2025 Plan Year
Individual QHP 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 BeWell - New Mexico's Health Insurance Marketplace. 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 BeWell, the OSI is responsible for determining if a plan meets certification requirements. BeWell will determine compliance with BeWell based criteria. For more information on these requirements, please see the 2025 QHP Letter to Issuers, or contact BeWell at 1- 833-862-3935.

Effect of Certification

A QHP certified for the 2025PY can be offered through BeWell, beginning November 1, 2024.

Contact

Please direct all questions regarding plan certification and this document to Viara Ianakieva at 505-508-9073 or viara.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: Submission and Certification Timeline

2025 PY REVIEW TIMELINE	
Activity	**Timeline**
Confidentiality Request	30 days prior to filing submission date
Application submission window opens	4/19/2024
Individual and SADP Form/Rate and Binder submission deadline	5/28/2024 (12 pm)
Individual and SADP plan transfer to BeWell	6/05/2024
Small Group forms and rates deadline *(issuers must submit as a Form/Rate filing with all templates under the Supporting Doc tab. Binders are not required for Small Group plans*)	6/10/2024
48-hour turn-around on carrier responses to Individual and SADP form and rate review objections	7/22/2024
24-hour turn-around on carrier responses to Individual and SADP form and rate review objections	7/29/2024
Approval, Certification and Transfer of Individual and SADP Plans	**8/12/2024**
48-hour turn-around on carrier responses to small group form and rate review objections	8/26/2024
24-hour turn-around on carrier responses to small group form and rate review objections	9/3/2024
Approval of small group plans	9/10/2024
URL Template Links and links in the plan documents to be live and active	9/15/2024
Open Enrollment Starts	11/01/2024

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 timeline, as specified above or in updated guidance. Issuers who fail to meet a deadline, submit an incomplete application or do not follow the processes outlined in this Guide 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 BeWell website.

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

Section III: New and Important Information

The below items are new or amended requirements:

- The Part II certification should be provided in all ACA rate filings, not just those with plan rate i increases greater than any threshold, e.g., 15%.
- Compliance with the 2025PY QHP Issuer Rate Guidance
- OSI will not require a separate Mental Health Parity checklist. Carriers will attest compliance in the 2025PY New Mexico Issuer Attestation.
- Limits on the Number of On-Exchange Non-Standardized Silver Plans Offered by Each Issuer. See Section VI for more details.
- An updated QHP form checklist to include new state mandates
- An updated QHP rate checklist
- Clarification on how deductible information is indicated in the SBCs
- Data change request process for changes to the Form/Rate filing
- Deductible charges in standardized plans
- Clarification of standardized plan cost-sharing requirements for services that are not listed in the SBC. Please refer to the Standardized Plan guidance for more information.
- Covered benefit language must closely align with the Benchmark requirements.
- SBC formatting requirements.
- Issuers must include language that demonstrates compliance with SB135.
- Prior authorization description in the EOC
- Clarification on how issuers should indicate coverage in the PBT for the below services:
    - Weight Loss Programs
    - TMJ
    - Gender Affirming Care

Section IV: General QHP Marketplace Participation Requirements

Issuers who offer a QHP through BeWell are 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. OSI requires all issuers offering small group plans to submit the completed CMS templates and tool screenshots. This information must be submitted under the Supporting Documentation tab of the Form/Rate filing.

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 2025 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 2025 Letter to Issuers.

To be certified, issuers 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 BeWell.
- A plan must satisfy all federal requirements for a QHP as specified in the Public Health Services Act as amended by the ACA.
- Issuers in the individual on-exchange market must enter into a Certification Agreement with BeWell.
- Issuers 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 BeWell. Issuers must offer at least one statewide plan at the gold and silver metal levels.

