New Mexico Health Insurance Exchange

Policy Manual for Plan Year 2022

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x. Publication Dates and Updates

This manual will be updated annually, or as required, based on changes in federal law, state law, or as directed by the New Mexico Health Insurance Exchange Board of Directors. A draft of the manual will be published for public comment before final publication. A draft version was released for comments on July 16, 2021. This version has been updated based on those comments and is being released on September 7, 2021. A summary of the changes is included in the table below.

Revision History

Date	Section	Summary (if applicable)
7/16/21		Initial Publication
9/3/21	1.2	Added Glossary and Acronyms and moved the section to an Appendix
	2.4	Updated the link to the web page for the "Everyone Qualifies for Coverage" brochure.
	2.4.4	Updated list of taxable income examples
	2.4.6	Updated information for tax household
	2.4.11	Updated employer sponsored insurance affordability standard for 2022, as published by IRS (https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36)
	2.5 and 2.5.2	Updates for clarification
	2.6	Removed description of eligibility for Catastrophic Plans, because catastrophic plans will not be offered on the Exchange for Plan Year 2022
	3.3.2.2	Clarified qualifying event for loss of Medicaid coverage
	4.3.1	Added information about selecting a new dental plan for the renewal year.
	4.4.3	Added contact information for the rescission process.
	4.4.4	Removed definition of cancelation; added reference to *Section 8 Appeals, Complaints and Grievances*
	5	Corrected error
	5.2.5	Added information about transferring payments to NMHIX which were made directly to carriers.

	5.3.1	Updated the grace period from 30 days to 31 days for enrollees without APTC; editorial corrections.
	5.4	Removed statement that the notice would be sent to the broker.
	5.4.2	Added language to clarify that this notice is sent by the Exchange.
	5.4.8	Clarified that applicable refunds will be paid automatically but may be requested sooner by an individual.
	6.2.1	Added information about the channels for reporting changes
	8	Added subsection 8.1 about Complaints and Grievances
	9.1	Updated the section to clarify the general description of the renewal process and timeline.
	9.2	Added information about the timeline for renewal notices.
	9.2.1	Clarified that SEPs would apply for members of plan that exits the Exchange before the end of the year.
	10.7	Editorial corrections.
	12	Editorial updates to descriptions.
9/7/21	Appendix	Added terms and acronyms
9/7/21	Throughout	Editorial corrections.

1. Overview

1.1 Purpose

The purpose of this document is to provide the following:

- Important information for consumers and stakeholders about the operational policies of the New Mexico Health Insurance Exchange (NMHIX), also known as beWellnm.
- A tool for the proper handling of consumer cases.

1.2 Definitions and Acronyms

See the Appendix for definitions of common terms and acronyms.

1.3 Resources

The beWellnm Help Center hosts a variety of useful articles, ranging from information about the Affordable Care Act to information about getting assistance with applications. Please visit www.beWellnm.com to learn more. We may also be reached through our Customer Engagement Center at 1-833-862-3935 (TTY: 711), or by chatting with a customer service representative via the website.

2. Eligibility

An individual completes a single streamlined application for enrollment in coverage through beWellnm. The single streamlined application determines both the eligibility to shop for and enroll in health or dental coverage and apply for financial assistance programs, including advance payments of the premium tax credit (APTC), health plans with reduced cost-sharing (known as cost-sharing reductions, or CSR), and Medicaid. The New Mexico Human Services Department (HSD) makes the final Medicaid eligibility determinations for individuals assessed by beWellnm as likely eligible for Medicaid. Please see *Section 2.5 Medicaid Eligibility and Financial Assistance* for additional information.

2.1 Who is eligible

45 CFR 155.305 (a)

An individual is eligible to shop for health or dental coverage, with or without financial assistance, through beWellnm by attesting to and verifying, where applicable, the following criteria:

a. The individual is a United States citizen, national, or a non-citizen who is lawfully present in the United States (See *Section 2.3 What is Considered 'Lawfully Present'* for additional information);
b. The individual is not incarcerated, other than incarcerated pending the disposition of charges; and
c. The individual is a resident of the State of New Mexico, provided that they live in New Mexico or intend to reside in New Mexico by the coverage effective date.

2.2 Eligibility Verification Standards

45 CFR 155.315 (a-j); 45 CFR 155.320 (a-e); 45 CFR 155.330 (a-g); 45 CFR 155.335

The Exchange follows the verification standards approved by Centers for Medicare and Medicaid Services (CMS), which are itemized in this section. In addition, the Eligibility Verification Plan is attached for reference.

2.2.1 Forms of documentation commonly used to verify U.S. citizenship or immigration status:

- U.S. passport or passport card
- Certificate of Naturalization (N-550/N-570)
- Certificate of U.S. citizenship (N-560/N-561)
- Documented evidence issued by a federally recognized Indian tribe
- U.S. birth certificate
- Copy of the front and back of a resident alien card
- Copy of another form of documentation showing legal status.

These are the most common examples. For a full list, please visit the Help Center at www.beWellnm.com. Also, see Section 2.2.4 for a description of the "Request for Information" notice.

In addition, beWellnm checks trusted data sources from the federal government to verify citizenship and immigration status, including: Social Security Administration and Department of Homeland Security.

2.2.2 Forms of documentation commonly used to verify income:

- Recent pay stubs
- Tax returns
- Unemployment benefit statements
- 1040 SE with Schedule C, F or SE (for self-employment income)
- Bank statements showing regular deposits
- Bookkeeping records

These are the most common examples. For a full list, please visit the Help Center at www.beWellnm.com. Also, see *Section 2.2.4* for a description of the "Request for Information" notice.

In addition, beWellnm checks trusted data sources from the federal government to verify income, including: Federal Tax Interface and Social Security Administration.

2.2.3 Residency requirements:

An individual must meet applicable residency standards.

For an individual who is age 21 and over, is not living in an institution, is capable of indicating intent and

- Intends to reside in New Mexico, including without a fixed address; or

- Has entered with a job commitment or is seeking employment in New Mexico (whether or not currently employed).

For an individual who is under the age of 21, is not living in an institution, is not eligible for Medicaid, and is not emancipated, the service area of the individual

- Is the New Mexico service area in which he or she resides, including without a fixed address; or
- Is the New Mexico service area of a parent or caretaker, with whom the individual resides.

Special rule for tax households with members in multiple service areas.

- If all of the members of a tax household are not within the same service area, any member of the tax household may enroll in a Qualified Health Plan (QHP) through beWellnm.

Temporary absence.

- BeWellnm will not deny or terminate an individual's eligibility for enrollment in a QHP if the individual meets the beWellnm residency standards but for a temporary absence from the service area and intends to return when the purpose of the absence has been accomplished.

2.2.4 Request for Information

When the Exchange is unable to verify information in the application using approved electronic interfaces, the applicant will receive a notice requesting more information. This "Request for Information" notice will provide more detail about the types of documents that can be used for verification (or proof) of statements on the application. It will also provide instructions about sending the documents.

2.3 What is Considered "Lawfully Present"

45 CFR 155.2; 45 CFR 155.300; 45 CFR 155.305; 26 CFR 1.36B-2

- Lawful Permanent Resident (LPR) (without having met the 5-year bar)
- Individual who is seeking, or has been granted, political asylum
- Refugee
- Cuban/Haitian entrant
- Paroled into the U.S.
- Conditional entrant (granted before 1980)
- Battered spouse, child, or parent victim of trafficking and his/her spouse, children, siblings, or parents
- Granted withholding of deportation or withholding of removal (under immigration laws or under Convention Against Torture (CAT))
- Temporary Protected Status (TPS)
- Lawful Temporary Resident (LPR)
- Individual with non-immigrant status (includes worker visas, student visas, and citizens of Micronesia, Marshal Islands, and Palau)
- Administrative order staying removal issued by the Department of Homeland Security
- Member of federally recognized Indian tribe or American Indian born in Canada

- Resident of American Samoa
- Deferred Enforced Departure (DED)
- Deferred action status (ineligible for APTC if granted deferred action under DACA program)

OR

An applicant for any of these statuses:

- Adjustment to LPR status
- Temporary Protected Status (TPS) with employment authorization
- Special immigrant juvenile status
- Victim of trafficking visa
- Asylum (those who are granted employment authorization, or are under the age of 14 and have had application pended at least 180 days)
- Withholding of deportation or withholding removal (under immigration laws or under CAT)

OR

With employment authorization:

- Registry applicants
- Order of supervision
- Applicant for cancellation of removal or suspension of deportation
- Applicant for legalization under Immigration Reform and Control Act (IRCA)
- Legalization under the Legal Immigration Family Equity Act (LIFE)

2.4 Financial Assistance: Advanced Payments of the Premium Tax Credit (APTC) and Cost Sharing Reductions (CSRs)

45 CFR 155.305 (f)(1-6);

Individuals who are eligible to shop for health or dental coverage through beWellnm, as described in Section 2.1, may also seek financial assistance to pay for health coverage. Individuals may be eligible for financial assistance by attesting to and verifying, where applicable, the following criteria:

a. Have a projected annual modified adjusted gross income (MAGI) between 100% and 400% of the Federal Poverty Level (FPL)
    - Most adults with incomes below 138% of the FPL will be eligible for Medicaid. Medicaid eligibility categories for children have higher income thresholds, up to 300% of the FPL. Additional information about income thresholds for coverage programs can be found in the "Everyone Qualifies for Coverage" brochure, found here.[1]
    - Special Income Rule: Lawfully present individuals who are ineligible for Medicaid due to immigration status may be eligible for APTC if household income is less than

[1] Available in multiple languages; https://www.bewellnm.com/financial-help/educational-materials/

100% of the FPL. A family can determine their APTC status by completing the application process.

b. Are a tax filer, or a member of household with a tax filer, who is married and filing jointly OR single and filing single;
c. Are not eligible for or enrolled in other qualifying minimum essential coverage (MEC), such as Medicare, Medicaid, other government-sponsored health insurance, or affordable employer-sponsored insurance that meets minimum value requirements;
d. Attest that they will file taxes for the year during which a tax credit is received. Married couples must file jointly in order to be eligible to receive a tax credit with the exception of victims of domestic violence or spousal abandonment; and
e. File a federal income tax return and reconcile the APTC for the year in which the individual (or the individual's spouse) received APTC.

Individuals who are determined eligible for APTCs must enroll in health coverage through beWellnm to receive the financial assistance.

