The New Mexico Health Insurance Marketplace Affordability Program
State Out-of-Pocket Assistance Reconciliation Guidance
Version 2

2023 Plan Year

NEW MEXICO | OFFICE OF SUPERINTENDENT OF INSURANCE

Published March 16, 2023

Table of Contents

Background

During the 2021 legislative session, the New Mexico Legislature worked with Governor Michelle Lujan Grisham to pass legislation establishing a Health Care Affordability Fund (HCAF). On April 8, 2021, Governor Lujan Grisham signed Section 59A-23F-11 NMSA 1978 into law, which directs the New Mexico Office of Superintendent of Insurance (OSI) to reduce health insurance premiums and out-of-pocket costs for New Mexicans who purchase individual and family coverage on New Mexico Health Exchange (NMHIX).

The state's Health Insurance Marketplace Affordability Program goes into effect on January 1, 2023. In addition to enhanced premium assistance, OSI provides lower out-of-pocket costs through the State Out-of-Pocket Assistance (SOPA) program, which is available to eligible individuals and families up to 300% of the Federal Poverty Level (FPL) through NMHIX during the 2023 Plan Year. SOPA is funded by appropriations approved by the New Mexico State Legislature from the HCAF.

SOPA builds upon the federal model of providing reduced out-of-pocket costs for lower-income enrollees, known as Cost Sharing Reductions (CSRs)[1]. Under this model, every health insurance issuer must offer "variants" of each of its Silver plans that have reduced out-of-pocket costs for covered services. These variants reduce maximum out-of-pocket limits, deductibles, co-payments, and coinsurance by enhancing the actuarial value of the underlying plan.

SOPA applies to Silver plans for eligible enrollees up to 200% FPL and Gold plans for eligible enrollees 200.01-300%. To help consumers easily identify which plans have SOPA based on their income level, NMHIX labels the plan as a "Turquoise Plan." Eligible enrollees who select plans at the applicable SOPA metal level have access to income-based Turquoise Plan variants with enhanced actuarial values, as shown in Table 1 below.

Table 1: Turquoise Plans

	Turquoise 1	Turquoise 2	Turquoise 3	Turquoise 4
FPL Range	Up to 150%	150.01-200%	200.01-250%	250.01-300%
Actuarial Value	99% AV	95% AV	90% AV	85% AV
SOPA Metal Level	Silver	Silver	Gold	Gold

Individuals with household income at or below 200% of FPL who choose a Silver plan will be enrolled in either a Turquoise 1 or Turquoise 2 Plan variant depending on household income. Similarly, individuals with household income between 200.01% FPL and 300% FPL who select a Gold plan will be enrolled in either a Turquoise 3 or Turquoise 4 Plan variant depending on household income.

[1] Under 13.10.29.7 (C)(11) NMAC, "Cost-sharing" means a copayment, coinsurance, deductible, or any other form of financial obligation of a covered person other than premium or share of premium, or any combination of any of these financial obligations as defined by the terms of the health benefits plan. Pursuant to 13.10.29.7 (P) NMAC, "State out-of-pocket assistance program, SOPA" means a fund program that reduces [out-of-pocket] costs for households that meet eligibility and income criteria established by the superintendent.

As with federal CSRs, actual SOPA amounts will depend on how much enrollees utilize covered services. OSI has adopted a similar approach, with monthly advance payments made to issuers that provide variants with reduced out-of-pocket costs and an annual reconciliation process to ensure final payment amounts reflect actual use of SOPA. Starting in 2023, issuers will receive monthly SOPA advance payments directly from OSI and, after the end of the Plan Year, must reconcile the total 2023 advance payments with the actual SOPA amounts provided to eligible enrollees for the 2023 Plan Year.

This guidance provides information on the process for reconciling the monthly SOPA advance payments that OSI makes to issuers and the actual SOPA amounts provided to eligible enrollees under the HCAF individual market program.

Reference Plan

The reference plan can be the Silver CSR variant (-05 or -06) or Gold standard variant (-01) of the underlying plan that qualifies for SOPA, depending on the enrollee's income. When calculating the SOPA amounts, it is important to identify the appropriate reference plan, as this is the plan that will be compared to the Turquoise variant when determining the SOPA amount. Table 2 provides a mapping of the reference plans and the Turquoise plans.

Table 2: Mapping of Turquoise Plans to Reference Plans

Federal Poverty Level	Turquoise Plan	Reference Plan
Up to 150% FPL	Turquoise 1 (-99 Variant)	CSR-06 Variant (Silver)
>150 - 200% FPL	Turquoise 2 (-95 Variant)	CSR-05 Variant (Silver)
>200 - 250% FPL	Turquoise 3 (-90 Variant)	Standard –01 Variant (Gold)
>250 - 300% FPL	Turquoise 4 (-85 Variant)	Standard –01 Variant (Gold)

The final SOPA amounts should reflect the difference between what the enrollee pays out-of-pocket under the applicable Turquoise variant and what the enrollee would have paid out-of-pocket under the reference plan as illustrated in Table 2.

For Turquoise 1 and Turquoise 2 variants, SOPA will leverage the exisitng federal CSRs and the value of these CSRs are incorporated in what the enrollee would have paid in the absence of the SOPA. For Turquoise 3 and Turquoise 4 variants, the reference plan is the standard variant of the applicable Gold plan. Gold plans are not eligible for federal CSRs but have a higher actuarial value compared to the standard Silver variant (70% AV) and CSR-04 Silver variant (73% AV).

OSI's current regulations and guidance provide on-exchange individual market issuers with general instructions on the process, timing, and data submission requirements for using reconciling SOPA payments. SOPA policies and program parameters appear in the 2023 Marketplace Affordability Program Policy and Procedures Manual. To reconcile SOPA advance payments with actual uptake of SOPA benefits after the 2023 Plan Year, OSI will permit two reconciliation methodologies. The section titled "The Standard Methodology" describes the methodology that OSI strongly prefers. Appendix A provides the details of the "Simplified Methodology."

SOPA Advance Payments

Starting in Plan Year 2023, OSI will obtain and validate data from NMHIX on a monthly basis that will detail subscriber-level enrollment within each plan's Turquoise variants and the underlying plan premium for the Turquoise enrollees. Based on this information, OSI will calculate monthly SOPA payment amounts. Advance payments are calculated by multiplying the enrollee's total premium for the month by the applicable SOPA Variant Multiplier found in Table 3. SOPA advance payments will be issued monthly. Information related to the advance payment of SOPA benefits can be found in Bulletin 2022-022 and the 2023 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedures Manual.

Table 3: 2023 SOPA Variant Multiplier

Income Tier	Turquoise Variant	SOPA Metal Tier	SOPA AV	SOPA Variant Multiplier
Up to 150% FPL	Turquoise 1	Silver	99%	.042
>150-200% FPL	Turquoise 2	Silver	95%	.066
>200-250% FPL	Turquoise 3	Gold	90%	.079
>250-300% FPL	Turquoise 4	Gold	85%	.040

Reconciliation of SOPA Advance Payments

At the end of the applicable Plan Year, and according to the SOPA payment reconciliation timeline (Table 4), all issuers must report issuer-level data and plan-level data using Template A to support SOPA reconciliation. Issuers must also submit policy-level data using Template B. OSI will reconcile SOPA advance payment amounts by comparing what the enrollee in a Turquoise plan paid to what the enrollee would have paid if enrolled in a reference silver or gold plan. This information will allow OSI to reconcile the difference between the amount of advance payments received by the issuer and the claims liability incurred by the issuer due to the difference in cost sharing between the SOPA plan and the corresponding reference Silver or Gold plan, as applicable.

For Turquoise 1 or Turquoise 2 Plans, SOPA =

Out-of-Pocket Spending Enrollees would have paid for EHBs in a reference Silver plan without SOPA (where federal CSRs are reflected) – Out-of-Pocket actually paid

For Turquoise 3 or Turquoise 4 Plans, SOPAs =

Out-of-Pocket Spending Enrollees would have paid for EHBs in a reference Gold plan without SOPA – Out-of-Pocket actually paid

End-of-Year Reconciliation =

Sum of monthly SOPA Advance Payments - Annual SOPA Amounts for an eligible policy (Template B), or a plan (data from Template B aggregated to the plan level, then to the issuer level (Template A)

Issuers will not be reimbursed for SOPA payments provided to enrollees who the issuer knew to be assigned to an incorrect Turquoise Plan variation that is more generous than the one for which they are eligible. NMHIX will determine the enrollees who are eligible for Turquoise plans based on their income level and other general eligibility factors. Since there is a one-to-one mapping between Turquoise plan variations and federal CSR plan variations for enrollees up to 200% FPL, issuers are required to check Turquoise plan variations against CSR plan variations to confirm that SOPA eligibility is accurately assigned to the appropriate Turquoise plan. Any SOPA, to the extent thereby or otherwise erroneously provided (such as SOPA for non-EHB or non-covered services or SOPA provided after a policy has been terminated), must be excluded from the reconciliation process. The only exception provided is one that permits issuers to seek reimbursement for SOPA provided during a retroactive termination or correction, in which the failure to terminate or correct was not the fault of the QHP issuer, for example, when the QHP issuer receives a late termination or correction notice from the Exchange.

Issuers will not be reimbursed for SOPA provided on services or drugs during the second or third months of an expired grace period or for newborns who are later not enrolled. For services that cross Plan Years, the issuer should adjudicate SOPA based on the year for which accumulators for the SOPA applied.

In the case of claims with coordinated benefits (COB), issuers should apply the COB amounts consistently to the reference and Turquoise plans. When using either the standard or simplified methodology for reconciling SOPA amounts, the issuer would reflect adjustments for COB claims when reporting total allowed costs. However, the amount paid by the issuer or by the enrollee would be reduced, as applicable, in both the reference plan and the Turquoise variant by any amounts that have been paid by a third party. Issuers may wait to re-adjudicate complex claims until the complete cost of the benefit has been accounted for; however, in such a case, the issuer must re-state claims for the entire policy, including the complete COB claim, reducing total allowed costs for EHB by the amount paid by another issuer, as applicable, in both the reference and the Turquoise plan, to ensure correct re-adjudication of SOPA provided for that policy. See the guidance below on Restatement of SOPA.

