



New Mexico Health Insurance Exchange Policy Manual for Plan Year 2023

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## x. Publication Dates and Updates

The New Mexico Health Insurance Exchange (referred to herein as beWellnm, NMHIX, or “the Exchange”) will update this policy manual annually for the upcoming plan year. A draft of the manual will be published annually for public comment prior to the final publication. BeWellnm will distribute policy memos if/as policies are revised or added during the plan year.

# 1 Overview

## 1.1 Purpose

The purpose of this document is to provide the following:

Important information for and stakeholders and individuals about the operational policies of beWellnm.

A tool for the proper handling of individual cases.

## 1.2 Definitions and Acronyms

See Appendix A for definitions of common terms and acronyms.

## 1.3 Resources

The beWellnm website include 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](http://www.beWellnm.com) to learn more.

Stakeholders and individuals may also contact the beWellnm 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), and health plans with reduced cost sharing (known as cost-sharing reductions, or CSR). Individuals can also use the application to apply for Medicaid. The New Mexico Human Services Department (HSD) makes the final Medicaid eligibility determinations for individuals assessed by beWellnm as likely eligible for Medicaid.

### 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:

- The individual is a United States citizen, national, or a non-citizen who is lawfully present in the United States;
- The individual is not incarcerated, other than incarcerated pending the disposition of charges; and
- The individual is a resident of the State of New Mexico, if they live in New Mexico or intend to reside in New Mexico by the coverage effective date.

### 2.2 Who is Considered “Lawfully Present”

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

The following individuals may be considered lawfully present:

- 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
- Certain Ukrainian nationals
- Paroled into the U.S.
- Conditional entrant (granted before 1980)
- Battered spouse, child, or parent



- Victim of trafficking and their 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
- 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)

For a list of documents an individual may provide to verify their lawful presence, visit [beWellnm's](#)

Knowledge Base Articles at [www.beWellnm.com](http://www.beWellnm.com)

## 2.3 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 may also seek financial assistance to pay for the coverage. Individuals may be eligible for financial assistance by attesting to and verifying, where applicable, the following criteria:

- Have a projected annual modified adjusted gross income (MAGI) over 100% of the Federal Poverty Level (FPL);
- Are a tax filer, or a member of household with a tax filer, who is married and filing jointly OR single and filing single;
- 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;
- Attest that they will file taxes for the year in which a tax credit is received. Married individuals must file jointly to be eligible to receive a tax credit except for victims of domestic violence or spousal abandonment; and
- File a federal income tax return and reconcile the APTC for any required year in which the individual (or the individual's spouse or dependents) received APTC.

An individual or family can determine their APTC status by completing the application. Individuals who are determined eligible for APTC must enroll in health coverage through beWellnm to receive the financial assistance.

**Note:** The American Rescue Plan Act of 2021 (ARPA) temporarily expanded eligibility for the premium tax credit by eliminating the rule that a taxpayer is not eligible for a premium tax credit if their household income exceeds 400% FPL. Instead, ARPA makes premium tax credits available to these households and caps how much of the household income must be paid towards premiums at 8.5%, based on the cost of the benchmark plan.

**Note:** 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](#).

**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 100% of the FPL.

## 2.4 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 in which the tax filer was required to reconcile the received APTC but 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.

**Note:** BeWellnm will not take action on data that comes back from the IRS flagged with an FTR issue in line with CMS flexibilities for Plan Year 2023.

## 2.5 Cost Sharing Reduction (CSR)

45 CFR 155.305(g)(1)(i)(A)-(C)

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:

1. Be eligible to enroll in a QHP through beWellnm;
2. Be eligible for APTC;
3. Purchase a Silver plan through beWellnm; and
4. Have a household MAGI less than or equal to 250% FPL.

## 2.6 Cost Sharing Reductions for American Indian/Alaska Natives

45 CFR 155.350(a); 45 CFR 155.305(g)(1)(ii); 25 USC 450b(d)

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. An AI/AN individual can use eligible CSRs on Bronze, Silver, or Gold level plans.

- 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.
- An AI/AN individual eligible for a QHP with a premium tax credit through beWellnm, with a household MAGI between 100% and 300% FPL, can choose a “zero cost sharing plan.” This means the individual will not have any out-of-pocket costs – such as deductibles, co-pays, or coinsurance – when getting care.

## 2.7 Income Used for Financial Assistance Application

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

Financial assistance (APTC and CSRs) is based on a household's expected income for the year of health coverage being applied for, not the prior year's income. Generally, household income is made up of income of the tax filer, their spouse, and their tax dependents (even if the spouse or dependents don't need coverage). Income is used to determine whether an individual or family is eligible to receive APTC/CSR and, if eligible, how much APTC they may receive. It is important to estimate household annual income as accurately as possible since tax credits are calculated using estimated taxable income.

Taxable income 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, including information on whether a dependent's income should count toward household MAGI, is available in the beWellnm Help Center at

[www.beWellnm.com](http://www.beWellnm.com).

## 2.8 Verification of Income for a Financial Assistance Application

45 CFR 155.320(c); 45 CFR 155.305(f)(1); 26 CFR 1.36 B-1

BeWellnm uses trusted data sources to verify the applicant's self-attestation of income. The attested income will be validated and considered "reasonably compatible" with the data source if the amount is no more than 50% lower. Income that is higher than information from the trusted data source will be accepted and is not subject to the reasonable compatibility threshold. If the data returned is not reasonably compatible, the individual will be asked to provide further documentation to verify income.

## 2.9 Determining Premium Tax Credit Amount

BeWellnm considers several factors when determining the premium tax credit, including:

Age of individual(s) as of the effective date of coverage

Household's projected modified adjusted gross income (MAGI)

Household size

Number of household members requesting and eligible for APTC

Tax households are made up of the taxfiler(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 taxfiler 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 purposes of APTC calculation.

