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

2024 Plan Year

HEALTH CARE
AUTHORITY

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Table of Contents

Background ... 3

Reference Plan ... 4

SOPA Advance Payments ... 5

Reconciliation of SOPA Advance Payments ... 5

Timing of Reconciliation Process ... 6

Determination of Total Allowed Essential Health Benefits ... 7

Identifying SOPA Reimbursable Benefits ... 8

The Standard Methodology ... 8

Re-Adjudication of Claims - Other Issues ... 8

Issuer Reporting Requirements ... 10

Issuer Attestations ... 10

SOPA Reconciliation Attestation Forms ... 10

Restatement of SOPA ... 11

Reporting Requirements ... 12

Submission Requirements ... 12

Standard File Naming Convention ... 14

Data Elements ... 15

Issuer Summary Information ... 15

Plan and Policy Information ... 15

Error/Discrepancy Correction Request for Reconsideration (if required) ... 15

Treatment of Confidential Information ... 15

Payment ... 15

Timing of payments and charges ... 16

Determination of Outliers ... 16

Error/Discrepancy Corrections and Appeals ... 16

Audit and Retention of Records ... 16

Data Submission Templates A, B and C, and Attestation Form A ... 17

Appendix A: Data elements and Definitions for Submitting Templates A, B, and C for SOPA Reconciliation Initial Submission or Requests for Reconsideration ... 18

DRAFT

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) Which was codified into law as Section 59A-23F-11 NMSA 1978. In 2024, the law was amended to replace the Office of Superintendent of Insurance with the Health Care Authority (HCA) as administrator of the fund. One purpose of the fund is to reduce health insurance premiums and out-of-pocket costs for New Mexicans who purchase coverage on New Mexico Health Exchange (NMHIX).

The state's Health Insurance Marketplace Affordability Program went into effect on January 1, 2023. In addition to enhanced premium assistance, the program provides for 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 starting with 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 the federal 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
FPL Range	Up to 150%	150.01-200%	200.01-300%
Actuarial Value	99% AV	95% AV	90% AV
SOPA Metal Level	Silver	Silver	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 a Turquoise 3 Plan variant.

[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 13.10.36.7 NMAC, "State out-of-pocket assistance program" 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. HCA 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 receive monthly SOPA advance payments directly from HCA during the applicable Plan Year and, after the end of the Plan Year, must reconcile the total advance payments with the actual SOPA amounts provided to eligible enrollees for the applicable Plan Year.

This guidance provides information on the process for reconciling the monthly SOPA advance payments that HCA 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 - 300% FPL	Turquoise 3 (-90 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 leverages the exisiting 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 variants, the reference plan is the applicable standard Gold plan. Gold plans are not eligible for federal CSRs but have a higher actuarial value compared to the standard Silver plans.

HCA obtains and validates data from NMHIX on a monthly basis that detail subscriber-level enrollment within each plan's Turquoise variants and the underlying plan premium for the Turquoise enrollees. Based on this information, HCA calculates monthly SOPA advance payment amounts, which 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 are issued monthly. Information related to the advance payment of SOPA benefits can be found in Bulletin 2022-022 and the 2024 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedures Manual.

HCA'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 2024 Marketplace Affordability Program Policy and Procedures Manual. This document describes the methodology to be used by carriers to

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reconcile SOPA advance payments with actual uptake of SOPA benefits for the 2024 Plan Year and beyond. HCA may allow alternative methodologies for new carriers and will provide guidance on allowable methodologies as needed.

SOPA Advance Payments

HCA obtains and validates data from NMHIX on a monthly basis that detail subscriber-level enrollment within each plan's Turquoise variants and the underlying plan premium for the Turquoise enrollees. Based on this information, HCA calculates monthly SOPA advance payment amounts, which 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 are issued monthly. Information related to the advance payment of SOPA benefits can be found in Bulletin 2022-022 and the 2024 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedures Manual.

Table 3: 2024 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
>200-300% FPL	Turquoise 3	Gold	90%	.079

Reconciliation of SOPA Advance Payments

After 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. HCA reconciles 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 allows HCA to reconcile the difference between the amount of SOPA 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 Essential Health Benefits (EHBs) in a reference Silver plan without SOPA (where federal CSRs are reflected) – Out-of-Pocket amounts actually paid

For Turquoise 3 Plans, SOPAs =

Out-of-Pocket Spending enrollees would have paid for EHBs in a reference Gold plan without SOPA – Out-of-Pocket amounts 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)

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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 determines 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 Qualified Health Plan (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 for 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 Turquoise plan applied. For enrollees that switch Turquoise plans during the year, HCA expects that cost sharing accumulators will be preserved across all plans so that the SOPA parameters could be appropriately applied.

