



NEW MEXICO | OFFICE OF  
SUPERINTENDENT  
OF INSURANCE

# **New Mexico Qualified Health Plan Submission Guide**

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Similar to the QHP certification process in past years, the New Mexico Office of Superintendent (NMOSI) will conduct reviews of qualified health plans (QHPs) and stand-alone dental plans (SADPs) and provide to CMS the determinations on individual QHPs and SADPs.

NMOSI evaluates health and dental plans against QHP and SADP certification standards as part of the state's traditional regulatory role for the insurance industry and/or enforcement of Title XXVII of the Public Health Service Act (PHS Act), or otherwise for state purpose.

### **On-Exchange Individual and SHOP Form & Rate Filings and Binders**

OSI will begin accepting QHP On-Exchange policies through SERFF as described in the timelines on the OSI website: <https://www.osi.state.nm.us/LifeHealthFiling/index.aspx>

All QHPs and dental and vision plans will need to be submitted to OSI through the National Association of Insurance Commissioner's System for Electronic Rate and Form Filing (SERFF). Carriers wishing to submit QHP policies for review must be licensed with OSI for the additional line of business designated as "Qualified Health Plan".

Carriers will also need to complete a statement of attestation with a wet signature to the OSI.

Instructions for completing the Company Licensing Bureau requirements for QHP Issuers will be posted on the OSI website.

## **QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN CERTIFICATION STANDARDS**

### **Licensure and Good Standing**

Consistent with 45 C.F.R. 156.200(b)(4), each QHP issuer must be licensed and in good standing in New Mexico to offer QHPs for the applicable market, product type, and service area. The issuer must be in compliance with all applicable state solvency requirements and is in good standing in the state in relation to compliance with state laws and regulations.

The issuer is required to amend its Certificate of Authority by adding a QHP or SADP designation prior to offering QHP and SADP plans. The amendment is facilitated by the NMOSI Company Licensing Bureau.

In addition to requiring state of good standing, NMOSI will consider any complaints it receives and other QHP issuer oversight findings that occur during the previous benefit years, including state enforcement findings, in its determination of whether an issuer's offering of a plan is in the interest of consumers. NMOSI will consult with CMS on these findings.

## **Service Area**

Consistent with regulations at 45 C.F.R. 155.1055(a), the Marketplace must ensure that each service area of a QHP covers a minimum geographic area that is at least the entire geographic area of a county, or a group of counties defined by the Marketplace, unless the Marketplace determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. The Marketplace must also 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 PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

For the benefit year, NMOSI will review requests for service areas that serve a geographic area smaller than a county to ensure that each service area meets the above regulatory standards, particularly with respect to ensuring that the establishment of this partial county service area is not discriminatory.

NMOSI requires that QHP and SADP issuers maintain at least one provider state-wide network.

In the QHP Application process, NMOSI considers the service area of a plan to be the county or set of counties (or partial counties) that is covered by that particular plan. Any change to the list of counties associated with a particular plan is considered a change in the service area, even if the issuer offers other plans or products in the counties (or partial counties) in question. QHP issuers will not be allowed to change their service area after their initial data submission except via petition to NMOSI. Changes to service areas will only be approved under very limited circumstances, such as:

- To address limitations in provider contracting: issuers will need to provide substantial documentation of their contracting efforts in the geographic areas dropped, including lists 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: issuers will need to 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.

Any additional circumstances would be severely limited and determined on a case by case basis and only based on state approval and significant evidence of necessity and the best interest of the consumer. NMOSI will not allow changes to service area after the final data submission date.

## **Network Adequacy**

Pursuant to 45 C.F.R. 156.230(a)(2), an issuer of a QHP that has a provider network must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will

be accessible to enrollees without unreasonable delay. Additionally, all QHP issuers must meet existing network adequacy standards established by regulation NMAC 13.10.22. All issuers applying for QHP certification will need to attest and demonstrate that they meet these standards as part of the certification/recertification process.

