TITLE 8 SOCIAL SERVICES
CHAPTER 401 HEALTH CARE AUTHORITY - HEALTH CARE AFFORDABILITY FUND
PART 2 HEALTH CARE AFFORDABILITY PLAN

8.401.2.1 ISSUING AGENCY: Health care authority ("HCA").
[8.401.2.1 NMAC - N, 05/05/2026]

8.401.2.2 SCOPE: These rules govern the establishment and provision of a health care affordability plan and administration of the health care affordability fund (the "fund"), including new programs for individuals losing other coverage. These rules do not change any program guidance issued prior to these rules.
[8.401.2.2 NMAC - N, 05/05/2026]

8.401.2.3 STATUTORY AUTHORITY: Section 59A-23F-12 NMSA 1978 (the "health care affordability plan").
[8.401.2.3 NMAC - N, 05/05/2026]

8.401.2.4 DURATION: Permanent.
[8.401.2.4 NMAC - N, 05/05/2026]

8.401.2.5 EFFECTIVE DATE: May 5, 2026 unless a later date is cited at the end of a section.
[8.401.2.5 NMAC - N, 05/05/2026]

8.401.2.6 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.
[8.401.2.6 NMAC - N, 05/05/2026]

8.401.2.7 DEFINITIONS:

A. "Actuarial Value" means the percentage of total average costs for covered benefits that a health insurance plan will cover.

B. "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.

C. "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.

D. "DACA" means deferred action for childhood arrivals.

E. "DACA coverage program" means an affordability protection program established to provide financial assistance for eligible DACA recipients.

F. "Eligible plan" means a health plan sold on the New Mexico health insurance exchange (the "exchange" or "marketplace") that meets the requirements for the marketplace affordability program or a plan that the HCA designates as an eligible plan under the DACA coverage program.

G. "Federal poverty level or FPL" means the federal poverty level issued annually by the U.S. department of health and human services for the applicable coverage year for the health insurance exchange.

H. "Income criteria" means parameters to establish eligibility for marketplace affordability programs or programs to maintain coverage for individuals losing coverage due to federal changes.

I. "Lawfully present individual" means a non-citizen who has an immigration status that allows them to purchase a qualifying health plan (QHP) on the exchange.

J. "Modified adjusted gross income or MAGI" means modified adjusted gross income as defined in 42 CFR § 435.60.

K. "Marketplace affordability program" means a program of the fund that reduces premiums and out-of-pocket costs for individuals and families who purchase individual or family coverage on the exchange.

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

M. "Plan year" means the year for which a participating health insurance issuer offers a health plan that meets QHP standards.

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

O. **“Program of the fund”** means a financial offering allocated by the health care affordability fund including initiatives such as the marketplace affordability program and small business health insurance premium relief.

P. **“QHP”** means a qualified health plan that meets established requirements for certification by the exchange.

Q. **“Small business health insurance premium relief initiative”** means a program of the fund to reduce premiums for small businesses that purchase plans that meet QHP standards in the small group health insurance market.

R. **“Small group plan purchaser”** means an employer who purchases one or more plans that meet QHP standards for any of its employees or owners through the small business health options program or directly from a health insurance issuer selling plans that meet QHP standards in the small group health insurance market.

S. **“State benchmark plan”** means a qualified health plan that has been approved for sale on the exchange and that is identified by the secretary as the plan to be used in developing affordability criteria. “State benchmark plan” does not refer to the essential health benefits benchmark plan established by the superintendent of insurance.

T. **“State out-of-pocket assistance program”** means a program of the fund that reduces out-of-pocket costs for households that meet eligibility and income criteria established by the secretary.

[8.401.2.7 NMAC - N, 05/05/2026]

8.401.2.8 MARKETPLACE AFFORDABILITY PROGRAM PREMIUM AND OUT-OF-POCKET ASSISTANCE: This rule governs the annual state premium assistance and out-of-pocket assistance programs offered on the state exchange.

A. **Affordability criteria:** Annually, the secretary will publish guidance specifying affordability criteria for the ensuing plan year. 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 guidance, the secretary may adjust the affordability criteria.