## 2.10 Calculating Age of Household Members

45 CFR 147.102

BeWellnm will calculate APTC using the ages of the household members based on the coverage start date.

## 2.11 Household Composition

To align with federal tax households, beWellnm will consider the following household relationships when calculating APTC:

- Spouse
- Child
- Adopted child
- Stepson/stepdaughter
- Ward
- Anyone who is in your legal custody (e.g., grandchild)
- Other relationships identified by the IRS

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

## 2.12 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 CFR 155.320(b)

Individuals with access to Employer Sponsored Coverage must provide information regarding the offered coverage during the application submission. Employer-Sponsored Coverage must be affordable and must meet minimum value standards for self-only and family coverage.

The cost of the annual premium for the lowest priced self-only plan must be less than 9.12% of annual household income in 2023 to be considered affordable. If the self-only coverage is affordable, the individual will not be eligible for financial assistance through beWellnm.

The cost of the annual premium for the lowest priced family coverage plan must be less than 9.12% of annual household income in 2023 to be considered affordable. If the family coverage is affordable the family will not be eligible for financial assistance through beWellnm.

If the employee's self-only or family coverage cost is considered unaffordable the individual and/or family may enroll through beWellnm and receive APTC and/or CSR if otherwise eligible.

## 2.13 Applying for APTC When Eligible for Retirement Coverage

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

If an individual 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 an individual's retirement coverage ends outside of the annual Open Enrollment Period (OEP) and the individual chooses not to re-enroll, they would be eligible for a Special Enrollment Period (SEP).

## 2.14 Applying for APTC When Enrolled in COBRA

26 CFR 1.36 B(c)

Individuals who are offered Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage can apply for health coverage with APTC through beWellnm instead of enrolling in COBRA.

If an individual is enrolled in COBRA coverage, they may be eligible for coverage through beWellnm but will not be eligible for financial assistance until their COBRA coverage expires, the employer stops contributing to COBRA, or they voluntarily drop their COBRA coverage and enroll in a new policy through beWellnm during the annual OEP. Individuals cannot voluntarily drop their COBRA coverage to enroll in coverage through beWellnm outside of the OEP.

**Note:** If an individual is enrolled in COBRA coverage and ceases COBRA coverage early due to non-payment, they will not qualify for an SEP outside of the OEP.

## 2.15 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, in most cases.

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).

- Individuals who receive free Medicare Part A cannot drop it without also dropping their retiree benefits (i.e., Social Security) and paying back all retirement benefits received and costs incurred by the Medicare program.
- Individuals over 65 years old who elect not to receive retirement benefits, or who are not eligible for Medicare, may be eligible for APTC and/or CSR.

Individuals who become eligible for benefits under Medicare while enrolled in coverage through beWellnm may maintain their marketplace coverage, but their APTC/CSR will be terminated. BeWellnm will send a notice and the individual will have 30 days to respond before beWellnm acts. Carriers will be informed of changes to an individual's coverage via the 834 transaction process. Individuals newly enrolled in Part A only or Part A and B may purchase coverage through beWellnm. However, they must contact the beWellnm Customer Engagement Center for assistance.

**NOTE:** Individuals should call the beWellnm Customer Engagement Center if they are over 65 and do not qualify for Medicare, only qualify for Premium Payment Medicare Part A and are not enrolled or are enrolled in Medicare but wish to purchase a full price plan. BeWellnm may be able to provide coverage and help paying for costs, in some cases.

**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.

**NOTE:** Individuals who are eligible for or enrolled in Medicare may purchase a stand-alone dental plan through beWellnm.

## 2.16 APTC and CSR Effective Date

45 CFR 155.310; 45 CFR 155.340; 45 CFR 155.330(b)(1)

Individuals who are enrolled on the Exchange with financial assistance and experience a change that impacts their eligibility for coverage, APTC and/or CSR are required to report the change to beWellnm within 30 days. BeWellnm will apply updated APTC amounts and/or CSR variant levels as follows:

- If changes are reported by the 23rd of the month, the new APTC amount will be effective on the first day of the following month.
- If changes are made between the 24th of the month and the last day of the month, the new APTC amount will be effective on the first day of the second month following the change (e.g., for a change reported on April 24, the new APTC amount would be applied on June 1).

Individuals who are enrolled through beWellnm with no financial assistance and subsequently gain eligibility for APTC will have the new APTC amount applied to their premiums as described above.

Individuals who are not enrolled through beWellnm and receive a new APTC eligibility determination, or who are enrolled and have a change in APTC or CSR, will have their new APTC amount and/or CSR level applied to their enrollment as described herein.

**Note:** The timelines outlined in this section are subject to change during Plan Year 2023. Contact beWellnm for confirmation, or with questions.

## 2.17 Applying APTC to Qualified Dental Plans

Individuals or families enrolled in a 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 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 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.

## 2.18 APTC and Tax Reporting

Individuals that are enrolled in a QHP through beWellnm and use APTC to lower their monthly payment must "reconcile" the APTC received during a given plan year when filing their federal taxes.



**Note:** In response to the impact of the COVID-19 public health emergency (PHE) on the processing of federal income tax returns, taxpayers whose 2020 APTC was more than their allowed premium tax credit (i.e., taxpayers who received more APTC than they were entitled to) were not required to reconcile their APTC for Plan Year 2020. In Plan Years 2021 and 2022, CMS did not act on data from the IRS for individuals who failed to file tax returns and reconcile a previous year's APTC with the premium tax credit allowed for the year. BeWellnm likewise will not act on FTR data from the IRS in Plan Year 2023.