- Issuers in the individual on-exchange market 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.
- Issuers 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.
- Issuers 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.
- Issuers in the individual on-exchange market must offer through BeWell 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 BeWell 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).
- Issuers 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.
- Issuers 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. The binder must contain copies of the approval and the Form/Rate filing should use the "Associated Filings" feature in SERFF to link the approved filings to the submission.

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

An 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 BeWell, 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, issuers must satisfy compliance standards mandated by state law, including timely submission and approval of compliance filings.

Issuers who offer a QHP, or other major medical coverage in New Mexico, during the 2025PY 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 2025PY 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 2025PY 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 2025PY.

Limits on the Number of On-Exchange Non-Standardized Silver Plans Offered by Each Issuer

In the individual, on-exchange market, carriers must offer at least one Gold and one Silver plan and carriers may offer only two non-standardized Silver plans, in addition to the standardized Silver plan in any rating area. If the two non-standardized Silver metal level plans are offered in the same area and produce similar rates (e.g., within +/- $10 PMPM for a 21-year-old), significant support must be provided explaining why plans are priced so similarly. OSI will consider additional plans in the Silver metal level only if there are significant differences between the plans' provider networks. An example of a "significant difference" between networks is a broad network vs. a narrow network. Carriers may offer only two non-standardized Gold plans in addition to the standardized Gold plan in any rating area. No additional requirements apply to Gold plans.

There is not a limitation to the number of Silver or Gold plans that can be offered in the individual off-exchange market or small group market.

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."

Issuers 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. Issuers 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, issuers shall upload this certificate of accreditation under the Supporting Documentation tab in the SERFF Plan Management module only.

Program Attestations

Issuers seeking certification or recertification of a QHP plan must complete and submit, via SERFF, the 2025PY New Mexico Issuer Attestation Response form.

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

Issuers must upload these forms under the Supporting Documentation tab in the SERFF Plan Management module. OSI will accept electronic signatures on the Attestations. The Life and Health staff will send the Attestation to Company Licensing, though it is still the issuer's responsibility to confirm that Company Licensing receives it.

Service Area

Issuers must identify the service area associated with each proposed plan in the Evidence of Coverage and specify if covered services are available outside of the service area. The Service Area information in the EOC must match the information that's entered in the Service Area template.

Issuers must offer at least one state-wide plan in the individual or small group market, or both, as applicable. If a plan has less than a state-wide service area, OSI will review to ensure that the service area 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

Issuers must clearly identify a limited network or a limited-service area as such. Member facing and marketing materials must specify that the provider network or service area are limited in nature. Issuers offering plans with limited-services areas must also offer the standardized plans with a limited-service area.

Issuers must identify the service area associated with each proposed plan in the Evidence of Coverage and specify if covered services are available outside of the service area. Issuers must offer at least one state-wide plan in the individual or small group market, or both, as applicable. If a plan has less than a state-wide service area, the issuer must ensure that the service area of a plan 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 approving a plan, 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 the SERFFbinder filing for Individual filings; for small group plans, under the Supporting Documentation of the Form/Ratee 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.

Issuers 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.

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

Quality Improvement

Issuers 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 issuers' on-going quality improvement initiatives and achievement of quality improvement goals.

This requirement is not applicable to small group plans.

Section VI: Other Compliance Requirements

Non-Discrimination

Issuers 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

Issuers must publish a drug formulary list for each proposed plan. 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, BeWell 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 issuers offer different formularies for different plans, each the formulary must clearly identify the plan to which it applies. Additionally, the formulary must reflect zero-cost-sharing for HIV and STI drugs.

The EOC for a plan 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 issuers' 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 applicable state and federal mental health parity laws and regulations. In particular, issuers should carefully review the final federal rule implementing the MHPAEA, issued on November 13, 2013, and generally applicable to plan and policy years on or after July 1, 2014. Issuers must also comply with the state mental health parity law enacted as SB273 in the 2023 legislative session and effect on January 1, 2024. Issuers must be prepared to submit their MHPAEA self-assessment tool as evidence of compliance, upon request. In addition, issuers must be prepared to demonstrate compliance with state MHPAEA law throughout the year. OSI will be conducting data calls and targeted market conduct exams to ensure compliance.

