



HEALTH CARE  
AUTHORITY

*FINAL*

**2027 Plan Year  
Health Insurance Marketplace Affordability Program  
Policy and Procedures Manual**

*Reducing Consumer Costs on  
BeWell, New Mexico's Health Insurance Marketplace*

*Issued June 16, 2026*

## Section I: Health Insurance Marketplace Affordability Program

### A. Overview and Summary of Changes

The Health Care Affordability Fund (HCAF or “the Fund”) was created in 2021 to reduce health care costs for New Mexicans. The law directs the New Mexico Health Care Authority (HCA) to implement several programs under the Fund, including programs to reduce health insurance premiums and out-of-pocket costs for individuals and families who qualify for federal financial assistance on BeWell, New Mexico Health Insurance Marketplace (BeWell, “The Marketplace”), and state-only funded programs supported by the Fund.

New Mexico’s Health Insurance Marketplace Affordability Program (MAP) launched on January 1, 2023, and has been adjusted each year since, depending on federal and state policy, as well as annual legislative funding appropriations. MAP only applies to plans sold on BeWell’s individual market platform and is not available to consumers who enroll in coverage off-Marketplace. Additional materials can be found on HCA’s [HCAF webpage](#).

This “2027 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedures Manual” describes the requirements for MAP in Plan Year 2027 (PY27), administrative policies and procedures, and rate filing requirements. Below is a summary of program changes for the PY27:

- The Puente Health Program (Puente Health), which began on January 1, 2026, was established to provide state-funded subsidies for lawfully present non-citizens who no longer qualify for the federal Premium Tax Credit (PTC) due to Public Law 119-21 (H.R. 1). In PY26, Puente is covering those under 100% (< 100%) of the Federal Poverty Level (FPL) (Section 71302 of H.R. 1); for PY27, those  $\geq 100$  and  $\leq 400\%$  of the FPL will now also lose federal subsidies (Section 73101 of H.R. 1), and Puente Health will cover them.
- Puente Health enrollees will qualify for Turquoise 3.
- State Out-of-Pocket Assistance (SOPA) Program payments will occur biannually and be reconciled no later than June 30, 2028.
- Maximum out-of-pocket limits for Turquoise 2 and 3 Variants are aligned with the Center for Consumer Information and Insurance Oversight’s (CCIIO’s) PY27 [PAPI Guidance](#).

### B. Federal Financial Assistance

Under the Patient Protection and Affordable Care Act (ACA), the federal government provides two types of financial assistance to qualifying individuals and families to lower their premiums and out-of-pocket costs.

#### **Advance Premium Tax Credit**

The Advance Premium Tax Credit (APTC) is a federal refundable tax credit that can be used to reduce monthly premium costs for qualifying households. The APTC amount is calculated based

on the essential health benefits (EHBs) portion of the premium of the second lowest cost Silver plan (SLCSP) that is available in the household's rating area. The APTC can only be used to purchase Qualified Health Plans (QHPs) offered on the BeWell Marketplace. A QHP is an insurance plan that is certified by BeWell and provides EHBs, follows established limits on cost sharing, and meets other requirements under the ACA. The Office of Superintendent of Insurance (OSI) reviews and approves the rates and forms associated with these QHPs.

The APTC can be used to purchase plans in any metal tier. The APTC cannot be used to purchase Catastrophic plans. As of the release of this Policy Manual, no issuers in New Mexico offer Catastrophic plans on the Marketplace. If the full premium of a QHP is less than the consumer's maximum APTC, the consumer only receives the portion of the maximum APTC that equals the EHB-share of the premium of the selected QHP. For example, if the full premium of a QHP is \$550 dollars, of which \$545 is for EHBs, and the consumer's maximum APTC is \$575, only \$545 of the APTC is applied toward the consumer's premium. The remaining \$5 premium is what the consumer pays each month.

### **Federal Silver Plan Variants for Cost Sharing Reductions**

Federal Cost Sharing Reductions (CSRs) are a discount that reduces the amount qualifying individuals and families must pay toward their out-of-pocket maximum, deductibles, co-payments, and coinsurance. The ACA sets standards for the percentage of care expenses a plan covers. This percentage is called the actuarial value (AV). All issuers must submit federal Silver plan variants with higher AVs than the standard 70% AV Silver plan. These variants provide CSRs to consumers with household income under 250% (< 250%) of the FPL who are eligible to purchase QHPs on the Marketplace. The AV levels are established by the ACA and vary by income cohort:

1. Qualifying individuals and families with incomes under 150% (< 150%) of the FPL are eligible for 94% AV Silver variants;
2. Qualifying individuals and families with income  $\geq 150$  and < 200% of the FPL are eligible for 87% AV Silver variants; and
3. Qualifying individuals and families with income  $\geq 200$  and < 250% of the FPL are eligible for 73% AV Silver variants.

