Department		$14,880.7	$955.3	$15,836.0
Total	**$17,283.1**	**$29,802.3**	**$2,108.4**	**$48,505.6**

Source: NMHIX General Ledger and Accounts Payable Documents
* 2013 and 2014 DDI expenditures; 2015 expenditures reflect SHOP maintenance cost
** PCG payment amounts are all inclusive of IT project management and consulting services.

NMHIX spent $18 million to enroll 877 people in the Small Business Health Options Plan, with a cost per enrollee of $21 thousand. States are required under the ACA to establish a Small Business Health Options Program (SHOP) for small businesses to purchase health insurance for their employees through an Exchange. By March 18, 2015, the state-run SHOP exchange had enrolled 524 people, including 345 employees and 179 of their dependents. Nearly 1,500 small businesses initiated applications in the SHOP exchange by the end of 2013, and several thousand employee names had been entered into the system. However, by December 2014, total enrollment was around 800 people, increasing to 877 as of March 31, 2015.

NMHIX anticipated a successful implementation of SHOP by using the commercial-off-the-shelf software solution developed by GetInsured that would ultimately provide completion in time for the 2014 Open Enrollment. SHOP was deployed in stages in the fall of 2013. The Be Well New Mexico (beWellnm.com) portal opened on October 1, 2013, with the state's SHOP marketplace signing up small businesses to buy coverage and select plans for their businesses. Employees were able to sign up for plans starting November 1, 2013.

Considering open enrollment for SHOP continues on a rolling basis throughout the year and the basic functionality of SHOP works, enrollment for small business remains low. The degree to which small employers find the SHOP marketplace user-friendly and cost-effective will be critical factors in determining whether they offer coverage through the SHOP, outside the SHOP, or not at all.

NMHIX reported the SHOP exchange needs $1.5 million in annual funding starting in 2015 when it must operate without financing from the federal government. In December 2014 the exchange board voted to impose a fee on all health insurance policies sold in the state of New Mexico, in order to raise the funds needed for Be Well New Mexico's SHOP exchange in 2015 and beyond.

At the high cost of $21 thousand per enrollee, NMHIX planned to spend an additional $5.7 million on SHOP; however, CMS did not approve the budget request. In May 2015 NMHIX board approved staff recommendations for SHOP enhancements in the 2015 budget to maximize the ability to use federal grant funds for implementation. NMHIX indicated the enhancement items of interest to New Mexico stakeholders include adult-dental, broker workbench tools, web broker functionality.

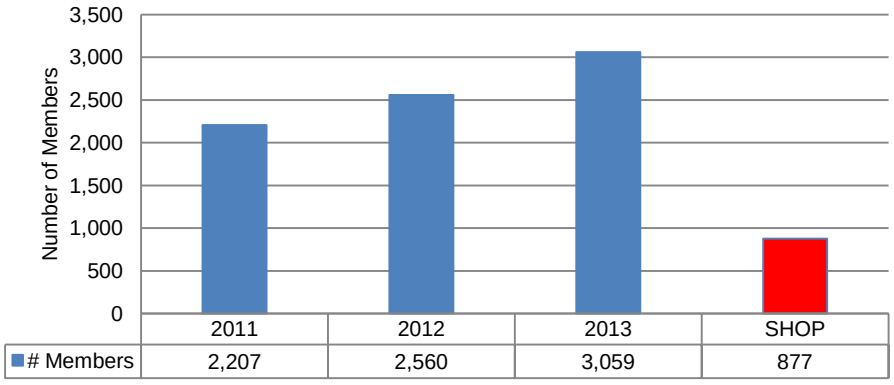
Table 27. NMHIX SHOP Board Approved Budget
As of May 15, 2015
(in thousands)

Budget Item	2015
SHOP Enhancements: July 2015 to March 2016	
Stand alone Dental	$1,698.0
Agent proposal Workbench	$2,800.0
Web Broker functionality	$1,200.0
Total	**$5,698.0**

Source: NMHIX Board Meeting

NMHIX failed to transition the small business population handled by the Alliance to the New Mexico SHOP, losing the opportunity to build upon several years of business experience for an improved return on investment. The Alliance small group membership had been growing at a 17 percent annual growth rate prior to the entity being dissolved in 2014, as required by Laws 2013, Chapter 53. The NMHIX Plan of Operation specifies the board adopt a transition plan for both the Alliance and the High Risk Pool but it remains unclear if one was developed and if so, whether it was implemented. The Alliance ran shop in 2013 and 2014 and NMHIX (beWellnm) assumed responsibility for SHOP as of January 1, 2015.

Chart 13. New Mexico Health Insurance Alliance
Small Group Average Annual Membership 2011 - 2013
SHOP Membership as of March 2015



Sources: NM Health Insurance Alliance - Leif Associates; NM SHOP data - NMHIX

The Government Accountability Office (GAO) November 2014 audit reported low initial SHOP enrollment is likely due to multiple, evolving factors. Though all of the SHOPs required by the ACA were operational, many features were not yet available and enrollment was low as of June 2014. Based on official estimates and stakeholders' expectations, enrollment for state-based SHOPs has been significantly lower than expected. Stakeholders identified several factors that may have led to current low SHOP enrollment and may affect future enrollment growth. Many stakeholders reported the primary incentive for employers to use the SHOPs has been the small business tax credit available to eligible employers who offer coverage through a SHOP, although some noted the credit may be too small and administratively complex to motivate many employers to enroll. Other factors identified hindering current enrollment include the ability of employers to renew plans that existed before the SHOPs—which, depending on state requirements, is permitted until October 1, 2016—and employer misconceptions about SHOP availability.

Stakeholders also described factors that may help stimulate or detract from future SHOP enrollment growth. For example, the phase-out of existing pre-SHOP plans, the implementation of employee choice by an increasing number of SHOPs, improved coordination with agents and brokers, and increased marketing to small employers may help stimulate enrollment growth. Conversely, other factors, such as the two-year limit on the availability of the small business tax credit and the likelihood, according to stakeholders, SHOP premiums will not be lower than non-SHOP premiums, may hinder future enrollment growth. The evolving and localized nature of these factors suggests a determination of the SHOP's long-term impact remains premature at this time. Adding to these factors, new private exchanges are popping up, and although they seem mainly geared to larger employers, long-term impact on the SHOP marketplace is not clear.

Once SHOP was implemented and operational, the NMHIX realized the limitations of a commercial-off-the-shelf approach. Using the commercial-off-the-shelf (COTS) software solution, GetInsured built the NMHIX SHOP site in just four months. NMHIX found functionality understood to be "industry standard" was not robust enough. In a response to CMS, NMHIX stated the application was not user friendly, making it cumbersome for individual consumers. NMHIX became concerned the level of difficulty in navigating the system could frustrate consumers and, ultimately, result in low enrollments. In addition, NMHIX received negative feedback from enrollment entities, brokers, carriers, and users experienced with dealing directly with brokers. Having IV&V activities during the development and implementation of SHOP would have likely identified these issues. The nature of COTS solutions does not reduce the requirement for IV&V because the solution still must be integrated with other components of target systems.

Defining the gaps between the requirements and the base functionality of the COTS solution is necessary to identify the tasks required to complete a successful implementation. "Off-the-shelf" products are generally presumed to be ready for use with limited tailoring. Such products are an alternative to developing fully customized products from the ground up. Too often COTS projects are not well thought out or well planned, running on the incorrect assumption that every COTS solution is a small integration project without the issues and complexities. This leads to unrealistic and poorly managed expectations, resulting in failed projects. These types of failures occur when projects fail to plan for or incorporate the additional activities unique to COTS intensive developments.

The NMHIX and GetInsured have continually been fixing defects and adding enhancements to the SHOP application since it was deployed in November 2013. The September 2014, SHOP defect log indicated 60 defects had been closed with 12 open and new. Although NMHIX provided access to project management documents, LFC could not review defect details because files were protected. Remediation of the defects is extremely important to maintain data integrity within the application and ensure all enrollment transactions are correct. In addition, remediation of the open defects is essential prior to implementing additional enhancements to the application, due to the possibility of dependencies on defective code.

GetInsured has been enhancing SHOP since the fall 2013 implementation. In addition, the March 2015 change control log shows 18 change requests, seven changes, and 11 added enhancements. NMHIX stated its change order budget, 35 percent of GetInsured's base contract, was inadequate to cover what was deemed to be essential to

complete a market place solution (SHOP and Individual). In 2014, the change order budgeted was $10.1 million. While there have been ten SHOP releases since the initial deployment, it is not clear how much of the change order budget was spent.

NMHIX spent $9 million for the implementation of the individual state-based exchange, with limited long term benefits to taxpayers. In July 2014 the NMHIX board voted to delay the implementation of the individual exchange and ultimately decided to forgo the implementation in May 2015. The board decision to delay the New Mexico individual state-based exchange implementation in July 2014 impacted GetInsured deliverables planned for 2014. In December 2014, GetInsured submitted a change request to revise the contract deliverables based on the board's decision to delay the implementation of the state-based exchange and remain on the federal exchange in 2015.

NMHIX approved the change request without processing a contract amendment to reflect the changes. The Change Management Plan states parties will execute a formal contract amendment for any change order that increases or decreases the maximum amount or the maximum deliverable cost. While the change request appeared to have a negative cost impact, reducing the contract amount by $142 thousand, a contract amendment may have reduced the potential for increased costs in light of the board's May 2015 decision to abandon the individual exchange. As a result, GetInsured will collect 99 percent of its fees of its $29 million contract. NMHIX legal counsel stated a change request in affect amends the contract.

NMHIX delays in contracting project management office (PMO) services and hiring an IT director, likely contributed to the lag in implementation of the individual exchange. PMO vendors are generally responsible for managing schedule, scope, budget, and all aspects of a project. The New Mexico Health Insurance Alliance (Alliance), NMHIX predecessor, awarded a competitive contract for project management services to Public Consulting Group (PCG), in June 2013, six months later than initially planned. The Alliance issued the request for proposals (RFP) for project management services on November 2, 2012, with proposals due November 21, 2102, and an estimated contract award January 2, 2013.

In addition, NMHIX did not hire an IT director until November 2013, five months after the PMO contract award and six months after the design, development and implementation (DDI) vendor (GetInsured) started working. As a result, GetInsured was working without NMHIX IT management and independent oversight during SHOP implementation and the initial development of the individual exchange.

While New Mexico did not succeed in implementing its state-based exchange, three states that implemented state exchanges moved to the federal exchange due to IT issues and financial problems. Initially, Nevada and Oregon implemented a state-based exchange but due to issues with IT vendor performance the federal exchange became more viable. Nevada abandoned its state-run health exchange, severed ties with software contractor Xerox and switched to the federal system, citing the company's inability to fix 1,500 technical glitches in the current exchange. Xerox had a $75 million contract with the state and has spent $12 million of that money, according to the state. The Silver State Exchange terminated the company's $75 million contract for work related to the ACA in May 2014.

In April 2014, Oregon state officials voted unanimously to switch over to the federal health insurance exchange, HealthCare.gov, citing the high cost of trying to fix the problematic state marketplace. The Oregon exchange had cost the state $248 million. In October 2014, Oregon gave up on trying to salvage a portion of the troubled Cover Oregon technology project, essentially abandoning all hope of getting any lasting benefit from the $240 million investment.

In addition, CMS found the Hawaii's exchange to be non-compliant with the ACA, including unresolved IT issues, a non-integrated eligibility enrollment system, and lack of financial sustainability. As a result, Hawaii's health exchange will transition to become a federally supported state-based marketplace similar to Nevada, New Mexico,

and Oregon. Hawaii spent over $130 million of its $204 million grant implementing its health exchange. Hawaii's January 2015 state auditor's report cited inadequate planning led to an unsustainable health exchange.

Four other states – Minnesota, Maryland, Massachusetts, and Vermont – have experienced massive problems with their health exchange websites, ranging from balky features to less than expected enrollment numbers. Eventually, it is expected that most of those sites will be folded into the HealthCare.gov website, resulting in almost a billion dollars in taxpayer funds wasted.

GetInsured implemented health exchanges in other states while working on New Mexico's exchange. Although several NMHIX project documents point to leveraging other states' efforts, such as Mississippi and Idaho, LFC staff could not determine to what extent any leveraging occurred. GetInsured completed exchanges for Idaho and Mississippi while under contract with New Mexico.

Initially, the NMHIX anticipated the state-based exchange for individuals would be implemented in eight to ten months. GetInsured began New Mexico SHOP implementation in June 2013and completed the project in November 2013, but after more than a year the individual exchange was never realized. In February 2014 Idaho contracted GetInsured to implement its state-based exchange and implementation was successfully completed in nine months, by November 2014. While Mississippi did not receive conditional approval from CMS to operate a state-based SHOP until October 1, 2013, GetInsured implemented Mississippi SHOP exchange in May 2014. Mississippi transferred the New Mexico SHOP technology as a base foundation and added Mississippi enhancements. However, Mississippi did not break out costs separately to determine the cost of each. The Mississippi SHOP solution (technology vendor) was $22.8 million. When combining New Mexico SHOP IT cost of $18.1 million, GetInsured was paid almost $41 million for SHOP. In contrast, Utah spent $500 thousand to implement its SHOP exchange with PlanSource, a nationally recognized insurance technology solution provider.

In addition, limited staff resources for GetInsured's New Mexico project may have also contributed to the lack of success in implementing the individual exchange. A project management weekly status report indicated GetInsured's resources were constrained with an individual's vacation, resignation of a staff member, and availability of other staff. During a project meeting held in August 2014 with NMHIX, PCG, and GetInsured, the group discussed the impact of these staffing issues on the NMHIX, and PCG opposed the schedule dates proposed by GetInsured. NMHIX PMO indicated the issue of running out time as it pertained to project resources and schedule. The NMHIX IT Director also noticed resource issues arising when GetInsured obtained other business. GetInsured indicated there was no resource contention with Idaho because the company was considering shifting resources from Idaho to New Mexico as needed. It is not clear if GetInsured shifted resources and actively solicited lessons learned from Idaho in the implementation of its individual exchange.

While the contract award to GetInsured was delayed, the vendor performed services without a letter agreement or final negotiated contract. The Alliance issued the request for proposals (RFP) for the implementation and establishment of a state-based health exchange, including services for the Small Business Health Options Plan (SHOP) on November 2, 2012. The Alliance extended the RFP deadline with an anticipated award by February 8, 2013. The Alliance had been set to name a vendor in February. That work was halted when some state lawmakers said New Mexico could not proceed with its exchange without enabling legislation. The legislation was passed and signed by the governor at the end of March 2013.

On May 17, 2013, NMHIX made its decision to award the contract to GetInsured. However, there were delays in negotiating the final contract until six months later. Base on the available information, it appears the NMHIX delay in contract negotiations with GetInsured is not adequately documented; documentation is limited to board meeting minutes. Technically, NMHIX awarded the $34 million contract to GetInsured on November 27, 2013. The following indicated the contract award was not in accordance with good business practices:

- As early as June 2013, GetInsured began initial work on contract deliverables related to and in furtherance of the project prior to a letter agreement.

- Because the negotiation of the definite contract was taking additional time to complete, NMHIX issued a letter agreement on August 10, 2013 to allow for payment for services completed.
    - GetInsured submitted a $4.4 million invoice dated August 1, 2013, for completion of three deliverables.
- The November 27, 2013 letter from GetInsured stated the definitive contract will supersede and replace the letter agreement in all respects retroactive to the effective date of May 17, 2013.
- The final contract format is not consistent with NMHIX sample contract provided with the RFP. It appears the contract is based on GetInsured's standard terms and conditions.

The NMHIX contract with GetInsured includes $11 million in maintenance costs. NMHIX has spent $371 thousand in maintenance costs since January 1, 2015. NMHIX awarded the $34 million competitive contract to GetInsured to design, develop, implement, operate, host and maintain the state's health exchange. The contract term is through December 31, 2017, with annual maintenance beginning January 1, 2015. The 2015 annual maintenance charges of $5.1 million for 2015 are included in the current contract amount.

Table 28. New Mexico Health Insurance Exchange
GetInsured Contract Maintenance Charges

Description	2015	2016	2017	Total
Software Platform and Ongoing Maintenance	$307,500	$157,917	$91,458	$556,875
Ancillary Costs	$37,512	$37,512	$37,511	$112,535
Hosting	$78,125	$78,125	$78,125	$234,375
Other	$2,917	$1,750	$1,750	$6,417
Total Monthly Maintenance	**$426,054**	**$275,304**	**$208,844**	**$910,202**
Total Annual Cost	**$5,112,648**	**$3,303,648**	**$2,506,128**	**$10,922,424**

Source: GetInsured Contract

The decision to delay the implementation of the individual state-based exchange also affects maintenance costs, resulting in lower cost for 2015. With the board's decision to remain on the federal based exchange, it is not clear what the additional impact will be. Software maintenance pricing tends to be a percentage of the investment to implement, typically 15 percent to 25 percent. According to NMHIX maintenance costs will be reduced in 2016 and 2017.

Table 29. New Mexico Health Insurance Exchange
GetInsured Revised Maintenance Charges

Description	2015	2016	2017	Total
Software Platform and Ongoing Maintenance	Contract change 12/3/2014	$157,917	$91,458	$249,375
Ancillary Costs		$37,512	$37,511	$75,023
Hosting		$78,125	$78,125	$156,250
Other		$1,750	$1,750	$3,500
Total Monthly Maintenance	**$74,167**	**$275,304**	**$208,844**	**$558,315**
Total Annual Cost	**$890,004**	**$3,303,648**	**$2,506,128**	**$6,699,780**

Source: GetInsured Change Request

The Human Services Department (HSD) met its obligation to develop an interface with the Automated System Program Eligibility Network (ASPEN) and the individual marketplace at a cost of $15.8 million. Although HSD plans to leverage the work completed, it is unclear how much of the $15.8 million investment will be useful. HSD established a memorandum of understanding (MOU) with NMHIX to provide a mechanism for moving federal funds received by NMHIX to HSD for costs associated with design, development, and implementation of an

information technology system that facilitates eligibility, advance premium tax credit, and cost sharing reduction determinations through ASPEN.

HSD participated in design and implementation meetings required with NMHIX and its IT vendor for the ASPEN state-based marketplace (SBM) interface project. HSD's independent verification and validation (IV&V) vendor reported, with the July 25, 2014, decision by the NMHIX Board of Directors to remain on the federal exchange until open enrollment 2015, the ASPEN SBM project schedule was significantly extended. With over 99 percent of user acceptance testing (UAT) activities successfully completed, UAT was considered to be concluded on October 31, 2014 for the system as specified.

CMS requiring a "single-door" approach for the application process, including a requirement for a "common consumer experience and outcome," represents a significant modification to the existing flows and will require changes to both HSD/ASPEN and NMHIX software. However, with NMHIX board decision to remain on the federal exchange, NMHIX requested HSD to issue a stop work notice to its IT vendor. HSD ceased all exchange-related work as of April 30, 2015.

The lack of adequate IT project oversight provides incomplete reporting to the NMHIX board, hinders decision making, and increases project at risk. Board meeting minutes indicate NMHIX provides limited information to the board on the status of IT. While there is indication an executive project dashboard is provided to the board, it does not reflect complete details on the status of the IT project. Information in the dashboard report is limited, independent validation and verification (IV&V) information is not included, and it does not provide a complete picture on the status of the project. The dashboard does not include how the project is tracking scope, schedule, cost, staffing, and quality, making the project reporting incomplete and not in line with best practices.

While SES IV&V processes follow best practices, independent validation and verification information is not included in project status reporting to the NMHIX Board. The IV&V vendor submitted monthly reports in accordance with its contract deliverable requirements. However, LFC review of board meeting minutes and presentations indicate IV&V reporting was infrequent with limited detail, and there is no evidence to support the results of IV&V were communicated to the board.

Although IT vendors told board members the project was on schedule, project documentation indicated otherwise. NMHIX IT director stated the primary risk to the success of the NMHIX technology project is the repeated delay and tardiness of task completion per the master project schedule by GetInsured, the technology vendor. The IV&V assessment also noted project concerns with scope management beginning April 2014 and schedule management in June 2014.

Table 30. Independent Verification and Validation Status of Phase II – Individual Exchange

IV&V Report	Scope	Schedule	Cost	Staffing	Quality
April -14 Initial Rpt					
May-14					
Jun-14					
Jul-14					
Aug-14					
Sep-14					
Oct-14					
Nov-14					
Dec-14					
Jan-15					

Source: SES Monthly IV&V Reports and Final IV&V Report

Process areas assigned a rating of YELLOW indicates these marginally meets expected implementation standards and processes are only partially compliant with established standard(s) as documented. These marginal ratings are intended to raise awareness from the Project Team sufficient to affect improved changes. There are several ways to define project success: the project met scope, time, and cost goals; the project satisfied the customer and sponsor; and the results of the project met its main objective.

The absence of an approved project schedule is not effective in accurately tracking and reporting on the project's progress. Following the board's July 2014 decision to remain on the Federal Facilitated Marketplace (FFM) for 2015, the project plan and schedule required to be re-baselined. IV&V noted with this size of a timeline shift in the project, few project processes are not impacted; processes and activities that had been reported as "complete" might now have to be re-visited. The duration shift would impact all stakeholders as well as stakeholders not directly related to the NMHIX project, but related to vendors of NMHIX. As of October 31, 2014, an approved schedule was not executed. The LFC review of project management files identified several project schedules in draft, including one dated January 23, 2015. NMHIX subsequently provided a more recent version of the schedule; however, it is not clear if the schedule has been approved.

The project repository files do not contain all project artifacts for the NMHIX project. The IV&V vendor reported the project lacks a comprehensive procedure for storage and control of project documents and artifacts. This lack of a storage procedure negatively impacts the security, quality, and integrity of the documentation. In software project development, an artifact is any of the parts of the plans used to create and develop the software. Artifacts define and document the project. When project artifacts are not maintained, there can be a lack of common understanding among the project team as to the location of documents, the approved version or baseline that should be used, and the availability of project references and standards. Retaining historical project documents can provide information for future projects, for on-going operational support, and for answering questions regarding the project.

LFC staff review of project repository files showed final and approved documents are not always maintained separately from draft versions. It is not clear if an accurate inventory of all project documents required for IV&V review and federal document tracking are included in the repository files.

NMHIX did not follow best practices for independent verification and validation, increasing project risk and likely being ineffective. The independent verification and validation (IV&V) vendor, Software Engineering Services (SES) began work in April 2014, after the Small Business Health Options Plan (SHOP) implementation in October 2013. NMHIX considers the SHOP implementation as Phase I and development and implementation of the Individual Exchange as Phase II. The NMHIX awarded a competitive contract for IV&V services in March 2014, nine months after the project management vendor and seven months after the IT and design, development and implementation (DDI) services vendor.

Planning and obtaining IV&V services should begin early in the project's life. IV&V is most effective when integrated into the entire project life cycle, conducted in parallel with the project development activities. IV&V provides management with an independent perspective on project activities and promotes early detection of project variances. This allows the project to implement corrective actions to bring the project back in-line, and provide decision criteria whether to proceed to the next development phase. The main check performed is whether user requirements are met ensuring the software solution is structurally sound, built to the required specifications and in compliance with regulations and budgets.

Similarly, Maryland's April 2014 audit reported the Maryland health insurance exchange development process faced many challenges. The early IV&V reports identified several critical project planning and management processes and protocols that had not been established even though the contract to develop its exchange was awarded 10 months prior to the issuance of the first IV&V report.

Without IV&V, application development for the Small Business Health Options Plan (SHOP) was not reviewed by a third-party and has the potential to result in deficiencies over time. The July 2013 project status meeting minutes showed the NMHIX needed to confirm whether or not New Mexico needed to have an IV&V vendor on board. However, when asked for the rationale regarding when the IV&V was brought into the project, the current NMHIX staff were not aware of the decision to wait until after SHOP was implemented. It is not clear why the NMHIX did not have IV&V during SHOP implementation and staff likely to know are no longer with the exchange.

The initial IV&V report for Phase II indicated key components in the project management plan were not in place, needed to be updated or not being followed. For example, NMHIX program procedures to govern change management are spread across multiple documents, some of which were not available in the project repository. Other change control procedures intended to extend to the operations and maintenance environment, where change may be needed due to defect discovery or NMHIX desire for enhancement, could be updated to ensure project team member understanding. The overarching NMHIX Project Management Plan's scope statement stated it covered NMHIX development and implementation activities of the project; there was no mention of ongoing operations and maintenance in the scope. Although IV&V is for Phase II, the individual exchange implementation, these items directly impact SHOP development and maintenance and operations.

The intent of verification and validation is to improve the quality of the software during the lifecycle process, not afterwards, and it must be performed at the same time as the software development. It should be done in a manner that provides early feedback to the development organization, allowing modifications to processes and products in a timely fashion. This proactive, but independent, approach results in fewer delays, reduced cost, higher product quality, and improvement of the development process itself.

Recommendations

The Legislature should consider providing more authority for the state's enterprise oversight of the New Mexico Health Insurance Exchange information technology projects. This would provide more authority to the state CIO's office and would equip New Mexico Health Insurance Exchange with the structure to ensure IT projects are carried out more effectively and economically in the future.

New Mexico Health Insurance Exchange should ensure final project documents are located in the project repository to ensure the project artifacts are accurate and complete to provide a documented audit trail.

