
# New Mexico Health Insurance Exchange Policy Manual Plan Year 2024

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# x. Publication Dates and Updates

The New Mexico Health Insurance Exchange (referred to herein as beWellnm, NMHIX, the “Exchange,” or the “Marketplace”) 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 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 includes a variety of useful articles, ranging from information about the Affordable Care Act (ACA) to information about getting assistance with applications. Please visit 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 health insurance coverage through beWellnm. The single streamlined application determines eligibility to (1) shop for and enroll in medical or dental coverage; and (2) 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 medical 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

Individuals with the following immigration statuses 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 and Haitian Humanitarian Parolees
- Cuban/Haitian entrant
- Certain Ukrainian nationals
- Paroled into the U.S.
- Granted parole for less than one year, including Nicaraguan and Venezuelan Humanitarian Parolees
- Granted parole for at least one year, including Nicaraguan and Venezuelan Humanitarian Parolees
- 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**

Individuals with the following statuses who have employment authorization:

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

For a list of documents an individual may provide to verify their lawful presence, visit beWellnm's Knowledge Base Articles at www.beWellnm.com.

## 2.3 Financial Assistance: Advanced Payments of the Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR)

45 CFR 155.305(f)(1-6)

Individuals who are eligible to shop for medical 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, that they meet 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 a 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;
- 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
- Filed a federal income tax return and reconciled 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 eligibility by completing the application. Individuals who are determined eligible for APTC must enroll in coverage through beWellnm to receive 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 the amount of household income that must be paid towards premiums at 8.5%, based on the cost of the benchmark plan. The Inflation Reduction Act (IRA) extends these tax credits through 2025.

**Note:** Most adults with incomes below 138% FPL will be eligible for Medicaid. Medicaid eligibility categories for children have higher income thresholds, up to 300% 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% FPL.

## 2.4 Failure to File and Reconcile (FTR)

45 CFR 155.305(f)(4)

BeWellnm will determine an individual ineligible for APTC if the taxpayer has failed to file a federal income tax return and reconcile their past APTC for two consecutive tax years. When a tax filer does not comply with this requirement, it is known as “Failure to File and Reconcile,” or FTR. BeWellnm will notify individuals if they are at risk of having their APTC discontinued.

**Note:** In line with CMS flexibilities for Plan Year 2024, beWellnm will not take action based on data that comes back from the IRS flagged with an FTR issue.

## 2.5 Cost-Sharing Reductions (CSR)

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

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

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

## 2.6 Cost-Sharing Reductions for American Indians/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 available CSR on Bronze, Silver, or Gold level plans.

- An AI/AN individual enrolled in a Marketplace plan 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 who is eligible for a Marketplace plan with a premium tax credit, and who has 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 essential health benefits through a Marketplace plan.
- An AI/AN individual enrolled in a Marketplace plan with an income below 100% or above 300% FPL can choose a plan with limited cost-sharing.

## 2.7 Income Used for Financial Assistance Application

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

Financial assistance (e.g., APTC and CSR) is based on a household's expected income for the year of coverage being applied for, not the prior year's income. Generally, household income includes the 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 annual household income as accurately as possible since tax credits are calculated using the 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 may 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.

## 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 from the data source 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 calculating 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
- County

Tax households are made up of the tax filer(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 tax filer 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 as of 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 recognized 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 CRF 155.320(b)

Individuals with access to employer-sponsored coverage must provide information regarding the offered coverage on their application. To qualify as minimum essential coverage (MEC), 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 8.39% of annual household income in 2024 to be considered affordable. If the self-only coverage is affordable, the individual will not be eligible for financial assistance if they enroll in coverage through beWellnm.

The cost of the annual premium for the lowest-priced family coverage plan must be less than 8.39% of annual household income in 2024 to be considered affordable. If the family coverage is affordable the family will not be eligible for financial assistance if they enroll in coverage through beWellnm.

If the cost of the employee's self-only or family coverage is considered unaffordable, the individual and/or family may enroll in coverage 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

An individual who is enrolled in retirement health insurance coverage can only purchase Marketplace coverage and apply for financial assistance if their current retirement coverage does not qualify as MEC. An individual may be eligible for APTC if the retirement coverage is not affordable and the individual is not currently enrolled.

**Note:** An individual whose retirement coverage ends outside of the annual Open Enrollment Period (OEP) and who chooses not to re-enroll is 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 coverage with APTC through beWellnm instead of enrolling in COBRA.

An individual who is enrolled in COBRA coverage 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 the COBRA coverage ends early due to non-payment, the individual 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 Exchange 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.

**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 Dates

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.

If changes are reported by the last day of the month, the new APTC amount will be effective on the first day of the following month.