(1) These are the affordability criteria that the secretary may consider in determining premium assistance eligibility for a plan year. The secretary 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 secretary;

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

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

(2) These are the affordability criteria that the secretary will consider to determine state out-of-pocket assistance eligibility. The secretary will use these criteria to establish state out-of-pocket assistance variants that adjust 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;

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

(d) the availability of sufficient appropriations to support the program.

B. **Income eligibility parameters:** Annually, the secretary will publish guidance specifying income eligibility parameters for the ensuing plan year. 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 guidance, the secretary 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 a federally-recognized tribe. In developing the criteria, the secretary 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) be eligible for the federal premium tax credit or meet all eligibility criteria for the federal Premium Tax Credit except for household income requirements; and

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

(2) The secretary 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: This rule governs disbursements to participating health insurance issuers for premium assistance or state out-of-pocket assistance provided to eligible enrollees who purchase eligible plans. Monthly, by the 15th of each month, the exchange shall report to the secretary 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 applicable calendar month.

(1) The monthly payment amount due to a participating health insurance issuer for premium assistance will 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 will 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 the secretary multiplied by expected annual household income as outlined in 45 C.F.R. § 155.305(f)(i) divided by 12.

(b) To the greatest extent possible, within 10 days of receiving the monthly accounting from the exchange, the secretary 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 secretary.

(2) The monthly payment amount to a participating health insurance issuer for state out-of-pocket assistance will be determined as a percentage 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 secretary to allow for the determination of actual out-of-pocket assistance amounts for the applicable plan year.

E. Eligibility appeals: Appeals for this program shall follow the same process that the exchange uses for federal subsidies.

[8.401.2.8 NMAC - N, 05/05/2026]

8.401.2.9 MINIMIZING COVERAGE DISRUPTIONS: This rule governs the agency's efforts to ensure a smooth transition into a QHP offered on the New Mexico health insurance exchange for individuals who no longer qualify for medicaid and the availability of sufficient appropriations to support the program.

A. Medicaid transition premium relief program: The secretary will issue a notice of program guidance establishing a program that fully covers the cost of the first month's premium for any QHP sold on the individual health insurance exchange for eligible individuals and their families. This premium payment will also cover any premium cost for non-essential health benefits no later than plan year 2027. The premium relief will be available to all members of a household that meet the eligibility requirements in Subsection B of this section. The payment may be used to effectuate coverage.

B. Eligibility for medicaid transition premium relief program: To qualify, a person in the household must:

(1) be a resident of the state of New Mexico who is eligible to purchase a QHP on the exchange;

(2) enroll in a QHP on the exchange within 120 calendar days of losing medicaid coverage.

(3) no longer be enrolled in medicaid at the time their QHP coverage begins;

(4) be determined eligible for federal premium tax credits; and

(5) have an expected household income at or below four hundred percent of the FPL.

C. Eligibility appeals: Appeals for this program shall follow the same process that the exchange uses for federal subsidies.

[8.401.2.9 NMAC - N, 05/05/2026]

8.401.2.10 SMALL BUSINESS HEALTH INSURANCE PREMIUM RELIEF INITIATIVE: This rule governs the agency's small business health insurance premium relief initiative, which applies to plans that meet QHP standards sold through the small business health options program or purchased directly from a health insurance issuer selling plans that meet QHP standards in the small group health insurance market.

A. Premium reduction percentage guidance: Annually, based on available funding, the secretary will issue guidance establishing a premium reduction percentage that will apply to all plans that meet QHP standards sold in the small group health insurance market. Health insurance issuers participating in the market shall discount charges to small group plan purchasers by the percentage established by the secretary and show the amount of the discount in all invoices to the purchaser. The secretary will allow issuers to apply the discount directly or through a credit on the following month's premium. The guidance will establish the percentage reduction, reporting requirements, timetable and process for issuer reimbursement, and other requirements. The secretary may issue additional guidance, if needed.