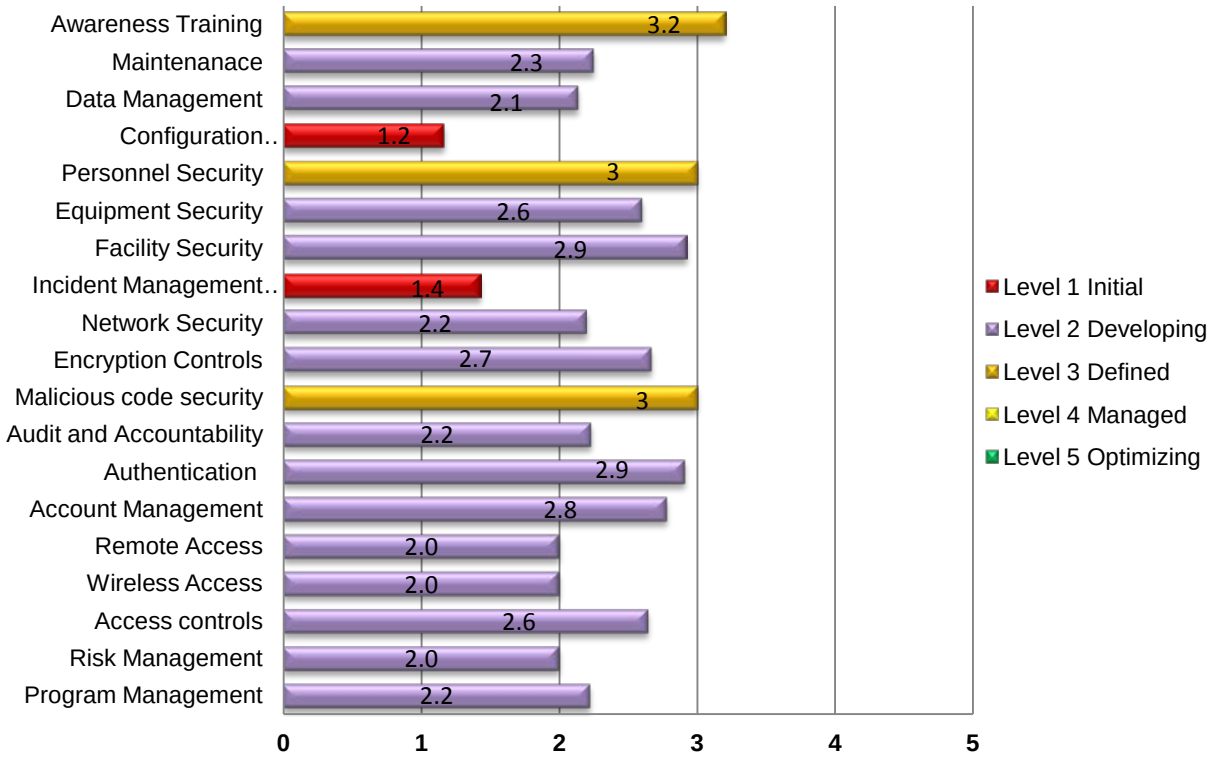
NMHIX INFORMATION SECURITY PROCESSES NEED IMPROVEMENT TO ENSURE SYSTEMS SECURITY AND COMPLIANCE WITH FEDERAL REQUIREMENTS AND INDUSTRY BEST PRACTICES

The Information Security Maturity and Compliance Assessment of the NMHIX identified various gaps and lack of maturity in some of the internal management, operational and security controls. The assessment evaluated the effectiveness and maturity of internal security policies and processes and mapped them to international information security standards and industry best practices. Information security processes need improvement to achieve a more secure information systems environment, a good level of compliance with industry best practices, and improve the level of security program maturity.

An information security program maturity model is a framework used as a benchmark for comparison when looking at an organization's security processes. LFC's information technology (IT) consultant used a maturity model based on Gartner's Information Technology Score methodology (**Appendix J**), to map the level which an organization is at in terms of its existing information security processes and procedures. The maturity assessment is crucial to identifying gaps and risk across security domains (Management, Technical, Operations) and within the security domains. Security 'Impact Zones' are identified within each security domain, and within each security impact zone there are multiple security processes evaluated as part of the assessment. The more mature an organization is against this benchmark, the less at risk it is in terms of risks associated with poor information security practices.

LFC's IT consultant determined NMHIX's overall security program maturity level is 2.4 out of a possible score of 5, with the desired level of 3. The Gartner scale Level 3 is considered to be compliant with regulatory and best practices.

Figure 4. NMHIX Security Zone Maturity Level



LFC's IT consultant identified areas of particular concern and priority that include a lack of:

- Defined formal information security program policies and procedures;
- IT risk assessments;
- IT disaster recovery plan for its local infrastructure; and
- Controls over removable media.

The 2014 HHS OIG audit of NMHIX identified vulnerabilities placing the confidentiality, integrity, and availability of NMHIX information at risk and could have allowed unauthorized access to sensitive consumer data. Vulnerabilities included data encryption, remote access, patch management, and USB port and device. The web application vulnerability scan revealed 64 vulnerabilities. In addition, the database vulnerability scan of the NMHIX database, which stores all sensitive user data, revealed 74 vulnerabilities. Specific details of the vulnerabilities identified are not mentioned because of the sensitive nature of the information. NMHIX agreed with the OIG findings and recommendations and provided corrective actions and implemented the OIG recommendations.

NMHIX implemented some security controls, policies and procedures to prevent vulnerabilities in its web site, database, and supporting information systems. However, the LFC IT consultant reported its policies and procedures do not always conform to Federal IT requirements and National Institute of Standards and Technology (NIST) recommendations to secure sensitive information stored and processed by the NMHIX. NIST is responsible for developing information security standards and guidelines, including minimum requirements for Federal information systems.

NMHIX has not established a formal information security program framework and architecture and security governance structure. NMHIX has some good management control practices in place, such as documenting some IT security policies and procedures and compiling an up-to-date inventory of all IT hardware, software, and software licenses. However, without a defined and approved information security program framework and governance structure, NMHIX increases its security risk. For example, NMHIX risks loss of control and ineffective security controls due to lack of corporate management oversight; data loss; system outages without coordinated, planned controls and resources; and non-compliance resulting in fines or other penalties. By basing its information security program framework on best practice international standards, NMHIX will have a solid foundation for a compliant information security program. NMHIX stated it is going to hire a dedicated Privacy/Security officer in the near future to ensure it has an adequate information security program.

NMHIX has not performed IT security risk assessments. Currently NMHIX does not have risk management assessment policy and procedures. A risk assessment indentifies critical and non-critical information and information systems, treats associated with critical systems, and determine the level of protective controls to be established based on the criticality of the information and systems. Information security controls are based on risks. To effectively implement security controls, the organization must know what risks are being mitigated. By performing risk assessments, various threats, vulnerabilities and risks can be identified and potential impacts can be evaluated. Controls then can be matched to the appropriate risks and security controls costs can be assessed against the costs of the risks.

NMHIX has developed some IT policies and procedures. However, some of its IT policies do not reflect current practices and are more best-practices documents than usable policies. Although most of the IT function is outsourced to vendors NMHIX should still have its own policies and standards to which the vendors must comply. Information security policies provide the basis for an information security program and set the direction for processes and controls. NMHIX does not have documented detailed procedures to implement the proposed IT security policies. Without documented procedures, it is difficult to comply with policies.

NMHIX has implemented some good defined technical domain controls. The technical domain focuses on: access control, audit and accountability, identification and authentication, network, system and communications protection. User account creation, and modification follow an established process, with an audit trail and NMHIX access is based on job positions linked to roles. Password management is in place, anti-virus software is implemented on client and server systems, and server, workstations, and laptops have full disk encryption.

NMHIX also has a documented Information System Access Policy. There is an established process for setting up user accounts and approval of access levels to applications. NMHIX documents this process using a System Access Request form. However, NMHIX is not conducting user access level reviews to critical applications. This should be done at least annually to ensure authorized users have the appropriate level of access to applications and user accounts of terminated employees are not left active.

Although NMHIX has an audit and accountability policy, it is not auditing information system activity and log-in monitoring on a regular basis. Establishing documented procedures ensure consistency in log reviews, help identify activities to be logged and reviewed, identify security controls to be monitored, and enhance identification of issues when they occur. ABBA Technology review server event logs every four to six weeks; event logs should be reviewed more frequently. Log management is essential to ensuring that computer records are stored in sufficient detail for an appropriate period of time. Routine log analysis is beneficial for identifying security incidents, policy violations, fraudulent activity, and operational problems.

NMHIX does not have a formal documented comprehensive IT disaster recovery strategy or plan. GetInsured has a formal, tested disaster recover (DR) plan for the SHOP system. NMHIX performs its due diligence by obtaining and reviewing this plan. However, GetInsured plan does not address recovery of other NMHIX systems or infrastructure. From discussions with ABBA Technologies personnel, NMHIX is expected to have its own written and tested DR plan. ABBA Technologies regularly backs up NMHIX data. However the backup device is housed in the same location as the NMHIX server. If a disaster occurred NMHIX would not be able to recover data from the backups. NMHIX has not developed a DR Plan for local infrastructure. NMHIX stated developing a DR plan will be covered in the scope of work as part of the upcoming Project Management Services request for proposals (RFP) approved during the May 2015 board meeting.

NMHIX does not have a policy to direct the development, implementation, and testing of the disaster recovery plan. A disaster recovery policy establishes the framework for the management, development, and implementation, training, and maintenance of a disaster recovery program, ensuring a disaster recovery plan is developed, tested and kept up-to-date. IT business continuity and disaster recovery planning is the process of analyzing information system infrastructure, systems, applications, and processes, and developing a plan for resumption of these functions and elements in the event of a system interruption or disaster.

A business impact analysis (BIA) is an essential component and first step in the business continuity and disaster recovery planning process. The BIA includes a work flow analysis and an assessment and prioritization of the business functions and processes that must be recovered. A BIA will identify how quickly essential business units and processes have to return to full operation following a disaster situation and the resources required to resume the business operations. Business impacts are identified usually on worst-case scenario, assuming the physical infrastructure supporting each respective business unit is destroyed and all records, equipment, etc. are not accessible for 30 days. The financial impacts and operational impacts must be addressed as well as the estimated recovery time frame.

In addition, identifying a DR team is necessary with defined roles and responsibilities during the occurrence of a disaster. Training for key personnel with assigned contingency roles and responsibilities should be implemented. It is preferable to use job positions rather than named individuals. Inventory of replacement equipment is necessary so in the event of a disaster, replacement equipment can be ordered in a timely manner. Having a comprehensive disaster recovery plan is crucial to NMHIX's operational reliability and minimizing the impact of any disruption to mission essential activities.

While NMHIX has good physical security at its office, the ABBA data center, and the Rackspace data center; controls over portable media are needed. NMHIX does not have a formal, documented and approved Portable Removable Media Policy. Portable media includes USB flashdrives, CDs, DVDs, iPods, and external hard drives. NMHIX does not have operational, preventative or detective controls in place to prevent an individual using a personal or non-encrypted USD flash drive to connect to NMHIX devices and network. McAfee antivirus software will scan removable media as soon as it is connected to a NMHIX computer. This will provide protection against malware.

Recommendations

The New Mexico Health Insurance Exchange should:

- Perform a risk assessment to determine what logs should be reviewed and the frequency of review;
- Develop and document detailed audit and log monitoring procedures for the various systems and applications;
- Implement restrictive security controls on logs to prevent unauthorized access, deletion, or modification of the logs;
- Develop a formal disaster recovery plan policy for its local infrastructure;
- Conduct a business impact analysis and risk assessment to determine the requirements for the disaster recovery plan;
- Develop a comprehensive disaster recovery plan based on results of the business impact analysis and risk assessment;
- Reference the risk assessment in the disaster recovery plan and document any high risk areas along with mitigation strategies;
- Develop a formal disaster recovery testing plan and conduct training and periodic testing at least annually;
- Document the disaster recovery plan revision history, ensuring personnel receiving the plan have the current version;
- Review, update, and distribute the disaster recovery and business continuity plan at least annually;
- Document and implement policy and procedures specifically addressing portable media protection; and
- Implement automated preventive controls configured to block the use of USB flash drives or automatically encrypt them if they are not encrypted.

THE CURRENT GOVERNANCE STRUCTURE LACKS OVERSIGHT, AND TRANSPARENCY COULD BE IMPROVED

As an independent nonprofit entity, the NMHIX meets federal regulations requiring it have a well-defined governing board (42 CFR Part 155.110(c)). The board's composition strives to balance consumer advocacy and industry input while meeting the expertise, diversity, and representational requirements and proscriptions of both the ACA and state law. In particular, the ACA prohibits "a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance" (42 CFR Part 155.110(C)(3)(ii)). Additionally, state law restricts governor appointees to no more than four from the same political party (Section 59A-23F-3(K) NMSA 1978). **Appendix K** lists the board make-up as of June 1, 2015, while **Appendix L** catalogs statutory compliance. Table 31, summarizing composition by statutory representation, shows industry experts outnumber consumer advocates by 3 to 1.

Table 31. NMHIX Board Statutory Representation

Representation Type	Number of Board Members
Ex officio	2
Consumer Advocate	1
Issuer	2
Health Care Provider	1
Unrestricted	7
Total	**13**

Source: Chapter 59A-23F-3 NMSA 1978

New Mexico's law might harbor members from a stringent interpretation of interest conflicts by exempting members simply by affiliation. Section 59A-23F-G stipulates board members shall comply with the conflict of interest provisions of the Governmental Conduct Act but then continues to exempt members from any conflict of interest based solely on association. As shown in **Appendix M**, it is fairly unique in that regard among the 12 states approved as state-based exchanges that operate with governing boards. Six states outright prohibited such affiliations (California, Minnesota, Nevada, Connecticut, Maryland, Massachusetts). Hawaii became the seventh state with such restrictions in 2014 by amending its statute to reassign such experts to advisory status. Where allowed, language limiting industry influence, such as abstaining on matters relevant to that member's affiliation, is included in recognition of this sensitive issue (Idaho). Other states included language clarifying conflict of interest to help preempt occasions where industry interests might clash with exchange interests (Minnesota, Washington).

The Governmental Conduct Act is clear in its prohibition of acting on behalf of oneself or family for financial gain to the detriment of the public. However, it does not speak to this unique circumstance of a board member potentially acting on behalf of his or her employer to its benefit but to the disservice of the NMHIX. Nor does the board's Conflict of Interest policy, recently updated, openly address this issue. Section 59A-23F-3(H) NMSA 1978, which stipulates each board member and employee of the organization shall have a fiduciary duty to the NMHIX, remains the single braking mechanism. In general, fiduciary duty means acting in the best interests of the public. Both Plan of Operation (Article II Section 1.2) and the Code of Conduct Policy (Section II.A) emphasize this concept of board members holding positions of public trust.

As of June 1, 2015, three of the thirteen board members were affiliated with issuers. By state law, two of the positions represent issuers. A member with a third issuer affiliation filled an unrestricted position. At that point the following health insurance companies held a board presence:

- Blue Cross Blue Shield;
- Health Connections Co-op; and
- Presbyterian.

As discussed earlier, seven states would bar board members with such affiliations from participating on their boards and Idaho would preclude the member from voting on matters relevant to his or her affiliation.

The Board operates under few restrictions and little state oversight. New Mexico was one of three states opting to use the public or private nonprofit paradigm, providing maximum "arm's length" relationship to state control. As already shown in **Appendix M**, six states initially chose other quasi-governmental structures while seven states formed their exchanges within existing executive agencies or created new ones.

As a consequence, key oversight mechanisms to help guide the effective use of funds are missing. Oversight functions performed by the Legislature and state agencies include the appropriation and budgeting processes; Department of Finance and Administration, Financial Control Division oversight of professional contracts and expenditures; accounting procedures defined by the Model of Accounting Procedures (MAPs); State Auditor review and approval of the annual audit; General Services Department, State Purchasing Division review of procurement; and Department of Information Technology review of IT projects. These roles fall under exempted law or administrative code listed in the right-hand column of Table 32.

Table 32. New Mexico Health Insurance Exchange Act
Applications of Additional State Law or Regulations

NMHIX is:	
Subject to the following:	**Not subject to the following:**
State Statute	State Statute
Governmental Conduct Act	Accountability in Government Act
Financial Disclosure Act	Audit Act
Inspection of Public Records Act	Budget Process
Open Meetings Act	Department of Information Technology Act
Per Diem and Mileage Act	Personnel Act
Tort Claims Act	State Rules Act
Administrative Code	Administrative Code
Title 2 Public Finance	Title 1 General Government Administration
Chapter 42 Travel and Per Diem	Chapter 2 Administrative Procedures
	Chapter 4 Procurement Code
	Chapter 7 Personnel Administration
	Chapter 12 Information Technology
	Chapter 15 General Records Retention and Disposition (GRDDS)
	Title 2 Public Finance
	Chapter 1 Public Finance General Provisions
Note: Section 4 (K) does require "periodic audits."	Chapter 2 Audits of Governmental Entities
Section 6 (C) requires an annual audit.	Chapter 20 Accounting by Governmental Entities
	Chapter 40 Expenditure of Public Funds

Source: Section 59A-23F NMSA 1978

New Mexico has limited structured oversight compared with other states. The primary means for legislative influence occurs in the appointment process for board members, with equal representation to the governor appointees. As indicated in **Appendix N**, five other states with governing boards offer a combination of executive and legislative selection but often to lesser degree. Four appoint members from the governor with legislative input or confirmation. Two, Maryland and Massachusetts, do not offer legislative participation in the appointment process.

However, as summarized in Table 33, these two states—and others—have implemented various controls in the midst of exclusions from statutory or regulatory rules meant to expedite operations. New Mexico lacks these controls.

Table 33. Sample Exchange Controls in SBE States with Governing Boards

State(s)	Control
Colorado, Hawaii, Idaho, Utah, Washington	Statute established legislative oversight committee or task force
California	State personnel agency reviews salaries
Colorado, Hawaii, Massachusetts, Minnesota, Nevada, Oregon	Subject to legislative audit, state auditor, or secretary of state audit
Minnesota	Subject to information technology oversight by state
Maryland, Massachusetts	Report on specific performance measurements and data, including fraud, waste and abuse prevention plan
Nevada	Subject to state's procurement code
Washington	Subject to allotment procedures
Minnesota	Budget submitted to the legislature

Sources: See Appendix N

Compensating reporting mechanisms to legislature and executive agencies are weak, further limiting outside review. The Act required quarterly reporting during the start-up phase and annual reporting thereafter, as depicted below. While the NMHIX reported regularly on activities to the Legislative Health and Human Services (LHHS) interim committee from May 2013 to last December, the abridged reporting requirement reduces legislative oversight. Furthermore, no reporting is required to any executive agency other than the Superintendent of Insurance, who already sits on the board. Thus, state expertise on key areas of procurement, information technology, and finance were not available as a matter of course to the NMHIX as a consequence.

Table 34. Reporting Requirements

			Reported to:	
Report on:	**To:**	**Timeframe:**	**LFC**	**LHHS**
Implementation of the Exchange	Legislature, the governor and the Superintendent of Insurance	Between July 1, 2013 and January 1, 2015	Aug 2013	May 2013 July 2013 Oct 2013 Dec 2013 July 2014 Aug 2014 Sept 2014 Oct 2014 Dec 2014
Annual Report	Legislature, the governor and the Superintendent of Insurance	January 1, 2015 and thereafter		April 2014
Other	Legislature, the governor and the Superintendent of Insurance	Upon request January 1, 2015 and thereafter		

Sources: LFC files and LHHS

In addition to frequency, the Act is short on prescribing reporting content while several states are more specific. Table 35 compares New Mexico's statutory requirement to what could be considered "best practice" examples. In particular, Maryland law contains specific performance measures focused on outcomes.

Table 35. Comparison of Reporting Content

State	Reporting Requirements
New Mexico	Report annually and upon request thereafter Publish administrative costs of the exchange as required by state or federal law
Massachusetts	Annually conduct a study of exchange activities and enrollment, including collecting data on expenses, claims, complaints, goal accomplishment
Maryland	Submit annual report on activities, expenditures and receipts of the exchanges, including specific data requirements and outcome measures

Source: Appendix N

Oversight normally associated with state agencies currently rests with the federal Office of Consumer Information and Insurance Oversight (OCIIO) at Centers for Medicaid and Medicare Services (CMS). While CMS will continue monitoring state-based exchanges per 45 CFR Part 155.1200, any degree of financial scrutiny will fade as the federal grants phase out.

The annual financial audit will become the primary external means to catch waste, fraud and abuse associated with NMHIX expenditures. The financial audit is limited in scope, verifying the financial statements are prepared in compliance with GAAP and reflect financial activity. Moreover, the NMHIX audit is exempt from the Audit Act, essentially allowing a state-created taxing authority to spend what could be considered public money without any oversight from the Office of the State Auditor (OSA). Unless the OSA actively reviews the financial particulars, detail will be obscured by the high level presentation of the financial statements. OSA approval of the audit would heighten confidence the NMHIX is operating in a fiscally sound manner.

The NMHIX lacks robust transparency and measures for accountability. Robust disclosure of key information would shed light on NMHIX operations in lieu of state oversight activities. At a minimum, NMHIX should follow federal regulations per the Act but compliance remains uncertain in key instances as shown in **Appendix O**. In particular, public access to key financial information is limited. Currently, the interested public needs to weed through board minutes and posted presentations to derive any meaningful information. In many instances, it is simply not available as the minutes appear to condense discussions and some key points remain unaccompanied by the associated documentation so relevant detail is lost. The annual audit, for example, is not publicly posted and essential grant information—such as use of funds—is lacking.

As documented in the Financial Policies and Procedures, such information could be available to the public "upon request" in most instances. However, the availability of the information is uncertain given the unknown implementation status of the various proposed practices.

Despite direction from the board, contracts are not posted to the website. In February 2014 a board member requested staff post the contracts list to the website. NMHIX staff complied the following month by posting the March 15, 2014, report but has not updated the site since then. Prior to the establishment of NMHIX, contracts administered by the Human Services Department for exchange grant activities were included on the state's Sunshine Portal. Contracts listed on USASPENDING.GOV are comprehensive for the entire state and available only by fiscal year. For FY14, the site reports $21 billion grants awarded to the state, 49 thousand transactions, and $374 million in sub-awards. Contract reporting lists recipient and amounts but not the state entity making the award. Consequently, information relating to NMHIX contracts has become obscured for the general public.

Dashboards relating exchange activities have not been posted on the website for almost a year, reducing reporting and accountability. The most recent dashboard, dated August 22, 2014, included sections on enrollments; call center performance, referrals, and volume; and status of systems development, including risk profiles. BVK produced weekly reports tracking similar information, adding website analytics, covering the first enrollment period starting in October, but these were not posted. A subsequent contract with Burson-Marstaller executed September 2014 incorporated a task to "evaluate overall dashboard reporting processes, and deliver reporting template to CEO." A draft dashboard was presented to the board the following November for approval but does not appear to be in use.

The NMHIX did submit Executive Dashboards related to information technology development but did not produce a master dashboard or other format normally associated for overall performance evaluation.

Committee meetings are open to the public at the discretion of the Chair, which might limit stakeholder input. As the sole determiner of policy, the board considered the Open Meetings Act only applied to board meetings. However, committees develop the recommendations for the board, which consistently adopts them. Thus, opportunities for stakeholder input into policy decisions can be curtailed to the extent committee meetings are closed, coming in at the backend of policy making through public comment during the official board voting process.

The website does contain a tab for committee meetings but the latest posted information dates from November 2014. An agenda posted for the Operations Committee November 13th meeting includes the date, location, and discussion items. It also included a public dial-in number for those requiring remote attendance. The website's

News tab does feature an April 2015 committee meeting announcement. In contrast, the Connecticut exchange posts an invitation to the public for all committee meetings and provides committee minutes in a broad array of website information that is easily accessible, consistently formatted, and posted under intuitive headings.

Recommendations

The Legislature should consider improving the transparency and oversight of the NMHIX by amending the New Mexico Health Insurance Exchange Act to:

- Require oversight by the Office of the State Auditor;
- Increase reporting requirements to the Legislature and Office of the Governor, including performance reporting associated with the Accountability in Government Act; and
- Outline financial reporting requirements to the public.

The NMHIX should improve transparency and accountability by considering posting a broader array of information on the website, including the following items:

- Committee agendas, minutes, and calendar;
- Financial information as recommended in **Appendix O**;
- Contracts;
- Stakeholder sections;
- Published reports, including customer satisfaction surveys;
- Dashboards, including performance metrics regarding enrollment; and
- Keeping the website current, with key documents appropriately archived for retrieval.

NMHIX FACES POTENTIAL OPERATING ISSUES IN THE ABSENCE OF ROBUST POLICIES AND PROCEDURES TO SUPPLANT STATE LAW AND ADMINISTRATIVE CODE

In key instances, policies and procedures were not developed timely or lacked the comprehensiveness provided by state rules to ensure staff performed tasks appropriately. Foreseeing the need for establishing protocols as an independent entity, the Act required the NMHIX to develop a Plan of Operations, including various policies and procedures and "additional provisions necessary and proper for the execution of the powers and duties of the board" (Section 59A-23F-5(D)(6) NMSA 1978).

NMHIX Policies and Procedures were slow in coming and lacked detail to encourage "best practices." While **Appendix P** tallies compliance status in adopting formal documents, Table 36 summarizes areas of current concern that are explored further in subsequent sections. In general, inadequate staffing or expertise compounded the absence of desk procedures to appropriately guide day-to-day activities.

