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

2025 Plan Year

HEALTH CARE
AUTHORITY

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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 or "the Fund") 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 the fund's administrator. One purpose of the Fund is to reduce health insurance premiums and out-of-pocket costs for New Mexicans who purchase coverage on BeWell, New Mexico's Health Insurance Marketplace (BeWell, "the Marketplace," or "the Exchange."

The State's Health Insurance Marketplace Affordability Program (MAP) provides financial assistance to lower out-of-pocket costs through the State Out-of-Pocket Assistance (SOPA) Program, which is available to eligible individuals and families with income up to 400% of the Federal Poverty Level (FPL) through the Marketplace. SOPA is funded by appropriations approved by the New Mexico State Legislature into 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 level 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 under 200% of the FPL and Gold plans for eligible enrollees between 200-400% of the FPL. To help consumers easily identify which plans have SOPA based on their income level, the Marketplace labels those plans as "Turquoise Plan." Eligible enrollees who select a Turquoise plan have access to income-based variants with enhanced actuarial values, as shown in **Table 1** below.

Table 1. Turquoise Plans

	Turquoise 1	Turquoise 2	Turquoise 3
FPL Range	Under 150%	≥ 150 and < 200%	≥ 200 and ≤ 400% FPL
Actuarial Value	99% AV	95% AV	90% AV
SOPA Metal Level	Silver	Silver	Gold

[1] "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 8.401.2 (T) 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 Secretary."

Individuals with household income under 200% of FPL who choose a Turquoise plan will be enrolled in either a Turquoise 1 or Turquoise 2 Plan variant, depending on income, with an underlying Silver plan. Similarly, individuals with household income between 200-400% of the FPL who select a Turquoise Plan, will be enrolled in a Turquoise 3 Plan variant with an underlying Gold Plan.

Actual SOPA amounts paid to issuers will depend on how much enrollees utilize covered services. The Issuers provide plan variants with reduced out-of-pocket costs to consumers, and the HCA provides monthly advance SOPA payments to issuers during the applicable Plan Year., There is an annual reconciliation process with the issuers to ensure final payment amounts reflect actual use of SOPA. After the end of the Plan Year, the total advance payments are reconciled with the actual SOPA amounts provided to eligible enrollees for the Plan Year.

This guidance provides information on the process for reconciling the monthly SOPA advance payments that the HCA makes to issuers and the actual SOPA amounts provided to eligible enrollees under the SOPA Program.

Reference Plan

The reference plan is either 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 it will be compared to the Turquoise variant to determine the SOPA amount. **Table 2** maps the reference plans to the Turquoise plans.

Table 2. Mapping of Turquoise Plans to Reference Plans

Federal Poverty Level	Turquoise Plan	Reference Plan
Under 150% FPL	Turquoise 1 (-99 Variant)	CSR -06 Variant (Silver)
≥150 - < 200% FPL	Turquoise 2 (-95 Variant)	CSR -05 Variant (Silver)
≥200 - ≤ 400% 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 2 variants, SOPA leverages the existing federal CSRs to reduce the cost of the SOPA Program to the State for these enrollees. Without the SOPA program, enrollees would only have plans with the actuarial values associated with the federal CSRs. 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; therefore, they still provide program savings. All program savings allow the Fund to support more consumers.

SOPA Advance Payments

The HCA obtains and validates data from BeWell on a monthly basis that details subscriber-level enrollment within each plan's Turquoise variants and the underlying plan premium for the Turquoise

enrollees. Based on this information, the 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**.

Table *3*. 2025 SOPA Variant Multiplier

Income Tier	Turquoise Variant	SOPA Metal Tier	SOPA AV	SOPA Variant Multiplier
Under 150% FPL	Turquoise 1	Silver	99%	.042
≥ 150 and < 200%	Turquoise 2	Silver	95%	.066
≥ 200 and ≤ 400% FPL	Turquoise 3	Gold	90%	.079

SOPA advance payments are issued monthly. Information on the advance payment of SOPA benefits is available in the "2025 Plan Year Health Insurance Marketplace Affordability Program Policy and Procedure Manual" ("Policy and Procedure Manual"). The HCA's current regulations and guidance provide on-Marketplace individual market issuers with general instructions on the process, timing, and data submission requirements for reconciling SOPA payments.

