2024 Plan Year
Individual and Small Group Market
Issuer Submission Guidance

State of New Mexico
Office of Superintendent of Insurance

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Section I: General Information and Background

Purpose

This guide provides information about the processes and standards for obtaining certification to offer a QHP through beWellnm. Because this guidance cannot supersede any applicable provision of federal or state law, users are encouraged to review the federal and state laws referenced in this document to resolve any questions concerning this guidance, as violations of the Insurance Code are subject to administrative penalties in accordance with NMSA 1978 Section 59A-1-18, and violation of the federal Affordable Care Act may also subject an insurer to penalties.

Background

Operating in partnership with beWellnm, the OSI is responsible for determining if a plan meets certification requirements. BeWellnm will determine compliance with beWellnm based criteria. For more information on these requirements, please see the 2024 QHP Letter to Issuers, or contact beWellnm at 1- 833-862-3935.

Effect of Certification

A QHP certified for the 2024PY can be offered through beWellnm, beginning November 1, 2023.

Contact

Please direct all questions regarding plan certification and this document to Viara Ianakieva at 505-508-9073 or Viara.Ianakieva@state.nm.usViara.ianakieva@osi.nm.gov. For legal questions, please contact the Life and Health Product Filing Bureau Legal Counsel, Cass Brulotte, at 505-231-9968 or cass.brulotte@osi.nm.gov.

Section II: QHP and SADP Certification and Submission Timeline

2024 PY QHP REVIEW TIMELINE	
Activity	**Timeline**
Confidentiality Request	30 days prior to filing submission date
QHP and SADP Application submission window opens	4/19/2023
QHP and SADP form/rate filing deadline for forms only.	05/22/2023
QHP and SADP Application submissions deadline (Complete Form/Rate Filings to include rates, Binders, as well as Transparency in Coverage and Plan ID Crosswalk data)	05/29/2023
Individual QHP and SADP Application Transfer to beWellnm (Forms and Rates)	06/05/2023
SHOP QHP and SADP Application Transfer to beWellnm (Forms and Rates)	06/05/2023
Risk Adjustment rate revisions	07/14/2023-07/21/2023
48-hour turn-around on carrier responses to form and rate review objections	07/26/2023
24-hour turn-around on carrier responses to form and rate review objections	08/02/2023
Approval, Certification and Transfer of Individual, SHOP, and SADP Plans	**08/14/2023**
URL Template Links to be live and active	09/01/2023
Open Enrollment Starts	11/01/2023

Please note that dates are subject to change based on factors such as delays in federal guidance, federal timelines, and System for Electronic Rate and Form Filing, "SERFF" enhancements. Issuers are expected to adhere to the QHP certification timeline, as specified above or in updated guidance. An issuer who fails to meet a deadline, submits an incomplete application or does not follow the processes outlined in this Guide will shall be found in violation of the Insurance Code. Incomplete or untimely submissions shall be subject to a $5,000 penalty for each incomplete or missing document in accordance with NMSA 1978 Section 59A-1-18.

Failure to meet the above deadlines may result in plan disapproval and preclude plan loading onto the beWellnm website.

Incomplete and inaccurate submissions will not be accepted. Penalties will be assessed per error.

Section III: New and Important Information

OSI is requiring the following new information:

- The Part II certification should be provided in all ACA rate filings, not just those with plan rate increases greater than any threshold, e.g., 15%.
- Compliance with the 2024PY QHP Issuer Rate Guidance
- Screen shots of all CMS review tool outputs
- Amended New Mexico Supplemental SOPA Variant Template
- New Mexico Standardized Health Plans: Issuers are required to offer one Silver and one Gold standardized plans as prescribed by beWellnm and found at https://www.bewellnm.com/wp-content/uploads/2023/02/Standardized-Health-Plan-Requirements-for-the-2024-Plan-Year.pdf. OSI will publish additional guidance on Standardized Plans after the beWellnm health benefits committee verifies that standardized plan designs are in compliance with the 2024 Actuarial Value Calculator.
- Limitation on the number of Silver and Gold plans. An issuer may offer no more than 3 plans associated with a statewide network for Silver and Gold plans (1 standardized and 2 non-standardized plans) and 1 plan associated with a limited, non-statewide network (1 non-standardized plan).
- A complete QHP forms checklist
- A complete QHP rate checklist

Section IV: General QHP Marketplace Participation Requirements

An issuer who offers a QHP through beWellnm is required to offer a mirrored off-exchange plan for each on-exchange plan. Issuers offering both HMO and PPO products must submit one Form/Rate filing for their HMO/EPO products, which contains the single risk pool rate information (e.g., actuarial memorandum, etc.) and all related HMO/EPO forms, and a separate Form/Rate filing for their PPO/POS products, with identical single risk pool rate information and all related PPO/POS forms. Unless the products have a different product structure (HMO vs PPO) or market (individual vs. group), there is no need to file separate product filings for the on-exchange, mirrored and off-exchange products.

All forms and the single risk pool rate information must be submitted together. Issuers must ensure that the actuarial memorandum adequately addresses the rates for all products and plans included in the single risk pool and may include separate sections in the actuarial memorandum for HMO/EPO vs. PPO/POS plans for the same carrier. EPO plans must be submitted as part of the HMO Form/Rate filing submission and POS plans must be submitted as part of the PPO Form/Rate filing submission. On-exchange and off-exchange forms must be clearly identified using the prescribed naming convention. In addition, the plan marketing name, displayed in the SBC and referenced in the PBT, should also indicate if the plan is on-exchange and off-exchange . The following example illustrates the filing requirements under different scenarios:

	Products/Markets	**Number of Form/Rate filings**
Carrier 1	HMO and EPO products – on-exchange, HMO and EPO products off -exchange (mirrored)/ Individual Market and Small Group	Two filings – one for the individual market (with rates and forms for the individual market) and one for the small group market (with rates and forms for the small group market).
Carrier 2	HMO and PPO products on-exchange and off-exchange (mirrored plans) in the individual market.	Two filings – one for the HMO products and one for the PPO products. The HMO product filing will include all forms related to the HMO product and rate-related information (actuarial memorandum and supporting exhibits, etc.) for all products included in the single risk pool i.e., all HMO and PPO products. The PPO product filing will include all forms related to the PPO product and rate-related information should be the same as the HMO product filing as they should both reflect all products in the single risk pool.

On-exchange and off-exchange forms must be clearly identified using the prescribed naming convention and filed together under the Forms Schedule tab in SERFF.

Issuers are also required to comply with the requirements of 13.10.36 NMAC, Health Care Affordability Fund (HCAF), and participate in the Health Insurance Marketplace Affordability Program. A draft of the 2024 Plan Year Health Insurance Marketplace Affordability Program Plan Year Policy and Procedures Manual will be shared after legislative appropriations are passed by the legislature and final version will be issued after the Governor signs the budget.

