2027 Plan Year
Individual QHP and Small Group Market
Issuer Submission Guidance

State of New Mexico
Office of Superintendent of Insurance

Contents

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 and offer a major medical plan in the Small Group market. This guidance does not supersede any applicable provision of federal or state law and issuers 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. The Office of Superintendent of Insurance (OSI) will enforce all state and federal laws, regardless of whether they are addressed in this guidance.

Background

Operating in partnership with BeWell, the OSI is responsible for determining if a plan meets rate and form certification requirements. BeWell will determine compliance with BeWell based criteria and issue the certification for final offering on the marketplace. For more information on these requirements, please see the 2027 QHP Letter to Issuers, or contact BeWell at partners@nmhix.com.

Effect of Certification

A QHP certified for the 2027PY can be offered through BeWell, beginning October 15, 2026.

Contact

Please direct all questions regarding plan certification and this document to Brittany ODell at brittany.odell@osi.nm.gov.

Section II: Submission and Certification Timeline

2027 PY RATE REVIEW TIMELINE	
Activity	**Timeline**
Confidentiality Request	At least 10 days prior to filing submission date
Individual Form filing deadline	6/5/2026
Individual Rate and binder deadline	Two weeks from Marketplace Affordability Program guidance, no later than 6/19/2026
Small Group Form/Rate deadline (The applicable binder templates must be submitted under the Supporting Doc tab.)	6/29/2026
Risk Adjustment rate revisions	7/7/2020 - 7/14/2026
48-hour turn-around on issuer responses to Individual form and rate review objections	8/17/2026
24-hour turn-around on issuer responses to Individual form and rate review objections	8/24/2026
Approval, Certification and Transfer of Individual Plans	8/31/2026
48-hour turn-around on issuer responses to small group form and rate review objections	9/11/2026
URL Template Links and links in the plan documents to be live and active	9/15/2026
24-hour turn-around on issuer responses to small group form and rate review objections	9/18/2026
Approval of small group plans	9/25/2026
Open Enrollment Starts	11/1/2026

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.

Penalties may be assessed pursuant to NMSA 1978, Section 59A-1-18 and 13.1.5 NMAC when an issuer demonstrates willful disregard of this guidance or of formal directives issued

by OSI.

Willful disregard may include, but is not limited to:

- Refusal to implement language revisions necessary to demonstrate compliance with applicable state laws or regulations;
- Repeated failure to amend errors after notice and opportunity to cure; or
- Deliberate submission of materials that do not conform to clearly communicated requirements.

Penalties will not be assessed for inadvertent errors or good-faith compliance efforts. Penalty amounts will be determined based on the nature and severity of the willful non-compliance. Failure to meet the deadlines noted above may result in plan disapproval and preclude plan loading onto the BeWell website. Incomplete and inaccurate submissions will not be accepted.

To ensure the binder data is sent to BeWell in a timely matter, issuers may be required to respond to binder objections sooner than the standard 5 business days.

Section III: New and Important Information

The below items are new or amended requirements:

- Compliance with the Confidentiality Guidance
- 2027PY QHP Form Guidance and Rate Guidance
- 2027PY Forms Checklist and Rate Checklist
- New legislative requirements
- Mental Health Parity and Substance Use (MH/SUD) supporting documentation
    - Substantially All and Predominant Analyses for Quantitative Treatment Limitations and Financial Requirements
    - Policies and procedures related to MH/SUD clinical criteria development/selection and application
    - List of MH/SUD services and corresponding procedure/service codes that require prior authorization
- Requirement to offer at least one statewide bronze plan
- Requirement to cover specified sex-trait modification procedures
- Clarification on cost-sharing requirements for DME, including CRT devices.
- DME exhibit requirement
- Catastrophic Plans

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 Centers for Medicare & Medicaid Services (CMS) templates and tool screenshots. This information must be submitted under the Supporting Documentation tab of the Form/Rate filing.

Forms and the single risk pool rate information must be submitted in a Form/Rate filing. 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 issuer. 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 Summary of Benefits and Coverage (SBC) and referenced in the Plans and Benefit Template (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**
Issuer 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).

Issuer 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 the Health Care Authority (HCA) for the Health Care Affordability Fund (HCAF), and to participate in the Health Insurance Marketplace Affordability Program. The HCA will share separate guidance pertaining to the Marketplace Affordability Program Plan.

Off HIX Only Silver Plans

OSI strongly urges issuers to offer Off HIX **only** silver plan options, which will allow unsubsidized enrollees to purchase a silver plan at a lower premium and promote consumer choice by increasing the number of affordable, high actuarial value plans. If an issuer chooses to offer Off HIX only plans, please refer to Section VIII for Off HIX only template requirements.