Reconciliation of SOPA Advance Payments

The "Policy and Procedure Manual" describes the methodology issuers will use to reconcile SOPA advance payments with actual uptake of SOPA benefits by enrollees for the 2025 Plan Year (PY25). The HCA may allow alternative methodologies for new issuers and will provide guidance on allowable methodologies, as needed.

After the end of the applicable Plan Year, all issuers must report issuer-level data and plan-level data using **Template A** to support SOPA reconciliation (see **Table 4**). Issuers must also submit policy-level data using **Template B**. The 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 the reference Silver or Gold plan. This information allows the 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 Equals:**
  - 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) ***minus*** the out-of-pocket amounts actually paid by enrollees.
- **For Turquoise 3 Plans, SOPA Equals:**
  - Out-of-pocket spending enrollees would have paid for EHBs in a reference Gold plan without SOPA (no federal CSRs reflected) ***minus*** out-of-pocket amounts actually paid by enrollees.
- **End-of-Year Reconciliation Equals:**

- Sum of monthly SOPA Advance Payments ***minus*** 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**).

There will be limitations on SOPA reimbursement in the following scenarios:

- Issuers will not be reimbursed for SOPA payments provided to enrollees who the issuer knew to be assigned to an incorrect Turquoise Plan variant that is more generous than the one for which they are eligible. BeWell determines the enrollees who are eligible for Turquoise plans based on their income level and other general eligibility criteria. Since there is a one-to-one mapping between Turquoise plan variants and federal CSR plan variants for enrollees under 200% of the FPL, issuers are required to check Turquoise plan variants against CSR plan variants to confirm that SOPA eligibility is accurately assigned to the appropriate Turquoise plan.
- Any SOPA incorrectly provided (such as SOPA for non-EHBs, non-covered services, or SOPA provided after a policy has been terminated) must be excluded from the reconciliation process.
- 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.

Note: The only exception is that issuers may 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, if the QHP issuer receives a late termination or correction notice from the Marketplace, they may still seek reimbursement.

For services that cross Plan Years, the issuer should adjudicate SOPA based on the year for which the accumulators for the Turquoise plan applied. For enrollees who switch Turquoise plans during the year, the HCA expects cost-sharing accumulators to be preserved across all plans so that the SOPA parameters can be applied appropriately.

For 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 the enrollee would be reduced, as applicable, in both the reference plan and the Turquoise variant, by any amounts 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 cases, the issuer must restate claims for the entire policy, including the complete COB claim, reducing total allowed costs for EHBs 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 the HCA the full SOPA advance payment amount for certain plans rather than re-adjudicate such claims. For example, issuers may decide to reimburse the 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 the HCA by emailing jessica.rosenthal@hca.nm.gov.

Timing of Reconciliation Process

Beginning with the PY25 SOPA reconciliation process, the HCA will transition to a single mandatory submission cycle. This will allow additional time for claims to be incorporated, with the PY25

reconciliation submission timeframe running from September 2026 to October 2026. PY25 restatements will occur during future submission cycles, if needed. Refer to **Table 4** for the dates associated with the PY25 cycle.

Issuers may include late claims from services provided in PY25 as close to the 2026 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. The HCA may permit any claims incurred in PY25 and not included in the 2026 submission window to be filed in the 2027 or any subsequent submission window(s).

Table 4. SOPA Reconciliation Timeline for 2025 Plan Year

Date	Activity
Plan Year 2025	
Guidance Draft Comment Period and Publication of Final Guidance	
April 21, 2026	Draft SOPA Reconciliation Guidance – Published for Comments
May 21, 2026	Draft SOPA Reconciliation Guidance – End of Comment Period
June 22, 2026	FINAL SOPA Reconciliation Guidance
Training for Issuers August 2026	
Data Submission, SOPA Reconciliation and Payments, Invoices Issued	
September 1, 2026	Data Submission Window Opens for PY25
October 31, 2026	Data Submission Window Closes for PY25
November 15, 2026	HCA Notifies Issuers of Reconciled Amounts and Sends Notification of Payments or Invoices to Issuers
December 31, 2026	Payment Cycle Ends, HCA Payments Made or Issuer Payments Received
Errors/Discrepancy Corrections and Appeals	
Refer to the section entitled “Errors/Discrepancy Corrections”	

Determination of Total Allowed Essential Health Benefits

Issuers must identify allowed EHB claims for reconciliation, since they will not be reimbursed for SOPA spending for benefits other than EHBs. In addition to issuers new to the New Mexico individual health insurance market, the HCA will permit issuers to use an alternative method to determine the total allowed EHBs for certain plans, including capitated plans, whose cost-sharing structure makes it difficult to distinguish between EHB and non-EHB claims without technology upgrades. These plans generally allow out-of-pocket spending for both EHB and non-EHB claims to accumulate toward deductibles and the reduced annual limitation on cost sharing.