Issuers may elect to reimburse OSI the full advance payment amount for certain plans rather than re-adjudicate such claims. For example, issuers may decide to reimburse OSI the full amount of advance payment for plans with little or no enrollment. Issuers that wish to return advance payments for all plans in a HIOS ID should notify OSI at by emailing Colin.Baillio@osi.nm.gov.

Timing of Reconciliation Process

The initial data submission for reconciliation of SOPA amounts provided to enrollees in the 2023 Plan Year will begin on January 29, 2024 and end on March 15, 2024. The second submission window for the 2023 Plan Year will open on July 1, 2024 and close on August 30, 2024. For the 2023 Plan Year, OSI will also provide a testing period, from January 5, 2024 through January 19, 2024. During the testing period, issuers will submit test files to OSI and will work with OSI to correct any technical problems related to the submission and processing of the files needed for the accurate reconciliation of SOPA amounts. Please note that issuers will be required to notify OSI of the choice of reconciliation methodology by March 10, 2023. Issuers initially choosing the simplified methodology and wanting to switch to the

standard methodology, will have up to January 19, 2024 to notify OSI of the change. No changes will be allowed for issuers initially choosing the standard methodology.

In response to questions from issuers related to the reconciliation process, for the 2023 Plan Year only, OSI will have an Interim Submission Period during the September to December 2023 timeframe (see Table 4) so that issuers can have a better understanding of the reconciliation process prior to the official reconciliation submission windows in 2024.

Issuers may include late claims from services provided in the 2023 Plan Year as close to the 2024 data submission deadline as is practical, as long as the issuer recalculates and restates all claims for the associated policy as necessary using the standard or simplified methodology (see Appendix A) and associated guidance prior to submission of such claims for reconciliation. OSI may permit any claims incurred in the 2023 Plan Year and not included in either of the two 2024 submission windows may be filed in the 2025 or any subsequent submission window(s). Issuers must inform OSI of the number of outstanding claims that are still being processed during the second submission cycle.

OSI requires that issuers wishing to use the simplified methodology, submit a proposed methodology that OSI approves before an issuer is allowed to use it in lieu of the stanadard methodology. Issuers wishing to use a simplified methodology must submit the proposed methodology to OSI for approval on March 10, 2023 (see Table 4). OSI will conduct webinars, pilot testing, and training in January 2023 and January 2024, in preparation for the first data submission cycle that occurs in January 2024 for Plan Year 2023 reconciliation. OSI will provide two reconciliation cycles in the year following the Plan Year; one that is completed by the end of June of that year, and another cycle that is completed by the end of November of that year. Refer to Table 4 for the dates associated with each cycle for Plan Year 2023.

Table 4: SOPA Reconciliation Timeline for the 2023 Plan Year

Date	Activity
2022	
Guidance Draft Production, Review and Publication of Final Guidance	
1. October 3, 2022 (Mon)	Draft SOPA Reconciliation Guidance Published for Comments
2. November 4, 2022 (Fri)	Draft SOPA Reconciliation Guidance – End of Comment Period
2023	
Issuer General Training/Methodology Selection and OSI Approval	
3. January 6, 2023 (Fri)	Final SOPA Reconciliation Guidance Published
4. January 20, 2023 (Fri)	Guidance Introduction and Issuer General Training Webinar (checklist for standard and simplified methodologies provided to issuers)
5. March 10, 2023 (Fri)	Issuers Submit Methodology and Submission Timeline Choice (checklist including examples of applying the simplfied methodoligies, if applicable)
6. April 10, 2023 (Mon)	OSI Sends Notification of Methodology Approval or Requests for Methodology Revision
Interim Reporting and Reconciliation	
1. October 2, 2023 (Mon)	Interim SOPA Reconciliation Data Submission Deadline
2. December 1, 2023 (Fri)	OSI Notifies Issuers of Interim Reconciled Amounts (informational only)
3. December 15, 2023	Issuers provide feedback to OSI regarding the reconciliation process
2024	
Data Submission, SOPA Reconciliation and Payments, Invoices Issued	
4. January 5, 2024 (Fri)	Reconciliation Template and Attestation Form Training
5. January 05, 2024 (Mon)	Testing Begins for All Issuers (submission of test templates)
6. January 19, 2024 (Fri)	Testing Ends for All Issuers
7. January 19, 2024 (Fri)	Issuers Notify OSI of Change To Standard Methodology (no change from standard to simplified methodology allowed)
8. January 29, 2024 (Mon)	First Data Submission Window Opens for PlanYear 2023
9. March 15, 2024 (Fri)	First Data Submission Window Closes for PlanYear 2023
10. April 19, 2024 (Fri)	OSI Notifies Issuers of Reconciled Amounts and Sends Invoices to Issuers
11. May 2024	First Payment Cycle Ends, OSI Payments Made, Issuers Payments Received
Errors/Discrepancy Corrections and Appeals	
Refer to Section entitled “Errors/Discrepancy Corrections and Appeals” on p. 17	
Second Submission Cycle	
12. July 1, 2024 (Mon)	Second Data Submission Window for 2023 Plan Year Begins
13. August 30, 2024 (Fri)	Second Data Submission Window for 2023 Plan Year Ends
14. September 30, 2024 (Mon)	OSI Notifies Issuers of Reconciled Amounts and Sends Invoices to Issuers (if applicable)
15. November 2024	Second Payment Cycle Ends, OSI Payments Made, Issuers Payments Received

Determination of Total Allowed Essential Health Benefits

Issuers must identify allowed EHB claims for reconciliation, since they will not be reimbursed for SOPA spending for benefits other than EHB. OSI will permit issuers to use an alternate method to determine the total allowed EHB for certain plans, including capitated plans, whose cost sharing structure makes it difficult to distinguish between EHB and non-EHB claims without technology upgrades. These plans generally allow out-of-pocket spending for both EHB and non-EHB to accumulate toward deductibles and the reduced annual limitation on cost sharing. Issuers may calculate claims amounts attributable to EHB, including cost-sharing amounts attributable to EHB, by reducing total claims amounts for each policy by the plan-specific percentage estimate of non-EHB claims submitted on the Unified Rate Review Template (URRT) for the corresponding Plan Year. Issuers should apply this percentage adjustment prior to re-adjudicating the policy's claims against the reference plan. To use this exception, issuers must attest that the non-EHB percentage estimate is less than 2 percent. These limitations help assure that the estimated percentage, which is calculated based on the proportion of claims attributable to EHB, does not overstate the proportion of SOPA spending associated with EHB, and that any inaccuracies in the estimate are unlikely to result in significant inaccuracies in SOPA reimbursement.

Identifying SOPA Reimbursable Benefits

Except for claims related to emergency services that are required to be covered under federal and state law, out-of-network claims are generally not eligible for SOPA and do not need to be included in total allowed EHB costs or the amount the issuer paid for EHB. If the reference plan does not cover EHB out-of-network, OSI will not reimburse issuers for any cost-sharing reduction provided to an enrollee for such non covered services. Total allowed costs for EHBs do not include fees, charges, interest or any other administrative costs for the issuer, unless such fees and charges are included in a plan's benefit design for the reference plan and the Turquoise plan variations.

Total allowed costs for EHB must be the same in the Turquoise plan and the reference plan and they should not include claims that are 100 percent covered, such as primary care visits, except in the case of the actuarial value simplified methodology, since the actuarial value of a plan is calculated based on cost sharing for all services.

The Standard Methodology

The standard methodology compares the claim-specific SOPA amounts paid for each policy in a Turquoise plan to the amount the eligible enrollee would have paid in the reference plan to determine the value of SOPA provided to enrollees. Issuers using this methodology must re-adjudicate actual claims incurred by each enrollee in a Turquoise plan as if he or she had been enrolled in the reference plan, to determine differences in deductible, copay, coinsurance, and other out-of-pocket expenses. The issuer first processes every claim using the SOPA structure of the enrollee's Turquoise plan and then re-processes the claim applying the cost sharing in the reference plan in order to establish SOPA amount for each allowed EHB claim within a policy. This double adjudication – first to pay the claim and then to determine the claim's cost-sharing amount under the different cost structure of the reference plan – results in a dollar-for-dollar reconciliation of SOPA provided.

Re-Adjudication of Claims - Other Issues

In the case of a policy that switches from self-only to a family plan or vice versa after a change in circumstances, such as marriage or death, and remains in the same Turquoise plan, or in the case of other changes of circumstance that result in multiple policies for the same subscriber in the same Turquoise plan during the Plan Year, e.g. because of a gap in coverage when the enrollee moved to another Turquoise variant or Medicaid, an issuer using the standard methodology may aggregate the policies into one policy report as long as the issuer calculates SOPA provided separately, as necessary, under the appropriate parameters for each policy for the period the policy was in effect. In either case, accumulators must be carried over in both the Turquoise and the reference plan, i.e., prior to adjudication, issuers must reduce the new plan deductibles by amounts paid into or accumulated in the old plan. Likewise, deductibles and copays in the reference plan should be reduced by the non-subsidized amount that would have been paid. For subscribers with multiple policies in the same Turquoise plan (i.e. a gap in coverage), issuers should aggregate the policies and file one report under the Turquoise plan using the first and last dates for which the policy was in effect.

In the case of a subscriber who changed Turquoise plans or variants during the year due to income changes, issuers must reconcile SOPA payments provided for that subscriber separately for each Turquoise plan or variant, using the applicable subscriber IDs and Start and End dates for each Turquoise plan or variant.[2] In such cases, issuers are required to carry over accumulators when enrollees are reassigned to a different Turquoise variant during the Plan Year and between the issuer and Medicaid during a Plan Year. Similarly, issuers are required to carry over accumulators if an enrollee must switch to a different metal tier in order to stay enrolled in Turquoise coverage. Except for a gap caused by assignment to Medicaid/CHIP coverage, issuers are not required to (but may) carry over accumulators for an enrollee who dropped coverage or was terminated and later re-enrolled in the same or different Turquoise plan or reference plan. Carryovers also must be reflected at the non-subsidized level in the reference plan to accurately determine how much the enrollee would have paid in the reference plan.

