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2024 SOPA RECONCILIATION
2nd Submission

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Agenda

1. Overview of 2024 SOPA Reconciliation Process
   a) Background
   b) Steps in SOPA Reconciliation Calculation
   c) Reconciliation Process
   d) Updated Reconciliation Process Timeline
   e) SERFF Submission Requirements
2. 2024 Changes
3. Overview of the Reports
4. SOPA Reconciliation Checklist
5. Resources
6. Summary of Common Issues
7. Open Discussion

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Background

- State Out-of-Pocket Assistance Program (SOPA)
  - Fashioned after the federal cost-sharing reduction (CSR) program
- Turquoise plans are plans with lower cost-sharing for eligible individuals purchasing health insurance on BeWell
- Eligible consumers pay the lower cost-sharing amount based on the Turquoise plan cost-sharing design
- Issuers' premiums reflect the reference plan
- HCA pays the difference in cost-sharing between the cost-sharing under the reference plan and the Turquoise plan
  - HCA makes estimated payments (advance payments) during the plan year, based on a multiplier applied to premiums
  - After the end of the Plan Year, the SOPA reconciliation process determines the actual difference in cost-sharing (actual SOPA), and this is compared to the advance payments. Issuers refund HCA if the advance payments exceed the actual SOPA and are paid additional amounts if the advance payments are less than the actual SOPA.

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Background: 2024 Advance Payment Multipliers

Income Tier	Turquoise Variant	Reference Plan	Turquoise Plan AV	SOPA Variant Multiplier
Up to 150% FPL	Turquoise 1	Silver 94% CSR Variant	99%	.042
>150% - 200% FPL	Turquoise 2	Silver 87% CSR Variant	95%	.066
>200% - 300% FPL	Turquoise 3	Gold Standard (80% AV) Plan	90%	.079

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Reconciliation Process

1. HCA makes advance payments to issuers during the applicable plan year to compensate issuers for the additional benefits paid under the Turquoise plan
2. Issuers submit required reconciliation information electronically in SERFF during the applicable window
   - Use Reconciliation Checklist to document data integrity checks performed
3. HCA reviews the information and requests clarification/correction of data
4. Issuers provide updated information
5. Repeat steps 3 and 4 until HCA is satisfied with data quality and consistency
6. Submission is finalized, payments made by/to issuers

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Steps in SOPA Reconciliation Calculation

1. Calculate the actual SOPA amount using 2024 claims data
   - For Turquoise 1 or Turquoise 2 Plans, SOPA =
     - Out-of-Pocket amounts enrollees would have paid for Essential Health Benefits (EHBs) in an applicable CSR variant plan – Out-of-Pocket amounts actually paid by the enrollee
   - For Turquoise 3 Plans, SOPA =
     - Out-of-Pocket amounts enrollees would have paid for EHBs in a reference Gold plan without SOPA – Out-of-Pocket amounts actually paid by the enrollee
2. Compare all SOPA payments and paid by HCA to the actual SOPA amounts for the applicable Plan Year
   a) Two submission cycles: January to June, July to November
   b) Opportunity for restatement of SOPA for a prior Plan Year

SOPA Reconciliation Timeline, Cont'd

2024 PY – Second Data Submission Cycle	
1. July 1, 2025 (Tues)	Second data submission window for PY 2024 opens
2. August 29, 2025 (Fri)	Second data submission window for PY 2024 closes
3. September 3, 2025 (Wed)	Training session for issuers
4. Five business days after objection	Issuers respond in SERFF
5. Five business days after response	Subsequent objections to issuers
6. October 6, 2025	Turnaround time shortens to two business days
6. October 31, 2025 (Fri)	HCA notifies issuers of reconciled amounts and sends invoices to issuers (if applicable)
7. November 26, 2025	Second payment cycle ends, HCA payments made, issuers payments received