These Silver plan variants have lower annual out-of-pocket maximums, deductibles, co-payments, and coinsurance applied to EHBs provided by in-network providers, compared to the standard (-01 variant) Silver plan.

Federal Silver variants must cover the same benefits and include the same network as the corresponding base Silver plan, also referred to as the standard plan/standard variant (not to be confused with "standardized/Clear Cost health plans"). The out-of-pocket costs for EHBs in any federal Silver plan variant may not exceed the out-of-pocket costs of the corresponding base Silver plan.

### **C. The Health Insurance Marketplace Affordability Program**

The MAP reduces premiums and out-of-pocket costs using funds appropriated by the New Mexico Legislature from the HCAF. MAP builds on top of, and in some cases replaces, the federal financial assistance available on BeWell to offer lower-cost coverage to qualifying individuals and families.

#### **Eligibility**

In order to qualify for MAP, consumers must:

1. Be eligible to purchase a QHP on the Marketplace;
2. Qualify for the federal PTC, the Puente Health Program, or meet all eligibility criteria for the federal PTC except for household income requirements; and
3. Meet income criteria established annually by the HCA Secretary.

**Note:** MAP programs are only applied to health insurance plans purchased on the BeWell Marketplace.

#### **Program Parameters**

Effective Date: January 1, 2027.

#### **New Mexico Premium Assistance Program Parameters**

- 1) State-funded New Mexico Premium Assistance can be used to purchase plans in any metal tier other than Catastrophic;
- 2) The premium assistance amount for PY27 is calculated using the SLCSP; and
- 3) State-funded premium assistance supplements the federal premium assistance using a sliding scale for eligible consumers based on their FPL, capping the SLCSP cost as a percentage of household income according to the sliding scale below.

**Table 1: New Mexico Premium Assistance Scale**

<b>Federal Poverty Level</b>	<b>NMPA Sliding Scale (Premium as % of Income)</b>
Under 150% (< 150%)	0%
≥ 150 and < 200%	0%
≥ 200 and < 250%	0-2%
≥ 250 and < 300%	2-5%
≥ 300 and < 400%	5-8.5%
≥ 400	8.5%

#### *New Mexico Premium Assistance for Native American Consumers*

State-funded premium assistance is enhanced for members of federally-recognized tribes who qualify for the federal Limited Cost Sharing Variant. Members of federally-recognized tribes ≥ 300 and ≤ 400% of the FPL have a premium sliding scale between 1-8.5% of their annual household income for the SLCSP.

**Table 2: New Mexico Premium Assistance for Native Americans**

Federal Poverty Level	NMPA Native American Sliding Scale (Premium as % of Income)
≥ 300 and ≤ 400%	1-8.5%

*Calculating Monthly New Mexico Premium Assistance Payments*

For PY27, the SLCSP in the relevant rating area is the benchmark for calculating New Mexico Premium Assistance. For eligible consumers under 200% (< 200%) of the FPL, the benchmark plan used to calculate the New Mexico Premium Assistance amount will be increased by 10%, which allows this population to receive additional New Mexico Premium Assistance.

**Note:** This will not affect the APTC amount. For all other eligible New Mexico Premium Assistance enrollees, the actual price of the SLCSP will be used in the calculation.

The monthly New Mexico Premium Assistance payment amount is calculated using the following equation for consumers **under 200% (< 200%) of the FPL:**

<p><b>Gross Monthly Premium for Second Lowest Cost Silver Plan <math>\times</math> 1.1 – Monthly Federal APTC – Applicable Percentage of Income Established by Secretary <math>\times</math> Expected Annual Household Income as Outlined in 45 C.F.R. § 155.305(f)(i) / 12.</b></p>
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The monthly New Mexico Premium Assistance payment amount is calculated using the following equation for consumers **≥ 200 and ≤ 400% of the FPL and Native Americans ≥ 300 and ≤ 400% of the FPL:**

<p><b>Gross Monthly Premium for Second Lowest Cost Silver Plan – Monthly Federal APTC – Applicable Percentage of Income Established by Secretary <math>\times</math> Expected Annual Household Income as Outlined in 45 C.F.R. § 155.305(f)(i) / 12.</b></p>
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The consumer’s net premium cannot be lower than \$0. If the combined federal and New Mexico Premium Assistance subsidies are greater than the gross premium of the plan selected by the consumer, the New Mexico Premium Assistance payment will be reduced by an applicable amount to reach a \$0 consumer payment, as applicable.