In the case of claims with coordinated benefits (COB), issuers should apply the COB amounts consistently to the reference and Turquoise plans. 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 HCA the full SOPA advance payment amount for certain plans rather than re-adjudicate such claims. For example, issuers may decide to reimburse HCA the full amount of SOPA 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 HCA by emailing Colin.Baillio@hca.nm.gov.

Timing of Reconciliation Process

The initial data submission for reconciliation of SOPA amounts provided to enrollees in the 2024 Plan Year will begin on January 27, 2025 and end on March 28, 2025. The second submission window for the 2024 Plan Year will open on July 1, 2025 and close on August 29, 2025. Issues that have not previously participated in the SOPA reconciliation process should contact HCA at least 4 months prior to the data

submission deadline to explore opportunities to test their submission data and process prior to the submission deadline.

Issuers may include late claims from services provided in the 2024 Plan Year as close to the 2025 data submission deadline as is practical, as long as the issuer recalculates and restates all claims for the associated policy as necessary prior to submission of such claims for reconciliation. HCA may permit any claims incurred in the 2024 Plan Year and not included in either of the two 2025 submission windows to be filed in the 2026 or any subsequent submission window(s).

HCA will provide two mandatory reconciliation cycles in the Reporting Plan Year; one that is completed by the end of June of the Reporting 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 2024.

Table 4: SOPA Reconciliation Timeline for the 2024 Plan Year

Date	Activity
2024	
Guidance Draft Production, Review and Publication of Final Guidance	
1. October 15, 2024	Draft SOPA Reconciliation Guidance Published for Comments
2. November 15, 2024	Draft SOPA Reconciliation Guidance – End of Comment Period
Training for New SOPA Entrant Only – Oct-Dec	
2025	
Data Submission, SOPA Reconciliation and Payments, Invoices Issued	
1. January 27, 2025 (Mon)	First Data Submission Window Opens for PlanYear 2024
2. March 28, 2025 (Fri)	First Data Submission Window Closes for PlanYear 2024
3. April 25, 2025 (Fri)	HCA Notifies Issuers of Reconciled Amounts and Sends Invoices to Issuers
4. June 2025	First Payment Cycle Ends, HCA Payments Made, Issuers Payments Received
Errors/Discrepancy Corrections and Appeals	
Refer to Section entitled “Errors/Discrepancy Corrections	
Second Submission Cycle	
5. July 1, 2025(Tues)	Second Data Submission Window for 2024 Plan Year Begins
6. August 29, 2025 (Fri)	Second Data Submission Window for 2024 Plan Year Ends
7. September 29, 2025 (Mon)	HCA Notifies Issuers of Reconciled Amounts and Sends Invoices to Issuers (if applicable)
8. November 2025	Second Payment Cycle Ends, HCA Payments Made, Issuers Payments Received

Determination of Total Allowed Essential Health Benefits

Issuers must identify allowed Essential Health Benefits (EHB) claims for reconciliation, since they will not be reimbursed for SOPA spending for benefits other than EHB. In addition to issuers that are new to the New Mexico individual health insurance market, HCA will permit issuers to use an alternate method to determine the total allowed EHB for certain plans, including capitated plans, whose cost sharing

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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 costs, HCA 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 include all claims.

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. [2] Issuers 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 determine the cost-sharing amount under the Turquoise plan and then to determine the claim's cost-sharing amount under the cost-sharing 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

[2] A simplified methodology may be available only for new market entrants, as an exception, on a case-by-case basis. If approved by HCA, guidance on the use of the simplified methodology will be made available to applicable carriers on an as-needed basis.

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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-level record 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 policy-level 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.[3] 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 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. HCA 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.

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.

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

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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[4] 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. HCA will limit the amount of SOPA payable for a policy to no less than zero. However, issuers should report the actual amount calculated, even if it is negative.

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.

Issuer Reporting Requirements

Issuers are required to report to HCA, 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. See Attestation Form A. 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

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

represent only SOPA for essential health benefits for which HCA reimbursement is permitted, these amounts must have been passed through by the issuer to such providers.

Restatement of SOPA

To ensure consistent and accurate results for restatements of SOPA provided for a Plan Year, and because the addition of data on missing or corrected claims may affect amounts of SOPA provided, HCA 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 HCA.

- When to restate: Issuers that identify an issue in data or calculations for SOPA provided that results in the issuer owing HCA must notify HCA as soon as the issuer identifies the issue. HCA 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 should submit to HCA for approval, a plan for administering the refunds including the methodology used to determine the amounts to be refunded and the timing of such refund payment.
- Restatements should not include data for which a discrepancy form was previously submitted and denied by HCA.

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- 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.
- HCA 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, HCA 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 discrepancy reporting, below.
- For restatements of SOPA provided, HCA 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 2024 Plan Year must submit the required information to reconcile such payments according to the timeline set forth in Table 4. Second round submissions are optional.