B. Reporting requirements and annual verification of accurate payments: Health insurance issuers selling plans that meet QHP standards in the small group health insurance market must report data related to enrollment, premiums, and reimbursement from the health care affordability fund to the health care authority on a regular basis, based on the requirements of the guidance. Following each calendar year, on a date established by the secretary, issuers must report data requested by the agency to verify the accuracy of payments made from the fund. The secretary will require issuers to replenish the fund if it is determined that any overpayment has been issued.

C. Payments to participating issuers: On a regular basis, as established in the guidance, HCA will make payments from the health care affordability fund to issuers for the remainder of the gross premium that would otherwise be owed by small group plan purchasers if the small business health insurance premium relief initiative were not in effect. The data received by HCA pursuant to Subsection B of 8.401.1.11 NMAC of this rule serves as the basis for HCA's regular payments to issuers from the health care affordability fund. Issuers must invoice the agency in accordance with the HCA's instructions in order to receive payment.

D. Notification of small group plan purchasers: The secretary will specify a date before the initiative goes into effect by which health insurance issuers must notify their small group plan purchasers about the premium reductions provided by the initiative. Issuers subject to the rule should reflect the premium reduction amount in all invoices.

E. Treatment as third-party payment: For the purposes of the federal risk adjustment program and federal medical loss ratio requirements, the state payment under this section should be considered a third-party payment that is part of the gross premium.

[8.401.2.10 NMAC - N, 05/05/2026]

8.401.2.11 MAINTAINING COVERAGE FOR THOSE LOSING ELIGIBILITY FOR FEDERAL FINANCIAL ASSISTANCE DUE TO SECTION 71301 AND 71302 OF PUBLIC LAW 119-21: This rule governs the agency's coverage affordability program for certain lawfully present individuals.

A. Affordability criteria: Annually, the secretary will publish guidance specifying affordability criteria for the ensuing plan year. 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 guidance, the secretary may adjust the affordability criteria.

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

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

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

(c) the number of individuals projected to enroll in the benefit; and

(d) the availability of appropriations to support the program.

(2) These are the affordability criteria that the secretary will consider to determine state out-of-pocket assistance eligibility. The secretary will use these criteria to establish state out-of-pocket assistance variants that adjust 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;

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

(d) the availability of sufficient appropriations to support the program.

B. **Income eligibility parameters:** Annually, the secretary will publish guidance specifying income eligibility parameters for the ensuing plan year. The secretary shall prioritize households under two hundred percent of the federal poverty level if appropriations are not sufficient to cover populations above that level. 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 guidance, the secretary may adjust the income eligibility parameters.

C. **General eligibility requirements:**

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

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

(b) be a lawfully present individual who has become ineligible for the federal Premium Tax Credit due to the enactment of Section 71301 and 71302 of Public Law 119-21; and

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

D. **Premium and state out-of-pocket assistance payment disbursements:** This rule governs disbursements to participating health insurance issuers for premium assistance or state out-of-pocket assistance provided to eligible enrollees who purchase eligible plans. Monthly, by the 15th of each month, the exchange shall report to the secretary 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 applicable calendar month.

(1) The monthly payment amount due to a participating health insurance issuer for premium assistance will 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 will be calculated using the following formula: gross monthly premium for state benchmark plan minus applicable percentage of income established by the secretary multiplied by expected annual household income as outlined in 45 C.F.R. § 155.305(f)(i) divided by 12.

(b) To the greatest extent possible, within 10 days of receiving the monthly accounting from the exchange, the secretary 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 secretary.

(2) The monthly payment amount to a participating health insurance issuer for state out-of-pocket assistance will be determined as a percentage of gross monthly premiums for enrollees of an eligible plan in a specified income tier.

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

E. **Eligibility appeals:** Appeals for this program shall follow the same process that the exchange uses for federal subsidies.