NMOSI will assess provider networks using a “reasonable access” standard, and will identify networks that fail to provide access without unreasonable delay as required by 45 C.F.R. 156.230(a)(2). In order to determine whether an issuer meets the “reasonable access” standard, NMOSI will focus most closely on those areas which have historically raised network adequacy concerns. These areas include the following:

- Hospital systems,
- Mental health providers,
- Oncology providers, and
- Primary care providers.

If NMOSI determines that an issuer’s network is inadequate under the reasonable access review standard, we will notify the issuer of the identified problem area(s) and will consider the issuer’s response in assessing whether the issuer has met the regulatory requirement and prior to making the certification or recertification determination.

### **Essential Community Providers**

Essential community providers (ECPs) include providers that serve predominantly low-income and medically underserved individuals, and specifically include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act (SSA). At 45 C.F.R. 156.235, CMS establishes requirements for inclusion of ECPs in QHP provider networks and provides an alternate standard for issuers that provide a majority of covered services through physicians employed by the issuer or a single contracted medical group. Indian health providers are included among ECPs.

*ECP Guideline:* An application for QHP certification that adheres to the general ECP inclusion standard does not need to provide further documentation. We will utilize a general ECP enforcement guideline whereby if an application demonstrates that at least 20 percent of available ECPs in each plan’s service area participate in the provider network, we will consider the issuer to have satisfied the regulatory standard. In addition, and as required for the prior year, we expect that the issuer offer contracts in good faith to:

- All available Indian health providers in the service area, to include the Indian Health Service, Indian Tribes, Tribal organizations, and urban Indian organizations, using the recommended model QHP Addendum for Indian health providers developed by CMS; and
- At least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.

As part of the issuer's QHP application, we expect that the issuer list the contract offers that it has extended to all available Indian health providers and at least one ECP in each ECP category in each county in the service area. To be offered in good faith, a contract should offer terms that a willing, similarly-situated, non-ECP provider would accept or has accepted. We would expect issuers to be able to provide verification of such offers if NMOSI chooses to verify the offers.

NMOSI will continue to assess QHP provider networks, including ECPs, and may revise its approach to reviewing for compliance with network adequacy and ECPs in later years.

### **Accreditation**

Issuers must be accredited by a recognized accrediting entity

For certification in the next benefit year, the National Committee for Quality Assurance (NCQA), URAC, and the Accreditation Association for Ambulatory Health Care (AAAHC) have been recognized by New Mexico as accrediting entities for the purpose of QHP certification. SADP issuers will not be reviewed for accreditation status.

The following calendar outlines the requirements established by NMOSI regarding issuers who are becoming newly accredited:

1<sup>st</sup> year of business on the exchange - QHP carriers have identified their business process and procedures and have already scheduled or plan to schedule their initial accreditation application.

2<sup>nd</sup> year of business on the exchange - QHP carriers have submitted their initial accreditation application.

3<sup>rd</sup> year of business on the exchange - QHP carriers become fully accredited including reporting of clinical quality data.

Issuers will be considered accredited if the QHP issuer is accredited with the following status: by AAAHC with "Accredited," status; by NCQA with "Excellent," "Commendable," "Accredited," and /or "Interim" status; or by URAC with "Full," "Provisional," and/ or "Conditional," status. An issuer will not be considered fully accredited if the accreditation review is scheduled or in process.

### **Patient Safety Standards for QHP Issuers**

Section 1311(h) of the Affordable Care Act states that beginning on January 1, 2015, QHP issuers are required to comply with patient safety standards and may only contract with hospitals and health care providers that meet specified quality improvement criteria. Section 156.1110 in the 2015 Payment Notice<sup>12</sup> outlines how QHP issuers can demonstrate compliance with these standards, on a transitional basis, for 2 years beginning January 1, 2015 or until further regulations are issued, whichever is later. Specifically, the regulation requires QHP issuers that contract with a hospital with greater than 50 beds to verify that the hospital, as defined in section 1861(e) of the SSA, is Medicare-certified or has been issued a Medicaid-only

CMS Certification Number (CCN) and is subject to the Medicare Hospital Condition of Participation requirements for:

- (1) A quality assessment and performance improvement program as specified in 42 C.F.R. 482.21; and
- (2) Discharge planning as specified in 42 C.F.R. 482.43.