**Note:** Consumers are not required to reconcile state premium assistance payments at the end of the year.

*Health Reimbursement Accounts*

Qualified Small Employer Health Reimbursement Account (QSEHRA) payments reduce the amount of New Mexico Premium Assistance commensurate with the QSEHRA contribution

amount after the APTC has been reduced to \$0. For example, consider a consumer with a \$100 gross premium who qualifies for \$50 of APTC and \$30 of New Mexico Premium Assistance, leaving a \$20 net premium. If this consumer received a \$60 QSEHRA payment, the APTC is reduced to \$0 since the \$60 QSEHRA payment exceeds the APTC amount. In this situation, the New Mexico Premium Assistance amount is reduced by \$10 to offset the remainder of the consumer's QSEHRA payment.

**Note:**

- Consumers who accept an Individual Coverage Health Reimbursement Account (ICHRA) will not be eligible for APTC or New Mexico Premium Assistance.
- QSEHRA and New Mexico Premium Assistance eligibility are both calculated in the BeWell system and will not directly impact issuer billing.

### **Native American Premium Assistance Program Parameters**

The HCA offers an additional premium assistance program for Native Americans called the Native American Premium Assistance Program (also known as the Premium Buy-down Program). In addition to the New Mexico Premium Assistance program described above, Native Americans who qualify will have access to a \$0 plan from each issuer in their rating area. That plan is the lowest-cost option offered by the issuer, with the consumer portion of the premium covered by the Native American Premium Assistance Program.

#### *Eligibility for Native American Premium Assistance Program*

To qualify for the Native American Premium Assistance program, a consumer must have a household income under 300% (< 300%) of the FPL and qualify for the federal Zero Cost Sharing Variant. If a consumer meets these qualifications, they will have access to at least one Zero Cost Sharing plan with a \$0 premium from every issuer. Lawfully present non-citizens who are no longer eligible for federal financial assistance are eligible for Native American Premium Assistance, though consumers must contact BeWell for support.

#### *Calculating State Payments for Native American Premium Assistance Program*

The Native American Premium Assistance payment amount is calculated by taking the gross premium of the lowest cost plan offered by an issuer, subtracting the federal APTC, then subtracting the state premium assistance from the New Mexico Premium Assistance program. The result of this calculation is the Native American Premium Assistance payment amount.

For consumers under 300% (< 300%) of the FPL, gross monthly premiums may include non-EHBs that cannot be covered by the federal APTC or New Mexico Premium Assistance. Non-EHBs are covered by Native American Premium Assistance and should be included in the gross monthly premium amount for the Native American Premium Assistance calculation so that the premium under this program is guaranteed to be \$0.

<p style="text-align: center;"><b>Gross Monthly Premium for Lowest Cost Plan Offered by Issuer – Monthly Federal APTC – Monthly New Mexico Premium Assistance Payment = State Native American Premium Assistance Payment</b></p>
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**Note:** Consumers are not required to reconcile state premium assistance payments at the end of the year.

### **Puente Health Program**

H.R. 1 was signed into law on July 4, 2025, and made several significant changes to eligibility for federal health coverage programs. The eligibility change that affected consumers enrolled in HCA’s MAP is Section 71302. This section disallows many lawfully present non-citizens under 100% (< 100%) of the FPL who are subject to the five-year waiting period for Medicaid from receiving the federal PTC during this period. This would have serious negative consequences on the health and well-being of low-income New Mexicans who do not have access to other forms of affordable coverage.

To address the impact of H.R. 1, the HCA established the Puente Health Program (Puente Health) a Coverage Protection Program to replace the loss of federal premiums and out-of-pocket cost support for applicable consumers. The information below outlines the parameters for Puente Health for consumers who were eligible for the APTC and CSRs through the Marketplace prior to January 1, 2026, and January 1, 2027, and whose income was under 100% (< 100%) of the FPL and  $\geq 100$  and  $\leq 400\%$  of the FPL, respectively. This section describes Puente Health’s requirements for PY27, and the administrative policy and procedure requirements for financial support. Puente Health only applies to plans sold on BeWell’s individual market platform and is not available to consumers who enroll in coverage off-Marketplace.

#### *Eligibility for Puente Health Program*

To qualify for Puente Health, consumers must:

1. Be eligible to purchase a QHP on the Marketplace;
2. Be a lawfully present non-citizen who has been determined ineligible for federal PTC under Sections 71301 and 71302 of H.R. 1; and
3. Have a household income  $\leq 400\%$  of the FPL.

#### *Puente Health Program Parameters*

The Puente Health Program provides premium and out-of-pocket assistance to eligible consumers.