- All submissions must be made electronically via the System for Electronic Rate and Form Filing ("SERFF").
- A separate (new) SERFF filing is required for each submission.
- Each filing must be submitted under the correct Type of Insurance (TOI), Sub-TOI and Filing Type as shown below. Failure to file under the correct Filing Type, TOI or Sub-TOI will result in an automatic filing rejection.

Each filing must be accompanied by a $15 filing fee pursuant to 59A-6-1(V) NMSA.Fees are required and deemed earned upon submission.

  - TOI: H016I Individual Health - Major Medical
  - Sub-TOI - SOPA Reconciliation
  - Filing Type - Required Reports

- Each filing should provide access to the interim, testing and prior annual submissions and make all affiliated prior submissions accessible through the "View Associated Filings" feature in SERFF. See the instructions below for using this feature.

1. Click on View Associated Filings

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TOI:	A03G Group Annuities - Deferred Variable	**State Tr Num:**		**State Status:**	
Sub-TOI:	A03G.005 Limited Flexible Premium	**Co Tr Num:**		**Co Status:**	
Filing Type:	Form	**Date Submitted:**	Not Submitted	**Disposition Date:**	
Effective Date Requested:		**Authors:**	zzIndustrySupportBW zzSERFFStaff, zzIndustrySupportCB zzSERFFSupport (i), zzIndustrySupport zzSERFFSupportAT (i)		

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Project Name:		**Project Number:**	
Status of Filing in Domicile:	Not Filed	**Date Approved in Domicile:**	
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TOI:	A03G Group Annuities - Deferred Variable	**State Tr Num:**		**State Status:**	
Sub-TOI:	A03G.005 Limited Flexible Premium	**Co Tr Num:**		**Co Status:**	
Filing Type:	Form	**Date Submitted:**	Not Submitted	**Disposition Date:**	
Effective Date Requested:		**Authors:**	zzIndustrySupportBW zzSERFFStaff, zzIndustrySupportCB zzSERFFSupport (i), zzIndustrySupport zzSERFFSupportAT (i)		

General Information | Form Schedule | Rate/Rule Schedule | Supporting Documentation | State Specific | Companies and Contact | Filing Fees | Filing Correspondence

Project Name:		**Project Number:**	
Status of Filing in Domicile:	Not Filed	**Date Approved in Domicile:**	
Domicile Status Comments:			
Filing Status Changed:	01/10/2019	**State Status Changed:**	
Company Status Changed:			

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3. Enter SERFF Tracking number for filing you are wanting to associate --> Click Add --> Save

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

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 applicable Plan Year during the following Plan Year
  - "init2" for the second submission for the applicable Plan Year during the reporting Plan Year
  - "restate_YYYY" for restatements processed in a later year (e.g., "restate_YYYY" for restatements processed after the reporting Plan Year for the applicable Plan Year employees)
- **Filedesc**: indicate one of the following:
  - **TEMPA** – Template A – Issuer and Plan level template
  - **TEMPB** – Template B – Policy and Enrollee level template
  - **TEMPC** – Template C – Error-Discrepancy Request for Reconsideration

DRAFT

Template
FormA: Attestation Form A: Allowed Costs for Essential Health Benefits

- **v#:** v followed by the version number (increment for each update to the filing)

Example 1: ABC_2024_init1_TEMPA_v2. xlsx is the second version of the initial 2024 issuer and plan level reconciliation template submitted during the first submission period in 2024 for ABC Health Plans.

Example 2: ABC_2024_restate_2026 TEMPA_v1. xlsx is the first version of the restated 2024 issuer and plan level reconciliation template submitted in 2026 for ABC Health Plans.

Data Elements

Issuer Summary Information

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, Policy, and Enrollee Information

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

Data elements at the plan level (reported in **Template A – Tab 2**) are aggregated information derived from individual policy level and enrollee level data (reported in **Template B)**, except that any negative SOPA values reported in Template B should be limited to zero in Template A.

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

Treatment of Confidential Information

Because claims information contains protected enrollee information, all documents uploaded in SERFF pursuant to this guidance will be treated as confidential.

Payment

HCA 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, HCA will validate data and perform outlier analysis, but will not audit the data. 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 applicable Plan Year, an initial adjustment will be made in June (end of main reconcilation cycle), with a second reconcilation cycle that ends in November that captures the plan year incurred claims not completed in March, the end of the initial data reconciliation submission

period for the Plan Year. Any claims incurred in the benefit year and not included for reconciliation in either of the two reconciliation submission windows for that year may be filed in the following year or later reconcilition submission window(s).