2.4.1 Failure to Reconcile (FTR)

45 CFR 155.305(f)(4)

Individuals are not eligible for APTC if they had APTC paid on their behalf for a prior year but their tax filer did not file a federal income tax return and reconcile APTC for that year. When a tax filer does not comply with this requirement, it is known as "Failure to File and Reconcile" or "FTR." Individuals will be notified if they are at risk for having their APTC discontinued in the new coverage year.

2.4.2 Cost Sharing Reduction (CSR)

Cost sharing subsidies reduce the out-of-pocket expenses (co-pays, co-insurance, and deductibles) for a qualified individual or family for QHPs only. To qualify for a cost sharing reduction, an individual or family must:

a. Be eligible for health coverage through beWellnm;
b. Be eligible for a premium tax credit and purchase a silver plan through beWellnm; and
c. Have a household MAGI less than or equal to 250% FPL.

2.4.3 Cost Sharing Reductions for American Indian/Alaska Natives

Additional cost sharing reductions are available to an individual who is an American Indian/Alaska Native (AI/AN) as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. §450b(d)).

a. An AI/AN individual enrolled in a QHP through beWellnm will not be responsible for any cost sharing requirement for an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contracted health services.
b. An AI/AN individual eligible for a QHP with a tax credit through beWellnm, with a household MAGI up to 300% FPL, can choose a "zero cost sharing plan". This means the individual will not have any out-of-pocket costs – like deductibles, co-pays, or coinsurance – when getting care.

Also, see Section 7 for additional information.

2.4.4 Income Used for Financial Assistance Application

45 CFR 155.320 (c)(ii); 45 CFR 155.320 (E)(ii)(iii)

Financial assistance (APTCs and CSRs) is based on a household's expected income for the year of health coverage, not last year's income. Generally, household income is made up of income for the tax filer, their spouse, and their tax dependents (even if they don't need coverage). Income is used to determine whether an individual or family is eligible to receive APTC, and, if they are eligible, how much APTC they receive. It is important to estimate as accurately as possible. Tax credits are calculated on estimated taxable income, which is based on the following common types of income:

- Wages/salaries
- Social Security retirement and Social Security disability
- Unemployment
- Self-employment
- Retirement or Pension
- Rent or royalty
- Capital gains
- Interest, dividends or other investment income
- Alimony (if finalized before January 1, 2019)
- Tips and gratuities
- Farming or Fishing income

Non-taxable income is not factored into APTC calculations. This income can include the following:

- Supplemental Security Income (SSI)
- Child support
- Workers' compensation
- Temporary Assistance for Needy Families (TANF)
- Veteran's benefits
- Federal income tax refunds
- Insurance proceeds (accident, health, and life)

The beWellnm application will collect information about current income, to assist in estimating income for the year of coverage. Users can attest to the total income calculation or make changes to their projected income. Additional information about income sources and eligibility is available in our Help Center at www.beWellnm.com.

2.4.5 Verification of Income for a Financial Assistance Application

45 CFR 155.320(c)

BeWellnm must use electronic interfaces to verify the applicant's self-attestation of income. If the data returned is not reasonably compatible with information provided in the application, further documentation will be required from the applicant to verify income. See *Section 2.2.2 Forms of Documentation Commonly Used to Verify Income* for the types of documents that may be requested to verify income.

2.4.6 Determining Tax Credit Amount

26 CFR 1.36 B-1

To determine the tax credit, several factors are considered. The following are reviewed by beWellnm:

- Age of consumer(s) as of the effective date of coverage
- Household's projected modified adjusted gross income (MAGI)
- Household size
- Number of household members eligible for APTC

Tax households are taxpayer(s) and any individuals who are claimed as dependents on one federal income tax return. Generally, this will include all the individuals that the primary taxpayer will claim an exemption for, including the following:

- Self
- Spouse
- Qualified children (as defined by IRS)
- Qualified dependents (as defined by IRS)

In cases of divorce, the parent who claims the child as a dependent on their tax returns is the only parent who can claim the child for their APTC calculation.

2.4.7 Calculating Age for Household Members

BeWellnm will calculate APTC using the ages of the family members as of their coverage start date.

2.4.8 Household Composition

To align with federal tax households, the following household relationships will be considered as part of the APTC calculation:

- spouse
- child
- adopted child
- stepson/stepdaughter
- ward
- anyone who is in your legal custody (e.g., grandchild)

Note: Generally, households for APTC are made up of tax filers and their tax dependents. Everyone in a tax household must be included in the APTC calculation.

2.4.11 Employer-Sponsored Coverage Affordability

26 CFR 1.36 (b-2)(C)(3); 26 CFR 1.36 (b-1)(e)(2); 26 CFR 1.36(b)(3); 26 CFR 601.105; 45 CRF 155.320(b)

Employer coverage is considered affordable—as it relates to the premium tax credit—if the employee's share of the annual premium for the lowest priced self-only plan is less than 9.61% of annual household

income in 2022.[2] Employees and their spouse and dependents that are offered employer-sponsored coverage that's affordable and provides minimum value are not eligible for a premium tax credit.

If someone thinks their employer-sponsored coverage does not meet minimum essential coverage, minimum value standard, or affordability requirements, they may file an appeal to have coverage reviewed for APTC eligibility. See *Section 8 Appeals* for additional information.

2.4.12 Applying for APTC When Eligible for Retirement Coverage

26 CFR 1.36 B-2(c)(3)(v); 45 CFR 156.145

If someone is enrolled in retirement health insurance coverage, they can only apply for financial assistance and purchase health insurance if their current coverage does not qualify as minimum essential coverage. A member may be eligible for APTC if the coverage is non-affordable and the member is not currently enrolled.

NOTE: If coverage ends outside of the Open Enrollment Period and they choose not to re-enroll, they would be eligible for a Special Enrollment Period.

2.4.13 Applying for APTC When You Have COBRA

26 CFR 1.36 B(c)

New Mexicans who are offered Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage can choose to apply for APTC instead of enrolling in COBRA[3].

If an individual is enrolled in COBRA coverage, they may be eligible for coverage through beWellnm but will not be eligible for financial assistance. Individuals will not be eligible to receive APTC until their COBRA coverage expires, the employer stops contributing to COBRA, or Open Enrollment allows them to voluntarily leave their COBRA policy and begin a new policy on the Exchange. Individuals cannot voluntarily drop their COBRA coverage for coverage through beWellnm outside of the Open Enrollment Period.

NOTE: If an individual is enrolled in COBRA coverage and cease COBRA early due to non-payment, they will not qualify for a Special Enrollment Period outside of Open Enrollment.

2.4.14 Medicare and APTC/CSR

26 CFR 1.36 (B)(c)(2)(v)

Individuals who are eligible for or receive Medicare are not eligible to receive APTC/CSR.

a. Individuals who receive Medicare Part A at a cost may drop Part A and Part B coverage, or they can choose not to enroll in Medicare at the time they become eligible (these individuals may be subject to tax penalties or Medicare penalties if they defer Medicare enrollment outside of the qualifying time).

[2] See: https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36

[3] This is also applicable to New Mexico continuation coverage, which may be offered to employees of companies with fewer than 20 employees.

b. Individuals who receive free Medicare Part A cannot drop it without also dropping their retiree benefits (i.e., Social Security) and paying back all received retirement benefits and costs incurred by the Medicare program.
c. Individuals over 65 years old who elect not to receive retirement benefits, or who are not eligible for Medicare, may be eligible for APTC.
d. For individuals that become eligible for benefits under Medicare after enrolling in coverage through beWellnm may maintain their coverage but their APTC/CSR will be terminated. BeWellnm will send a notice and the individual will have 30 days to respond before any action is taken. Carriers will be informed of changes to individual's coverage via the 834 transaction process. Please see the 834 Companion Guide, found here.[4]

NOTE: Medicare Part B alone is not considered minimum essential coverage. However, if someone is eligible for Part B, it is assumed they are also eligible for Part A, and they won't be eligible for APTC.

2.4.15 APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340

Consumers, who are currently enrolled on the Exchange with financial assistance and experience a change that impacts their APTC and/or CSR will have their updated APTC amount applied to their enrollment, as follows:

- If changes are made by the 23rd of the month, new APTC amount will be effective at the 1st of the following month of the change.
- If changes are made on 24th of the month or after, the new APTC amount will be effective at the 1st of the second month following the change – e.g., for a change made on April 24, new APTC would be applied on June 1. Individuals are required to report any changes that may affect their eligibility for coverage, APTC, and CSRs within 30 days of the change. See *Section 6 Reporting Changes and Redeterminations* for additional information.

Consumers who are currently enrolled on the Exchange with no financial assistance and subsequently gain eligibility for APTC will have the new APTC amount applied to their premiums as described above.

Consumers who are not enrolled and receive a new APTC eligibility determination, or who are currently enrolled and have a change in APTC or CSR, will have their new APTC and/or CSR level amount applied to their enrollment following the enrollment rule (See *Section 4 Enrollment*). See *Section 3.3.2 Special Enrollment Period and Qualifying Life Events* and *Section 6 Reporting Changes and Redeterminations* for additional information.

2.4.16 Applying APTC to Qualified Dental Plans

Individuals or families enrolled in a Qualified Health Plan (QHP) through beWellnm may only apply tax credits to a Qualified Dental Plan (QDP) if they have applied the maximum amount of tax credit to their QHP and there are credit funds remaining. Tax credits may only defray the portion of a QDP premium

[4] https://www.bewellnm.com/wp-content/uploads/2021/05/NMHIX_834_Companion_Guide_08182020.pdf

allocable to the pediatric dental Essential Health Benefit and would only be applied if a minor in the household was not receiving the pediatric dental benefit through the family's health plan.

Any tax credits will only become effective on the first day of the first full month during which the individual is enrolled in a QHP and QDP and not enrolled in other minimum essential coverage.

2.4.17 APTC and Tax Reporting

Individuals that are enrolled in a QHP through the Exchange and use APTC to lower their monthly payment, must "reconcile" when filing their federal taxes. See Section 11 for additional information, as well as Section 2.4.1 about Failure to Reconcile.

2.5 Medicaid Eligibility and Financial Assistance Applications

Applications for health coverage with financial assistance will be assessed for Medicaid eligibility by beWellnm. If one or more members of a household are assessed as likely eligible for Medicaid, their application will be transferred to the New Mexico Human Services Department (HSD) for a final determination of Medicaid eligibility. Applications of individuals assessed as likely not eligible for Medicaid will not be sent to HSD for a final Medicaid determination, unless requested by the individual.

Note: Medicaid with limited benefits, such as Family Planning, is not considered minimum essential coverage. Applicants found eligible for and/or enrolled in Family Planning Medicaid are still eligible for financial assistance, such as tax credits, through the Exchange.