## 2.19 Health Care Affordability Fund (HCAF)

Effective Plan Year 2023, beWellnm will implement programs established by OSI with funding through the implementation of from the New Mexico Health Care Affordability Fund (HCAF). These programs are collectively referred to as the Marketplace Affordability Program (MAP). The Marketplace Affordability Program includes the programs outlined below. This policy manual contains a summary of the Marketplace Affordability Program. More detailed information can be found at: <https://www.osi.state.nm.us/pages/bureaus/consumer/resources/health-care-affordability-fund>

### 2.19.1 New Mexico Premium Assistance (NMPA)

Individuals and families with household incomes up to 400% FPL who qualify for federal premium tax credits through beWellnm are eligible for NMPA. NMPA provides:

- for individuals and families up to 200% FPL: no-cost premium options
- for individuals and families between 200–400% FPL: reduced premiums

### 2.19.2 Native American Premium Assistance

AI/AN individuals and families with household incomes up to 400% FPL who qualify for federal premium tax credits through beWellnm are eligible for NAPA. NAPA provides:

- for AI/AN individuals with household incomes up to 300% FPL: no-cost premium options
- for AI/AN individuals with household incomes between 300 - 400% FPL: reduced premiums

Enrollees are not required to reconcile NMPA and NAPA payments on their coverage year tax returns as they do for APTC. NMPA and NAPA cannot be applied to dental plans.

### 2.19.3 State Out-of-Pocket Assistance (SOPA)

Individuals and families with household incomes up to 300% FPL who qualify for federal premium tax credits through beWellnm are eligible for SOPA. SOPA, which is funded by the Health Care Affordability Fund, provides extra savings on out-of-pocket costs for certain plans. Plans with SOPA are labeled as Turquoise Plans.

To benefit from SOPA, when plan shopping, individuals must select a Turquoise Plan. There are four levels of Turquoise Plans, based on household income:

- up to 150% FPL (Level 1)
- between 150-200% FPL (Level 2)
- between 200-250% FPL (Level 3)
- between 250%-300% FPL (Level 4)

#### 2.19.4 Medicaid Transition Premium Relief

The Medicaid Transition Premium Relief program will be implemented in Plan Year 2023, when the Public Health Emergency (PHE) ends. This program covers one month of premium for individuals or families who lose Medicaid coverage and enroll in coverage through beWellnm. This program is available to individuals and families who:

- no longer qualify for Medicaid after the PHE;
- qualify for a federal premium tax credit through beWellnm; and
- have an income at or below 400% FPL.

The maximum amount of available APTC will be applied to the premium before the Medicaid transitional premium relief is applied.

## 3 Medicaid Eligibility and Financial Assistance Applications

BeWellnm will assess applications for health coverage with financial assistance for Medicaid eligibility. If one or more members of a household are assessed as likely eligible for Medicaid, their application(s) will be transferred to HSD for a final determination of Medicaid eligibility. BeWellnm will not send applications of individuals assessed as likely not eligible for Medicaid to HSD for a final Medicaid eligibility 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 beWellnm.

### 3.1 Opt-out of Medicaid determination

BeWellnm will send information for all individuals on a financial assistance application who are assessed as likely eligible for Medicaid to HSD for a final determination of Medicaid eligibility. If an individual 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 an individual who is assessed as likely eligible for Medicaid “opts out” of a final Medicaid determination, the individual will not be eligible for financial assistance (i.e., APTC) to purchase health coverage through beWellnm. The individual may purchase a marketplace health plan without financial assistance.

### 3.2 Requesting a final Medicaid determination

Applications of individuals assessed as ineligible for Medicaid will not be sent to HSD for a final determination of Medicaid eligibility. However, an individual may elect to have their application sent to HSD for a Medicaid determination.

### 3.3 Catastrophic Plans and Exemptions

45 CFR 155.605

Catastrophic Plans will not be offered on the Exchange for Plan Year 2023.

### 3.4 Requesting an Exemption

45 CFR 155.605

CMS is responsible for processing hardship exemptions for New Mexicans. For more information on how individuals may request an exemption, visit [www.healthcare.gov](http://www.healthcare.gov) or <https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/>.

## 4 Application

### 4.1 How to Apply

An individual may apply online, by phone, or by mail using beWellnm’s designated application. The application can be downloaded at [www.beWellnm.com](http://www.beWellnm.com). Certified enrollment counselors and brokers are available to help individuals with their applications at no cost. Individuals can find free local help at [www.beWellnm.com](http://www.beWellnm.com), or by calling the Customer Engagement Center.

### 4.2 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. If an individual attests to meeting the eligibility criteria and such attestation cannot be verified by trusted data sources, beWellnm will request additional documentation from the applicant to verify attestations. This notice is called a Request for Information (RFI). The RFI notice will let the individual know that they have 90 days to provide documentation (proof).

An individual will be determined conditionally eligible during this “reasonable opportunity” period based on their attestation, pending submission and verification of the requested documentation.

If, after the 90 days, beWellnm remains unable to verify the information attested to, an individual’s eligibility will be determined based on the information available from the trusted data sources. In some cases, an individual and/or their tax household may lose all or partial eligibility for coverage or financial assistance.

BeWellnm may extend the reasonable opportunity 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. If an applicant does not have documentation to resolve their inconsistency because it does not exist or is not reasonably available, except for an inconsistency related to citizenship or immigration status, beWellnm will provide exceptions on a case-by-case basis and may 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.

### 4.3 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 for the upcoming year. However, beWellnm may offer additional enrollment opportunities, including an extended OEP. The OEP dates by plan year are in the table below.

Plan Year	Open Enrollment Period
2022	November 1, 2021 – January 15, 2022
2023	November 1, 2022 – January 15, 2023

#### 4.4 Coverage Effective Dates during Open Enrollment Period

During Open Enrollment, if a household wants health insurance coverage to start on January 1, they must select a plan for enrollment and make their first month’s premium payment (the “binder” payment) no later than December 23.

Individuals who select a plan for enrollment between December 24 and January 15, and who make their first month’s premium payment by January 23 will receive a coverage effective date of February 1.