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 2025, each Turquoise variant must closely resemble the

general features of its standard variant, unless otherwise specified in the 2025 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 2025 Plan Year Health Insurance Marketplace Program Policy and Procedures Manual.

Standardized (Clear Cost) Plans

All individual market health insurance issuers offering Qualified Health Plans (QHPs) on the New Mexico Health Insurance Exchange during the 2025 Plan Year are required to offer Standardized Health Plans adopted by the Board of Directors. The Standardized Health Plans offered by each issuer must comply with all applicable federal and state laws and regulations. For Standardized Health Plans, health insurance issuers must only offer the benefits enumerated in the plan designs adopted by the Board of Directors and may not alter the plan design for any covered service. Health insurance issuers must use the same statewide network for Standardized Health Plans as used by other plans they offer on the Exchange. For the 2025 BeWell Board Approved Standardized plan designs, refer to BeWell Requirements for 2025 Standardized Plans.https://BeWell.com/wp-content/uploads/2024/02/Complete_with_DocuSign_2025-Standardized-Plan-2.26.2024.pdf

For standardized plan services that require a deductible, copays apply with the deductible. Issuers should refer to the BeWell website for the standardized plan cost-sharing guidance.

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

Issuers must comply with all federal laws and regulations pertaining to coverage for AI/AN individuals, including 42 U.S. Code § 18071(d). Individual QHP 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 cost-sharing 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, including those offering small group plans, 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

Issuers must file proposed rates for each plan. 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.

OSI will issue separate Rate Guidance for the 2025PY.

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. Issuers who propose 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).

Section VIII: SERFF Filing Submission Requirements for QHPs

This section outlines the issuer and plan-level submission requirements for each plan. Issuers must submit the CMS required templates via SERFF in Excel and .xml formats. All Individual plan templates must be submitted in the Binder filings. Small group plan templates must be submitted under Supporting Documentation in the Form/Rate filing. Issuers offering individual QHPs are also required to comply with HIOS and BeWell 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, BeWell or the NAIC SERFF teams. Issuer and plan data and information will be transferred by OSI securely and directly to BeWell through SERFF.

The QHP application review and certification process begins when issuers submit 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 2025 Plan Year by August 15, 2024. Issuers who want to withdraw a previously issued plan from consideration must submit a formal request for withdrawal to OSI and BeWell.

Issuers must submit red-lined versions of approved plan forms, along with a summary of the material changes, which would include items such as benefits that have been added or deleted, changes to prior authorization processes, or services that require prior authorization, definition changes, etc.The redlines and summaries should be submitted as a PDF. 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 BeWell and provide the tracking number of the affiliated, approved, network adequacy filing.

Small group plans are subject to the same requirements as Individual QHP plans, with the exception of a binder submission. OSI will use the CMS review tools to help determine compliance and requires each small group plan application to include complete templates under the Supporting Documentation tab.

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 BeWell 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 (redacted and unredacted)
- Supporting Exhibit to actuarial memorandum (redacted and unredacted)
- Medical rate filing template (redacted and unredacted)
- Medical rate filing checklist
- Medical form filing checklist
- Unified Rate Review Template (URRT)
- 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. Please refer to the rate guidance for all requirements.

