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| Adherence to Legislative Intent | New Mexico Center on Law and Poverty | In 2020, the Legislature authorized the Exchange to design standardized health plans. As part of this legislative authorization, the Exchange was empowered with designing plans that made "more services available before a deductible amount is applied to a benefit;" provided "predictable cost sharing;" and reduced "barriers to maintaining and improving health[.]" BeWellnm's proposed plan requirements will certainly provide New Mexicans with quality, affordable coverage options meeting the Legislature's goals. Not only do these plans require many high-value, necessary services—such as preventive and primary care—to have the lowest out-of-pocket costs, they also provide lower, more affordable deductibles and out-of-pocket maximums. This is a terrific opportunity for our state, as individuals and families who may ordinarily forgo purchasing coverage on the Exchange due to real or perceived cost may now be incentivized to purchase coverage and access the care they need when they need it. | The Committee appreciates the commenter's statement. The Committee agrees that the legislative intent is met and strikes a thoughtful balance between many of the important priorities established by the legislature. |
| 5-Tier Prescription Drug Design | Blue Cross Blue Shield of New Mexico | We appreciate the Health Benefit Committee's work to establish Standardized Plans and their willingness to engage with stakeholders on the designs of these plans, including the adoption of a 5-tier pharmacy drug tier in the draft proposal. At BCBSNM, we utilize a 6-tier pharmacy benefit for prescription drugs. This tiering in the generic space, not currently adopted by the committee, ensures that members utilize lower cost generic options where they exist. We would again, respectfully, request that Board adopt a 6 tier benefit for prescription drugs that includes both generics and preferred generic categories. | The Committee discussed this topic at length during several meetings and remains concerned about the additional complexity this could create for consumers. Other commenters (see below) also note that adding more tiers could create operational challenges for issuers that currently only use 4 tiers.<br><br>**The Committee unanimously agreed to maintain the proposed design.** |
| 5-Tier Prescription Drug Design | Molina | Molina found, after reviewing the design for the [5]-tier* proposed structure, there are inconsistencies when analyzing typical industry standards, also, when comparing to standard plan designs from CMS, it was found to be further misaligned when taking into consideration the mandate for preferred specialty cost-sharing to be a lower | The Committee appreciates the comment and recognizes that this is a unique approach. Because issuers currently have different arrangements around prescription drug tiering, the Committee faces a challenge with how to maintain plan |

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| | | rate than non-preferred non-specialty drug cost-sharing. Molina suggests for consideration that designs more closely align with such standards to allow for adoption, implementation, data collection and review in early stages of plan standardization.<br><br>* The Committee has modified this comment to ensure this concept remains consistent across this document. Molina's original comment includes preventive drugs as a 6th tier. | transparency while accommodating these arrangements.<br><br>**The Committee determined that a reasonable accommodation to issuers that do not use two separate tiers for the specialty tier would be to allow the option of a single tier at the Preferred Specialty co-pay level. The Standardized Health Plan Requirements document has been updated to reflect this accommodation.** |
| Inclusion/Relative Co-pay of Non-Preferred Specialty Drug Tier | Debbie Righter | The Non-Preferred Brand Tier should NEVER be more than the Specialty Rx and should not be subject to deductible. I saw some of the discussion on this and realized how confused the committee must be on Rx. Specialty Rx is always more expensive than Preferred Brand or Non-Preferred Brand Rx. Please consider - not subject to deductible / coinsurance if there are copays. | The Committee had extensive discussion on this point and was fully aware of the cost differences between the non-preferred brand and specialty drugs. The Committee's goal is to ensure patients with chronic conditions are not subject to exorbitant costs if they need access to specialty medications, particularly if there are no alternatives in other tiers. The Committee noted that there is no overlap in the drugs covered in the brand and specialty tiers. Therefore, individuals would not be able to opt for a specialty medication in lieu of a brand medication. It is appropriate to design a cost sharing structure that maintains relativities between preferred generic (lowest), brand (mid), and specialty (highest) medications, which the proposed standardized plans achieve. However, the Committee did not see value in increasing costs on specialty |