Plan Selection	Payment Deadline	Coverage Effective Date
November 1 – December 23	December 23	January 1
December 24 – January 15	January 23	February 1

A new member or a current enrollee may 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 enrolled in a QHP and made the first month’s premium payment (i.e., the binder payment), but then enrolled in a different QHP before the end of the OEP, the initial coverage will be canceled. The first premium payment will be applied to the new plan.

#### 4.5 Easy Enrollment

New Mexico’s Easy Enrollment Act will take effect in 2023. In accordance with this legislation, New Mexico taxpayers will be able to check a box on their 2022 state income tax return, giving the New Mexico Taxation and Revenue Department permission to share information with the Human Services Department (HSD) and beWellnm for the purpose of determining whether the individual qualifies for Medicaid, or for health coverage through beWellnm. Interested individuals will first be assessed for Medicaid eligibility by HSD. Those who are not eligible for Medicaid will be transferred to beWellnm. BeWellnm will notify the individuals that they can continue their application for health coverage at [www.beWellnm.com](http://www.beWellnm.com).

## 5 Special Enrollment Periods and Qualifying Life Events

45 CFR 155.420

Individuals may apply for coverage through a Special Enrollment Period (SEP) if they experience a qualifying life event.

**Note:** This policy manual contains basic information about SEPs and qualifying life events. Further information, including a detailed SEP matrix, can be found in the Knowledge Base Articles on beWellnm's website.

### 5.1 Qualifying Life Event

A qualifying life event (QLE) is a change in an individual's situation — like having a baby or losing health coverage — that can make the individual eligible for an SEP, allowing them to enroll in coverage outside the annual Open Enrollment Period.

There are four basic types of QLEs: (1) loss of health coverage (e.g., losing job-based insurance or eligibility for Medicaid); (2) changes in household (e.g., getting married or having a baby); (3) changes in residence (e.g., moving to or from New Mexico); and (4) other QLEs (e.g., becoming a U.S. citizen or leaving incarceration).

Individuals must attest that the information they provide on the application is true, including the circumstances that qualify them for an SEP. They may be required to submit documents to confirm their eligibility to enroll based on the applicable QLE.

### 5.2 Effective Dates for Coverage through an SEP

Changes to enrollments will be effective in accordance with the effective dates based on enrollment and payment of the premium, except in the case of court order, birth, adoption or placement for adoption or foster care, as described below. Any APTC or CSRs will be effective consistent with the coverage effective date.

For enrollment of an individual into a new policy, the individual can choose among the following for their effective date of coverage:

- The date of birth, adoption, etc. (for an SEP related to birth, adoption, etc.); enrollees should call the Customer Engagement Center for help with this option;
- The 1<sup>st</sup> of the month following the reported change (if enrollment is completed by the 23<sup>rd</sup> of the month); or
- The 1<sup>st</sup> of the second month following the reported change month (if enrollment is completed on or after the 24<sup>th</sup> of the month).

### 5.3 Reporting Requirements for Qualifying Events

Qualifying life events must be reported to beWellnm within 60 days of the event. BeWellnm may require documents proving that the qualified individual, enrollee, or dependent has experienced one or more qualifying life events.

**Note:** Loss of minimum essential coverage can be reported 60 days prior to the event.

### 5.4 Getting Assistance

BeWellnm will help individuals and families apply for and enroll in coverage. Individuals may also apply for and enroll in coverage with a licensed and certified insurance broker, certified enrollment counselor, or community organization that provides free local help. For information about assistance, please visit [www.beWellnm.com/Enrollment](http://www.beWellnm.com/Enrollment)

### 5.5 Enrollment Completion and Effective Dates

BeWellnm requires the first month's premium payment to be remitted to beWellnm no later than the 23<sup>rd</sup> 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 with a retroactive effective date in certain circumstances, such as when individuals transition from Medicaid to Exchange coverage after the Public Health Emergency (PHE) ends.

If an applicant fails to complete the enrollment process outlined above by the 23<sup>rd</sup> day of the month, they may select a later effective date of coverage if they do so within the annual OEP or an applicable SEP.

An individual must comply with beWellnm's reasonable requests for information necessary to verify the information attested to on the application to maintain enrollment in a plan

## 6 Termination of Coverage

45 CFR 155.430

Termination of marketplace coverage 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 QHP or QDP must cover the enrollee and the covered services that the enrollee received from the coverage effective date until the termination date. A member 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).

### 6.1 Voluntary Termination

A member 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 OEP unless they qualify for an SEP or if they are an American Indian or Alaska Native. A member can request voluntary termination through the online application or by contacting the Customer Engagement Center.

A member who voluntarily terminates coverage may select a termination date of at least 14 calendar days from the date of the termination request or a later date within the plan year. BeWellnm may grant a member'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 a member is delinquent in paying monthly premiums at the time of the request to terminate, the member must pay all outstanding premiums by the end of the delinquency period to avoid a retroactive 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.

### 6.2 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. If the Head of Household is deceased, the remaining household members will be eligible for an SEP based on loss of minimum essential coverage. They must complete a new account to enroll in new coverage. The deceased Head of Household should be included in this new account (as a dependent, not as the new Head of Household) for tax purposes for the rest of the coverage year.

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.

### 6.3 Termination for Fraud

45 CFR 147.128. 45 CFR 147.128

BeWellnm or the QHP or QDP carrier may terminate or rescind an enrollee's coverage if the QHP or QDP carrier identifies 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 termination date, and CMS will recoup any APTC 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](mailto:compliance@nmhix.com) to initiate a rescission as described in this section.

### 6.4 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 beWellnm.

Effective dates for retroactive termination of coverage:

- The last day of the coverage month before the member is 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.

## 6.5 Enrollee Age-Out

BeWellnm conducts enrollee age-out throughout the year as specified below.

### 6.5.1 For Pediatric Only Dental Plans

A member'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 for the following plan year during the annual OEP.