Issuers using the standard methodology are required to first set all accumulators to zero and then reprocess individual claims for each policy or variant in their original order. When transferring accumulators, issuers should transfer an enrollee's accumulated SOPA in the order in which SOPA is required in the new plan or variant; for example, if the original plan does not have a deductible and the new plan has a deductible, the issuer should first transfer amounts for any type of out-of-pocket spending incurred by the consumer in the original plan to the new plan's deductible. OSI encourages issuers that voluntarily transfer accumulators to follow this same process.

In general, issuers handling complex circumstances should apply reasonable rules consistently and in such a way that the reconciliation calculation best captures the difference between the enrollee's actual payments under the Turquoise plan and the cost sharing that would have been required under the reference plan.

***Fee-for-service plans*:** In the case of plans that compensate the applicable providers in whole or in part on a fee-for-service basis, recoverable SOPA does not include amounts that are not reimbursed to providers.

[2] Refer to Template B for reporting requirements for these cases.

Fully capitated plans or capitated pay arrangements within fee-for-service plans: The SOPA amount is the difference between the out-of-pocket spending for essential health benefits the enrollee paid in the Turquoise plan and what the enrollee would have paid in the reference plan.

Zero cost-sharing and limited cost-sharing Qualified Health Plans: SOPA amounts will not apply to individuals enrolled in zero cost sharing or limited cost-sharing plans. Therefore, a reconciliation is not needed for these types of plans.

Qualified Health Plans other than zero cost-sharing and limited cost-sharing plans: Issuers are not required to reduce cost sharing for non-emergency services[3] for covered out-of-network EHB in Turquoise plans. However, a QHP may reduce cost sharing for non-emergency services for covered out-of-network EHB to simplify plan design. If the issuer reduces cost sharing in this circumstance, it should include these out-of-network EHB claims when calculating SOPA provided.

In situations where the reference plan cost sharing is less than the actual amount paid by the enrollee, issuers should enter a negative number for "SOPA Provided" at the (03) Policy Detail Record. In the rare event that the standard methodology calculation of what enrollees would have paid in the reference plan suggests a negative amount of SOPA was provided to all members across a SOPA plan, OSI will not subtract that amount from advance payments for SOPA.

Issuers using a third-party administrator (TPA) – which makes re-adjudication of claims in their natural order complex—may, after setting claims to zero, first adjudicate all medical claims and then all pharmaceutical claims in a policy against the reference plan. These issuers may not process claims in any other order other than their original order. This process applies to TPAs for other subsets of benefits. As applicable, a TPA should first process medical claims, followed by pharmaceutical claims, and then any other subset of benefits, for example vision, dental, and substance use disorder benefits. These additional categories of claims should be re-adjudicated in the order that best approximates the natural order in which they were incurred, so that, for example, if a preponderance of vision claims pre-date claims for dental care, the vision claims group should be re-adjudicated before the dental claims.

The Simplified Methodology

Several issuers indicated that the standard methodology for SOPA reconciliation could be challenging during the early years of the program. While it is OSI's preference that issuers use the standard methodology, OSI will allow issuers to use the simplified methodology or, if there are fewer than 12,000 member months in a particular plan, the AV methodology during the early years of the program. **Please refer to Appendix A for a detailed description of the simplified methodology.**

Changing Reconciliation Methodologies

For Plan Years 2023 and 2024, issuers must notify OSI if they select to use the standard methodology and submit the simplified methodology and examples for OSI to approve as per the timelines in Table 4 for Plan Year 2023 and as per a timeline that will be provided for Plan Year 2024. Consistent with OSI's goal of encouraging issuers to use the standard methodology, OSI will permit issuers to switch to the standard methodology for the Plan Years 2023 and 2024 at any time up to four business days prior to the data admission deadline for the applicable year. **Issuers wishing to switch to the standard methodolgy for**

[3] Refer to the Bulletin on Surprise Billing 2021-017

Plan Year 2023 after the initial methodology selection deadline may do so by notifying OSI no later than January 19, 2024.

Issuer Reporting Requirements – All Methodologies

Issuers are required to report to OSI, for each policy for the Plan Year, the total allowed costs for essential health benefits charged for the policy for the Plan Year, broken down by the amount the issuer paid, the amount the enrollee paid, and the amount enrollee(s) would have paid for the same benefits under the reference plan without Turquoise plan SOPA payments. The processes above provide issuers with dollar amounts they need to establish claims costs for Turquoise plan SOPA payments.

Issuer Attestations

Issuers must attest that SOPA amounts represent only EHB SOPA for which HCAF reimbursement is permitted, including amounts reimbursed by issuers to fee-for-service providers. If the issuer is estimating non-EHB as a percentage of claims, the issuer must attest that they used a reasonable method to determine total allowed EHB cost and that non-EHB represents less than 2 percent of EHB. If the issuer has selected the simplified methodology, the attestation document must include the effective parameters that were used to re-adjudicate claims for each reference plan and a description of how the issuer calculated effective cost-sharing parameters for each applicable subgroup in that reference plan. See Attestation Forms A through C. Because many aspects of the claims re-adjudication process involve actuarial estimation or results, attestations must be signed by an actuary or senior company executive capable of financially binding the company. The issuer's actuary may delegate the signature to the chief executive officer or other senior company official capable of financially binding the company as an authorized representative.

SOPA Reconciliation Attestation Forms

1. ***Attestation Form A:*** This attestation concerns allowed costs for essential health benefits. Issuers must attest that SOPA amounts provided to enrollees and submitted for reimbursement represent only SOPA for essential health benefits for which OSI reimbursement is permitted, these amounts must have been passed through by the issuer to such providers. **Issuers that are estimating essential health benefits must use Attestation Form B.**
2. ***Attestation Form B:*** This attestation concerns allowed costs for essential health benefits for issuers that estimate total allowed essential health benefits. **These issuers must submit this form, instead of Attestation Form A**. Attestation must be provided for each plan for which the issuer uses the plan-specific percentage estimate of non-essential health benefit claims submitted on the Unified Rate Review Template or other reasonable method for the corresponding Plan Year to calculate claims amounts attributable to essential health benefits. An issuer using this procedure is required to do so for all Turquoise plan variants for which the criteria below are met and must list each plan on this attestation.
3. ***Attestation Form C***: **Simplified Methodology – Effective Parameters and Formulas**. Used for simplified methodology reconciliation requirements and parameters. It has attestation for parameters calculated for both the simplified methodology and the simplified actuarial value methodology.

Restatement of SOPA

To ensure consistent and accurate results for restatements of SOPA provided during a Plan Year, and because the addition of data on missing or corrected claims may affect amounts of SOPA provided, OSI is providing issuers this guidance on the restatement process for prior–year SOPA provided. This process also should be used for current year restatements, as when claims are presented after the issuer has re-adjudicated the policy but before the policy is submitted to OSI.

- When to restate: Issuers that identify an issue in data or calculations for SOPA provided that results in the issuer owing OSI must notify OSI as soon as the issuer identifies the issue. OSI may require the issuer to submit a restated file for the Plan Year if the error is identified within the restatement window.
- A restatement of SOPA provided for a Plan Year must include all policies for which the issuer provided SOPA, whether or not SOPA amounts for a policy are being amended.
- Issuers should use the most up-to-date data file format to submit prior year restatements (i.e., 2023 restatement data must be submitted in the same file format as the 2024 data submission).
- Issuers may submit recalculations of existing policies, and policies that were not reported in the original Plan Year data submission.
- SOPA are provided to eligible enrollees on a policy basis. The purpose of re-adjudication is to approximate the experience of the enrollee in the reference plan. Therefore, for each additional claim for which SOPA was provided, prior to re-calculating the value of SOPA provided for any new claim, issuers must adjudicate and re-adjudicate all claims on the policy as applicable, and adjust the reference plan accumulators as applicable, to ensure correct calculation of SOPA provided.
- If the new claim is added to a policy that has been aggregated with other policies under one Exchange-assigned subscriber ID, all claims and policies under the Exchange-assigned subscriber ID must be adjudicated and re-adjudicated, as applicable, to ensure proper accounting for accumulators in both the Turquoise plan and the reference plan and, finally, accurate calculations of SOPA are provided.
- For a particular Plan Year restatements, when adjudicating and re-adjudicating the new claim and other claims on the policy(s) to determine SOPA provided, the issuer should use the same methodology that the issuer selected for the same Plan Year.
- If, after re-adjudication of the new claim(s) and associated SOPA provided for the claim and subsequent claims or policies for a subscriber, the subscriber is determined to have paid an excess amount of SOPA (more than what the subscriber would have paid under the restated amount of SOPA for the policy), issuers must comply with refund requirements under 45 CFR 156.410(c).
- Restatements should not include data for which a discrepancy form was previously submitted and denied by OSI.
- Restatements of SOPA provided in a past year must be submitted in a separate data file and may not be aggregated with current year data.
- Issuers must use the restatement process to claim reimbursements for SOPA provided on medical services in a past year even if the claim was not presented or paid until after the year ended. For

example, a claim received and paid in 2024 for a medical service provided in 2023 should be adjudicated and re-adjudicated with other claims on the 2023 policy, using the policy's 2023 parameters and the issuer's methodology for that plan and submitted in a separate file as a restatement of 2023 SOPA provided. Such claims may not be re-adjudicated outside the associated policy or added to 2024 Plan Year claims.

- Issuers must report the full SOPA amount provided for restated policies for the Plan Year, not just the incremental amount of the SOPA adjustment.
- OSI will permit issuers to file a discrepancy form for a restated policy, as long as the restated information differs from the information provided for that policy in previous data and discrepancy submissions. Likewise, OSI will permit issuers to request a reconsideration of a final discrepancy report for restated policies as long as the restated information differs from the information provided in the prior year SOPA submission. See the discussion of appeals and discrepancy reporting, below.
- For restatements of SOPA provided, OSI will calculate charges owed by issuers by comparing the SOPA provided in the original data submission for the Plan Year to the restated amount for Plan Year as submitted by the issuer.

Reporting Requirements

Submission Requirements

All issuers receiving SOPA advance payments for the 2023 Plan Year must submit the required information to reconcile such payments according to the timeline set forth in Table 4. All submissions must be made electronically via the System for Electronic Rate and Form Filing ("SERFF"). For auditing purposes, each filing must be submitted under the correct TOI, Sub-TOI and Filng Type as follows:

TOI: H016 Individual Health Organizations - Health Maintenance (HMO)
Sub-TOI - SOPA Advanced Payments
Filing Type - Required Reports

In addtion, each filing must be accompanied by a $15 filing fee pursuant to 59A-6-1V NMSA.

