2022 Plan Year QHP and SADP Issuer Submission Guide

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Glossary

Actuarial Value means the percentage paid by a health plan of the percentage 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.

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 in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Direct Enrollment Entity means an entity that an Exchange permits to assist consumers with direct enrollment in qualified health plans offered through the Exchange in a manner considered to be through the Exchange as authorized by §155.220(c)(3), §155.221, or §156.1230 of this subchapter.

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 a QHP or an SADP issuer, and the rights of an enrollee, under a health plan.

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 "NMHIX" means the health insurance marketplace where qualified individuals can purchase a QHP or an SADP.

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 or an SADP through NMHIX. The open enrollment period for 2022 coverage is from November 1, 2021 through January 15, 2022, unless otherwise published by NMHIX.

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 or otherwise.

Stand Alone Dental Plan or "SADP" means a dental plan that provides pediatric oral services established as an essential health benefit under ACA § 1302(b) and defined under the New Mexico Benchmark plan.

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

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.

General Information and Background

Purpose

This guide provides information about the processes and standards for obtaining certification to offer a QHP or an SADP on NMHIX. 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.

Background

Operating in partnership with NMHIX, the OSI is responsible for determining if a plan meets certification requirement. NMHIX will determine compliance with Exchange based criteria. For more information on these requirements, please see the 2022 QHP Letter to issuers, or contact NMHIX at 1-833-862-3935.

Effect of Certification

A QHP or an SADP certified for the 2022PY can be offered through NMHIX, beginning November 1, 2021.

Contact

Please direct all questions regarding plan certification and this document to Viara Ianakieva at 505-508-9073 or Viara.Ianakieva@state.nm.us. For legal questions, please contact the Life and Health Product Filing Bureau Legal Counsel, Todd Baran, at 505-660-8172 or Todd.Baran@state.nm.us.

QHP Certification and Submission Timeline

PY2022 QHP Certification Submission Schedule	
Activity	Date
QHP and SADP Application submission window opens	4/22/2021
Optional Early Bird QHP and SADP Application submissions deadline	5/19/2021
Initial QHP and SADP Application submissions deadline (Form and Rates Filings and Binders, as well as Transparency in Coverage and Plan ID Crosswalk data must be submitted via SERFF).	6/11/2021
Individual Plans Initial Form and Rates Transfer to CMS and NMHIX	6/13/2021-6/15/2021
SHOP Plans Initial Form and Rates Transfer to NMHIX	6/18/2021
Rate Amendments (deadline for application changes)	7/14/2021-7/18/2021
Individual Plans 2nd Transfer of Forms and Amended Rates to CMS and NMHIX	7/19/21-7/21/2021
SHOP Plans 2nd Transfer of Forms and Amended Rates to NMHIX	7/22/2021
48-hour turn-around on carrier responses to form and rate review objections	08/02/2021
24-hour turn-around on carrier responses to form and rate review objections	08/09/2021
Approval & Certification for Individual and SHOP Plans	**08/14/2021**
Open Enrollment Starts	11/01/2021

Please note that dates are subject to change based on factors such as, delays in federal guidance, federal timelines, and 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 or does not follow the processes outlined in this Guide may have its QHP application denied.

General QHP Marketplace Participation Requirements

An Issuer who offers a QHP through NMHIX is required offer a mirrored off-exchange plan for each on-exchange plan.

Certification and Recertification

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.
- The Issuer must meet the QHP Application submission deadlines established by the Centers of Medicare and Medicaid Services (CMS), OSI and NMHIX.
- 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 NMHIX.
- An Issuer must offer at least one certified plan in both the silver and gold coverage levels, as described in 45 C.F.R. §156.140, throughout each service area in which it offers coverage through the Exchange.
- An Issuer must submit three variations for each silver plan reflecting reduced cost-sharing on the essential health benefits (45 C.F.R. § 156.420(a)).
- An issuer must allow any person under the age of 21 at the beginning of the plan year to purchase any QHP offered by that Issuer.
- An Issuer 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 attest compliance with all QHP operational requirements described in subparts D, E, H, K, L, and M of 45 C.F.R. Part 156.

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 NMHIX, 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 2021PY must file proof of compliance issued by OSI during the preceding 12 months. Proof of compliance shall be filed under the supporting documents tab in SERFF with its 2022PY 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 2022PY 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.

Service Area

An Issuer must identify the service area associated with each proposed QHP or SADP and disclose it in the Evidence of Coverage. 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.