Individuals who are enrolled in coverage 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 enrolled in coverage through beWellnm and have a change in APTC or CSR will have their new APTC amount and/or CSR level applied to their enrollment as described above.

**Note:** The timelines outlined in this section are subject to change during Plan Year 2024. 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 be used to defray the portion of a QDP premium allocable to the pediatric dental essential health benefit and would only be applied if a minor (under age 19) in the household was not receiving the pediatric dental benefit through the family's medical plan.

Any tax credits will be 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 who are enrolled in a QHP through beWellnm and use APTC to lower their monthly premium payment must "reconcile" the APTC received during the plan year with the premium tax credit (PTC) allowed when filing their federal tax returns. BeWellnm will determine individuals ineligible for APTC if the taxpayer has failed to file a federal income tax return and reconcile their past APTC for two consecutive years.

**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, 2022, and 2023, CMS and beWellnm 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 2024.

## 2.19 Health Care Affordability Fund (HCAF)

Effective Plan Year 2023, beWellnm implemented programs established by Office of Superintendent of Insurance (OSI) with funding 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 only 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 and 400% FPL: reduced premiums

### 2.19.2 Native American Premium Assistance (NAPA)

American Indian and Alaska Native (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% and 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 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 three levels of Turquoise Plans, based on household income:

- up to 150% FPL (Level 1)
- over 150% through 200% FPL (Level 2)
- over 200% through 300% FPL (Level 3)

### 2.19.4 Medicaid Transition Premium Relief (MTPR)

The Medicaid Transition Premium Relief program was implemented in Plan Year 2023, when the Medicaid continuous coverage requirement and Public Health

Emergency (PHE) ended. 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;
- qualify for a federal premium tax credit through beWellnm; and
- have an income at or below 400% FPL.

The maximum amount of available APTC and NMPA will be applied to the premium before the MTPR 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:** An individual who is assessed as likely eligible for Medicaid and “opts out” of a final Medicaid determination will not be eligible for financial assistance (i.e., APTC) to purchase coverage through beWellnm. However, the individual may purchase a Marketplace plan without financial assistance.

## 3.2 Requesting a Final Medicaid Determination

Applications of individuals assessed as likely 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 final Medicaid determination.

## 3.3 Catastrophic Plans and Exemptions

45 CFR 155.605

Catastrophic Plans will not be offered on the Exchange for Plan Year 2024.

## 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 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. 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 or by calling the Customer Engagement Center.

## 4.2 Verification of Application Information

When an individual applies for health coverage through beWellnm, they agree (or "attest") to the truth of the information provided by signing the application. BeWellnm will use the applicant's attestations, in combination with trusted data sources, like the Internal Revenue service (IRS) and the Social Security Administration (SSA), 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 may send a notice to request additional documentation from the applicant. 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 for coverage and financial assistance during this 90-day "reasonable opportunity" period based on their attestation, pending submission and verification of the requested documentation.

If, after the 90-day reasonable opportunity period, beWellnm remains unable to verify the information attested to because the requested information was not received, 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 and/or financial assistance. BeWellnm will grant individuals with income inconsistencies an additional 60 days to resolve the income RFI.

Note: In some instances (e.g., income discrepancies), a consumer's self-attested data may be used for eligibility if information is not available from trusted data sources and/or there is a system error.

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 may 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)

45 CFR 155.410

BeWellnm will offer an Open Enrollment Period (OEP) consistent with federal requirements for individuals to apply for health coverage for Plan Year 2024. However, beWellnm may offer additional enrollment opportunities, including an extended OEP. The OEP for Plan Year 2024 is November 1, 2023 through January 15, 2024.

## 4.4 Coverage Effective Dates During the OEP

During the OEP, a household must select a plan for enrollment and make their first month's premium payment (the "binder" payment) no later than December 31 for coverage to begin January 1. Individuals who select a plan for enrollment and pay their first month's premium by January 31st will receive a coverage effective date of February 1.

| Plan Selection | Payment Deadline | Coverage Effective Date |
|---|---|---|
| November 1 – December 31 | December 31 | January 1 |
| January 1 – January 15 | January 31 | February 1 |

An enrollee may change their plan selection during the OEP. However, the last plan selected and effectuated at the end of the OEP will be the coverage in which the individual is enrolled. If a consumer enrolls in a plan and pays the first

month's premium (the binder payment), but then enrolls in a different plan before the end of the OEP and before coverage takes effect, the initial coverage will be canceled. The first premium payment will be applied to the new coverage. A consumer who is enrolled in effectuated January coverage and changes their plan selection between January 1 and January 15 will keep their coverage under the first plan for January only.