Table 36. Summary of Policy and Procedure Issues

Policy and Procedure	Issue(s)	Result
Preliminary Plan of Operation within 60 days	• Procedures for handling and accounting for the Exchange's assets and money not prepared within 60 days. • Alliance staff handling Exchange finances Exchange used QuickBooks until November 2013 when Abila MIP implemented.	2013 A-133 Audit lists 6 significant deficiencies.
Financial Policies and Procedures	Not developed until December 2013.	2013 A-133 Audit lists 6 significant deficiencies.
Current issues: Errors and potential non-allowable expenditures might indicate the need for additional training and supervisor oversight prior to posting entries. Difference between Human Services Department documents might indicate NMHIX has $60 thousand less in remaining grant funding than recorded. See Appendix Q.		
Internal Controls (Separation of Duties)	Not completed until sufficient staffing in September 2014 and Segregation of Duties Matrix implemented.	Lack of segregation of duties: Repeat finding for 2014 audit but considered resolved for 2015.
Grant Management	• Staff not knowledgeable about federal grants. • No Grants Manager.	2013 Single Audit lists 6 significant deficiencies 2014 Single Audit: 2 findings resolved, 4 repeated.
Current issues: Prior and planned expenditures might be non-allowable by the Center for Medicaid and Medicare, requiring payment from another funding source and raises risk for audit findings; grant reporting on website is incomplete.		
Procurement Policy and Procedures	• Not implemented until March 21, 2014. • Exchange apparently used Alliance Procurement policy for early procurements. • Inconsistent thresholds between Board Policy and internal Financial Policies and Procedures. • No detailed procurement procedures. • No Central Procurement Officer. • Inconsistent records.	• Repeat audit finding. • Missing procedures to replace Procurement Code to ensure proper handling of procurements and effective use of taxpayer dollars. • Contracts based on time and materials made it difficult to gauge deliverables and tended to increase costs. • Poor records management for procurements led to minimal transparency.
Current issues: Insufficient procedures might lead to additional procurement problems and cost overruns; June 2015 Policy & Procedure 2015-0001 has numerous areas for improvement per 1 NMAC 4: lacks processes for under $100 thousand; places business owner in position of procurement officer, removing arms length oversight; excludes administrative details, such as handling of RFP submissions to ensure confidentiality; requires more detailed documentation and file retention processes to substantiate fair, competitive process to obtain most beneficial procurement..		
Contract Administration	Vendor Management Role was instituted November 2014 but high level role description does not ensure compliance with "best practice" desk procedures.	• Lack of robust contract management and vendor oversight. • One instance of contract lacking fee schedule.
Current issue: Vendor Management Roles and Policy & Procedures 2015-0001 do not specify source documents to retain in procurement file for audit trail; lack processes for post-award contract oversight to ensure contract compliance with terms and deliverables.		
Records Management	Policy and procedure not adopted until May 2015.	Insufficient record management.
Current issue: Records policy is formally adopted but not in practice.		

Source: LFC Analysis

The 2013 single audit reflected lack of implementing sufficient financial procedures. As a provider of public service and funded exclusively by public monies, the NMHIX must ensure that it operates in a fiscally sound manner. To aid in this effort, published federal requirements for grants cover all phases of a grant award. Most important to recipients, OMB Circular A-110 (relocated to 2 CFR Part 215) provides the administrative procedures and policies that they must follow once they have received the award.

Broadly, the requirements specify the recipient should safeguard all assets, expend funds appropriately, and maintain adequate financial records that are supported by source documentation.

The Alliance, a quasi-governmental entity created in 1996 to offer small business health insurance, had been designated as the exchange entity until the enactment of the New Mexico Health Insurance Act in 2013 that dissolved the Alliance and created the NMHIX.

As a result of transferring financial operations from the Human Services Department to NMHIX, the NMHIX operated in non-compliance with federal regulations, as reported by the 2013 A-133 Single Audit that reported six significant deficiencies reported in **Appendix Q**.

The NMHIX has taken key steps to remediate early weaknesses in internal controls to improve financial management. Hiring a third financial staff in September 2014 allowed the NMHIX to properly isolate the major responsibilities of authorizing transactions, maintaining custodianship of assets, recording transactions, and reconciling or verifying transactions and accounts. The subsequent NMHIX Segregation of Duties Matrix adequately addressed the core areas of financial management, assigning specific activities across four positions including two accountants, the CFO and the CEO in certain circumstances. Payroll has been outsourced, creating another level of separation for an area that had been problematic.

Moreover, an Agreed-Upon Procedures external review to assess compliance with CFR Subpart H 155.700 through 155.740 (Small Business Health Options Program or SHOP) found no financial issues associated with SHOP, including receipts, accounts receivable and disbursements to issuers. This third-party review adds confidence the controls are working in that program to produce financial reporting in accordance with GAAP (45 CFR part 155.1200(a)(1)).

Finally, staff underwent 140 hours of combined training covering all modules in the Avila MIP accounting system, A-133 compliance with grant regulations, and federal 1099 reporting. Thus, while some of the 2013 findings were repeated for 2014 (such as the segregation of duties issue), it appears the NMHIX has addressed most deficiencies to a large extent.

An initial review of the general ledger (GL) for January 2014 through March 2015 raises potential concerns. Because the NMHIX did not deliver the GL until 70 days into the evaluation, a comprehensive analysis was not performed given time constraints. Thus, the noted issues accompanying the evaluation in **Appendix Q** are not confirmed findings but point to areas worthy of further investigation, particularly for systemic issues with potential to impact financial integrity beyond the federal grant lifecycle. Additionally, the 2014 audit was not issued until the end of August and delivered in the post-fieldwork phase in October 2015. While financial tables were updated to reflect the new data, no additional analysis was performed.

Records management needs improving. Records were not available or difficult to obtain from the NMHIX, particularly from the early months following inception. For example, documents substantiating selection processes for procurement, normally compiled in a procurement file, did not exist for some procurements prior to August 2014. Thus, the NMHIX remains out of compliance with 2 CFR Part 215.46 (Procurement records) that should include the following items, at a minimum, for purchases over the federal threshold of $25,000:

(a) Basis for contractor selection;
(b) Justification for lack of competition when competitive bids or offers are not obtained; and
(c) Basis for award cost or price.

The NMHIX currently does not have a custodian to implement the recently adopted Records Policy. The board did not adopt a formal records policy until May 15, 2015. Comprehensive provisions cover retention and destruction of both electronic and hard copy records as well as addressing security issues. They outline a strong records management program, headed by a custodian with significant responsibilities. Among them, the custodian is to report any breaches and appropriate corrective actions annually to the Operations Committee. This key position is not reflected on NMHIX organization chart, nor do any of the position descriptions include the activities to ensure compliance with the new policy.

The exemption from the Procurement Code left NMHIX susceptible to procurement irregularities in the absence of strong, well documented policies, administrative procedures, and knowledgeable staff. Procurement standards established in 2 CFR Part 215.40 through Part 215.48 require extensive actions on the part of recipients for compliance. As already noted, NMHIX operated almost a full year without a formal, written Procurement Policy in place. Adopted in March 2014, it sets forth key provisions as listed in **Appendix R**. Most notable, the threshold for using a competitive procurement process and requiring board approval was set at $100 thousand versus the state's thresholds of $60 thousand for tangible goods and $50 thousand for professional services.

The NMHIX lacks detailed processes to guide procurement execution or a centralized procurement office with such expertise. The New Mexico Administrative Code (NMAC) provides regulations to direct procuring activities for public entities, from describing pre-bid conferences to bid evaluation and award (1 NMAC 4.1). While appearing overly complicated, every conceivable eventuality has been considered and prescriptive actions clearly laid out to ensure procurements are fair, consistent, and afford the greatest competition possible.

The NMHIX has not developed comparable administrative processes or desk procedures. The current CEO improved oversight by assigning procurement and contract responsibilities to appropriate staff and developing a Vendor Management Role document. However, as discussed further below, the document merely summarized responsibilities without step-by-step instructions on how to carry them out. Furthermore, staff did not attend state-sponsored procurement training as is available for state employees performing purchasing activities.

NMHIX processed a $430 thousand amendment for the PCG project management contract, without board approval. NMHIX procurement policy states "an amendment greater than $100 thousand must be approved by the Board." NMHIX March 31, 2015, contract reporting to the board shows an increase in PCG's contract from $4.7 million to $5.1 million. The amendment dated January 20, 2015, is not consistent with what was reported to the board. While the amendment reallocated the amounts in the scope of work, it did not change the total contract value.

Whether NMHIX performed due diligence to obtain the best value for early professional services is uncertain and at least two procurements most likely should have been competitively bid but were not. Current NMHIX staff suggested the NMHIX temporarily used the Alliance Procurement Policy until NMHIX adopted its own, which set the competitive procurement and board approval threshold at a higher $150 thousand. Two contracts exceeded this amount by a wide margin but were not competitively bid. One for consulting services appears subject to "pyramiding," the practice of artificially dividing contracts to avoid threshold requirements and then subsequently increasing them to meet the true need. The other was leased building space. There is no documentation to support either as sole source procurements.

A contract for marketing services might have been inappropriately awarded. Documents reviewed for NMHIX initial marketing and public relations procurement, which resulted in hiring a company that was fired nine months later for perceived ineffectiveness, reveal several discrepancies that remain un-reconciled. First, the best and final offer (BAFO) values for the awarded vendor, BVK, differ significantly from one document to another, with a variance of over $4 million to the final contract amount.

The Evaluation Committee awarded BVK the full 20 points allowed for budget criteria based on what appears as the low offer of $3.4 million to $4.2 million, bringing the total score to 86, just under K2MD's combined score of 88. However, the final contract ballooned to over $7.7 million, without any justification yet provided, raising the question whether the firm's BAFO was artificially set low to win the contract and then adjusted upwards during contract finalization.

More recently, one firm received the lowest ranking for a competitive procurement but was awarded a contract. The Waite Company, providing outreach services since November 2014, responded to RFP 2014-003 (Education and Outreach Services) and was awarded a $650 thousand contract. The firm had received the lowest rating (35 compared with the highest of 90) in its initial review. The NMHIX now considers Waite its main outreach partner, with no documentation to substantiate how the lowest ranked firm obtained this lead role.

The NMHIX contract practices failed to control costs. NMHIX issued time-and-material (T&M) contracts, paying the vendors incrementally based on effort, not necessarily results. The Federal Acquisition Regulation states a time-and-materials contract may be used only when it is not possible at the time of placing the contract to estimate accurately the extent or duration of the work or to anticipate costs with any reasonable degree of confidence. They are the least preferred type of contract for public procurements because they do not encourage efficiency and cause contracting agencies to bear more risk than in fixed price contracts. Fixed price contracts are more desirable because they reduce agencies' risk by shifting it to the contractor when there is adequate price competition.

NMHIX awarded the first Time and Materials (T&M) contract in June 2013. NM Health Insurance Alliance, NMHIX predecessor, awarded the competitive contract for project management services to Public Consulting Group (PCG), under a T&M arrangement, with a maximum not to exceed amount of $3.2 million. The contract term was for two years, with three one-year options to extend. The optional work on an as-needed basis in Amendment No. 3 of the RFP appears to be additional effort, but was defined as consulting services in the final contract, adding an additional $1.5 million to the contract value. The contract was awarded five months later than initially planned, having an impact on effective project management.

The BVK contract and oversight might have led to unreasonable costs. The original BVK agreement omitted performance criteria as a precursor to payment, with NMHIX consenting to pay the contractor "for services and for costs and expenses necessarily incurred by the contractor in the provision of the services and the performance of the scope of work rather than upon "satisfactory performance." Furthermore, an hourly fee schedule was omitted from the contract. Technically, BVK could have charged higher than industry standard hourly rates, maximizing the cost.

Table 37 lists BVK billing rates by level of service. Travel time was billed at the same rate as productive time; usually travel rates can be negotiated as a flat ("port-to-port") rate or lower.

Table 37. Sample Billing Rates for BVK

Level of Service	Hourly Rate
Account Management/Account Planning	$150-$295
Creative Conception	$295
Copywriting	$250
Administrative Support	$ 90

Source: NMHIX

Moreover, BVK tacked on a five percent sales tax (later called Gross Receipts Tax (GRT) on the invoices) for all non-media charges, including travel, meals, mileage, hourly billings, and third-party invoices. Not only was much of the work performed in Wisconsin and, therefore, not subject to New Mexico gross receipts tax, Wisconsin does not assess a sales tax on professional services. It is not known if BVK remitted any valid collections for work performed in New Mexico to the state's Taxation and Revenue Department or claimed its exemption rights for work performed outside the state.

While the entire $7.3 million paid to BVK did not involve GRT (media charges were subject to a permissible net 8.5 percent commission instead), NMHIX might have been overcharged a significant amount.

Lack of post-award oversight meant NMHIX was non-compliant with federal rules. Federal regulations require a system for contract administration to ensure contractor performance conforms to standards (2 CFR Part 215.47). Minimal oversight is apparent for early contractors, a concern particularly for the contracts initiated under time and material (T&M) terms.

Because T&M contracts provide for the payment of labor costs on an hourly basis, they provide no positive profit incentive to the contractor for cost control or labor efficiency – the more time and money spent, the more profitable it is for the contractor. Therefore, appropriate oversight of contractor performance is required to give reasonable assurance that efficient methods and effective cost controls are in place.

The NMHIX did not adequately monitor costs and contract performance for its project management vendor, placing funds at risk, resulting in overpayment of $271 thousand. NMHIX approved some of the PCG invoices for reimbursement of $315 thousand without appropriate documentation required by the contract. Some of PCG invoices included summarized hours by individual and billing rate, without detail hours log or time sheets. The PCG contract requires a detailed statement accounting for all services performed and maintain detailed time and expenditure records that indicate the date; time, nature and cost of services rendered.

In addition, NMHIX reimbursed its project management vendor $256 thousand for 2,048 hours billed at $125 per hour. NMHIX time-and-materials contract with PCG included billing rates by labor category but the $125 billing rate was not included in the contract. If the work is the same as that originally contracted for, the contractor may not charge for different categories at different rates unless there is a contract modification that reflects the agreement of both parties to the changes. NMHIX did not amend the PCG contract to add a different labor category and billing rate. In addition, while NMHIX IT director requested a specific PCG individual to stop work December 5, 2014, the individual continued to work, resulting in an additional overpayment of $15 thousand. By using T&M contracts that are not properly monitored, NMHIX increased its risk of higher project costs and noncompliance with federal procurement requirements.

NMHIX did not have a process for formal acceptance of PCG's deliverables, making it difficult to determine if all tasks for each deliverable were complete. While PCG invoices included individual time logs with tasks worked on, NMHIX only monitored hours billed and not the completion of deliverables. This is one of the risks in a time-and-materials contract arrangement. Other than the CEO sign-off and approval of the vendor invoice, there was no evidence NMHIX verified the completion of all tasks. Determining if all tasks in each deliverable were complete was not well documented and could not be always verified. For example, the lessons learned deliverable remains in draft and several project management documents were revised numerous times and appear not to be finalized.

The IV&V vendor also reported NMHIX has inadequate documented process for deliverable management. The project does not have a baseline process for managing deliverables from its vendors. To remediate this, NMHIX documented a process in place to address the GetInsured deliverables. However, it lacks the detail to support deliverables from all NMHIX vendors. The purpose of a deliverable review and acceptance plan is to define how the NMHIX review and acceptance process will be performed and managed for contract required documents, as well as for deliverables submitted in non-document form. The plan should identify the steps, processes, output artifacts, and resources necessary to efficiently and effectively receive, review and accept NMHIX deliverables. This process should apply to internal as well as contract deliverables. The IV&V vendor recommended NMHIX establish a deliverable review and acceptance process for all vendors, including PCG.

> 2 CFR Part 215.47 "A system for contract administration shall be maintained to ensure contractor conformance with the terms, conditions and specifications of the contract and to ensure adequate and timely follow up of all purchases. Recipients shall evaluate contractor performance and document, as appropriate, whether contractors have met the terms, conditions and specifications of the contract."

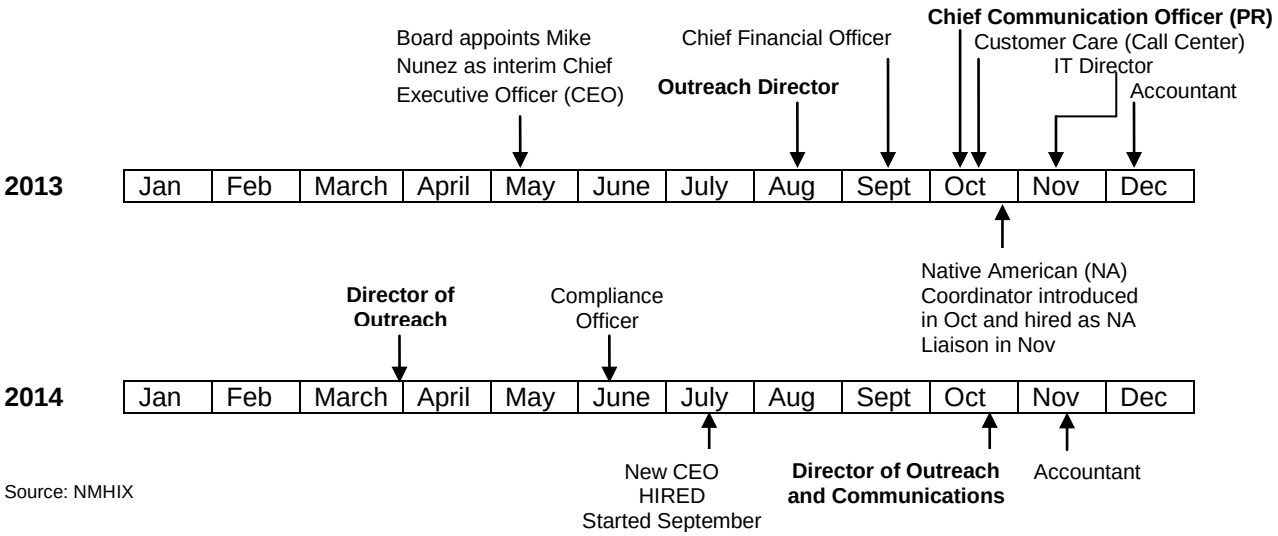
Although NMHIX recently assigned a staff vendor manager to each contract, NMHIX still lacks contract administration procedures. The vendor manager role is responsible for ensuring that the vendor performs as contracted. When invoices are received, the vendor manager is responsible for ensuring that the services were performed in accordance with expectation and contract. The manager signs an attestation to that

effect prior to the payment of the invoice. In addition, NMHIX procurement policy does not specify the minimum documentation required for contract files and does stipulate that all source documents (for example, receipts, purchase orders, invoices, bid materials, requests for proposals, record of contract negotiations, justification for contract amendments, etc.) be retained to ensure a clear and consistent audit trail is established.

Although PCG provided other states project management services for health insurance exchange projects, it is not clear why NMHIX selected a time-and-material contract arrangement. T&M billing arrangements are typical when the full scope of the project is not well understood. NMHIX initial RFP required a not-to-exceed total fixed fee for project management services. The RFP required the vendor's cost proposal to include total dollars by deliverable and provide estimated hours, average hourly rate, and total cost for staff and other components to support the total fix fee. However, the RFP was subsequently amended switching to a T&M billing model for PMO services, requiring vendors to submit a new cost proposal based on hourly rates for Project Managers, Business Analysts, Technical Analysts and other categories, and a not-to-exceed cost for the scope of work. However, the procurement documentation to support the decision for a T&M contract was not available. While the PCG contract scope of work includes defined tasks, there are no cost estimates, milestones or timeline, and the contract does not include performance measures.

The NMHIX experienced staffing shortfalls and turnover, contributing to operational issues. New Mexico's enabling statute exempted NMHIX from the State Personnel Act, presumably to expedite hiring of qualified personnel, but slow hiring and turnover prevented stable staffing for two years. The board complied with statutory requirements to hire staff to carry out the purpose of the New Mexico Health Insurance Exchange Act (Section 59A-23F-4(F)) by hiring an interim CEO and directing him to hire staff. While two key positions were filled by August, in September the board expressed concerns over the lack of staff and urged the CEO to speed up the hiring process. The CEO used Alliance staff and contractual help as a short term solution.

Figure 5. Timeline of NMHIX Key Personnel



Source: NMHIX

By December, five additional key staff were on board, including the Chief Financial Officer, Native American Liaison, and IT Director. During this time, the Outreach Director left after one month and the Chief Communication Officer, hired in October, was gone by the following March. The interim CEO converted the substitute contractor providing outreach services to a full time employee in April when her contract expired. Thus, the NMHIX experienced significant turnover in positions concerning communications and outreach, with four people performing these functions under various titles within a 13-month period.

Furthermore, only one senior staff remains in the same position hired during the interim CEO leadership, with 57 percent turnover of the original 14 staff hired. The lack of sufficient staff marking the early start-up months turned to staff turnover as new leadership and changes in direction took hold. The new CEO reorganized immediately, combining the Outreach and Communications (public relations) functions under one director who was hired in October, two weeks before open enrollment began.

Since October 2014, the organizational structure has been modified three times in response to staff turnover and changing environmental factors. Top line management positions have shrunk from five to three, with the Compliance Officer position eliminated. Most notable, the latest reorganization merged two divisions—Customer Service Center and Information Technology (IT) — under a single Senior Operations Manager that oversees functions as diverse as IT and broker relations. The grant denial for further IT development was the main catalyst for the consolidation.

The NMHIX Call Center might duplicate costs of the Human Services Department (HSD). HSD, which currently operates five call centers, was planning on issuing an RFP in August to consolidate them for improved customer service. Xerox, which also operates the NMHIX referral call center, handles the three call centers for Medicaid. Potential exchange savings might be generated through establishing a memorandum of understanding between HSD and the NMHIX (based on a cost allocation plan) for a full service customer experience covering both the exchange and HSD clientele. NMHIX spends about $865 thousand on the call center annually.

Recommendations

The New Mexico Health Insurance Exchange (NMHIX) should:

- Develop stronger procurement Policies and Procedures detailing the procurement process, selection process by type, evaluation committee processes and reporting, documentation and record keeping, contract development, and post-selection process including vendor oversight, with detailed administrative procedures to ensure compliance;
- Clarify thresholds, including gross receipt tax, and align them consistently throughout all documents;
- Require NMHIX staff assigned in a vendor manager role complete the one and three-day trainings offered by the State Purchasing Division;
- Consider centralizing procurement oversight under a Chief Procurement Officer who has undergone the State Procurement Officer training and has relevant experience (if appropriate for procurement volume);
- Review opportunities to reduce costs, such as partnering with HSD for call center activities rather than maintaining a separate facility;
- Use the State Purchasing Division website for statewide pricing and notices of vendor suspension or debarment;
- Implement the Records Policy by designating a records custodian; and
- Archive historical procurement information as sufficiently as possible.

The NMHIX should adopt formal rules, authorities, roles and responsibilities for stakeholder groups, including:

- A formal Communication Policy per Section 59A-23F-3(S)(2) and (5) addressing communications with stakeholder groups that includes:
- A delineated method and format for stakeholder groups to submit input for key decisions as well as board procedures to "duly consider recommendations" in addition to public comment periods, including board committee interactions.

October 22, 2015

Mr. David Abbey
Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Dear Mr. Abbey,

After only two and a half years in operation, the New Mexico Health Insurance Exchange (NMHIX) is delivering on our mission to expand access to high-quality and affordable health insurance to New Mexicans. On behalf of the NMHIX Board of Directors and leadership, we would like to thank the Legislative Finance Committee (LFC) for taking the time to review our program and to provide recommendations on areas where NMHIX can continue to improve.

During our review of the LFC recommendations, we were pleased to see several areas of alignment where NMHIX is already implementing the listed recommendations. While the insight provided by the LFC is important to our mission, the Exchange identified some misunderstandings and incorrect attributions that have significant implications for the observations of the report.

Establishment of the Exchange: Commitment to New Mexicans

With the start of the 2016 Open Enrollment Period just around the corner and 44,302 New Mexicans currently covered through the Exchange, the road to arrive at today's success has not been without its challenges.

- The New Mexico Health Insurance Exchange Act, which called for the establishment of the NMHIX as a non-profit public corporation, was passed just 187 days before the start of the first Open Enrollment Period on March 28, 2013.
    - Certainly, we would have appreciated the luxury of the two and a half years that our colleagues in Maryland[1], or the three years that California[2], had to get ready to open their doors for the first time.
- Following the passage of the Act, a 13-member Board of Directors convened – and after the first meeting in April 2013 in less than six months, NMHIX successfully put in place a new brand, website, call center, and developed a network of enrollment assisters – allowing beWellnm to open our doors on October 1, 2013 to assist New Mexicans in shopping for health insurance, many for the first time.

This immense effort took place while also ensuring NMHIX met commitments to the Legislature and the constantly evolving federal regulations.

- After the end of the second enrollment period and a few months into our second year of operations, in August 2014, the NMHIX Board concluded a national search for a CEO and brought on new leadership to the organization in August 2014.

[1] http://kff.org/health-reform/state-profile/state-exchange-profiles-maryland/
[2] http://kff.org/health-reform/state-profile/state-exchange-profiles-california/

- Soon, the new CEO directed important operational and staff changes, continued to build on the governance structure, and used data to inform a targeted outreach and marketing strategy for the second Open Enrollment Period.

Building Awareness and Enrollment: NMHIX is working for New Mexicans

With the first enrollment period technical challenges behind us, the staff focused on building awareness of the Exchange, reaching the uninsured in the state, and enrolling New Mexicans in coverage.