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:

- To address limitations in provider contracting (the Issuer must provide substantial documentation of its contracting efforts, including a list of providers with whom the issuer attempted to contract and the contracts offered).

- 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).

Network Adequacy

A QHP that offers more favorable cost-sharing for benefits received from contracted providers must have an adequate provider network. A network is adequate if it includes a sufficient number and types of providers, including providers who specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay. 45 C.F.R. § 156.230(a)(2). If a proposed plan offers more favorable cost-sharing, or if an enrollee obtains benefits from a provider who is in a subset, or tier of all contracted providers, the Issuer must establish network adequacy for the network or network tier with the most favorable cost-sharing features. Before certifying a QHP, OSI must approve the network associated with a specific plan design. If an Issuer proposes to offer multiple plan designs that will have different networks, or network tiers, approval of the network for one plan design will not satisfy approval requirement for a plan design with a different network configuration. The Issuer must obtain approval of each, distinct network configuration. For tiered networks, an Issuer is required to obtain an approval only for the network that offers the most favorable cost-sharing. Also, 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 can establish network adequacy compliance in one of four ways:

1. If OSI approved the adequacy of the network associated with a QHP within the preceding 12 months, the Issuer may file the OSI issued disposition notice under the supplemental documents tab in SERFF.

2. If OSI conditionally approved the adequacy of the network associated with a QHP within the preceding 12 months, the Issuer may file the OSI issued disposition notice under the supplemental documents tab in SERFF, and file with OSI Life and Health Division compliance staff all supplemental information listed in the disposition notice. Any such filing shall be made at least 45 days before the QHP certification deadline.

3. If the proposed QHP will have an open network, the Issuer may provide the verification referenced in Rule 13.10.22.8(J) NMAC for the specific network associated with the proposed QHP.

4. If the Issuer cannot establish compliance under paragraph (1), (2), or (3) the Issuer shall file with OSI Life and Health Division compliance staff a preliminary access plan pursuant to Rule 13.10.22.8(A) NMAC. Any such filing shall be made at least 45 days before the QHP certification deadline. If OSI approves the preliminary access plan, the Issuer shall file a follow-up access plan within six months of the preliminary plan approval. If OSI rejects the follow-up access plan, OSI may order the Issuer to treat certain benefits offered by the QHP as having been received by a provider participating in the network with the most favorable cost-sharing for purposes of member cost-sharing obligations.

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 mandated by 45 C.F.R., § 156.235(a)(1) or (5).

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

Accreditation

A 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"). OSI will verify each Issuer's accreditation status for certification or recertification. An Issuer who only offers an SADP does not need to be accredited.

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.

Program Attestations

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

- Compliance Plan and Organizational Chart Cover Sheet
- 2022 State Based Exchange Issuer Program Attestation Response Form (Response Form)
- Interoperability Attestation and Justification 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. An Issuer must upload these forms under the Supporting Documentation tab in the SERFF Plan Management module. Due to

the COVID-19 Public Health Emergency, OSI is not requiring wet signatures on the Attestations and will accept electronic signatures instead.

Rates

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

An Issuer shall provide rates and a redacted actuarial memorandum for publication on OSI's rate review website as required by NMSA 1978, § 59A-18-13.2(D). A non-redacted version of the actuarial memorandum must be submitted as confidential, and confidential material must be outlined in a confidentiality request in accordance with the requirements of OSI Bulletin #2014-004.

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.

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.

Plan Design

A QHP and, as applicable, a SADP 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 coverage and benefit mandates of the New Mexico Insurance Code (NMSA Chapter 59A) including Section 59A-16-13.1 NMSA 1978; Article 22 (Health Insurance Contracts); Article 22A (Preferred Provider Arrangements); Article 23 (Group and Blanket Health Insurance Contracts); Article 23C (Small Group Rate and Renewability); and, as applicable, Article 46 (Health Maintenance Organizations).

Prescription Drugs

An Issuer must publish a drug formulary list for each proposed QHP. 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 must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, OSI, NMHIX 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, and the process to appeal an issuer's denial of a request for such an exception.

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.

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.

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.

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 an annual limitation on cost-sharing. A proposed plan shall specify whether such cost-sharing accumulation is allowed.

Acceptance of Third Party Payments

A proposed plan shall specify that it accepts third party payments as mandated by 45 C.F.R. § 156.1250, and shall clearly specify whether the plan allows or refuses any other third party payments.

SHOP Specific Requirements

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.
- 45 C.F.R. §155.1000(c).