## 4.5 Easy Enrollment

New Mexico's Easy Enrollment Act took effect in 2023. The Easy Enrollment Act leverages the state income tax system to make it easy for uninsured New Mexicans to find and enroll in quality affordable health coverage. Easy Enrollment allows New Mexico residents to start the health insurance enrollment process by checking a box on their state income tax return. By checking the box, taxpayers give the state tax agency permission to share relevant information used to assess eligibility for low-cost or no-cost health coverage with the Human Services Department (HSD), which oversees Medicaid, and beWellnm. Information for those who are not eligible for Medicaid will be transferred to beWellnm. BeWellnm will notify these individuals that they can continue their application for health coverage at 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 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 OEP.

There are four basic types of QLEs:

- loss of health coverage (e.g., losing job-based insurance or eligibility for Medicaid);
- changes in household (e.g., getting married or having a baby);
- changes in residence (e.g., moving to New Mexico); and
- other QLEs (e.g., becoming a U.S. citizen or no longer being incarcerated).

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 of Coverage When Enrolling Through an SEP

Changes to enrollments will be effective in accordance with the coverage 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. A change in APTC or CSR will also be effective as of the coverage effective date.

A consumer who enrolls in a new plan may choose among the following effective dates of coverage:

- The 1st of the month following the reported change (if enrollment is completed by the last day of the month in which the change is reported); or
- The 1st of the second month following the reported change; or
- As applicable, the date of birth, adoption, placement for adoption or foster care, etc. Consumers may also choose a coverage effective date of the 1st of the month following the event. Enrollees should call the Customer Engagement Center for help.

BeWellnm also offers earlier coverage effective dates for consumers attesting to a future loss of MEC. This allows the consumer to avoid a gap in coverage. Example: If a consumer attests between May 16 and June 30 that they will lose other MEC on July 15 and selects a plan on or before June 30, coverage may be effective on July 1.

Consumers who apply with beWellnm after losing Medicaid coverage can choose a retroactive effective date of coverage, back to the first day of the month in which the consumer enrolls in a plan. For example, if a consumer loses Medicaid on July 31, and selects a Marketplace plan on August 25, coverage can start on August 1.

## 5.3 Reporting Requirements for Qualifying Life 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 (MEC) 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.

## 5.5 Enrollment Completion and Effective Dates

The first month's premium payment must be received by beWellnm no later than the last day of the month before 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 due to the end of the Public Health Emergency (PHE) and the Medicaid continuous coverage requirement.

An applicant who fails to complete the enrollment process outlined above by the last day of the month before coverage may select a later effective date of coverage if they do so within the annual OEP or an applicable SEP. If an applicant fails to complete the enrollment process within the OEP or SEP, their enrollment will be canceled.

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 Exchange 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 health plan 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 before the termination date), or retroactively (e.g., termination due to death or a failure to pay premiums due by the end of a grace period).

## 6.1 Voluntary Termination

A member may voluntarily terminate their insurance coverage for any reason at any time. However, a member who voluntarily terminates their coverage is not eligible to re-enroll in coverage through beWellnm until the next OEP, unless they qualify for an SEP or are an American Indian or Alaska Native. A member can request voluntary termination of coverage through their online account 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 for which the termination is requested.

A member who is delinquent in paying their monthly premiums at the time of the request to terminate 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

An enrollee's coverage may be terminated if the enrollee dies during the plan year. The enrollee's death may be reported by an applicant or their household

members who were included in the initial application and who are at least 18 years old. The death can be reported through the member's online account or by calling the Customer Engagement Center. If the household member does not have access to the online account, the member can initiate termination of the deceased's coverage by calling the Customer Engagement Center.

If the Head of Household dies during the plan year, the remaining household members will be eligible for an SEP based on loss of minimum essential coverage. They must create 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 plan year.

The documentation below must be submitted to beWellnm:

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

## 6.3 Termination for Fraud

45 CFR 147.128.

BeWellnm or the health plan carrier may terminate or rescind an enrollee's coverage if the 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 health plan must provide 30 days advance written notice to each enrollee or participant affected by the intended termination.

In cases of fraud, the effective date of the termination may be retroactive. Further, as allowed by state law, the health plan 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 paid for that period. BeWellnm will provide the enrollee notice of the termination. If a 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.

Carriers may rescind coverage only in cases of fraud or intentional

misrepresentation of material fact. Carriers should contact 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's coverage, retroactively terminated. All retroactive termination requests must be submitted to and approved by the beWellnm Premium Billing Department. BeWellnm defines retroactive termination as a termination with an effective date before the current month.