In addition, QHP issuers are required to collect and maintain documentation of the CCNs from their applicable network hospitals.

As part of the certification, QHP issuers will be required to demonstrate compliance with these patient safety standards as part of the QHP application with an attestation that they have collected and are maintaining the required documentation from their network hospitals.

### **Rates**

Regulations at 45 C.F.R. 155.1020 require a Marketplace to consider all rate increases when certifying plans as QHPs. NMOSI will consider issuers' data and actuarial justifications provided in the Unified Rate Review Template (URRT), and other information submitted as part of the rate filing.

- The QHP issuer's justification for all rate increases will be captured in the submission of Part I of the rate filing justification (URRT).
- To ensure consumer transparency, issuers must publish information from Part I of the rate filing justification by posting the information on the issuer's website.

Rates that are too high or too low could have undesirable consequences for consumers. If rates are too high, consumers may be overpaying for coverage. If rates are too low, consumers may purchase a plan in which the pricing is not sustainable over time, potentially leading to significant rate increases in future years. Such increases could be disruptive to consumers who remain in the plan and to consumers who switch to more effectively priced plans but experience changes in prescription drug formularies or provider networks. In addition, QHP rates specifically, the rate for the second lowest cost silver plan – directly impact the value of premium tax credits as well as other federal outlays.

### **OPM Certification of Multi-State Plans**

The U.S. Office of Personnel Management (OPM) is responsible for implementing the Multi-State Plan (MSP) Program as required under section 1334 of the Affordable Care Act. In accordance with section 1334(d) of the Affordable Care Act, MSP options offered by MSP issuers under contract with OPM are deemed to be certified by a Marketplace.

Issuers seeking to offer MSP coverage must apply to participate via OPM's online application portal. OPM will evaluate issuer applications and determine which issuers are qualified to

become MSP issuers. OPM works closely with states in reviewing benefits and rates to achieve its goals of offering more choice for consumers and maintaining a level playing field for all issuers within a state.

Upon OPM participation approval the issuers are required to submit a mirrored plan and binder for NMOSI review. Prior to OPM final approval of the plans/binders, if changes are mandated by OPM, the issuer must notify the NMOSI and make necessary changes to mirrored plans/binders.

For more information on requirements for MSP issuers, issuers should visit <http://www.opm.gov/healthcare-insurance/multi-state-plan-program/issuer/>. OPM will post specific instructions regarding the application timeline and process when available.

### **Certification of Consumer Operated and Oriented Plans (CO-OPs)**

Consistent with the approach applied in previous years, CO-OPs are expected to apply for QHP certification using the same processes applied to other QHP issuers.

## **QUALIFIED HEALTH PLAN AND STAND-ALONE DENTAL PLAN DESIGN**

For purposes of QHP certification, NMOSI will collect an attestation that issuers' QHPs will not discriminate against individuals on the basis of health status, race, color, national origin disability, age, sex, gender identity or sexual orientation, consistent with 45 C.F.R. 156.200(e).

In addition to complying with EHB non-discrimination standards, QHPs must not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs (see 45 C.F.R. 156.225).

NMOSI will analyze information contained in the Plans and Benefits Template, including, but not limited to, the "explanations" and "exclusions" sections, with the objective of identifying potentially discriminatory anomalies or wording.