Issuers may calculate claims amounts attributable to EHBs, including cost-sharing amounts attributable to EHBs, 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 two (2) percent. These limitations help ensure that the estimated percentage, calculated from the

proportion of claims attributable to EHBs, does not overstate the proportion of SOPA spending associated with EHBs, and that any inaccuracies in the estimate are unlikely to result in significant errors in SOPA reimbursement.

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 EHBs. If the reference plan does not cover EHB out-of-network costs, the 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 variants. Total allowed costs for EHBs 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 the enrollee had been enrolled in the reference plan to determine differences in deductible, copayments, 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 the 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 the SOPA provided.

As HCAF programs expand to include additional populations, future groups may qualify for specific exceptions aligned with expanded program criteria.

Re-Adjudication of Claims - Other Issues

Policy Changes within Same Turquoise Plan/Variant

An issuer using the standard methodology may aggregate multiple policies of a subscriber 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, under the following circumstances:

- In the case of a policy that switches from a "self-only" to a "family" plan, or vice versa, after a change in circumstances, such as marriage or death, and remains the same Turquoise plan (same Turquoise variant), or

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

- In the case of other changes of circumstance that result in multiple policies for the same subscriber in the same Turquoise plan (same Turquoise variant) during the Plan Year, e.g., due to a gap in coverage when the enrollee moved to another Turquoise variant or Medicaid.

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 copayments 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, as mentioned above, issuers should aggregate the policies and file a single policy-level report under the Turquoise plan, using the first and last dates the policies were holistically in effect.

Policy Changes Across Multiple Turquoise Plans/Variants

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 within the Plan Year, and when transfers occur between the issuer and Medicaid during the Plan Year. Similarly, issuers are required to carry over accumulators if an enrollee must switch to a different metal tier to remain enrolled in Turquoise coverage. Except for a gap caused by assignment to Medicaid 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 must also be reflected at the non-subsidized level in the reference plan to accurately determine how much the enrollee would have paid under the reference plan.

Additional Information on Accumulators

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 out-of-pocket costs in the order in which they were acquired to the new plan or variant. For example, if the original plan did 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. The 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.

SOPA and Plan Types

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 not reimbursed to providers.

Fully Capitated Plans or Capitated Pay Arrangements within Fee-for-Service Plans

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

The SOPA amount is the difference between the out-of-pocket spending for EHBs that the enrollee paid under the Turquoise plan and what the enrollee would have paid under 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 plan types.

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 for covered out-of-network EHBs in Turquoise plans.[4] However, a QHP may reduce cost sharing for non-emergency services for covered out-of-network EHBs to simplify plan design. If the issuer reduces cost sharing in these circumstances, the issuer should include these out-of-network EHB claims when calculating the 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. The HCA will limit the amount of SOPA payable for a policy to no less than zero dollar. However, issuers should report the actual amount calculated, even if it is negative.

Issuers Using a Third-Party Administrator

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 benefit subsets. As applicable, a TPA should first process medical claims, followed by pharmaceutical claims, and then any other benefit subsets (i.e., 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 predate 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 the HCA the total allowed costs for EHBs charged for each policy for the Plan Year. These are to be 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 the dollar amounts needed to establish claim costs for Turquoise plan SOPA payments.

Issuer Attestations – Attestation Form A

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. These SOPA amounts must have been passed through by the issuer to the applicable providers. If the issuer is estimating non-

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

EHBs as a percentage of claims, the issuer must attest that they used a reasonable method to determine the total allowed EHB cost, and that non-EHBs represent less than two (2) percent of EHBs. See **Attestation Form A**. Since many aspects of the claims re-adjudication process involve actuarial estimation of 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.

Restatement of SOPA

The HCA is providing guidance on the restatement process for SOPA that was provided in a prior year for the following reasons:

- 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 the amounts of SOPA provided.

This process should also 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 the HCA.