BeWellnm will allow retroactive terminations in the following circumstances:

- The individual obtained or was enrolled in other minimum essential coverage (MEC).
- 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.
- 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 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 to beWellnm.
- The notification of the death of an individual by a household member or authorized representative. Documentation is required to be submitted to beWellnm before processing the termination in the system.

The individual must request retroactive termination within 60 days of discovering the circumstance. 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 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 Dependents on Family Medical and Dental Plans

A dependent's enrollment will 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 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 plan 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 Bill 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's 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. 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 include a list 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 adheres to a premium payment threshold policy. This policy allows an enrollee to make a payment that is less than the premium, but within the "threshold" amount. 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 $1.00. The policy applies to the initial premium payment (the binder 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 unpaid amount will remain on the account.

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

45 CFR 155.410; 45 CFR 155.420

Subscribers must make their binder payment to complete their enrollment and for coverage to be effectuated. The binder payment must consist of the first month's full premium or be within the payment threshold.

The binder payment is due on the last day of the month prior to the month of coverage. Payment must be received for coverage to begin on the 1st of the following month. During the OEP, if payment is made after this date, coverage

will begin on the 1st day of the second month. For a qualified SEP, the payment is due on the last day of the month prior to coverage 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. There are no grace periods for binder payments. Premium payments are submitted to the carrier by beWellnm 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 are applied from the oldest to the newest coverage month. If premium for all months of coverage is not paid, the premium will not be submitted to the carrier until the remaining premium is paid.

If a retroactive enrollment is added to an already effectuated enrollment, all outstanding retroactive premiums must be paid by the next monthly billing cycle due date. Failure to pay any outstanding premium by the due date will trigger a grace period.

### 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 are due to beWellnm on the last day of the month before 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 and 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 on their next bill. Any questions will be answered by consumers either logging into their online accounts or calling the Premium Billing Department.

Subscribers who 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

For renewals, a binder payment is not required as the renewal is a continuation of coverage, and no new effectuation is required. This includes re-enrollments in another plan within the same product, or in a different plan in a different product offered by the same issuer.

### 7.3.5 Payment Types

Subscribers can choose to make one-time payments 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 stored 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 beWellnm to automatically deduct their monthly premium from their bank account or debit/credit card each month.

- Recurring ACH payments are processed on the 18th 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 19th 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. If two consecutive recurring payments are returned for non-sufficient funds, beWellnm may terminate the enrollment in recurring payments.

Subscribers will receive an electronic notification before the funds are 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 before the recurring payment process, the subscriber 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 (TTY: 711). There is no transaction fee to the payer for this service.

Subscribers can make a payment over the phone with the Premium Billing Department by calling 1-833-862-3935 (TTY: 711), option 5.

### 7.3.11 Direct to Carrier

BeWellnm discourages direct to carrier payments, which 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. Carriers should 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 Premium Billing Department at PremiumBilling@nmhix.com 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 and 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. The carrier should follow the steps above to notify NMHIX.

## 7.4 Returned Payments

Upon notification by beWellnm's bank of a returned payment, the returned payment will be reversed in the subscriber's account. 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 the 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, before 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 APTC:

- With APTC, the grace period is 90 days
- Without APTC, the grace period is 30 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: There is a 90-day grace period for QDP enrollment only when the member is enrolled in a QHP with APTC. The 30-day grace period applies to dental policies with no APTC (e.g., stand-alone dental plans).

### 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 of 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 enrollment for a May coverage month:

APTC

| May Coverage<br>Payment Due 4/30 | |
|---|---|
| May 1 | Late Notice 1 |
| June 1 | Late Notice 2 |
| July 1 | Late Notice 3 |
| August 1 | Termination Notice<br>Termination processed effective 5/31 |

Non-APTC

| May Coverage<br>Payment Due 4/30 | |
|---|---|
| May 1 | Late Notice |
| June 1 | Termination Notice<br>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, the amount due, and the due date. 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 health plan 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 (e.g., 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 (e.g., 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, before 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 an 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 Premium Billing Department by calling 1-833-862-3935 (TTY: 711).

## 7.9 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 beWellnm's 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 Premium Billing Department.

## 7.10 Bankruptcy

If an individual policyholder files for bankruptcy, the end creditor is the individual's respective carrier. 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.

## 7.11 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 beWellnm Finance Department. Refunds will not be processed until 15 days after beWellnm has received payment.

Subscribers with active coverage are encouraged to allow beWellnm to apply overpayments or credit balances to future months of coverage. It is unlikely that a refund would be issued before the next premium is due.

Any uncashed checks over three years old may be escheated to the New Mexico Taxation and Revenue Department as unclaimed property. A final notice will be sent to the individual regarding the unclaimed property. Refund checks are voided after 120 days if uncashed and 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 account.