2.5.1 Opt-out of Medicaid determination

As stated in Section 2.5, beWellnm will send information for all members of a financial assistance application who are assessed as eligible for Medicaid to the HSD for a final Medicaid eligibility determination. If a member does not want their application sent to HSD for a Medicaid determination, they will be given an opportunity to "opt out" of the Medicaid determination.

Important note: if a member who is assessed as likely eligible for Medicaid selects this option, the member will not be eligible for financial assistance (i.e., APTC) to purchase health coverage through the Exchange. The member may purchase a marketplace health plan without financial assistance.

2.5.2 Requesting a final Medicaid determination

As stated in Section 2.5, applications of individuals assessed as ineligible for Medicaid will not be sent to HSD for a final Medicaid determination. However, if an individual does want their application sent to HSD for a Medicaid determination, they will be given an opportunity to request a final Medicaid determination.

2.6 Catastrophic Plans and Exemptions

Catastrophic Plans will not be offered on the Exchange for Plan Year 2022.

2.6.1 Requesting an Exemption

The Centers for Medicare and Medicaid Services (CMS) is responsible for hardship exemption processing for New Mexico. To find out more information on how to request an exemption, please

visit www.healthcare.gov or https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/.

3. Application

3.1 How to Apply

An individual may apply online, by phone, or by mail using beWellnm's designated application form. The application form can be downloaded at www.beWellnm.com. Certified Enrollment Counselors (CECs) and Brokers are available to help individuals with their application at no cost. For information on getting free local help, please visit www.beWellnm.com.

3.2 Verification of Application Information

BeWellnm will use the applicant's attestations, in combination with trusted data sources, to determine eligibility to purchase coverage, and if applicable, eligibility for financial assistance (as described in Section 2.4). If an individual attests to meeting the eligibility criteria and such attestation cannot be verified by trusted data sources or other information available to beWellnm, beWellnm will request additional documentation from the applicant to verify attestations. This is called a Request for Information (RFI). The individual will be determined eligible during this inconsistency period based on their attestation, pending submission and verification of the requested documentation. In that case, the individual will be notified and will have 90 days to provide documentation. See *Section 2.2. Eligibility Verification Standards* for additional information.

If, after the 90 days, beWellnm remains unable to verify the attestation, the individual's eligibility will be determined based on the information available from the data sources.

Individuals required to submit proof of their incarceration status and who fail to do so will be terminated from coverage.

Individuals required to submit proof of their lawful presence in the United States and who fail to do so may be terminated, depending on available data.

BeWellnm may extend the inconsistency period if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period or for other good cause. For an applicant who does not have documentation to resolve their inconsistency because it does not exist or is not reasonably available, with the exception of an inconsistency related to citizenship or immigration status, beWellnm will provide exceptions on a case-by-case basis to accept an applicant's attestation for the information that cannot be verified, along with an explanation of circumstances as to why the applicant does not have documentation.

3.3 When to Apply

3.3.1 Open Enrollment Period (OEP) and Coverage Effective Dates

45 CFR 155.410;

BeWellnm will offer Open Enrollment Periods (OEP) consistent with federal requirements of each year for individuals to apply for health coverage in the upcoming year. However, beWellnm may offer additional enrollment opportunities, including an extended OEP. For applications for health coverage in calendar year 2022, the following OEP will apply:

Plan Year	Open Enrollment Period
2022	November 1, 2021 – January 15, 2022

3.3.1.1 Coverage Effective Dates during Open Enrollment Period

During Open Enrollment, if a household wants health insurance coverage to start on January 1, they must complete their enrollment no later than December 23 of the prior year. See *Section 4 Enrollment* for additional information.

Consumers who enroll in coverage between December 24 and January 15 will receive a coverage effective date of February 1. Individuals who qualify for a Special Enrollment Period during the annual OEP may receive a coverage effective date as indicated in 3.3.2.

An individual can make changes to their plan selection during the OEP. However, the last election made by the end of the OEP that is effectuated will be the coverage in which the individual is enrolled. If the individual is enrolled in a QHP and paid for the first month's premium payment (i.e., binder payment), but then selected and enrolled in another QHP before the end of the OEP, the initial coverage will be canceled. The initial carrier will be notified of the cancellation by beWellnm.

3.3.2 Special Enrollment Periods and Qualifying Life Events

45 CFR 155.420;

Outside of Open Enrollment, individuals may apply for coverage through a Special Enrollment Period (SEP) if they experience a qualifying life event.

BeWellnm will allow unenrolled qualified individuals, current enrollees, and any dependent(s) to enroll in or make changes to their plan selection during a plan year of any of the below listed qualifying events within 60 days of the qualifying event (unless otherwise noted).

3.3.2.1 Effective Dates for Coverage through an SEP

Changes to enrollments will be effective in accordance with S*ection 4.2 Enrollment Completion and Effective Dates* except in the case of court order, birth, adoption or placement for adoption or foster care, as described below. Any APTCs or CSRs will be effective with the coverage effective date.

- For enrollment of a member into a new policy, the consumer can choose among the following for their effective date of coverage:
    - The date of birth (for SEP related to birth). Members should call the Customer Engagement Center for help with this option.

- The 1st of the month following the reported change (if enrollment is completed by the 23rd of the month), or
- The 1st of the second month following the reported change month (if enrollment is completed on or after the 24th of the month)

3.3.2.2 Qualifying Events

Qualifying events applicable to a qualified individual, enrollee, or their dependent(s) triggering the loss of minimum essential coverage (as defined by § 5000A of the Internal Revenue Code) are provided in the list below.

Qualifying events triggered by the loss of Minimum Essential Coverage include:

- Losing employer-sponsored insurance due to death of the subscriber employee, reduction of the hours of employment, and termination of employment (regardless of whether the individual is eligible for or elects COBRA).
- Loss of coverage through the subscriber's plan due to subscriber's Medicare eligibility.
- Losing coverage due to death, legal separation, divorce, or cessation of dependent status.
- Moving to New Mexico or moving within the state.
- Losing access to coverage because the plan a health plan is decertified or no longer providing benefits.
- Losing access to coverage due to exhaustion of COBRA coverage.
- Losing access to coverage due to the expiration of a non-calendar year group health plan, including an Individual Coverage Health Reimbursement Arrangement (ICHRA), individual health insurance coverage, or Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code). This qualifying event is valid if there is an option to renew such coverage.
- Losing eligibility for public qualifying minimum essential coverage, such as Medicare or Medicaid, or affordable employer-sponsored coverage that meets minimum value standards.

Loss of coverage does not include voluntary termination or loss due to failure to pay premiums, including failure to pay COBRA premiums prior to expiration of COBRA coverage, or situations allowing for a rescission as specified in 45 CFR § 147.128, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan.

Qualifying events applicable to a qualified individual, enrollee, or their dependent(s) include:

- Gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or court-ordered care of a child.
- Losing pregnancy-related coverage.
- Gaining access to a QHP or dental plans due to release from incarceration.
- Gaining or maintaining status as American Indian or Native Alaskan as defined by section 4 of the Indian Self-Determination and Education Assistance Act. See, 25 U.S.C. § 450b(d).
- Becoming newly eligible for beWellnm enrollment due to satisfying requirements for citizenship, status as a national or lawful presence.

- Unintentional, inadvertent, or erroneous enrollment or no enrollment in a health or dental plan due to the error, misrepresentation, misconduct, or inaction of an officer, employee or agent, of beWellnm, the U.S. Department of Health and Human Services (HHS), or non-Exchange entities providing enrollment activities, as determined by beWellnm. An error would include incorrect calculation of Advance Premium Tax Credits (APTCs) or Cost Sharing Reductions (CSRs).
- Demonstrating to beWellnm, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances. Individuals with exceptional circumstances will need to contact the Customer Engagement Center for assistance.
- Becoming newly eligible for APTCs based on a finding that the individual will no longer be eligible for affordable employer-sponsored coverage meeting minimum value standards in the next 60 days provided that the individual is permitted to terminate existing coverage.
- Experiencing domestic abuse or spousal abandonment. Victims applying for financial assistance and married to the spouse who abused or abandoned them must attest on their application that they expect to file taxes as "Married Filing Separately" to be considered for APTCs.
- Gaining access to or newly being provided an ICHRA or QSEHRA through an employer. A qualified individual, enrollee, or their dependent will have 60 days before the start of the ICHRA or QSEHRA to enroll, unless the ICHRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year (See 45 CFR 155.420(c)(3)).
- Applications for coverage on the Exchange during the annual Open Enrollment Period or during a Special Enrollment Period that receive a determination for Medicaid either after Open Enrollment has ended or more than 60 days after the qualifying event for the Special Enrollment Period; or
- Applications for coverage at HSD during the annual Open Enrollment Period that are determined ineligible for Medicaid after Open Enrollment has ended.

Qualifying events applicable to a qualified enrollee or their dependent(s) include:

- Adequately demonstrating to beWellnm that the health or dental plan in which the individual is enrolled substantially violated a material provision of its contract with the enrollee. In such cases, individuals will need to contact the Customer Engagement Center for assistance.
- Becoming newly eligible or newly ineligible for APTCs or CSRs.

3.3.2.3 Reporting Requirements for Qualifying Events

The life event(s) must be reported to beWellnm within 60 days of the event. BeWellnm may require documents proving that the qualified individual, enrollee or their dependent(s) meets one or more of the above criteria. Loss of minimum essential coverage can be reported 60 days prior to the event.

3.4 Getting Assistance

BeWellnm will help individuals and families apply for and enroll in coverage. BeWellnm also works with health insurance brokers, certified enrollment counselors, and community organizations to provide free local help. For information about assistance, please visit www.beWellnm.com.