Timing of Payments and Charges

HCA expects to issue a report to each issuer showing, for validated data, SOPA reconciliation payments and charges for the Plan Year by June of the following year. 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 HCA. 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

HCA 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, HCA will conduct a comparison against other metrics to determine if the issuers' reported amounts are within a reasonable range compared to other issuers. HCA 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

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 HCA using the discrepancy form for a 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 HCA, HCA's incorrect application of the relevant methodology, or HCA's mathematical error of the amount to be paid for SOPA amounts for a Plan Year. Reconsideration requests shall be submitted to Colin.Baillio@hca.nm.gov and filed in SERFF.

Once a decision is made, the issuer cannot request further reconsideration of any of the issues that were adjudicated in a subsequent data submission year.

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."

DRAFT

In order to comply with this regulatory requirement, issuers must submit to HCA 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. HCA intends to provide instructions 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 HCA or its designee to assess compliance with the relevant requirements regarding SOPA payments, as determined by the Superintendent.

Data Submission Templates A, B and C, and Attestation Form A

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 A 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 Form A

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Appendix A: 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 HCA:** Amount the issuer shows received from HCA for the plan year January 1 to December 31, 2024. Issuers should include adjustments to advance payments for the 2024 plan year that were received by the closeout of advance payments in the June 2025 payment cycle. For restatements, the issuer should report the total amount of advance payments for the 2024 plan year as of the closeout payment cycle for the 2025 plan year (this amount should match the original data file.)
- **RECONCILIATION METHODOLOGY:** The methodology – standard or AV simplified, method (if approved by HCA) selected by the issuer.
- **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

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- **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"). 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.

DRAFT

- **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. The 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).
- **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, but no less than zero.) This is the amount that will be subtracted from payment for SOPA to the issuer for the benefit year.
- **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 plan year.

Policy Information (Template B) – Tab 1

One record should be added for each subscriber in each Turquoise plan variant. All values for each enrollee in a policy should be rolled up to the subscriber level.

- **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-ISSUED SUBSCRIBER ID:** The 12-digit SUBSCRIBER_ID in the beWellnm Monthly SOPA Advance Payment Data Files.
- **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.
- **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").
- **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. 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, above.)
- **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 the SOPA advance payment to the issuer for the benefit year.

Enrollee Information (Template B) – Tab 2

One record should be added for each enrollee, even if there is no claim for a Turquoise plan for the applicable policy, and for each period of service for each applicable plan during the plan year.

- **RECORD CODE:** Record code at the enrollee level is always 04.
- **ISSUER SUBSCRIBER ID:** The subscriber ID is the unique identifier provided by the carrier and attributed to the insured/contract holder.
- **EXCHANGE-ISSUED SUBSCRIBER ID:** The 12-digit SUBSCRIBER_ID in the beWellnm Monthly SOPA Advance Payment Data Files
- **EXCHANGE-ISSUED MEMBER ID:** The 12-digit MEMBER_REFERENCE_ID in the beWellnm SOPA Advance Payment Data Files
- **EXCHANGE ASSIGNED POLICY ID:** If this is an aggregated policy record, report the current Policy ID Number.

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- **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 enrollee was enrolled in this Turquoise plan variant**.** If the issuer is filing more than one policy record for this enrollee, 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 enrollee 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 enrollee.
- **POLICY END DATE:** Last date the enrollee was enrolled in this policy.
- **TOTAL ANNUAL PREMIUM:** The annual premium amount billed for this enrollee. (Format: $0,000.00)
- **SELF ONLY/OTHER THAN SELF-ONLY:** For issuers using the simplified AV methodology only, report whether coverage under this policy is self only, or other than self-only. Values for this data element can be Self-only or Other-than-self-only. Consolidate any other categories into these two values using the drop-down menu.
- **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. (Format: XX.0,000)
- **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 on this policy. (See, "Determination of Total Allowed Essential Health Benefits"). 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. (Format: $0,000.00)
- **ACTUAL AMOUNT THE ENROLLEE(S) PAID FOR EHB:** The amount (including the restated amount, if submitted as part of a restatement file) each enrollee on this policy paid (or are liable for) in cost sharing for all EHB services. (Format: $0,000.00)

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- **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. 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, above.)
- **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 benefit year.

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 4 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)

04- Member Level Record (Issuer/Plan Year/Discrepancy Reason/Subscriber Policy/Member 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.

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

(04) Member level records should be populated for each issuer/plan year/policy discrepancy reason that affects a specific subscriber ID. Records with Record-Code 04 should be positioned immediately after the 03 Policy 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 HCA and is submitting them for the first time
3	HCA Mathematical Error for Amount (HCA used wrong SOPA advance payment amount, HCA 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 miscalculated SOPA Provided)
6	Issuer Incorrect application of the standard methodology (Issuer or its TPA failed to follow HCA 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

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