Certification and Recertification

The process for certification and recertification is consistent with prior years. Please note, omission of any federal or state requirement from this Submission Guide does not mean compliance with those requirements is not necessary. For additional guidance, please see the 2024 Letter to Issuers.

To be certified, an issuer and its plan must meet the following criteria:

- The issuer must register in Center for Consumer Information & Insurance Oversight's (CCIIO), Health Insurance Oversight System (HIOS), obtain a HIOS Issuer ID for Rate Review, and register its HIOS Product IDs.
- The issuer must be licensed as a health insurer and be in good standing in New Mexico.
- The issuer must meet the QHP Application submission deadlines established by OSI and beWellnm.
- A plan must satisfy all federal requirements for a QHP as specified in the Public Health Services Act as amended by the ACA.
- An issuer must enter into a Certification Agreement with beWellnm.
- An issuer in the individual on-exchange market must offer at least one certified plan in both the silver and gold coverage levels, as described in 45 C.F.R. §156.140, in each service area in which it offers coverage through beWellnm. OSI is requiring at least one statewide plan at the gold and silver metal levels.
- An issuer must submit Turquoise variants for each Silver and Gold plan, reflecting reduced cost-sharing pursuant to forthcoming rules issued under the Health Care Affordability Fund, §59A-23F-12 NMSA in the individual market.
- An issuer in the individual on-exchange market must submit three federally-required variants for each silver plan reflecting reduced cost-sharing on the essential health benefits (45 C.F.R. § 156.420(a)). Each silver and each gold plan should include additional plan variations, as applicable, in accordance with rules and guidance for New Mexico's Marketplace Affordability Program. See the Marketplace Affordability Program Policy Manual for additional details.
- An issuer in the individual on-exchange market must submit at least one zero cost-sharing plan and one limited cost-sharing plan for each metal level and plan variation.
- An issuer must offer through beWellnm a child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through beWellnm

to individuals, who, as of the beginning of the plan year, have not attained the age of 21. 45 C.F.R. §156.200(c)(2).

- An issuer must attest to compliance with all QHP operational requirements described in subparts D, E, H, K, L, and M of 45 C.F.R. Part 156.
- An issuer shall provide evidence of OSI approval of managed health care compliance filings. See https://www.osi.state.nm.us/pages/bureaus/mcb/resources/compliance-deadlines.

OSI will review recertification criteria annually. The recertification process will involve a review of the certification criteria reflected in this document.

License and Good Standing

A QHP issuer must be licensed and in good standing in New Mexico. 45 C.F.R. § 156.200(b)(4). OSI, in consultation with CMS and beWellnm, will consider any complaints it receives and other QHP issuer oversight findings, including state enforcement findings, to determine whether an issuer is in good standing.

At a minimum, to satisfy the "good standing" requirement, an issuer must satisfy compliance standards mandated by state law, including timely submission and approval of compliance filings.

An issuer who offered a QHP, or other major medical coverage in New Mexico, during the 2024PY must file proof of compliance issued by OSI during the preceding 12 months. These filings are provider grievance, member grievance, utilization management, network adequacy, continuous quality improvement, cultural and linguistic diversity and contracts with providers in New Mexico. Proof of compliance shall be filed under the supporting documents tab in SERFF with its 2024 PY issuer application.

A new to the market issuer who lacks available data or experience to support a required compliance filing shall not be disqualified from 2024PY participation for that reason but must submit compliance filings as soon as the required data and experience become available, and must either be accredited, or in the process of being accredited, as addressed more fully below at the time of QHP application submission.

Benchmark plan

New Mexico's Benchmark plan remains unchanged for the 2024PY.

Section V: MHC Compliance Requirements

Accreditation

QHP issuers must be accredited, or be in the process of being accredited, by an accrediting entity recognized by the Department of Health and Human Services ("HHS") pursuant to 45 C.F.R. § 156.275 and 45 CFR § 155.1045."

An issuer shall provide confirmation of accreditation for each product type offered, e.g., HMO, EPO, PPO and shall upload this information under the Supporting Documentation tab in the SERFF Plan Management module.

A QHP issuer shall promptly notify OSI of any accreditation review scheduled for the upcoming plan year. An issuer shall notify OSI within five business days if there is a change in accreditation status or if there is a failure to maintain up-to-date accreditation. If accreditation is granted during the QHP certification process, an issuer shall upload this certificate of accreditation under the Supporting Documentation tab in the SERFF Plan Management module.

Program Attestations

An issuer seeking certification or recertification of a QHP plan must complete and submit, via SERFF, the following forms:

- Compliance Plan and Organizational Chart Cover Sheet
- 2024 New Mexico State Based Exchange Issuer Program Attestation Response Form (Response Form).

An issuer who responds "No" to the optional attestation section of the Response Form must provide a justification for not providing a compliance plan.

The forms and instructions are available on the CMS QHP Certification website and the Life and Health Product Filing Bureau section of the OSI website. An issuer must upload these forms under the Supporting Documentation tab in the SERFF Plan Management module. OSI will accept electronic signatures on the Attestations.

Service Area

An issuer must identify the service area associated with each proposed QHP in the Evidence of Coverage and specify if covered services are available outside of the service area.
An issuer must offer at least one state-wide plan in the individual or small group market, or both, as applicable. If a QHP has less than a state-wide service area, OSI will review to ensure that the service area of a QHP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the ACA, or other factors that exclude specific high utilizing, high cost

or medically underserved populations.

Service Area and Narrow Networks

An issuer must clearly identify a limited network or a limited-service area as such. Member facing and marketing materials must prominently specify that the provider network or service area are limited in nature.

An issuer must identify the service area associated with each proposed QHP in the Evidence of Coverage and specify if covered services are available outside of the service area. An issuer must offer at least one state-wide plan in the individual or small group market, or both, as applicable. If a QHP has less than a state-wide service area, the issuer must ensure that the service area of a QHP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the ACA, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

Network Adequacy

Before certifying a QHP, OSI must approve the network associated with a specific plan design. Please see the new and existing network filing guides and templates on the OSI website for more information. Issuers are required to upload the network Cover Letter from the relevant, approved network adequacy filing under the Supporting Documentation tab in each SERFF form and rate filing. A copy of the Cover Letter template is available at https://a.storyblok.com/f/132761/x/26c271aeb3/providers-information-template-10-3-22.xlsx.

The Summary of Benefits and Coverage (SBC) must disclose the cost-sharing applicable to all services and benefits obtained at each in-network tier and out-of-network if applicable.

An issuer shall immediately report to OSI any material change in an approved network. The issuer shall also make appropriate updates to all applicable state and federal templates, directories and related documents.

Essential Community Providers (ECP)

Each plan network must include essential community providers (ECPs) as described in the existing network adequacy filing guidelines found on the OSI website.

A QHP application must include sufficient data and analysis for OSI to determine that the plan satisfies the applicable ECP standard.

Quality Improvement

An issuer must submit a Quality Improvement Strategy ("QIS") Implementation Plan and Progress Report Form. To download the latest version of the form, go to https://www.qhpcertification.cms.gov/s/Application%20Materials.