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 BeWell's 2027 Letter to Issuers.

To be certified, issuers must meet the following criteria:

- The issuer must register in the Center for Consumer Information & Insurance Oversight, 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, NMSA 1978, Section 59A- 23F-12 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 approvals 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, and financial viability 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 2027PY 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, contract certificates with providers, and consumer assistance in New Mexico. Copies of the approved compliance documents shall be filed under the Supporting Documents tab of the Form/Rate filing in SERFF. Issuers should also use the Associated Filings function in SERFF to associate those filings.

A new to the market issuer who lacks available data or experience to support a required compliance filing shall not be disqualified from 2027PY 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 2027PY.

Limits on the Number of On-Exchange Non-Standardized Silver Plans

In the individual, on-exchange market, issuers must offer at least one Gold and one Silver plan and issuers 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. Issuers 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 or Bronze plans.

There is no limitation on the number of Silver, Gold or Bronze 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 2027PY 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.

Issuers must clarify in the "Eligibility" section of the EOC that a potential enrollee must live or work in the service area to be eligible, per 45 CFR 155.305(a)(3)(i).

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 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 certifying a QHP or approving a small group 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 binder filing for QHPs; for small group plans, under the Supporting Documentation of the Form/Rate filing. A copy of the Cover Letter template is available at: Cover-Letter_v1.xlsx
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 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 (QIS)

QHP Issuers must submit a Quality Improvement Strategy 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.

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, sexual orientation (45 C.F.R. 156.200(e)) or gender identity (13.10.41.8 NMAC), 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 MH/SUD parity state and federal regulations). 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 formulary must also fully comply with all state statutes and regulations, including, but not limited to, those outlined in the formulary checklist.
- Each formulary submitted should be checked independently against the formulary checklist. A separate checklist shall be submitted together with each formulary.

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 and Substance Use Disorder Parity

All individual and small group plans must comply with the applicable state and federal MH/SUD parity laws and regulations. Issuers should carefully review the federal Mental Health Parity and Addiction Equity Act (MHPAEA), , which are generally applicable to plan and policy years on or after January 1, 2027. Issuers must submit the following:

- Substantially All and Predominant Analyses for Quantitative Treatment Limitations and Financial Requirements.
- Note: OSI will provide a sample template plans may use for guidance. However, plans may instead use their own comparable template as long as, for each plan, issuers clearly show thorough documentation of the "substantially all" and "predominant" test for each Financial Requirement (FR) and Quantitative Treatment

Limitation (QTL) for each applicable classification, according to 45 CFR 146.136(c)(1)(ii) and 45 CFR 146.136(c)(3)(i).Policies and procedures related to MH/SUD clinical criteria development/selection and application

- List of MH/SUD services and corresponding procedure/service codes that require prior authorization

All MH/SUD materials must be submitted in the Form/Rate filing under Supporting Documentation and utilize the following naming convention. Please indicate "MH Parity Filing" before the document title of each of the above-listed MH/SUD parity filings. For example, "MH Parity Filing – (title of document__".

Issuers must comply with NMSA 1978, Sections 59A-23-22 and 59A-46-61, which were passed during the 2023 legislative session and effective on January 1, 2024. In addition, issuers must demonstrate compliance with state and federal MH/SUD parity laws and regulations throughout the year according to regular MH/SUD parity OSI compliance filings.

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 NMSA 1978, Sections 59A-22-56, 59A-23-15, 59A-46-56, 59A-47-50.

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

All individual market health insurance issuers offering Qualified Health Plans on BeWell, New Mexico's Health Insurance Marketplace during the 2027 Plan Year are required to offer 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 2027, each Turquoise variant must closely resemble the general features of its standard variant, unless otherwise specified in the 2027 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.

The HCA will release additional information about Turquoise Plan requirements in the 2027 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 BeWell, New Mexico's Health Insurance Marketplace during the 2027 Plan Year are required to offer Standardized Health Plans adopted by the BeWell 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. Additional information about the Standardized Health Plans is available on the Health Care Authority website.

Issuers must fully adhere to the prescribed cost-sharing and cost-sharing structure and should not set a separate fee or cost-sharing structure unless specifically directed to do so.

Bronze Plans

To promote great affordability and ensure the availability of lower-premium options for consumers, BeWell will require all QHP issuers to offer at least one statewide Bronze plan. Issuers must also clearly indicate whether any bronze plan has been designed using the expanded MOOP.