#### Premium Assistance

To reduce monthly premiums for eligible consumers, Puente Health provides premium assistance using New Mexico Premium Assistance through the Marketplace.

#### Premium Assistance Parameters for Puente Health Program

The criteria for premium assistance under Puente Health:

1. State-funded premium assistance can be used to purchase a plan of any metal tier other than Catastrophic.
2. The premium assistance amount for PY27 is calculated using the SLCSP.
- 3.
4. Consumers between 0 and  $\leq 400\%$  of the FPL follow the same sliding scale in **Table 1** for the percentage of income they are required to pay for their premium.
5. Consumers are not required to reconcile state premium assistance payments at the end of the year.

### Calculating Monthly Puente Health Premium Assistance Payments

See the “*Calculating Monthly New Mexico Premium Assistance Payments*” section above regarding calculating premium assistance for those under 200% ( $< 200\%$ ) of the FPL. This calculation also applies to those in the Puente Health Program.

**Note:** If the consumer is eligible for premium assistance under the Puente Health Program and their household income increases to above 400% ( $> 400\%$ ) of the FPL, they will no longer qualify for the Puente Health Program. If the consumer continues with their Marketplace plan, the consumer is responsible for paying the full premium cost.

### Health Reimbursement Accounts

The information under the “*Health Reimbursement Accounts*” section under New Mexico Premium Assistance also applies to Puente Health.

### **Medicaid Transition Premium Relief Program Parameters**

The HCA’s Medicaid Transition Premium Relief (MTPR) Program eliminates premium costs for the first month for eligible individuals (and their households) transitioning from Medicaid to a QHP through the BeWell Marketplace.

### *Eligibility for Medicaid Transition Premium Relief Program*

To qualify, the applicable household member must meet the following criteria:

- Be a resident of the state of New Mexico who is eligible to purchase a QHP on the Marketplace;
- Enroll in the QHP on the Marketplace within 120 calendar days of losing Medicaid coverage;
- No longer be enrolled in Medicaid at the time their QHP coverage begins;
- Be determined eligible for federal PTC or Puente Health; and
- Have an expected household income  $\leq 400\%$  of the FPL.

Premium relief will cover the premium for the Marketplace shopping group for all household members of the program-eligible consumer and can be used to activate coverage. Lawfully present non-citizens who are no longer eligible for federal financial assistance are still eligible for MTPR, though consumers should contact BeWell for support. This premium payment will also cover any premium costs associated with non-essential health benefits.

## State Out-of-Pocket Assistance Program Parameters

To reduce consumer out-of-pocket costs, the HCA builds upon the framework of the ACA’s CSRs to enhance the AV of certain plans through the State Out-of-Pocket Assistance (SOPA) Program. Issuers are required to submit variants that meet AV targets established by the HCA Secretary. To simplify the plan choice landscape for consumers, the underlying metal tier for plans that offer robust out-of-pocket assistance is replaced with a “Turquoise” label during the shopping experience on the BeWell Marketplace.

### *SOPA Applicability for Non-Puente Members*

- 1) State-funded out-of-pocket assistance only applies to Turquoise plans with an underlying **Silver plan** for eligible consumers with income under 200% (< 200%) of the FPL.
- 2) State-funded out-of-pocket assistance only applies to Turquoise plans with an underlying **Gold plan** for eligible consumers with income  $\geq 200$  and  $\leq 400\%$  of the FPL.

**Table 3. State Out-of-Pocket Assistance Actuarial Values for Non-Puente Members**

Federal Poverty Level	ACA AV Level for Relevant Federal Variants	Marketplace Affordability Program AV Level for SOPA/ “Turquoise” Plans
Under 150% (< 150%)	94% AV (Silver)	99% AV (Silver)
$\geq 150$ and < 200%	87% AV (Silver)	95% AV (Silver)
$\geq 200$ and $\leq 400\%$	80% AV (Gold)	90% AV (Gold)

### *Turquoise Variant Actuarial Values*

Turquoise Variant names correspond with specific AV requirements. The naming conventions must match the level of income-based out-of-pocket assistance offered to consumers, as shown in **Table 5**. The “Turquoise” label helps consumers identify which plans qualify for the most savings.

**Table 4: SOPA Plan Actuarial Values and Metal Levels for Non-Puente Members**

Plan Number	Turquoise 1	Turquoise 2	Turquoise 3
FPL Range	< 150%	$\geq 150$ and < 200%	$\geq 200$ and $\leq 400\%$
Actuarial Value	99% AV	95% AV	90% AV
SOPA Metal Level	Silver	Silver	Gold

The 73% federal Silver variant must still be available for purchase by qualifying consumers, but it will not be marked as a Turquoise Plan.