Quality improvement initiatives must be described in detail in the filing description and rating materials. OSI reserves the right to inquire about the status of an issuer's on-going quality improvement initiatives and achievement of quality improvement goals.

Section VI: Other Compliance Requirements

Non-Discrimination

An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 C.F.R. § 156.125). In addition, a QHP cannot include terms that discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 C.F.R. § 156.200(e)), or have a benefit design that has the effect of discouraging the enrollment of individuals with significant health needs (45 C.F.R. § 156.225(b)). OSI will review proposed plan documents to identify potentially discriminatory anomalies or wording.

Prescription Drugs

An issuer must publish a drug formulary list for each proposed QHP. Health plans must cover at least the greater of:

- one drug in every United States Pharmacopeia (USP) therapeutic category & class; or
- the same number of drugs in each USP category & class as New Mexico's benchmark plan.

OSI will review each formulary for compliance with 45 C.F.R. § 156.122 (non-discrimination in QHP prescription benefit design and MHPEA). A formulary must be up-to-date, accurate, and include a complete list of all covered drugs. The formulary must also include quantity limits, tiering structure, prior authorization and step therapy requirements, as well as any restrictions on the manner in which a drug can be obtained. A formulary must include and identify prescription drugs required by the ACA, as well as drugs covered as a medical benefit. The formulary shall also include any drugs mandated under state law.

The formulary must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, OSI, beWellnm and the general public. A formulary is easily accessible when it can be viewed on the plan's public website, through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number. If an issuer offers different formularies for different plans, each the formulary must clearly identify the plan to which it applies.

The EOC for a QHP must clearly describe the formulary coverage, the process an enrollee can follow to request access to a drug not on the formulary or an exemption from step-therapy requirements, and the process to appeal an issuer's denial of a request for such an exception or exemption.

OSI will use the CMS Cost Share Tool, Category & Class Drug Count Tool and the Formulary Review Suite Tool, including Non-discrimination Formulary Clinical Appropriateness and the Non-Discrimination Formulary Outlier Tools, to identify potentially discriminatory benefit designs.

Issuers should complete cost-sharing fields in the Prescription Drug Template for the most typical or most utilized benefit cost-share design.

Issuers can describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Benefit Explanation field of the Plans & Benefits Template.

Issuers should place preventive, including contraceptives, and BH/SUD drugs in a separate Zero Cost Share Preventive tier in the formulary and Prescription Drug Template.

The Drug Formulary should appropriately identify Preventive care, contraceptives and behavioral Health/Substance Use treatment drugs as cost share free. In addition, the formulary should not contain any step therapy requirements or require utilization review for contraceptive drugs.

Issuers should remove all obsolete drugs from their formularies.

Mental Health Parity and Addiction Equity Act (MHPAEA)

All individual and small group plans must comply with the federal MHPAEA and applicable regulations. In particular, issuers should carefully review the final rule implementing the MHPAEA, issued on November 13, 2013, and generally applicable to plan and policy years on or after July 1, 2014. Issuers should review the final rule to determine whether a particular plan is subject to the MHPAEA and is compliant with that statute and regulations. Issuers must be prepared to submit their MHPAEA self-assessment tool as evidence of compliance, upon request.

Rehabilitative and Habilitative Services

Issuers cannot impose quantitative limitations on habilitative and rehabilitative services. Cost sharing for physical therapy shall mirror cost-sharing for primary care services pursuant to Sections 59A-22-56, 59A-23-15, 59A-46-56, 59A-47-50 NMSA 1978.

New Benefits

Unless requested by OSI staff, or required by state or federal law, issuers cannot add new benefits to their proposed health plans, after the QHP application has been submitted.

Turquoise Plans

Turquoise Plans are health plans that have State Out-of-Pocket Assistance (SOPA) applied to reduce out-of-pocket costs for consumers. In Plan Year 2024, each Turquoise variant must closely resemble the general features of its standard variant, unless otherwise specified in the 2024 Plan Year Health Insurance Marketplace Program Policy and Procedures Manual. For example, if a standard variant has copays for specialist visits, its Turquoise variants must also have copays for specialist visits. To the greatest extent possible, issuers should maintain the general relativities for the out-of-pocket cost design for all variants of a plan. In addition, the maximum out-of-pocket limit, deductible, copays, and coinsurance for Turquoise variants cannot exceed the amount that is offered under the plan's standard variant.

OSI will release additional information about Turquoise Plan requirements in the 2024 Plan Year Health Insurance Marketplace Program Policy and Procedures Manual.

Special Guidance for Coverage for American Indians/Alaska Natives (AI/AN)

An issuer must comply with all federal laws and regulations pertaining to coverage for AI/AN individuals, including 42 U.S. Code § 18071(d). The EOC must include a variable provision(s) with the language applicable to AI/AN plan designs.

Issuers are strongly encouraged to offer contracts to all Indian Health Care Providers in their service area and to use the Centers for Medicare and Medicaid Services Model QHP Addendum for Indian Health Care Providers when contracting.

The Summary of Benefits and Coverages for each AI/AN plan must demonstrate costsharing for all 3 tiers (a tier for in-network tier for Indian Health Care Providers (IHCP), a tier for Non-IHCP In-Network Providers and the tier for Out-of-Network Providers).

Endorsements

Endorsements shall not be submitted for review and approval with new contracts. Except in extenuating circumstances, endorsements should be used only to amend previously approved policies and certificates. Standardized language mandated via Bulletin, must be included in the policy language under the applicable section.

CMS Template Review Tools

Issuers are required to submit screen shots of the review tools outputs.

Student Health Plans

A student health plan is subject to the same submission requirements and review processes as an individual QHP.

Section VII: Rates

An issuer must file proposed rates for each QHP. OSI will review proposed rates, justifications and actuarial memoranda for compliance with state and federal rating standards, as well as OSI issued guidance.

Upon request, all rate related information will be kept confidential during the QHP review period. Public Access will be allowed once all filing is dispositioned. For more information regarding confidentiality requests see, Section X.

Rate increases for QHPs are subject to the reporting and review requirements in 45 C.F.R. § 154.215 related to the submission of a Rate Justification.

Please see additional 2024PY QHP Issuer Rate Guidance.

Actuarial Memorandum

Rates must be supported by a detailed Actuarial Memorandum. Non-EHB benefits, value added offerings, wellness programs and quality improvement initiatives must be described in detail in the Actuarial Memorandum.

The Part II certification should be provided in all ACA rate filings, not just those with plan rate increases greater than any threshold, e.g., 15%.

Rates will be determined based on provider contracts that are in effect as of the rate filing submission date. An issuer who proposes to change a service area after the initial data submission must petition OSI. OSI will approve a change to a service area under very limited circumstances, such as:

- Expansions at the request of the state to address an unmet consumer need.
- To address a data error in the issuer's initial Service Area Template submission (the issuer must provide significant evidence documenting the error, including evidence in other parts of the QHP Application indicating an intent to cover a different area and/or a mismatch with the service area in the issuer's form filing).