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, 2025
- **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
    - **AMEX** – Actuarial Memorandum Exhibits – unredacted
    - **AMEXR** – Actuarial Memorandum Exhibits - redacted
    - **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
- **ECP-NA -** Essential Community Providers Template

Rate Filing Example: ABC_010125_i_MEDOn_v1_RTCK. Xlsx is the initial 2025 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_010125_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, 2025
- **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 variant and small group plan marketing names must include correct information, without omission of material fact, and do not include content that is misleading. During the review OSI will ensure that the following criteria is met:

- Plan names are accurate and not misleading.
- Plan names are consistent between plan variants and are used consistently in all parts of the 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 are unique and cannot be used by issuers 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", issuers 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". Please note that the 73% variant name for QHP Silver On Exchange can be used for the 73% percent variant.
- Plan names for narrow networks or service areas indicate the limited nature of the plan and include language such as "with limited Network" or "with limited Service Area."
- Turquoise plans 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 "Gold HMO Healthy Choice 1", the marketing names for the Turquoise variant should be 4"HMO Health Choice 1 Turquoise 3."
- Standardized plans are named "Clear Cost" with the issuer name and metal level, for example, "ABC (Issuer) Clear Cost Silver."

Plan Design and Contract Requirements

A plan 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 contract, 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 2025 QHP maximum out-of-pocket will be
  - $9,200 for self-only coverage and $18,400 for other than self-only coverage
- For 2025 HSA eligible HDHP plans, the maximum out-of-pocket will be
  - Pending IRS announcement
- For 2025 HSA eligible HDHP plans, the minimum deductible will be
  - Pending IRS announcement
- For the 73% AV silver plan variations, the maximum out-of-pocket will be
  - $7,350 for self-only coverage and $14,700 for other than self-only coverage
- For the 87% and 94% AV silver plan variations, the maximum out-of-pocket will be
  - $3,050 for self-only coverage and $6,100 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 2025.

Cost sharing requirements issued by CMS can be found at https://www.cms.gov/files/document/2025-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.

If issuers choose to offer value-added benefits, these benefits must be available across all plans, including the Turquoise and Standardized plans.

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, as well as provide a direct link to a webpage that includes this information. In addition, the EOC must explicitly describe all benefits.

The following standardized language must be incorporated into the EOC pursuant to Bulletin #2021-029, Bulletin # 2021-017, Bulletin #2023-023 and the Grievance Rule summary found on the OSI website.

- Behavioral health cost share elimination
- Prior Authorization requirements
- Balance Billing
- Contraceptive Coverage
- Grievance Rule
- Medical Necessity and Nondiscrimination Standards for Coverage of Prosthetics and Orthotics

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 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. Products and services that are specified in the Benchmark must also be specified in detail in the EOC. OSI will object to all EHB descriptions that are vague and do not include at least the minimum services required under the Benchmark.

Vision benefits can be offered by endorsement or embedded in the plan. Vision services offered through an endorsement must still be a part of the plan package, meaning the endorsement is not optional. 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.

Each EOC or COC must clearly describe how a member shall obtain medically necessary services and drugs and, as well as describe the prior authorization process for medically necessary services from a provider that is not in-network.

Each EOC or COC should clarify that the cost-sharing for Gender Affirming Care and TMJ benefits aligns with the applicable service. For example, if the person needs prescription drugs for gender affirming care, their cost-sharing will be the prescription drug cost-sharing. If they receive outpatient surgery, the outpatient surgery their cost-sharing will be the outpatient prescription drug cost-sharing.

URL links in the template and consumer facing documents must be live no later than 9/15. 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. The off-exchange designation is not required for small group plans.
- 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 HIOS Plan Standard Component ID in the lower right corner of the first page of the SBC.
- 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 small group, 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." This information should align with the network names that are entered in the Network ID template.
- 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. These requirements do not apply to the zero-cost-sharing plans.
- 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 BeWell.
- 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 shall specify that the plan accepts cost-sharing accumulation for any third-party payment (such as a drug manufacturer’s coupon) and that the rebated amount will count towards to the insured’s cost-sharing. This requirement does not apply to the zero cost-sharing SBCs.
- Issuers should not submit SBCs for the Silver 87% AV and 94% AV plans. 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 in the SBC, such as habilitative and rehabilitative services cannot have quantitative limitations. This includes combinations with other coverage, for example SNFs.
- Cost-sharing for prescription drugs must be successive for each tier.
- Each SBC cost-sharing scenario must accurately reflect the consumer’s cost-sharing. Issuers should review and comply with the CMS instructions when populating the cost-sharing in the SBC and PBT.
- The SBC font should be Arial Narrow.
- For columns that address multiple services, issuers must use separators between the services. Issuers should use a comma to separate cost-sharing and a semicolon to separate cost-sharing from additional language. For example, in the “If you have a test” section: $40 lab, $60 x-ray; deductible does not apply.
- If a deductible applies, the SBC must include the disclaimer, “All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.” If the service does not require a deductible, carriers must add “Deductible does not apply in the column.” The absence of this disclaimer means the deductible applies.