Catastrophic Plans

Issuers must explicitly identify any catastrophic (CAT) plans offered. OSI will not permit multi-year CAT plans; all CAT plans must be filed and approved on a single-year basis. Issuers must also clearly indicate whether any CAT plan has been designed using the expanded MOOP.

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

QHP Issuers must comply with all federal laws and regulations pertaining to coverage for AI/AN individuals, including 42 U.S.C. 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

All issuers, including those offering small group plans and non-mirrored Off Exchange (HIX) only individual plans, are required to submit completed binder templates and screen shots of the review tools outputs. For all non-QHPs, issuers must submit this information under Supporting Documentation in the Form/Rate filing.

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.

Rate-related information will not be set for public access during the QHP review period. Public Access will be allowed once all filings are dispositioned. For more information regarding confidentiality requests, please refer to the Confidentiality Guidance.

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

Please refer to the Rate Guidance for more information.

Actuarial Memorandum

Rates must be supported by a detailed Actuarial Memorandum. The following must be described in detail in the Actuarial Memorandum: non-essential health benefits, value added offerings, wellness programs, and quality improvement initiatives.

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 the 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 On HIX Individual plan templates must be submitted in the Binder filings. Issuers must submit small group and non-mirrored Off HIX only plan templates under Supporting Documentation in the Form/Rate filing. Off HIX only and small group plans must submit the following templates in .xlsm format:

- ECP/NA
- PBT
- Prescription Drug
- Service Area
- Network ID
- Rate Data

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 2027 Plan Year by August 17, 2026. Issuers who want to withdraw a previously issued plan from consideration must submit a formal request for withdrawal to OSI and BeWell. A formal request is only required if the plan was included in the binder. OSI will not allow issuers to withdraw a plan after initial rates are posted on the CMS website.

Issuers must submit red-lined versions of approved plan forms, along with a summary of the material changes, such as changes in benefits, changes to prior authorization processes or services that require prior authorization, definition changes, etc. The redlines and summaries should be submitted as a PDF. Issuers may upload redlined versions to the Forms Schedule during the review but must upload clean versions before the plans are certified.

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 in 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

Issuers 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.

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

- **IssuerName**: Up to 6 Characters which identify the issuer
- **MMDDYY**: e.g., 010127 for filings effective January 1, 2027
- **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_01012027_i_MEDOn_v1_RTCK. Xlsx is the initial 2027 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_010127_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 issuers should use the following naming convention:

IssuerNameMMDDYYmkt_ SBC_Mtlvl_Filedescrp__Zero_On_HSA_Ded_Cop_ v#

- **IssuerName**: Up to 6 Characters which identify the issuer
- **MMDDYY**: e.g., 01012027 for filings effective January 1, 2027
- **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)

HIOS Plan IDs

QHP issuers must establish a unique HIOS Plan ID for each plan it offers and may not reuse HIOS plan IDs. In other words, once a plan has terminated, its HIOS plan ID may not be associated with another plan.

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. Plan names cannot exceed 270 characters. A plan name that exceeds 90 characters will not fully display unless the consumer hovers over the name. 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 "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 NMSA 1978, Section 59A-16-13.1; and the following articles in the Insurance Code: 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 2027 QHP maximum out-of-pocket will be
  - $12,000 for self-only coverage and $24,000 for other than self-only coverage
- For 2027 health savings account (HSA) eligible high-deductible health plan (HDHP) plans, the maximum out-of-pocket will be
  - Pending IRS announcement
- For 2027 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
  - $9,600 for self-only coverage and $19,200 for other than self-only coverage
- For the 87% and 94% AV silver plan variations, the maximum out-of-pocket will be
  - $4,000 for self-only coverage and $8,000 for other than self-only coverage

For plans 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 2027.

Issuers must indicate if any bronze or CAT plan has been designed using the expanded MOOP.

Wellness Plans or Other Value-Added Products or Services

Rates shall not include the cost to the issuer 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 cost of these offerings, if any, may only be borne by the member as part of a separate and express agreement. A value-added product or service notice must be filed as outlined in the Value-Added Products and Services Filing Instructions.

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.

New and Amended Legislative Requirements

The EOC must demonstrate compliance with recent legislative changes, including:

- HB 38 – Wheelchair Coverage (language requirements outlined below)
- HB 306 - Prohibit Certain Health Care Facility Fees (standard language included below)
- SB 20 – Prior Authorization & Prescription Drugs

EOC

- The EOC must include all provisions enforceable under the insurance contract and specify all covered benefits, services, exclusions, and 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.

- 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 skilled nursing facilities.