4. Enrollment

4.1 Enrollment Requirements

To enroll in a non-group product through beWellnm, an individual/family must:

a. Establish eligibility for a plan through the beWellnm's application process. (See *Section 2 Eligibility* and *Section 3 Application.*)
b. Request enrollment during an Open Enrollment Period or qualify for a Special Enrollment Period, if applicable. (See Section 3.3)
c. Provide the following additional information when selecting a plan:
    i. Selected plan name and carrier;
    ii. Effective date. During initial enrollment, in most cases, prospective enrollees may choose from the next two available effective dates:
        A. On or before the 23rd day of the month, an applicant may choose either the first of the month following application for enrollment or the first of the second month following application for enrollment. For example, on May 15, an applicant may choose an effective date of June 1 or July 1
        B. After the 23rd of the month, an applicant may choose either the first day of the second month following application for enrollment or the first day of the third month following application for enrollment. For example, on May 25, an applicant may choose an effective date of July 1 or August 1; and
    iii. Sign or e-sign and accept the Terms and Conditions of enrollment, in accordance with the below:
        A. For paper submissions, the adult applicant or legally designated representative must physically sign the enrollment form as well as the Terms and Conditions agreement. If the enrollee is under 18 years of age, the parent or legal guardian must sign both forms. Once signed, both forms may be delivered in person, mailed, or legibly faxed to beWellnm. See *Section 1.3 Resources* for additional information or visit www.beWellnm.com for contact information.
        B. For electronic submissions, the adult applicant must e-sign the enrollment form as well as the Terms and Conditions agreement by "clicking" on a confirmation button, such as "I agree." If the enrollee is under 18 years of age, the parent or legal guardian must e-sign both forms. By clicking on the confirmation button, the enrollee or parent or legal guardian attests that the information provided in the online application is correct and agrees to beWellnm Terms and Conditions.
        C. For submissions made by phone to the Customer Engagement Center (CEC), the applicant or parent or guardian may either:
            - attest to agreement by voice, in which case the CEC representative can complete the submission electronically, including the signatures of the enrollee; or
            - sign and mail in a printed, completed application generated by the CEC representative; and

iv. Submit full payment for the first month of coverage in accordance with the designated due date. See *Section 5 Financial Management and Premium Billing* for additional information.

4.2 Enrollment Completion and Effective Dates

Any additional request for information required for enrollment, signed and accepted Terms and Conditions and payment for the first month of coverage must be received by beWellnm no later than the 23rd calendar day of the month prior to the requested effective date of coverage. BeWellnm may, in its discretion, request that a carrier accept an individual's enrollment request retroactively in exceptional circumstances.

If an applicant fails to complete the enrollment process outlined above by the 23rd day of the month, and they are within an Open or Special Enrollment Period, they may re-select a later effective date pursuant to the process above. For example, Applicant A has a Special Enrollment Period open for 60 days beginning June 1. On June 10, Applicant A requests enrollment in a health plan effective July 1, but does not pay by June 23 to effectuate coverage. Because Applicant A's Special Enrollment Period is still open, they may submit a new enrollment request on June 28 for coverage effective August 1 and must pay by July 23 to effectuate coverage.

The prospective enrollee(s) must comply with beWellnm's reasonable requests for information necessary to verify the application for coverage in order to maintain enrollment in a plan.

4.3 Enrollee Age-Out

4.3.1 For Pediatric Only Dental Plans

An enrollee's eligibility for pediatric dental benefits ends at the end of the plan year in which the enrollee attains age 19. The household can choose a different dental plan during Open Enrollment for the next year's coverage.

4.3.2 For Dependents on Family Medical and Dental Plans

A dependent enrollee's enrollment ends as of the last day of the month in which the enrollee attains age 26, if the enrollee is not the subscriber or the subscriber's spouse or domestic partner. However, a dependent enrollee who is disabled will not experience changes in enrollment as a result of attaining age 26.

4.3.3 For Catastrophic Plans

An enrollee's eligibility ends at the end of the plan year in which the enrollee attains age 30, unless the enrollee provides documentation showing that he or she has been granted a Certificate of Exemption from the Individual Mandate pursuant to 26 U.S.C. 5000A(e)(1) or 26 U.S.C. 5000A(e)(5). See Section 2.6 *Catastrophic Plans and Exemptions* for additional information.

4.4 Termination of Coverage

45 CFR 155.430

A termination through beWellnm may be either voluntary (i.e., initiated by the enrollee) or involuntary (i.e., initiated by beWellnm). If an enrollee's coverage is terminated, the Qualified Health Plan (QHP) or Qualified Dental Plan (QDP) must cover the enrollee and the covered services that the enrollee received, from the coverage effective date until the termination date. An enrollee may voluntarily end their health coverage without terminating their dental coverage, or terminate their dental coverage without terminating their health coverage. A termination can be effective in the future (e.g., a termination requested by the enrollee up to 60 days prior to the termination date), or retroactively (e.g., the enrollee died, or failed to pay premiums due by the end of a grace period). To select a future or retroactive termination date, please call the Customer Engagement Center.

4.4.1 Voluntary Termination

An enrollee may voluntarily terminate their health insurance coverage for any reason at any time. However, if a member voluntarily terminates, they are not eligible to re-enroll in coverage through beWellnm until the next open-enrollment period unless they qualify for a Special Enrollment Period (SEP) or if they are an American Indian or Alaska Native. Voluntary termination can be requested by the enrollee(s) online or by contacting the Customer Engagement Center.

An enrollee who voluntarily terminates coverage may select a termination date of at least 14 calendar days from the termination request date or a later date within the plan year. BeWellnm may grant an enrollee's request to terminate coverage sooner than 14 days. The termination date is always the last day of the month in which the termination is requested.

If an enrollee is delinquent in paying monthly premiums at the time of the request to terminate, the enrollee must pay all outstanding premiums by the end of the delinquency period to avoid a retroactive change of the termination date. If the enrollee fails to pay all outstanding premiums, the termination date will be determined according to beWellnm's non-payment of premium policy. See *Section 5.4 Termination for Non-Payment* for details regarding termination for non-payment.

4.4.2 Termination Due to Death

The termination of an enrollee's coverage due to death may be reported by an applicant or their household members. The death can be reported through their online account or by calling the Customer Engagement Center. If the household member does not have access to the online account, the termination of the deceased's coverage can be initiated through the Customer Engagement Center. BeWellnm will conduct redeterminations of eligibility for the remaining members of the household.

The documentation below must be submitted to beWellnm:

- Copy of official death certificate; or
- Statement from someone qualified to attest to death, such as coroner or licensed funeral director.

4.4.3 Termination for Fraud

BeWellnm or the QHP or QDP carrier may terminate an enrollee's coverage if it is rescinded in accordance with 45 CFR 147.128. In such cases, a QHP or QDP carrier may terminate an enrollee's coverage through beWellnm if an enrollee performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact in connection with the enrollee's coverage.

The QHP or QDP must provide 30 days advance written notice to each enrollee or participant affected by the intended termination.

In cases of fraudulent activity, the effective date of the termination may be retroactive Further, if state law allows, the QHP or QDP carrier may deny medical or dental claims not yet received but incurred after the retroactive effective date of termination and reverse any paid medical or dental claims incurred after the retroactive effective date of termination. BeWellnm will refund any premiums paid by the enrollee for the period after the retroactive effective date of termination, and CMS will recoup any APTCs or CSRs paid for that period, as well. BeWellnm will provide the enrollee notice of the termination. If a QHP carrier rescinds coverage for fraud, and in the next OEP the enrollee enrolls in the same QHP that was rescinded due to fraud, the carrier must accept the enrollment.

Only in cases of fraud or intentional misrepresentation of material fact may Carriers rescind coverage. Carriers should contact compliance@nmhix.com to initiate a rescission as described in this section.

4.4.4 Retroactive Termination

An enrollee (actively enrolled or previously terminated) may request to have their policy, or a household member, retroactively terminated. All retroactive termination requests must be submitted to and approved by the NMHIX Premium Billing Department. A retroactive termination is defined by beWellnm as a termination with an effective date prior to the current month.

BeWellnm will allow retroactive terminations in the following circumstances:

- The individual obtained other Minimum Essential Coverage (MEC). The Individual must request termination within 60 days of discovering the enrollment;
- The individual demonstrates to beWellnm that they attempted to terminate their enrollment and experienced a technical error that did not allow them to terminate their enrollment through beWellnm, and requests retroactive termination within 60 days after they discovered the technical error;
- The individual demonstrates to beWellnm that their enrollment was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of beWellnm, its instrumentalities, or a non-beWellnm entity providing enrollment assistance or conducting enrollment activities. The Individual must request cancellation within 60 days of discovering the enrollment;
- The individual demonstrates to beWellnm that they were enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with beWellnm, and requests cancellation within 60 days of discovering the enrollment;
- The notification of the death of an individual by a household member or authorized representative. Documentation is required to be submitted to beWellnm prior to processing the termination in the system.

Any requests for retroactive termination outside of these circumstances will be reviewed and approved or denied at the sole discretion of the NMHIX Finance Department.

Effective dates for retroactive termination of coverage:

- The last day of the coverage month the Individual is determined eligible for other MEC; or

- The day before the QHP or QDP policy effective date if the Individual was enrolled in error or without their knowledge; or
- The date of death.

For information about reinstatement of coverage, see *Section 5.4.6 Reinstatement*. For information about appeals, see *Section 8 Appeals, Complaints and Grievances.*

5. Financial Management and Premium Billing

Beginning with plan year 2022, individuals will receive their premium bills from beWellnm and will begin making payments to the New Mexico Health Insurance Exchange beginning with their January 2022 coverage. Individuals will continue to make payments to their carrier for coverage months prior to January 2022.

BeWellnm's financial management system is the system of record for all transactions related to billing and payment for coverage purchased through the Exchange. This section details the policies, procedures and rules governing the following for the Individual Exchange:

- Premium Billing
- Premium Payments
- Non-Payment of Premium and Terminations
- Refunds
- Returned Payments

Refer to the 820 and 834 Companion Guides[5] for information on the following:

- Premium reconciliation
- Premium aggregation
- 820 carrier remittance process
- Notification and confirmation of file exchange
- Report generation and transmission
- Edits, corrections, and adjustments due to retroactive eligibility changes or other reasons

5.1 Premium Billing

5.1.1 Premium Billing Generation

Premium bills are generated on the 5th of each month in advance of the month of coverage (e.g., May 5th for June coverage). The billed amount is based on the enrollee's current plan selection. The bill includes

[5] The companion guides can be found here: https://www.bewellnm.com/state-based-exchange/sbe-carriers/

the current month billed amount and adjustments for any transactions (adds/terms/changes) processed since the last billing cycle. One consolidated bill will include both Medical and Dental (if applicable). Premium bills are mailed to the policyholder's mailing address on record (or the authorized representative, if one has been selected). Premium bills are also posted to their beWellnm online account. If the subscriber has elected to receive electronic notifications as their communication preference, they will receive an email notifying them when a new bill is available in their online account.

5.1.2 Premium Billing Detail

Premium bills include the subscriber's name and ID, plan, carrier, coverage month, due date, APTC amount (if applicable), and any outstanding balance. The total amount due is summarized and reduced by the APTC amount. Each premium bill will also include a listing of all enrolled dependents for the coverage month. If a subscriber has enrolled in recurring payments, their premium bill will include a message indicating that the amount will be withdrawn from their bank account information on file.