Standard File Naming Convention

Issuers are expected to submit the following documents related to the SOPA reconciliation process, using the standard naming convention, as outlined below:

- Template A: Issuer and Plan level Templates
- Template B: Policy-level Template
- Template C: Error/Discrepancy Correction Request for Reconsideration Template (if needed)
- Attestation Form A: Allowed Costs for Essential Health Benefits
- Attestation Form B: Estimate of Allowed Costs for Essential Health Benefits
- Attestation Form C: Simplified Methodology Effective Parameters and Formulas

IssuerName_YYYY_submission_ Filedesc_v#.filetype

- **IssuerName**: Up to 6 Characters which identify the issuer
- **Benefit Year :** "YYYY**"** e.g., 2023 for the 2023 Plan Year
- **Submission**: **indicate one of the following**:
    - "init1" for initial reconciliation submission for the 2023 Plan Year during 2024
    - "init2" for the second submission for the 2023 Plan Year during 2024
    - "restate_YYYY" for restatements processed in a later year (e.g., "restate_2025" for restatements processed in 2025 for the 2023 Plan Year employees)
- **Filedesc**: indicate one of the following:
    - **TEMPA** – Template A – Issuer and Plan level template
    - **TEMPB** – Template B – Policy level template
    - **TEMPC** – Template C – Error-Discrepancy Request for Reconsideration Template
    - **FormA:** Attestation Form A: Allowed Costs for Essential Health Benefits
    - **FormB:** Attestation Form B: Estimate of Allowed Costs for Essential Health Benefits
    - **FormC:** Attestation Form C: Simplified Methodology Effective Parameters and Formulas
- **v#:** v followed by the version number (increment for each update to the filing)

Example 1: ABC_2023_init1_TEMPA_v2. xlsx is the second version of the initial 2023 issuer and plan level reconciliation template submitted during the first submission period in 2023 for ABC Health Plans.

Example 2: ABC_2023_restate_2025 TEMPA_v1. xlsx is the first version of the restated 2023 issuer and plan level reconciliation template submitted in 2025 for ABC Health Plans.

Data Elements

Issuer Summary Information (All methodologies)

Data to be inputted in **Template A – tab 1** – each data element given in this section's list spells out what each data item means and information about the issuer, IDs, aggregated amounts of EHB claims, amounts paid by policyholders, the issuer, and actual SOPA amounts provided for all QHPs under this issuer, and other issuer-level info.

Plan and Policy Information (All methodologies)

Data to be inputted in **Template A** – **tab 1** (issuer) and **tab 2** (plan level) and **Template B** (policy level).

Data elements at the plan level (reported in **Template A – tab 2**) are aggregated information derived from individual policy level data (reported in **Template B)**

Error/Discrepancy Correction Request for Reconsideration (if required)

Data to be inputted in **Template C** relate to error/discrepancy correction request for consideration.

Please refer to **Appendix B** for a list of data elements that explain how to interpret the data elements required for filling **Templates A, B, and C**

Data Elements for the Simplified Methodology Effective Parameters Report

Issuers using the simplified methodology, including issuers of HMO-like plans, must list all reference plan subgroups and then report the effective parameters calculated for reference plan subgroups associated with each plan variation subgroup with claims sets in the Turquoise plans, as appropriate. Issuers should use Attestation Form C to report effective parameters and to attest that the issuer applied the correct parameters and correct formula for each subgroup on the policy. Issuers using the AV methodology exclusively do not submit Attestation C. Refer to the Elements for the Simplified Methodology Effective Parameters Report heading in Appendix A for the list of simplified methodology effective parameters.

Treatment of Confidential Information

It is the public policy of State of New Mexico that "all persons are entitled to the greatest possible information regarding the affairs of government and the official acts of public officers and employees." *See,* §14-2-5 NMSA 1978. Furthermore, §59A-2-12 (B) NMSA 1978 mandates that "no filing required to be made with the superintendent under the Insurance Code shall be deemed confidential unless expressly so provided by law."

To that end, the Office of Superintendent utilizes SERFF for filing submissions, as it provides for free public access. The presumption is that all information submitted through SERFF is a public record, and shall be treated as such.

When a required filing may be deemed confidential under New Mexico law, the issuer must, in accordance with Bulletin 2022-001, submit a request for confidential treatment form to OSI ***prior to submission in SERFF***. OSI will review the request, and make a determination. If the request is granted, the issuer may then upload the approved confidentiality determination to SERFF, along with the document in question. *See,* https://www.osi.state.nm.us/news/bulletins/bulletin-2022-001.

It is the responsibility of the issuer to timely submit the request, upload any approved determination, and ensure the approved item has been flagged as confidential in SERFF. If the issuer designates an item as confidential in SERFF without uploading an approved confidentiality determination, OSI reviewers shall reset the item to public access.

Payment

OSI will reconcile advanced SOPA payments made to issuers for the particular Plan Year. Prior to issuing payments or invoices for reconciled initial data or reconciled restated data, OSI will validate data and perform outlier analysis. The amount of SOPA portion of advance payments to be reconciled is the amount provided to the issuer as of the final adjstment to advance payments for the Plan Year. For the 2023 Plan Year, an initial adjustment will be made in June 2024 (end of main reconcilation cycle), with a second reconcilation cycle that ends in October 2024 that captures 2023 incurred claims not completed by

March 15, 2024, the end of the initial data reconciliation submission period for the 2023 Plan Year. Any claims incurred in the 2023 benefit year and not included for reconciliation in either of the two 2024 reconciliation submission windows may be filed in the 2025 or later reconcilition submission window(s).

Timing of payments and charges

OSI expects to issue a report to each issuer showing, for validated data, SOPA reconciliation payments and charges for the 2023 Plan Year by June 2024. An issuer will be reimbursed any amounts necessary to reflect the full amount of the SOPA provided or, as appropriate, the issuer will be charged for excess SOPA advanced payment amounts paid by OSI. Charges are subject to netting as appropriate in the next closest monthly payment cycle. As noted above, an issuer's annual reconciled amount will be adjusted up or down for validated restatement amounts.

Determination of Outliers

OSI will conduct an analysis on issuer reported valid SOPA amounts to determine whether they are within an expected range, based on an analysis of other issuers' submissions and a threshold derived from that analysis. Specifically, OSI will conduct a comparison against other metrics of issuer risk (e.g., risk adjustment data) to determine if the issuers' reported amounts are within a reasonable range compared to other issuers. OSI will withhold SOPA reconciliation payments to all issuers flagged as outliers based on our analysis until the outlier status is sufficiently and reasonably addressed by the issuer with an explanation or data resubmission.

Error/Discrepancy Corrections and Appeals

Error/Discrepancy Corrections

Issuers may file discrepancy forms (see Template C) to correct errors that directly affect the calculation of their reconciled SOPA amount within 15 days of the date of notification of the results of the reconciliation of the cost-sharing reduction portion of advance payments (for example, subscriber ID errors or errors in calculation of amounts)

Issuers must report all identifiable errors to OSI using the discrepancy form for 2023 Plan Year prior to requesting a reconsideration.

Issuers may, within 15 days of the date of notification of the results of the reconciliation of the SOPA portion of advance payments request reconsideration to contest a processing error by OSI, OSI's incorrect application of the relevant methodology, or OSI's mathematical error of the amount to be paid for SOPA amounts for Plan Year 2023. Reconsideration requests shall be submitted to Colin Baillio at Colin.Baillio@osi.nm.gov and filed in SERFF.

Issuers must request reconsideration prior to proceeding to an appeal.

Appeals

If issuers contest the outcome of a submitted request for reconsideration, they may request a hearing to contest the outcome of reconcilation in accordance with §59A-4-15 NMSA. Hearings must be requested within 30 days of the resolution of the request for reconsideration.

Reconciliation of the SOPA portion of advance payments to actual SOPA amounts provided by an issuer for the Plan Year is the final determination of SOPA payments for the Plan Year. Therefore, any hearing

requests must be based on a final determination of the amount of advance payments. Hearing requests must be made in accordance with 13.1.5.9 NMAC.

Audit and Retention of Records

Under 13.10.36.9 NMAC, "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."

In order to comply with this regulatory requirement, issuers must submit to OSI summary statistics on the administration of the SOPA program, including failure to adhere to any standards set forth by the Superintendent with regard to the implementation of the SOPA subsidies. OSI intends to provide instruction on that data submission at a later date. Additionally, issuers that offer a QHP in the individual market through an Exchange may be subject to audit by OSI or its designee to assess compliance with the relevant requirements regarding SOPA payments, as determined by the Superintendent..

Data Submission Templates and Attestation Forms

Issuers must use data submission Template A and Template B for SOPA reconciliation data at the issuer, plan, and policy levels. If needed, issuers must use Template C to submit error or discrepancy correction or submit a request for reconsideration. Please refer to Appendix B for a list of data elements and definitions for filling SOPA reconcoliation templates A, B, and C initial submission or submitting requests for reconsideration and the description of these data elements.

Issuers must accompany SOPA reconciliation data submissions with Attestation Forms A, B, or C as applicable.

Appendix A: The Simplified Methodology

Issuers that select, and are approved by OSI to use the simplified methodology for 2023 plan year SOPA reconciliation, may use the simplified methodology when submitting SOPA data for the 2023 plan year reconciliation in the spring of 2024.

Under the simplified methodology, issuers first calculate estimated or effective cost-sharing parameters for their reference plans and then apply these to a policy's total allowed EHB claims to determine the value of SOPA payments provided to enrollees. This method may be used only when there are sufficient enrollees in reference plan subgroups to make such calculations sufficiently reliable. If credibility cannot be established, the simplified AV methodology (AV method), described below, must be used. The AV method requires issuers to compare the annual limitation on cost sharing for the reference plan to total allowed EHB claims for the policy to determine the amount of SOPA payments provided.