### *Limited Cost Sharing Turquoise 3 Variants for Native Americans*

Federal laws and regulations require issuers to offer Limited Cost Sharing Variants to Native Americans with income over 300% ( $\geq 300\%$ ) of the FPL. These plans provide access to Indian health care providers without out-of-pocket costs. Since Turquoise 3 covers those with income  $\leq 400\%$  of the FPL, special variants must be created for eligible Native Americans to ensure that these federal cost-sharing protections continue to be offered for SOPA-eligible Native Americans. -03 Gold variants for Native Americans with income  $\geq 300$  and  $\leq 400\%$  of the FPL are replaced with a -13 variant that has the same out-of-pocket cost design as the issuer's -90 variant (90% AV), with no cost sharing applied to services provided by Indian health care providers.

### *State Out-of-Pocket Assistance Program for Puente Members*

Puente Health members are not eligible for federal CSRs. To ensure Puente Health members can benefit from reduced out-of-pocket costs, they will be eligible for Turquoise 3 variants.

**Table 6. SOPA Plan Actuarial Values and Metal Levels for Puente Members**

<b>Plan Number</b>	<b>Turquoise 3</b>
<b>FPL Range</b>	$\leq 400\%$
<b>Actuarial Value</b>	90% AV
<b>SOPA Metal Level</b>	Gold

### *Hierarchy for SOPA-Eligible Plan Variants*

Certain federal variants will be replaced by unique state variants for eligible consumers.

- Silver -06 variants will be replaced by a -99 variant (Turquoise 1).
- Silver -05 variants will be replaced by a -95 Turquoise Variant (Turquoise 2).
- Gold -01 variants will be replaced by a -90 Turquoise Variant for consumers with income  $\geq 200$  and  $\leq 400\%$  of the FPL.
- Gold -03 variants will be replaced by a -13 Turquoise Variant for Native Americans  $\geq 300$  and  $\leq 400\%$  of the FPL.

Consumers with income  $\geq 200$  and  $< 250\%$  of the FPL will continue to have access to the -04 Silver variant. However, SOPA will **not** be applied to the -04 Silver variant. **Tables 7 and 8** demonstrate which federal variants will be replaced with state variants.

**Table 7: Turquoise Variant Hierarchy for Non-Puente Members**

<b>SILVER PLANS</b>			
<b>Income Range (FPL)</b>	<b>Current Federal Variant ID</b>	<b>Does SOPA Apply to Silver?</b>	<b>New Turquoise Variant ID</b>
Under 150% (< 150%)	- 06	Yes	- 99
≥ 150 and < 200%	- 05	Yes	- 95
≥ 200 and < 250%	- 04	No	N/A

<b>GOLD PLANS</b>			
<b>Income Range (FPL)</b>	<b>Current Federal Variant ID</b>	<b>Does SOPA Apply to Gold?</b>	<b>New Turquoise Variant ID</b>
Under 150% (< 150%)	- 01	No	N/A
≥ 150 and < 200%	- 01	No	N/A
≥ 200 and ≤ 400%	- 01	Yes	- 90
≥ 300 and ≤ 400% (Native Americans)	- 03	Yes	- 13

**Table 8. Turquoise Variant Hierarchy for Puente Members**

<b>GOLD PLANS</b>			
<b>Income Range (FPL)</b>	<b>Current Federal Variant ID</b>	<b>Does SOPA Apply to Gold?</b>	<b>New Turquoise Variant ID</b>
≤ 400%	- 01	Yes	-90

*Turquoise Variants and Standardized Health Plans*

All issuers are required to offer Turquoise Variants for Standardized Health Plans, known on the BeWell Marketplace as “Clear Cost” plans. Click [here](#) to view the final amended plan designs approved by the BeWell Board of Directors.

**Note:** When capturing AV calculator screenshots, use the underlying metal tier that corresponds to the Standardized Health Plan being represented by the Turquoise Variant.

*Maximum Annual Limitation on Cost Sharing for Turquoise Variants*

For qualifying individuals and families with income ≥ 150 and ≤ 400% of the FPL, the maximum out-of-pocket limit for Turquoise Variants cannot exceed \$4,000 (\$8,000 for families) in PY27, which is equal to the amount specified in the [2027 PAPI Parameters Guidelines](#) for consumers who qualify for 94% AV and 87% AV variants.

For qualifying individuals and families with income under 150% (< 150%) of the FPL, the

maximum out-of-pocket limitation cannot exceed \$500 for individuals (\$1,000 for families in PY27).