### 6.5.2 For Dependents on Family Medical and Dental Plans

A dependent's enrollment will automatically be terminated the last day of the month in which the dependent attains age 26. The enrollment will not automatically terminate if the individual aging out is the subscriber, the subscriber's spouse, or domestic partner. A dependent enrollee who is disabled will not experience changes in enrollment because of attaining age 26.

### 6.5.3 For Catastrophic Plans

A member's eligibility ends at the end of the plan year in which the enrollee attains age 30, unless the enrollee provides documentation showing that they have 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).

## 7 Financial Management and Premium Billing

BeWellnm's financial management system is the system of record for all transactions related to billing and payment for coverage purchased through beWellnm. Carriers will not be involved in, and should not engage in, premium billing and collection of Exchange premiums.

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 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

The companion guides can be found at: <https://www.bewellnm.com/state-based-exchange/sbe-carriers/>

### 7.1 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 plan they elected to enroll in. The bill includes the current month billed amount and adjustments for any transactions (adds/terms/changes) processed since the last billing cycle. One consolidated bill includes both Medical and Dental (if applicable).

Premium bills are mailed to the subscriber'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 a

notification letting them know when a new bill is available in their online account.

## 7.2 Premium Billing Detail

Premium bills include the subscriber's name and ID, plan, carrier, coverage month, due date, APTC and Marketplace Affordability Program (MAP) amounts (if applicable), and any outstanding balance. The total amount due is summarized and reduced by the APTC and MAP amounts. 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 bill will include a message indicating their payment will be withdrawn from the subscriber's bank account or credit/debit card on file.

## 7.3 Premium Payments

### 7.3.1 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 payment(s) received are equal to or greater than the threshold amount of \$5.00. The policy applies to the initial premium payment, any subsequent premium payments, and 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 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.

### 7.3.2 Initial Payment (aka "binder payment" or "binder")

45 CFR 155.410; 45 CFR 155.420

Subscribers must make their binder payment to complete their enrollment and for 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 will be effectuated.

The binder payment is due on the 23<sup>rd</sup> of the month for coverage to begin on the 1<sup>st</sup> of the following month. If payment is made after the 23<sup>rd</sup> of the month, coverage will begin the 1<sup>st</sup> day of the second month during Open Enrollment. For a qualified SEP, the payment is due on the 23<sup>rd</sup> of the month or within seven (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 the 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, the 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 any outstanding premium by the due date will trigger a grace period.

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 to make coverage effective as of the first day of the upcoming coverage year.

### 7.3.3 Ongoing Payments

To maintain continuous coverage, enrollees must continue paying their premium for each month they are enrolled until they terminate. 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's 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 to review their bill, and determine the financial impact of those changes to their next bill. Any questions will be answered by customers either logging into their online accounts or calling the Premium Billing Department.

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.

### 7.3.4 Payment for Renewals

BeWellnm will not require binder payments for members who are automatically re-enrolled in coverage for Plan Year 2023.

### 7.3.5 Payment Types

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

Payment Method	One Time	Recurring
Personal Checks	X	
Cashier's Checks	X	
Money Orders	X	
Automated Clearing House (ACH)	X	X
Debit and Credit Cards	X	X

### 7.3.6 One-time payments online

Subscribers can make payments online by accessing their account on the beWellnm portal. The banking/card information entered for one-time payments is not retained in the system and must be re-entered when making subsequent one-time online payments.

### 7.3.7 One-time payments by mail

Subscribers can mail a check or money order, made out to the New Mexico Health Insurance Exchange or NMHIX, along 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

### 7.3.8 One-time payment in person:

- Subscribers choosing to hand-deliver payments can do so at the beWellnm administrative office at:
- 7601 Jefferson St NE, Suite 120 | Albuquerque, NM 87109.

### 7.3.9 Recurring payments

Subscribers that elect recurring payments authorize NMHIX to automatically collect their monthly premium from their bank account or debit/credit card each month.

- Recurring ACH payments are processed on the 18<sup>th</sup> of the month for the following month of coverage.
  - The amount withdrawn will be the total amount due on the bill.
- Recurring debit/credit payments are processed on the 19<sup>th</sup> of the month for the following month of coverage.
  - The member enters a fixed amount to be withdrawn each month. If their premium changes, they must update the amount and make a one-time payment for any outstanding balance if applicable.

Recurring payments can only be set up after a subscriber has made their initial payment.

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 bill. If it does not appear on their bill, the subscriber must 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 recurring payment information is not updated prior to the recurring payment process, they must 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.

### 7.3.10 Payment by Phone

Subscribers can use the automated payment system to pay by debit/credit card by calling 1-833-862-3935.

Subscribers can also make a payment over the phone with the NMHIX Premium Billing Department by calling 1-833-862-3935, option 4.

**Note:** 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.

### 7.3.11 Direct to carrier

Direct to carrier 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 must be forwarded to beWellnm 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

**Note:** For members in a grace period, the carrier will send a secure email notification to the NMHIX Premium Billing Department at [PremiumBilling@nmhix.com](mailto: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

For any premium payments made to and deposited by the carrier, the carrier must issue a replacement check to NMHIX and send it to the lockbox address provided above. Follow the steps above to notify NMHIX.

## 7.4 Returned Payments

Upon notification of a returned payment by NMHIX's bank, the returned payment will be reversed in the NMHIX system. 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.

## 7.5 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.

## 7.6 Grace Periods

Subscribers have a grace period before their coverage can be terminated for non-payment.

### 7.6.1 Grace Period Window

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

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.

**Note:** Grace periods are applicable to dental plans that have associated APTC.

### 7.6.2 Payment of 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 subscriber.

### 7.7 Non-Payment of Premium and Notices

If premium payment has not been received by beWellnm by 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 an example of the timeline for non-payment of premium for both APTC and Non-APTC for a May coverage month:

APTC

May Coverage Payment Due 4/30	
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	
May 1	Late Notice
June 1	Termination Notice Termination Processed Effective 4/30

### 7.7.1 Late Notice

The Late 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.