- Vision benefits may 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 and costs for the benefit are not separate from the base rates**. Vision benefits embedded in an HMO may offer out-of-network services and benefits. Vision endorsements must be submitted in the major medical Form/Rate filing and should not be submitted as a stand-alone vision Form/Rate filing. OSI will reject vision endorsements that are submitted in a separate, stand-alone Form/Rate filing. **This applies to both individual QHPs and small group plans.**

- Each EOC or Certificate of Coverage (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 TMJ benefits aligns with the applicable service. For example, if the person needs prescription drugs, their cost-sharing will be the prescription drug cost-sharing. If they receive outpatient surgery, their cost-sharing will be outpatient prescription drug cost-sharing.

- Each EOC or COC must clarify that the immunizations are covered based on recommendations from the Department of Health, as required under §59A-16-2(G).

- Each HMO EOC or COC must contain language stating that out-of-network Urgent Care is covered if a person cannot reasonably access an in-network Urgent Care center, per 13.10.21.8(D) NMAC.

- Each EOC or COC must address HB 306 by including the following language: "New Mexico's Fair Pricing for Routine Medical Care Act limits when medical facilities may charge facility fees. We recommend checking with the facility at the time you schedule your appointment—and again when services are provided—to determine whether any facility fees apply. You may contact the New Mexico Department of Health if you have concerns that a facility fee is being charged improperly."

- Per 13.10.41 NMAC, each EOC or COC must state that medically necessary specified sex-trait modification procedures will be covered. The EOC should also clarify that the applicable cost-sharing will depend on the category of services.

- Each EOC or COC must clarify that coverage is provided for durable medical equipment (DME), which includes complex rehabilitation technology (CRT) devices. The COC or EOC must list the equipment covered under the regular DME category and indicate that the cost-sharing for this equipment is indicated in the SBC under the DME category. It's OSI's expectation that regular DME will continue to be covered at the same level of cost-sharing as in previous years.

  The EOC or COC must also list the devices that fall under the CRT devices category and clarify that the applicable cost-sharing for these devices aligns with the inpatient medical/surgical benefit in the SBC. Only a device that meets the definitions under Sections 59A-16-21.4(B), 59A-22-62(N), 59A-23-32(N) and 59A-46-72(N) may be listed as a CRT device.

- URL links in the template and consumer-facing documents should be active as soon as

possible and no later than 9/15/2026. Affiliated content is subject to OSI's review and approval.

Standardized Benefit Language

To encourage consistency across issuer EOC, clarity in the language and a streamlined review process, OSI strongly encourages issuers to adhere to the standardized language.

- The intent of the standardized language is to address covered services, specifically those services outlined in the EHB. The language is **not** meant to be all encompassing or comprehensive. Issuers must include language for all provisions that are not addressed.
- Issuers are welcome to offer a more generous benefit than what is contemplated in the standardized language by removing exclusions, adding additional services, or amending exclusions to be less restrictive.
- Issuers are also welcome to add clarifying language, such as under what circumstances a service is covered, clarification that coverage for out-of-network services applies only to covered services or under what category the benefit falls. OSI will closely review this language to ensure it is not overly restrictive and fully complies with state and federal law.
- Issuers are not required to keep the language in the same order and are welcome to move sections around and reformat to align with their EOCs. For example, if an Issuer uses a prescription drug rider, they may move the prescription drug language there. For small group plans, issuers may move certain policy provisions that only affect the policyholder to the policy as opposed to the certificate.
- The standardized language uses "you" and "we" throughout to make the language more readable to consumers, but issuers may use other terminology such as "covered person."

Issuers **must** include the standardized language OSI issued via bulletin to address the following items:

- Behavioral health cost share elimination – Bulletin 2025-007
- Pre-exposure Prophylaxis – Bulletin 2022-016
- Prior Authorization requirements – Bulletin 2025-007
- Out-of-Network Care and Balance Billing – 2025-007
- Contraceptive Coverage – Bulletin 2021-029
- Mental Health and Substance Use Disorder Service Coverage – Bulletin 2024-013

For behavioral health, issuers may clarify that cost share elimination applies to in-network services only.

Summary of Benefits and Coverage (SBC)

An SBC must comply with the standards set forth 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. The SBCs must be designated as "POLA" in the "Form Schedule" tab.