# 8 Reporting Changes and Redeterminations

45 CFR 155.335

BeWellnm is required to redetermine eligibility for a Marketplace health insurance coverage, 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 or foster care, marriage, divorce, death, etc.;
- Residency, including a change to a residential and/or mailing address;
- Citizenship, nationality, or lawful presence;
- Native American 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 change.

## 8.3 Reporting Changes for Enrollees Receiving Financial Assistance

Only individuals who requested an eligibility determination for financial assistance (e.g., APTC) are required to report changes within 30-days related to:

- Eligibility determination for or enrollment in other health insurance, including Medicare, Medicaid, other government-sponsored health insurance, or employer-sponsored coverage;
- Income; and
- 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 who are receiving financial assistance (e.g., APTC). If beWellnm identifies updated information through data matching, it will notify the enrollee and provide them 30 days to provide their own updated information.

- If the enrollee confirms the information in the notice, their eligibility will be updated in accordance with the effective dates outlined in the notice.
- 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.
- 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 the information obtained through data matching is related to income, family size, or family composition. If the enrollee does not respond to data matching information 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 medical or dental plan will be effective at the end of the month in which the determination occurs, except for terminations due to death.

An enrollee who reports a change in income that results in an assessment by beWellnm that the enrollee is likely eligible for Medicaid may remain eligible for Marketplace 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 advance payments of the premium tax credit 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 the 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. Members who do not choose to end their coverage may remain eligible for and enrolled in their Marketplace coverage, but without financial assistance. The member will be responsible for the full cost of the health plan purchased through beWellnm.

**Note:** A consumer can request on their beWellnm application that their Marketplace coverage be terminated automatically if they are determined eligible for Medicaid by HSD. This helps the consumer avoid dual coverage in Medicaid and through beWellnm.

# 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)

An AI/AN individual must meet all eligibility and enrollment criteria to enroll in health coverage through beWellnm. An AI/AN individual may enroll in a health plan, and/or may 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 American Indians/Alaska Natives (AI/AN).

- An AI/AN consumer enrolled in a Marketplace plan 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 consumer who is eligible for a Marketplace plan with a premium tax credit, and who has a household MAGI between 100% and 300% FPL, can choose a zero cost-sharing plan. This means the consumer will not have any out-of-pocket costs, such as deductibles, co-pays, or coinsurance, when getting essential health benefits through a Marketplace plan. These consumers can enroll in a limited cost-sharing plan at any level.

- An AI/AN individual enrolled in a Marketplace plan with an income below 100% or above 300% FPL can choose a plan with limited cost-sharing. This means the consumer does not have to pay co-payments, deductibles, or coinsurance when getting care from an Indian health care provider. They do, however, need a referral from an Indian health care provider when getting essential health benefits through a Marketplace plan to avoid paying co-payments, deductibles, or coinsurance.

# 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. An applicant or enrollee may appeal the following decisions:

An eligibility determination, including:

- An initial determination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions;
- A redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions;
- A determination of eligibility for an enrollment period; or
- 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. 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 or call the Customer Engagement Center at 1-833-862-3935 (TTY: 711).

## 10.2 Complaints and Grievances

Individuals may also file a complaint (or grievance) with beWellnm about Exchange operations. Complaints may be submitted online at www.beWellnm.com or by calling the Customer Engagement Center. Individuals may request a response to the complaint or may send complaints anonymously. BeWellnm will review all complaints upon receipt. BeWellnm will transfer complaints it receives that should be directed to another party (e.g., a complaint that a carrier denied benefits) to that party, and will do so by secure electronic communication, as appropriate.

# 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 enrollee's medical and/or dental insurance coverage for the next plan year if the enrollee is determined eligible to enroll in coverage.

BeWellnm will update a household's information for the renewal year and send a renewal notice to the Head of Household. This notice will contain currently available eligibility information (e.g., program eligibility, tax credit information). If the household's information is correct and they do not have any changes to report, they do not 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. Members of the household who are eligible for the next plan year will be renewed into the same or similar ("mapped" or "crosswalked") plan and notified through the renewal notice. Enrollees may elect a different plan, as described in the renewal notice.

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

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

If an insurance carrier exits the individual Exchange, or is decertified by beWellnm at the end of the plan year, beWellnm will terminate that carrier's member enrollments at the end of the plan year. Individuals will be automatically enrolled in a 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 change plans anytime during the Open Enrollment Period.

Note: If a carrier leaves the individual Exchange before the end of the coverage year, members enrolled in plans issued by that carrier will be eligible for an SEP to select a new plan.