Student Health Plans

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

OPM Certification of Multi-State Plans

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan (MSP) Program, 42 U.S.C. § 18054(d).

For more information on requirements for a MSP, go to: http://www.opm.gov/healthcare-insurance/multi-state-plan-program/issuer.

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. An Issuer is also required to comply with HIOS and NMHIX 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, NMHIX and the NAIC SERFF teams. Issuer and plan data and information will be transferred by OSI securely and directly to NMHIX 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 2022 Plan Year by August 13, 2021. An Issuer who wants to withdraw a previously issued plan from consideration must submit a formal request for withdrawal to OSI and NMHIX.

HIOS Issuer ID

Prior to completing a Plan and Benefits Template and submitting a QHP application, an Issuer must register their HIOS Product IDs via HIOS and obtain HIOS Issuer ID for Rate Review.

Administrative Information

The QHP certification process requires an Issuer to submit administrative data that will be used for operational purposes. An Issuer is required to submit this information annually as part of their Binder Submission and report changes to previously reported information within 30 days. Issuers must contact OSI for details on the data elements to be collected and their method of delivery to OSI and NMHIX.

Plan Crosswalk

An Issuer must crosswalk the 2021 QHP plan ID and service area combinations to a 2022 QHP Plan ID. This data will facilitate enrollment transactions from NMHIX 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.

Transparency in Coverage

45 C.F.R. §§155.1040(a) and 156.220 require an Issuer to disclose transparency information to OSI, NMHIX and the public. The transparency 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 June 11, 2021. 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. 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.

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 and supplemental documentation submitted as part of the QHP application. In addition, the information reported in HIOS or the NMHIX Plan Management portal must be consistent with the information included in the QHP Application submitted via SERFF.

SBC

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

The 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:

- 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.
- Each SBC must be appropriately labeled and reflect the plan name, metal level and whether the plan is a High Deductible Health Plan (HDHP), HSA eligible or Catastrophic plan.
- The Plan Name displayed on the SBC must be identical to the Plan Marketing Name stated in the P&B Template.

- Silver plans with Actuarial Value of 94% and 87% must include the designation "with EXTRA SAVINGS" at the end of the plan name.
- 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 readily obtainable (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."
- All terms included in CMS's Uniform Glossary shall be underlined and hyperlinked in the SBCs.
- An SBC must reflect the $25 cap on insulin, free COVID tests, services and vaccines, no prior-authorizations for gynecological or obstetrical ultrasounds, as well as physical therapy cost-sharing limitations.
- 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 federal poverty level who is otherwise eligible for tax credits through the Exchange.
- 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.
- A QHP that denies cost-sharing accumulation for any third-party payment (such as a drug manufacturer's coupon) must clearly express this limitation in the "Limitations, Exceptions, and Other Important Information" column of the SBC.

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.

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.

URLs

An Issuer must submit CMS mandated URL data for each proposed QHP. Each URL should lead to live, active webpages that contain accurate information by the below deadlines.

URL Type	Submission Deadline	Live and Active Deadline
Transparency in Coverage	June 11, 2021	Upon Submission
SBC, Plan Brochure, Payment, Formulary and Network	August 14, 2021	September 10, 2021

Filing Fees

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

SERFF Template Requirements for QHPs, SADPs and Off-Exchange Plans

An Issuer must use CMS mandated data templates. NMHIX will use 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 NMHIX Plan Management Portal and ensure accuracy during Plan Preview.

Data templates are also required for off-Exchange Mirrored and non-Mirrored plans.

Template Name				Pediatric EHB Stand Alone Dental Plans Offered On-Exchange
	Individual and SHOP Plans Offered On-Exchange	Individual and SHOP Plans Offered Off - Exchange (Mirrored)	Individual, SHOP & Large Gr Plans Offered Off-Exchange Only (Non-Mirrored)	
Administrative Data Template	X	X	X	X
Business Rule Template	X	X	X	X
Essential Community Provider (ECP)/Network Adequacy Template	X	X		X
Network ID Template	X	X	X	X
Plan and Benefit Template	X	X	X	X
Plan Crosswalk Template	X			X
Prescription Drug Template	X	X	X	
Rate Data Template	X	X	X	X
Service Area Template	X	X	X	X
Transparency in Coverage Template	X	X	X	X
Unified Rate Review Template	X	X	X	X

SADP Requirements

An Issuer may apply to offer a SADP that includes coverage of pediatric dental essential health benefits. An Issuer may also apply to offer a SADP that includes both pediatric and adult dental benefits, or adult-only coverage.