Basis for Rate Development

Rates must be developed based on the law in effect and the Health Insurance Marketplace

Affordability Program Policy and Procedures Manual issued by OSI.

All benefits in excess of EHB specified in the EOC must also be described in the Actuarial Memorandum.

Section VIII: SERFF Filing Submission Requirements for QHPs

This section outlines the issuer and plan-level submission requirements for each QHP. An issuer must submit the required QHP data and information via SERFF in Excel and .xml formats. An issuer is also required to comply with HIOS and beWellnm submission requirements. A submission requirement may change prior to the opening of the QHP submission window subject to new guidance and information from OSI, CMS/CCIIO, beWellnm or the NAIC SERFF teams. Issuer and plan data and information will be transferred by OSI securely and directly to beWellnm through SERFF.

The QHP application review and certification process begins when an issuer submits a SERFF filing with forms and rates, as well as a SERFF Binder and required compliance filings, to OSI for review and approval. OSI expects to complete the certification or recertification process for the 2024 Plan Year by August 15, 2022. An issuer who wants to withdraw a previously issued plan from consideration must submit a formal request for withdrawal to OSI and beWellnm.

Red-lined versions of approved QHP forms must be provided, along with a summary of the changes. The Part II certification should be provided in all ACA rate filings, not just those with plan rate increases greater than any threshold.

The General Description of each SERFF filing shall indicate whether the issuer has direct enrollment with beWellnm and provide the tracking number of the affiliated, approved, network adequacy filing.

Alignment of Data Template information with Form filing documentation, including Summary of Benefits and Coverage (SBCs)

All data in a QHP Application must be complete, accurate and consistent between the EOC, SBC, data template, approved compliance filings, and supplemental documentation submitted as part of the QHP application. In addition, the information reported in HIOS or the beWellnm Plan Management portal must be consistent with the information included in the QHP application submitted via SERFF.

Standardized Naming Convention

Carriers are expected to submit the following documents using the standard naming convention, as outlined below:

- Actuarial memorandum
- Medical rate filing template
- Medical rate filing checklist
- Medical form filing checklist
- All forms submitted under the Forms Schedule Tab in SERFF

All naming conventions and terminology must be consistent between the Form/Rate filing, binder and

templates.

For example, each form included in the filing should reflect the name of the plan as it is stated in the binder and listed within the PBT.

CarrierName_YYYYmkt_ Plantype (Form Only)_Exchangetype_v#_ Filedesc.filetype

- **CarrierName**: Up to 6 Characters which identify the carrier
- **MMDDYY**: e.g., 010124 for filings effective January 1, 2024
- **mkt**: **indicate one of the following**:
  - "i" for individual (non-group)
  - "s" for filings that include small groups only, (2 to 50 employees)
  - "l" for filings that include large groups only (more than 50 employees)
  - "g" for filings that include groups of all sizes (more than 2 employees)
- **Plantype (forms only): indicate one of the following, if there are differences between forms by plan type.**
  - PPO
  - PPO_POS
  - HMO
  - HMO_EPO
  - EPO
  - POS
- **Exchangetype: indicate one of the following**
  - MedOn (Medical On-Exchange)
  - MedOff (Medical Off-Exchange)
- **v#**: v followed by the version number (increment for each update to the filing)
- **Filedesc**: indicate one of the following:
  - **AMR** – Actuarial Memorandum – redacted
  - **AM** – Actuarial memorandum – unredacted
  - **RTCK** – Rate checklist
  - **FMCK** – Form checklist
  - **CER** = Certificate/EOC
  - **SBC** = Summary of Benefits and Coverage
  - **POL** = Policy/Contract
  - **AP** = Application
  - **EF** = Enrollment form
  - **End** = Endorsement
  - **Form**=Formulary
  - **Rd** = Rider
  - **ID** = ID or RX Card

- **RT** – Rates Template
- **ECPT -** Essential Community Providers Template

Rate Filing Example: ABC_010124_i_MEDOn_v1_RTCK. Xlsx is the initial 2024 medical rate filing checklist for the ABC Health Plans individual on Exchange filing. The Plan Type field is not required for rates as there is only one rate filing checklist submitted for each single risk pool.

Forms Example: ABC_010124_i_HMO_MEDOn_v2_Plan1_SBC.xlsx is the 2nd revision of the Summary of Benefits and Coverage for the On Exchange, named Plan 1*, offered by ABC Health Plans. The Plan Type field is used in this case as the form will vary by Plan Type, and a separate form filing checklist is required for each policy/COC/EOC form.

*Plan 1 is the name of the plan as it is stated in the title of the SBC and is listed under the Plans tab in the binder and specified as the plan name in the PBT.

For: SBCs carriers should use the following naming convention:

CarrierNameMMDDYYmkt_ SBC_Mtlvl_Filedescrp__Zero_On_HSA_Ded_Cop_ v#

- **CarrierName**: Up to 6 Characters which identify the carrier
- **MMDDYY**: e.g., 010123 for filings effective January 1, 2024
- **Mkt:** indicate one of the following:
  - "i" for individual (non-group)
  - "s" for filings that include small groups only, (2 to 50 employees)
  - "l" for filings that include large groups only (more than 50 employees)
  - "g" for filings that include groups of all sizes (more than 2 employees)
- **Metallvl**: indicate one of the following:
  - Bronze
  - Silver
  - Gold
  - Platinum
  - Turquoise 1, 2, or 3 (as applicable)
- **Filedesc**: indicate all of the following as applicable:
- **Lmt** – Limited Cost Sharing Plan Variation
- **Zero**– Zero Cost Sharing Plan Variation
- **On**
- **Off**
- **HDHP/HSA** indicate if the plan is HSA eligible HDHP plan

- **Ded_Cop or Ded_Coins:** indicate the deductible and PCP visit copay or coinsurance
- **v#**: v followed by the version number (increment for each update to the filing)

Plan and Plan Variant Marketing Names

QHP plan and plan variant marketing names must include correct information, without omission of material fact, and do not include content that is misleading. During the QHP Application review, OSI will be ensuring that the following criteria is met:

- Plan names must be accurate and not misleading
- Plan names must be consistent between plan variants and used consistently in all parts of the QHP application - SBC, PBT, Actuarial Memorandum and AV screen shots. If there is a long name, there must be a legend to specify the short and long name.
- Plan names must be unique and cannot be used by an issuer in the various types of products that they offer in New Mexico during any given plan year. For example, if there is an individual on-exchange plan named "HMO Healthy Choice Plan 1", an issuer cannot use the same name for one of their gold plans in the group market. In addition, the plan marketing names must have a differentiating factor that is not based on the plans metal tier. For example, you cannot have a plan marketing name "Gold 1".
- Plan names for narrow networks or service areas must indicate the limited nature of the plan and include language such as "with limited Network" or "with limited Service Area."
- Turquoise plans must include the name of the base plan, followed by the Turquoise naming convention. The metal level of the standard variant does **not** need to be included in the name. This information should be displayed in the lower right corner of each SBC. For example, if the base plan name is "HMO Healthy Choice 1", the marketing names for the Turquoise variants should be "HMO Health Choice 1 Turquoise 4" and "HMO Health Choice 1 Turquoise 3."