Details on Restatement

- SOPA is 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 recalculating 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 the correct calculation of SOPA provided.
- When to Restate: Issuers that identify an issue in data or calculations for SOPA provided to consumers that results in the issuer owing the HCA funds must notify the HCA as soon as the issuer identifies the issue. The 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., 2024 restatement data must be submitted in the same file format as the 2025 data submission).
- Issuers may submit recalculations of existing policies and policies that were not reported in the original Plan Year data submission.
- If a 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. This will ensure proper accounting of accumulators in both the Turquoise plan and the reference plan; then accurate calculations of SOPA are provided.

- For a particular Plan Year's restatements, the issuer should use the same methodology that the issuer selected for the same Plan Year when adjudicating and re-adjudicating the new claim and other claims on the policy(s) to determine SOPA provided .
- If 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) after re-adjudication of the new claim(s) and associated SOPA provided for the claim and subsequent claims or policies for a subscriber, issuers should submit to the HCA for approval a plan for administering the refunds. This should include the methodology used to determine the amounts to be refunded and the timing of the refund payment.
- Restatements should not include data for which a discrepancy form was previously submitted and denied by the HCA.
- 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 2025 for a medical service provided in 2024 should be adjudicated and re-adjudicated with other claims on the 2024 policy, using the policy's 2024 parameters and the issuer's methodology for that plan, and submitted in a separate file as a restatement of 2024 SOPA provided. Such claims may not be re-adjudicated outside the associated policy or added to 2025 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.
- The 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, the HCA will permit issuers to request reconsideration of a final discrepancy report for restated policies, provided the restated information differs from the information 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 the Plan Year, as submitted by the issuer.

Reporting Requirements

Reporting Deadlines

Each month BeWell may provide their "CurrentMonth" report any time during the month and a "SOPA_AdjustmentMonth_[MONTH]" report by mid-month. The "CurrentMonth" report will be paid in the following month, along with the "SOPA_AdjustmentMonth_[MONTH]" report for that following month.

  - For example, February Data

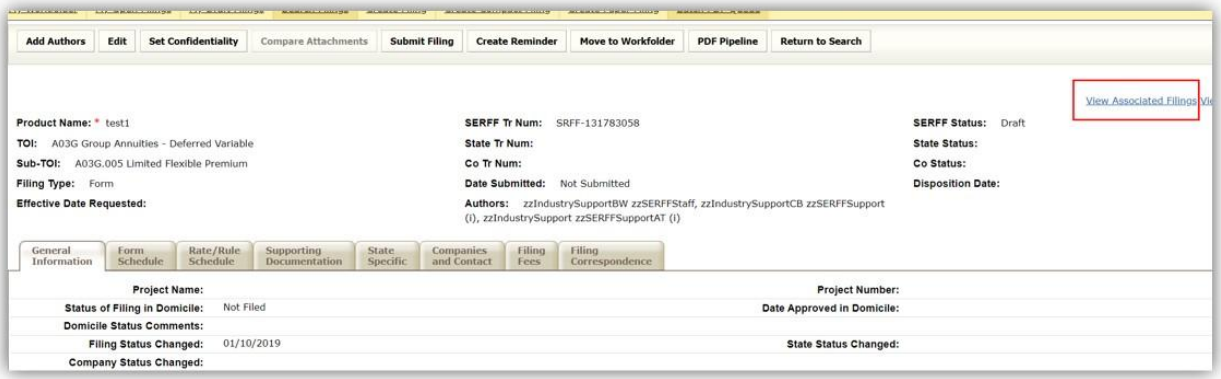
- "CurrentMonth" February SOPA report submitted any time in February.
- Adjustment monthly report for Feb. SOPA submitted by mid-March, labeled "SOPA_AdjustmentMonth_March" report.
- THEREFORE, February "Current Month" SOPA and February adjusted amount (though labeled as March) paid by HCA to issuers on March Notice of Payments.

