Frequently Asked Questions

As the New Mexico Health Insurance Exchange (NMHIX), also known as beWellnm, transitions to a full state-based exchange (SBE), we are providing this FAQ document to provide information about the transition and operations as an SBE. These FAQs are primarily for the use by carriers. Additional information will be published in the forthcoming NMHIX Policy Manual. If you have additional questions, please email them to SBE-Transition@nmhix.com.

To help navigate our frequently asked questions page you can click on the links below.

Communications and Notices

Are member notices available for review or will they be shared with carriers?

- Only notice templates will be shared with carriers and will include timelines of when notices are sent to members. Carriers will not receive copies of notices sent to members. A full list of member notices will be provided in the forthcoming NMHIX Policy Manual.

What methods of communication will be available to members for delivery of correspondence?

- Members can select paper or electronic delivery as their communication preference. Electronic delivery is a notification by email or text (based on member preference) that a notice is available in their secure inbox. Carriers will not receive an indicator of the selected delivery preference; members will need to contact their carrier to provide this.

Will beWellnm send renewal notices?

- We will send both preliminary and final renewal notices to members beginning with plan year 2022 coverage. A full list of member notices will be provided in the forthcoming NMHIX Policy Manual.

Will beWellnm have an IVR?

- We will use an IVR to support calls.

What calls will beWellnm handle versus the carriers?

- BeWellnm's Customer Engagement Center will handle all calls related to eligibility and enrollment, including questions about billing and payments. Carriers will continue to service their members for claims and medical care questions.
- Carriers can redirect Exchange related calls to beWellnm's Customer Engagement Center. When the beWellnm staff determines a caller requires interaction with the carrier, the caller will be transferred to the appropriate carrier call center.

Go to top of page

Member Data Migration and Transition

Will CMS send existing 2021 member data to NMHIX?

- There will be data migration from Healthcare.gov to the beWellnm platform beginning in the fall of 2021. Additional information about data migration and renewal process is available here.

How will eligibility changes and premium adjustments for 2021 and 2022 be managed?

- Individuals will be required to log into Healthcare.gov for changes that impact 2021 plan year coverage; All changes for 2021 will be managed on Healthcare.gov.
- Individuals will be required to log into the beWellnm platform for changes that impact 2022 plan year coverage.
- Premium adjustments will be billed by beWellnm for 2022 coverage months only; carriers will be responsible for 2021 coverage months.

What is the cutoff date for applying on Healthcare.gov?

- Individuals will continue to access Healthcare.gov to make changes to their coverage for 2021 and earlier as long as FFM allows it. Healthcare.gov will not process 2022 enrollment transactions.

- The FFM portal will notify the consumers via online banners and other communication channels that applying/renewing for coverage for Plan Year 2022 will occur on the beWellnm platform and applying/renewing for Plan Year 2021 will occur on the FFM platform.

How are credits handled for members that overpay their 2021 premium?

- Premium payments made in advance to carriers for coverage months beyond December 2021 should be refunded directly to the member by the carrier.

Will carriers invoice members for 2022 coverage?

- Carriers will discontinue invoicing members after December 2021 coverage. NMHIX will begin invoicing members for coverage beginning January 2022.
- Carriers should include content on their member portal instructing members to make payment through the member's beWellnm account. Members will be able to login at www.beWellnm.com.

Will NMHIX provide a different Trading Partner ID for carriers?