SERFF Submission Requirements – 2024 PY SOPA Only

- Separate SERFF filings for each submission cycle
- Use correct TOI/Sub-TOI/Filing Type:
  - TOI: H016I Individual Health - Major Medical
  - Sub-TOI - SOPA Reconciliation
  - Filing Type - Required Reports
- Cover letter
  - "As of" date for claims runout
  - Extract date (per Template A) – date the reports were run to populate the templates included in the filing
  - Submission cycle
  - Methodology used
  - Indicate the submissions included. E.g., 2024 PY – initial submission, 2023 PY restated submission
  - Notes for reviewer related to the filing
    - E.g., reasons for negative SOPA, including examples
- Files (use correct naming convention – see page 14 of the *2024 SOPA Reconciliation Guidance*):
  - Template A
  - Template B
  - Attestation Form A or Form B

SERFF Submission Requirements – Associated Filings

- Attach all associated filings (1st and 2nd submissions for the 2023 plan year, 1st submission for the 2024 PY) in the applicable link
- Each filing should make all prior submissions accessible through the "View Associated Filings" feature in SERFF
  - See pages 12 to 14 of the *2024 SOPA Reconciliation Guidance*

SERFF Submission Requirements – 2023 Restatements

- Issuers must notify the HCA by January 31, 2025, if restating the 2023 SOPA reconciliation
- All templates and attestations must be included in the SERFF filing for the 2024 PY
- Use separate files for 2023 and 2024 with correct naming convention (see page 14 of the *2024 SOPA Reconciliation Guidance*)
- Include all policies for which the issuer provided SOPA, even if SOPA amounts for a policy are not being amended
- Use the 2024 data file format to submit the 2023 restatements
- Submit recalculations of existing policies and policies that were not reported in the 2023 PY data submission

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2024 Filing Requirements

- Election of SOPA methodology is locked in for the plan year
  - Cannot be changed in subsequent submissions or restatements for the same plan year
- Two tabs in Template B
  - Tab 1 is on the subscriber level
    - Includes all subscribers with a claim on the policy (by any member)
  - Tab 2 is on the member level and includes all enrollees in Turquoise plans, **even if there are no claims**
- Second submission is required (was optional for 2023 plan year)
- Checklist
- Cover letter

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Overview of Reports

- Template A
  - Issuer level
  - Plan level
- Template B
  - Policy/subscriber level
  - Member/enrollee level

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Template A – 01 Issuer-Level Reporting

Record-Code	HIOS ID	Issuer Extract Date	Plan Year	Total Actual SOPA Amount	SOPA Amount Advanced to the Issuer by HCA	Reconciliation Methodology	Total Number of Turquoise Plan Variants under this HIOS ID	Total Number of Subscriber IDs in all Turquoise Plan Variants Under this HIOS ID	Technical POC First and Last Name	Technical POC Email Address	Technical POC Organization Title	Technical POC Phone Number	Business POC First and Last Name	Business POC Email Address	Business POC Organization Title	Business POC Phone Number
01		MMDDYYYY	2024													

- 'SOPA Amount Advanced to the Issuer by HCA' includes the net of **ALL** amounts paid by HCA for the 2024 PY
- Include all enrollees in Turquoise plans, even if claims are $0 or advance payments are $0
- Entries must:
  - Tie with entries in the 04 Member-Level Reporting tab of Template B
  - Be consistent with 02 Plan-Level Reporting tab of Template A
- Issuer Extract Date – run date of report

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Template A – 02 Plan-Level Reporting

Record Code	QHP ID	Total Annual Premium	Total Allowed Costs For EHB	Actual Amount the Issuer Paid For EHB	Actual Amount the Enrollee(s) paid for EHB	Actual Amount the Enrollee(s) Would Have Paid for EHB Under the Reference Plan	SOPA Provided	Total Number of Exchange Subscriber IDs in this Plan
02								