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

Issuers 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 9/15/2024. URL links contained within the URL template must be live and active no later than 9/15/2024.

SERFF Template Requirements for QHPs

Issuers must use CMS and BeWell mandated data templates. All Individual Plan Binders must include the required templates. The small group form/rate filings must include the required templates, listed below, under the Supporting Documentation tab:

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 (applies to the individual market only)
8. Frozen Plan Template (applies to the individual market only)
9. Plan ID Crosswalk Template (applies to the individual market only)
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 (applies to the individual market only)
14. Unified Rate Review
15. Silver to Gold Mapping Template (applies to the individual market only)

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

Administrative Data Template

The QHP certification process requires issuers to submit an Administrative Data Template that will be used for operational purposes. Issuers are required to submit this information annually as part of their SERFF Binder Submission (form/rate filing for small group issuers) 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.

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 should not be included in the Form/Rate filing.

Design Type Field

Issuers must indicate in the PBT which plans are standardized by marking "Design Type 5" in the "Design Type" Field.

Zero Cost-sharing Services

If a service does not require any cost-sharing, the PBT should reflect "No Charge." Entries that show "$0" or "0%" in lieu of "No Charge" are not acceptable. Please refer to the CMS instructions for more information.

Benefits Explanation

To ensure the insured understands how the cost-sharing applies, issuers should enter a clarifying explanation to the "Benefits Explanation" section of the "Benefits Package" tab in the PBT. The explanations inserted in this section will transfer to the "Explanations" section of the cost-sharing table that's populated on the BeWell website.

Weight Loss Programs – The populated cost-sharing should align with the standardized plan guidance and the benefit explanation should state "Listed cost-sharing does not include prescription drugs and surgery. See EOC for cost-sharing information for all other weight loss services."

TMJ – The populated cost-sharing should align with the standardized plan guidance and the benefit explanation should say "Listed cost-sharing is applicable to Outpatient Surgical Services only. See EOC for cost-sharing information for all other TMJ services."

Gender Affirming Care - The 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." The EOC should specify that the insured will pay the cost-share applicable to the service they receive.

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-exchange "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 1 with EXTRA SAVINGS", for the 99% AV level silver plan, "99" 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. OSI will require an additional Turquoise variant for zero-cost-sharing Native American plans. Please refer to the Health Care Affordability Manual for additional information.

Plan Crosswalk

Issuers must crosswalk the 2024 QHP plan ID and service area combinations to a 2025 QHP Plan ID. This data will facilitate enrollment transactions from BeWell 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 .xlsm formats.**

For the 2025PY, BeWell 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

BeWell requires issuers to submit a Frozen Plan template specifying the data for the plans that will not be offered on the BeWell during the 2025PY. The template must be submitted in a **.xlsx format** and uploaded under the Supporting Documentation tab of the Plan Management binder. This requirement applies to individual on-exchange plans only. trans

Issuer URL Template

URL template must be submitted with the rest of the plan materials part of a QHP Application. BeWell requires issuers to submit URL data for the plans they intend to offer on the BeWell 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 15, 2024.

Supplemental SOPA Variant Template

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.

OSI will require issuers to submit two SOPA templates: one macro-enabled and one that is not macro-enabled. We will issue the templates and instructions when CMS releases the 2025PY PBT.