- According to the most current Census data released in September of 2015, between 2013 and 2014 the uninsured rate in our state fell 4.1% to 14.5%[3].
- This reduction in the uninsured can be attributed in part to the more than 220,000 enrolled in Medicaid[4] since Medicaid expansion, and the 44,302 of individuals enrolled in the Exchange.

As a frontier state with a culturally, linguistically and geographically diverse population, it is paramount that NMHIX be responsive to this environment.

- We have made great strides in raising awareness across a diverse population through our outreach and marketing efforts.
- As the 5th largest state geographically with the 13th smallest population, the NMHIX requires creative thinking to reach our extremely diverse population and do so economically. NMHIX has been very successful in meeting this challenge in a very short amount of time.
    - For example, awareness levels of the beWellnm brand nearly doubled in the first two months of the second Open Enrollment Period to more than half of New Mexicans – and half of uninsured New Mexicans – aware of the Exchange.
    - Additionally, NMHIX has reduced our marketing, outreach and consumer assistance cost per enrollee by approximately 50% during the second Open Enrollment Period, and we are projected to spend even less in Open Enrollment three.
    - A recent NMHIX survey completed in August 2015 showed that 36% of recent beWellnm enrollees were uninsured prior to getting coverage through the Exchange, and 20% of them had been without coverage for more than five years.
        - Additionally, 57% of enrollees are either very satisfied or satisfied with their health insurance coverage demonstrating the Exchange is working for New Mexicans.

Measurement: Meeting Objectives

The question of how to measure success is one that all State-Based Exchanges are facing. One measure is market penetration of eligible populations.

- A new Kaiser Family Foundation report released on October 13, 2015, found that of approximately 233,000 New Mexicans that are still uninsured, only 13% are eligible for a tax credit. [5]

[3] http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf
[4] http://www.nmlegis.gov/lcs/handouts/ALFC%20081915%20Item%2021%20Progress%20Report%20Healthcare%20Workforce.pdf
[5] http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/

    - This demonstrates that the Exchange has captured much of its target population: New Mexicans eligible for a tax credit.
- The tax credit is a key to enrolling individuals in coverage and we intend to continue to demonstrate the strength of that credit.
    - For example, in plan year 2015, the average premium of a NMHIX plan with tax credit applied is $127 a month, and 49% of New Mexicans enrolled through beWellnm selected a plan with a premium under $100 a month.[6]

Sustainability Plan: Fulfilling our Mission

Another key to our success has been the establishment of a sound financial sustainability model for the Exchange.

- While states that allowed the federal government to operate their exchanges are subject to a 3.5% user fee on all plans sold through the Exchange, and many State-Based Exchanges question their ability to sustain their long-term operations, New Mexico's market-wide assessment on major medical carriers in the state to cover reasonable administrative expenses is being held up by many – including CMS – as a national model for success.
- The model adopted by the Board in December 2014 will allow NMHIX to continue to work towards our mission of expanding access to health insurance at the lowest cost possible to New Mexicans.
- Additionally, because we are a full State-Based Exchange, the federal government was not able to charge New Mexico carriers for the use of the technology for the first three years. This means that New Mexico on-exchange carriers will have saved an estimated $19 million in user fees[7].

Included on the pages that follow is additional information specifically addressing the observations that the LFC staff have made following their review of NMHIX. We hope that this information can continue the important discussion that LFC has started on the future of the Exchange.

We look forward to working with all stakeholders in New Mexico, including the Legislature, to build on our successes of beWellnm, New Mexico's Health Insurance Exchange, in the months and years ahead as we continue to expand access to high-quality, affordable health insurance to all New Mexicans.

Sincerely,

Amy Dowd
Chief Executive Officer

[6] http://aspe.hhs.gov/sites/default/files/pdf/83656/ib_2015mar_enrollment.pdf

[7] NMHIX estimate based on effectuated enrollment and average monthly premium for all members over the first three plan years.

LFC Observation: While Accelerating Medicaid Expansion, New Mexico Health Insurance Exchange Enrollment for Individuals Remains Low

While the LFC report notes that the Exchange has made strides in providing coverage to New Mexicans, it inconsistently defines baseline values of the uninsured population in New Mexico, inaccurately defines the percentage of uninsured eligible to shop on the Exchange, NMHIX enrollment number targets, as well as the Exchange's impact on Medicaid. These inconsistencies are negatively impacting the report's assessment of enrollment success.
In 2013, the NMHIX Board defined the mission of the organization to enroll all qualified New Mexicans in the New Mexico Health Insurance Exchange thereby improving the collective health and well-being of New Mexicans by facilitating better access to competitive, affordable, high-quality, timely medical care through greater healthcare coverage.

In our two and a half years in operation, NMHIX has been successful in providing access to quality, affordable healthcare to qualified New Mexicans. As referenced previously, U.S. Census data released in September of 2015 notes that the overall uninsured rate in our state fell by 4.1% between 2013 and 2014 to 14.5%[8], with over 44,000 individuals now insured through the Exchange.

Additionally, a new Kaiser Family Foundation report released on October 13, 2015 found that of the approximately 233,000 New Mexicans that are still uninsured, only 13% are eligible for a tax credit. [9] This means that the Exchange's remaining target population for enrollment with a tax credit is approximately 30,333 individuals – a much lower pool of potential consumers than previous estimates. When compared to our enrollment numbers and reviewing the entire New Mexico insurance landscape, the positive impact of the Exchange is clear.

NMHIX Enrollment

The Exchange is aware that various estimates of exchange eligibility and the uninsured rate exist and change over time. However, the LFC report cites inconsistent figures for the same time periods that attempt to point to New Mexico's overall low enrollment compared to other states and the national average. For example, the report notes that that according to U.S. Census American Community Survey (ACS) data, the uninsured baseline for New Mexico was 430,000 individuals, or roughly one in five New Mexicans in 2012 and by 2013, 382,000 individuals were uninsured. On the following page of the report, a Kaiser Family Foundation (KFF) 2013 value of 422,000 uninsured New Mexicans, with 70 percent of those individuals likely eligible for public plans or subsidies is cited -- a value widely different than the 382,000 figure previously noted. Additionally, in a table on page 17 of the report, a KFF figure of 153,000 eligible individuals during the first Open Enrollment Period and 156,000 eligible individuals during the second Open Enrollment Period is cited – again changing the baseline number and time period for which the report measures current enrollment.

Diving deeper into the baseline number of 422,000 uninsured individuals that the report utilizes, 70 percent of whom the report cites as eligible for subsidies, the report's estimated pool of subsidy-eligible shoppers would be 92,840 individuals, with an additional 80,180 shoppers eligible to shop on the exchange but not eligible for a tax credit. By this calculation, there would be 173,020 individuals out of the entire pool of the uninsured population eligible to shop on the

[8] http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-253.pdf
[9] http://kff.org/health-reform/issue-brief/new-estimates-of-eligibility-for-aca-coverage-among-the-uninsured/

Exchange, either with or without subsidies. Without utilizing consistent data to illustrate the change in the uninsured population over time, the report inaccurately describes the changing health insurance landscape of the state.

The mischaracterization of the pool of uninsured individuals compared to enrollment further impacts the report's inaccurate enrollment assessment. Many individuals included in the report's accounting of the uninsured (for example, the first cited baseline figure of 430,000 uninsured New Mexicans) are in fact are not eligible to shop on the Exchange. The report's estimate does not note that uninsured individuals with incomes below the federal poverty level who would be eligible to enroll in Medicaid are included in the overall uninsured estimates. These individuals are not eligible for financial assistance through the Exchange and are unlikely to have the resources to purchase coverage in the Marketplace. Also included in the report's eligibility figures are individuals and families that are enrolled in off-Exchange coverage – these individuals have selected for one reason or another, to buy their coverage direct from the carriers.

On page 15, the unsubsidized eligible category includes people that, while technically eligible to shop on the Exchange due by various determinants such as income or citizenship, they are actually excluded from shopping on the Exchange because they have the option of affordable employer-based coverage. These individuals erroneously included in the pool of potential exchange customers further incorrectly increases the overall population that Exchange enrollments are compared to, reducing the percentage of enrollment the Exchange is responsible for in this analysis.

NMHIX regularly examines different numbers to measure enrollment success over time, seeks to utilize consistent measures, and has communicated these values to the Board of Directors in public meetings and we adjust as new data becomes available.

The U.S. Census Small Area Health Insurance Estimates (SAHIE) states that the New Mexico population eligible to shop on the Exchange in 2012 was 380,000[10] individuals. Using the U.S. Census American Community Survey (ACS) and SAHIE data inputs, the Kaiser Family Foundation (KFF) determined that the number of New Mexicans eligible to shop with the Exchange in 2014 to be 153,000[11] and in 2015 to be 156,000[12]. This figure does include legally-residing individuals who are uninsured or those that have purchased non-group coverage directly from a carrier, they have incomes above Medicaid/CHIP eligibility levels, and who do not have access to employer-sponsored coverage. As of the latest enrollment data release, the Exchange had enrolled 28% of potential enrollees. KFF is widely known as the most credible source for this kind of information and this methodology level sets enrollment figures against the individuals who are actually able to shop on the Exchange. As noted previously, while the LFC report does cite this number briefly, more often, the report cites other, out-of-date information and does not accurately include it in its overall assessment, thus contradicting previously cited figures that reduce the overall Exchange enrollment impact for the state.

[10] http://www.census.gov/did/www/sahie/
[11] http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2014/
[12] http://kff.org/health-reform/state-indicator/marketplace-enrollment-as-a-share-of-the-potential-marketplace-population-2015/

The other information that the LFC report fails to take into consideration is the newly released Census data and also a newly released KFF analysis of the state of health coverage in New Mexico. Available as of October 2015, KFF notes that there are estimated to be only 233,000 uninsured left in New Mexico. Of this number, they estimate that 109,000 are Medicaid eligible and only 31,000 uninsured individuals are eligible for tax credits through the Exchange, illustrating the Exchange has already captured a larger percent of its target population. The Exchange continues to consider new data as it is released in order to make decisions and alter estimates accordingly.

Additionally, comparisons drawn to other states listed in the report do not paint an accurate picture of how New Mexico compares to enrollment elsewhere. The report's comparison of New Mexico to other states appears to be a random comparison as it does not accurately compare New Mexico's enrollment figures to states of similar demographic characteristics. The U.S. Census, a source recognized as being more accurate than the Gallup Well Being Index figure used in the report, recently reported that the uninsured rate in New Mexico had been reduced by 4.1% to a new low of 14.5%. This puts New Mexico ahead of Texas, which has an uninsured rate is 19.1% (and only saw a reduction of 4%), and Florida, which has an uninsured rate of 16.6%. While often promoted as having high enrollment, Florida only saw a reduction in uninsured of 3.4% from 2013 to 2014.

The report also utilizes effectuation and plan selection numbers differently, which misrepresents the penetration rate. The report outlines that NMHIX reported it had enrolled about a third of its targeted pool by February 28, 2015, up from a 21% penetration rate the prior year. After the second enrollment period, there were 44,307 effectuated individuals (individuals actively using and paying for their coverage). According to KFF, utilizing the national effectuation number for the same period, the national average of penetration rate was 34%. By using state and national effectuation numbers, NMHIX is tracking only 6 points behind national averages, compared to the 10 points the report cites on page 18. Combined with the report's various and inaccurate numbers of eligible individuals to shop on the Exchange, these data deficiencies inaccurately describe how the Exchange's enrollment compares to other states and national averages.

Successfully meeting enrollment projections are another part of how the Exchange measures its enrollment success. The report inaccurately states the CEO Amy Dowd was hesitant to set a projection heading into the second enrollment period, which is untrue. Multiple stakeholders are involved in setting enrollment projections including NMHIX CEO Amy Dowd, who worked with carriers to develop the estimated projection of 50,000 - 55,000 individuals enrolled during the second enrollment period. This number was discussed with the Board of Directors and agreed upon at the November 21, 2014 Board meeting and is referenced in the minutes from that meeting.

Furthermore, the Exchange is tasked with ensuring an efficient operations model is in place that keeps costs to enroll New Mexicans as low as possible. The Exchange has also developed a sustainability model that works for New Mexico. New Mexico's plan to issue a market-wide assessment on all carriers to cover the reasonable administrative expenses of the Exchange is being held as a national model. Many costs for the Exchange in 2013, 2014 and 2015 were not directly related to acquisition of 2014 and 2015 enrollees, but rather to start-up costs with starting a new business and building long-term operations. A more fair assessment of the cost per enrollee would be to review the marketing and outreach dollars spent to reach each individual. Using that analysis, NMHIX spent approximately $424.76 per enrollee in 2014 and

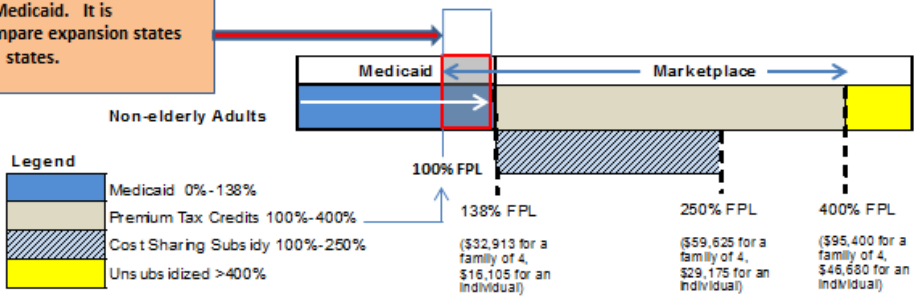
was able to cut that number nearly in half by 2015 with an approximate Marketing and Outreach cost of $211.12. Overall, the Exchange spent less for the 2015 Open Enrollment and reached more people than the previous year. NMHIX seeks to lower this number even further and the marketing and outreach budget for 2016 is even lower than 2015.

Medicaid Enrollment

As residents of a Medicaid Expansion state, many New Mexicans that previously did not qualify to receive Medicaid now have access to this public health insurance program. The report notes that the Exchange has impacted Medicaid enrollment, when in fact, Medicaid Expansion in New Mexico has had the reverse effect, with Medicaid reducing Exchange enrollment.
Although the Exchange acknowledges that the expansion in Medicaid has contributed to a reduction in the overall uninsured population in New Mexico, the Exchange has not intentionally increased the enrollment in Medicaid. Many individuals who believed they would qualify for tax credits through the Exchange actually qualified for Medicaid after the Expansion, thus eliminating them from the eligible pool of Exchange applicants, reducing the ceiling of possible Exchange enrollments. Because of the Affordable Care Act's "no wrong door" policy for health coverage, with the ultimate goal of increasing health insurance coverage for New Mexicans no matter the source, the Exchange refers applicants who are found to be eligible for Medicaid to the New Mexico Human Services Department (HSD) for further support and visa-versa.

NMHIX UPDATED CHART: Figure 1 from the LFC program review only illustrates the scenario if a state has expanded Medicaid, and completely ignores the important market difference in non-expansion states. Because New Mexico is a Medicaid Expansion state, the individuals that fall between 100% and 138% of FPL who otherwise would have qualified for tax credits through the Exchange if Medicaid was not expanded, now qualify for Medicaid. It is misleading to compare expansion states to non-expansion states.

Figure 1. Pathways to Coverage Under the ACA



Source: ASPE (As used in LFC Program Review Report, page 5)

In non-expansion states, Medicaid eligible individuals are well below 138% of Federal Poverty Line (FPL) – and in many states there is a gap between individuals that are eligible for Medicaid and individuals at 100% FPL, where eligibility for the Exchange begins. Individuals eligible for tax credits on the Exchange must fall between 100% and 400% FPL. For Medicaid Expansion

states such as New Mexico, coverage for individuals under 65 years of age with incomes up to 138% of the federal poverty level now qualify for Medicaid as illustrated by the amended LFC

Figure 1 above. Individuals who fall between the 100% and 138% FPL qualify for tax credits through Exchanges in non-expansion states, but qualify for Medicaid in expansion states. As mentioned previously, because New Mexico is a Medicaid Expansion state, this portion of the population both reduces the overall pool of Exchange eligible individuals and, for those whose first stop was the Exchange for health coverage, led them to receive coverage through Medicaid instead. The Exchange agrees with the report that "it is reasonable to assume expansion was the main contributor to increased health insurance coverage for uninsured New Mexicans," (LFC Program Review Report, page 16) however takes the position that Medicaid expansion, while overall having a positive impact on the uninsured rate, in effect reduced the possible number of individuals who could shop and purchase plans through the Exchange.

Recommendations	NMHIX Response
• The New Mexico Health Insurance Exchange Board should consider determining the minimum number of enrollees in both the individual and business markets that justify retaining the NMHIX in the present format.	After a lengthy cost-benefit analysis and multiple rounds of stakeholder input and public comment, NMHIX and its Board of Directors have put a model in place to ensure the long-term financial sustainability of the Exchange. New Mexico's market-wide assessment on carriers in the state to cover the reasonable administrative expenses of the Exchange is being held nationally as an example model. This Financial Sustainability plan spreads costs over time and is predictable. Additionally, NMHIX has been able to utilize the federally facilitated marketplace technology for three Open Enrollment Periods at no cost with significant savings.
• The New Mexico Health Insurance Exchange Board should use actuarial analysis and other available sources of data and methodologies for modeling.	The NMHIX currently uses analysis from multiple sources, including actuarial analysis from OSI and the carriers, to inform our enrollment projections process and appropriately plan operations.
• The New Mexico Health Insurance Exchange Board should continue to investigate the barriers to enrollment and identify those amenable to corrective actions.	The Exchange agrees with this recommendation. The NMHIX Board of Directors and staff continually research and analyze the enrollment and population landscape to inform decisions. The Exchange also recently selected a vendor to support us with additional behavioral-based research to gain greater insights on why New Mexicans decide to enroll in health insurance or not.
• The Legislature could consider reviewing operations at key junctures to reassess New Mexico's health insurance exchange structure and amend statute if necessary to adopt the most cost effective and efficient delivery of health insurance options to New Mexico citizens.	The NMHIX reports regularly to the Legislative Health & Human Services Committee (LHHS). The Exchange most recently reported to LHHS on September 24, 2015. The Exchange also works collaboratively with OSI and HSD, and has the Secretary of HSD and the Superintendent of Insurance represented on the Board of Directors.

LFC Observation: Extensive Marketing and Outreach Efforts Were Costly with Mixed Results

Following a change in leadership at beWellnm, the priorities of how to reach and enroll New Mexicans also changed between the first Open Enrollment Period to the Second Open Enrollment Period, thus impacting the Marketing and Outreach budget. In addition utilizing lessons learned from the first enrollment period and from other states, the new Exchange CEO and new Senior Director of Communications & Outreach shifted how outreach and education strategies were implemented, leading to a successful second enrollment period.

First Open Enrollment Period

The first Open Enrollment Period began just 187 days following the passage of the Exchange's founding legislation. Although New Mexico had a very limited window of time to ramp up its marketing and outreach activities, NMHIX successfully put in place a new brand, website, call center, and developed a network of enrollment assisters, opening for business on October 1, 2013.

Many challenges were faced during this first foray into implementing the ACA. As with every other exchange utilizing the federal platform (and many stand-alone exchange technologies) the first few weeks of Open Enrollment were fraught with technology challenges. What many don't realize is that the Board had the foresight to slow the technology development process and ensure that we had enough time to build a technology that works. Healthcare.gov technology began working effectively for the majority of people by November 30, 2013. For many others in states like Oregon, Hawaii, Nevada, and Massachusetts the technology never worked during that first Open Enrollment Period and many had to go without coverage. However, the loss of nearly two months of the enrollment period and the frustrations of those that were shopping certainly had impact on the first year's enrollment results. In fact, many people continued to have technical difficulties with completing applications well through the end of the first Open Enrollment Period. CMS allowed individuals that had tried to get coverage by the end of the Open Enrollment Period and failed to keep trying until April 15, 2014.

During the first Open Enrollment Period, which ran between October 1, 2013 and March 31, 2014, as demonstrated with NMHIX's own market research, many New Mexicans were generally unaware of the Exchange and how health coverage would work with the new Affordable Care Act in place. In addition, New Mexico's demographics are unique, and tailoring communications to its Native American, Hispanic, rural, and frontier populations was important to encouraging successful enrollment.

For both enrollment periods, when assessing the impact of marketing budgets on enrollment, it is important to understand the structure of media and advertising, and how people are reached by utilizing various media channels and marketing tools. The report notes that enrollment did not correlate to the dollars spent in counties across the state, with some counties that had very little money devoted to them outpacing enrollment in counties that received more marketing dollars. Most of the Exchange's marketing spend was on state-wide advertising (i.e. Albuquerque based TV stations and print publications), which have a reach across the majority of the state. To draw a direct correlation of marketing spend to enrollment by county is not an accurate measurement of spending effectiveness because although media outlets may be based in metro centers, their media reach extends far beyond county lines. The Exchange believes that enrollment in

counties outside of a metro center illustrates the effectiveness of the messages that reached New Mexicans across the state.

Second Open Enrollment Period

Following the close of the first Open Enrollment Period, the Exchange leadership, staff and vendors reviewed their efforts and compiled lessons learned to apply to next Open Enrollment Period. The NMHIX Board of Directors concluded that some of the vendors were not as effective as they could have been and sought to procure new vendors for the second enrollment period.

Following competitive bids for Marketing, Outreach & Communications, Research and Website support the evaluation committee selected new vendors to gain more expertise and insight into New Mexico's unique population characteristics to better inform advertising and marketing. New benchmark surveys were conducted, as the original survey did not address the change in the uninsured population, only the general population. New Exchange leadership made a concerted effort to review the results of the first Open Enrollment with the Board of Directors and stakeholders to find ways to improve the strategy for the next Open Enrollment.

The Exchange also built a large partnership network to leverage the expertise and presence of trusted community organizations. A large part of delivering on our mission is our commitment to consumer assistance. From 2014 to 2015, we saw our consumer assistance network of Enrollment Counselors, agents and brokers grow significantly. For the second enrollment period, beWellnm leadership implemented stronger coordination with agents and brokers through educational webinars, surveys, more regular communication, and hired a Broker Relations Manager to serve as a direct liaison between this community and the Exchange. Doing so provided a more direct dialogue with agents and brokers, informing them at a higher level and helping to improve our outreach strategy over the course of Open Enrollment. More than 500 Enrollment Counselors, agents and brokers were trained and certified through the Exchange.

For the second enrollment period, the Exchange further engaged communities and embraced the power of in-person assistance in order to continue to build awareness of the Exchange. We took a holistic approach to developing our marketing and outreach strategy. To gain insight into how to best reach people across the state and create messages that would resonate with them, market research was an important tool for laying the foundation of our outreach strategy and tested for a new baseline level of awareness of the Exchange itself that would allow us to track our progress over time. We also launched our walk-in consumer assistance center in Albuquerque with our partner Native American Professional Parent Resources (NAPPR), which offers the face-to-face help New Mexicans prefer.

Some highlights that illustrate the network of partnerships and outreach of our second Open Enrollment include:

- 302 organizations allowed the Exchange to communicate with their members and constituencies and to mobilize them toward a meeting or event.
- 138 elected officials were invited to events and encouraged to send the invite information to their constituencies.
- 122 organizations circulated invite emails to their membership lists.
- Three tele-town hall events consisting of 37,000 postcard and autodial invites resulted in 6,112 participants.
- 74 enrollment and outreach events were held, most of which were a combination of several organizations per event.
- Total enrollment and outreach event participation of more than 5,700 people.

Impacting the second enrollment marketing and outreach strategy was a shift in the budgetary priorities for the Exchange. As the report states, the outreach strategies for the second Open Enrollment Period were more effective than the first as a result of new leadership and utilizing lessons learned the Exchange was actually able to reach more individuals during the second Open Enrollment Period, all the while, spending less money overall.

By utilizing new, more in depth and scheduled research, the Exchange found that levels of Exchange awareness increased significantly from 39% on November 2014 to 54% by January of 2015. Interestingly, awareness of the Exchange by uninsured "young invincibles" ages 18 to 34 increased from 29% to 54% over the same time period, with 62% of the overall uninsured population aware of beWellnm. As with any start up business, as insight is drawn from experience, tactics shifted to reflect new information and meet objectives.

Overall, the LFC report muddles the assessment of outreach success. The report assumes that there is a connection between outreach and the "pace" of enrollment. In reality, there is not a direct correlation between outreach strategies and the pace of enrollment. Page 27 of the report also notes that although outreach strategies improved for the Second Open Enrollment Period, the pace of new enrollments slowed. However, as the LFC report itself outlines on page 19, it is expected that the pace of new enrollments will slow over time. The new leadership that put in place updated strategies for the second enrollment period focused on utilizing market research and hyper-local outreach to target populations that led to the successful enrollment and renewal of plans for more than 44,000 New Mexicans.