- Include all enrollees in Turquoise plans, even if claims are $0 or advance payments are $0
- Tie with the 01 Issuer-Level Reporting tab of Template A and the 04 Member-Level Reporting tab of Template B
- Total Annual Premium
- Claims
- SOPA – values limited to $0, **do not delete** entries with negative SOPA
- Number of Exchange Subscribers
  - Should tie with report from the Exchange

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Template B – 03 Policy-Level Reporting

Record Code	Subscriber ID	Exchange Issued Member ID	Exchange Assigned Policy ID	QHP ID	Plan Variant Benefit Start Date	Plan Variant Benefit End Date	Policy Start Date	Policy End Date	Total Annual Premium	Total Allowed Costs For EHB	Actual Amount the Issuer Paid for EHB	Actual Amount the Enrollee(s) Paid for EHB	Actual Amount the Enrollee(s) Would Have Paid for EHB Under the Reference Plan	Actual SOPA Provided

- Include all Turquoise plan policies with at least 1 claim
- Must reconcile with 04 Member-Level Reporting tab
- Information included:
  - Subscriber/Member ID
  - QHP ID
  - Dates
  - Total Annual Premium
  - Claims
  - SOPA (may be negative)

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Template B – 04 Member-Level Reporting

- Include all enrollees in Turquoise plans, even if claims are $0 or advance payments are $0
- Multiple records for members with multiple periods of enrollment
- Must reconcile with 03 Policy-Level Reporting tab, and any differences documented and explained
- Information included:
  - Subscriber/Member IDs
  - Dates
  - Premium
  - Claims
  - SOPA Amount (may be negative)

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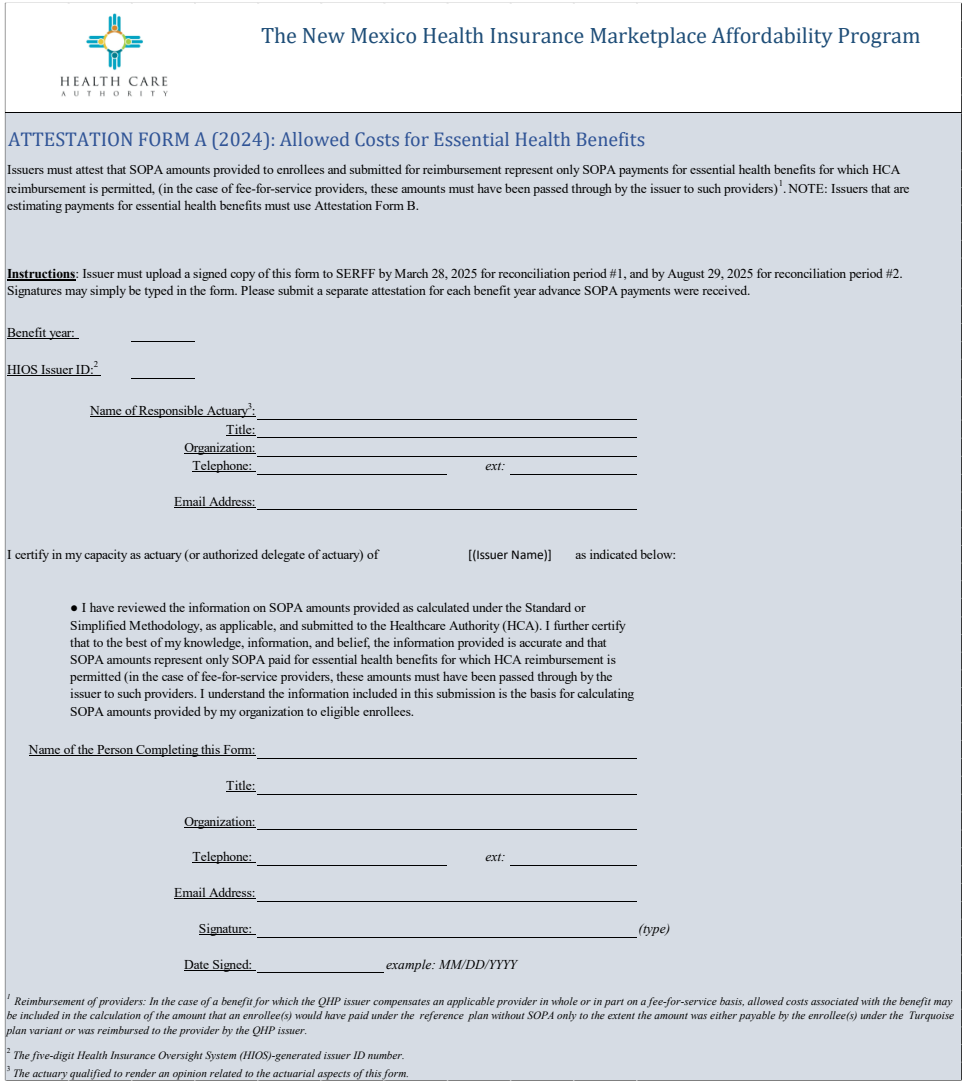
Walkthrough of SOPA Reconciliation Checklist