Transparency in Coverage

45 C.F.R. §§155.1040(a) and 156.220 require issuers to disclose transparency information to OSI, BeWell 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 20, 2024.

All URLs contained within the template must be live and remain active during the entire plan year.

This requirement is not applicable to small group plans.

Silver to Gold Mapping Template

In instances when BeWell can determine that a consumer meets the following criteria, issuers should use a unique plan mapping methodology for the 2025 plan year:

1) The consumer would otherwise be automatically re-enrolled in either a -01 or -04 Silver variant; and

2) The consumer is guaranteed to have access to a Gold plan offered by their current issuer that has:
   a. An identical provider network as the plan into which they would otherwise be enrolled;
   b. An identical drug formulary as the plan into which they would otherwise be enrolled; and
   c. Has a lower premium than the Silver plan into which they would otherwise be automatically re-enrolled.

Issuers should map individuals who meet these criteria into a Gold plan. This template must be submitted in **.xlsx format**. OSI will post instructions on the website.

This requirement is not applicable to small group plans.

Required Use of CMS Review Tools and Data Integrity Tool

Issuers 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 and form/rate 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 enforcement action including but not limited to penalties and 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 BeWell 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), issuers must pay a rate and form fee of $80 for each QHP package. A package is each unique combination of rates and all associated forms, including EOC, SBC, Application, Enrollment form, Formulary and any Riders/Endorsements. For example, if a policy comes with 3 SBCs, the carrier must pay for 3 form and rate packages or ($30+$50) x3=$240. Note that if a carrier has the same product in multiple rating areas, they must pay the filling fee for the package in each rating area.

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. The card must also contain a form number. In addition, the cards must include the plan 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 must comply with federal and state laws regarding guaranteed renewability.

Variability

Variability 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 that it accepts third party payments, other than payments mandated by 45 C.F.R. § 156.1250, within the EOC and SBCs.

Cost-Sharing Accumulation

Issuers must 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, that 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: Small Group Specific Requirements

All small group products 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. Small group plans must be submitted as a Form/Rate filing. Since small group plans are no longer sold on the BeWell platform, issuers are not required to submit binders for small group plans. However, issuers must utilize the CMS templates and submit them under the Supporting Documentation tab of the Form/Rate filing. Issuers offering small group plans must also run the CMS tools and submit screenshots of the results.

Small group plans are subject to the same 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 2025PY 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 previous years, 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.

Upon submission, issuers shall mark all rate related materials as confidential. OSI will remove temporary confidentiality upon plan approval and certification. Confidentiality requests must be clear so OSI can easily identify the items that are temporarily confidential and the items that are permanently confidential.

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 issuers identify 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: Data Change Requests

Issuers must complete a data change request to amend information in binder after it has been certified. OSI and BeWell must approve the request before OSI reopens the binder. Once OSI and BeWell approve the request, the issuer must upload a copy of the approval under Supporting Documentation in the binder.

Issuers must complete a data change request to amend information in the Form/Rate filing after it has been approved. Once OSI approves the request, the issuer must upload the approval under Supporting Documentation in the form/rate filing.

Requests made too close to, or after open enrollment may be denied. Requests for changes that are less favorable to the consumer may be denied.

Section XII: 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 2025PY.

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 BeWell 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 BeWell.

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

Enrollee means a qualified individual enrolled in a QHP or a qualified employee enrolled in a small group plan. Enrollee also means the dependent of a qualified employee enrolled in a small group plan, consistent with applicable law and the terms of the group health plan. Provided that at least one employee enrolls in a small group plan, enrollee also means a business owner enrolled in a small group plan, or the dependent of a business owner enrolled in a small group plan.

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 "BeWell" 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 BeWell. The open enrollment period for 2025 coverage is from November 1, 2024, through January 15, 2025, unless otherwise published by BeWell.

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 BeWell.

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).