Submission Requirements

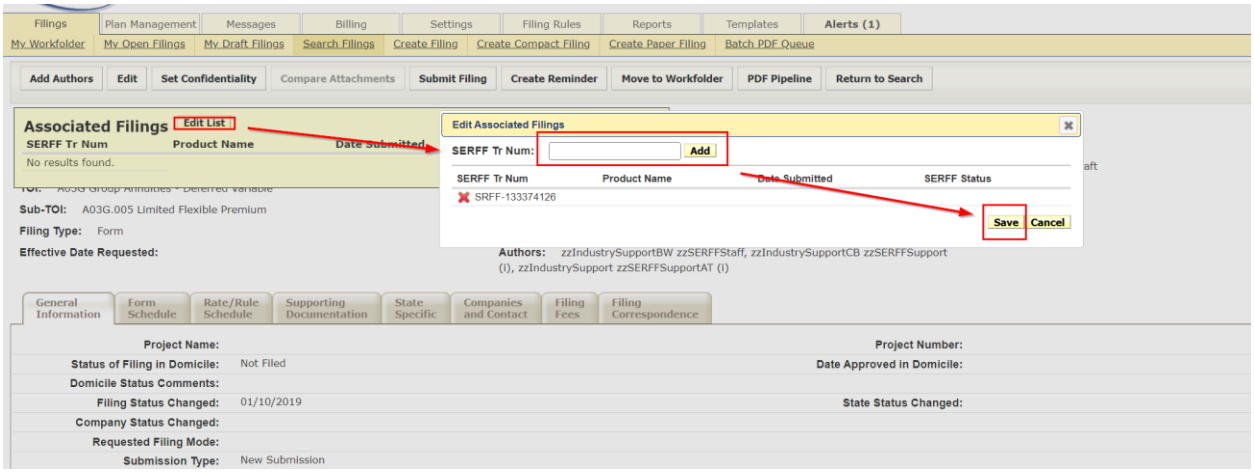
All issuers receiving SOPA advance payments for the 2025 Plan Year must submit the required information to reconcile such payments according to the timeline set forth in **Table 4** above.

- 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" in the top right-hand corner of the SERFF screen.



2. Click "Edit List" in the View Associated Filings pop-up: Enter the SERFF Tracking Number for the filing you want to associate. Then click "Add" and "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., 2025 for the 2025 Plan Year)
- **Submission - indicate one of the following**:
    - "init1" for reconciliation submission for the applicable Plan Year during the following 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 enrollees)
- **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 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_2025_init1_TEMPA_v2. xlsx is the second version of the 2025 issuer and plan level reconciliation template submitted during the submission period in 2025 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 Data Elements

Issuer Summary Information

Data to be inputted in **Template A – Tab 01** – each data element included in **Appendix A** 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 input for in **Template A** – **Tab 1** (issuer), **Tab 2** (plan level), **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 input for **Template C** relates to the error/discrepancy correction request for consideration.

Please refer to **Appendix A** for a list of data elements and their definitions to assist in filling out **Templates A, B, and C**.

Treatment of Confidential Information

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

Payment

The 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, the HCA will validate data and perform outlier analysis, but will not audit the data. The amount of the SOPA portion of advance payments to be reconciled is the amount provided to the issuer as of the final adjustment to advance payments for the Plan Year. For the applicable Plan Year, see **Table 4** above regarding reconciliation process dates. Any claims incurred in the benefit year and not included for reconciliation in the

reconciliation submission window for that year may be filed in the following year or later reconciliation submission window(s).

Timing of Payments and Charges

The HCA expects to issue a report to each issuer showing, for validated data, SOPA reconciliation payments and charges for the Plan Year by the date listed in **Table 4** above. An issuer will be reimbursed any amounts necessary to reflect the full amount of the SOPA provided or the issuer will be charged for excess SOPA advanced payment amounts paid by the HCA, as appropriate. Charges are subject to netting in the next closest monthly payment cycle, as appropriate. As noted above, an issuer's annual reconciled amount will be adjusted up or down based on validated restatement amounts.

Determination of Outliers

The HCA will analyze 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, the HCA will compare the issuers' reported amounts against other metrics to determine whether they fall within a reasonable range relative to other issuers. The HCA will withhold SOPA reconciliation payments to all issuers flagged as outliers based on the analysis until the outlier status is sufficiently and reasonably addressed by the issuer, with an explanation or data resubmission.

Error/Discrepancy Corrections

Issuers may file discrepancy forms (see **Template C**) to correct errors that directly affect the calculation of their reconciled SOPA amount. This must be done 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 calculating amounts).

Note: Issuers must report all identifiable errors to the 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 the HCA, the HCA's incorrect application of the relevant methodology, or the HCA's mathematical error of the amount to be paid for SOPA amounts for a Plan Year. Reconsideration requests shall be submitted to jessica.rosenthal@hca.nm.gov and filed in SERFF.