In contrast to the claim-by-claim comparison that is used for the standard methodology, the simplified methodology provides a way for issuers to compare the sum of all EHB claims incurred for a Turquoise plan policy to the expected cost for the same claims in the reference plan.

When using the simplified methodology, issuers calculate the estimated amount the enrollee would have paid under the reference plan by developing and then applying "effective" cost-sharing parameters for the reference plan to the total allowed costs for EHB claims for the Turquoise policy. First, issuers must develop between two to six estimated or effective cost-sharing parameters for the reference plan using calculations provided by OSI. [4] These estimated or effective cost parameters are calculated based on the average claims experience of enrollees in the reference plan and its subgroups, if any. Then, issuers use mathematical formulas A, B, or C, described below, to apply these cost-sharing parameters to the total allowed cost for EHB claims for each policy or policy subgroup in a Turquoise plan to determine the total cost sharing amount for these claims in the reference plan.

Formulas A, B, and C for Calculaing SOPA Payments

For Turquoise plan policies with total allowed costs for EHB for the plan year that are:

(A) Less than or equal to the effective deductible, the amount that the enrollees would have paid under the reference plan is equal to the total allowed costs for EHB under the policy for the plan year multiplied by the effective pre-deductible coinsurance rate.

(B) Greater than the effective deductible but less than the effective claims ceiling, the amount that the enrollees would have paid under the reference plan is equal to the sum of (x) the average deductible, plus (y) the effective non-deductible cost sharing, plus (z) the difference, if positive, between the total allowed costs under the policy for the plan year for EHB that are subject to a deductible and the average deductible, multiplied by the effective post-deductible coinsurance rate.

(C) Greater than or equal to the effective claims ceiling, the amount that the enrollees would have paid under the reference plan is equal to the annual limitation on cost sharing for the reference plan, or, at the QHP issuer's election on a policy-by-policy basis, the amount calculated pursuant to the standard methodology,

[4] The following effective cost-parameters must be calculated for reference plan subgroups: Average deductible; Effective deductible; Effective pre-deductible coinsurance rate; Effective post-deductible coinsurance rate; Effective non-deductible cost sharing; and Effective claims ceiling.

Subgroups refer to the separate or different benefits provided within each plan, or populations under the plan. For example, one reference plan may have different out-of-pocket deductibles for individuals and families, and may also require enrollees in both groups to pay an out-of-pocket deductible for medical benefits and a separate deductible for pharmacy benefits. Such a reference plan would have four subgroups and require four sets of effective cost-sharing parameters.

- Individual (self-only) medical
- Individual (self-only) pharmacy
- Enrollment group (other than self-only) medical
- Enrollment group (other than self-only) pharmacy

If the plan has a combined deductible for medical and pharmacy claims, but different deductibles for individuals and families, the issuer would need to develop effective parameters for two referernce plan subgroups:

- Individual (self-only) combined medical and pharmacy
- Enrollment group (other than self-only) combined medical and pharmacy

Each subgroup of the reference plan must have an adequate number of enrollee member months with a certain claims set in order for the estimated cost-sharing parameters under the simplified methodology to be credible. Each of these reference plan subgroups must have enrollment of at least 12,000 member-month per plan year with in-network EHB claims that are above the reference plan's effective deductible but below the annual limitation on cost sharing. Therefore, it is possible for subgroups to meet or exceed 12,000 member months of enrollment but fall short of the claims set needed to conduct the analysis. (Because they lack sufficient in-network EHB claims above the reference plan's effective deductible but below the annual limitation on cost sharing.

If a plan does meet the threshold for each subgroup, the issuer must use the following estimated reference plan parameters in one of three formulas (A, B, or C) to calculate SOPA payments provided: the effective deductible, the effective pre-deductible coinsurance rate, the effective post-deductible coinsurance rate, and the effective claims ceiling**.**

If any subgroup of the reference plan does not meet the credibility threshold, the issuer must use the simplified actuarial value methodology to establish costs for all subgroups of the reference plan.

If a reference plan and its subgroups meets the membership credibility standard, but its benefit design does not require members to meet a deductible, meaning there are no claims in which the issuer can calculate the effective deductible and other parameters required for the simplified methodology, the issuer should use the simplified actuarial value methodology.

Definition of Member Months for the Credibility Threshold

Guided by several CMS Notices of Benefit and Payment Parameters rules, OSI requires issuers to have at least 12,000 member months in each of the subcategories of the reference plan for the entire plan year ***to meet the credibility threshold for the simplified methodology.*** To assess the availaibility of member months credibility threshold, QHP issuers must count both on and off-Marketplace members of a reference plan (that is, enrollees in the reference plan that purchase the plan through the Marketplace or directly from the issuer) when determining whether the reference plan meets the credibility standard.

2023 Plan Year Credibility Threshold: For the purpose of establishing the 12,000 member month credibility threshold for a reference plan or its subgroups for the 2023 plan year, issuers may include

enrollees who applied to the plan no later than January 31, 2023, and remained in the plan until the end of the plan year on December 31, 2023.

Using the Simplified Methodology

Issuers using the simplified methodology must first determine how many subgroups are in the reference plan, and then determine whether each of these subgroups has at least the minimum member month enrollment. Issuers then calculate the first two effective cost-sharing parameters of the reference plan for each subgroup, and sort the policies in each subgroup by utilization to determine whether there are enough member months with claims that can be analyzed using this method. (Each subgroup would need claims for the plan year that were incurred after the effective deductible (for the subgroup) but with in-network cost sharing that is less than the annual limitation on cost sharing.) Issuers then calculate the remaining effective parameters, and use the provided formula appropriate to the claims set for each policy or policy subgroup to calculate the value of SOPA payments provided for that policy.

To use the simplified methodology, follow these five steps:

Step One: ***Determine how many subgroups are in the reference plan for which the issuer must calculate separate cost-sharing parameters.*** For example, if the reference plan has separate parameters for self-only and for other than self-only, it would have at least two subgroups. If the plan also has separate medical and pharmacy deductibles, the plan would need to develop sets of cost-sharing parameters based on costs for enrollees in a total of four subgroups: self-only medical, self-only pharmacy, other than self-only medical and other than self-only pharmacy. For plans with separate medical and pharmaceutical deductibles but a combined annual limitation on cost sharing, issuers should develop separate effective cost sharing parameters for the medical and pharmaceutical claims. However, the total amount of cost sharing estimated under the reference plan for any policy must be limited to the combined annual limitation on cost sharing.

Step Two: ***Determine if one or more subgroups has a plan design similar to an HMO, in which 80 percent or more of total allowed costs for EHB is not subject to a deductible.*** For a plan or any portion of a plan with 80 percent of total allowed cost for EHB not subject to a deductible, issuers must use the separate calculation for such plans as described below.

Step Three: ***For plan designs with 20 percent or more of total allowed costs for EHB that is subject to a deductible***, calculate the number of enrollees (member months) in each subgroup in the reference plan. For this part of the credibility threshold test, issuers must have at least 12,000 member months in the reference plan subgroup for the entire plan year. ***If one or more subgroup fails to meet the minimum 12,000-member month threshold, the issuer should proceed immediately to use the simplified actuarial value methodology***. Otherwise, the issuer proceeds with this method to determine if the plan meets the credibility threshold for certain claims sets.

Step Four: ***For all reference plans whose subgroups meet the 12,000 member month minimum, calculate the first two effective parameters (average and effective deductibles) for each subgroup using the instructions below.*** Next, sort policies in each reference plan subgroup into the following groups: policies with total allowed EHB claims less than/equal to the newly calculated effective deductible; policies above the effective deductible but for which in-network cost sharing is below the annual limitation on cost sharing for the reference plan, and policies with in-network cost sharing that is greater than/equal to the annual limitation on cost sharing[5].

[5] https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf

Determine whether for each reference plan subgroup there are at least 12,000 member months with claims incurred after the effective deductible for that subgroup but for which associated in-network cost sharing is below the annual limitation on cost sharing for the reference plan. ***If there are at least 12,000 member months with such claims in each subgroup, calculate the remaining effective parameters.***

Step Five: ***Select the formula (A, B, and/or C) appropriate to the total claims of each subgroup in a policy. Using the formula for each subgroup, apply the effective parameters appropriate to the subgroup to the total allowed essential health benefits to find out what the policy holder would have paid for these same services in the reference plan***. The value of SOPA provided by the issuer for this policy is equal to the sum of amounts calculated for each subgroup on the policy, minus the payment that the enrollee actually paid under the Turquoise plan. See formulas below.

Issuers whose plans meet the credibility threshold for the simplified method - with more than 12,000 member months in all subgroups, and 12,000 member months of claims falling after the effective deductible but before the annual limitation on cost sharing - would develop and submit effective cost-sharing parameters only for subgroups with actual enrollees in the Turquoise plan. For instance, if a plan has separate self-only and other than self-only cost-sharing parameters, but all the Turquoise plan subscribers were enrolled in self-only coverage during the plan year, the issuer does not need to calculate or report parameters for the other than self-only option.

In the case of a policy that switches from self-only to other than self-only or vice versa after a change in circumstances, such as marriage or death, and remains in the same QHP Turquoise plan variation, an issuer may aggregate the two policies into one report if the issuer calculates separate effective cost-sharing parameters for self-only coverage and other than self-only coverage for the Turquoise plan variation. In such a case, ***when a Turquoise plan policy is self-only for part of the year, and then becomes other than self-only (or vice versa), the issuer should apply the set of effective cost-sharing parameters (or the AV method, one minus the actuarial value of the reference plan) for the type of coverage for which the Turquoise plan policy was for the greatest number of coverage months. If the type of coverage of the policy was evenly split, the QHP issuer should default to the other than self-only coverage effective cost-sharing parameters.*** Note: Issuers may aggregate policy reports after a change in circumstance regardless of whether the issuer calculates separate effective cost-sharing parameters for self-only coverage and other than self-only coverage).