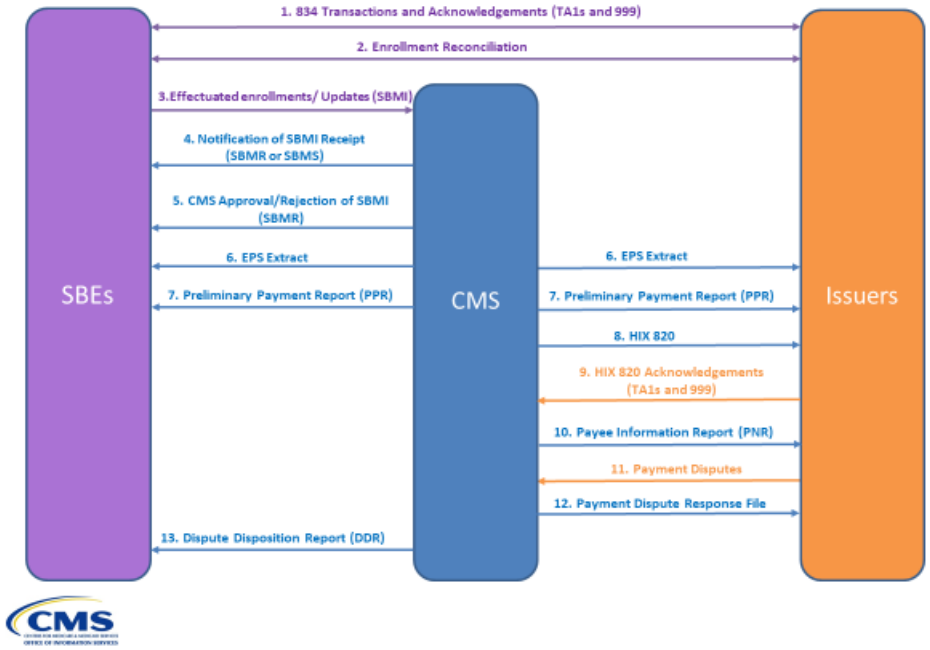
- The carrier's Trading Partner ID will remain as assigned by CMS -- the existing HIOS ID.

Will carriers continue to receive monthly 820s from CMS for APTC?

- CMS will continue to submit 820s and payment for APTC to carriers. The timing of the APTC payment from CMS to the carriers will not change as this is not a NM SBE prescribed process or timeline.
- Carriers will continue to receive the Preliminary Payment Report (PPR) from CMS ahead of the actual payment and delivery of the 820. NMHIX will also receive this report for informational purposes.

Are there changes to the Policy-Based Payment process?

- NMHIX will begin submitting SBMI files to CMS beginning with plan year 2022 coverage to notify CMS who has paid, so that CMS knows to pay APTC. NMHIX will provide SBMIs at least monthly to CMS that coincide with the CMS monthly payment cycle.
- Carriers will continue to communicate policy-based payment disputes to CMS.



How does effectuation impact subsidy payments and the NMHIX SBMI file to CMS?

- Coverage must be effectuated in order for members to appear in the SBMI file.

Go to top of page

Application and Enrollment

What happens if a member's ZIP code crosses counties, (e.g., a ZIP code that could be considered in both Bernalillo and Valencia counties).

- The user will have to select the county they live in. If there are multiple counties for the ZIP code, the user will have an option to select the county.
- We will be completing address verification for mailing notices and will create a back-end review process to verify county selection, if necessary.

What will be the system of record for the State Based Exchange?

- For Plan Year 2022 coverage and beyond, the beWellnm platform will be the system of record for all QHP eligibility, including APTC/CSR, QHP enrollment, demographic, premium billing and premium payment information. Any changes in demographic information must be reported directly to beWellnm by the individual. Eligibility, enrollment and demographic information and subsequent changes will be communicated to carriers via 834 files.

What are the requirements for carrier assigned IDs?

- The beWellnm platform will support a 30-character string. The ID must remain unique and should not change throughout the individual's enrollment with the carrier.

When is an enrollment effectuated?

- A member's enrollment effectuation is triggered by their binder payment. Effectuation is a multi-part process. Upon receipt of binder payment, the Exchange transmits the 834 enrollment EDI to Issuer, Issuer responds with a TA1/999 acknowledgement of the 834 EDI, and then subsequently, the Issuer transmits an effectuation file back to the Exchange, thereby completing the enrollments effectuation. An individual may shop for and enroll in a health plan through beWellnm (i.e., create an account, apply for coverage, and make a plan selection) without paying a premium, but the enrollment will not be effectuated.

When is Open Enrollment for 2022?

- The Open Enrollment Period for NMHIX will be November 1, 2021, through January 15, 2022.[1]

Does NMHIX assign providers to members?

- No. NMHIX will not assign providers to members.

What are the NMHIX reinstatement rules?

- Reinstatement rules are based on 45 CFR 155.430(e). NMHIX will process reinstatements, which will then be submitted on an 834 to carriers if approved.
    - An Individual terminated due to non-payment of premium may request to have their policy reinstated through NMHIX. All other reinstatement requests must be submitted through the appeal process. If terminated for non-payment, the Individual must pay all premiums, including premiums owed for coverage during the grace period and premiums for coverage months since the end of the grace period.

[1] Subject to final Board approval

- Upon approval of a reinstatement, the Individual and any dependents will be reinstated in their previous coverage.
- An Individual may be reinstated only once per calendar year.

Who validates eligibility for Special Enrollment Periods (SEP)?