5.2 Premium Payments

5.2.1 Premium Payment Threshold

45 CFR 155.400(g)

BeWellnm has implemented a premium payment threshold policy. The policy considers a payment to have been made in full once the enrollee pays an amount equal to or greater than the threshold amount of $5 of the enrollee-responsible portion. The policy applies to the initial premium payment, any subsequent premium payments and to any amount outstanding at the end of a grace period for non-payment of premium. If an enrollee has paid within the threshold but has not paid the full premium, the enrollee will still owe the balance.

If the enrollee makes subsequent premium payments within the threshold, but has not paid the full amount due, the enrollee will be considered to be current on all payments due for the purpose of determining whether to place the enrollee into a grace period. If the enrollee continues paying an amount less than the owed amount including past due premiums, the owed amount will accumulate and may increase beyond the threshold amount. If that is the case, the enrollee's account will be considered delinquent and the enrollee will be subject to the grace period for failure to pay premiums.

5.2.2 Initial Payment (aka "binder payment" or "binder")

45 CFR 155.410; 45 CFR 155.420

Subscribers must make their binder payment (first month's premium payment) to complete their enrollment and prospective coverage to be effectuated. The binder payment must consist of the first month's full premium, or be within the payment threshold. If the enrollee has paid the initial premium within the payment threshold, the coverage can be effectuated.

The binder payment is due on the 23rd of the month for coverage to begin the 1st of the following month. If payment is made after the 23rd of the month, coverage will begin the 1st day of the second month during Open Enrollment. 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. If the binder is not paid on or before

the due date the policy will be canceled. Grace periods are not granted for binder payments. Premium payment is submitted to a carrier once a full month's premium is received for the coverage month.

For retroactive effective dates, the binder payment must consist of premium due for all months of retroactive coverage through the first prospective month of coverage. Payments will be applied from the oldest to the newest coverage month. If premium for only one month of coverage is paid, premium will not be submitted to the carrier.

If a subscriber adds a retroactive enrollment to an already effectuated enrollment, the enrollee must pay all outstanding retroactive premiums by the next monthly billing cycle due date. Failure to pay outstanding premium by the due date will trigger a grace period. See *Section 5.3 Grace Periods* for additional information.

Regulations grant exchanges flexibility to establish a deadline relative to the annual Open Enrollment Period by which an individual's first month's premium must be received in order to make coverage effective as of the first day of the upcoming coverage year.

5.2.3 Ongoing Payments

Enrollees must continue paying their premium for each month they are enrolled until they terminate, to ensure there is no disruption to coverage. Premium payments, other than payment for the first month of coverage, are due to beWellnm on the last day of the month prior to the month of coverage (e.g., payment is due April 30 for May coverage). Payments must be received in full, or within the payment threshold. The payment threshold considers enrollees to have paid in full and avoids triggering a grace period for non-payment of premium and avoids terminating coverage for non-payment of premium.

Any balance will be carried forward to the following month. Payments received the following month will be applied to the outstanding balance first and then to the current month balance.

Subscribers who make changes to their account after the monthly billing process has run, and before they submit their payment, should log into their online account, or call the Customer Engagement Center, to review their bill and determine the financial impact of those changes on their next bill. The customer will still owe the amount due displayed on the first bill. Any questions will be answered by customers either logging into their online accounts or calling the customer engagement center.

Subscribers that do not pay their full balance by the payment due date are at risk of experiencing an interruption in coverage. It is the subscriber's responsibility to make sure they are paid in full by the payment due date.

5.2.4 Payment for Renewals

See Section 9.3

5.2.5 Payment Types

Policyholders can choose to make one-time payments on a monthly basis or enroll in recurring payments. BeWellnm accepts the following payment types:

Payment Method	One-Time	Recurring

Personal Checks	✓	
Cashier's Checks	✓	
Money Orders	✓	
Automated Clearing House (ACH)	✓	✓
Debit and Credit Cards	✓	

- **One-time payments online** – Subscribers can make payments on-line by accessing their account on the beWellnm portal. A confirmation number will be issued after completing an online payment, and subscribers should retain the confirmation number for their records. The banking/card information entered for one-time payments is not retained in the system and will need to be re-entered when making subsequent one-time online payments.

- **One-time payments by mail** - Subscribers can mail a check or money order, made out to the New Mexico Health Insurance Exchange or NMHIX, with their statement. The check or money order and statement must be mailed to the NMHIX lockbox:

  NMHIX |P.O. Box 26508 | Albuquerque, NM | 87125-6508

- **Recurring payments** – Subscribers that elect recurring payments authorize NMHIX to automatically collect their monthly premium from their bank account each month. Recurring payment are scheduled to be deducted from subscriber bank accounts on the 18th of the month for the following month of coverage. Recurring payments can only be set up after a subscriber has made their initial payment in full. Subscribers will receive an electronic notification prior to the funds being deducted. A notation that they are enrolled in recurring payments will appear on their monthly bill. If it does not appear on their bill, the subscriber will need to log into their online account, or contact beWellnm, to confirm the recurring option has been selected and the payment account information is correct. If the update to the recurring information is not updated prior to the recurring payment process, they will need to make a one-time payment by the due date to avoid disruption of coverage. BeWellnm will carry forward the recurring payment from one policy year to another. A subscriber is required to attest online and agree to the terms and conditions when selecting recurring payments.

- **By phone** – Subscribers can make a payment over the phone with NMHIX Premium Billing Department by calling the beWellnm Customer Engagement Center at 1-833-862-3935. When complete, a confirmation number will be provided to the subscriber.

- **In person** - Subscribers choosing to hand-deliver payments can do so at the beWellnm office at:

  7601 Jefferson St NE, Suite 120 | Albuquerque, NM 87109.

  It is critical for individuals mailing or dropping off a payment to make their check payable to the New Mexico Health Insurance Exchange or NMHIX and include their statement and/or account

number with their payment to ensure the payment is applied appropriately. Failure to include this information could result in a disruption of coverage.

- **Direct to carrier -** Direct payments are discouraged by beWellnm, and may require extra processing time and/or result in disruptions to coverage.
    - Premium payments that are made directly to a carrier for coverage months beginning January 2022 shall be forwarded to the Exchange by the carrier:
        - Endorse the back of the check/money order: *Pay to the order of NMHIX*
        - Mail to the NMHIX lockbox:

          NMHIX |P.O. Box 26508 | Albuquerque, NM | 87125-6508
        - For members in a grace period, the carrier shall send a secure email notification to the NMHIX Premium Billing Department at PremiumBilling@nmhix.com 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
    - For any premium payments made to and deposited by the carrier, the carrier will need to issue a replacement check to the NMHIX and send it to the lockbox address provided above. Follow the steps above to notify NMHIX.
    - Any remaining credit for coverage months prior to 2022 should be refunded directly to the individual by the carrier.

5.2.6 Returned Payments

Upon notification of a returned payment by NMHIX's bank, the returned payment will be reversed in the NMHIX system, and a notification will be sent to the subscriber. It is the subscriber's responsibility to pay the outstanding amount immediately. If not paid, the outstanding coverage month will trigger a grace period, and the policy may be subject to termination for non-payment of premium.

If a subscriber submits two returned payments within a year, beWellnm may request that payment be made with guaranteed funds such as money order, bank cashier check, certified check or traveler's checks.

5.2.6 Payment Application

Payments are applied from the oldest to newest invoice. For example, if a subscriber has not paid the full premium for coverage in April and May, any payment made for June coverage will first be applied to satisfy

the April balance, and then applied to satisfy the May balance, prior to being applied to the balance for June coverage.

A premium payment will not be submitted to the carrier until the full month's premium is received for the coverage month.

5.3 Grace Periods

5.3.1 Grace Period Window

45 CFR 155.430; 45 CFR 156.270(d) and (g)

Subscribers have a grace period before their coverage can be terminated for non-payment. If premium payment has not been received by beWellnm 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 31-days

Partial payments will not adjust a grace period. If a subscriber 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.

5.3.2 Payment of Medical Claims Incurred During the Grace Period

For enrollees receiving an APTC, carriers must pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. Carriers must notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

If the enrollee's coverage is terminated for non-payment of premiums retroactively to the last day of the first month of the grace period, the carrier may deny any claims that were pended for services received during the second and third months of the grace period. However, the carrier cannot retroactively deny claims from the first month of the grace period. Any premium received by beWellnm for coverage beyond the retroactive termination date will be refunded to the enrollee.

5.4 Non-Payment of Premium and Notices

If premium payment has not been received by beWellnm on or before the due date, a grace period is triggered for the subscriber and generates a series of notices throughout the grace period. The types and frequency of notices are based on whether a subscriber is receiving an APTC.

Below is a timeline for non-payment of premium for both APTC and Non-APTC for a May coverage month:

APTC

May Coverage *Payment Due 4/30*	
Notice Date	Notice Type
May 1	Late Notice 1
June 1	Late Notice 2
July 1	Late Notice 3
August 1	Termination Notice Termination processed effective 5/31

Non-APTC

May Coverage *Payment Due 4/30*	
Notice Date	Notice Type
May 1	Late Notice
June 1	Termination Notice Termination processed effective 4/30

5.4.1 Late Notice

The notice informs the subscriber 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.

5.4.2 Termination Notice

The Termination Notice sent by beWellnm informs the subscriber that their policy has been terminated. The notice includes the termination effective date and reason for termination. Termination notices are always sent to the subscriber and authorized representative, if applicable, by mail, regardless of whether the subscriber has elected electronic notifications as their communication preference.

Once an individual's plan has been terminated, they are not able to re-enroll in a marketplace Qualified Health Plan (QHP) until the next Open Enrollment Period, unless they qualify for a Special Enrollment Period in the interim. Loss of coverage for failure to pay premiums does not trigger a Special Enrollment Period.

Carriers are notified of terminations due to non-payment via the 834.

5.4.3 Termination for Non-Payment of Premium

In accordance with 45 CFR §155.430(b)(2)(ii), beWellnm will terminate an enrollee's coverage for non-payment of premiums if payment is not made in full by the end of a policyholder's grace period. The termination process is run on the 1st of each month. The policy is retroactively terminated, and the termination effective dates are as follows:

- APTC - Termination effective date is the last day of the first month of the grace period (non-payment for May coverage is terminated effective May 31).
- Non APTC – Termination is effective the last day of the coverage month for which the last payment was made in full (non-payment for May coverage is terminated effective April 30).

To avoid termination, an enrollee must pay all outstanding premiums in full, or within the premium payment threshold, prior to the end of the grace period. The acceptance of any partial payment does not establish a waiver of rights to terminate an enrollee for non-payment of premiums and does not "reset" a grace period.