#### *Turquoise Variant Out-of-Pocket Requirements for Primary Care and Generic Medications*

Issuers may only use co-payments for primary care visits and generic prescription medications for Turquoise Variants. Coinsurance is not allowed for these services. In addition, the deductible cannot apply to these services. These requirements only apply to Turquoise Variants and do not apply to any other variant.

#### *Cohesion Between Standard and Turquoise Variants*

In PY27, each Turquoise Variant must closely resemble the general features of its standard variant. For example, if the standard variant of a plan uses co-payments for specialist visits, its Turquoise Variant must also use co-payments for specialist visits. The exception to this rule is the requirement that primary care and generic medications cannot require coinsurance for Turquoise Variants.

To the greatest extent possible, issuers should maintain the overall relativities for the cost-sharing amounts for all variants of a plan. For an example of variants that meet this standard, see [BeWell's Standardized Health Plan designs](#). The HCA recognizes that perfect relativity may not always be achievable and will grant issuers flexibility to meet AV targets. As is true of federal CSR variants, the maximum out-of-pocket limit, deductible, co-payments, and coinsurance for Turquoise Variants cannot exceed the amount that is offered under the plan's standard variant.

#### *De Minimis Variation for Turquoise Variants*

The AV for Turquoise Variants may only vary +1/0 in PY27.

#### *Turquoise Variants and Mid-Year Income and Household Status Changes*

Some individuals and families may experience changes in income or other household circumstances during PY27 that could place them in an income cohort that corresponds with a Turquoise Variant that has a different underlying metal level than that in which they originally enrolled. For example, if a consumer reports an income change that causes household income to shift from 195% of the FPL at the time of enrollment to 205% of the FPL later in the year, that consumer would now qualify for Turquoise 3 Variants. Since SOPA can apply to different metal levels based on income, the new underlying metal level of the Turquoise Variant in this example (Gold) would be different from the original variant of the plan (Silver). In such circumstances, enrollees are permitted to switch plans to maintain enrollment in a Turquoise Variant. Enrollees should contact BeWell to make this change, if necessary.

When SOPA-eligible consumers switch from one plan offered by an issuer to another plan offered by the same issuer due to changes in household circumstances, issuers must carry over any out-of-pocket costs incurred by the consumer while enrolled in their original plan to their new plan. This means that cost-sharing accumulators should not be reset when plan changes occur under these circumstances. See **Attachment C** for plan hierarchy details.

### *Turquoise Variant Risk Adjustment Induced Demand Factors*

OSI included Turquoise Variant Risk Adjustment Induced Demand Factors in its [2027 Rate Guidance](#).

#### **D. Marketplace Affordability Program Administration**

To minimize duplication of effort, the administration of MAP has been aligned with federally required procedures to the greatest extent possible.

#### **New Mexico Premium Assistance Monthly Payments**

BeWell will aggregate New Mexico Premium Assistance payment amounts for each issuer on a monthly basis and report the amounts to the HCA. The HCA will issue New Mexico Premium Assistance payments to the issuer on a monthly basis. Upon approval from the HCA, BeWell will submit the corresponding New Mexico Premium Assistance report file to each issuer. Consumers will not need to reconcile New Mexico Premium Assistance payments at the end of the year, as they do for the APTC. All invoices sent to consumers should clearly show the federal APTC and the amount of the New Mexico Premium Assistance payment received by the issuer to reduce their premiums.

The Puente Health Program is included as part of the New Mexico Premium Assistance reporting and payments to issuers. The HCA will issue premium assistance payments for these two programs to the issuer on a monthly basis within the MAP Notice of Payment.

There may be instances where the New Mexico Premium Assistance amount will need to be adjusted due to delayed consumer reporting or delayed BeWell staff processing. BeWell reconciles New Mexico Premium Assistance during monthly comparisons with the issuers. Issuers may also report discrepancies with the New Mexico Premium Assistance report on a monthly basis. BeWell oversees this process and should be consulted should any questions arise.

#### **State Out-of-Pocket Assistance Payments and Reconciliation**

As defined by the HCA Secretary and detailed in a forthcoming proposed rule, SOPA payments will be paid directly to the issuer by HCA in the form of biannual payments, subject to an end-of-year reconciliation. The biannual payments are calculated by multiplying the gross member-level premium by the SOPA Variant Multiplier applicable to the enrollee's Turquoise Variant and rolled up into 6-month batches. **Table 10** shows the multipliers. HCA will provide the data to issuers each month and provide the biannual payments after 6 and 12 months of program data are available.

Reconciled SOPA payments for PY27 will be made to issuers no later than June 30, 2028. MAP SOPA Reconciliation Guidance for PY27, including for the Puente Health Program, will be issued by HCA at a later date.