## 11.4 Payments for Renewal Coverage

BeWellnm will process premium payments for renewal coverage. BeWellnm does not require binder payments for members who are automatically re-enrolled in coverage. Premium payments for January 2024 coverage for members who are automatically re-enrolled in coverage are due on December 31, 2023.

# 12 Dental

## 12.1 Dental Open Enrollment

45 CFR 155.410

For dental insurance purchased with a medical 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

## 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

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

## 12.5 Disenrollment

Enrollees may terminate their dental coverage without terminating their medical coverage. Those enrolled as dependents in 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 Applying Leftover APTC to a Dental Plan

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

APTC may only be applied to a Qualified Health Plan (QHP), unless there is excess APTC and the subscriber is also enrolled in a Qualified Dental Plan (QDP) with pediatric dental benefits.

Leftover member-level APTC will be carried forward from the medical plan to the dental plan if the following conditions are met:

The member has selected a medical plan and:

- the member-level leftover APTC after medical plan shopping is greater than $0;
- the maximum possible APTC has been applied towards the essential health benefits portion of the medical plan;
- The consumer has not selected a medical plan with pediatric dental benefits; and
- There is at least one minor (under 19 years of age) member in the dental plan shopping group.

## 12.8 Qualified Dental Plans

Individuals may shop for and purchase a stand-alone dental plan without purchasing a medical plan. The applicant must be determined 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, and not being incarcerated.

# 13 Tax Reporting

Individuals who are enrolled in a QHP through beWellnm and who use APTC to lower their monthly payments 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.

## 13.1 Form 1095-A

In January of each year, beWellnm mails IRS Form 1095-A, *Health Insurance Marketplace Statement*, to tax filers who enrolled in a QHP through beWellnm during the prior year, except for those enrolled in dental-only plans. The Form 1095-A is also generated electronically and posted to the tax filer’s online account.

Individuals will use the information provided on Form 1095-A to complete IRS Form 8962, *Premium Tax Credit*. Application tax filers must complete and file a Form 8962, regardless of whether they are required to file a tax return, to claim the premium tax credit (PTC) or to be eligible for APTC in future years.

BeWellnm also provides the IRS with monthly and yearly data regarding all individual enrollment and APTC payments made to QHP carriers on behalf of enrollees. The IRS uses this data when processing individual federal income tax returns (for example, to reconcile APTC, process PTC claims, and grant exemptions). Annual reports are submitted to the IRS at the end 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 report to verify information on the tax filer's 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 should contact beWellnm at 1-833-862-3935 (TTY: 711).

# 14 Notices

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

| Notice Name | Notice Details |
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| **Account Transfer** | 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). |
| **Age Out** | The Age Out notice informs the HOH that the specific member in their household is moving out of their shopping group at the end of the month in which the member turned 26 years of age. |
| **Appeal Acknowledgement** | 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. |
| **Appeal Decision (Informal)** | The Appeal Decision (Informal) notice informs the appellant of beWellnm's informal resolution of the appeal. The notice also provides instructions for requesting a hearing if the appellant |

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| | disagrees with the informal decision. |
| **Appeal Request for Information (RFI)** | An Appeal RFI notice is sent to request additional information that may be needed to resolve the appeal. |
| **Communication Preference Change** | The Communication Preference Change notice informs the member of their change in communication preference. |
| **Eligibility Approval** | The 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. |
| **Eligibility Denial** | The Eligibility Denial notice informs the applicant that they or members on their application are not eligible for health coverage or financial assistance through beWellnm and includes the reason(s) why eligibility was denied. |
| **Eligibility Termination** | The Eligibility Termination notice informs the recipient(s) that the enrolled members in the household are no longer eligible for 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.) |
| **Late Notice - Premium Payment** | This notice informs the subscriber that their premium payment has not been received and they must remit payment to avoid termination for non-payment of premium. |
| **Periodic Data Matching (PDM)** | The Periodic Data Matching notice is used to notify a health plan enrollee that there may be a change in or termination of existing benefits due to information received during the PDM process. |

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| **Renewal Notice** | The Renewal notice will be used to notify the household of their enrollment information for the upcoming plan year |
| **Request for Identity Proof (RIDP)** | 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. |
| **Request for Information (RFI)** | The Request for Information notice is sent to the recipient when there is unverified data on file for an eligibility on an applicant. It may request proof of SSN, citizenship, income, or incarceration status, for at least one individual identified on an application. |
| **Request for Information (RFI) Reminder** | This notice reminds the recipient to provide the documentation requested in the RFI notice to verify the recipient's eligibility application information. |
| **Special Enrollment Period Decision** | The Special Enrollment Period Decision notice is sent to the recipient when there is an SEP determination, including whether the household is eligible or ineligible for the SEP. It may also request additional information necessary to verify eligibility for the SEP. |
| **Tax Liability (Employer)** | The Tax Liability notice informs the employer that their employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions through beWellnm. BeWellnm is not currently sending Tax Liability notices. |