Finally, the LFC report attempted to illustrate low enrollment is a result of financial barriers to purchasing Exchange plans. The Exchange acknowledges that cost is a barrier to enrollment for segments of the population, however, the Exchange has no jurisdiction or impact on the cost of premiums or the Advance Premium Tax Credit (APTC) offered to qualifying to individuals to help pay for their monthly premiums. Unlike states such as California, New Mexico is not an active purchaser of health plans. Health plans establish their plan rates, the Office of the Superintendent of Insurance approves rate increases or decreases, and the Exchange Board reviews the plans that will be offered on the Exchange. To imply that the cost of premiums is impacted by the Exchange in any way is inaccurate. Per the founding legislation, the Exchange is charged with increasing access to healthcare, and through its outreach and communications strategies works to educate consumers on the value of purchasing health insurance through the Exchange. There are a variety of factors at play that influence the cost of premiums, including

• Continuing efforts to increase outreach coordination across the state, using key partnerships that cross county lines—such as federally qualified health centers—to establish a wide net of enrollment counselors;	The Exchange agrees with this recommendation. Federally qualified health centers are part of current Exchange enrollment network.
• Using longer term contracts for lead enrollment groups so they don't lose staff while contracts are pending;	The Exchange follows the procurement policy to set appropriate contract terms and per federal grant requirements.
• Considering working with stakeholders to adopt additional "boots on the ground" activities; Coordinating statewide campaigns leveraging appropriate state agencies, such as the Human Services Department, Department of Indian Affairs, and Department of Health;	The Exchange agrees with this recommendation and is coordinating with numerous agencies and partners across the state including those named here. In addition, enrollment counselors are dual- trained as Medicaid and Exchange counselors.
• Establishing a stakeholder presence on the NMHIX website to increase transparency and public participation;	The Exchange agrees with this recommendation.
The NMHIX should consider allocating additional funding toward outreach and enrollment efforts by:	
• Adding additional walk-in centers for heightened one-on-one availability;	The Exchange is aligned on these recommendations, and has implemented these items.
• Adding longer hours at peak periods such as during evening hours and weekends, especially for Open Enrollment Periods;	
• Identifying regional needs and adapting processes accordingly;	
• Considering year-round education program to sustain momentum;	Year-round education and insurance literacy education has not been a grant-allowable activity, but we do have education and information available year round – including efforts to promote the Special Enrollment Period (SEP) throughout the year. New educational content is being added to the beWellnm website for Open Enrollment three. The Exchange agrees with this recommendation.
• Exploring mobile units deployed to underserved areas;	Mobile units used by other states proved expensive and ineffective in the first open enrollment period. Therefore, mobile was evaluated and ruled out by NMHIX due to the high-cost and potentially low return. As part of our outreach strategy, we take into consideration regional needs and will be deploying a kiosk program this year for Open Enrollment three.

• Considering methods to improve retention in qualified health plans, such as implementing consumer education programs on health insurance literacy to maximize benefits;	Year round education and insurance literacy education has not been a grant allowable activity, but we do have education and information available year round – including efforts to promote SEP throughout the year, and new educational content is continuously being added to the beWellnm website.
• Improving enrollment by educating consumers on the advanced premium tax credit and cost sharing mechanisms to make silver plans more affordable; and	The Exchange agrees with this recommendation. The primary focus of the beWellnm advertising campaign is cost savings and affordability.
• Using less costs methods to raise and sustain awareness.	The Exchange is constantly evaluating ways to lower cost methods to raise awareness and welcomes discussions on the topic, however, the LFC program review indicates that increased awareness is not a direct cause of enrollment. Survey data suggests awareness of the Exchange, and access to assistance, remain key factors influencing both education and enrollment.

LFC Observation: After Five Years and Spending Almost $85 million, New Mexico Has Marginally Met Key Objectives for Implementing Its Individual Exchange That Now Faces Key Uncertainties

An Exchange is more than the technology system that it uses to enroll individuals, and the technology solution that an exchange uses is irrelevant to State-Based Exchange (SBE) status. The report seems to miss this point and concludes that New Mexico never implemented a State-Based Exchange as envisioned in the New Mexico Health Insurance Exchange Act. This assertion is inaccurate. On a national level, the NMHIX is considered a State-Based Exchange that uses the healthcare.gov technology to enroll individuals. As a State-Based Exchange we have successfully enrolled over 44,000 New Mexicans into coverage, established a robust and data-driven marketing program, and coordinated with partners across the state to provide local outreach and an in-person assistance network of over 300 in-person assisters and brokers.

Further, it should be noted that of the 17 SBEs that are listed in the report that moved to try and build their technology in the first or second year, six of those states (Minnesota, Massachusetts, Nevada, Hawaii, Maryland and Oregon) all experienced significant technology failures. New Mexico, having made the wise decision not to implement its own technology solution in a short period of time, watched these failures, and was able to carefully deliberate the best path forward for New Mexico. After watching the difficulty and complexity of implementing a technology solution and after a lengthy cost-benefit analysis, the Board of Directors voted to continue to operate an SBE while using individual enrollment technology from the federal government. This

approach represented a lower cost and more efficient way of meeting our mission of expanding access to high-quality and affordable insurance to New Mexicans while giving the Exchange more flexibility to focus on outreach and education to reach as many New Mexicans as possible. As New Mexico moves forward with this approach, we are also negotiating with CMS to get additional data and information on enrollees to inform our outreach strategy moving forward.

The LFC report also highlights the risk of the Exchange potentially repaying federal funds. However, NMHIX is actively taking steps to mitigate that risk by cooperating in a second level review process for grant funds conducted by CMS called an IT Restriction Lift. IT Restriction Lifts are additional financial controls established after the initial approval of grant funding to examine proposed IT work and associated costs. If an IT Restriction Lift is approved, funding is then accessible to draw down for a particular project.

The limitation with the LFC program review as written is that the review was conducted when negotiations were still underway with CMS for how NMHIX could use its remaining grant funds. Since the program evaluation has completed, CMS has lifted any restrictions on IT spend up to and beyond the period of time that LFC has reviewed.

Recommendation	NMHIX Response
The New Mexico Health Insurance Exchange Board should: • Base operating budgets on confirmed revenue sources; we based our operating budget on being as low cost as possible. The benefit of having a sustainability plan is the ability to raise funds as needed. • Continue working with CMS to define allowable and non-allowable costs and revise the 2015 remaining expenditures accordingly; • Prioritize key outlays in outreach and education for targeted groups; • Augment the current Goals and Objectives with a robust array of outcome performance measures and a monitoring plan based on available data, adjusted as more data becomes available; • Continue developing relevant data sources through completed negotiations with CMS and funded research studies as well as developing a data warehouse; • Perform risk assessments and mitigation strategies more consistently and effectively; • Consider conducting a SWOT analysis (Strengths, Weaknesses, Threats and Opportunities); • Monitor NMHIX performance more often that once a year; and • Post results to the website for heightened transparency.	The Exchange is generally aligned with the majority of the recommendations in this section, and many of these items are underway or implemented.

LFC Observation: Despite an Investment of Over $48 million, NMHIX Abandoned Implementing the Individual Exchange and Small Business Enrollment Remains Low

Individual Exchange Technology

An Exchange is more than the technology where people enroll. As it related to the technology, NMHIX did not abandon its individual exchange technology as stated in the LFC report. The NMHIX staff and Board of Directors made a strategic and fiscally responsible decision following a careful cost-benefit analysis and input from multiple stakeholders to not incur additional costs and take on additional risk of implementing a state-specific technology solution for the individual market. After in-depth discussions beginning in January of 2015 and additional review during the March 31, 2015 Board meeting, the Exchange Board decided that it wanted to devote funds and resources to bringing people to the Exchange and utilize the federal platform that was already working for New Mexicans. Following that decision, the Board and staff evaluated all Exchange contracts for necessary changes to reflect the decision on the individual technology solution and present a modified budget for 2015 and sets priorities for the future. To classify this deliberate decision to change course as an abandonment misrepresents the time and multiple rounds of stakeholder input that was devoted to coming to this decision. The New Mexico model is now recognized as a viable alternative, and a model under consideration by other states for running their exchanges.

The LFC report also incorrectly states that NMHIX will spend $6 million winding down the effort for the individual exchange and there are $11 million in maintenance costs. As reported at the August 2015 Board meeting, the final wind down costs have been reduced to $2.6 million, and will be paid for by federal grants. The maintenance costs will be reduced to a much lower rate based on our change in direction to the lease model. Therefore, this statement represents a point in time before the Exchange had finalized the longer-term costs for the Maintenance & Operations for GetInsured based on our change in direction to the lease model. The GetInsured Maintenance & Operations costs approved by the Board of Directors for 2016 and 2017 are $1.5 million per year. This information was presented in the September Board meeting.

On page 39 of the report, LFC notes that delays in NMHIX contracting project management office (PMO) services and hiring an IT director likely contributed to the lag in implementation of the individual exchange. The Exchange believes that it could not have acted in a faster manner. Per the timeline listed below, the first action undertaken by the Alliance was to issue procurement and only by June 2013, a few short months after the enabling legislation passed, which is when the Alliance was approved to work on behalf of the Exchange, the Exchange approved the selection of PCG as its PMO vendor.

- November 2, 2012 – NMHIA issued procurement, under Alliance for service to be delivered to the Exchange

- January 2, 2013 – NMHIA contract award (per NMHIA report to NMHIX Board on May 17)
- March 28, 2013 – enabling legislation passed
    - Section 13: The Board of the Alliance ceases to exist and the Exchange Board will govern the Alliance
- May 16/17, 2013
    - Appointed Interim CEO of NMHIX on 17th
    - NMHIX discussed and approved the selection of PCG as PMO vendor
- June 19/20, 2013
    - PCG contract signed by Chairman Damron and Interim CEO Nunez
- September 2013
    - Contract schedule as provided to incoming CFO in September 2013 documented the total value of PCG contract as $4,698,000
- January 20, 2015
    - Amendment reviewed by legal counsel and did not require Board approval because it did not increase the total contract amount.

In fact, the LFC report on page 39 notes, "Initially, Nevada and Oregon implemented a State-Based exchange but due to issues with IT vendor performance the federal exchange became more viable." NMHIX believes this is precisely what supports our efforts to make deliberate decisions as circumstances change over time with regard to the technology, operations and management of the Exchange to ensure that we continue to function efficiently to meet our mission and provide an exchange at the lowest cost possible to New Mexicans. The LFC implies that other states moved faster, however, moving faster, as illustrated by this same point, does not ensure success. As the report highlights, "Four other states – Minnesota, Maryland, Massachusetts, and Vermont – have experienced massive problems with their health exchange websites, ranging from balky features to less than expected enrollment numbers. Eventually, it is expected that most of those sites will be folded into the Healthcare.gov website, resulting in almost a billion dollars in taxpayer funds wasted." New Mexico is proud that our deliberate approach to developing our Exchange has precluded us from this list.

Further contributing to the inaccurate description of New Mexico's individual exchange success, is LFC's criticism of Exchange vendors. For example, page 40 of the report negatively characterizes the fact that Get Insured (GI), NMHIX's technology vendor, was working on other states while working on New Mexico's platform. NMHIX disagrees that this was a detriment to the individual exchange. To the contrary of the report's analysis, CMS encourages states to re-use technology in order to leverage experience and lessons learned from other states to improve the overall functionality of exchange technology platforms. Also contrary to the point made on the pages 39 and 40, the NMHIX was not aware of any resources constraints that had any negative impact on our technology development. NMHIX's CEO, who was previously the Executive Director of the Idaho Health Insurance Exchange, can verify that different teams were deployed to both exchanges, and there was no resource contention between the two operations.

The report also notes that the Exchange did not follow best practices for independent verification and validation (IV&V), thereby increasing project risk and leading to an ineffective project. NMHIX had regular meetings with IV&V to discuss areas of improvement. We have provided evidence that IV&V areas were acted on in a document to the LFC that outlines this

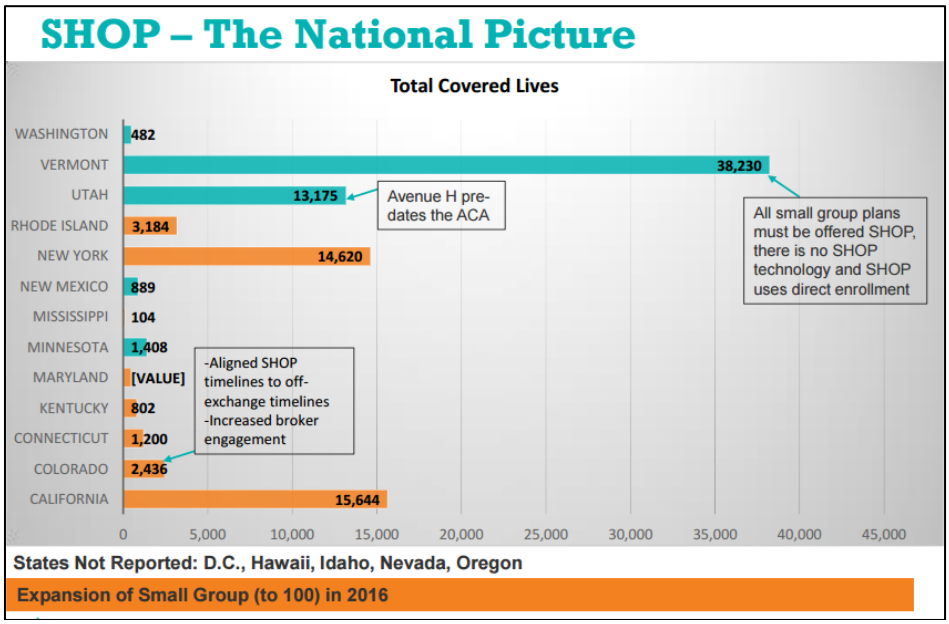
process. Retroactively, LFC also notes that the Exchange did not initially have an IV&V vendor from the outset of operations. However, following CMS guidance, the Exchange performed in-house IV&V activities at the beginning of the Exchange's existence. Even though these actions were approved by CMS, prior to the second enrollment period, NMHIX brought on external IV&V services in the spring of 2014 to ensure that protocols and objectives were being met.

Small Business Enrollment

The LFC review also criticizes the NMHIX small business health options program (SHOP) enrollment level. However, they do so without appropriate context. The New Mexico Exchange, like all other exchanges, saw that SHOP enrollment across the board was lower than expected. It is important to remember it is a requirement of the ACA that State Based Exchanges have a SHOP as part of their exchange operations. The US Government Accountability Office (GAO) published a report in November of 2014[13], regarding SHOP implementation and addressed several challenges that SHOP exchanges faced across the country, including low awareness and complexity of the tax credit. This report and its observations are cited by the LFC report, however does not provide a level of context to describe NMHIX's small business program.

As the table below illustrates, as of June 2014, national enrollment in SHOP was low, with the largest enrollment in Vermont. However, Vermont required that all small group plans in the state be offered only through the SHOP, thus creating an artificial market for their small business program. In Utah, another outlier in SHOP enrollment, the SHOP Exchange pre-dates the ACA. The Utah exchange was established in 2010 and has grown over 5 years, whereas the other SHOP exchanges have only been in place for 2 years. The GAO report also identified opportunities for growing enrollment SHOP including additional coordination and training with brokers, expanding employee choice, and increasing marketing efforts to small businesses which exchanges including NMHIX are having ongoing discussions about.

[13] http://www.gao.gov/products/GAO-15-58



Since this May 15, 2015 budget was issued, and following the grant re-budget submitted to CMS, NMHIX has shifted its priorities and does not plan to spend this dollar amount on the small business program. The NMHIX is still evaluating whether there would be future investment in the Small Business technology. The Board recently approved $500,000 in enhancements – and is still yet to be determined if and what it would be spent on. NMHIX continues to make a concerted effort to make SHOP, now called beWellnm for Small Business, more attractive to small business owners across the state by exploring new policies, enrollment tools and engagement of agents and brokers to help increase awareness of the benefits of the Small Business Program.

Recommendation	NMHIX Response
New Mexico Health Insurance Exchange should ensure final project documents are located in the project repository to ensure the project artifacts are accurate and complete to provide a documented audit trail.	The Exchange agrees with this recommendation. NMHIX has a new Project Management Services vendor in place, and any IT projects will follow this process and best practices.

LFC Observation: NMHIX Information Security Processes Need Improvement to Ensure Systems Security and Compliance with Federal Requirements and Industry Best Practices

The LFC Program Review alleges that the Exchange is not compliant with Federal Requirements, however this is not accurate. A comprehensive site visit by the Centers from Medicare and Medicaid Services (CMS) in September, which is a tool used to evaluate all phases of State-Based Exchange operations, validated our compliance with Privacy & Security procedures. During this site visit, as a matter of recommendation, CMS suggested two items that the Exchange adopt moving forward. First, that the NMHIX hire a Privacy & Security Officer and second, that a risk assessment be conducted annually. In light of this communication, the

Exchange is adding these items to its overall work-plan. However, it is notable that neither of these items constitute a lack of compliance with Federal Regulations, and such a statement is erroneous. Furthermore, all recommendations but one that are beneficial in their usefulness to the Exchange were in the process of implementation before the LFC's observations were communicated. The one exception has been noted and will be implemented.

The LFC's IT Consultant alleged that the Exchange was lacking in four areas of concern. The first item identified was "defined formal information security program policies and procedures." The Exchange is aware of the value of robust and evolving Internal IT Security Policies, which is evidenced by the fact that such policies have in fact been implemented. To date, nine are in use.

- IT-0001 Acceptable Use
    - Origination Date: 12/2014
    - Latest Review: 06/2015
- IT-0002 Data Encryption
    - Origination Date: 09/2014
    - Latest Review: 06/2015
- IT-0003 Asset Management
    - Origination Date: 03/2015
    - Latest Review: 06/2015
- IT-0004 Password Policy
    - Origination Date: 04/2015
- IT-0005 Information System Access
    - Origination Date: 04/2015
- IT-0006 Incident Response and Reporting
    - Origination Date: 08/2014
    - Latest Review: 06/2015
- IT-0007 Physical Environment Protection
    - Origination Date: 09/2014
    - Latest Review: 06/2015
- IT-0008 Granting Obtaining Revoking User Access Acceptable Use
    - Origination Date: 09/2014
    - Latest Review: 06/2015
- IT-0009 Systems & Applications Change Notification Policy
    - Origination Date: 08/2014
    - Latest Review: 08/2015

Later in the document, the IT Consultant states that the Exchange is "without a defined and approved information security program framework and governance structure." However, as noted above, policy IT-0007 is specifically regarding Physical Environment Protection. This document, drafted in accordance with CMS SSP and ACA guidance, is "responsible for physical and environment protection in conjunction with other legally binding contractual obligations as determined by NMHIX." This policy, initially adopted in September of 2014, contradicts the aforementioned allegation.

The second area of concern is that the Exchange has no "IT risk assessment." While true, CMS has no requirement for a Risk Assessment to be compliant. Despite this, the Exchange agrees that there is value in such an analysis, and has already begun the process to obtain an assessment. The third area of concern states that the Exchange lacks an "IT disaster recovery plan." Per CMS Regulation, the NMHIX has established a Disaster Recovery Plan over its Exchange products, specifically the Small Business Health Options Program (SHOP). In doing this, it has satisfied its compliance requirements and secured that technology. However, the Exchange is also in the process of acquiring an Enterprise-wide Disaster Recovery Plan. This is not a requirement, but has been pursued as part of good business practice. The fourth and final recommendation is that the Exchange should establish controls over removable media, such as USB Memory Drives. NMHIX agrees with the value of a policy, and will be implementing it moving forward.

The LFC IT Consultant also observed that, "ABBA Technology review server event logs every four to six weeks; event logs should be reviewed more frequently." The Exchange is compliant with CMS requirements in evaluating event logs. However, it seems that the consultant is referencing National Institute of Standards and Technology (NIST) best practice guidance when referencing event log review frequency. NIST appears to give no specific guidance on how often an organization the size and structure of the Exchange should be reviewing logs beyond "regularly," nor has any such guidance been provided by the LFC IT Consultant. Given that the NMHIX is well within CMS requirements and continues to regularly check event logs, clear documentation for best practice would be requested to pre-empt any further action.

Recommendation	NMHIX Response
• Perform a risk assessment to determine what logs should be reviewed and the frequency of review; • Develop and document detailed audit and log monitoring procedures for the various systems and applications; • Implement restrictive security controls on logs to prevent unauthorized access, deletion or modification of the logs;	The Exchange currently regularly reviews and documents its logs. If an IT Risk Assessment (which will be conducted) recommends changes to frequency or content, action will be taken.

• Develop a formal disaster recovery plan policy; • Conduct a business impact analysis and risk assessment to determine the requirements for the disaster recovery plan; • Reference the risk assessment in the disaster recovery plan and document any high risk areas along with mitigation strategies; • Develop a formal disaster recovery testing plan and conducts training and periodic testing at least annually; • Review, update and distribute the disaster recovery and business continuity plan at least annually;	NMHIX currently has a Disaster Recovery Plan for all of its Technology. However, a process to implement an enterprise-wide Disaster Recovery Plan is currently underway.
• Document the plan revision history, ensuring personnel receiving the plan have the current version;	As noted above, the Exchange currently has multiple IT Privacy & Security Policies with clear tracking of their origination, review, and anticipated review. These policies are available to all personnel and distributed as they are reviewed.
• Document and implement policy and procedures specifically addressing portable media protection; and • Implement automated preventive controls configured to block the use of USB flash drives or automatically encrypt them if they are not encrypted.	The Exchange agrees with this recommendation, and will be implementing this recommendation within its IT Privacy & Security Policies.

LFC Observation: The Current Governance Structure Lacks Oversight, and Transparency Could Be Improved

Throughout this section, the author's opinion of the best practices for an Exchange lead to inaccurate conclusions that do not match the reality that NMHIX is operating in compliance with the New Mexico Health Insurance Exchange Act and federal law and regulations, and is making significant efforts to be as transparent as possible.

The report acknowledges that the current composition of the NMHIX Board of Directors is in compliance with federal regulations and state law. The NMHIX agrees with this conclusion.

The report expresses concern, however, that the Board of Directors includes members who are representatives of health insurance issuers, and that New Mexico law "might harbor" members from a stringent interpretation of interest conflicts. In fact, the New Mexico Health Insurance Exchange Act *requires* that at least two members shall be representatives of health insurance issuers, and expressly exempts industry representatives from certain conflict of interest provisions that may otherwise apply: "directors who are representatives of health insurance issuers shall not be considered to have a conflict of interest with respect to those directors' association with their respective health insurance issuers." Section 59A-23F-3(G)(4). Federal

regulation also recognizes that the governing body of a state based exchange may benefit from the expertise of individuals associated with the health insurance industry. 45 CFR 155.210 says that a state must ensure that consumer interests are represented by, among other things, ensuring that the exchange governing body "is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance."

Further, the report states that the Governmental Conduct Act "does not speak to this unique circumstance of a board member potentially acting on behalf of his or her employer to its benefit but to the disservice of the NMHIX." The NMHIX disagrees, and believes that such action by a Board member contrary to the interest of the Exchange is prohibited.

The NMHIX has found the presence of health insurance industry representatives on the Board of Directors to be productive and any potential conflict of interest issues arising from their presence to be manageable. All Directors are subject to the Governmental Conduct Act and the numerous ethical provisions in the Act prohibiting official acts for personal or familial gain, nepotism, and inappropriate influence on contracting, to name a few. All Directors are required to act in the public interest, and not for private gain. All Directors have a duty to act in the best interests of the Exchange. These principles are found in law and apply to all Directors, including health insurance representatives. NMHIX internal policy restates and reinforces these principles.

The LFC authors may disagree with the decision of the legislature and federal regulators to permit and encourage participation by health insurance issuers on the NMHIX Board of Directors. The authors are entitled to this opinion, and it may be a point for further discussion with the New Mexico Legislature.

Furthermore, the report cites that six states have outright prohibited issuer participation on members with affiliation with health insurance issuers. However, it should be noted that five of the six states that do not allow issuers on the Board (Nevada, Minnesota, Maryland, Hawaii and Massachusetts) were nationally recognized for their experiences with significant failures in operations. Additionally, 42 CFR Part 155.110(c) (4) stipulates that a state should ensure that an Exchange has a governing board that has individuals with experience that in some cases is only gained through affiliation with a health insurance issuer and "ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured."

The author's opinion of what constitutes best practices for an Exchange also lead to conclusions that do not match the reality that NMHIX is operating in compliance with federal statute and the provisions of the New Mexico Health Insurance Exchange Act. This opinion driven approach leads the author to conclude that because under the New Mexico Health Insurance Exchange Act the NMHIX is not subject to oversight from several state agencies that the oversight and transparency is limited and that financial audits are not sufficient. If the legislature decides to change reporting or oversight requirements in the future, the NMHIX will comply, however it is not expected the NMHIX will adhere to standards that are not required by federal regulation nor defined by the New Mexico Health Insurance Exchange Act.

The reality is that whether the NMHIX is subject oversight by various state agencies or not, the external financial audit and the audits that the NMHIX is subject to by the federal government each year are, in fact, more stringent and thorough than typical practice of state audits. Further, it is untrue that federal audits will cease once NMHIX no longer receives federal grants and these will continue moving forward. In fact, on the top of page 51, the LFC report states that the annual financial audit will become the primary external means to catch waste fraud and abuse and the financial audit is limited in scope. What the LFC report neglects to highlight is that CMS has ongoing oversight responsibilities of the Exchange and requires that the Exchange conduct a SMART program audit in addition to the financial audit. These two audits working in tandem ensure both the operational and financial health of the organization, and are ongoing.

In the financial review section of the report, as well as in Appendix O and Q, LFC quoted sections of the NMHIX 2013 Single Audit Report findings as validation for why the NMHIX should not have transferred the financial operations from the Human Services Department to the NMHIX. The LFC also makes several observations regarding the system of financial policies and procedures at the Exchange. However, these observations are made following state accounting rules, whereas the Exchange is obligated to follow CMS and federal grant requirements.