A subscriber that is terminated for non-payment, is not able to re-enroll in coverage through the Exchange until the next Open Enrollment Period, unless he qualifies for a Special Enrollment Period (SEP). Loss of coverage for failure to pay premiums does not qualify for a SEP. However, if the enrollee becomes eligible for an SEP based on other circumstances, the enrollee may enroll in a new plan or a plan from which the coverage was terminated for non-payment.

During the annual OEP, enrollees whose coverage was terminated for non-payment of premiums before the end of the plan year will be able to apply for an eligibility determination, and, if determined eligible, will be permitted to enroll in coverage for the new plan year.

5.4.4 Termination Inquiries

Subscribers, brokers and carriers with inquiries regarding non-payment terminations can contact the NMHIX Premium Billing Department by calling the Customer Engagement Center at 1-833-862-3935. All inquiries will be reviewed and responses will be provided to the submitter.

5.4.5 Collection After Termination

BeWellnm will not continue with collection activities of outstanding balances when an enrollee is terminated for non-payment. The carrier may directly collect any outstanding premium from the enrollee. If a terminated enrollee pays any outstanding premium to beWellnm, the premium will be forwarded to the respective carrier.

5.4.6 Reinstatement

A subscriber terminated due to non-payment of premium may request to have their policy reinstated through beWellnm. All other reinstatement requests must be submitted through the appeal process (see *Section 8 Appeals*). The reinstatement request must be submitted to beWellnm within 60 days following the termination. The subscriber 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. The subscriber and any dependents will be reinstated in their previous coverage. An individual may be

reinstated only once per calendar year. Reinstatement decisions are at the sole discretion of the NMHIX Premium Billing Department.

5.4.7 Bankruptcy

If an individual policyholder files for bankruptcy, the end creditor is the individual's respective carrier. As further explained above, after the coverage of an enrollee is terminated, beWellnm will cease collection activities. If beWellnm is served with any notice pursuant to Section 362(a) of the Bankruptcy Code, beWellnm may forward the notice and its attendant documents to the carrier.

5.4.8 Refunds

Individuals with valid credits on their account may request a refund by calling the beWellnm Customer Engagement Center or by mail. (Otherwise, refunds will be processed monthly.) Requests will be reviewed and approved or denied by the NMHIX Finance Department. Refunds and/or notification of denied requests will be mailed to the subscriber's address on file. Refunds will not be processed until 15 days after a payment has been received by beWellnm.

If a subscriber has active coverage with continuous enrollment, they are encouraged to allow overpayments or credit balances to be applied to future months of coverage. It is unlikely that a refund would be issued before the next premium is due.

Any uncashed checks that are over three years old may be escheated to the New Mexico Taxation and Revenue Department as unclaimed property annually. A final notice will be sent to the individual regarding the unclaimed property. Refund checks are voided after 120 days if uncashed. A permanent stop payment is issued by the bank.

Valid refund requests for deceased account holders will honored from an estate's administrator or other individual appointed by law. The refund check will be made payable to the estate of the deceased account holder. BeWellnm cannot change the name on the refund check to that of another person or family member if that person or family member is not an Authorized Representative on the account.

6. Reporting Changes and Redeterminations

45 CFR 155.335

BeWellnm is required to redetermine eligibility for a Qualified Health Plan (QHP) or Qualified Dental Plan (QDP), as well as any federal assistance (if applicable), for an enrollee and their dependent(s) based upon a change to any eligibility criteria.

This includes information reported by the enrollee or obtained by beWellnm through a data match during the plan year. A change reported by the enrollee may need to be verified before it is finalized, including by ensuring that the information provided is consistent with the records of beWellnm (i.e. beWellnm was able to confirm the change by matching with electronic data sources) or that the enrollee has provided documentation to support the change. If a change cannot be verified, beWellnm must redetermine eligibility based on other information it has.

6.1 Enrollee Responsibility

An enrollee and the dependent(s) must report any changes that impact eligibility for coverage through the Exchange and/or financial assistance within 30 days of the event. [See 45 CFR 155.3359(e)]

6.1.2 Reporting Changes

Enrollees must report changes related to:

a. Family size or composition due to birth, adoption, placement for adoption, marriage, divorce, death, etc.;
b. Residency, including a change to a residential and/or mailing address;
c. Citizenship, nationality, or lawful presence;
d. Indian status (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. §450b(d)); and
e. Incarceration status.

The same channels for submitting applications – online, over the phone, by mail, or with an assister – are also available for reporting changes.

6.1.3 Reporting Changes for Enrollees Receiving Financial Assistance

Only individuals who requested an eligibility determination for financial assistance (e.g., APTCs) are required to report changes related to:

a. Eligibility determination for or enrollment in other health insurance, including Medicare, Medicaid, other government-sponsored health insurance, or employer-sponsored coverage;
b. Income; and
c. Employment status, including any change in eligibility for employer-sponsored insurance.

6.1.4 Changes Found during Data Matching Process

BeWellnm is required by federal law [45 CFR 155.330(d)] to periodically check data of enrollees receiving financial assistance (e.g., APTCs). If beWellnm identifies updated information through data matching, beWellnm will notify the enrollee and provide them 30 days to provide their own updated information (plus 5 days for mailing).

a. If the enrollee confirms the information in the notice, their eligibility will be updated in accordance with the effective dates outlined in section 6.2.
b. If the enrollee provides different information, beWellnm will verify the information provided by the enrollee and update eligibility in accordance with the effective dates outlined in Section 6.2.
c. If the enrollee does not respond to the notice, beWellnm will update the eligibility using the information collected via data matching at the end of the month in which the 35th day after mailing occurs, unless such data matching is related to income, family size, or family composition. If the enrollee does not respond to data matching regarding income, family size, or family composition, no change will be made to the eligibility.

6.2 Effective Dates for Changes

Changes will be effective as follows:

a. Changes that result in an individual no longer being eligible for a health or dental plan through the Exchange will be effective at the end of the month in which the determination occurs. Enrollment will be terminated at the end of the month, except for terminations due to death. See *Section 4.4.2 Termination Due to Death*.
    i. For the effective of date changes to financial assistance (i.e., APTC), please see *Section 2.4.15 APTC and CSR Effective Date*.
b. If an enrollee reports a change in income that results in an assessment by the Exchange that the enrollee is likely eligible for Medicaid, the enrollee may remain eligible for QHP coverage until a Medicaid determination is completed by HSD:
    i. If the new household income is at or above 100% of the federal poverty level, and if the enrollee is otherwise eligible for subsidies, the enrollee may receive premium tax credits and other cost savings at the new income level until their income has been verified.
    ii. If the new household income is below 100% of the federal poverty level, the enrollee may receive their current level of subsidies through the end of month following the month of the reported change, after which time the individual will become eligible for unsubsidized coverage until their income is verified.
    iii. If determined eligible for Medicaid by HSD, members may choose to end their QHP coverage. If members do not choose to end their Exchange coverage, they may remain eligible and enrolled in the QHP, but without financial assistance. The member will be responsible for the full cost of the Marketplace plan purchased through the Exchange.

7. Rule Specific to American Indian and Alaska Native (AI/AN) Individuals and Families

There are special provisions for AI/AN individuals and families regarding eligibility, enrollment, and cost sharing. An AI/AN individual is defined as a person who is a member of a federally recognized tribe. (For specific definition see *Indian Self Determination and Education Assistance Act*, 25 U.S.C. §450b(d); see also 45 CFR §155.350.)

The following policies apply only to AI/AN individuals who want to enroll or have enrolled in a QHP through the Exchange.

7.1 Rule Regarding Enrollment for American Indian/Alaska Natives

In order to enroll in a QHP, an AI/AN individual must meet all other eligibility criteria and must also meet all enrollment criteria. However, an AI/AN may enroll in a health plan or change their health plan once per month, throughout the year.

7.2 Cost Sharing Reductions for American Indian/Alaska Natives

Additional cost sharing reductions are available to an individual who is an American Indian/Alaska Native (AI/AN).

a. An AI/AN individual enrolled in a QHP through beWellnm will not be responsible for any cost sharing requirement for an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contracted health services.
b. An AI/AN individual eligible for and enrolled in a QHP with a tax credit through beWellnm with a household MAGI up to 300%, can choose a "zero cost sharing plan". This means the individual will not have any out-of-pocket costs – like deductibles, co-pays, or coinsurance – when getting care.

8. Appeals, Complaints and Grievances

8.1 Appeals

45 CFR 155.500 – 45 CFR 155.555

An applicant or enrollee has the right to appeal certain decisions or determinations made by beWellnm. As defined in federal regulation, beWellnm accepts appeals for the following:

- An eligibility determination, including:
    - An initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions
    - A redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions
    - A determination of eligibility for an enrollment period
    - A failure by the Exchange to provide timely notice of an eligibility determination

Individuals have 90 days from the date of their eligibility notice to file an appeal on any issue listed above. Appeals are submitted by following the instructions at www.beWellnm.com. Additional information is available in the Help Center.

BeWellnm will send a letter confirming receipt of the appeal request and explanation of health coverage while the appeal is pending. The appeal process can take up to 90 days; however, beWellnm will work to resolve appeals promptly.

BeWellnm will work to resolve appeals prior to a hearing. Should an appeal require adjudication, the appeal will be heard by the New Mexico Human Services Department (HSD) for a final determination. HSD will issue written notice of the appeal decision within 90 days of the date an appeal request is received.

Individuals seeking assistance to file an appeal may visit www.beWellnm.com or call the Customer Engagement Center at 1-833-862-3935.

8.2 Complaints and Grievances

Individuals may also file a complaint (or grievance) with beWellnm about Exchange operations. Complaints may be submitted online via the Help Center at www.beWellnm.com or by calling the Customer Engagement Center. Individuals may request a response to the complaint or may send complaints anonymously. BeWellnm will review all complaints upon receipt. Any online or paper complaint received by beWellnm that should be directed to another party – for example, a complaint (grievance) about a denial of benefits by a carrier -- will be transferred by secure electronic communication. Complaints received over the phone will be transferred to the appropriate partner. BeWellnm will work with its partners to identify the appropriate communication channels for transfer of such complaints.

9. Renewals

9.1 General

A household enrolled in QHP coverage will renew their membership during the subsequent annual Open Enrollment Period. The current year coverage will end on December 31, and the renewal coverage will typically start on January 1. Households that do not pay for their January coverage by the due date will still have an opportunity to enroll in the renewal plan for coverage starting February 1.