Plan Design and Contract Requirements

A QHP must conform to the plan design standards specified in 45 C.F.R. Subpart B – Essential Health Benefits Package. Additionally, each plan must comply with the contact, coverage and benefit mandates of the New Mexico Insurance Code (NMSA Chapter 59A) and the New Mexico Administrative Code (NMAC Title 13), including Section 59A-16-13.1 NMSA 1978; Article 18 (Insurance Contract), Article 19 (Policy Language Certification), Article 22 (Health Insurance Contracts); Article 22A (Preferred Provider Arrangements); Article 22B (Prior Authorization), Article 23 (Group and Blanket Health Insurance Contracts); Article 23C (Small Group Rate and Renewability); Article 23E (Health Insurance Portability), Article 46 (Health Maintenance Organizations), Article 57 (Patient Protection Act) and Article 57A (Surprise Billing Protection).

Cost-sharing Requirements

- For 2024 QHP maximum out-of-pocket will be
  - $9,450 for self-only coverage and $18,900 for other than self-only coverage

- For 2024 HSA eligible HDHP plans, the maximum out-of-pocket will be
  - Pending IRS announcement
- For 2024 HSA eligible HDHP plans, the minimum deductible will be
  - Pending IRS announcement
- For the 73 percent AV silver plan variations, the maximum out-of-pocket will be
  - $7,550 for self-only coverage and $15,100 for other than self-only coverage
- For the 87 percent and 94 percent AV silver plan variations, the maximum out-of-pocket will be
  - $3,150 for self-only coverage and $6,300 for other than self-only coverage

- For QHPs that qualify for State Out-of-Pocket Assistance, issuers should refer to the Marketplace Affordability Program Policy and Procedures Manual for the reduced maximum annual limitation on cost-sharing for 2024.

Cost sharing requirements issued by CMS can be found at https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf.

Wellness Plans or Other Value-Added Products or Services

Rates shall not include the cost to the carrier of any value-added product or service, such as wellness plans that may be offered to an enrollee. These costs shall not be treated as, or included in the general, administrative expense category. The costs of these offerings must be borne by the member as part of a separate and express agreement or shall be taken out of the carrier's profits. A value-added product or service notice must be submitted via SERFF separately. The statutory guidelines for value added products or services can be found in Section 59A-16-17 (G) NMSA 1978.

Value added offerings must be described in detail in the filing description and rating materials.

EOC

The EOC must include all provisions enforceable under the insurance contract and specify all covered benefits, services, exclusions, limitations. The EOC must identify all benefits and services that require prior authorization or provide a direct link to a webpage that includes this information. In addition, the EOC must explicitly describe all non-EHB benefits.

The following standardized language must be incorporated into the EOC pursuant to Bulletin #2021-029, Bulletin # 2021-017 and the Grievance Rule summary found on the OSI website.

- Behavioral health cost share elimination
- Prior Authorization requirements
- Balance Billing
- Contraceptive Coverage
- Grievance Rule

All standardized language must be identical to the language prescribed by OSI. For behavioral health, issuers may clarify that cost share elimination applies to in-network services only.

Issuers are required to provide red-lined versions for the existing plans and each form updated during the QHP application review process.

EHB eligible benefits, such as habilitative and rehabilitative services cannot have quantitative limitations. This includes combinations with other coverage, for example SNFs.

EHB benefits specified in the EOC must at a minimum reflect language specified in the NM EHB Benchmark.

Vision benefits can be offered by rider or embedded in the plan. Vision benefits embedded in an HMO may offer out-of-network services and benefits.

Each EOC or COC must describe in detail how the individual and family Deductible and Maximum Out of Pocket Limits apply.

Each EOC or COC must include a direct link to the issuer website where a list of all benefits for which a prior-authorization is required. The prior-authorization list must be consistent with the prior-authorization list included in provider contracts, and in compliance with all state and federal requirements.

URL links should be accurate and active. Affiliated content is subject to OSI's review and approval.

Summary of Benefits and Coverage (SBC)

An SBC must comply with the standards set forth in in 45 C.F.R. §147.200.

An SBC cannot be used to add provisions to the contract. All policy provisions must be clearly stated in the EOC. The SBC can only summarize the plan features and display cost-sharing features.

An SBC must also meet the following criteria:

- SBC naming conventions - the plan marketing name must include the words on-exchange, off-exchange, native American limited and native American zero, as well as include the metal level of the plan and the actual name of the plan.
- Each SBC must have a unique form number and be listed as a separate item under the Forms Schedule tab of the SERFF filing submission.
- Each SBC must include the following information in the lower right corner of the first page of the SBC:
    - HIOS Plan Standard Component ID

- Plan name
- Base plan name and metal level
- Turquoise plan designation, if applicable
- Whether the plan is for on-exchange or off-exchange

- Each SBC must be appropriately labeled and reflect the plan name, metal level and whether the plan is HSA eligible HDHP.
- The Plan Name displayed on the SBC must be identical to the Plan Marketing Name stated in the P&B Template.
- Marketing plan names and plan names specified in the SBCs for all Turquoise plans should specify the number of the Turquoise plan and include the phrase "with Extra Savings". For example, "Health Plan Turquoise 3 with EXTRA SAVINGS", for the 90% AV level gold.
- A separate SBC must be submitted for each unique plan.
- Each SBC must accurately represent the product features and plan variation and accurately summarize the provisions of the EOC.
- Each SBC must also provide notice of covered abortion services in the "other covered services" section. 45 C.F.R. § 156.280(f).
- All URL links included on the SBC must be active and readily accessible (that is, without requiring logging into a website, entering a policy number, clicking through several web pages, or creating user accounts, memberships, or registrations) to consumers, including shoppers, and link directly to the information referenced on the SBC.
- Each SBC must state the name of the network that is being used and link the provider network to the URL address to the plan-specific provider directory. For example, "Yes. See [insert actual network name] Network at www.xxx.com or call [1-xxx-xxxx] for a list of network providers."
- Each SBC must provide a direct link to the plan-specific formulary under the "If you need drugs to treat your illness or condition" section.
- All terms included in CMS's Uniform Glossary shall be underlined and hyperlinked in the SBCs and take the insured to the correct location in the glossary.
- Each SBC must reflect the $25 cap on insulin, free COVID vaccines, no cost sharing for COVID testing and treatment, no prior- authorizations for gynecological or obstetrical ultrasounds, and cost-sharing for physical therapy cannot exceed cost-sharing for a PCP visits.
- Emergency room care and medical transportation must be the same cost-sharing for in and out of network.
- The "Limitations, Exceptions, & Other Important Information" section for emergency care must state that balance billing is not allowed for out-of-network services.
- Each SBC must arcuately list each service not subject to the deductible in the section titled "Are there services covered before you meet your deductible?".
- Each SBC must clearly identify all services that are offered at "No Charge" or not subject to the deductible, including but not limited to:

  - In-network preventive health
  - Covered, in-network behavioral health services and prescription drugs
- Each separate network tier and associated cost-sharing must be properly identified in the SBC.
- A separate SBC shall be provided for each zero cost-sharing plan applicable to AI/AN enrollees with income under 300% of the federal poverty level who is otherwise eligible for tax credits through beWellnm.
- A separate SBC shall be provided for each limited cost-sharing plan applicable to an AI/AN enrollee for any item or service furnished through Indian Health Care Providers or through referral under purchase/referred care services as defined in Section 1402(d)(2) of the ACA.
- Each Native American limited cost plan SBC must have 3 tiers. Two in-network tiers and one out-of-network tier.
- Each zero or limited cost-sharing plan SBC must include "Native American" before the plan identifying information in the plan marketing name. For example, "Native American Gold 2 Plan."
- A separate SBC shall be provided for each Turquoise variant.
- A separate SBC shall be provided for each zero-cost sharing plan. In addition, a separate SBC is required for each mirrored plan.
- Each SBC should specify whether a QHP accepts cost-sharing accumulation for any third-party payment (such as a drug manufacturer's coupon). If not, the SBC must clearly explain that third party payments do not apply to the deductible. This information should be displayed in the "Limitations, Exceptions, and Other Important Information" column in the prescription drug coverage section of the SBC.
- Issuers are not required to submit SBCs for the Silver 87% AV and 94% AV plan variants. However, all rate related materials and templates should reflect the standard 87/94 silver metal level plan design. Issuers are required to justify a change in the CSR variant(s) if the old variant(s) still meet the applicable AV threshold(s) by Including the justification it the SERFF filing description or cover letter, as well as in the actuarial memorandum.
- EHB eligible benefits specified the SBC, such as habilitative and rehabilitative services cannot have quantitative limitations. This includes combinations with other coverage, for example SNFs.

Additional SBC instructions, templates and related materials can be found on the DOL website at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits.

Excluded & Other Services Section:

- If infertility treatment is not covered, specify (unless for medical condition

causing the infertility),

- If routine eye care is not covered for adults, specify (Adult)
- If dental care is not covered for adults, specify (Adult, routine dental)

Other Covered Services Section:

- If abortion is covered, include the service in this section
- If acupuncture is covered, specify any exceptions such as (no less than 20 visits for non- habilitative and non-rehabilitative services/)
- If chiropractic care is covered, specify any limits or restrictions such as (no less than 20 visits for non-habilitative and non-rehabilitative services
- If hearing aids are covered, specify any limits or restrictions such as (one hearing aid per ear every 36 months)
- If weight loss programs are covered, specify any limits or restrictions such as (only dietary evaluations and counseling for medical management of morbid obesity and obesity are covered)

URLs

An issuer must submit URL data for each proposed QHP. URL links in member facing materials such as EOCs, SBCs and formularies should lead to live, active webpages that contain accurate information by the deadlines described in Section III. All links in the member facing materials must be active prior to the certification due date. URL links contained within the URL template must be live and active no later than 9/1/2023.

SERFF Template Requirements for QHPs

An issuer must use CMS and beWellnm mandated data templates. All Individual and SHOP Plan Binders must include the following templates:

1. Administrative Data Template
2. Business Rule Template
3. Essential Community Provider (ECP)/Network Adequacy Template
4. Network ID Template
5. Plan and Benefit Template
6. New Mexico Supplemental SOPA Variant Template (applies to the individual market only)
7. URL Template
8. Frozen Plan Template
9. Plan ID Crosswalk Template
10. Prescription Drug Template
11. Rate Data Template (should not include rates based on tobacco usage in the individual market)
12. Service Area Template
13. Transparency in Coverage Template
14. Unified Rate Review

BeWellnm will use the data from the templates to populate the beWellnm.com platform with rates, benefits, service area, and provider network data. An issuer must review this data in the beWellnm Plan Management Portal and ensure accuracy during Plan Preview.

Administrative Data Template

The QHP certification process requires an issuer to submit an Administrative Data Template that will be used for operational purposes. An issuer is required to submit this information annually as part of their SERFF Binder Submission and report changes to previously reported information within 30 days.

Plans and Benefits Template

Issuers are required to use the CMS version of the Plans and Benefits Template.

If an issuer's cost-sharing structure does not fit within a template, the Centers for Medicare & Medicaid Services (CMS) recommends that the issuer fill out the copay and/or coinsurance that is typical for most enrollees (i.e., highest utilization). However, in order to ensure that insureds are not charged a copay or coinsurance that is higher than expected, OSI is requiring issuers to utilize the highest cost-sharing that is associated with the benefit or service.

Issuers are required to include Silver plans for the 87% AV and 94% AV plan variations. Please note that

CMS requires these two plan variants to be included, although these two plan variations are replaced by the plan's Turquoise 1 and Turquoise 2 variants. Therefore, the SBCs for the 87% AV and 94% AV plan variation do not need to be included in the Form/Rate filing.

Gender Affirming Care section of the PBT should be left blank. Gender Affirming Care is very broad and the cost sharing for the various benefit and services that fall in this category vary significantly. Therefore, OSI will rely on cost sharing that fall under each respective benefit category. For example, cost sharing for gender affirming surgery shall be the same as cost sharing for other surgical benefits. Respectively, cost sharing for gender affirming counseling will be the same as cost sharing for behavioral and mental health outpatient visits, or "no charge."

Naming Conventions in Federal and Supplemental Plans and Benefits Templates

Each plan marketing name must be identical to the plan name displayed on the SBC and specify whether the plan is an HSA eligible HDHP plan. In addition, each variant Plan Marketing Name must be identical to the base plan name with the exception of the metal level plan description. For example, for "New Mexico Health Plan Gold 1", the plan names on the cost share variances tab should be as follows:

- "New Mexico Health Plan Gold 1 Off Exchange", for off-excahnge "00" variant
- "New Mexico Health Plan Gold 1 On Exchange", for on-exchange "01" variant
- "New Mexico Health Plan Gold 1 Zero", for the zero cost-sharing plan, "02" variant
- "New Mexico Health Plan Gold 1 LCS", for the limited cost-sharing plan, "03" variant
- "New Mexico Health Plan 1 Turquoise 3 with EXTRA SAVINGS", for the 90% AV level gold plan, "90" variant

This requirement applies to both the Federal and Supplemental templates.

"Turquoise" variants with State Out-of-Pocket Assistance applied should not be submitted in the federal Plans and Benefits Template. Issuers should follow instructions in the section titled "OSI Supplemental SOPA Variant Template" below.