The following are several examples of observations where the LFC team has misinterpreted the data they reviewed without consulting the Exchange or seeking clarification on the conclusions they were forming.

- The authors assert that the Exchange should have recorded 2013 audit fees as prepaid expenses in 2013, and then concludes that 2013 expenses may have been understated because the Exchange did not record the 2013 audit fees in 2013. It appears the author does not understand the accounting for this type of transaction. Since the 2013 Audit was conducted in 2014, the audit fees were expenses of 2014, and there would be no prepaid expense in this scenario.
- A conclusion that the NMHIX was not following a modified accrual basis, which is hypothetical or academic. The NMHIX is not a state agency and would not follow the state government accounting methodology. NMHIX correctly followed the basis of accounting that was recommended by their independent external audit firm, as described in the Notes to their Audited Financial Statements for December 31, 2014 and 2013.
- A statement that “NMHIX uses accruals that are processed by journal entries. Journal entries do not have ID.” Accruals are typically posted to the general ledger through the use of journals which is generally how accounting systems work. The statement that NMHIX journal entries do not have IDs is inaccurate. All journals posted in the NMHIX accounting system are sequentially numbered.
- A statement that “Payments for vendors should aggregate as much as possible under the unique ID in the AP system.” This conclusion is incorrect. A vendor ID is a mandatory field in NMHIX’s Accounts Payable system. There is no way to overwrite this control.
- Also in Appendix Q the LFC states, “Youth Development, Inc, for example, has transactions posted for both enrollment and outreach activities although the entity did not respond to the Education and Outreach RFP.” This is misleading given that YDI responded to and was awarded a contract under the Enrollment Entity RFP, which included outreach activities as part of the services they provided.

Unfortunately, the aforementioned instances are representative of many errors held by the authors regarding the Exchange's financial system. The Exchange is proud that the 2014 Audit Report was a clean audit report, and the NMHIX financial statements were found to be prepared in accordance with Generally Accepted Accounting Principles (GAAP). There were no new Single Audit findings and corrective action had been taken on all findings from 2013.

In addition, the NMHIX is committed to transparency and has developed robust policies and governance structures to comply with the Inspection of Public Records Act, the Government Conduct Act, and the Open Meetings Act as required in the New Mexico Heath Insurance Exchange Act to ensure transparency and accountability. The policies in place that support transparency and oversight are available to the public on the NMHIX website (http://www.nmhix.com/nmhix-board/board-policies/) and the NMHIX is operating in accordance with these policies and procedures.

New Mexico State Law	NMHIX Policy to Comply
Inspection of Public Records Act	The New Mexico Health Insurance Exchange has a designated public records custodian and clear instructions on how to submit written requests for public information available on its website.[14] The NMHIX Notice of Right to Inspect Public Records is also publicly available at the NMHIX offices.
The Government Accountability Act	The Code of Conduct: Governing Principles and Conflict of Interest policy amended in May 2015[15] addresses the requirements to operate in accordance with this act for both employees and directors.
The Open Meetings Act	In 2013, 2014 and 2015, the New Mexico Health Insurance Exchange Act passed an Open Meetings Act resolution to establish policies and procedures for NMHIX to operate in accordance with the open meetings act. The most current resolution is available on the website.[16]

With these robust policies in place, we agree with the assessment that there are always more opportunities for transparency even if these items are not required by statute. While the primary focus of attention in our first two years has been developing web content and tools to help consumers get enrolled in coverage, this year the NMHIX is allocating resources to make information on the activities of the Board more easily accessible and available. This process is already underway. For example, since the new CEO started in the late summer of 2014, the presentation used at each Board meeting between September 2014 and September 2015 has been posted online to increase transparency, and includes quarterly financial and annual budget reporting.

Additionally, tracking and using data to inform our operations are both very important to ensure that NMHIX is operating as efficiently as possible to meet the needs of New Mexicans. As such,

[14] http://www.nmhix.com/wp-content/uploads/2013/01/07-14-14-IPRA-Notice-of-Right-to-Inspect-Public-Records.pdf
[15] http://www.nmhix.com/wp-content/uploads/2015/05/Signed-Code-of-Conduct.pdf
[16] http://www.nmhix.com/wp-content/uploads/2015/04/NMHIX-Resolution-No-2015-1.pdf

the NMHIX is also allocating resources from our federal grant to commission a vendor to implement a data reporting system that will also be used to support reporting at Board meetings.

Recommendation	NMHIX Response
The Legislature should consider improving the transparency and oversight of the NMHIX by amending the New Mexico Health Insurance Exchange Act to:	
• Require oversight by the Office of the State Auditor	NMHIX is audited by external auditors and by the federal government. The NMHIX is required by statute to perform an annual audit.
• Increase reporting requirements to the Legislature and Office of the Governor, including performance reporting associated with the Accountability in Government Act	The NMHIX is subject to and complies with a number of reporting requirements: (1) reports to the legislature, the governor, and the Office of the Superintendent of Insurance; (2) submit information accounting for all activities, receipts, and expenditures of the NMHIX to the Superintendent of Insurance; (3) obtain an annual audit by an independent auditor; and (4) publish the administrative costs of the exchange.
• Outline financial reporting requirements to the public	NMHIX presents detailed budget information at Board meetings.
The NMHIX should improve transparency and accountability by considering posting a broader array of information on the website, including the following items:	
• Committee agendas, minutes, and calendar;	The Exchange appreciates these recommendations from LFC staff and will take this under advisement.
• Financial information as recommended in Appendix Q	
•Contracts;	
• Stakeholder sections;	
• Published reports, including customer satisfaction surveys;	
• Dashboards, including performance metrics regarding enrollment; and	
• Keeping the website current, with key documents appropriately archived for retrieval.	

LFC Observation: NMHIX Faces Potential Operating Issues in the Absence of Robust Policies and Procedures to Supplant State Law and Administrative Code

The NMHIX has made prudent choices thus far to maintain the efficacy of its operations. Further, the Exchange has been responsive when potential improvements have been proposed by numerous sources. This was especially important given the haste by which operations had to be established, as noted previously, 187 days before Open Enrollment. However, some issues detailed by the LFC as ongoing which could interfere with operations are not accurate to the most recent documentation.

The LFC states, “2013 A-133 Audit lists 6 significant deficiencies.” While this is valid, it is insufficient to provide a current appraisal of the NMHIX operations. Consistent with the Exchange’s effort to be responsive and optimize efficacy, the 2014 A-133 Audit identified no

new findings and that all previously identified items were successfully addressed. The timeframe for this annual audit's completion did not allow for LFC review, however, it is incredibly important to note as part of the current state of operations.

The LFC also alleges that there are issues with the Exchange utilizing Alliance procurement policy in the early stages. Senate Bill 221 of 2013, the New Mexico Health Insurance Exchange Act, established that all Alliance contracts were binding to the Exchange. To establish consistency, the NMHIX Board quickly and judiciously assumed the Alliance contracts and procurement policy. While operations continued, updated procurement policies were concurrently developed that would be entirely under the Exchange's umbrella. However it is important to note that the utilization of the Alliance procurement policy and procedures was not only compliant with the statutory authority, but also sensible given the timeframe.

Later the LFC states, "NMHIX processed a $450 thousand amendment for the PCG project management contract, without Board approval. NMHIX March 31, 2015, contract reporting to the Board shows an increase in PCG's contract from $4.7 million to $5.1 million… it appears payments to PCG exceeded the contract scope of work by $140 thousand." The entire contract, including all scopes of work with PCG totals $4,698,000. With regards to the Program Review allegation, it is important to note that this amount has not changed since the new CEO joined the Exchange, nor with the January 20th amendment. The amendment referenced shifted money from one scope of work to another without increasing the amount, and therefore did not require Board approval. However, in inquiring upon the statement above, the LFC did identify a typing error in the Board meeting contract reporting. At the March 31st meeting a contract schedule was provided to Board members and the LFC Program Review representative which did reflect the additional money applied to one scope, per the amendment, but without a reduction to the other scope. This error was rectified in the May 15th Board meeting contract schedule, which was also provided to the LFC. With all of this in mind, ultimately the amendment did not increase the total contract amount, nor breach the Exchange's procurement policy.

The LFC states, "Lack of post-award oversight meant NMHIX was non-compliant with federal rules." However, during the recent A-133 audit, the Exchange's external auditors evaluated the controls in place and did take note of the system for procurement, monitoring of contracts, and vendor performance. In their evaluation, along with CMS oversight and communication, it was determined that the current policies and procedures continue to be compliant with federal requirements.

Later within this section the LFC alleges, "In addition, the NMHIX reimbursed its project management vendor $256 thousand for 2,048 hours billed at $125 per hour. NMHIX time-and-materials contract with PCG included billing rates by labor category but the $125 billing rate was not included in the contract." Upon reviewing this observation, it is important that the Exchange point out the history of the $125 per hour bill rate. When reviewing work performed in the PCG contract, it was determined that certain Time & Material deliverables could be fulfilled by a lower cost resource. This was agreed upon by both parties and subsequently saved taxpayer dollars. The Exchange recognizes the value of amending the contract to reflect this cost-savings, but it is important to note that no overpayment occurred nor was work paid for that did not occur. Further, had such overpayment occurred, the external auditors would have identified such an incidence. This did not happen, nor did any such overpayment occur, which was integral to the Exchange receiving a "clean" 2014 A-133 audit. The Exchange did not overpay this contract. In addition, the NMHIX did not exhaust the full contract value before the contract termed.

Later within the same paragraph the LFC states, “In addition, while NMHIX IT director requested a specific PCG individual to stop work on December 5, 2014, the individual continued to work, resulting in an additional overpayment of $15,000. By using T&M contracts that are not properly monitored, NMHIX increased its risk of higher project costs and noncompliance with federal procurement requirements.” The Exchange did not put a stop work order on a specific employee but rather requested that work stop on a specific project. Further, the work referenced here was approved to continue. If a stop work order had gone into effect, the continued practice of the Exchange is to send a letter notifying the vendor of such development. This is evidenced by other stop work orders that have been executed, including the BVK contract. Finally, the controls are in place for the Exchange to leave invoices unpaid if a vendor continues work after having received a stop-work order.

Recommendations	NMHIX Response
• Develop stronger procurement Policies and Procedures detailing the procurement process, selection process by type, documentation and record keeping, contract development, and post-selection process including vendor oversight, with detailed administrative procedures to ensure compliance; • Require NMHIX staff assigned in a vendor manager role complete the one and three-day trainings offered by the State Purchasing Division;	The procurement process has been codified and is subject to regular review. Given that the Exchange is subject to Federal grant requirements, it is important to note that all procurement policies must be compliant with those regulations. The NMHIX has a process in place which includes all of the recommended items in this bullet. The Exchange will assess the value of having staff complete trainings offered by the State Purchasing Division as it relates to the ongoing operations and evolution of the organization.
• Clarify thresholds, including gross receipt tax, and align them consistently throughout all documents;	The Exchange already clarifies these matters in contracts.
• Consider centralizing procurement oversight under a Chief Procurement Officer who has undergone the State Procurement Officer training and has relevant experience (if appropriate for procurement volume);	The Exchange will assess the value of assuming the additional expense of a C-suite staff salary and expertise as it relates to ongoing operations, evolution of the organization, and appropriateness to the amount of procurements.
• Review opportunities to reduce costs, such as partnering with HSD for call center activities rather than maintaining a separate facility;	A clearly defined call center is a federal requirement of all State-Based Exchanges, and has been fulfilled successfully. However, the NMHIX will continue to identify partnership opportunities while fulfilling the requirements to CMS oversight.
• Use the State Purchasing Division website for statewide pricing and notices of vendor suspension or debarment;	The Exchange regularly references this website, and has a process in place by which it evaluates vendor suspensions and disbarments.

• Implement the Records Policy by designating a records custodian; and • Archive historical procurement information as sufficiently as possible.	A records custodian existed at the time of LFC review, and other individuals have been cross-trained to ensure redundancies are in place. Further, policies to archive historical information exist and continue to be refined.
• A formal Communication Policy per Section 59A-23F-3(S)(2) and (5) addressing communications with stakeholder groups that includes: • A delineated method and format for stakeholder groups to submit input for key decisions as well as Board procedures to "duly consider recommendations" in addition to public comment periods, including Board committee interactions.	A formal communication policy currently exists, and has since before the time of the Program Review. A format for stakeholder input is in place through a variety of mediums. Public comment, the Stakeholder Advisory group, and consistent meetings have established strong communication. Notably, the Stakeholder Advisory Group provides recommendations directly to Board members, staff, and vendors. Further, the Exchange continues to embrace all formats of stakeholder communication, whether codified or not, given that every New Mexican is a stakeholder.

APPENDIX A: EVALUATION SCOPE, METHODOLOGIES, AND OBJECTIVES

Evaluation Objectives.
Assess the status of the New Mexico Health Insurance Exchange (NMHIX) performance and operations, review budget allocation and expenditures, and assess the status of implementation, including planning, project management and oversight, and security.

Scope and Methodology.

- Reviewed applicable laws and regulations.
- Reviewed available project contracts, budgets, and financial data.
- Reviewed enrollment data and analyses from reliable third-party sources.
- Performed analysis to yield meaningful conclusions.
- Reviewed comparative state information.
- Reviewed available project management plans, project status reports, and project deliverables for the implementation of the health insurance exchange project.
- Reviewed available independent verification and validation (IV&V) project reports.
- Interviewed NMHIX board members, the Chief Executive Officer, and other staff.
- Interviewed staff from umbrella enrollment organizations.

Evaluation Team.
Michelle Aubel, Program Evaluator
Brenda Fresquez, Program Evaluator

Authority for Evaluation. The LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. The LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, the LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conference. The contents of this report were discussed with representatives from the New Mexico Health insurance Exchange during the exit conference on October 19, 2015.

Report Distribution. This report is intended for the information of the Office of the Governor, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: ACA EXCHANGE FUNDING TO STATES

ACA Exchange Funding to States
as of October 14, 2014
(in thousands)

State		Grant Total
Alabama		$9,772.5
Alaska	N/A	$0.0
Arizona		$30,877.1
Arkansas		$58,149.8
California		$1,065,683.1
Colorado		$178,931.0
Connecticut		$164,466.5
Delaware		$21,258.2
District of Columbia		$133,573.9
Florida	N/A	$0.0
Georgia		$1,000.0
Hawaii		$205,342.3
Idaho		$69,395.6
Illinois		$154,813.1
Indiana		$7,895.1
Iowa		$59,683.9
Kansas		$1,000.0
Kentucky		$253,698.4
Louisiana	N/A	$0.0
Maine		$6,877.7
Maryland		$171,013.1
Massachusetts		$184,058.8
Michigan		$41,517.0
Minnesota		$155,020.5
Mississippi		$38,039.3
Missouri		$21,865.7
Montana		$1,000.0
Nebraska		$6,481.8
Nevada		$90,773.8
New Hampshire		$11,868.1
New Jersey		$8,897.3
New Mexico		$123,281.6
New York		$11,253.7
North Carolina		$87,357.3
North Dakota		$1,000.0
Ohio		$1,000.0
Oklahoma		$1,000.0
Oregon		$304,963.6
Pennsylvania		$34,832.2
Rhode Island		$140,410.1
South Carolina		$1,000.0
South Dakota		$6,879.6
Tennessee		$9,110.2
Texas		$1,000.0
Utah		$6,408.0
Vermont		$172,641.1
Virginia		$15,862.9
Washington		$266,026.0
West Virginia		$20,832.8
Wisconsin		$999.8
Wyoming		$800.0
Total		**$4,359,612.5**

Source: Congressional Research Service and CMS, Center for Consumer Information and Insurance Oversight (CCIIO)

APPENDIX C: NEW MEXICO UNINSURED AND TARGET POPULATION

Table 1. Uninsured by County with Number and Percent of Eligible People

	Uninsured (UI)*		138%-400% FPL	
County	**#**	**%**	**#**	**% UI**
Bernalillo County, NM	114,477	20%	51,276	45%
Catron County, NM	693	28.4	287	41%
Chaves County, NM	12,541	22.9	5,604	45%
Cibola County, NM	4,939	23.1	2,102	43%
Colfax County, NM	1,920	19.5	853	44%
Curry County, NM	8,809	20.3	3,798	43%
DeBaca County, NM	414	28.4	176	43%
Dona Ana County, NM	45,396	25.2	17,398	38%
Eddy County, NM	8,101	17.2	3,849	48%
Grant County, NM	3,949	17.9	1,674	42%
Guadalupe County, NM	660	20.8	261	40%
Harding County, NM	119	24.5	47	39%
Hidalgo County, NM	797	21.3	314	39%
Lea County, NM	13,105	22.3	6,479	49%
Lincoln County, NM	3,947	26.5	1,758	45%
Los Alamos County, NM	779	5.3	325	42%
Luna County, NM	5,031	26.3	1,926	38%
McKinley County, NM	19,804	29.7	7,816	39%
Mora County, NM	883	23.7	306	35%
Otero County, NM	12,374	23.2	5,482	44%
Quay County, NM	1,255	19	544	43%
Rio Arriba County, NM	8,351	24.9	3,714	44%
Roosevelt County, NM	3,908	23.7	1,569	40%
San Juan County, NM	27,529	24.9	13,071	47%
San Miguel County, NM	4,673	20.7	1,694	36%
Sandoval County, NM	20,677	17.7	9,444	46%
Santa Fe County, NM	27,769	23.5	12,407	45%
Sierra County, NM	1,774	23.1	681	38%
Socorro County, NM	3,369	23.7	1,320	39%
Taos County, NM	6,398	24.5	2,821	44%
Torrance County, NM	2,741	22.1	1,101	40%
Union County, NM	625	21.7	280	45%
Valencia County, NM	14,082	22.1	6,210	44%
	381,889		**166,587**	44%

Source: 2013 Small Area Health Insurance Estimates (SAHIE)

*Under age 65

Table 2. Top Targeted Population by County

County	Estimated Number 138% FPL- 400% FPL
Bernalillo County	51,276
Dona Ana County	17,398
San Juan County	13,071
Santa Fe County	12,407
Total	94,152

Source: SAHIE 2013

APPENDIX D: PERCENT AND CHANGE OF UNINSURED POPULATION

State	2013 (%)	2014 (%)	Percentage Point Change
Massachusetts	3.7	3.3	(0.4)
Vermont	7.2	5	(2.2)
Hawaii	6.7	5.3	(1.4)
Minnesota	8.2	5.9	(2.3)
Iowa	8.1	6.2	(1.9)
Connecticut	9.4	6.9	(2.5)
Wisconsin	9.1	7.3	(1.8)
Rhode Island	11.6	7.4	(4.2)
Delaware	9.1	7.8	(1.3)
Maryland	10.2	7.9	(2.3)
North Dakota	10.4	7.9	(2.5)
Ohio	11	8.4	(2.6)
Kentucky	14.3	8.5	(5.8)
Michigan	11	8.5	(2.5)
Pennsylvania	9.7	8.5	(1.2)
West Virginia	14	8.6	(5.4)
New York	10.7	8.7	(2.0)
Washington	14	9.2	(4.8)
New Hampshire	10.7	9.2	(1.5)
Oregon	14.7	9.7	(5.0)
Illinois	12.7	9.7	(3.0)
Nebraska	11.3	9.7	(1.6)
South Dakota	11.3	9.8	(1.5)
Maine	11.2	10.1	(1.1)
Kansas	12.3	10.2	(2.1)
Colorado	14.1	10.3	(3.8)
New Jersey	13.2	10.9	(2.3)
Virginia	12.3	10.9	(1.4)
Missouri	13	11.7	(1.3)
Arkansas	16	11.8	(4.2)
Indiana	14	11.9	(2.1)
Wyoming	13.4	12	(1.4)
Tennessee	13.9	12	(1.9)
Alabama	13.6	12.1	(1.5)
California	17.2	12.4	(4.8)
Utah	14	12.5	(1.5)
North Carolina	15.6	13.1	(2.5)
Arizona	17.1	13.6	(3.5)
South Carolina	15.8	13.6	(2.2)
Idaho	16.2	13.6	(2.6)
Montana	16.5	14.2	(2.3)
New Mexico	**18.6**	**14.5**	**(4.1)**
Mississippi	17.1	14.5	(2.6)
Louisiana	16.6	14.8	(1.8)
Nevada	20.7	15.2	(5.5)
Oklahoma	17.7	15.4	(2.3)
Georgia	18.8	15.8	(3.0)
Florida	20	16.6	(3.4)
Alaska	18.5	17.2	(1.3)
Texas	22.1	19.1	(3.0)

APPENDIX E: NMHIX PERFORMANCE METRICS

NMHIX Performance Metrics for Enrollment

Enrollment Performance Metrics	Target	Actual	Open Enrollment 1 Meet Target?		Open Enrollment 2 Meet Target?	
			Yes	No	Yes	No
CBO Projection for 1st Year NMHIX Enrollment – Penetration Rate	25%	21%		x		
NMHIX 1st Year Estimate - Number	83,000	32,062		x		
National Average Penetration Rate – Year 1 FFM States[1]	**27%**	**21%**		x		
NMHIX 2nd Year Estimate - Number	-	-			-	-
Issuer 2nd Year Estimate - Number	50k-55k	52,358			x	
National Average Penetration Rate – Year 2 FFM States[1]	**43%**	**34%**				x
Wakely Consulting Group LT Target for Eligible Residents[2]	65%-75%					

Sources: Congressional Budget Office (CBO), NMHIX, ASPE, LFC Analysis

[1]Due to issues with the federal platform in Year 1 and consistency from year to year, performance for SBE states has been excluded.

[2]Wakely Long Term (LT) Target: *Now the Hard Part; The Rate of Health Care Enrollment is Set to Slow,* The New York Times, March 23, 2015

Comparative Penetration Rates as of February 22, 2015

Vermont	70%	Alabama	38%
Florida	64%	Massachusetts	37%
Maine	60%	Utah	37%
District of Columbia	57%	Illinois	37%
Pennsylvania	53%	Mississippi	37%
Delaware	53%	Louisiana	36%
North Carolina	51%	Oregon	35%
New Hampshire	51%	**New Mexico**	**34%**
Georgia	50%	New York	33%
Connecticut	49%	Arizona	33%
Michigan	49%	Oklahoma	32%
South Carolina	48%	West Virginia	32%
Virginia	46%	Washington	32%
Idaho	45%	Nebraska	32%
Montana	45%	Wyoming	32%
California	44%	Nevada	29%
Rhode Island	43%	Maryland	26%
Wisconsin	43%	Arkansas	26%
New Jersey	43%	Ohio	25%
Indiana	43%	Colorado	25%
United States	42%	Alaska	24%
Kentucky	41%	Hawaii	23%
Tennessee	40%	North Dakota	23%
Missouri	40%	Minnesota	22%
Kansas	39%	South Dakota	21%
Texas	39%	Iowa	20%

Source: Kaiser Family Foundation

APPENDIX F: COMPLIANCE WITH CONSUMER REQUIREMENTS

NMHIX Compliance with Consumer Assistance and Stakeholder Requirements

Requirement	Regulatory or Statutory Reference	Purpose	Status of NMHIX Compliance
Call Center	45 CFR Part 155.205(a)	Provide a toll free call center to assist consumers	Contracted with XEROX for bilingual referral call center. Operational October 1, 2013. Originally located in Alamogordo, Xerox moved the facility to Albuquerque June 2015.
Internet website	45 CFR Part 155.205(b)	Provide standardized information on health plans such as premiums and coverage, metal level, quality ratings, other relevant information for informed decision making	www.BeWellNM.com for English speakers and www.SeguroQuiSiNM.com for Spanish speakers. Developed SHOP full service website. Developed individual website that links to HealthCare.gov, the federal website for individual enrollment.
Walk-in Center Native American Service Center	Section 59A-23F- 3(S)(6) NMSA1978 Section 59A-23F-4(C) NMSA1978	Provide one-on-one assistance for enrollment	Established by Native American Professional Parenting Resources (NAPPR) in October 2014, located at 2301 San Pedro in Albuquerque. Grand Opening November 2014 added 2 staff from New Mexico Primary Care Association to serve non-Native American customers.
Outreach & Education	45 CFR Part 155.205(e)	Educate consumers about the exchange and insurance affordability programs to encourage participation	Enrollment Period 1: 10 small grantees, five larger ones Enrollment Period 2: Seven grantees
Stakeholder Consultation	45 CFR Part 155.130 Section 59A-23F- 3(S)(2) NMSA1978	Bring in expertise and advocacy	Stakeholder Advisory Committee active comprised of 23 positions: Health Insurance Issuers: 5 Dental Insurance Issuers: 3 Insurance Brokers: 2 Consumer Advocates: 5 Providers and Practitioners: 5 Employers: 3
Native American Advisory Committee	45 CFR Part 155.130(F) Section 59A-23F-3(S)(4) NMSA1978	Advise the N<MHIX board on Native American issues and implementation	Committee active, with 24 Tribes/Pueblo./Nation positions
Native American Liaison	Section 59A-23F-3 (S)(5) NMSA1978	Ensure communication and collaboration with Native American communities	Function filled September 2013
Enrollment			
Navigator Program	45 CFR Part 155.210	Enroll people	250+ Enrollment Counselors Umbrella organizations: New Mexico Primary care Association (NMPCA) Native American Professional Parent Resources (NAPPR) University of New Mexico CAC program set up at various hospitals
Certified Enrollment Counselors (CAC)	45 CFR Part 155.225	Enroll people	
Healthcare Guides			