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| **Termination Notice - Non-payment of Premium** | 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

| Term | Acronym | Definition |
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| **Account Holder** | | An individual who initially creates an account with beWellnm, whether individually or with the help of a customer service representative. |
| **Adjusted Gross Income** | AGI | Total (or “gross”) income for the tax year, minus certain allowed adjustments. Adjustments include deductions for conventional IRA contributions and student loan interest. |
| **Applicant** | | Any Individual listed on an application. |
| **Authorized Representative** | ARD | Someone an enrollee chooses to act on their behalf with beWellnm, such as a family member or other trusted person. Some authorized representatives may have legal authority to act on the enrollee's behalf. |
| **Cancellation** | | When an enrollment ends on or before the date coverage becomes effective resulting in coverage never having been effective. This occurs when an applicant fails to pay their first month’s premium (binder payment), |

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| | | and their policy is canceled. Unlike terminations, cancellations do not require prior notification. |
| **Carrier** | | A carrier, or issuer, is an entity licensed by the New Mexico Office of 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. |
| **Centers for Medicare & Medicaid** | CMS | The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Program (CHIP), and the federally facilitated Marketplace (FFM). |
| **Certified Enrollment Counselor** | EC | A person who is trained and certified by beWellnm to provide in-person counseling and to assist consumers who need help applying for Marketplace programs. Their services are free to consumers. |
| **Complex Household** | | An application that includes some members who are eligible for a QHP with tax credits, and some members who are eligible for Medicaid. |

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| **Customer Engagement Center** | CEC | BeWellnm's call center. |
| **Customer Service Representative** | | An employee of the beWellnm Customer Engagement Center (CEC). |
| **Dependent(s)** | | A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents. |
| **Employer- Sponsored Insurance** | ESI | Employer-sponsored Insurance (ESI) is purchased through an employer, union, or by a self- employed individual. |
| **Federal Data Services Hub** | FDSH | The Centers for Medicare & Medicaid Services (CMS) offers a tool called the Federal Data Services Hub (the Hub, or FDSH) 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 |

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| | | income, citizenship, immigration status, access to minimum essential coverage, etc. |
| **Federal Poverty Level** | FPL | A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage. HHS publishes updated FPL numbers in January each year. Once published, the new figures will be used for determining eligibility for Medicaid for 2024. The 2023 FPL income numbers are used to calculate savings on Marketplace insurance plans for Plan Year 2024. |
| **Federal Tax Information** | FTI | Any record, file, transaction, tape, or cartridge received directly from the IRS or the Medicare Coordination of Benefits (COB) contractor that contains a beneficiary or spouse name, SSN, employer name and address, and taxpayer identifier number. |
| **Federally Facilitated Marketplace** | FFM | A service that helps people shop for and enroll in affordable health insurance. The federal |

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| | | government operates the Federally Facilitated Marketplace, available at HealthCare.gov, for most states. Some states, like New Mexico, run their own marketplaces. |
| **Financial Management System** | 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). |
| **Health Insurance Portability and Accountability Act** | HIPAA | The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to improve the efficiency and effectiveness of the nation's healthcare system. The law includes provisions to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also defines requirements for the privacy and security of protected health information. |
| **Health Insurance Exchange** | HIX | Also known as the Health Insurance Marketplace. A service that helps people shop for and enroll in |

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| | | 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. |
| **Human Services Department** | HSD | New Mexico's Human Services Department (HSD) manages state and federal public assistance programs. HSD administers the Medicaid program as well as the integrated eligibility system (ASPEN) used to determine eligibility for those programs. |
| **Internal Revenue Service** | IRS | A division of the US Treasury Department responsible for ensuring compliance to the Federal Tax Code. |
| **Issuer** | | See definition of Carrier. |
| **Medicaid** | | Medicaid is one of the 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. |

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| **Minimum Essential Coverage** | MEC | Any insurance coverage that meets the Affordable Care Act requirement for having health coverage. To avoid the penalty for not having insurance for Plan Years 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. |
| **Modified Adjusted Gross Income** | MAGI | The figure used to determine eligibility for the premium tax credit and other savings for Marketplace health insurance plans and for Medicaid and the Children's Health Insurance Program (CHIP). MAGI is adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. |
| **National Producer Number** | NPN | The National Producer Number (NPN) is a unique identifier assigned through the National Association of Insurance Commissioner’s |