Upon renewal, coverage will be effective January 1 of the succeeding year. A qualified individual or family who enrolls in their existing coverage through the Exchange and whose coverage initially started after January 1, will have a plan year of less than 12 months and will renew their membership during the subsequent annual Open Enrollment Period for coverage effective on January 1.

Monthly premiums are calculated based on rates in effect on the enrollee's effective date of coverage. An eligible individual or family who enrolls in QHP coverage through the Exchange may be sent an annual redetermination notice which includes information regarding the eligibility of the enrollee and their dependent(s). The enrollee must respond to this notice within 30 days by reporting changes online or by calling the Customer Engagement Center.

9.2 Automatic Renewals

45 CFR 155.335; 45 CFR 156.290 (5); 45 CFR 155.430

BeWellnm automatically renews individual health and/or dental insurance coverage for the next plan year if the individual is found eligible.

BeWellnm will update a household's information for the renewal year and send a preliminary eligibility notice for the renewal year to the Head of Household. This notice will contain currently available eligibility information – e.g., income. The household will have an opportunity to review the information in the preliminary eligibility notice. If necessary, the household may update their information for the renewal year. If the household's information is still correct, they don't have to take any action. This preliminary eligibility notice will be sent at the beginning of October.

If members of the household are eligible for the next plan year, they will be renewed into the same or similar ("mapped") plan and notified through their final renewal notice. Consumers may elect a different plan, as described in the final renewal notice. The renewal notice will be sent at the end of October.

Consumers who are no longer eligible to purchase health insurance on the Exchange are not renewed.

9.2.1 Cross-walked Renewals when a Carrier Leaves the Exchange

If an insurance carrier exits the Exchange market, or they are decertified by the Exchange at the end of the plan year, the Exchange terminates the consumer's enrollment at the end of the plan year. Consumers are automatically enrolled in a health plan with a similar design and premium (known as a cross-walked plan), as directed by the New Mexico Office of Superintendent of Insurance. Consumers may change coverage during the Open Enrollment Period.

If a carrier leaves the Exchange before the end of the coverage year, Special Enrollment Periods will apply.

9.3 Payments for Renewal Coverage

BeWellnm will process premium payments for renewal coverage beginning with Plan Year 2022. See *Section 5 Financial Management and Premium Billing* for additional information.

10 Dental

10.1 Dental Open Enrollment

45 CFR 155.410

For dental insurance purchased with a medical health plan, the same Open Enrollment and Special Enrollment Periods apply. However, individuals may shop and enroll in a Stand-Alone Dental Plan year-round. See *Section 10.8 Stand Alone Dental Plan* for additional information.

10.2 Rate Codes

To determine the dental premium, count members of the household age 19 or older and the three oldest children who are still 18 years old or younger, and add their individual premium amounts together to get the household premium amount.

10.3 Pediatric Dental Age Limits

Anyone 18 years of age or under can enroll in a pediatric dental plan.

10.4 Pediatric Dental Plans

Households with dependents are not required to purchase a QHP with embedded pediatric dental or child-only dental plans.

10.5 Disenrollment

Consumers can end dental coverage without terminating health coverage.

Consumers enrolled as dependents on a dental policy which includes adult coverage, will be automatically disenrolled at the end of the month in which the member turns 26.

10.6 Renewals

45 CFR 155.335 (j); 77 FR 18309, 18315

Dental health insurance plans will be renewed for consumers during the Open Enrollment period.

10.7 Left over APTC for Dental

45 CFR 155.1030; 45 CFR 155.340; 26 CFR 36B-3(e) Also See Section 2.4

Any APTC that remains available, or left over, after shopping for a health plan, may be used for dental for the dental plan shopping. Member level APTC left over shall be carried forward from the health plan to the dental plan for a member if the below conditions are met.

The member has selected a health plan and:

1. If the member level left over APTC after health plan shopping is greater than $0

   And

2. The member had applied maximum possible APTC towards the 100% of the essential health benefit premium percentage of the health plan

   And

3. The user has not selected a medical plan with Pediatric dental benefits.

   And

4. There is at least one minor (Age less than 19 years) member in the dental plan shopping group.

10.8 Stand Alone Dental Plan

Consumers will be able to shop and purchase a dental plan without the purchase of a QHP associated with their account. The applicant will need to be deemed eligible by the Exchange to purchase a dental plan. Individuals may shop and enroll in a Stand-Alone Dental Plan year-round.

NOTE: APTC is not applicable to Stand Alone Dental Purchases.

NOTE: Eligibility is dependent on citizenship status, New Mexico residency, not incarcerated, and not deceased.

11. Tax Reporting

Individuals that are enrolled in a Qualified Health Plan (QHP) through the Exchange and that use APTC to lower their monthly payment must “reconcile” when filing their federal taxes. Individuals will receive IRS Form 1095-A (Health Insurance Marketplace Statement) from beWellnm. The Form 1095-A provides individuals with information about their health insurance coverage so that application tax filers can:

- File their taxes;
- Reconcile advance payments of the premium tax credit (APTC); and
- Claim the premium tax credit (PTC).

Individuals will get one Form 1095-A for each plan in which they or members of their household were enrolled during the tax year. They may receive multiple forms if they:

- Changed plans in the middle of the year
- Added or removed members from a plan during the year

Individuals are not eligible for APTC if they had APTC paid on their behalf for a prior year but their tax filer did not file a federal income tax return and reconcile APTC for that year. When a tax filer does not comply with this requirement, it is known as "Failure to File and Reconcile" or "FTR." See *Section 2.4.1 Failure to Reconcile (FTR)* for more information.

If an individual did not receive Form 1095-A or have questions regarding the information on Form 1095-A they can contact beWellnm at 1-833-862-3935.

11.1 Form 1095-A

In January of each year, beWellnm generates and mails Forms 1095-A to tax filers who enrolled in a QHP through beWellnm during the prior year, except for those enrolled in catastrophic or dental only plans. Forms 1095-A are also generated electronically, and posted to enrollee's online accounts.

The information provided on a Form 1095-A is used to complete Form 8962 with the Internal Revenue Service (IRS). Application tax filers must complete and file a Form 8962, regardless of whether they are required to file a tax return, to claim premium tax credits (PTC), or be eligible for APTC in future years.

BeWellnm also provides the IRS monthly and yearly data regarding all individual enrollment and APTC payments made to QHP carriers on behalf of enrollees, which IRS uses when processing individuals' Federal income tax returns (e.g., to reconcile APTC, process PTC claims, and grant exemptions). Annual reports are submitted to IRS following completion of the coverage year, identifying tax-filers or other relevant adults who received APTC (or whose tax dependent(s) received APTC) related to an individual policy purchased through the Exchange. The IRS uses the information in the annual reports to verify information included on individual-submitted Form 8962. Please visit IRS Forms and Publications for complete IRS instructions.

12. Notices

BeWellnm will provide notices to individuals that informs them about the status of their applications, their eligibility for programs, premium payments and other important information. Notices will be sent by U.S. mail or electronic notification (via secured inbox) based on communication preference selected by the subscriber. Notices will also be sent to the authorized representative or enrollment counselor (or Navigator) if one has been designated.

Notice Name	Description
Account Transfer	The Inbound/Outbound Response Account Transfer notice informs the Head of Household that he/she needs to take required action so that they can be determined/re-determined for their household's eligibility for a qualified health plan (QHP).
Age Out	The Age Out notice informs the HOH that the specific member in their household is moving out of his/her shopping group as the member is turning 26 years of age.
Appeal Acknowledgement Form	Acknowledges receipt of an appeal submission to beWellnm, and informs the user of next steps.
Appeal Decision (Informal)	The Appeal Decision (Informal) notice informs the appellant of beWellnm's informal resolution of the appeal. The notice also provides instructions for requesting a hearing if the appellant disagrees with the informal decision.
Appeal Rejection	An appeal rejection may be sent if an appeal was not submitted timely or the user is requesting review of a decision or issue that is not subject to appeal.
Appeal Request for Information (RFI)	An Appeal RFI is sent to request additional information that may be needed to resolve the appeal.
Billing Statement	
Communication Preference Change	The notice informs the member of their change in communication preference.
Eligibility Approval	The QHP approval notice informs the applicant that they have been approved or provisionally approved for QHP benefits. The notice is triggered at the tax household level.
Eligibility Denial	The denial notice informs the applicant that they or members of their application are not approved for health benefits through beWellnm and includes the reason(s) why the individual was not approved.
Eligibility Termination	The Eligibility Termination notice informs the recipient(s) that the QHP enrolled members in the household are no longer eligible for any QHP coverage through QHP exchange following a program determination or other action that may have caused a person to lose eligibility (e.g., batch or administrative closing etc.).
Final Renewal	The Final Renewal Notice will be used to notify the household member(s) whose medical plan and/or dental plan will be auto renewed during the annual auto renewal processing. The notice

	will inform the household members about the medical plan and/or dental plan they will be auto-enrolled in for the upcoming year and will specify the actions that members can take going forward with an explanation of the options available.
Late Notice - Premium Payment	This notice informs the subscriber that their premium payment has not been received and they must remit payment to avoid termination for non-payment of premium.
Periodic Data Matching (PDM)	This notice is used to notify QHP enrollee(s) that there may be a downgrade or termination from existing benefits due to a data match triggered during the PDM process.
Preliminary Eligibility Determination	The Preliminary Eligibility Determination notice will be used to notify household members of their preliminary program eligibility determination for the upcoming year and will specify the actions that members can take moving forward with an explanation of the options available. During the transition year, this notice will also invite members to beWellnm.com.
Request for Identity Proof (RIDP)	When the Exchange is unable to verify information in the application using approved electronic interfaces, the applicant will receive a notice requesting more information. This "Request for Information" notice will provide more detail about the types of documents that can be used for verification (or proof) of statements on the application. It will also provide instructions about sending the documents.
Request for Information (RFI)	The Request for Information (RFI) notice is sent to the recipient when there is unverified data on file for an eligibility on an applicant. It may include requests for proof of SSN, Citizenship, Income, Incarceration Status, etc., affecting at least one individual in a household's eligibility determination.
Special Enrollment Period Decision (SEP)	The QHP Special Enrollment Period (SEP) Decision Notice is sent to the recipient when there is a SEP determination, including whether the household is eligible or ineligible for the SEP, along with any additional information that may be needed to verify the SEP. Accordingly, it may include requests for proof of adoption, new address, marriage, death, or other proof of qualifying event as determined during SEP determination.
Tax Liability (Employer)	This Tax Liability Notice informs the employer that his / her employee has been determined eligible for APTC through the QHP Exchange.
Termination Notice - Non-payment of Premium	This notice informs the subscriber that their policy has been terminated. The notice includes the termination effective date and reason for termination.