### **Section Prescription Drugs**

Regulations at 45 C.F.R. 156.122 establish that a health plan that provides EHB must cover at least the greater of (1) one drug in every United States Pharmacopeial Convention (USP) category and class or (2) the same number of prescription drugs in each USP category and class as the state's EHB -benchmark plan. As part of the QHP Application, issuers must provide a URL that links to the specific formulary for each plan and must also provide information regarding formularies to consumers. The URL link should direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, that are specific to a given QHP. The URL provided to the Marketplace as part of the QHP Application should link directly to the formulary, such that consumers do not have to log on, enter a policy number or otherwise navigate the issuer's website before locating it. If an issuer has multiple formularies, it should be clear to consumers which formulary applies to which QHP(s). Additionally, formularies should be in a searchable format, or include a search field for the drug name.

### Stand-alone Dental Plans

Issuers submitting applications for certification of SADPs must comply with the New Mexico Benchmark in accordance with NMAC 8.310.2.G.

QHP issuers are permitted to offer QHPs through a Marketplace that omit coverage of the pediatric dental EHB if a SADP exists in the same service area in which they intend to offer coverage.

### Certification Standards Applicable to Stand-alone Dental Plans

| Certification Standard Applies |                   | Certification Standard Does Not Apply  |
|--------------------------------|-------------------|--|
| Essential Health Benefits      | Actuarial Value   | Accreditation                          |
| Annual Limits on Cost Sharing  | Licensure         | Cost-sharing Reduction Plan Variations |
| Network Adequacy               | Inclusion of ECPs | Unified Rate Review Template           |
| Marketing                      | Service Area      | Meaningful Difference                  |
| Non-discrimination             |                   |  |

### Cost Sharing Reduction Plan Variation Reviews –

NMOSI requires QHP issuers to submit three plan variations for each silver level QHP an issuer offers through the Marketplace, as well as zero and limited cost-sharing plan variations for all QHPs an issuer offers through the Marketplace. These should not be submitted as separate plans, but rather variations of each plan. This required information should be indicated within the binder template.

Certification review will include a review of each submitted Plans and Benefits Template to ensure that Silver plan variations:

- Meet AV requirements.
- Do not have an annual limitation on cost sharing that exceeds the permissible threshold for the specified plan variation.

## CONSUMER SUPPORT AND RELATED ISSUES

### Provider Directory

It is required that QHPs to make their provider directories available to the Marketplace for publication online by providing the URL link to their network directory. The URL should link to direct consumers to an up-to-date provider directory where the consumer can view the provider network that is specific to a given QHP. The URL provided to the Marketplace as part of the QHP Application should link directly to the directory, such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer's website before locating the directory. If an issuer has multiple provider directories, it should be clear to consumers which directory applies to which QHP(s). Further, the directory is to include location, contact

information, specialty, and medical group, any institutional affiliations for each provider, and whether the provider is accepting new patients. We encourage issuers to include languages spoken, provider credentials, and whether the provider is an Indian health provider. Directory information for Indian health providers should describe the service population served by each provider, as some Indian health providers may limit services to Indian beneficiaries, while others may choose to serve the general public.

Provider directories should include the following statement - "For Native American plan members, IHS and 638 health facilities or other tribal health facilities will be included at in-network rates, even if they are not listed as part of the plan network." (See IHCA, Section 206(a) and (i) and 25 USC 1621e(a) and (i) and Title 45 Code of Federal Regulation, Part 156, Subpart E1.)

### **Complaints Tracking and Resolution**

We encourage consumers to report complaints and concerns to the Marketplace Call Center as well as to the issuers of the QHPs in which they are enrolled. CMS expects QHP issuers to thoroughly investigate and resolve consumer complaints received directly from members or forwarded to the issuer by the state through the issuer's internal customer service process and as required by New Mexico law.

### **Coverage Appeals**

QHPs are required to meet the standards for internal claims and appeals and external review established by NMAC 13.10. and all other state law as applicable.

### **Meaningful Access**

Issuers must comply with NMAC 13.10. and all other state law as applicable, and are encouraged to comply with the requirements that they ensure meaningful access by limited-English proficient (LEP) speakers and by individuals with disabilities. [http://www.lep.gov/interp\\_translation/trans\\_interpret.html](http://www.lep.gov/interp_translation/trans_interpret.html)