Source: LFC Analysis

APPENDIX G: NEW MEXICO ENROLLMENT METRICS BY COUNTY

Percent Change from First Enrollment to Second Enrollment by County

County	2015 Plan Selection	2014 Plan Selection	% Change, 2014 to 2015	County	2015 Plan Selection	2014 Plan Selection	% Change, 2014 to 2015
Torrance	281	92	205%	Colfax	304	182	67%
Otero	891	367	143%	Luna	457	274	67%
Lincoln	637	293	117%	San Miguel	439	269	63%
McKinley	401	186	116%	Grant	500	309	62%
Curry	1,185	584	103%	Taos	1,501	927	62%
San Juan	1,328	690	92%	Roosevelt	356	226	58%
Lea	1,178	641	84%	Bernalillo	17,341	11,053	57%
Eddy	1,313	716	83%	Sandoval	2,931	1,919	53%
Cibola	159	88	81%	Valencia	1,342	876	53%
Chaves	1,477	835	77%	Quay	152	100	52%
Don Ana	5,610	3,206	75%	Guadalupe	85	59	44%
Rio Arriba	430	246	75%	Hidalgo	68	54	26%
Los Alamos	299	175	71%	Sierra	132	111	19%
Socorro	219	129	70%	De Baca	74	N/A	N/A
Santa Fe	7,366	4,374	68%	Union	62	N/A	N/A
				HHS Enrollment	48,518	28,981	67%
				Enrollments<50	3,840	3,081	
				HHS Enrollment	52,358	32,062	63%

Source: NMHIX from ASPE data

*By ZIP code; excludes ZIP codes with 50 or fewer plan selections

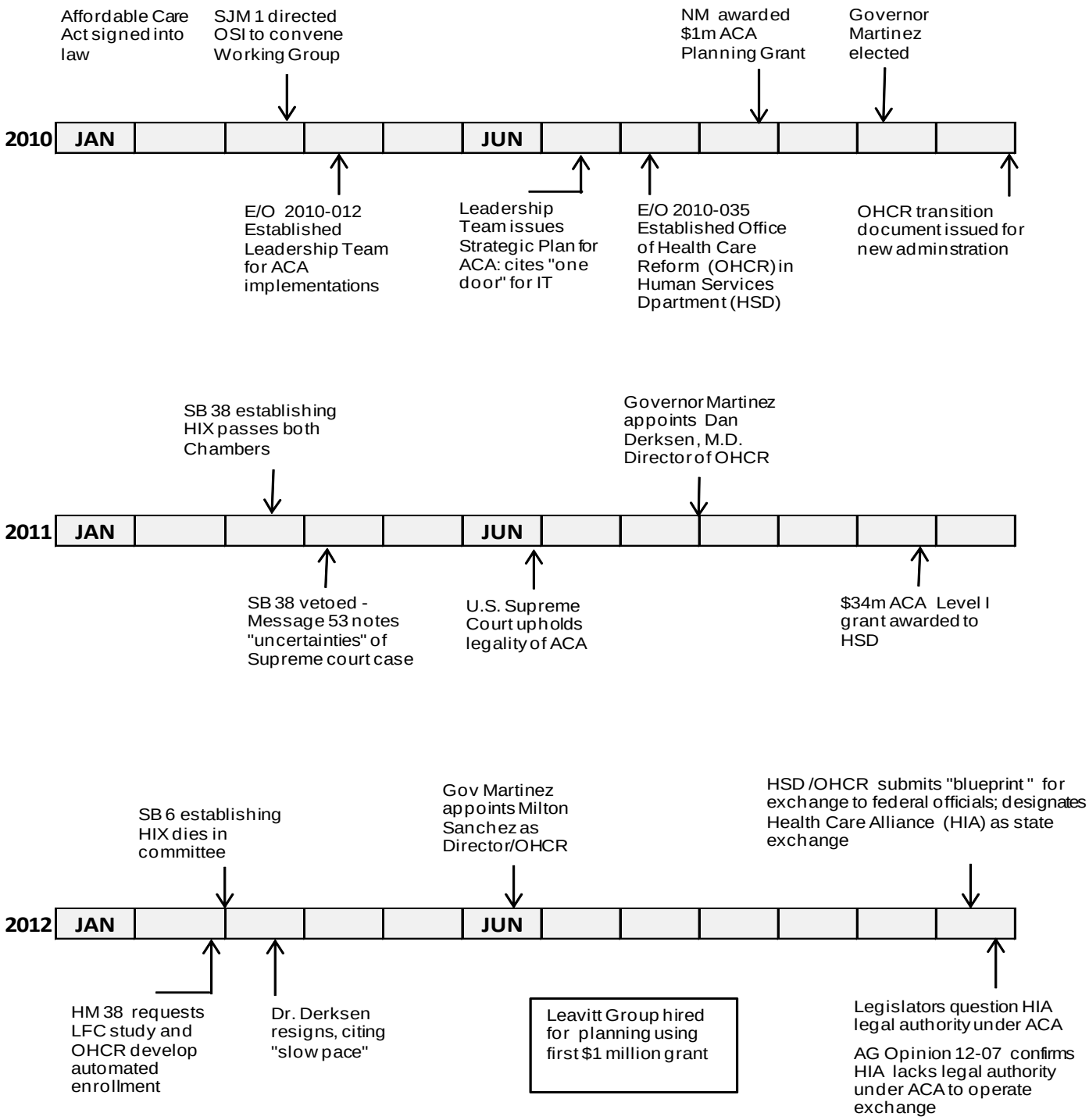
Penetration Rate as an Indicator of Advertising Effectiveness*

County	138%-400% FPL	# Enrolled	Penetration Rate	Media $ %
Santa Fe	12,407	7,366	59.4%	2.6%
Taos	2,821	1,501	53.2%	1.1%
Lincoln	1,758	637	36.2%	0.7%
Eddy	3,849	1,313	34.1%	0.5%
Bernalillo	51,276	17,341	33.8%	
Sandoval	9,444	2,931	31.0%	
Total Metro Area	60,720	20,272	33.4%	69.1%
Dona Ana	17,398	5,610	32.2%	15.2%
Curry	3,798	1,185	31.2%	0.6%
Grant	1,674	500	29.9%	0.7%
Chaves	5,604	1,477	26.4%	3.8%
San Miguel	1,694	439	25.9%	0.8%
Torrance	1,101	281	25.5%	0.0%
Luna	1,926	457	23.7%	0.0%
Roosevelt	1,569	356	22.7%	0.0%
Valencia	6,210	1,342	21.6%	0.0%
Lea	6,479	1,178	18.2%	0.5%
Socorro	1,320	219	16.6%	0.0%
Otero	5,482	891	16.3%	0.6%
Rio Arriba	3,714	430	11.6%	0.5%
San Juan	13,071	1,328	10.2%	2.8%
Cibola	2,102	159	7.6%	0.0%
McKinley	7,816	401	5.1%	1.1%

Sources: SAHIE population data; ASPE March 2015 Issue Brief, K2MD media budget

*Counties with > 1,000 potential pool

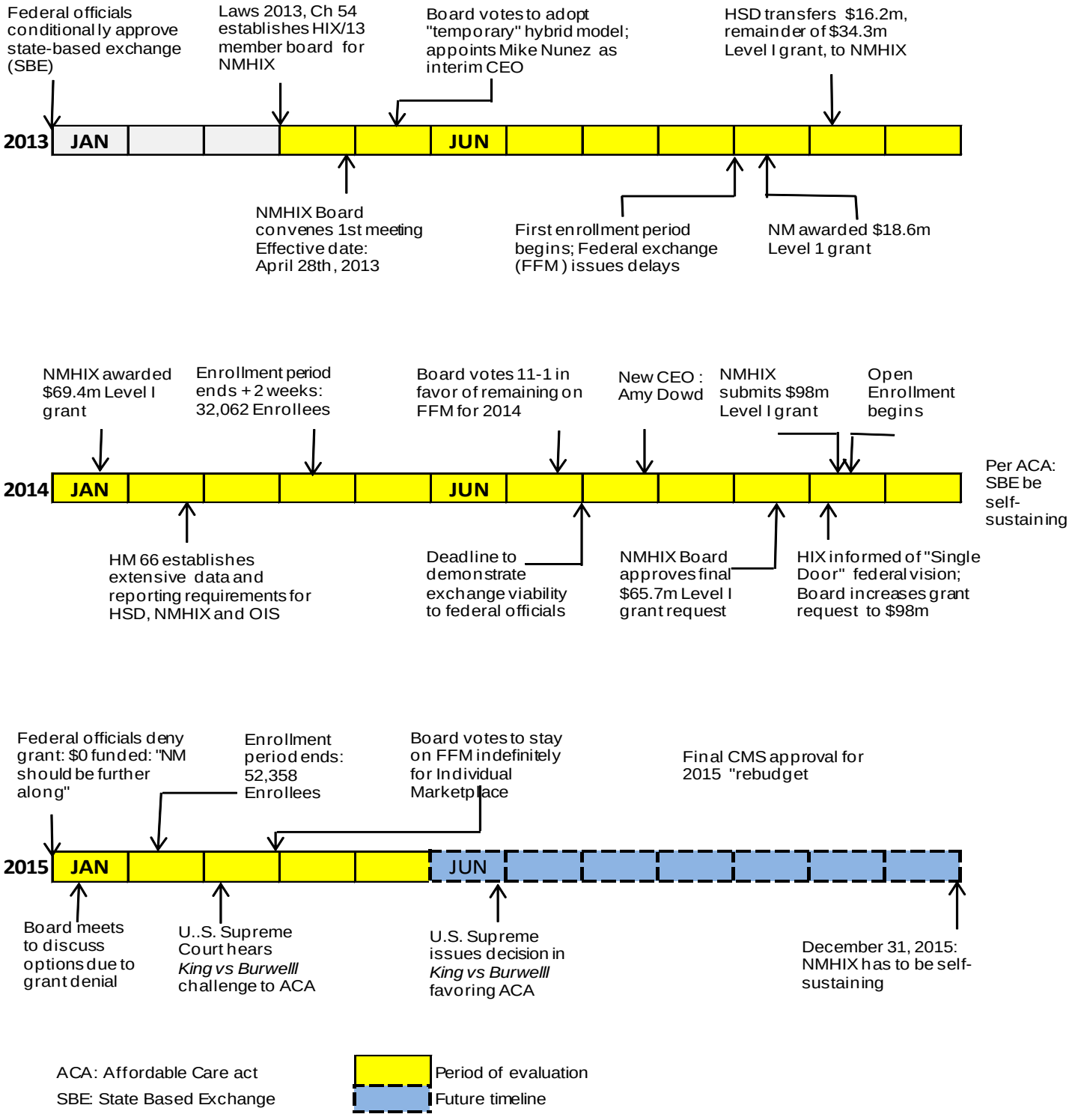
APPENDIX H: NEW MEXICO EXCHANGE TIMELINE FROM 2010 TO 2015



ACA: Affordable Care act

SBE: State Based Exchange

(continued on next page)


Federal officials conditionally approve state-based exchange (SBE)
Laws 2013, Ch 54 establishes HIX/13 member board for NMHIX
Board votes to adopt "temporary" hybrid model; appoints Mike Nunez as interim CEO
HSD transfers $16.2m, remainder of $34.3m Level I grant, to NMHIX
2013
JAN
JUN
NMHIX Board convenes 1st meeting Effective date: April 28th, 2013
First enrollment period begins; Federal exchange (FFM) issues delays
NM awarded $18.6m Level 1 grant
NMHIX awarded $69.4m Level I grant
Enrollment period ends + 2 weeks: 32,062 Enrollees
Board votes 11-1 in favor of remaining on FFM for 2014
New CEO : Amy Dowd
NMHIX submits $98m Level I grant
Open Enrollment begins
2014
JAN
JUN
Per ACA: SBE be self-sustaining
HM 66 establishes extensive data and reporting requirements for HSD, NMHIX and OIS
Deadline to demonstrate exchange viability to federal officials
NMHIX Board approves final $65.7m Level I grant request
HIX informed of "Single Door" federal vision; Board increases grant request to $98m
Federal officials deny grant: $0 funded: "NM should be further along"
Enrollment period ends: 52,358 Enrollees
Board votes to stay on FFM indefinitely for Individual Marketplace
Final CMS approval for 2015 "rebudget
2015
JAN
JUN
Board meets to discuss options due to grant denial
U..S. Supreme Court hears King vs Burwelll challenge to ACA
U.S. Supreme issues decision in King vs Burwelll favoring ACA
December 31, 2015: NMHIX has to be self-sustaining
ACA: Affordable Care act
SBE: State Based Exchange
Period of evaluation
Future timeline

APPENDIX I: MODIFIED 2015 BUDGET APPROVED AUGUST 2015

New Mexico Health Insurance Exchange
2015 Modified Budget Compared to Budget Approved by Board of Directors on May 15, 2015

Board approved 8/21/2015

Account Title	Budget Approved by Board of Directors on 5/15/15	Modified 2015 Budget Proposal: Total Modified Budget	Modified 2015 Budget Proposal: Funded from Grant per CMS Approval of Revised Budget	Modified 2015 Budget Proposal: Funded from Operating Funds
Salaries	$ 1,523,448	$ 1,481,449	$ 917,138	$ 564,311
Fringe	398,515	416,009	269,630	146,379
Equipment	308,815	150,846	111,044	39,802
Supplies	7,638	10,000	6,387	3,613
Travel	66,397	53,683	40,340	13,343
Other	306,652	292,421	199,797	92,624
IT Contractual:		-		
HSD - Eligibility	1,797,315	1,797,315	1,797,315	-
IT Vendor	3,188,852	3,188,752	2,298,752	890,000
Independent Validation & Verification - old	108,933	172,308	172,308	-
Project Management Services - old contract	133,441	133,441	133,441	-
Change in Scope Costs - IT Vendor	5,971,946	2,600,000	2,600,000	-
Project Management Services - new procurement	1,909,091	1,300,000	1,300,000	-
Independent Validation & Verification - new	300,000	75,000	75,000	-
Data Reporting System - new procurement	750,000	1,691,384	1,691,384	-
SHOP Enhancements	5,698,000	1,072,307	-	1,072,307
Non-IT Contractual:				
Auditing/Accounting Services	121,455	119,455	119,455	-
Privacy & Security Audit	100,000	450,000	450,000	-
Legal & HR Consulting	607,000	531,759	334,858	196,900
Board of Directors Expenses	39,083	39,427	39,427	-
Referral Call Center	862,932	875,864	425,864	450,000
Website Development	1,807,579	1,430,775	1,430,775	
Marketing - Advertising & Media	4,902,150	4,619,809	3,674,767	945,042
Marketing Surveys	190,450	230,400	230,400	-
Market Analysis	2,133,333	1,200,000	1,200,000	-
State Network for Exchanges	-	25,000	25,000	-
Healthcare Guides & Navigators	2,674,463	3,354,373	3,254,373	100,000
Outreach	1,627,456	5,847,586	5,847,586	-
Stakeholder Communication/PR	1,723,250	2,242,844	2,012,027	230,817
Plan Management				
OSI MOU	825,000	-	-	-
Total	$ 40,083,196	$ 35,402,207	$ 30,657,068	$ 4,745,139

Source: NMHIX

APPENDIX J: INFORMATION SECURITY PROGRAM MATURITY MODEL

Information Security Program Maturity Model

An information security program maturity model (ISPMM) is a framework used as a benchmark for comparison when looking at an organization's security processes**.** An ISPMM is a service mark that provides a model for understanding the capability maturity of an organization's security processes. A security maturity model is specifically used when evaluating the capability to implement information security strategies and the level at which a company could be at risk from these strategies.

Gartner's Information Technology (IT) Score Maturity Levels

An ITScore-based methodology assessment represents an evaluation of a risk and security program compared against key indicators of maturity. This includes management processes, personnel and organization, technology and tools, and business culture. It is important to note the highest levels of information security maturity may not necessarily be attainable, or even desirable for all enterprises. However, the process of continuous improvement that ITScore and ISPMM make possible can deliver significant improvements in each of the security domains and can significantly reduce an enterprises' risk exposure. In some cases, it may also deliver improvements in the effectiveness and efficiency of related business processes.

***Information Security Maturity Levels*:**

1= Initial

Processes are non-existent or ad hoc, inconsistent, disconnected, undocumented; no formal policies, processes or responsibilities. There is a lack of assigned tasks.

2= Developing

Processes starting to be documented, some recognition for the need of formal policies, processes and security program; base responsibilities are being assigned; Awareness efforts are beginning; procedures becoming repeatable and consistent.

3= Defined

Defined policies, procedures/operations/system configurations have been formalized and documented; security program defined; clear commitment from management; assigned management for security; increased user awareness; initial metrics defined; risk assessments performed; compliance requirements are being met.

4= Managed

Information security governance structure established; enterprise-wide focus versus IT focus; aligned with business goals and requirements; information security program and architecture fully defined; effective metrics (KRI, KPI); engaged with business units.

5= Optimizing

Full information security governance structure in place and integrated with enterprise governance; Continuous process improvement in place; Enterprise wide risk aware culture, information security risk management integrated with Enterprise Risk Management; Board level visibility to security and risk management; information owners accountable; Security as a strategic business imperative for enterprise.

APPENDIX K: NMHIX BOARD OF DIRECTORS AS OF JUNE 1, 2015

Composition of NMHIX Board					
Name/Board Position	**Required Affiliation**	**Statutory Reference**	**Expertise (Self reported via survey)**	**Term Began**	**Term Ends**
John Franchini, Superintendent of Insurance	NM OSI	Ex officio		N/A	N/A
Brent Ernest, Secretary	HSD	Ex Officio		N/A	N/A
Kurt Shipley BCBS	Health Insurance Issuer	GOV	Purchasing coverage in the individual market Purchasing coverage in the small employer market Health care finance Health care economics Health care policy Provision of health care services	Replaced Ben Slocum 2 Year Term	6/30/2016
Dr. Deane Waldman	Consumer Advocate	GOV	Health care finance Health care economics Health care policy Administration of a private or public health care delivery system Provision of health care services	6/30/2013 Reappointed	6/30/2016
Terriane Everhart	Unrestricted	GOV	Purchasing coverage in the small employer market Starting a small business with 50 or fewer employees	6/30/2014 Reappointed	6/30/2017
Dr. JR Damron	Unrestricted	GOV	Purchasing coverage in the individual market Health care policy Starting a business with 50 or fewer employees Provision of health care services	6/30/2013 Reappointed	6/30/2016
Gabe Parra Health Insurance Issuer-Presbyterian	Unrestricted	GOV	Health care finance Health care policy Health care economics Administration of a private or public health care delivery system	6/30/2013	6/30/2015
Dr. Larry Leaming CEO, Roosevelt County Special Hospital District-Portales	Health Care Provider	Pres Pro Tempore-Minority leader	Purchasing coverage in the small employer market Health care finance Health care policy Administration of a private or public health care delivery system Information Technology Provision of health care services	6/30/2014 Reappointed	6/30/2017
Patsy Romero	Unrestricted	Pres Pro Tempore	Purchasing coverage in the individual market Purchasing coverage in the small employer market Health care finance Health care policy Provision of health care services Enrollment of underserved residents Administration of a private or public health care delivery system Information Technology Starting a business with 50 or fewer employees Provision of health care services	6/30/2015 Reappointed	6/30/2018
Teresa Gomez	Unrestricted	Pres Pro Tempore	Purchasing coverage in the individual market Purchasing coverage in the small employer market Health care policy	6/30/2015 Reappointed	6/30/2018

Continued on next page.

Name/Board Position	Required Affiliation	Statutory Reference	Expertise (Self reported via survey)	Term Began	Term Ends
Dr. Martin Hickey Health Connections COOP	Health Insurance Issuer	Speaker	Health care finance Health care economics or actuarial Health care policy Enrollment of underserved residents Administration of a private or public health delivery system Information technology Starting a business with 50 or fewer employees Provision of health care services	2 Year Term	6/30/2015
David Shaw, CEO Nora-Lea General Hospital	Unrestricted	Speaker- Minority Leader	Health care finance Health care policy Enrollment of underserved residents in Health care coverage Administration of a private or public health care delivery system Provision of health care services	5/30/2014 Reappointed	6/30/2017
Jason Sandel	Unrestricted	Speaker	Health care policy Administration of a private or public health care delivery system	6/30/2013 Reappointed Resigned	6/30/2016 July 2015

Sources: NMHIX and Board of Director surveys

APPENDIX L: NMHIX COMPLIANCE WITH GOVERNANCE REQUIREMENTS

CFR 155.110 (c) and Section 59A-23F-3 NMSA 1978 Compliance

c) *Governing board structure.* If the Exchange is an independent State agency or a non-profit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that:			
CFR 155.110	**Section 59A-23F-3 NMSA 1978**	**In Compliance?**	**Source**
(2) Holds regular public governing board meetings that are announced in advance;	M. and S. Is subject to Open Meetings Act	Yes	Published Notices Website
(3) Represents consumer interests by ensuring that overall governing board membership:			
(i) Includes at least one voting member who is a consumer representative;	E. (2)	Yes	Updated Board Terms as of 3/16/15
(ii) Is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and	E. See Appendix K	Yes	Updated Board Terms as of 3/16/15
(4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.	J. (1)-(10) See Appendix K	Yes	Per self-completed Board member surveys
d) *Governance principles.* (1) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.		See table below.	Board Minutes Board Policies Conflict of Interest forms
	I. Be composed, as a whole, to assure representation of the state's Native American population, ethnic diversity, cultural diversity and geographic diversity	See table below.	Per self-completed board member surveys

Geographic and Ethnic Cultural Diversity

(Ex officio members excluded)

Ethnic/Cultural Diversity	
Caucasian	7
Hispanic	3
Native American	1
Geographic Representation	
Central NM – Albuquerque	5
Southern NM – Las Cruces	1
Northern NM – Including Santa Fe County	2
Southeast NM – Lovington and Portales	2

Source: Board surveys

APPENDIX M: GOVERANCE FOR STATE-BASED EXCHANGES

Types of Governance Structures for State-Based Exchanges

Type of Structure	States	Board	Conflict of Interest
State Agency or Administratively Attached	California: Independent state agency **Covered California (Statute 2010)**	5 Members Governing	Members cannot be affiliated with any entity involved in the exchange.**
	Kentucky: Office of Kentucky Health Benefit Exchange in the Cabinet of Health and Family Services **Kynect (EO 2012)**	11 Members Advisory	N/A
	Minnesota: Established as a board Under Section 15.012 – State Agencies, (a) **MNSure (Statute 2013)**	7 Members Governing	Members cannot be affiliated with a health carrier, provider, or other entity providing services through Exchange within one year or while serving; spouse cannot be executive of a health carrier; defines conflict of interest as an association that has the potential to bias or has appearance of biasing decisions.**
	Nevada*: State agency **Nevada Health Link (Statute 2011)**	10 Members Governing	Cannot be affiliated with insurance carriers** or be a legislator.
	New York: Within Department of Health **New York State of Health (EO 2012)**	No board. Uses stakeholder input	N/A
	Rhode Island: New division within the Office of the Governor **HealthSourceRI (EO 2011)**	Advisory Board and Experts Committee	N/A
	Vermont: Division within the Department of Health Access, part of the Agency of Human Services **VT health Connect (Statute 2011)**	27 Members Advisory Board	N/A
Quasi-governmental	Connecticut: public instrumentality and political subdivision of the state **Access Health CT (Statute 2011)**	14 Members Governing	Does not allow any representatives of the insurance industry or providers.**
	Idaho: independent body corporate and politic **Your Health Idaho (Statute 2013)**	19 Members Governing	Allows affiliations of issuers, providers, etc. Full disclosure required: abstain from any vote on the matter.
	Maryland: public corporation and independent unit of state government **Maryland Health Connection (Statute 2011)**	9 Members Governing	Members cannot be affiliated with any entity involved in the exchange.**
Note: Cover Oregon closed on June 30, 2015 and the marketplace was transferred to the Oregon Department of Consumer and Business Services with a 13-member advisory board.	Massachusetts: independent body politic and a public instrumentality **Massachusetts Health Connector (Statute 2006)**	11 Members Governing	1 shall be a member of the Mass Association of Health Underwriters; member cannot be an employee of a licensed carrier.**
	Oregon*: Independent public corporation **Cover Oregon (Statute 2011)**	9 Members Governing	Limits the number of members with affiliations of issuers, providers, etc. to 2 of the 7 appointees.
	Washington: Public-private partnership separate from the state **WA Health Plan Finder (Statute 2011)**	11 Members Governing	Member cannot be appointed if decisions could benefit own financial interests or financial interests of entity he or she represents

Public Non-profit	Colorado: Non-profit unincorporated public entity **Connect for Health Colorado (Statute 2011)**	12 Members Governing	Allows affiliations of issuers, providers, etc. Board members cannot make decisions that benefit them financially.
	New Mexico*: Nonprofit public corporation **bewellNM (Statute 2013)**	13 Members Governing	Specific language exempts conflict of interest merely by affiliation; Requires Conflict of Interest Policy
Private Non-profit	Hawaii: Private Non-profit **Hawaii Health Connector (Statute 2011)**	12 members 9 voting Governing	Revised law (2014) eliminates members representing insurers or dental benefit providers**; allows for board to create advisory committee of such experts

Source: NCSL, state statutes and Executive Orders
*States considered state-based exchanges using the federal facilitated marketplace
**The enabling statute prohibits members (and sometimes spouses) from having an affiliation with Exchange entities, such as issuers, providers, brokers, etc. as a more stringent application of ACA Conflict of Interest provision that prohibits a majority of the Board be so represented.42 CFR 155.110 (C)(3)(ii)

APPENDIX N: STATE COMPARISON OF REPORTING REQUIREMENTS

SBE States w/Governing Board	#	Appointments of Board Members Made by:				Reporting Requirements*
		Governor Only	Governor w/Legislative Confirmation	Combination of Governor and Legislature	Unique Characteristics	
California	5			X	Fund is established that is continuously appropriated. State personnel agency reviews salaries. Exempts from disclosure staff and board deliberative processes. Provides for an exclusion from public's right of access to meetings or writings.	Make available to the public an extensive list of information; publish annual budget, including salaries; provide annual report to governor and legislature and post online; be responsive to legislative inquiries; provide special report on merging business and individual markets; report on financial condition to legislature and executive.
Colorado	12 (9 voting)			X	Law establishes Legislative Health Benefit Exchange Implementation Review Committee. All monies subject to audit by Legislative Audit Committee.	Report all monies received to the Legislative Audit Committee. Requires post-enactment review after 5 years.
Connecticut	14			X	Requires a collaborative cost-benefit analysis of the cost impact to the state of the ACA.	Submit annual audit to legislature. Report at least annually on adverse selection impacts. Report annually to governor and legislature on operations, grants and financial status.
Hawaii	15 (Initial 2011 law) 12 (9 voting 2014 law)		X Subject to the advice and consent of the Senate		Revised laws (2014) established Legislative Oversight Committee, changed composition of board; added general fund appropriation. Requires annual audit by State auditor. Stipulates legislative access to, inspect and make copies of documents in addition to State auditor and state Insurance Commissioner.	Submit Annual Report and Sustainability Plan to legislature including state and federal audits. Posts report to website. Submit annual financial statements each fiscal year.
Idaho	19 (17 voting)			X 14 appointed by governor 3 appointed by legislature	Highlights reporting by having a separate Section 41-6106. Health Care Task Force established under existing authority.	Submit annual report to governor, director and legislature. Also report to appropriate Senate and House of Representatives committees specific changes annually.