- Beginning with plan year 2022 enrollment, NMHIX will validate SEP eligibility. The validation process will begin within 1 day of submission through the beWellnm Platform.

Is the member effective during the SEP validation process?

- Applicants will be allowed to shop and enroll, even in instances when additional information is necessary to validate their SEP eligibility.

Is there an appeal process for SEP denials?

- Yes. NMHIX will provide the appeal process in the member's denial notice. Additional information about appeals can be found in the Policy Manual.

How are member-requested terminations handled?

- A member may voluntarily terminate their health insurance coverage for any reason at any time. A member may end their health coverage without terminating their dental coverage, or terminate their dental coverage without terminating their health coverage. Members and/or their authorized representatives can report the death of a family member to terminate the member's enrollment.
- The termination date is always the last day of the month in which the termination is requested, except for termination due to death which will be the date of death.

Can a member request a retroactive termination?

- Retroactive terminations and cancellations will be allowed only in the following circumstances:
    - The member demonstrates to NMHIX that he or she attempted to terminate the enrollment and experienced a technical error that did not allow the termination to be submitted.
    - The member demonstrates to NMHIX that his or her enrollment through NMHIX was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.
    - The member demonstrates to the Exchange that he or she was enrolled through NMHIX without his or her knowledge or consent by any third party.
- Members must make the retroactive termination request within 60 days after discovering the error or enrollment.

Can a carrier request a member termination?

- A carrier will be able to request to terminate a member's coverage if it is rescinded in accordance with 45 CFR 147.128. In such cases, a carrier may terminate a member's coverage through NMHIX if a member performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact in connection with the member's coverage.
- The carrier must provide 30 days advance written notice to each member or participant affected by the intended termination. NMHIX will also provide the member notice of the termination.
- In cases of fraudulent activity, the effective date of the termination may be retroactive. NMHIX will refund any premiums paid by the member for the period after the retroactive effective date of termination, and CMS will recoup any APTCs or CSRs paid for that period.

Will members be able to select a broker/agent on beWellnm portal?

- A member will be able to select a broker/agent on the beWellnm platform. The agent information will be passed to the carrier on the 834.

Go to top of page

Premium Billing & Payment

When are premium bills generated?

- Premium bills will be generated on the 5th of the month for the following coverage month.

How are changes to an enrollment billed?

- Any changes to a member's enrollment that impact their premium will be included as an adjustment in the next month's premium bill if the change is made after the billing cycle. NMHIX does not have a rebilling process.

How are members billed for health and dental coverage?

- Members will be billed for both health and dental in a single monthly invoice. Members will make a single payment for both health and dental.

When do members begin making payments to the Exchange?

- Members will begin making payments to the Exchange for coverage effective January 2022 coverage. For example, binder payments for coverage beginning January 1, 2022, must be paid to NMHIX by December 23, 2021. See answer to "What are NMHIX binder payment rules?" below.
- Members will continue to make payments to their carrier for outstanding premium for coverage months prior to January 2022.

What are the due dates for premium payments?

- Initial binder payments will be due by the 23rd of the month preceding the first coverage month. For example, binder payments for coverage beginning January 1, 2022, must be paid to NMHIX by December 23, 2021.
- All other premium payments will be due the last day of the month before the month of coverage (i.e., January 31, 2022, for February 2022 coverage).

Will NMHIX have thresholds for premium payments?

- NMHIX will implement a premium payment threshold policy of $10.
    - If the payment amount is short by $10.00 or less, he/she will not be considered delinquent and avoids triggering a grace period.
    - A binder is considered to be paid in full as long as the payment is within $10.00 of the account balance (or premium bill amount).
    - If a member continues to underpay and the accumulated underpayment amount exceeds the threshold, the member will have failed to make a payment and a grace period will be triggered.
    - The premium payment threshold no longer applies for members in a grace period. The member must make all past-due payments in full.

What are the binder payment rules?

- Members must make their binder payments by the 23rd of the month prior to the month of coverage. For a qualified SEP, the payment is due on the 23rd of the month or within 7 days after requesting the enrollment, whichever is later.
- NMHIX requires binder payments for renewals because the Exchange is responsible for billing. The cleanest, simplest process will be to collect the binder prior to sending enrollments, both new and renewing. This also forces the delinquency, termination, and reinstatement cycles to be specific to a plan year enrollment and avoids them bridging a renewal cycle.
- The payment threshold of $10 applies to the binder. If the initial monthly premium (aka binder) is less than $10, the member will be effectuated immediately, even if the binder payment is not made.