### 7.7.2 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 due to non-payment of premiums is not considered a Qualifying Life Event to trigger a Special Enrollment Period. Carriers are notified of terminations due to non-payment via the 834.

### 7.7.3 Termination for Non-Payment of Premium

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 the 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 beWellnm until the next Open Enrollment Period, unless they qualify 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.

Individuals must pay both their medical plan and dental plan premiums in full. Failure to pay the premium for either plan type will result in the termination of both plans.

## 7.8 Termination Inquiries

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

## 7.9 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.

## 7.10 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. 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.

## 7.11 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.

## 7.12 Refunds

Individuals with valid credits on their account may request a refund by calling the beWellnm Premium Billing Department or by mail, otherwise, refunds will be processed monthly. Requests will be reviewed and approved or denied by the NMHIX Finance Department. Refunds will not be processed until 15 days after 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 by an estate's administrator or other individual appointed by law for deceased account holders will be honored. 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 accou

## 8 Reporting Changes and Redeterminations

45 CFR 155.335

BeWellnm is required to redetermine eligibility for a QHP or 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.

### 8.1 Enrollee Responsibility

45 CFR 155.335(e)

An enrollee and the dependent(s) must report any changes that impact eligibility for coverage through beWellnm and/or financial assistance within 30 days of the event.

### 8.2 Reporting Changes

Enrollees must report changes related to:

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

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

### 8.3 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 within 30-days related to:

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

**Note:** BeWellnm will rerun eligibility for enrollees who report changes. A new eligibility determination may result in changes to the enrollee's premium and/or APTC amounts.

## 8.4 Changes Found during Data Matching Process

45 CFR 155.330(d)

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

1. If the enrollee confirms the information in the notice, their eligibility will be updated in accordance with the effective dates outlined in the notice.
2. 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 8.5 Effective Dates for Changes.
3. 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.

## 8.5 Effective Dates for Changes

Changes will be effective as follows: Changes that result in an individual no longer being eligible for a health or dental plan through beWellnm 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.

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 pending a Medicaid determination by HSD. Thereafter:

- 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.
- 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.

- If determined eligible for Medicaid by HSD, members may choose to end their QHP coverage. If members do not choose to end their coverage through beWellnm, 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 beWellnm.

**Note:** when completing the beWellnm application, individuals can attest that they request that their QHP coverage, along with applicable financial assistance, be closed automatically if they are found eligible for Medicaid. Taking this option can help individuals avoid dual coverage in Medicaid on the Exchange.



## 9 American Indian and Alaska Native (AI/AN) Individuals and Families

25 U.S.C. §450b(d); 45 CFR §155.350

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.

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

### 9.1 Rule Regarding Enrollment for American Indian/Alaska Natives

45 CFR 155.420(d)(8)

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

### 9.2 Cost Sharing Reductions for American Indian/Alaska Natives

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

- 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.
- 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.

## 10 Appeals, Complaints and Grievances

### 10.1 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. Reasons in which an applicant or enrollee can appeal are as follows:

An eligibility determination, including:

1. An initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions
2. A redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions
3. A determination of eligibility for an enrollment period
4. A failure by beWellnm 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](http://www.beWellnm.com). Additional information is available in the beWellnm Help Center.

BeWellnm will work to resolve appeals prior to a hearing. Should an appeal require adjudication, the appeal will be heard by 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 with filing an appeal may visit [www.beWellnm.com](http://www.beWellnm.com) or call the Customer Engagement Center at 1-833-862-3935.

### 10.2 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](http://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

## 11 Renewals

### 11.1 General

A household enrolled in QHP coverage will have their coverage renewed prior to the annual Open Enrollment Period. The current year coverage will end on December 31, and the renewal coverage will typically start on January 1.

A qualified individual or family whose coverage initially started after January 1, will have a plan year of less than 12 months, and will have their coverage renewed during the annual OEP for coverage effective on January 1.

### 11.2 Automatic Renewals

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

BeWellnm will automatically renew an individual's health and/or dental insurance coverage for the next plan year if the individual is found eligible to enroll in coverage.

BeWellnm will update a household's information for the renewal year and send a notice for the renewal year to the Head of Household. This notice will contain currently available eligibility information – e.g., income. If the household's information is still correct and they do not have any changes to report, they don't have to take any action. The household may update their information for the renewal year during the annual OEP. The renewal notice will be sent prior to the annual OEP. 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. Individuals may elect a different plan, as described in the renewal notice.

Individuals who are no longer eligible to purchase health insurance through beWellnm will not be renewed into coverage for the new plan year. Individuals will be notified if they will not be renewed. Individuals can reapply and enroll in coverage, if eligible, during the annual Open Enrollment Period.

### 11.3 Cross-walked Renewals when a Carrier Leaves the Exchange

If an insurance carrier exits the individual Exchange market, or they are decertified by beWellnm at the end of the plan year, beWellnm will terminate the individual's enrollment at the end of the plan year. Individuals will be automatically enrolled in a health plan with a similar design and premium amount, known as a cross-walked plan, as directed by the New Mexico Office of Superintendent of Insurance (OSI). Individuals may elect to change coverage anytime during the Open Enrollment Period.

**Note:** If a carrier leaves the individual Exchange before the end of the coverage year, a Special Enrollment Period will be available to select a new plan.

## 11.4 Payments for Renewal Coverage

BeWellnm will process premium payments for renewal coverage beginning with Plan Year 2023. BeWellnm will not require binder payments for members who are automatically re-enrolled in coverage for Plan Year 2023. Premium payments for January coverage for members who are automatically re-enrolled in coverage are due on December 31, 2022.