Plan Crosswalk

An issuer must crosswalk the 2023 QHP plan ID and service area combinations to a 2024 QHP Plan ID. This data will facilitate enrollment transactions from beWellnm to the issuer for enrollees in the Individual Market who have not actively selected a different QHP during Open Enrollment. Issuer crosswalk authorization forms are available at https://www.qhpcertification.cms.gov/s/Plan%20Crosswalk. This requirement does not apply to off-exchange only plans.

A plan crosswalk is required with all (individual, group, on-HIX) QHP Application submissions and must be submitted under the Supporting Documentation tab in .xml and .csv formats.

For the 2024PY, beWellnm will enable a county-level plan crosswalk. If utilizing the county-level

crosswalk, issuers must

1) apply the crosswalk to all counties within a rating area; and

2) submit to OSI the rationale for applying the unique crosswalk within certain rating areas but not others.

Frozen Plan Template

BeWellnm requires issuers to submit a Frozen Plan template specifying the data for the plans that will not be offered on the beWellnm during the 2024PY. The template must be submitted in a .xlsx format and uploaded under the Supporting Documentation tab of the Plan Management binder.

Issuer URL Template

URL template must be submitted with the rest of the plan materials part of a QHP Application. BeWellnm requires issuers to submit URL data for the plans they intend to offer on the beWellnm portal. Issuer URL templates must be submitted in .csv format. In addition, the following are the only acceptable issuer URL types:

1. Plan Brochure
2. Summary of Benefits and Coverage
3. Formulary
4. Network
5. Transparency in Coverage

Issuer URL templates must include all of the following columns:

1. URL Type
2. URL ID
3. Market Type
4. Product Type
5. Current URL
6. New URL

In order to avoid transfer issues, prior to uploading the URL Template, each issuer shall ensure the following:

1. There are no empty spaces after each URL address.
2. The URL ID column includes all Plan and Formulary IDs
3. "Current URL" fields are left blank if there are no applicable current URLs.
4. The URL template is amended to remove all company payment URLs. All "Payment" rows are entirely deleted.
5. Issuer's URL template must be submitted in .csv format.
6. URL template links must be live and active no later than September 1, 2023.

OSI Supplemental SOPA Variant Template

Issuers are required to submit a New Mexico Supplemental SOPA Variant Template under the Supporting Documentation tab of the Plan Management Binder in .xls format.

The Plan Marketing Name corresponding with each Standard Component ID Variant must be identical to the base plan name with the exception of the metal level plan description. For example, for "New Mexico Health Plan Gold", the plan names on the cost share variances tab should be as follows:

- New Mexico Health Plan Turquoise 3 with EXTRA SAVINGS, for variant "90" (90%AV level gold plan)

For additional information regarding this template see the Marketplace Affordability Program Policy and Procedures Manual.

Transparency in Coverage

45 C.F.R. §§155.1040(a) and 156.220 require an issuer to disclose transparency information to OSI, beWellnm and the public. The transparency of coverage data must be reported in the Binder Submission via the Transparency in Coverage Template and uploaded under the Templates tab in the SERFF Plan Management module no later than May 29, 2023.

All URLs contained within the template must be live and remain active during the entire plan year. The template is available at https://www.qhpcertification.cms.gov/s/Transparency%20in%20Coverage.

Required Use of CMS Review Tools and Data Integrity Tool

An issuer must use the CMS Review tools, including the Data Integrity Tool, prior to submitting data to OSI. All errors must be corrected prior to the binder submission. In addition, issuers are required to submit screenshots with the outputs obtained from running the CMS tools. The review tools are available at https://www.qhpcertification.cms.gov/s/Review%20Tools.

Failure to correct errors identified by the CMS review tools prior to submission may result in denial of QHP certification.

Readability

Submitted forms must comply with the following readability standards found under 59A-22-2 NMSA, 59A-19-4 NMSA:

- The readability score must be based on the Microsoft Word Flesch Reading Ease test and have a score of 40 or higher. Forms with a Microsoft Word Flesch Reading Ease score lower than 40 will not be approved by OSI or transferred to beWellnm for certification.
- Health care policies, contracts, and certificates, dental policies and certificates, and certificates

of coverage with more than 3,000 words printed on not more than three pages, or more than three pages of text regardless of the number of words, shall contain a table of contents. (This requirement does not apply to riders or endorsements.)

- Each form must be printed in font size not less than 10 point.
- Each form entered under the SERFF Forms Schedule tab shall include the form's readability score.

Filing Fees

Pursuant to NMSA 1978, §59A-6-1(V), an issuer must pay a rate and form fee of $80 for each QHP package. A package is each unique combination of EOC, SBC, Application, Enrollment form, Formulary and any Riders/Endorsements.

ID Cards

ID cards must be submitted for review and approval. The ID cards should have OSI's Managed Health Care Bureau's (MHCB's) website and phone number, on the card. In addition, the cards must include the plan variant marketing name as shown on the SBC and specified in the PBT and indicate that there is no cost-sharing for covered behavioral health care services. Issuers may mark the plan name, as well as other administrative information as variable, as long as they provide SOV describing the variability. More information can be found under the "No Behavioral Health Cost-Sharing" section of the OSI website.

Guaranteed Renewability

All individual and small group plans, on and off-exchange, must comply with federal and state laws regarding guaranteed renewability.

Variability

Variability in Qualified Health Plans will be allowed in very limited circumstances. An example of permissible variability is to allow for administrative changes such as to populate the policy number, insured's name(s) and effective date(s). All variability must be clearly described in a Statement of Variability (SOV). For specific variable language, the SOV must state the exact language as it will appear in the form that will be issued to the consumer. If language is bracketed because it will either be included or excluded, the SOV must state so and explain under what circumstances the information will be included or removed.

The following are explicitly prohibited:

- Benefit and cost sharing variability in a product. Exact values must be provided in each Summary of Benefits and Coverages (SBC).
- Nested brackets, indicating variability within the variable information.
- General and vague explanations and use of phrases such as "as necessary," "as negotiated by the

policyholder," "flexibility in plan design," "but not limited to" or "will comply with statutory requirements".

No change in variability can be made which in any way expands the scope of the wording being changed.

Acceptance of Third-Party Payments

A proposed plan shall specify *whether or not* it accepts third party payments, other than payments mandated by 45 C.F.R. § 156.1250, within the EOC and SBCs.

Cost-Sharing Accumulation

An issuer may allow an enrollee who uses direct support offered by drug manufacturers for specific prescription drugs to have the value of the support counted toward Maximum Out of Pocket Limit. A proposed plan shall specify, within the EOC and SBCs, *whether or not* such cost-sharing accumulation is allowed.

Special Guidance for Turquoise Variants

See the Health Insurance Marketplace Affordability Policy and Procedures Manual for information related to Turquoise variants and required New Mexico Supplemental SOPA Variant Template.