For subscribers with multiple policies in the same Turquoise plan (i.e., a gap in coverage), ***issuers should aggregate the policies and file one report under the Turquoise plan using the first and last dates for which the policy was in effect.***

In the case of a subscriber who changed Turquoise plans during the year, ***issuers must reconcile SOPA amounts provided to that subscriber separately for each Turquoise plan, using the applicable Start and End dates for each Turquoise plan.***

OSI's policy on carrying over accumulators when an enrollee switches to a new Turquoise plan, or from a plan that is not eligible for SOPA to a Turquoise plan and back and forth to Medicaid must be followed for the simplified methodology as well as the standard methodology. In all cases, the deductible amount in the new plan must be reduced by the amount paid toward deductibles and co-pays in the old Turquoise plan and by the amount that would have been paid toward deductibles and co-pays in the associated reference plan, prior to adjudication and re-adjudication.

Issuers should transfer an enrollee's accumulated cost sharing in the order in which cost sharing is required in the new plan; for example, if the original plan does not have a deductible and the new plan has a deductible, the issuer should first transfer amounts for any type of cost sharing incurred by the consumer in the original plan to the new plan's deductible. OSI encourages issuers that voluntarily transfer accumulators to follow this same process.

Finally, we note that plans that use a capitated pay arrangement for certain specialty providers would follow the steps for reconciling HMO-like plans for these provider claims, and add the result to the amount calculated in step 5, above, to obtain total SOPA provided for the Turquoise plan.

Calculation of Parameters for the Simplified Methodology

Average Deductible: For reference plans with only one deductible, the average deductible is that deductible. If a subgroup (self-only or other than self-only, etc.,) of the reference plan has more than one deductible, e.g. separate deductibles for in-network and out-of-network claims, the average deductible is the weighted average of the deductibles, that is, weighted by the allowed costs for EHB under the reference plan that are subject to each separate deductible. Exclude any service not subject to a deductible.

This calculation is performed on all claims in the subgroup.

- Allowed costs for EHB for this calculation includes in-network and out-of-network EHB when both accumulate to the deductible.
- The Average Deductible refers to the average of in-network and out-of-network deductibles, weighted by the allowed costs for EHB subject to those deductibles.
- Average Deductible in a group plan is calculated on the other than self-only deductible: the simplified methodology does not account for embedded deductibles for individuals so these embedded deductibles should be ignored for the purpose of this analysis.

Effective Deductible: This is the sum of the Average Deductible (above) and the average total allowed costs for EHB that are not subject to any deductible for the reference plan for the plan year.

The average total allowed costs for EHB that are not subject to any deductible must be calculated based only on reference plan policies with total allowed costs for EHB that are above the Average Deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

The QHP issuer must calculate the average total allowed costs for EHB for Group 1 policies that are not subject to any deductible.

The effective deductible is equal to the sum of the average deductible and average total allowed costs for EHB that are not subject to any deductible

QHP issuers should only consider associated out-of-network cost sharing when determining whether or not the cost sharing incurred under a policy is less than the annual limitation if the issuer counts out-of-network cost sharing toward the annual limitation.

Services that are not subject to a deductible, even if these services require co pays and coinsurance, may not be included in the calculation of the average deductible used in the Effective Deductible equation, above. If services are subject to a deductible to a limited extent, for example, after a set number of copays, such services may be included in the weighted average of the Effective Deductible. The weighted average of the Effective Deductible would be weighted by the allowed costs for EHB under the reference

plan that are subject to each separate deductible – those with a limited deductible and those with no deductible.

Classification of Policies

The remaining four effective cost-sharing parameter calculations and formulas are performed on certain claims sets; therefore, issuers must classify reference plan subgroup policies by utilization (establish the remaining claims sets) to use them.

The claims sets are:

- Policies with in-network cost sharing that is greater than or equal to the annual limitation on cost sharing (used in Formula C, below);
- Policies with total allowed costs for EHB that are less than or equal to the effective deductible;
- Policies with total allowed costs for EHB that are above the effective deductible, but for which associated in-network cost sharing is less than the annual limitation on cost sharing.

Effective Pre-deductible Coinsurance Rate:

This rate must be calculated using only the reference plan policies with total allowed costs for EHB that are less than or equal to the Effective Deductible.

This rate is the proportion of the total allowed costs for EHB under the reference plan for the plan year incurred for those reference plan (subgroup) enrollees and payable as cost sharing (including co pays and coinsurance on services not subject to the deductible).

Effective Post-deductible Coinsurance Rate:

This rate must be calculated using only the subset of claims (cost data) from reference plan policies that have total allowed costs for EHB that are above the effective deductible, but for which associated cost sharing is less than the annual limitation on cost sharing.

This is the quotient of the portion of average EHB claims subject to a deductible during the plan year and paid by enrollees as cost sharing other than through a deductible, over the average EHB costs subject to a deductible minus the average deductible. The calculation is provided in the formula below.

$$\text{Effective Post-Deductible Coinsurance rate} = \frac{\text{Average cost sharing other than deductible, for costs subject to a deductible}}{\text{Average EHB allowed costs subject to a deductible} - \text{Average Deductible}}$$

Effective non-deductible cost-sharing:

This amount equals the average portion of total allowed costs for EHB that are not subject to any deductible for the reference plan incurred for reference plan enrollees and payable by the enrollees as cost sharing.

This amount must be based only on policies in the reference plan with total allowed costs for EHB that are above the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

Effective claims ceiling:

This is the average amount of total allowed claims for a policy that results in cost sharing by an enrollee that meets the annual limitation on cost sharing. The calculation is provided in the formula below.

$$\text{Effective claims ceiling} = \text{The Effective Deductible} + \frac{\text{Annual limitation on cost sharing} - \text{average deductible} - \text{Effective non-deductible cost sharing}}{\text{Effective post-deductible coinsurance rate}}$$

Formulas to Calculate the Value of Cost Sharing in the Reference Plan

For each subgroup in a policy, use the formula appropriate to the claims set to establish what the enrollee would have paid in the reference plan and then calculate the value of SOPA payments provided for that subgroup. (Further, issuers must use the subgroup's particular effective parameters when applying effective parameters under the formula. The last step is to add results from each subgroup calculation to determine the SOPA payments provided for the policy.) (As discussed in, "Using the Simplified Methodology," above, the value of SOPA payments provided is the amount the enrollee would have paid in the reference plan minus what the enrollee did pay under the Turquoise plan.)

Use Formula A *for reference plan policies with total allowed costs for EHB that are less than or equal to the effective deductible)*

- The amount that the enrollees would have paid under the reference plan is equal to the total allowed cost for EHB under the policy for the plan year multiplied by the effective pre-deductible coinsurance rate.

Use Formula B *for reference plan policies with total allowed costs for EHB that are greater than the effective deductible but less than the effective claims ceiling:*

- The amount that the enrollees would have paid under the reference plan is equal to the sum of (x) the average deductible, plus (y) the effective non-deductible cost sharing, plus (z) the difference, if positive, between the total allowed costs under the policy for the plan year for EHB that are subject to a deductible and the average deductible, multiplied by the effective post–deductible coinsurance rate.

Use Formula C *for Reference plan policies with total allowed costs for EHB that are greater than or equal to the effective claims ceiling*

- The amount that the enrollees would have paid under the reference plan is equal to the annual limitation on cost sharing for the reference plan, or, at the QHP issuer's election, on a policy-by-policy basis, the amount calculated pursuant to the standard methodology. (The option to use the standard methodology here allows issuers to recoup SOPA amounts provided to enrollees who incurred a significant amount of services from out-of-network providers for which enrollee cost sharing was payable even after reaching the annual limitation on cost sharing.)

The Simplified Methodology for HMO-like Plans

Calculation of Parameters

The effective cost-sharing parameters below are for HMO-like plans or plans with HMO-like characteristics in certain specialties, for example when reference plans have a capitated model for transplant care. Issuers must follow the following process to calculate sets of parameters when more than 80 percent of a plan's total allowed costs for EHB is not subject to a deductible. **Use the identical Steps 1 and 2 as described above** for the simplified methodology to determine how many sets of subgroups of effective cost-sharing parameters to calculate, and confirm whether for each subgroup, more than 80 percent of the plan's total EHB is not subject to a deductible. Then:

- **Step 3:** Calculate parameters for the reference plan. Issuers of HMO-like plans calculate only two parameters because for each subgroup of an HMO-like plan, the average deductible, the effective non-deductible cost sharing, and the effective deductible will each equal zero, and the effective pre-deductible coinsurance rate is the same as the effective post-deductible insurance rate.
- **Step 4:** After calculating parameters, issuers must verify that each reference plan subgroup contains at least 12,000 member months in the reference plan in and out of the Exchange. Unlike other plan designs, HMO-like plans in which more than 80 percent of total allowed costs for EHB is not subject to a deductible are not required to meet the standard for claims above the effective deductible and below the annual limitation, since most claims will be at or near the annual limitation. ***Plans with insufficient member months in one or more subgroups must use the alternate simplified actuarial value methodology***.
- **Step 5:** Select the formula (A, B, and/or C) appropriate to the total claims of each and every subgroup in a policy. Use the appropriate formula to calculate for each policy subgroup that requires separate parameters the amount enrollees in the Turquoise plan would have paid in the reference HMO plan. The SOPA amount provided by the issuer is equal to the sum of amounts calculated for each subgroup on the policy, minus the cost sharing that the enrollee actually paid under the Turquoise plan. Issuers of HMO-like plans use Formulas A and C in these calculations.

Calculations for HMO-like Plans:

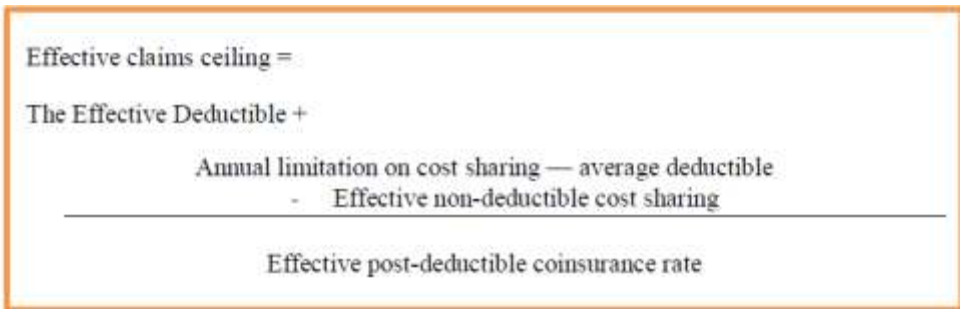
Average deductible = 0, Effective deductible = 0, Effective non-deductible = 0

Effective (pre and) post-deductible coinsurance rate = *Calculate the effective pre- and post-deductible insurance rate using all reference plan policies for the subgroup with associated cost sharing for EHB that is less than the annual limitation on cost sharing.*

The coinsurance rate(s) is equal to (=) the proportion of the total allowed costs for EHB under the reference plan for the plan year incurred for reference plan enrollees and payable as cost sharing (including cost sharing payable through a deductible).