Attestation Forms – Form A



HEALTH CARE AUTHORITY

The New Mexico Health Insurance Marketplace Affordability Program

ATTESTATION FORM A (2024): Allowed Costs for Essential Health Benefits

Issuers must attest that SOPA amounts provided to enrollees and submitted for reimbursement represent only SOPA payments for essential health benefits for which HCA reimbursement is permitted, (in the case of fee-for-service providers, these amounts must have been passed through by the issuer to such providers)[1]. NOTE: Issuers that are estimating payments for essential health benefits must use Attestation Form B.

Instructions: Issuer must upload a signed copy of this form to SERFF by March 28, 2025 for reconciliation period #1, and by August 29, 2025 for reconciliation period #2. Signatures may simply be typed in the form. Please submit a separate attestation for each benefit year advance SOPA payments were received.

Benefit year: _____

HIOS Issuer ID:[2] _____

Name of Responsible Actuary[3]: _____
Title: _____
Organization: _____
Telephone: _____ *ext:* _____
Email Address: _____

I certify in my capacity as actuary (or authorized delegate of actuary) of [(Issuer Name)] as indicated below:

- I have reviewed the information on SOPA amounts provided as calculated under the Standard or Simplified Methodology, as applicable, and submitted to the Healthcare Authority (HCA). I further certify that to the best of my knowledge, information, and belief, the information provided is accurate and that SOPA amounts represent only SOPA paid for essential health benefits for which HCA reimbursement is permitted (in the case of fee-for-service providers, these amounts must have been passed through by the issuer to such providers. I understand the information included in this submission is the basis for calculating SOPA amounts provided by my organization to eligible enrollees.

Name of the Person Completing this Form: _____
Title: _____
Organization: _____
Telephone: _____ *ext:* _____
Email Address: _____
Signature: _____ *(type)*
Date Signed: _____ *example: MM/DD/YYYY*

[1] *Reimbursement of providers: In the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid under the reference plan without SOPA only to the extent the amount was either payable by the enrollee(s) under the Turquoise plan variant or was reimbursed to the provider by the QHP issuer.*

[2] *The five-digit Health Insurance Oversight System (HIOS)-generated issuer ID number.*

[3] *The actuary qualified to render an opinion related to the actuarial aspects of this form.*

Attestation Forms – Form B

The New Mexico Health Insurance Marketplace Affordability Program

HEALTH CARE AUTHORITY

ATTESTATION FORM B (2024): Estimate of Allowed Costs for Essential Health Benefits

Issuers that estimate total allowed essential health benefits 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 benefit year to calculate claims amounts attributable to essential health benefits. An issuer using this procedure is required to do so for all Turquoise plans for which the criteria below are met, and must list each plan on this attestation.