Maryland	9	**X**			2011 law created the nonreverting exchange fund not subject to Section 7-302 of the State Finance and Procurement Article. Exchange administers the fund and Comptroller accounts for the fund. 2012 law created a joint legislative/executive committee to conduct a further study of specific financing mechanisms to determine the most appropriate and effective option; ultimate decision on financing to be determined during the 2013 General Assembly.	Sustainability Plan was due to governor and General Assembly on 12/1/12. Requires the MHBE to establish and report to the General Assembly its plan for a fraud, waste and abuse prevention program. Submit annual report on activities, expenditures and receipts of the Exchange to governor, legislature and secretary, including specific data requirements on outcome measures.
Massachusetts	11	4 appointed by governor; 3 appointed by attorney general			Exchange established in 2006. Separate authority created in 2012. For purposes of information technology (IT), the authority is considered a state agency and is subject to IT oversight. Biennial audit by state auditor. Limits investigations to board or state auditor.	Submit annual report of receipts and expenditures to board, governor, general court (legislature) and state auditor. Annually conduct a study of the exchange activities and enrollment, including collecting data on expenses, claims, complaints, goal accomplishment; submit report to governor and legislature. Annual reports to legislature are available online: Legislature Archive.
Minnesota	7		**X** 6 members appointed by governor with advice and consent of both the Senate and House of Representatives; 1 ex officio		Established Legislative Oversight Committee; reviews operations at least annually and provides recommendations necessary changes in policy, implementation, and statutes. Fund established in Treasury is appropriated. Requires annual review by legislative auditor under Section 3.971. The legislative auditor may make recommendations on consolidating or eliminating any services deemed duplicative. Subject to IT oversight: Considered a state agency for purpose of Minnesota Government Practices Act.	Budget submitted to the legislature. Report to legislature any agreements with Office of Enterprise Technology and Commissioners of Human Services. Health, or Commerce. Submit annual report to legislature covering performance metrics. Must publish its administrative and operational costs on a website, including any misuse of funds.

					Has multiple, detailed, and stringent data sharing clauses.	
Nevada	10 (7 voting)			**X** 5 appointed by governor; 2 appointed by legislature; 3 ex officio are nonvoting	The exchange is subject to legislative and executive branch audits. The exchange is subject to the state's Procurement Code. Exchange may request a general fund advance from the Department of Administration (DOA); if approved DOA must notify state controller and Fiscal Analysis Division of the Legislative Counsel Bureau.	Submit annual fiscal and operational reports to governor and legislature. Prepare annual report for the public summarizing exchange activities and contributions to the health of Nevada residents.
New Mexico	13			**X** 6 appointed by governor, including 1 ex officio; 6 appointed by legislature; 1 ex officio	Prohibits staff from affiliations with health care issuer or provider. Includes 2 designated members with affiliations with issuers; 1 designated member affiliated with a health care provider. Members subject to conflict-of- interest provisions EXCEPT Secretary of Human Services and directors associated health care provider or issuer are not considered to have a conflict of interest simply because of these affiliations. Shall operate consistent with Governmental Conduct Act, Inspection of Records Act, Financial Disclosure Act and Open Meetings Act.	Provide quarterly reports to superintendent of insurance, governor and legislature on exchange implementation between July 1, 2013 and January 1, 2015 and annually thereafter and upon request. Submit financial information annually to superintendent of insurance and as required by federal law. Obtain annual audit. Publish the administrative cost of the exchange as required by state or federal law.
Oregon**	9		**X** Appointed by governor and confirmed by Senate		Oregon Health Insurance Fund is created and funds were continuously appropriated to the exchange. Required annual financial audit by the secretary of state. Required biannual performance audit by secretary of state. Required exchange to notify secretary of state of corrective actions taken or to be taken within 90 days of the report.	Secretary of state submits audits to governor, legislature and other state agencies, including recommended corrective actions; the report shall be available for public inspection. Exchange shall report quarterly to legislature on financial condition; implementation; development of IT system; any information requested by legislature. Exchange shall report annually to governor and legislature and other state agencies on activities and operations; statement of financial conditional role of insurance

						producers in the exchange; and recommendations for eligibility.
Washington	11 (9 voting)	**X** Governor appoints members; must appoint two members from each legislative list.		**X** Each of two largest caucuses in the Senate and House of Representatives shall submit a list of 5 nominees.	Four members must be selected from submissions from the four Senate and House majority and minority caucuses. A Joint Select Committee on Health Care Reform collaborated on a wide range of implementation options. Public money subject to allotment procedures but not appropriations. Subject to provisions of the Open Public meetings Act and Public Records Act.	Initial report required on implementation options to governor and legislature.

Sources: State Enabling Statutes
*All had reporting requirements to federal agencies: Health and Human Services; CMS
**Represents original statutory language. The Oregon exchange was transferred to the Department of Consumer and Business Services with a 13-member advisory board in June 2015.

APPENDIX O: REGULATIONS PROMOTING TRANSPARENCY

NMHIX Compliance with Federal Regulations Promoting Transparency

Reference	Description of NMHIX Activity	Recommended
2 CFR Part 155.1200 (b)(1) A financial statement in accordance with GAAP presented to HHS by April 1 of each year	Financial statements are to be submitted to HHS by April 1 of each year. February 28, 2014 board minutes mention "2013 Financials were presented." However, the minutes do not clarify if the financial statements related to the Alliance or to the Exchange. In addition, such presentations are not always posted on the website to review.	Provide monthly financial statements to Board in a standardized format and post to website
2 CFR Part 155.1200 (c) External Audits (3) Make public a summary of results of the external audit	The September 19, 2014 board meeting discussed the NMHIX 2013 audit but it is not posted to the website nor is the presentation posted for that meeting. The Exchange 2014 audit is not completed as of June 22, 2015.	Post audit on website
2 CFR Part 155.1200 (c)(2) Inform HHS of any material weaknesses or significant deficiencies and provide corrective action plan addressing issues	2013 audit had 6 deficiencies. Board discussed the issues at the September 19, 2014 board meeting, including an action plan. Presentation is not posted. It is unclear whether the action plan was submitted to HHS.	Post action plan and progress in implementation, updated as appropriate
2 CFR Part 155.205 (2) Publishes the following financial information (iv) Administrative costs of the exchange (v) Monies lost to waste, fraud or abuse	While administrative costs are discussed at board meetings, the Exchange does not publish them in a consistent manner for public review. Some presentations are posted and some are not, making it difficult to track for comparison purposes.	Report status of operations and administrative costs on the website in a consistent frequency and format.
2 CFR Part 170 Appendix A Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS)	USASpending.gov reports $85.6 million awarded to NMHIX for FY2014, which ties to combination $16.2 million and $69.4 million so NMHIX is reporting to (FSRS). NMHIX website posts two grant applications and one Notice of Award. The final November 2014 grant application is missing and one NOA. Grant expenditures by award are not posted.	Post all grant activity: request, award, and expenditures by line item and by vendor. Post contracts over 25,000.
2 CFR Part 170 Appendix A Federal Funding Accountability and Transparency Act Subaward Reporting System (FSRS)	Report five most highly compensated executives to FSRS. Four of the NMHIX staff earn $100 thousand or more. With the end of federal grants, any such disclosures will also cease.	Post salaries on website.

Sources: Code Federal Regulations and LFC Analysis

NMHIX Financial Reporting Schedule

Current/Proposed Practice	Public Access	Frequency	In Compliance with Policy?
Provide interim and audited financial statements to OSI, HSD, legislature and the Office of the Governor	By Request	Annually	2013 Submitted 2014 Outstanding June 2015 Finalized August 2015
Monthly financial statements prepared and provided to Finance committee for review and presented quarterly to the Board	By Request	Monthly and Quarterly	Standardized financial statements do not appear to be prepared monthly or submitted to the board quarterly.
Annual Report	Made Available	Annually - By June 1st	2014 Submitted 2015 Outstanding

Source: NMHIX and LFC Analysis

REDW Findings in Agreed Upon Procedure for SHOP

Analysis of 45 CFR Part 155.205, REDW identified several instances where the Exchange's website did not have the required disclosures including:
a. The results of the enrollee satisfaction survey (Section 1311(c)(4) of the ACA Note: As of July 2015, results are still not posted to the website.
b. Quality ratings assigned in accordance with Section 1311(c)(3) of the ACA Note: Revised CMS start date is January 1, 2016 for this requirement.
c. Medical loss ratio information in accordance with 45 CFR part 158(b)(1)(vi) Note: As of July 2015, MLR information still not posted to the website.
d. Transparency of coverage measures reported to the Exchange during certification in accordance with 45 CFR Part 155.040(b)(1)(vii) Note: As of July 2015, this information still not posted to the website.
g. Monies lost to waste, fraud, and abuse 45 CFR part 155.205 (b)(2(v) Note: The management response indicated the NMHIX has a waste, fraud and abuse hotline in place but it was not found on either the NMHIX or the bewellnm websites.

Source: NMHIX REDW Agreed Upon Procedure, March 2015

APPENDIX P: POLICIES AND PROCEDURES COMPLIANCE

Board Document	Complied?	Date of Compliance	Main Provisions
Preliminary Plan of Operation within 60 days Section 59A-23F-5(A) and (C) NMSA 1978	Unknown. NMHIX did not respond to request and Board minutes do not reference a 60 Day Plan.		1. Establish procedures to implement the Exchange consistent with statute 2. Establish procedures for handling and accounting for the Exchange's assets and money
Plan of Operation within 6 months Section 59A-23F-5(A), (B), and (D) NMSA 1978	Yes	Board minutes: Approved 8 to 4. August 16, 2013	See table below.
Communications Policy	N/A	December 18, 2013 October 17, 2014	1. Guidelines for external communications for NMHIX employees, directors, contracting partners: • With media • IPRA requests • Use of social media • Primary spokespeople 2. Goals of NMHIX Communication: • Be clear and concise • Be transparent • Be accurate • Be timely • Engage media and stakeholders
Communications Policy and Consultation Policy with Stakeholders 45 CFR Part 155.130 Section 59A-23F-3(S)(2) and (5) NMSA 1978 Section 59A-23F-5(D)(4)(a) NMSA 1978	Partially	August 16, 2013 Approved as part of Plan of Operations	Note: the Native American Advisory Committee includes a section regarding Native American Committee/NMHIX consultation principles in its *Guiding Principles and Protocols.* Section 5.4 of the Plan of Operations specifies the board shall create stakeholder groups and duly consider recommendations but does not provide definitions, protocols, procedures or formats for discussion purposes. Article X provides more guidance regarding Native American communication and collaboration.
Procurement Policy Section 59A-23F-5(D)(6) NMSA 1978	Yes but almost a year after inception	March 21, 2014	1. Delegates authority to contract to CEO 2. $100,000 threshold for board approval 3. Reporting requirements: • Contract list • Register of checks 4. Competitive process: • Over $100,000 • Sealed bid-least expensive • Sealed Proposal-other factors • RFP process 5. Exemptions • $100,000 or lower • Emergency • Sole Source 6. Alternatives for pricing: • 3 quotes or bids • Cost or price analysis • Conduct negotiations 7. Comply with federal regulations 8. Protest or complaint 9. Conflict of Interest
Code of Conduct : Governing Principles and Conflict of Interest 45 CFR Part 155.110(d)(1) Section 59A-23F-5(D)(5) NMSA 1978 Plan of Operation	Yes	April 30, 2013 May 15, 2015	1. In accordance with Governmental Conduct Act 2. Maintain ethical standards 3. Position of public trust 4. Defines personal financial interest 5. Defines procurement restrictions for Board Director or employee 6. Restrictions on gifts 7. Disclosure of conflict of interests for board members and employees 8. Violations
Disclosure of Financial Interests 45 CFR Part 155.110(d)(2)	Yes	Annually on file	1. Disclosure of personal financial information

(Continued)

Board Document	Complied?	Date of Compliance	Main Provisions
Notice of Right to Inspect Public Records Section 59A-23F-3(M) NMSA 1978	Yes	June 7, 2013	1. Submit request to Records Custodian 2. 15 calendar days to respond 3. $.50 fee per page for copies
Open Meetings Act Resolution Section 59A-23F-3(M) NMSA 1978	2015-01 Posted to website	June 7, 2013 March 31, 2015	1. Meetings-call of the Chair 2. Regular meeting – 7 days notice 3. Special Meetings – 72 hours 4. Emergency meeting-24 hours 5. Agendas- 72 hours
Record Retention Policy 2 CFR Part 215.46	Yes but over two years after inception	May 15, 2015	1. Establishes Records Custodian 2. Retention of records • Retention periods • Compliance with state and federal law 3. Improper destruction 4. Privacy and Security 5. Electronic records • Retention follows content • Shall establish and maintain an IT system to produce, use and store data files • Enable to search via indexing • Restrict access • Include metadata • Archival periods
Per Diem and Mileage Section 59A-23F-3(R) NMSA 1978			1. Section 4.10 of the Plan of Operation specifies board members may receive per diem and mileage in accordance with the Per Diem and Mileage Act according to a travel policy established by the board.
Travel Policy Section 59A-23F-3(R) NMSA 1978	Unknown. Travel policy provided is not signed or posted to website.	Unknown. Provided Travel Policy is dated July 19,2013 but is not signed or posted.	1. Per diem tracks with 2 NMAC 42.2.8 2. Mileage tied to federal rate and not state mileage rate per 2 NMAC 42.2.11(B). 3. Applies to board members only as non-salaried public officials.

Plan of Operation: Section 59A-23F-5(D) NMSA 1978

Statutory Requirement	Actions
(1) establish a statewide consumer assistance program, including a Navigator program	Partnered with outreach, education and enrollment entities. Established walk-in center for Native Americans and non-Native Americans. Established Navigator program through New Mexico Primary Care Association.
(2) establish consumer complaint and grievance procedures for issues relating to the exchange	Article VIII Complaints and Grievances sets protocol for complaint against the Exchange. Section 8.2 covers complaints against a health insurance issuer and others, governed by Office of the Superintendent of Insurance.
(3) establish procedures for alternative dispute resolution between the exchange and contractors or health insurance issuers	Article IX establishes protocol for alternative dispute resolution between the Exchange and Health Insurance Issuers. Provision for disputes with vendors is contained in contracts.
(4) develop and implement policies that:	
(a) promote effective communication and collaboration between the exchange and Native American entities	Established Board Native American Standing Committee. Hired a Tribal Liaison. Created and approved appointments to Native American Advisory Committee. Contracted for Native American outreach and enrollment with New Mexico Native American Professional Parenting Resources.
(b) promote cultural competency	Included in all training. Included in Article X, Section 10.3
(5) establish conflict of interest policies and procedures	Initially approved April 30, 2013 and revised May 15, 2015 to align directly with the Governmental Conduct Act.
(6) contain additional provisions necessary and proper for the execution of the powers and duties of the board	Elected officers Established standing committees with charters: Finance, Operations, Marketing and Outreach, Native American, and Executive. Article VI covers financial management, including annual audit. Established Sustainability Plan per statute and federal regulation. Note: Plan of Operation specifies January 1, 2015 (Article XIII) but the NMHIX has been operating under January 1, 2016 date for operational self-sufficiency.

Source: LFC Analysis

APPENDIX Q: PRELIMINARY FINANCIAL RECORDS REVIEW

Note: The evaluation completed fieldwork with the last information request submitted on June 1, 2015. The final 2015 budget and 2014 audit were received on October 19 and October 20, respectively. Thus, tables with financial data were updated in the report and narratives revised accordingly but no further analyses were performed.

2013 Single Audit Findings

- Exchange did not meet procurement requirements of 45 CFR Part 92.36:
  - No formal policies and procedures in place for 2013;
  - No written selection procedures for contract awards; and
  - Staff lacked experience operating federal grants and applicable OMB Circulars A-133 or A-87* for grant management;
- No Procurement Policies and Procedures for 2013 created a risk of violating federal suspension and debarment requirements;
- Insufficient staff expertise and lack of procedures for payments resulted in non-compliance with OMB Circular A-87 to ensure costs are necessary, reasonable, authorized or not prohibited:
  - Non-Allowable expenses – Staff reimbursed a vendor for alcohol costs;
  - Costs not authorized and/or verified as received by the Exchange prior to vendor being paid:
    - 9 of 40 disbursements tested were not approved before payment was made;
    - 2 of 40 disbursements tested did not reconcile to supporting documentation; and
- Lack of staff meant insufficient separation of duties for internal control sufficiency.

General Ledger Review-List of Concerns

Note: The following questions would have been discussed with staff had the general ledger been received timely; they are not findings:

1. Transaction entries might indicate further training or additional supervisor oversight is required to accurately record transactions to comply with GAAP. In a sample of 18 transactions for rent, seven anomalies were detected.

General Ledger Initial Review (January 1, 2014- March 31, 2015)
Account Code 5515-Rent

Issue	Concern	Corrected?	Result
Wrong account code used for 2 transactions	Call Center April 2014 accrual booked: $53,931.60 Expense reimbursement PO box: $232	Reversed Reversed 3/16/2015-most likely audit adjustment.	If not corrected immediately, can misstate expenses.
NMHIX uses accruals that are processed by journal entries. Journals do not appear to have vendor IDs.	It appears 1 month booked by journal rather than using accounts payable module per 2014Fin008, Recording Accruals. It is unclear if accruals are being recorded and reversed correctly.	No	Payments for vendors should aggregate as much as possible under the unique ID in the AP module. Otherwise payments get distributed, complicating expense reporting.
Prepaid expense not booked in correct period.	Jan 2014 paid in December 2013 not booked as a prepaid. Had to correct in 2014.	Yes	Potential for financial misstatement. of expenses. Overuse of journals to correct entries also complicates reconciliations and expense reporting.
Multiple entries for same transaction	Five entries to reclass prepaid rent to expense. Looks like transaction booked twice and then one reversed. Questionable oversight prior to posting transactions to the GL.	Nets out to single debit for Sept 14 rent	Complicates GL reconciliation and it clutters GL. Duplicate t entries not always caught timely can misrepresent financial statements.

Source: LFC Analysis

2. Furthermore, February and March lease payments recorded in the general ledger for the main office do not tie to the lease contracted monthly amount of $6,382.60 for year two. Lease payments should tie to the contract and if additional charges are incurred, for maintenance as an example, they should be recorded separately using the correct account code.

Jan 2015	$6,382.60	Ties to contract
Feb 2015	$6,464.88	Does not tie to contract
March 2015	$6,570.17	Does not tie to contract

3. NMHIX directors are subject to the Per Diem and Mileage Act (Sections 10-8-1 through 10-8-8 NMSA 1978) "subject to the travel policy set by the board" (Laws 2013, Chapter 54, Section 3 (R)). The policy tracks with the statute by allowing reimbursement for actual lodging expenses. However, the policy for mileage sets the reimbursement rate at the IRS statutory rate rather than aligning with 2.42.2.11 NMAC that sets the state mileage rate at 80 percent of the federal rate in effect the prior year. Thus, it is not clear if the Exchange is using the mileage reimbursement rate set under the state's rules, currently $0.45 per mile, or the federal rate at $57.5 cents per mile. Additionally, actual expenses for meals are limited by Section 10-8-4(K)(2) NMSA 1978 to a maximum of $30.00 for in-state travel and $45.00 for out-of-state travel for a 24-hour period. Board expenses totaled $181 thousand from inception through February 2015 and included out-of-state trips; a review of expense logs is required to evaluate compliance.

4. The Exchange uses the full accrual method of accounting rather than modified accrual used by the state. 2014 FIN008 governs the process but a review of the general ledger indicating a number of correcting entries makes it difficult to discern if the accruals are being reversed accurately to reflect expenditures in the proper expenditure code.

5. Three of 15 consumer assistance vendors appearing in the general ledger, or 20 percent, either have misclassified account codes used for second enrollment transactions or performed duties that might have fallen outside the respective contractual scope of work. Youth Development, Inc, for example, has transactions posted for both enrollment and outreach activities although the entity did not respond to the Education and Outreach RFP.

6. Late fees of almost $1,000 raise the question of whether invoices are being monitored for timely payment.

Several potential issues relating to grant management, ranging from non-allowable costs to tracking grant expenditures, include the following noted items:

- Non-allowable costs for promotional items, including T-shirts, chap stick, foam fingers, coasters, and knit caps;
- Non-allowable reimbursements for meetings to improve staff morale;
- No pre-approval from CMS for conferences;
- Lack of cost allocation plan between the NMHIX and the Human Services Department for services provided toward enrolling Medicaid or Exchange clients for the other entity;
- No separate general ledger expenditure code for the Navigator costs to separate these costs from other consumer support activities;
- No identifiable fund code for Navigator expenditures in the general ledger;
- Lack of grant tracking, including expenditures against budget by the managing staff and grant expenditures by vendor within the financial department; and
- A discrepancy in the grant funding used by the Human Services Department (HSD) might mean the NMHIX has about $80 thousand less remaining to expend. The discrepancy arises between the amount recorded in the HSD 2013 financial statements for the $34.3 million Planning and Establishment grant expended and the documented unexpended amount relinquished to the NMHIX.

APPENDIX R: PROCUREMENT POLICY

New Mexico Health Insurance Exchange Procurement Policy

SECTION	PRIMARY PROVISIONS
II.B. Authority to Contract Delegated to Chief Executive Officer	1. Delegates authority to CEO for contracting, subject to Board oversight
II.C. Limitations and restrictions	1. Report regularly to the Board: at all Board meetings; shall include: (1) a list of current contracts and related information (2) a check register
	2. CEO may procure goods or services less than $100,000 without prior Board approval; any contract that exceeds or is expected to exceed the $100,000 threshold over the lifetime of the contract or is amended to exceed the threshold, must be approved by the Board.
	3. Provides for emergency procurement
	4. Limits contract terms to one year or less, with additional terms up to five years
II.D. Competitive procurement	1. To maximum extent possible, procure goods and services with open and free competition; provide safeguards for maintaining a procurement system of quality and integrity; and maximize the purchasing value of NMHIX funds
	3. Sets threshold at $100,000 for competitive sealed bid or proposal process
	3.i. (1) Defines bid for occasion when contract award will be made to the lowest responsive bidder on the basis of price and other quantifiable factors
	3.i (2)-(4) Specifies means of issuing an invitation to bid
	3.ii.(1) Defines competitive sealed proposal to include other criteria for basing an award
	3.ii. (2)-(5) Outlines basic steps for proposal process
II.D.4. Establishes ability to use alternative means of procurement for purchases under $100,000; emergency; sole source	4.ii. Conduct a good faith review of available sources
	4.iii Obtain, when possible, a quotation or bid regarding the goods or services from at least three qualified and interested parties
	4.iv. Conduct a cost or price analysis
E. Procurement measures consistent with federal rules and regulations	1. Comply with standards in 45 CFR 74 and 45 CFR 92.36
	1.i. Avoid purchasing unnecessary items
	1.ii. Where appropriate, do lease-purchase analysis
	1.iii (1) – (6) Sets forth procurement guidance in accordance with federal regulation, such as accurate descriptions
	2. Appropriate type of procuring instrument (e.g., hourly rate, fixed price, cost reimbursable, purchase orders and incentive contracts)
	3. Provision for using responsible contractors, including review for federal disbarment or suspension
F. Protest or complaint	(1) –(4) Sets forth steps to file a complaint and tasks Exchange with resolution; directs complainant to file dissatisfaction of resolution with CEO
G. Conflict of Interest	1. Sets forth the standards of conduct governing the performance of NMHIX employees engaged in the award and administration of contracts

Source: NMHIX Procurement Policy