What happens if a member overpays their premium?

- If a member overpays their premium, only the premium amount billed will be sent on the 820. The remainder will either be applied to a subsequently billed month and appear on a future 820, or be refunded if terminated.

Will members need to enter banking information for their recurring payments with NMHIX?

- Member's banking information for recurring payments will need to be provided by the individuals. This information will not be transferred from the Carriers. The bank funds transfer details are not included in the carrier 820 file.
- Recurring payments can only be set up after a policyholder has made their initial payment in full.

When is the recurring payment run date?

- The recurring payment process is run once a month. Payments will be deducted from the policyholder's account on file on the 18th of the month for the following coverage month.

What are the grace periods for individuals?

- Individuals have a grace period before their coverage is terminated for non-payment. If premium payment has not been received by NMHIX on or before the first day of the coverage month, a grace period is triggered. The grace period is different for enrollees who receive an APTC:
  - With APTC, the grace period is 90-days
  - Without APTC, the grace period is 30-days
- If a policyholder is eligible for an APTC but elects not to receive the credit in advance, they do not qualify for the 90-day grace period. The 90-day grace period only applies to Enrollees who are receiving an APTC.
- Partial payments will not adjust a grace period.

Do grace periods apply to dental?

- Grace periods are applied at the policy level and applied to both health and dental. If the total is not paid in full, or within the $10 total threshold, the premium will not be satisfied.

What notices are sent when a member is late making their payment?

- NMHIX will send Late and Termination notices to members in a grace period. Notices are sent on the 1st of the month.

Late Notice	Month 1	Month 2	Month 3	Month 4
APTC	✓	✓	✓	
Non-APTC	✓			

Termination Notice	Month 1	Month 2	Month 3	Month 4
APTC				✓
Non-APTC		✓		

- Late Notice - Notifies the policyholder that their premium payment has not been received and they must remit payment to avoid termination for non-payment of premium. The notice includes the grace period, coverage month(s) outstanding and amount due. The notice will include coverage months billed since the grace period.
- Termination Notice - Notifies the policyholder that their policy has been terminated. The notice includes the termination effective date and reason for termination.

How will the carrier know to pend claims for members in a grace period?

- NMHIX will indicate when a member is in a grace period with 'Pend' and 'Unpend' flags in the daily 834. This will be sent in the 2750 loop with qualifier of PEND/UNPEND and includes a date in the DTM. Refer to the 820 and 834 Companion Guides for more information.

How are member refunds handled?

- NMHIX Finance will handle all member refunds. Carriers will see an adjustment in the 820 after the refund has been processed in the beWellnm platform.

How are returned payments handled?

- NMHIX will adjust the members account accordingly and will notify the member of the return and will request a replacement payment.
- Carriers will see an adjustment in the 820 with coverage month provided.

Can members pay dental premium only or must they pay both health and dental?

- Members must pay both health and dental premium to be considered paid in full. Payment is accepted at the account level, meaning if medical and dental policy exists and the total amount is not paid in full, or within the $10 total threshold, neither policy will be sent to carriers. For new and renewing policies, the binder will not be considered satisfied.

What if a member sends a payment to a carrier directly?

- Premium payments made directly to a carrier for coverage months beyond 2021 must be forwarded to the Exchange. The procedure is as follows:
    - Endorse the back of the check/money order - "Pay to the order of NMHIX"
    - Mail to the Exchange lockbox:
        - NMHIX
          PO Box **TBD**
          Albuquerque, NM
    - Provide NMHIX a weekly report of direct to carrier payments using the template below. The process for submitting the report will be provided at a later date.

        - For members in a grace period, the carrier shall send a secure email notification to the NMHIX Premium Billing department at <email> to ensure the account is marked as paid to avoid termination for non-payment. The email should include the following information:
            - Subject line: [Carrier Name] Premium Payment
            - Content: Member name/ID
            - Payment amount
            - Date received

Will NM be charging a user fee for 2022?

- NMHIX assesses all major medical (and Medicaid) carriers in the market and does not add a user fee to the premium bill. See *Article XIII* of the beWellnm Plan of Operations for more details.

Go to top of page

FORM 1095-A Health Insurance Marketplace Statement

Will NMHIX send Form 1095-A to members?