Effective Claims Ceiling

The effective claims ceiling is the same as for non-HMO plans; that is, the estimated average amount of total allowed cost for EHB for a policy that results in enrollee cost sharing that meets the annual limitation on cost sharing. The calculation is provided in the formula below.



Formulas to Calculate Value of Cost Sharing in the Reference Plan for HMO-like Plans

Calculate the value of the SOPA amounts provided by applying the effective cost-sharing parameters of the reference plan to the total allowed costs for EHB for the Turquoise plan.

HMO-like plans use two of three formulas provided in the simplified methodology to calculate the cost sharing enrollees would have paid in the reference plan. For each policy in a Turquoise plan, use the formula appropriate to the claims set to calculate the value of SOPA amounts provided.

For Turquoise plan policies with total allowed costs for EHB for the plan year that are **less than the effective claims ceiling,** use **Formula A** to calculate the amount the enrollees in the applicable subgroup would have paid under the reference plan.

- The amount that the enrollees would have paid under the reference plan is equal to the total allowed cost for EHB under the policy for the plan year multiplied by the effective pre-deductible coinsurance rate.

For Turquoise plan variation policies with total allowed costs for EHB for the plan year that are **greater than or equal** to the effective claims ceiling, use **Formula C** to calculate the amount the enrollees in the applicable subgroup would have paid under the reference plan.

- The amount that the enrollees would have paid under the reference plan is equal to the annual limitation on cost sharing for the reference plan (the particular reference plan's annual limitation), or, at the QHP issuer's election, on a policy by policy basis, the amount calculated pursuant to the standard methodology. (The option to use the standard methodology here allows issuers to recoup SOPA payments provided to enrollees who incurred a significant amount of services from out-of-network providers for which enrollee cost sharing was payable even after reaching the annual limitation on cost sharing.)

Simplified Actuarial Value Methodology (AV method)

Issuers that selected the simplified methodology ***and whose reference plans lack sufficient enrollment to provide a credible estimate of average claims data must use a methodology derived from the reference plan actuarial value*** (from the Actuarial Value calculator) to estimate cost sharing under the reference plan. This methodology requires issuers to compare the annual limitation on cost sharing for the reference plan or a CMS calculation using the plan's actuarial value, whichever is less, to total allowed EHB claims for the policy to determine the actual amount of SOPA provided. (As discussed in, "Using the Simplified Methodology," above, issuers must subtract the amount an enrollee paid under a Turquoise plan from the

amount the enrollee would have paid in the reference plan, here calculated according to the AV method, to obtain the SOPA provided.)

Under the AV method, the amount enrollees in a Turquoise plan policy would pay under the reference plan is the lesser of :

1. the annual limitation on cost sharing for the reference plan, or
2. the product of (x) one minus the reference plan's actuarial value and (y) the total allowed cost for EHB.

The calculation to determine reference plan cost is provided in the formula below:

AV Method to determine Reference Plan Cost Sharing =

The Lessor of:

1. The Annual Limitation of Cost Sharing for the Reference Plan, or,
2. (1-AV) *Actual Allowed Cost for EHB for the Plan Year

Issuers then determine SOPA provided using the formula below:

AV Method to Calculate SOPA Provided =

AV Method Reference Plan Cost – Amount the Enrollee(s) Paid in Turquoise Plan Cost Sharing

When using this methodology, please note:

- The total allowed costs for EHB in the reference plan include SOPA provided for covered out-of-network EHB.
- In the case of capitated or discounted services, issuers that report total allowed costs for the reference plan using their internal pricing mechanisms must ensure that total allowed costs for EHB in the reference plan are the same as total allowed costs in the Turquoise plan variant.
- Actuarial value as calculated does not include out-of-network costs.
- Issuers must use the in-network annual limitation on cost sharing when a reference plan has separate in-network and out-of-network limitations on cost sharing.
- Issuers must use the other than self-only annual limitation on cost sharing for the reference plan for family plans with embedded individual limits. For single coverage, issuers should use the self-only annual limitation on cost sharing for the reference plan.
- Issuers must use the full dollar value of the annual limitation on cost sharing for the reference plan in the equation for the AV methodology even if a member is enrolled for less than the full plan year.
- In situations where the reference plan cost sharing is less than the amount paid by the enrollee paid under a Turquoise plan variant, issuers should enter a negative number for SOPA Provided at the (03) Policy Detail Record. In the rare event that the simplified actuarial value methodology calculation of what enrollees would have paid in the reference plan suggests a negative amount of

SOPA was provided to all members across a Turquoise plan variant, OSI will not subtract that amount from advance SOPA payments.

Issuers using the simplified methodology, including issuers of HMO-like plans, must list all reference plan subgroups and then report the effective parameters calculated for reference plan subgroups associated with each Turquoise plan subgroup with claims sets in the Turquoise plan, as appropriate.

Issuers must use Attestation Form C to report effective parameters and to attest that the issuer applied the correct parameters and correct formula for each subgroup on the policy. Issuers using the AV methodology exclusively do not submit Attestation C.

Appendix B: Data elements and Definitions for Submitting Templates A, B, and C for SOPA Reconciliation Initial Submission or Requests for Reconsideration

Issuer Summary Information (Template A)

- **RECORD CODE:** Record code at the issuer level is always 01.
- **HIOS ID:** The five-digit Health Insurance Oversight System (HIOS)–generated Issuer ID number.
- **ISSUER EXTRACT DATE:** Date information extracted by issuer.
- **Plan YEAR:** The plan year (January to December). For restatements, enter the plan year for which SOPA are being restated.
- **TOTAL ACTUAL SOPA AMOUNT:** Total SOPA amount provided by this QHP issuer to enrollees in all Turquoise plan variants. For restatement files, this is the SOPA amount provided by this QHP issuer to enrollees in all (03) Policy Detail Records, including restated policies and policies that are not being restated.
- **SOPA AMOUNT ADVANCED TO THE ISSUER BY OSI:** Amount the issuer shows received from OSI for the plan year January 1 to December 31, 2023. Issuers should include adjustments to advance payments for the 2023 plan year that were received by the closeout of advance payments in the June 2024 payment cycle. For restatements, the issuer should report the total amount of advance payments for the 2023 plan year as of the closeout payment cycle for the 2023 benefit year (this amount should match the original data file.)
- **RECONCILIATION METHODOLOGY:** The methodology – standard, simplified, or simplified AV method selected by the issuer. Issuers using AV method exclusively must select the simplified AV methodology.
- **TOTAL NUMBER OF TURQUOISE PLAN VARIANTS UNDER THIS HIOS ID:** Total count of Turquoise plan variants for the QHP issuer under this HIOS ID. This count should include only Turquoise plan variants with enrollment, regardless of whether SOPA payments were provided.
- **TOTAL NUMBER OF SUBSCRIBER IDs in ALL TURQUOISE PLAN VARIANTS UNDER THIS HIOS ID:** Count all subscriber IDs associated with a (03) Policy Detail Record in all Turquoise plan variants for this QHP issuer. For restatement files, this is the total number of (03) Policy Detail Records, including restated policies and policies that are not being restated.

- **TECHNICAL POINT OF CONTACT First and Last Name:** First and last name of the issuer's technical point of contact
- **TECHNICAL POINT OF CONTACT Email address:** Email address of the issuer's technical point of contact
- **TECHNICAL POINT OF CONTACT Organization**: Organization of the issuer's technical point of contact
- **TECHNICAL POINT OF CONTACT Phone Number:** Phone number of the issuer's technical point of contact
- **BUSINESS POINT OF CONTACT First and Last Name:** First name of the issuer's business point of contact
- **BUSINESS POINT OF CONTACT Email Address:** Email of the issuer's business point of contact
- **BUSINESS POINT OF CONTACT Organization:** Organization of the issuer's business point of contact
- **BUSINESS POINT OF CONTACT Phone Number:** Phone number of the issuer's business point of contact

Plan and Policy Information

Plan Information (Template A)

- **RECORD CODE:** Record code at the plan level is always 02.
- **QHP PLAN ID:** The 16-digit HIOS-generated qualified health plan identification number. This includes the 14-digit reference plan ID plus the 2-digit Turquoise plan variant ID.
- **TOTAL ANNUAL PREMIUM:** Aggregate billed premium before subsidies for this Turquoise plan variant.
- **TOTAL ALLOWED COSTS FOR EHB:** Total allowed costs (including restated total allowed costs, if submitted as part of a restatement file) for essential health benefits incurred by the enrollee(s) on this plan variant. (See, "Determination of Total Allowed Essential Health Benefits"). For **Formula B** of the simplified methodology only, this means total allowed costs for EHB, subject to a deductible for the policy. Issuers, including issuers of capitated plans, may use plan-specific percentage estimates of non-EHB claims submitted on the Unified Rate Review Template (URRT) or any other reasonable method to determine total allowed costs for EHB. Total allowed costs in the Turquoise plan variants must be the same as those in the associated reference plan.
- **ACTUAL AMOUNT THE ISSUER PAID FOR EHB:** This is the total dollar amount (including the restated total dollar amount, if submitted as part of a restatement file) the issuer

paid to providers for all EHB services to enrollees on this plan variant. This includes SOPA reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability. Note: Because of discounts and amounts paid by other insurers, total actual amounts paid for EHB by the issuer and by enrollees may not equal total allowed costs.

