TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 36 HEALTH CARE AFFORDABILITY FUND

13.10.36.1 ISSUING AGENCY: New Mexico Office of Superintendent of Insurance ("OSI").
[13.10.36.1 NMAC – N, 5/1/2022]

13.10.36.2 SCOPE: These rules govern the establishment and provision of a Health Care Affordability Plan and administration of the Health Care Affordability Fund (the "Fund").
[13.10.36.2 NMAC – N, 5/1/2022]

13.10.36.3 STATUTORY AUTHORITY: Section 59A-23F-12 NMSA 1978 (the "Health Care Affordability Plan").
[13.10.36.3 NMAC – N, 5/1/2022]

13.10.36.4 DURATION: Permanent.
[13.10.36.4 NMAC – N, 5/1/2022]

13.10.36.5 EFFECTIVE DATE: May 1, 2022, unless a later date is cited at the end of a section.
[13.10.36.5 NMAC – N, 5/1/2022]

13.10.36.6 OBJECTIVE: These rules establish policies, procedures, and controls for the establishment and maintenance of a *"Health Care Affordability Plan"* as funded by the *"Health Care Affordability Fund"* to achieve the public policy purposes in the manner prescribed under Sections 59A-23F-11 and 59A-23F-12 NMSA 1978.
[13.10.36.6 NMAC – N, 5/1/2022]

13.10.36.7 DEFINITIONS: Terms are as defined in the Insurance Code, and as supplemented below.

A. "Advance state payments" means marketplace affordability program payments by the fund to a participating health insurance issuer on a monthly basis to lower premium and state out-of-pocket assistance for consumers.

B. "Affordability criteria" means the factors used to determine the amount of premium assistance or state out-of-pocket assistance that will be provided from the fund on behalf of an eligible individual.

C. "Attachment range" means the amount of claims costs incurred by a participating health insurance issuer for a covered person's covered benefits in a plan year, above and below which the claims costs for benefits are eligible for reinsurance payments under the small group reinsurance program.

D. "Coinsurance rate" means the reimbursement percentage paid by the fund to a health insurance issuer participating in the small group reinsurance program for claims incurred for a covered person's covered benefits in a plan year which are in the attachment range.

E. "Eligible plan" means a health plan sold on the New Mexico health insurance exchange (the "exchange" or "marketplace") that meets the requirements for the state premium assistance program.

F. "Federal poverty level or FPL" means the federal poverty level issued annually by the U.S department of health and human services at aspe.hhs.gov/poverty-guidelines/.

G. "Income criteria" means parameters to establish eligibility for marketplace affordability programs.

H. "Modified adjusted gross income or MAGI" means household size and income calculated to determine eligibility for financial assistance on the New Mexico health insurance exchange.

I. "Marketplace affordability program" means a fund program that reduces premiums and OOP costs for individuals and families who purchase individual or family coverage on the exchange.

J. "OOP" means out-of-pocket.

K. "Participating health insurance issuer" means a health insurance issuer who is authorized to sell a QHP on the exchange or in the fully-insured small group market who has confirmed in writing its intention to participate in a specified fund program prior to the commencement of the plan year.

L. "Plan year" means the year for which a participating health insurance issuer underwrites qualifying health insurance coverage.

M. "Premium assistance" means a fund program that pays a participating health insurance issuer to cover a portion of the premium obligation of a person who meets premium assistance affordability criteria.

N. "QHP" means a qualified health plan.

O. "Reinsurance payment" means an amount paid to a participating health insurance issuer under the small group reinsurance program.

P. "Small group reinsurance program" means a program to reduce premium rates for small businesses that purchase coverage in the fully-insured small group market through the purchase of reinsurance for claim costs that fall in the attachment range.

Q. "State benchmark plan" means a qualified health plan that has been approved for sale on the exchange and that is identified by the superintendent as the plan to be used in developing affordability criteria.

R. "State out-of-pocket assistance program" means a fund program that reduces OOP costs for households that meet eligibility and income criteria established by the superintendent.

[13.10.36.7 NMAC – N, 5/1/2022]

13.10.36.8 APPROPRIATIONS REQUESTS: This rule governs appropriation requests.

A. Annually, the superintendent will submit appropriation requests to the legislative finance committee for each fund program. OSI will post proposed program parameters associated with the budget request on the agency's website upon submission to the legislative finance committee.

B. The request for each fund program shall meet these minimum standards:

(1) for the affordability program, sufficient funding to provide premium reductions for individuals under four hundred percent of the FPL and OOP cost reductions for individuals under two hundred-fifty percent of the FPL;

(2) for the small business affordability program, sufficient funding to realize premium reductions for qualified health plans across the small group market; and

(3) for the uninsured program, sufficient funding to expand coverage to eligible individuals under two hundred percent of the FPL before expanding further up the income scale.