## 12 Dental

### 12.1 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, although they may only change or enroll in a stand-alone dental plan once per month.

### 12.2 Rate Codes

45 CFR 147.102

To determine the dental premium, beWellnm will count members of the household that are 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.

### 12.3 Pediatric Dental Age Limits

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

### 12.4 Pediatric Dental Plans

Households with dependents are not required to purchase a QHP with embedded pediatric dental included in the QHP benefits, or child-only dental plans. Households seeking pediatric dental has the option to purchase a dental plan.

### 12.5 Disenrollment

Enrollees may terminate their dental coverage without terminating their health coverage. Those 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.

### 12.6 Dental Renewals

45 CFR 155.335 (j)

Dental health insurance plans will be renewed for enrollees during the Open Enrollment Period.

## 12.7 Left over APTC for Dental

45 CFR 155.340; 26 CFR 36B-3(e)

Any APTC that remains available, or left over, after shopping for a qualified health plan, may be applied to pediatric dental benefits. 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.

## 12.8 Qualified Dental Plans

Individuals will be able to shop and purchase a QDP (also referred to as a stand-alone dental plan) without the purchase of a QHP associated with their account. The applicant must be deemed eligible by beWellnm to purchase a dental plan. Individuals may shop for and enroll in a stand-alone dental plan year-round.

**Note:** APTC is not applicable to stand-alone dental plans.

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

## 13 Tax Reporting

Individuals who are enrolled in a QHP through beWellnm and who 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 a federal tax return for the coverage year;
- Reconcile advance payments of the premium tax credit (APTC); and
- Claim the premium tax credit (PTC), if they have not taken the full amount in advance.

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; and/or
- 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.”

**Note:** In accordance with CMS guidance, beWellnm’s FTR processes will remain suspended in Plan Year 2023.

### 13.1 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 the 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 beWellnm. 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.

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

## 14 Notices

Notices will be sent by U.S. mail or electronic notification (via secured inbox) based on the communication preference selected by the individual. The below table provides a general description of the notices that may be sent from beWellnm and a general description.

Notice Name	Notice Details
<b>Account Transfer</b>	The inbound/outbound response Account Transfer notice informs the Head of Household that they need to take required action so that they can be determined/re-determined for their household's eligibility for a Qualified Health Plan (QHP).
<b>Age Out</b>	The Age Out notice informs the HOH that the specific member in their household is moving out of their shopping group as the member is turning 26 years of age.
<b>Appeal Acknowledgement</b>	The Appeal Acknowledgment notice acknowledges receipt of an appeal submission to beWellnm and informs the user of next steps. It also includes information on whether an appeal was timely submitted and/or involves an issue that is not subject to appeal.
<b>Appeal Decision (Informal)</b>	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.
<b>Appeal Request for Information (RFI)</b>	An Appeal RFI notice is sent to request additional information that may be needed to resolve the appeal.
<b>Billing Statement</b>	
<b>Communication Preference Change</b>	The Communication Preference Change notice informs the member of their change in communication preference.
<b>Eligibility Approval</b>	The QHP Eligibility Approval notice informs the applicant that they have been approved or provisionally approved for a QHP and other benefits. The notice is triggered at the tax household level.
<b>Eligibility Denial</b>	The Eligibility Denial notice informs the applicant that they or members of their



	<p>application are not approved for health coverage or other benefits through beWellnm and includes the reason(s) why the individual was not approved.</p>
<b>Eligibility Termination</b>	<p>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 beWellnm following a program determination or other action that may have caused a person to lose eligibility (e.g., batch or administrative closing etc.)</p>
<b>Late Notice - Premium Payment</b>	<p>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.</p>
<b>Periodic Data Matching (PDM)</b>	<p>This notice is used to notify QHP enrollee(s) that there may be a change in or termination of existing benefits due to information received during the PDM process.</p>
<b>Preliminary Eligibility Determination</b>	<p>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.</p>
<b>Renewal Notice</b>	<p>This notice will be used to notify the household of their enrollment information for the upcoming plan year.</p>
<b>Request for Identity Proof (RIDP)</b>	<p>RIDP is the process of validating sufficient information that uniquely identifies an individual (e.g., credit history, personal demographic information, and other indicators). Individuals must be identity proofed to gain access to the beWellnm online application. BeWellnm uses the Experian identity verification system (Experian) to remotely perform identity proofing.</p>

<b>Request for Information (RFI)</b>	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.
<b>Request for Information (RFI) Reminder</b>	The RFI Reminder notice reminds the recipient to provide the documentation requested in the RFI notice to verify the recipient's eligibility application information.
<b>Special Enrollment Period Decision (SEP)</b>	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.
<b>Tax Liability (Employer)</b>	The Tax Liability notice informs the employer that their employee has been determined eligible for premium tax credits through beWellnm. BeWellnm is not currently sending Tax Liability notices.
<b>Termination Notice - Non-payment of Premium</b>	This notice informs the recipient that their policy has been terminated. The notice includes the termination effective date and reason for termination.

## 15 Appendix: Terms and Acronyms

<b>Term</b>	<b>Acronym</b>	<b>Definition</b>
<b>Account Holder</b>		An individual who initially creates an account with beWellnm, whether individually or with the help of a customer service representative.
<b>Adjusted Gross Income</b>	AGI	Total (or "gross") income for the tax year, minus certain allowed adjustments. Adjustments include deductions for conventional IRA contributions and student loan interest.
<b>Applicant</b>		Any Individual listed on an application.
<b>Authorized Representative</b>	ARD	Someone an enrollee chooses to act on their behalf with beWellnm, such as a family member or other trusted person. Some authorized representatives may have legal authority to act on the enrollee's behalf.