[8.401.2.11 NMAC - N, 05/05/2026]

8.401.2.12 **PROGRAM FOR UNINSURED DACA RECIPIENTS LOSING ELIGIBILITY FOR EXCHANGE COVERAGE AND FEDERAL FINANCIAL ASSISTANCE:** This rule governs the DACA coverage program for certain individuals with DACA status. Coverage options for the DACA coverage program are to be provided through off-exchange plans offered by issuers selling plans that meet QHP standards on the exchange and are funded through appropriations authorized by the legislature for the purpose of providing "resources for planning, design and implementation of health care coverage initiatives for uninsured New Mexico residents." The secretary may establish enrollment caps if necessary to ensure program sustainability. To enroll in the DACA coverage program, individuals must be determined eligible through HCA's approved vendor.

A. **Affordability criteria:** Annually, the secretary will publish guidance specifying affordability criteria for the ensuing plan year. 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 guidance, the secretary may adjust the affordability criteria.

(1) These are the affordability criteria that the secretary may consider in determining premium assistance eligibility for a plan year. The secretary 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 an enrollee's MAGI that would be needed to purchase the state benchmark plan as established by the secretary;

(c) the number of individuals projected to enroll in the benefit;

(d) the off-exchange plans eligible for state assistance; and

(e) the availability of appropriations to support the program.

(2) The secretary may establish affordability criteria for an out-of-pocket assistance program and consider the following criteria in establishing such a program:

(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;

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

(d) the availability of sufficient appropriations to support the program.

B. Income eligibility parameters: Annually, the secretary will publish guidance specifying income eligibility parameters for the ensuing plan year. The secretary shall prioritize households under two hundred percent of the federal poverty level if appropriations are not sufficient to cover populations above that level. 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 guidance, the secretary may adjust the income eligibility parameters.

C. General eligibility requirements:

(1) To qualify for state premium and out-of-pocket assistance under the DACA coverage program, consumers must:

(a) Be a DACA recipient as established by federal guidelines;

(b) not have access to other health coverage that meets federal minimum essential coverage standards or other third-party payor programs;

(c) be a resident of New Mexico;

(d) not be incarcerated;

(e) meet income criteria established annually by the secretary.

D. Premium and state out-of-pocket assistance payment disbursements: This rule governs disbursements to participating health insurance issuers for premium assistance or state out-of-pocket assistance provided to eligible enrollees who purchase eligible plans. Monthly, by a date established by the secretary in guidance, issuers shall report to the secretary the total amount due for premium assistance or state out-of-pocket assistance for coverage of its eligible enrollees for the applicable calendar month.

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

(a) The methodology for calculating monthly state premium assistance amounts shall ensure similar affordability criteria as premium assistance under the marketplace affordability program.

(b) To the greatest extent possible, within 10 days of receiving the monthly accounting from the issuer, the secretary 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 secretary.

(2) The monthly payment amount to a participating health insurance issuer for state out-of-pocket assistance will be determined as a percentage 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 secretary to allow for the determination of actual out-of-pocket assistance amounts for the applicable plan year.

E. Appeal rights and process:

(1) Applicants or their authorized representatives may appeal any adverse program eligibility or assistance decision, including eligibility status, income/residency findings, assistance tier, or effective date.

(2) The authorized eligibility determination vendor shall issue a written notice that states the decision and effective date, the reasons, how to appeal, the filing deadline, and the availability of free language services and disability accommodations.

(3) Appeals must be filed within 30 calendar days of the notice date. Late appeals may be accepted for good cause. Appeals may be filed by methods specified in guidance. An authorized representative may be designated at any time.

(4) An impartial member of the agency's eligibility vendor shall decide first-level appeals. A written decision is due within 20 calendar days of receipt, or within 3 business days if expedited due to risk of care disruption. If no timely decision is issued, the appellant may proceed to a final appeal.

(5) A final appeal may be filed with the health care affordability bureau within 30 calendar days of the vendor decision or a vendor delay. The bureau will conduct a review and issue a written decision within 45 calendar days, or within five business days if expedited. The bureau's decision is the final administrative action.
[8.401.2.11 NMAC - N, 05/05/2026]

History of 8.401.2 NMAC: [RESERVED]

HISTORY OF REPEALED MATERIAL: [RESERVED]

OTHER: 8.401.2 NMAC, Health Care Authority Plan filed 11/11/2025 as an emergency rule, now filed as permanent rule**,** effective 5/5/2026.