Section IX: SHOP Specific Requirements

All small group products, on-exchange, mirrored and off-exchange only plans, offered by the same carrier will be in the same single risk pool and reviewed together using the same criteria as specified in the checklist.

SHOP plans are subject to the same submission requirements and review processes as an individual QHP, and to these additional requirements:

- All federal and state laws applicable to small group plans
- All requirements of NMAC, Title 13, Chapter 10, applicable to small group plans
- 45 C.F.R. §156.285
- 45 C.F.R. §155.725

For rating purposes, issuers should use the average number of employees over the previous year, counting all full time (30 or more hours a week) (FT) and full-time equivalent employees (FTEs). OSI is requiring all issuers to follow the IRS guidance found at https://www.federalregister.gov/documents/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage.

Section X: Confidentiality Request Policy

OSI recognizes that carriers may consider certain information to trade secrets or otherwise eligible for confidentiality under New Mexico law. To ensure a level playing field and encourage a competitive market, upon request, all rates will remain confidential during the entire QHP review period. Issuers are expected to submit their best competitive and actuarily sound rates with their initial QHP application.

OSI requires issuers to file **both temporary and permanent** confidentiality requests, for review and approval, prior to the 2024PY QHP Application submission. Each confidentiality request must be submitted at least 10 days in advance of a QHP Application submission, pursuant to Bulletin #2022-003. However, due to the lateness of issuers confidentiality requests during the 2023PY review, OSI is requiring all confidentiality requests to be submitted at least 30 days prior to the QHP application submission target date. **Failure to submit a timely confidentiality request will result in issuer information being public until approval of the confidentiality request has been granted**.

Please note that expedited requests and exceptions to the process will not be accepted.

Confidentiality request forms must be complete, accurate and specify the form name of and parts of the QHP application that need to be kept confidential. Confidentiality request forms must specify if the request is permanent, for the life of the filing, or temporary, for the duration of the QHP review period. Multiple items can be requested on each confidentiality form, but different request forms must be used for temporary and permanent requests. Once the QHP review is over, public access will be granted to items, such as rate related filings, that were only granted temporary confidentiality in accordance with Bulletin 2022-003, while the items that were granted permanent confidentiality in accordance with Bulletin 2022-001, will remain confidential.

Temporary confidentiality determinations shall specify that public access is to be removed for the URRT, Rate and Supporting documentation tabs once the QHP filing is dispositioned.

If confidentiality is not requested, it cannot be granted, and all documents will be made publicly available. OSI staff shall not remind issuers to request confidentiality, as this is a voluntary process. Issuers are required to use the Confidentiality Request Form and Determination Notice issued by OSI. No other form will be accepted. A copy of the OSI approved form can be viewed and downloaded at https://www.osi.state.nm.us/pages/bureaus/life-and-health-division/resources/confidentiality

For more information regarding permanent confidentiality requests and determinations, review Bulletin 2022-001 at https://www.osi.state.nm.us/news/bulletins/bulletin-2022-001.

For more information regarding temporary confidentiality requests and determinations during the QHP review period, please review Bulletin 2022-003 at https://www.osi.state.nm.us/news/bulletins/bulletin-2022-003.

Approved confidentiality determinations must be submitted by the issuer under the Supporting Documentation tab of the SERFF submission. **Issuers may NOT flag an item as confidential in SERFF unless it is accompanied by an approved confidentiality determination.** If an issuer identifies an item as confidential in SERFF without uploading an approved determination, OSI shall remove the confidentiality tag to ensure compliance with the Inspection of Public Records Act, NMSA 1978 Section 14-2-1- et seq.

It is the issuer's responsibility to ensure that:

1) Confidentiality requests are submitted timely; and
2) Approved confidentiality determinations are uploaded into SERFF.

Failure to adhere to the confidentiality process will result in items maintaining public access.

Any inquiries regarding confidentiality requests and determinations should be directed to Cass Brulotte, Life & Health Attorney, at cass.brulotte@osi.nm.gov.

Section XI: Glossary

Actuarial Value means the percentage paid by a health plan of the total allowed costs of benefits.

ACA means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Benefit Year means a calendar year for which a health plan provides coverage for health benefits.

Catastrophic Plan means a health plan described in section 1302(e) of the ACA. Catastrophic plans cannot be offered during the 2024PY.

Certificate means any certificate issued under an individual or group accident and health insurance policy that has been delivered or issued for delivery in this state, regardless of the state in which the policyholder is domiciled.

Cost-sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits. Such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Cost-Sharing Reductions (CSRs) means reductions in cost-sharing for an eligible individual enrolled in a silver level plan through beWellnm or for an individual who is a member of a federally-recognized tribe who qualifies for a Zero Cost Sharing Variant enrolled in a QHP through beWellnm.

Direct Enrollment Entity means an entity that beWellnm permits to assist consumers with direct enrollment in qualified health plans offered through beWellnm as authorized by §155.220(c)(3), §155.221, or §156.1230.

Enrollee means a qualified individual or qualified employee enrolled in a QHP. Enrollee also means the dependent of a qualified employee enrolled in a QHP through the Small Business Health Options Program (SHOP), and any other person who is enrolled in a QHP through the SHOP, consistent with applicable law and the terms of the group health plan. Provided that at least one employee enrolls in a QHP through the SHOP, enrollee also means a business owner enrolled in a QHP through the SHOP, or the dependent of a business owner enrolled in a QHP through the SHOP.

EOC – means “evidence of coverage” or the contract document, e.g., policy or certificate that expresses the obligations of an QHP issuer, and the rights of an enrollee, under a health plan.

Group Policy means a health insurance policy, which is part of the insurance contract, and is issued to a group subject to 59A-23-3.

Group Health Plan – means a health plan that provides medical care (including items and services paid for as medical care) benefits to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Health Insurance Issuer or Issuer - means a life and health insurance company or health maintenance organization ("HMO") authorized as such by the New Mexico Office of Superintendent of Insurance ("OSI").

Health Insurance Product means a QHP, or several QHPs of a common issuer that share a common set of health benefits.

New Mexico Health Insurance Exchange or "beWellnm" means the health insurance marketplace where qualified individuals can purchase a QHP.

Office of Superintendent of Insurance or "OSI" means an adjunct agency controlling all powers relating to state supervision of insurance, insurance rates and rate practices, together with collection of insurance licenses, taxes or fees, and all records pertaining to such supervision.

Open Enrollment Period means the period each year during which consumers may enroll or change coverage in a QHP through beWellnm. The open enrollment period for 2024 coverage is from November 1, 2022, through January 15, 2024, unless otherwise published by beWellnm.

Plan means a specific combination of health insurance benefits, cost-sharing, provider network and service area.

Plan Year means a consecutive 12-month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year fiscal year, or other designated 12-month period.

QHP means a Qualified Health plan certified to be sold through beWellnm.

Special Enrollment Period means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP outside of the annual open enrollment period.

Turquoise Variant means a plan variant that is eligible for state-funded out-of-pocket assistance (SOPA).