**Table 10: 2027 SOPA Variant Multiplier**

<b>Turquoise Variant</b>	<b>SOPA Metal Tier</b>	<b>SOPA AV</b>	<b>SOPA Variant Multiplier</b>
Turquoise 1	Silver	99%	.042
Turquoise 2	Silver	95%	.066
Turquoise 3	Gold	90%	.079

### **SOPA Reporting Requirements and Reconciliation**

Issuers must reconcile advance SOPA payments annually. MAP SOPA Reconciliation Guidance for PY27, including for the Puente Health Program, will be issued by HCA at a later date.

**Notes:**

- For -99 and -95 Turquoise Variants, issuers should submit the amount the enrollee(s) would have paid for the same EHB claims had they been enrolled in -06 and -05 Silver variants, respectively.
- For the -90 Turquoise Variant, issuers should submit the amount the enrollee(s) would have paid for the same EHB claims had they been enrolled in the -01 Gold variant.
- For the -13 Turquoise Variant, issuers should submit the amount the enrollee(s) would have paid for the same EHB claims had they been enrolled in the -03 Gold variant.

## **Section II: Rate Filing Requirements**

### **A. Supplemental SOPA Variant Plans and Benefits Template**

For SOPA-eligible Turquoise Variants, issuers are required to enter the cost-sharing design for each plan in HCA’s “Supplemental SOPA Variant Plans and Benefits Template” in the “Supporting Documentation” tab of the binder. Issuers should fill out this template the same way they would fill out the federal “Plans and Benefits Template.” The state version will not automatically calculate the plan AV. Issuers should enter the AV output from the AV calculator. In situations where the plan designs are incompatible with the AV calculator, issuers should use an appropriate alternative method pursuant to 45 CFR 156.135(b)(2) or 45 CFR 156.135(b)(3).

In the HIOS Plan ID, issuers should add the corresponding variants after the standard component, as shown below:

- Turquoise Plan 1: 00001NM1234567-**99**
- Turquoise Plan 2: 00001NM1234567-**95**
- Turquoise Plan 3: 00001NM9876543-**90**

## **B. Actuarial Value Calculator Requirements**

For each SOPA-eligible variant, issuers must submit a supplemental AV calculator output demonstrating that the cost-sharing design meets the HCA’s AV targets. Issuers should use the 2027 federal AV calculator to produce the output sheets. The AV for Turquoise Variants cannot be lower than what is prescribed and may only be one (1) point higher than in the applicable variant. The screenshot of the calculator output will show an error message. Issuers must ensure that the AV output is within the de minimis range. If it is entered incorrectly, HCA will notify OSI of the issue during the rate review period.

Step 1: In “Name” insert “Turquoise Variant #” and enter the corresponding number of the income tier before entering the full plan name.

Step 2: In “Desired Metal Tier,” select “Platinum.”

Step 3: Enter plan cost-sharing information.

Step 4: Click “Calculate” to generate an output.

Step 5: Verify that the AV output is within the de minimis range.

Step 6: Name the output tab the [HIOSPlanID\_Turquoise Plan Number]. The “Turquoise Plan Number” should be the number of the corresponding income tier. The plan number for the income tier under 150% (< 150%) of the FPL is “1.” The plan number for the income tier ≥ 150 and < 200% of the FPL is “2.” The plan number for the income tier ≥ 200 and ≤ 400% of the FPL is “3.”

Please see **Table 11** for the correct desired metal tier for each Clear Cost plan variant.

**Table 11: Desired Metal Tier for Clear Cost Plan Variants**

<b>Clear Cost Plan Variant</b>	<b>Desired Metal Tier</b>
Clear Cost Turquoise 1 with EXTRA SAVINGS	Platinum
Clear Cost Turquoise 2 with EXTRA SAVINGS	Platinum
Clear Cost Turquoise 3 with EXTRA SAVINGS	Platinum
Native American Clear Cost Turquoise 3 LCS with EXTRA SAVINGS	Platinum
Clear Cost Gold	Gold
Clear Cost Silver	Silver
Clear Cost Silver 73%	Silver
Clear Cost Silver 87%	Gold
Clear Cost Silver 94%	Platinum

### **C. Federal Filing Requirements**

Issuers are still required to submit the ACA’s variants for federal validation using the federal “Plans and Benefits Template.” The federal “Plans and Benefits Template” must be completed and accompanied by an attestation of accuracy. Issuers should submit an attestation of accuracy for the Turquoise Variants to HCA with its “Supplemental SOPA Variant Plans and Benefits Template.”

## **Attachments**

### **Attachment A: Supplemental SOPA Variant Plans and Benefits Template**

Click [here](#) to view an unformatted blank version of the SOPA template.