Appendix: Terms and Acronyms

Term	Acronym/ Primary	Definition
Account Holder		An Individual who initially creates an account through the UI (Individual or CSR Portal).
Adjusted Gross Income	AGI	Total (or "gross") income for the tax year, minus certain allowed adjustments. Adjustments include deductions for conventional IRA contributions and student loan interest.
Applicant		Any Individual listed on an application.
Authorized Representative	ARD	Someone an enrollee chooses to act on their behalf with the Marketplace, such as a family member or other trusted person. Some authorized representatives may have legal authority to act on the enrollee's behalf.
Cancellation		When an enrollment ends on the date coverage became effective resulting in coverage never having been effective. This occurs when an applicant fails to pay their first month's premium or binder, their policy is cancelled. Unlike terminations, cancellations do not require prior notification.
Carrier		Carrier, or Issuer, is an entity licensed by the New Mexico Office of the Superintendent of Insurance (OSI) as an insurance provider, and is seeking to offer one or more Qualified Health Plans and/or Stand-Alone Dental Plans through the Exchange.
Center for Consumer Information & Insurance Oversight	CCIIO	The Centers for Medicare & Medicaid Services' Center for Consumer Information and Insurance Oversight (CCIIO), part of the Department of Health & Human Services (DHHS), provides national leadership in setting and enforcing standards for health insurance that promote fair and reasonable practices to ensure that affordable, quality health coverage is available to all Americans. CCIIO is the federal oversight agency for health insurance marketplaces.
Centers for Medicare & Medicaid Services	CMS	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace.
Certified Application Counselor	CAC	An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers.

Term	Acronym/ Primary	Definition
Children's Health Insurance Program	CHIP	The Children's Health Insurance Program (CHIP) is a joint federal/State program that provides health insurance for children in families that do not have health insurance coverage and are not eligible for Medicaid. This is one of three insurance affordability programs addressed in the Affordable Care Act.
Complex Household		An application that contains members who are eligible for QHP and Medicaid.
Customer Engagement Center	CEC	The call center for the New Mexico Health Insurance Exchange, also known as beWellnm.
Customer Service Representative	CSR	Staff of the CEC who help consumers with the marketplace applications.
Dependent(s)		A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.
Employer-Sponsored Insurance	ESI	Employer sponsored insurance (ESI) is purchased through an employer, union, or by a self-employed individual.
Enrollment Counselor	EC	Trained individuals who are available to provide in-person counseling and assistance to consumers in need of help with applying for Marketplace programs. See also Certified Application Counselor.
Federal Data Services Hub	FDSH	The Centers for Medicare & Medicaid Services (CMS) offers a tool called the Data Services Hub (the Hub) that helps verify information used to determine eligibility for enrollment in qualified health plans and insurance affordability programs. The Hub provides one connection to the common federal data sources needed to verify consumer application information for income, citizenship, immigration status, access to minimum essential coverage, etc.
Federal Poverty Level	FPL	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

Term	Acronym/ Primary	Definition
Federal Tax Information	FTI	Any record, file, transaction, tape or cartridge received directly from the IRS or the Medicare Coordination of Benefits (COB) contractor that contains a beneficiary or spouse name, SSN, employer name and address and taxpayer identifier number.
Federally Facilitated Marketplace	FFM	A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Federally Facilitated Marketplace, available at HealthCare.gov, for most states. Some states, like NM, run their own Marketplaces.
Financial Management System	FMS	A module of the NM Exchange system that produces the premium bills, tracks receivables, and sends electronic data interchange (EDI) files to the carriers at designated times (EDI 834 is a daily file; EDI 820 is a monthly file).
Health Information Portability and Accountability Act	HIPAA	The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to improve the efficiency and effectiveness of the nation's health care system. The law includes provisions to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also defines requirements for the privacy and security of protected health information.
Health Insurance Exchange		Also known as Health Insurance Marketplace. A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states, like NM, run their own Marketplaces.
Human Services Department	HSD	New Mexico's Human Services Department (HSD) manages state and federal public assistance programs. HSD administers the Medicaid program as well as the integrated eligibility system (ASPEN) used to determine eligibility for those programs.
Integrated Eligibility System	IES	System used to determine and manage the life cycle of eligibility for various health and human services programs. The Human Services Department and its vendor Deloitte administer this system, codenamed ASPEN, in the state of New Mexico.
Internal Revenue Service	IRS	A division of the US Treasury Department responsible for ensuring compliance to the Federal Tax Code.
Issuer		See definition for Carrier.
Medicaid		Medicaid is one of three insurance affordability programs addressed in the Affordable Care Act. The Human Services Department administers the Medicaid program in the State of New Mexico.

Term	Acronym/ Primary	Definition
Minimal Acceptable Risk Standards for Exchange	MARS-E	The MARS-E suite of documents defines a risk-based Security and Privacy Framework for use in the design and implementation of Exchange information technology (IT) systems for which CMS has oversight responsibility.
Minimum Essential Coverage	MEC	Any insurance plan that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance for plans 2018 and earlier, an individual must be enrolled in a plan that qualifies as minimum essential coverage (sometimes called "qualifying health coverage"). Examples of plans that qualify include: Marketplace plans; job-based plans; Medicare; and Medicaid & CHIP.
Modified Adjusted Gross Income	MAGI	The figure used to determine eligibility for premium tax credits and other savings for Marketplace health insurance plans and for Medicaid and the Children's Health Insurance Program (CHIP). MAGI is adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.
National Producer Number	NPN	The National Producer Number (NPN) is a unique identifier assigned through the National Association of Insurance Commissioner's (NAIC's) licensing application process. The NPN is used to track individuals and business entities on a national basis.
New Mexico Health Insurance Exchange	NMHIX	The New Mexico Health Insurance Exchange, established by state law in 2013, in accordance with the federal Affordable Care Act, is a marketplace for qualified individuals to shop for and compare health insurance. Qualified individuals may also receive financial assistance (tax credits) to lower the cost of insurance. NMHIX, commonly known as beWellnm, also run marketplace for small business.
Non-Financial Assistance	Non-FA	A non-financial assistance application determines eligibility for a QHP without financial assistance.

Term	Acronym/ Primary	Definition
Nonqualified Individual Lawfully Present	ILP	Qualified status indicates that individuals may be eligible for financial assistance through the Marketplace, if they otherwise meet the Marketplace eligibility requirements, or may be eligible for full Medicaid and CHIP coverage. The term "lawfully present" is used to describe immigrants who have: "Qualified non-citizen" immigration status without a waiting period; Humanitarian statuses or circumstances (including Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking); Valid non-immigrant visas; Legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals).
Office of Superintendent of Insurance	OSI	The Office of the Superintendent of Insurance (OSI) is the regulatory agency for insurance products in New Mexico. See www.osi.state.nm.us for more information.
Open Enrollment Period	OE or OEP	The yearly period when people can enroll in a health insurance plan without a qualifying event.
Patient Protection and Affordable Care Act	PPACA	The first part of the comprehensive health care reform law enacted on March 23, 2010. The law was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is usually used to refer to the final, amended version of the law. (It's sometimes known as "PPACA," "ACA," or "Obamacare.") The law provides numerous rights and protections that make health coverage fairer and easier to understand, along with subsidies (through "premium tax credits" and "cost-sharing reductions") to make it more affordable. The law also established state health insurance exchanges.
Periodic Data Matching	PDM	PDM includes the process by which Health Insurance Exchanges periodically examine available data sources to identify consumers enrolled in Exchange health plans with financial help at the same time they're determined eligible for or enrolled in Medicare. If a consumer has been determined eligible for or is enrolled in MEC Medicare, s/he is generally not eligible to receive financial assistance to help pay for a Marketplace plan premium or for covered services. If consumers are eligible for minimum essential coverage (MEC) through Medicaid or the Children's Health Insurance Program (CHIP), they are not eligible for advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs) to help pay for a Marketplace plan premium and covered services.

Term	Acronym/ Primary	Definition
Personally Identifiable Information	PII	Personally identifiable information (PII), defined by the Office of Management and Budget (OMB), refers to information that can be used to distinguish or trace an individual's identity, like their name, Medicare Number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, like date and place of birth, mother's maiden name, etc.
Protected Health Information	PHI	The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.
QHP Only Household		A household will be considered a QHP only household if there are only QHP members in the application before renewal process starts.
Qualified Dental Plan	QDP	A dental plan certified by the OSI and NMHIX to be offered on the Exchange.
Qualified Health Plan	QHP	An insurance plan that's certified by OSI and NMHIX, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements under the Affordable Care Act. All qualified health plans meet the Affordable Care Act requirement for having health coverage, known as "minimum essential coverage."
Remote Identity Proofing	RIDP	RIDP is the process of validating sufficient information about an applicant (e.g., credit history, personal demographic information, and other indicators) to uniquely identify them.
Request for Information	RFI	A request for Information (RFI) is sent to the head of household when there is unverified data on file for an eligibility on an applicant. It may include requests for proof of SSN, Citizenship, Income, Incarceration Status, etc., affecting at least one individual in a household's eligibility determination.

Term	Acronym/ Primary	Definition
Social Security Administration	SSA	The Social Security Administration (SSA) administers two programs that provide benefits based on disability: the Social Security disability insurance program (title II of the Social Security Act (Act)) and the Supplemental Security Income (SSI) program (title XVI of the Act).
Social Security Number	SSN	The nine-digit Social Security number that is a person's first and continuous connection with Social Security. It helps identify and accurately record covered wages or self-employment earnings. It is also used to monitor a person's record once they start receiving benefits.
Special Enrollment Period	SEP	A Special Enrollment Period may let an individual or family apply for and enroll in health coverage outside of the annual Open Enrollment Period, or during Open Enrollment for an earlier coverage start date.
Stand-alone dental plan	SADP	A type of dental plan offered through the Marketplace that's not included as part of a health plan.
State Based Marketplace	SBM	States like NM that run a State-based Marketplace are responsible for performing all marketplace functions for the individual (and potentially small group) market. Consumers in these states apply for and enroll in coverage through marketplace websites established and maintained by the states.
System for Electronic Rates and Forms Filing	SERFF	SERFF represents the state-of-the art for insurers and regulators seeking efficient operations. The form submittal, document management and review access provided by the platform accelerates the pace of market-entry for new and renewing products, while ensuring compliance with consumer protection requirements.
Trusted Data Source	TDS	The external data sources which the used to verify the application data. The TDS are offered through the Federal Data Services Hub (FDSH).

Attachment: Eligibility Verification Plan