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| | | (NAIC's) licensing application process. The NPN is used to track individuals and business entities on a national basis. |
| **New Mexico Health Insurance Exchange** | NMHIX | The New Mexico Health Insurance Exchange, established by state law in 2013, in accordance with the federal Affordable Care Act, is a marketplace for qualified individuals to shop for and compare health insurance. Qualified individuals may also receive financial assistance (tax credits) to lower the cost of insurance. NMHIX is commonly known as beWellnm. |
| **Non-Financial Assistance** | Non-FA | A non-financial assistance application determines eligibility for a QHP without financial assistance. |
| **Nonqualified Individual Lawfully Present** | ILP | Qualified status indicates that individuals may be eligible for financial assistance through beWellnm, if they meet other 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 |

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| | | Temporary Protected Status, Special Juvenile Status, asylum applicants, Convention Against Torture, victims of trafficking); valid non-immigrant visas; or legal status conferred by other laws (temporary resident status, LIFE Act, Family Unity individuals). |
| **Office of Superintendent of Insurance** | OSI | The Office of Superintendent of Insurance (OSI) is the regulatory agency for insurance products in New Mexico. See www.osi.state.nm.us for more information. |
| **Open Enrollment Period** | OE or OEP | The annual period when people can enroll in a health insurance plan without a qualifying event. |
| **Patient Protection and Affordable Care Act** | PPACA | The first part of the comprehensive healthcare 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 |

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| | | easier to understand, along with subsidies (through premium tax credits and cost-sharing reductions) to make it more affordable. The law also established state health insurance exchanges. |
| **Periodic Data Matching** | PDM | PDM is the process by which health insurance exchanges periodically examine available data sources to identify individuals enrolled in Marketplace health plans with financial help at the same time they're determined eligible for or enrolled in Medicare or Medicare. Generally, individuals who have been determined eligible for or are enrolled in MEC through Medicaid or Medicare generally are not eligible to receive financial assistance to help pay for a Marketplace plan premium or for covered services. |
| **Personally Identifiable Information** | PII | Personally identifiable information (PII), defined by the Office of Management and Budget (OMB), refers to information that can be used to distinguish or trace an individual's identity, like their name, Medicare Number, biometric records, etc. alone, or when |

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| | | combined with other personal or identifying information which is linked or linkable to a specific individual, like date and place of birth, mother's maiden name, etc. |
| **Protected Health Information** | PHI | The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. |
| **QHP Only Household** | | A household will be considered a QHP only household if there are only QHP members in the application before the renewal process starts. |
| **Qualified Dental Plan** | QDP | A dental plan certified by the OSI and beWellnm to be offered on the Exchange. |
| **Qualified Health Plan** | QHP | An insurance plan that is certified by OSI and beWellnm, provides essential health benefits, follows established limits on cost-sharing (like deductibles, co-payments, coinsurance, and out-of-pocket maximum |

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| | | amounts), and meets other requirements under the Affordable Care Act. All qualified health plans are considered “minimum essential coverage.” |
| **Remote Identity Proofing** | RIDP | RIDP is the process of validating sufficient information about an applicant (e.g., credit history, personal demographic information, and other indicators) to uniquely identify them. |
| **Request for Information** | RFI | A Request for Information (RFI) is a notice sent to the head of household when there is unverified eligibility data on file for an applicant. It may include requests for proof of SSN, citizenship, income, incarceration status, etc., affecting at least one household member’s eligibility determination. |
| **Social Security Administration** | SSA | The Social Security Administration (SSA) administers two programs that provide benefits based on disability: the Social Security disability insurance program (title II of the Social Security Act (Act)) and the Supplemental Security Income (SSI) program (title XVI of the Act). |
| **Social Security Number** | SSN | The nine-digit Social Security number that is a |

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| | | person's first and continuous connection with Social Security. It helps identify and accurately record covered wages or self-employment earnings. It is also used to monitor a person's record once they start receiving benefits. |
| **Special Enrollment Period** | SEP | A Special Enrollment Period may let an individual or family apply for and enroll in health coverage outside of the annual Open Enrollment Period, or during the Open Enrollment Period for an earlier coverage start date. |
| **State-Based Marketplace or State- Based Exchange** | SBM/SBE | States like New Mexico that run a State-based Marketplace are responsible for performing all marketplace functions for the individual market. Individuals in these states apply for and enroll in coverage through marketplace websites established and maintained by the states. |
| **Trusted Data Source** | TDS | The external data source that beWellnm uses to verify application data. The TDS is offered through the Federal Data Services Hub (FDSH). |