<b>Cancellation</b>		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 payment, and their policy is cancelled. Unlike terminations, cancellations do not require prior notification.
<b>Carrier</b>		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 Qualified Dental Plans (also known as stand-alone dental plans) through beWellnm.
<b>Centers for Medicare &amp; Medicaid Services</b>	CMS	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs, and the federally facilitated Marketplace.
<b>Certified Enrollment Counselor</b>	CEC	An individual (affiliated with a designated organization) who is trained and able to help individuals, small businesses, and their employees as they look for health coverage options through beWellnm, including helping them complete eligibility and enrollment forms. Their services are free to individuals.
<b>Complex Household</b>		An application that includes some members who are eligible for a QHP with tax credits, and some members who are eligible for Medicaid.
<b>Customer Engagement Center</b>	CEC	The call center for the New Mexico Health Insurance Exchange, also known as beWellnm.
<b>Customer Service Representative</b>	CSR	Staff of the CEC who help individuals with beWellnm applications.
<b>Dependent(s)</b>		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.

Term:	Acronym Cont.	Definition Cont.
<b>Employer-Sponsored Insurance</b>	ESI	Employer-sponsored insurance (ESI) is purchased through an employer, union, or by a self-employed individual.
<b>Enrollment Counselor</b>	EC	Trained individuals who are available to provide in-person counseling and assistance to individuals in need of help applying for Marketplace programs. See also Certified Enrollment Counselor.
<b>Federal Data Services Hub</b>	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 individual application information for income, citizenship, immigration status, access to minimum essential coverage, etc.
<b>Federal Poverty Level</b>	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. HHS publishes updated FPL numbers in January each year. Once published, the new figures will be used for determining eligibility for Medicaid for 2023. The 2022 FPL income numbers are used to calculate savings on Marketplace insurance plans for plan year 2023.
<b>Federal Tax Information</b>	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.
<b>Federally Facilitated Marketplace</b>	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 New Mexico, run their own Marketplaces.

Term Cont.	Acronym Cont.	Definition Cont.
<b>Financial Management System</b>	FMS	A module of the New Mexico Health Insurance 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).
<b>Health Information Portability and Accountability Act</b>	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.
<b>Health Insurance Exchange</b>	HIX	Also known as the Health Insurance Marketplace. A service that helps people shop for and enroll in affordable health insurance. The federal government operates the federal Marketplace, available at HealthCare.gov, for most states. Some states, like New Mexico, run their own Marketplaces. New Mexico's Marketplace is the New Mexico Health Insurance Exchange, also known as beWellnm.
<b>Human Services Department</b>	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.
<b>Internal Revenue Service</b>	IRS	A division of the US Treasury Department responsible for ensuring compliance to the Federal Tax Code.
<b>Issuer</b>		See definition of Carrier.

Term Cont.	Acronym Cont.	Definition Cont.
<b>Medicaid</b>		Medicaid is one of three insurance affordability programs addressed in the Affordable Care Act. The New Mexico Human Services Department (HSD) administers the Medicaid program in the State of New Mexico.
<b>Minimum Essential Coverage</b>	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. There currently is no penalty for not having minimum essential coverage.
<b>Modified Adjusted Gross Income</b>	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.
<b>National Producer Number</b>	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.
<b>New Mexico Health Insurance Exchange</b>	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 runs a marketplace for small business.

Term Cont.	Acronym Cont.	Definition Cont.
<b>Non-Financial Assistance</b>	Non-FA	A non-financial assistance application determines eligibility for a QHP without financial assistance.
<b>Nonqualified Individual Lawfully Present</b>	ILP	Qualified status indicates that individuals may be eligible for financial assistance through beWellnm, if they otherwise meet beWellnm eligibility requirements, or may be eligible for full Medicaid 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).
<b>Office of Superintendent of Insurance</b>	OSI	The Office of the Superintendent of Insurance (OSI) is the regulatory agency for insurance products in New Mexico. See <a href="http://www.osi.state.nm.us">www.osi.state.nm.us</a> for more information.
<b>Open Enrollment Period</b>	OE or OEP	The yearly period when people can enroll in a health insurance plan without a qualifying event.
<b>Patient Protection and Affordable Care Act</b>	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.

Term Cont.	Acronym Cont.	Definition Cont.
<p><b>Periodic Data Matching</b></p>	<p>PDM</p>	<p>PDM includes the process by which Health Insurance Exchanges periodically examine available data sources to identify individuals enrolled in Exchange health plans with financial help at the same time they're determined eligible for or enrolled in Medicare. If an individual has been determined eligible for or is enrolled in MEC Medicare, they are generally not eligible to receive financial assistance to help pay for a Marketplace plan premium or for covered services. If individuals are eligible for minimum essential coverage (MEC) through Medicaid, 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.</p>
<p><b>Personally Identifiable Information</b></p>	<p>PII</p>	<p>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.</p>
<p><b>Protected Health Information</b></p>	<p>PHI</p>	<p>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.</p>



Term Cont.	Acronym Cont.	Definition Cont.
<b>QHP Only Household</b>		A household will be considered a QHP only household if there are only QHP members in the application before renewal process starts.
<b>Qualified Dental Plan</b>	QDP	A dental plan certified by the OSI and beWellnm to be offered on the Exchange.
<b>Qualified Health Plan</b>	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."
<b>Remote Identity Proofing</b>	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.
<b>Request for Information</b>	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.
<b>Social Security Administration</b>	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).

Term Cont.	Acronym Cont.	Definition Cont.
<b>Social Security Number</b>	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.
<b>Special Enrollment Period</b>	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.
<b>State-Based Marketplace or State-Based Exchange</b>	SBM/SBE	States like New Mexico that run a State-based Marketplace are responsible for performing all marketplace functions for the individual (and potentially small group) market. Individuals in these states apply for and enroll in coverage through marketplace websites established and maintained by the states.
<b>Trusted Data Source</b>	TDS	The external data sources which the used by beWellnm to verify the application data. The TDS is offered through the Federal Data Services Hub (FDSH).