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| | | | medications for the sole purpose of maintaining relativities between the non-preferred brand and preferred specialty categories. **The Committee unanimously agreed to maintain this approach and plans to review data and consumer feedback on this question when considering changes in future Plan Years.**<br><br>The deductible on the non-preferred brand tier is intended to encourage use of medications in the preferred brand tier and helps to minimize the use of deductibles on other services. **The Committee unanimously agreed to maintain this approach.** |
| Inclusion/Relative Co-pay of Non-Preferred Specialty Drug Tier | Molina | Molina would like to note that some issuers who don't currently split specialty into preferred and non-preferred levels the separation of and rate arrangement consisting of the preferred specialty tier with a lower rate than the non-specialty non-preferred tier rate can present some significant challenges administratively of offering separate types of pharmacy benefit structures within the same state. Molina suggests for consideration setting the preferred specialty drug cost-sharing higher than the non-preferred drug tier and allowing issuers to offer plans with a single specialty tier if they don't break specialty up into preferred and non-preferred. The unique [5]-tier* proposal for the standard plans in such a manner may pose operational challenges.<br><br>* The Committee has modified this comment to ensure this concept remains consistent across this document. Molina's original comment includes preventive drugs as a 6th tier. | Setting the specialty drug tier at a higher co-pay level than non-preferred brand medications could increase costs on those who need specialty medications. As noted above, the Committee's goal is to ensure patients with chronic conditions are not subject to exorbitant costs if they need access to specialty medications, particularly if there are no alternatives in other tiers. Issuers are allowed and encouraged to design non-standardized plans that use a different approach. As noted above, the Committee agreed to allow issuers to offer a single specialty tier in the 2024 Plan Year at the preferred co-pay level. **The Committee unanimously agreed to maintain the proposed non-** |

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| | | | **preferred brand and preferred specialty co-pay values.** |
| Non-Turquoise Silver Actuarial Value | Blue Cross Blue Shield | Additionally, in review of the proposed standardized benefit designs following assessment under the 2024 AV calculator, we request that the silver standard plan align as close as possible to 70%AV. In light of current rules that silver non-standard plans not exceed the silver standard plan AV, this will offer health insurers the greatest flexibility in adopting non-standard plans. | State statute prohibits issuers from offering non-standardized Silver plans with an actuarial value (AV) lower than the standardized Silver plan with the lowest AV (59A-23F-9H). The federal government allows AVs for Silver plans to vary within the range of 70-72% AV. Currently, the AV for the proposed standardized Silver plan is 70.2%. This is only a .2 percentage point difference from the floor required by the federal government. **The Committee unanimously agreed to maintain the existing plan design for the standard Silver variant. Once CMS's 2024 AV calculator is released, the committee will revisit the AV level to ensure it does not vary significantly from the current AV estimates.** |
| Use of Co-pays and Elimination of Coinsurance | New Mexico Center on Law and Poverty | We also applaud beWellnm's proposal to shift Exchange plans from using coinsurance to using copays. Coinsurance is frequently too unpredictable for individuals and families—even when they can reasonably plan out the care they expect to receive in a given year. Copays provide individuals and families with much more transparency and predictability when they shop for coverage and plan for their healthcare. | The Committee appreciates the comment and applauds the Legislature's strong commitment to improving cost predictability for consumers. |
| Co-pays after the deductible has been met | Debbie Righter | Add-on Copays after Deductible / Coinsurance should be removed from ER and Inpatient Care. Change the Deductible and raise it if necessary but PLEASE do not create complex Benefit Designs like these. We already have one carrier in the market that does this and consumers | Deductibles only apply to a few select services in the proposed standardized plan designs. The deductible is intended to incentivize use of lower-cost services before resorting to higher-cost options. |

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| | | are so confused and dislike them greatly. Keep the designs simple and easy to understand and straight forward - do not mix deductibles and copays together. | Removing co-pays after the deductible would require increases in the deductible/out-of-pocket maximum or would require higher co-pays on other services. **The Committee unanimously agreed to maintain this design element for the 2024 Plan Year but will revisit this in future years and solicit feedback from consumers.** |
| General Design Recommendation: $0 Deductible and Co-pays Only | Debbie Righter | Would have been much better if the committee had gone with $0 deductibles and copay only plans that were so popular in 2021 and 2022. Clients can understand them much better and love them. | This could be an option to explore in future years. To avoid contributing to "choice overload", the Committee decided early on to focus on only offering one Silver and one Gold standardized plan, opting to take a more balanced approach to the various elements that make up plan design. **The Committee will consider this as a topic of discussion for the 2025 Plan Year.** |
| Emergency Service Co-Pay Levels | Debbie Righter | Copays could have been higher for ER and per day at 2 or 3-day max or a flat copay for inpatient. There is nothing wrong with $50 / $100 / $300 / $500 ER copays to discourage inappropriate us~~e~~age of ER. ER is for life and limb threatening care and 8 out 10 ER visits for life and limb threatening care are admitted to the hospital and ER copays are waived anyway - they just raise the cost of the benefit plan. Members should be using virtual visits, primary care and urgent care - not ER for non-life or non-limb threatening care. | The committee used other design features to encourage use of lower-cost services before using higher-cost services, including significantly limiting co-pays and not applying the deductible to primary care and urgent care. The committee also sought to balance the need for these incentives with the reality that the ER is sometimes the only option for rural residents with limited access to services. OSI believes the committee strikes the right balance with the existing plan design. **The Committee unanimously agreed to maintain the proposed ER and inpatient co-pay values.** |