- **ACTUAL AMOUNT THE ENROLLEE(S) PAID FOR EHB:** The amount (including the restated amount, if submitted as part of a restatement file) all enrollees on this Turquoise plan variant paid (or are liable for) in cost sharing for all EHB services.
- **ACTUAL AMOUNT THE ENROLLEE(S) WOULD HAVE PAID FOR EHB UNDER THE REFERENCE PLAN**: The amount (including the restated amount, if submitted as part of a restatement file) the enrollee(s) would have paid for the same EHB claims had he/she/they been enrolled in the reference plan without SOPA. For the standard methodology, dollar amounts entered here must be calculated in accordance with the Standard Methodology section of this guidance on re-adjudication of claims. Issuers should first equate all claims to zero and adjudicate claims as if the enrollee had been in the reference plan from the beginning of the year. (See discussion of claims re-adjudication on page 14, above.) For the simplified methodology, dollar amounts entered here must be calculated in accord with Attachment A.
- **SOPA PROVIDED:** The SOPA Provided amount is the amount (including the restated amount, if submitted as part of a restatement file) enrollees would have paid under the reference plan, minus the amount the enrollees did pay under the applicable Turquoise plan variant (and reimbursed to fee-for service providers, if applicable.) This is the amount that will be subtracted from payment for SOPA to the issuer for the 2023 benefit year. For the simplified actuarial value methodology, SOPA Provided is the amount remaining when actual enrollee EHB cost sharing is subtracted from the lesser of the annual limitation on cost-sharing for the reference plan or the product of (x) one minus the reference plan's actuarial value and (y) the total allowed costs for EHB. For the simplified methodology, SOPA Provided is the sum of SOPA amounts calculated for all subgroups on this policy; for example, if a policy has separate medical and pharmaceutical parameters, actual SOPA Provided must be calculated separately and added together.
- **TOTAL NUMBER OF EXCHANGE SUBCRIBER IDS IN THIS PLAN:** Enter the total count of Exchange subscriber IDs enrolled in this Turquoise plan at any point during the 2023 plan year.

Policy Information (Template B)

- **RECORD CODE:** Record code at the policy level is always 03.
- **SUBSCRIBER ID:** The subscriber ID is the unique identifier provided by the carrier and attributed to the insured/contract holder..
- **EXCHANGE ASSIGNED POLICY ID:** If this is an aggregated policy record, report the current Policy ID Number.
- **QHP ID:** The 16-digit HIOS-generated QHP identification number. This includes the 14- digit standard plan ID plus the 2-digit Turquoise plan variant ID

- **PLAN VARIANT BENEFIT START DATE:** First date the subscriber was enrolled in this Turquoise plan variant**.** If the issuer is filing more than one policy record for this subscriber, the start date may be different from the Policy Start Date.

- **PLAN VARIANT BENEFIT END DATE:** Last date the subscriber was enrolled in this Turquoise plan variant.

- **POLICY START DATE:** First date the subscriber enrolled in this policy. This is the start date for the most current Policy ID and may be different from the plan variant start date for this subscriber.

- **POLICY END DATE:** Last date the subscriber was enrolled in this policy.

- **TOTAL ANNUAL PREMIUM:** The annual premium amount billed for this policy.

- **SELF ONLY/OTHER THAN SELF-ONLY:** For issuers using the simplified and simplified AV methodology only, report whether coverage under this policy is self only, or other than self-only.

- **ANNUAL LIMITATION ON COST SHARING FOR THE REFERENCE PLAN:** This is the annual limitation on cost sharing for the reference associated with this Turquoise plan. Required only for issuers using the simplified and simplified AV methodology. If the policy is self-only, the annual limitation should be the self-only annual limitation.

- **ACTUARIAL VALUE AMOUNT OF THE REFERENCE PLAN:** This is the AV of the reference plan associated with this Turquoise plan variant for the applicable plan year. Required only for issuers using the simplified AV methodology.

- **TOTAL ALLOWED COSTS FOR EHB:** Total allowed costs (including restated total allowed costs, if submitted as part of a restatement file) for essential health benefits incurred by the enrollee(s) on this policy. (See, "Determination of Total Allowed Essential Health Benefits"). For **Formula B** of the simplified methodology only, this means total allowed costs for EHB, subject to a deductible for the policy. Issuers, including issuers of capitated plans, may use plan-specific percentage estimates of non-EHB claims submitted on the Unified Rate Review Template (URRT) or any other reasonable method to determine total allowed costs for EHB. Total allowed costs in the Turquoise plan variants must be the same as those in the associated reference plan.

- **ACTUAL AMOUNT THE ISSUER PAID FOR EHB:** This is the total dollar amount (including the restated total dollar amount, if submitted as part of a restatement file) the issuer paid to providers for all EHB services to enrollees on this policy. This includes SOPA reimbursement amounts to fee-for-service providers to the extent the issuer reimbursed fee-for-service providers. Issuers that provide for essential health benefits on a partially or fully capitated basis should enter all amounts paid by the issuer for those services. This value does not include enrollee liability. Note: Because of discounts and amounts paid by other insurers, total actual amounts paid for EHB by the issuer and by enrollees may not equal total allowed costs.

- **ACTUAL AMOUNT THE ENROLLEE(S) PAID FOR EHB:** The amount (including the restated amount, if submitted as part of a restatement file) all enrollees on this policy paid (or are liable for) in cost sharing for all EHB services.

- **ACTUAL AMOUNT THE ENROLLEE(S) WOULD HAVE PAID FOR EHB UNDER THE REFERENCE PLAN**: The amount (including the restated amount, if submitted as part of a restatement file) the enrollee(s) would have paid for the same EHB claims had he/she/they been enrolled in the reference plan without SOPA. For the standard methodology, dollar amounts entered here must be calculated in accordance with the Standard Methodology section of this guidance on re-adjudication of claims. Issuers should first equate all claims to zero and adjudicate claims as if the enrollee had been in the reference plan from the beginning of the year. (See discussion of claims re-adjudication on page 10, above.) For the simplified methodology, dollar amounts entered here must be calculated in accord with Appendix A.

- **ACTUAL SOPA PROVIDED:** The SOPA Provided amount is the amount (including the restated amount, if submitted as part of a restatement file) enrollees would have paid under the reference plan, minus the amount the enrollees did pay under the applicable Turquoise plan variant (and reimbursed to fee-for service providers, if applicable.) This is the amount that will be subtracted from payment for SOPA to the issuer for the 2023 benefit year. For the simplified actuarial value methodology, SOPA Provided is the amount remaining when actual enrollee EHB cost sharing is subtracted from the lesser of the annual limitation on cost-sharing for the reference plan or the product of (x) one minus the reference plan's actuarial value and (y) the total allowed costs for EHB. For the simplified methodology, SOPA Provided is the sum of SOPA amounts calculated for all subgroups on this policy; for example, if a policy has separate medical and pharmaceutical parameters, actual SOPA Provided must be calculated separately and added together.

- **ACTUARIAL VALUE of the REFERENCE PLAN:** This is the actuarial value of the reference plan associated with this Turquoise plan as reported to OSI and BeWellnm for the 2023 benefit year. Required for the simplified actuarial value methodology only.

Data Elements for the Simplified Methodology Effective Parameters Report

Issuers using the simplified methodology, including issuers of HMO-like plans, must list all reference plan subgroups and then report the effective parameters calculated for reference plan subgroups associated with each Turquoise plan subgroup with claims sets in the Turquoise plan, as appropriate. Issuers should use Attestation Form C to report effective parameters and to attest that the issuer applied the correct parameters and correct formula for each subgroup on the policy. **Issuers using the AV methodology exclusively do not submit Attestation C.**

Request for Reconsideration for Error/Discrepancy Correction

Instructions

Issuers must use Template C to submit a request for reconsideration to correct and error or reporting discrepancy. Additional data elements are required for the Request for Reconsideration or error/discrepancy corrections. Some data elements used in Template A and B are used for filling of Template C (Error/Discrepancy Correction Request for Reconsideration).

In addition, there are data elements that are specific to the request for reconsideration submission. The following instructions and additional data elements apply to submitting a request for reconsideration (if applicable)

Template C comprises 3 records:

01: Issuer Summary Record (Issuer/Plan Year Level)

02: Discrepancy Summary Record (Issuer/Plan Year/Discrepancy Reason Level)

03. Policy Level Record (Issuer/ Plan Year/ Discrepancy Reason/ Subscriber Policy Level)

01- Issuer Summary Record (Issuer/Plan Year Level)

One 01 record should be created for each Issuer and plan year. If an issuer is reporting multiple discrepancies for a plan year, the information must be reported in the "02" and "03" records that correspond to the HIOS ID and plan year in the "01" record.

02- Discrepancy Summary Record (Issuer/Plan Year/Discrepancy Reason Level)

One 02 record should be created for each Discrepancy Reason Type Code reported for the issuer and plan year indicated in the corresponding "01" Issuer Summary record. The Issuer should submit the applicable Discrepancy Reason Type Code for each issue the issuer is disputing. Records with Record Code 02 should be positioned immediately after the 01 Issuer/Plan Year record they are associated with. Table 1 provides the list of Discrepancy Reason Codes and their definitions

03- Policy Level Record (Issuer/Plan Year/Discrepancy Reason/Subscriber Policy Level)

(03) Policy level records should be populated for each issuer/plan year/discrepancy reason that affects fewer than "all" subscriber IDs. Records with Record-Code 03 should be positioned immediately after the 02 Issuer Year Discrepancy record they are associated with.

Table 1: Discrepancy Reason Type Codes and Definitions

Discrepancy Reason Type Code	Discrepancy Reason Type Definition
1	Incorrect Subscriber ID: Issuer provided an incorrect subscriber ID.
2	Issuer did not submit these subscriber IDs in its SOPA Reconciliation data file submission to OSI and is submitting them for the first time
3	OSI Mathematical Error for Amount (OSI used wrong SOPA advance payment amount, OSI otherwise miscalculated SOPA Provided or the reconciled SOPA amount, or incorrect amount stated in the report of SOPA reconciliation charges and payments for a plan year)
4	Issuer Processing Error: Reporting a processing error (submitted incorrect or incomplete information in the data file, or a claims processing error affected the amount of SOPA provided that was reported in the data file)
5	Issuer Mathematical Error for Amount (Issuer reported incorrect amounts for the amounts paid for services, or applied incorrect actuarial value in simplified method formula and/or miscalculated SOPA Provided)
6	Issuer Incorrect application of the relevant methodology (Issuer or its TPA failed to follow OSI guidance on re-adjudication of claims, or issuer used the incorrect methodology)
7	Claims data or policies submitted in the wrong plan year
8	Other