### **Attachment B: Sample AV Calculator with Turquoise Variants**

See the sample on page 18.

### **Attachment C: Marketplace Plan Variant Descriptors**

See pages 19-20.



Attachment C: Marketplace Plan Variant Descriptors

Variant ID	Type	Metal	Variant Name	Eligible Population	Description
01 Variant	Federal	All Metal Tiers	Standard Variant	N/A	The 01 variant is the "standard variant" for on-marketplace plans. This is the base plan that does not have any cost-sharing/out-of-pocket modifications. It is the version that issuers use to price the plan. <b>No State Out-of-Pocket Assistance or federal CSRs are applied.</b>
02 Variant	Federal	All Metal Tiers	Zero Cost Sharing Variant	Eligible members of federally-recognized tribes under 300% (< 300%) FPL	The 02 variant is a version of the plan that <b>does not have any out-of-pocket costs for covered services.</b> This is also called the "Zero Cost Sharing Variant." It is only available to eligible <b>members of federally-recognized tribes with income under 300% (&lt; 300%) of the FPL.</b>
03 Variant	Federal	All Metal Tiers	Limited Cost Sharing Variant	Eligible members of federally-recognized tribes $\geq 300\%$ FPL	The 03 variant is a version of the plan that <b>does not have any out-of-pocket costs for covered services that are provided through Indian health care providers.</b> All other out-of-pocket costs for non-Indian health care providers remain the same as they otherwise would. This is also called the "Limited Cost Sharing Variant." It is only available to eligible <b>members of federally-recognized tribes with income <math>\geq 300\%</math> of the FPL.</b>
04 Variant	Federal	Silver Only	CSR 73 Variant	Eligible individuals $\geq 200$ and $< 250\%$ FPL	The 04 variant is a required version of each Silver plan and has a <b>73% AV</b> cost-sharing design. It is available to individuals with income <b><math>\geq 200</math> and <math>&lt; 250\%</math> of the FPL.</b>
05 Variant	Federal	Silver Only	CSR 87 Variant	Eligible individuals $\geq 150$ and $< 200\%$ FPL	The 05 variant is a required version of each Silver plan and has an <b>87% AV</b> cost-sharing design. It is available to individuals with income <b><math>\geq 150</math> and <math>&lt; 200\%</math> of the FPL.</b> In New Mexico, this variant gets <b>replaced by the 95 Turquoise variant.</b>
06 Variant	Federal	Silver Only	CSR 94 Variant	Eligible individuals under 150% ( $< 150\%$ ) FPL	The 06 variant is a required version of each Silver plan and has a <b>94% AV</b> cost-sharing design. It is available to individuals with income <b>under 150% (<math>&lt; 150\%</math>) of the FPL.</b> In New Mexico, this variant gets <b>replaced by the 99 Turquoise variant.</b>

Variant ID	Type	Metal	Variant Name	Eligible Population	Description
90 Variant	State	Gold Only	Turquoise 3 Variant	Eligible individuals $\geq$ 200 and $\leq$ 400% FPL	The 90 variant is a required version of each Gold plan and has a <b>90% AV</b> cost-sharing design. It is available to individuals with income $\geq$ <b>200</b> and $\leq$ <b>400% of the FPL</b> . <b>It replaces the 01 variant for Gold plans</b> for individuals who qualify.
13 Variant	State	Gold Only	Turquoise 3 Limited Cost Sharing Variant	Eligible members of federally-recognized tribes $\geq$ 300 and $\leq$ 400% FPL	The 13 variant is a required version of each Gold plan and has a <b>90% AV</b> cost-sharing design with no cost sharing applied for Indian health care providers. It is available to members of federally-recognized tribes with income $\geq$ <b>300</b> and $\leq$ <b>400% of the FPL</b> . <b>It replaces the 03 variant for Gold plans</b> for individuals who qualify.
95 Variant	State	Silver Only	Turquoise 2 Variant	Eligible individuals $\geq$ 150 and $<$ 200% FPL	The 95 variant is a required version of each Silver plan and has a <b>95% AV</b> cost-sharing design. It is available to individuals with income $\geq$ <b>150</b> and $<$ <b>200% of the FPL</b> . <b>It replaces the 05 variant for Silver plans</b> for individuals who qualify.
99 Variant	State	Silver Only	Turquoise 1 Variant	Eligible individuals under 150% ( $<$ 150%) FPL	The 99 variant is a required version of each Silver plan that has a <b>99% AV</b> cost-sharing design. It is available to individuals with income <b>under 150% (<math>&lt;</math> 150%) of the FPL</b> . <b>It replaces the 06 variant for Silver plans</b> for individuals who qualify.