- NMHIX will begin providing Form 1095-A to individuals enrolled in QHP and Stand-Alone Dental Plan (SADP) coverage through NMHIX with plan year 2022. The 1095-A Forms will be sent prior to January 31 each year and sent according to the account holder's notification preferences. The form can also be accessed through the applicant's NMHIX online account.

What if a member did not receive their 1095-A or it is incorrect?

- In cases when an applicant believes their 1095-A document is incorrect, they can request a correction review by contacting the beWellnm Customer Engagement Center. Additionally, members can call the Customer Engagement Center in the event they did not receive their 1095-A form.

Go to top of page

EDI Transactions

Where can I get the EDI specifications for 820 and 834 files?

- For rules related to format and content of EDI transactions, and managing the exchange of EDI transactions between NMHIX and carriers, refer to the 820 and 834 Companion Guides . The 820 and 834 Companion Guides address the EDI requirements for the Individual SBE.

When will payment and 820 files be sent to carriers?

- Both premium aggregation and 820 files from NMHIX to the Carriers will be sent monthly on the 2nd business day of the month.

What is the purpose of the 820 and 834 discrepancy files?

- The purpose of the discrepancy files is to support the carriers with the management of enrollment in their enrollment/claims system.

Will NMHIX require a confirmation file from the carriers?

- Participating carriers must provide TA1/999 and Effectuations in order to participate in the Exchange. NMHIX shall expect effectuation for members for the following:

- A new plan is shopped at the Exchange
  - initial
  - change in CSR variant
  - change of plan
  - renewals (change in policy year)
- A new member is getting added to an existing plan
- A plan is being reinstated

How will the carriers reconcile enrollment with NMHIX?

- NMHIX will provide carriers with a full monthly 834 audit file and carriers will be responsible for reconciling their own enrollment. NMHIX will continue to provide daily 834 files to report changes that occur during the month. A reconciliation guide will be provided to explain the process and what will be required of carriers.

Will the reconciliation discrepancy process/format be similar to the FFM Enrollment Resolution & Reconciliation (ER&R) process?

- The reconciliation process will not be similar. A reconciliation guide will be provided to explain the process and format.

For Reconciliation, how does beWellnm determine which data is accurate?

- The beWellnm system will be considered the source of truth. The reconciliation process will ensure that data is accurate in both NMHIX and carrier systems allowing issues identified by carriers to be reported to the Exchange. This also allows carriers to validate that both premium revenues generated from participation on the exchange is supported by the enrollment records loaded in the carrier's enrollment/claims system.

Go to top of page

Plan Management

How do carriers set up an account on beWellnm's Plan Management portal?

- A step-by-step process will be shared with the carriers as a part of the Carrier onboarding process. It will be a straightforward process where the carrier administrator will receive an email to come on to the platform and register by providing their name and email address.

Will carriers continue loading templates directly into SERFF?

- Yes, the process with SERFF will remain the same, as carriers will continue loading templates directly into SERFF. You can view the Plan Management presentation for more information.

When will users be able to view plans available for Plan Year 2022?

- We expect that users will be able to view plans available for Plan Year 2022 as of October 1, 2021, through the anonymous ("window") feature. Please see the Letter to Issuers for more information. At that time users will be invited onto the system to claim their accounts which have been transferred from Healthcare.gov. This occurs in preparation for Open Enrollment starting November 1, 2021.

Go to top of page

Acronyms and Descriptions

ACRONYM/TERM	DESCRIPTION
ACA	Affordable Care Act
AI/AN	American Indian or Alaska Native
APTC	Advanced Premium Tax Credit
beWellnm Platform	New Mexico Health Insurance Exchange's consumer facing online marketplace
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CSR	Cost-Sharing Reduction
EDI	Electronic Data Interchange
EFT	Enterprise File Transfer
Exchange	New Mexico Health Insurance Exchange
FDSH	Federal Data Services Hub
FFE	Federally Facilitated Exchange
FFM	Federally Facilitated Marketplace
FPL	Federal Poverty Level
FTI	Federal Tax Information
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HSD	New Mexico Human Services Department
Hub	Federal Data Services Hub
NMHIX	New Mexico Health Insurance Exchange
OEP	Open Enrollment Period
PA	Primary Applicant

QDP	Qualified Dental Plan
QHP	Qualified Health Plan
SBE	State Based Exchange
SBM	State Based Marketplace
SEP	Special Enrollment Period
SFTP	Secure File Transfer Protocol
SHOP	Small Business Health Options Program

Go to top of page