Only a SADP certified by OSI can be offered through NMHIX. Each SADP must be certified annually and satisfy these general requirements:

- Issuer is licensed and in good standing;
- Issuer complies with non-discrimination rules;
- SADP meets service area and network access requirements, including ECPs; and
- SADP complies with benefit design standards such as cost-sharing limits, actuarial value requirements and essential health benefits designed for an SADP.

Certification and Recertification of an SADP

An Issuer must submit SERFF filings and the associated Binder to OSI by June 11, 2021. The Plan Management Binder must contain all templates and requested SADP data elements.

Licensing and Good Standing

An SADP 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 NMHIX, 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.

Service Area

An Issuer must identify the service area associated with each proposed SADP and disclose it in the EOC. An Issuer must offer at least one plan with a state-wide service area. Any other service area must cover a minimum geographic area that is at least the entire geographic area of a county, or a group of counties, unless OSI determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interests of qualified individuals and employers. 45 C.F.R. § 155.1055(a). OSI will review to ensure that the service area of an SADP 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.

Outline of Coverage

An Issuer must provide an Outline of Coverage (OOC) for each SADP. Each OOC file name must indicate if the plan option is for an adult or pediatric dental coverage. In addition, each OOC must have a form number in the lower left corner and a HIOS Plan Standard Component ID in the right lower corner of the form.

ECP

An SADP network must include ECPs as required in 45 C.F.R. §156.235.

EHBs and Actuarial Value

A pediatric SADP must provide the pediatric dental EHB mandated by the NM Benchmark plan, and meet the actuarial value requirement specified in 45 C.F.R. § 156.150.

Adult dental benefits are not subject to any actuarial value requirement.

Non-Discrimination

An Issuer and its SADP must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation, and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. 45 C.F.R. § 156.200(e) and 156.225(b). OSI will review information contained in the contract, Plans and Benefits Template, OOC and all relevant documents, including, but not limited to the "explanations" and "exclusions" sections, to identify potentially discriminatory anomalies or wording.

SERFF Filing Submission Requirements for SADPs

An Issuer must submit the SADP data and information via SERFF for OSI's review, approval and certification. An Issuer must also make necessary submissions in the HIOS and the NMHIX Plan Management systems. CMS/CCIIO, NMHIX and/or the NAIC SERFF team may change submission requirements prior to the opening of the SADP submission window. Issuer and plan data and information will be transferred securely by OSI to NMHIX through SERFF.

Administrative Information

The SADP certification process requires an Issuer to submit administrative data that will be used for operational purposes. An Issuer is required to submit this information annually as part of their Binder Submission and report changes to previously reported information within 30 days. Issuers must contact OSI for details on the data elements to be collected and their method of delivery to OSI and NMHIX.

HIOS Issuer ID

Prior to completing a Plan and Benefits Template and submitting an SADP application, an Issuer must register their HIOS Product IDs via HIOS and obtain HIOS Issuer ID for Rate Review.

Cost-sharing Limitations

The annual limitation on cost-sharing for a 2022PY SADP will be $375 for one child and $750 for two or more children. For more information on how this limitation is determined, please refer to 45 C.F.R. § 156.150 and to the 2022 Letter to Issuers. Adult dental coverage included in an SADP is not subject to these cost-sharing limitations.

Alignment of Data Template information with Form filing documentation and OOC

All data contained within an SADP Application must be complete, accurate and consistent between the policy documents, OOC, data templates and supplemental documentation submitted as part of the application. In addition, the information reported in HIOS or the NMHIX Plan Management portal must be consistent with the information included in the SADP Application submitted via SERFF.

Required Use of CMS Review Tools and Data Integrity Tool

An Issuer must use the CMS Review tools prior to submitting data to OSI. 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 an SADP certification.

URLs

A SADP Issuer must submit CMS mandated URL data for the plan(s) it intends to offer on the Exchange. Each URL should lead to a live, active webpage that contains accurate information by the deadlines below.

URL Type	Submission Deadline	Live and Active Deadline
Transparency in Coverage	June 11, 2021	Upon Submission
OOC, Plan Brochure, Payment, and Network	August 14, 2021	September 10, 2021

Filing Fees

NMSA 1978, §59A-6-1(V) requires a rate filing fee to be submitted for each SADP variation. This means that a $50 fee is due for the rates associated with each OOC. A package submission fee must be paid for each combination of a single policy, its associated application, OOC, and riders or endorsements.