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 following **(not all requirements apply to zero cost-sharing plans):**
    - The $25 cap on insulin
    - No cost sharing for COVID testing and treatment
    - No prior- authorizations for gynecological or obstetrical ultrasounds
    - Cost-sharing parity for physical therapy and PCP visits
    - Same level of cost-sharing for emergency out-of-network services
    - No balance billing for out-of-network services.
    - The plan accepts plan accepts cost-sharing accumulation for any third-party payment (such as a drug manufacturer's coupon) and that the rebate will count towards to the insured's cost-sharing
    - Cost-sharing for prescription drugs must be successive for each tier Preventive and behavioral health care must reflect "No Charge"
- 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?". 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, issuers must add "Deductible does not apply in the column." The absence of this disclaimer means the deductible applies.
- Each separate network tier and associated cost-sharing must be properly identified in the SBC.
- If all material plan elements are the same in the zero cost-sharing plans, Issuers may submit one SBC 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. Issuers are required to bracket the plan marketing name and HIOS ID number. The SOV must explicitly state that these will change to accommodate the correct name and number and include a list of all names and numbers that may appear. Issuers must continue to pay the fee for each zero-cost sharing plan variation.
- 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 is required for each mirrored plan.
- 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.
- 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.

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)

Not all the requirements listed above apply to small group plans.

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 9/15/2026. URL links contained within the URL template must be live and active no later than 9/15/2026.

Plan Brochures for the Plan Brochure links in the URL must be submitted as soon as possible but no later than 8/24/26 so OSI has sufficient time to review and approve the brochures before the links are live. Please email Dianne Simmons at Dianne.Simmons@osi.nm.gov when the plan brochures are submitted.

Supporting Documentation

Issuers must submit an exhibit demonstrating compliance with the cost-sharing requirements under HB 38. The exhibit should clearly identify:

- The equipment covered under the standard DME benefit, and
- The CRT devices and accessories assigned to the higher tier that will be subject to the inpatient medical/surgical cost-sharing requirements. Only a device that meets the definitions under Sections 59A-16-21.4(B), 59A-22-62(N), 59A-23-32(N) and 59A-46-72(N) may be listed as a CRT device.

Issuers should present this information as it applied for the 2026PY and as it will apply for the 2027PY. OSI expects the 2027 cost-sharing for standard DME to closely align with the cost-sharing applied in 2026.

SERFF Template Requirements

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 (not applicable to small group)
7. URL Template (not applicable to small group)
8. Plan ID Crosswalk Template (not applicable to small group)
9. Prescription Drug Template
10. Rate Data Template (should not include rates based on tobacco usage in the individual market)
11. Service Area Template
12. Transparency in Coverage Template (not applicable to small group)
13. Unified Rate Review
14. Silver to Gold Mapping Template (not applicable to small group)

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.

Benefits Explanation

To ensure the PBT clearly indicates all services that are covered, issuers should indicate that the below services are covered and 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.

While issuers already mark the services below as covered, these services should include an explanation, so consumers understand the scope of coverage:

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

- **TMJ** – The benefit explanation should say "Listed cost-sharing is applicable to Outpatient Surgical Services only. See EOC for cost-sharing information for all other services" The populated cost-sharing should align with the "Outpatient Surgery Physician/Surgical Services" cost-sharing.

Sex-Trait Modification Services

Since the cost-sharing depends on the category of service, issuers should **not** add this category to the PBT.

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 2026 QHP plan ID and service area combinations to a 2027 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 .csv formats.**

For the 2027PY, 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.

HIOS IDs for terminated plans may not be reused.

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. Please note that Issuers are required to enter a link in the "Payment" category. Please refer to the URL template for instructions.

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)

Issuers must submit complete and upload the SOPA templates.

Transparency in Coverage

45 C.F.R. 155.1040(a) and 45 C.F.R. 156.220 requires 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 26, 2026.

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 2027 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**.

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 NMSA 1978, Sections 59A-19-4 and 59A-22-2:

- 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. A singular Flesch score may apply to the entire policy document, pursuant to NMSA 1978, Section 59A-19-4(E).
- 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, Section 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 issuer must pay for 3 form and rate packages or ($30+$50) x3=$240. Note that if an issuer 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. Issuers may mark the plan name, as well as other administrative information as variable, as long as they provide SOV describing the variability.

Indicate clearly, "No cost-share (co-pay, deductible, co-insurance) for covered behavioral health care services".

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 the issuer accepts these discounts and rebates and they count towards the insured's cost-sharing, per NMSA 1978, Section 59A-22-53.3.

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 issuer 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.

Quarterly Updates

If an issuer intends to update rates, filings must be submitted to OSI at least 105 days in advance of the effective date to allow for adequate review time.

Section X: Confidentiality Request Policy

OSI recognizes that issuers 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 actuarially sound rates with their initial QHP application. Please refer to the Confidentiality Request guidance.

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.

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 45 C.F.R. 155.220(c)(3), 45 C.F.R.
155.221, or 45 C.F.R. 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 NMSA 1978, Section 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, 2025, through January 15, 2027, 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).