Instructions: Issuer must upload a signed copy of this form to SERFF by March 28, 2025 for data reconciliation period #1 and by August 29, 2025 for data reconciliation period #2. Signatures may simply be typed in the form. Please submit a separate attestation for each benefit year advance SOPA payments were received.

Benefit year: _____

HIOS Issuer ID:[1] _____

Qualified Health Plan ID(s)[2] _____ _____

(List all QHPs for which the issuer has estimated the percentage of essential health benefits for the purpose of calculating SOPA provided.) _____ _____

_____ _____

_____ _____

_____ _____

Name of Responsible Actuary[3]: _____

Title: _____

Organization: _____

Telephone: _____ *ext:* _____

Email Address: _____

I certify in my capacity as actuary (or authorized delegate of actuary) of [(Issuer Name)] as indicated below:

- I have reviewed the information on SOPA amounts provided as calculated under the Standard or Simplified Methodology, as applicable, and submitted to OSI. I further certify that to the best of my knowledge, information, and belief, the information provided is accurate and that SOPA amounts represent only SOPA paid for essential health benefits for which HCA reimbursement is permitted, (in the case of fee-for-service providers, these amounts must have been passed through by the issuer to such providers).

- I also certify that to the best of my knowledge, information, and belief, that the non-essential health benefit percentage estimate of total allowed costs for essential health benefits for (insert issuer name) is less than 2 percent, as required by OSI for an issuer to be able to calculate claims amounts attributed to essential health benefits for the purpose of SOPA reconciliation using the plan-specific percentage estimate of non-essential health benefit claims submitted on the Uniform Rate Review Template for the corresponding benefit year, or other reasonable method (insert explanation) I understand that the information included in this submission is the basis for calculating SOPA amounts provided by my organization to eligible enrollees.

Name of the Person Completing this Form: _____

Title: _____

Organization: _____

Telephone: _____ *ext:* _____

Email Address: _____

Signature: _____ *(type)*

Date Signed: _____ *example: MM/DD/YYYY*

[1] *The five-digit Health Insurance Oversight System (HIOS)-generated issuer ID number.*
[2] *The 16-digit HIOS-generated qualified health plan identification number.*
[3] *The actuary qualified to render an opinion related to the actuarial aspects of this form.*

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Resources

- *The 2024 New Mexico Health Insurance Marketplace Affordability Program State Out-of-Pocket Assistance Reconciliation Guidance*
- *2024 Marketplace Affordability Program Policy and Procedures Manual*

Summary of Common Issues

Template B

1. Data input errors
    a) Duplicates
    b) Inconsistent dates
    c) Incomplete or missing data
2. Treatment of different SOPA eligibility levels for partial-year segments, on- and off-Exchange
3. Application of the maximum out-of-pocket (MOOP), particularly for family coverage with partial year segments
4. Negative SOPA amounts
    a) Review carefully and explain the reason for the negative SOPA, include examples like:
        i. Data errors
        ii. Plan design issues
        iii. Other

Summary of Common Issues, Cont'd

5. Template A, Issuer-Level (01):
   a) Advance payments should reflect all payments received from HCA for that plan year, **including any payments made after the 1st submission for PY 2024**
6. Template A, Plan-Level (02):
   a) The number of subscriber IDs may differ from the Issuer-Level (01) if there are unique Subscriber/Plan combinations
      i. Issuer-Level would have just the unique Subscribers
   b) Premiums and enrollee count should reflect all enrollees in each plan, even if there are $0 claims or $0 advance payments and reconcile with Template B, Member-Level (04)
   c) All claim amounts should reconcile with Template B
   d) SOPA amounts should reconcile with Template B, Policy-Level (03) SOPA amounts, with negative amounts limited to zero

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Open Discussion

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Please submit questions to Jess Rosenthal at: jessica.rosenthal@hca.nm.gov