[13.10.36.8 NMAC – N, 5/1/2022]

13.10.36.9 PREMIUM ASSISTANCE AND ANNUAL OOP PROGRAMS: This rule governs the annual state out-of-pocket assistance and premium assistance programs.

A. Affordability criteria: Annually, the superintendent shall publish a bulletin specifying affordability criteria for the ensuing plan year. Absent extenuating circumstances that mandate an earlier rate filing, the superintendent shall allow issuers at least 15 days from publication of the bulletin to make an initial QHP rate filing. If the federal government changes policies that will affect the cost of the program to the state or the cost to enrollees after the issuance of the bulletin, the superintendent may adjust the affordability criteria.

(1) These are the affordability criteria that the superintendent may consider to determine premium assistance eligibility for a plan year. The superintendent will use these criteria to establish a premium sliding scale based on household income:

(a) the percentage of an enrollee's MAGI as computed according to federal standards;

(b) the percentage of enrollee's MAGI that would be needed to purchase the state benchmark plan as established by the superintendent;

(c) the percentage of New Mexico residents at or below a given the FPL percentage; and

(d) The federal premium sliding scale for marketplace coverage.

(2) These are the affordability criteria that the superintendent may consider to determine state out-of-pocket assistance eligibility. The superintendent will use these criteria to establish state cost sharing reduction variants that improve the actuarial value of certain QHPs offered on the exchange:

(a) an enrollee's MAGI as computed according to federal standards;

(b) plan type and metal level tiers that qualify for state out-of-pocket assistance; and

(c) actuarial values for plans that qualify for state out-of-pocket assistance.

B. Income eligibility parameters. Annually, the superintendent shall publish a bulletin specifying income eligibility parameters for the ensuing plan year. Absent extenuating circumstances that mandate an earlier rate filing, the superintendent shall allow participating health insurance issuers at least 15 days from publication of the bulletin to make an initial QHP rate filing. If the federal government changes policies that will affect the cost of

the program to the state or the cost to enrollees after the issuance of the bulletin, the superintendent may adjust the income eligibility parameters. The income eligibility parameters may differ for the premium assistance program, state out-of-pocket assistance program or premium assistance for state residents who are members of federally-recognized tribes. In developing the criteria, the superintendent may consider the following factors:

(1) the income distribution of current marketplace enrollees;

(2) the income distribution of uninsured individuals who qualify for coverage on the New Mexico health insurance exchange; or

(3) health insurance market stability issues and year-over-year trends in premium rate affordability.

C. General eligibility requirements.

(1) To qualify for state out-of-pocket and premium assistance, consumers must:

(a) be eligible to purchase a QHP on the exchange;

(b) qualify for federal premium assistance; and

(c) meet income criteria established annually by the superintendent.

(2) The superintendent will issue criteria for premium assistance that is available to members of federally-recognized tribes. To qualify, individuals must:

(a) meet all other criteria for state premium assistance; and

(b) be a member of a federally-recognized tribe.

D. Premium and state out-of-pocket assistance payment disbursements. Disbursements for premium assistance or state out-of-pocket assistance to a participating health insurance issuer of an eligible enrollee who purchases an eligible plan are governed by this rule. Monthly, by the 15th of each month, the exchange shall report to the superintendent the total amount due to each participating health insurance issuer for premium assistance and state out-of-pocket assistance for coverage of its eligible enrollee(s) for the preceding calendar month.

(1) The monthly payment amount due to a participating health insurance issuer for premium assistance shall be the monthly aggregate amount of premium assistance for all eligible enrollees of the health insurance issuer for the month.

(a) Monthly state premium assistance amounts shall be calculated using the following formula: gross monthly premium for state benchmark plan minus monthly federal premium tax credit minus applicable percentage of income established by superintendent multiplied by expected annual household income as outlined in 45 C.F.R. § 155.305(f)(i) divided by 12.

(b) Within 10 days of receiving the monthly accounting from the exchange, the superintendent will, by voucher, request that the secretary of finance and administration issue warrants as necessary to ensure payment to each participating health insurance issuer for the monthly amount determined to be due by the superintendent.

(2) The monthly payment amount to a participating health insurance issuer for state out-of-pocket assistance shall be determined as a percentage set by the superintendent of gross monthly premiums for enrollees of an eligible plan in a specified income tier, aggregated across all qualifying income tiers.

(3) To facilitate reconciliation, a health insurance issuer must track or accurately estimate claim costs in accordance with guidance published by the superintendent to allow for the determination of actual utilization of out-of-pocket assistance.

[13.10.36.9 NMAC – N, 5/1/2022]

History of 13.10.36 NMAC: [RESERVED]