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

Audit and Retention of Records

Under 8.401.2.8 NMAC, "To facilitate reconciliation, a health insurance issuer must track or accurately estimate claim costs in accordance with guidance published by the secretary to allow for the determination of actual of out-of-pocket assistance amounts for the applicable plan year."

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

Data Submission Templates, Checklist, 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 an error or discrepancy correction, or a request for reconsideration. Please refer to Appendix A for a list of data elements and descriptions for filling out SOPA reconciliation Templates A, B, and C for submission, or for submitting requests for reconsideration. Issuers must accompany SOPA reconciliation data submissions with **Attestation Form A**.

Appendix A: Data Elements and Definitions for Submitting Templates and Checklist for SOPA Reconciliation 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-generated (HIOS) 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 the SOPA is 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 across all (03) Policy Detail Records, including restated and non-restated policies.
- **SOPA AMOUNT ADVANCED TO THE ISSUER BY HCA:** Amount the issuer shows received from the HCA for the Plan Year January 1 to December 31, 2025. 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.)
- **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 an (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 both restated and non-restated policies.
- **TECHNICAL POINT OF CONTACT First and Last Name:** First and last name of the issuer's technical point of contact.

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

Plan Information (Template A)

- **RECORD CODE:** Record code at the plan level is always 02.
- **QHP PLAN ID:** The 16-digit HIOS-generated QHP 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 EHBs incurred by the enrollee(s) on this plan variant. (See "Determination of Total Allowed Essential Health Benefits" section above.) Total allowed costs for the Turquoise plan variants must match 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 EHBs 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:** Due to discounts and amounts paid by other insurers, total actual amounts paid for EHBs by the issuer and by enrollees may not equal total allowed costs.
- **ACTUAL AMOUNT THE ENROLLEE(S) PAID FOR EHB:** The amount (including the restated amount if submitted as part of a restatement file) all enrollees on this Turquoise plan variant paid (or are liable for) in cost sharing for all EHB services.

- **ACTUAL AMOUNT THE ENROLLEE(S) WOULD HAVE PAID FOR EHB UNDER THE REFERENCE PLAN**: The amount (including the restated amount if submitted as part of a restatement file) the enrollee(s) would have paid for the same EHB claims had 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 above).
- **SOPA PROVIDED:** 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 the 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 issuer and attributed to the insured/contract holder.
- **EXCHANGE-ISSUED SUBSCRIBER ID:** The 12-digit SUBSCRIBER_ID in the BeWell 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 EHBs incurred by the enrollee(s) on this policy. (See "Determination of Total Allowed Essential Health Benefits" section above.)
- **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 used by enrollees on this policy. This includes SOPA reimbursement amounts paid to fee-for-service providers, to the extent the issuer reimbursed them. Issuers that provide for EHBs 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:** Due to discounts and amounts paid by other insurers, total actual amounts paid for EHBs 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) that 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 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 amount (including the restated amount if submitted as part of a restatement file) that 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 issuer and attributed to the insured/contract holder.
- **EXCHANGE-ISSUED SUBSCRIBER ID:** The 12-digit SUBSCRIBER_ID in the BeWell Monthly SOPA Advance Payment Data Files.
- **EXCHANGE-ISSUED MEMBER ID:** The 12-digit MEMBER_REFERENCE_ID in the BeWell 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 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)
- **TOTAL ALLOWED COSTS FOR EHB:** Total allowed costs (including restated total allowed costs if submitted as part of a restatement file) for EHBs incurred by the enrollee on this policy. (See "Determination of Total Allowed Essential Health Benefits" section above). 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 EHBs. Total allowed costs for the Turquoise plan variants must match 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 paid to fee-for-service providers, to the extent the issuer reimbursed them. Issuers that provide for EHBs 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 is liable for) in cost sharing for all EHB services. (Format: $0,000.00)
- **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 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 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.

Checklist - Instructions

A checklist for issuers has been developed to detail the information that needs to be provided, as well as basic data integrity checks for issuers to perform on the data before submitting it in SERFF.

The checklist must be included with every version of a submission. It should be submitted following the standard file naming convention: IssuerName_YYYY_submission_ Checklist_v#.xlsx.

All fields under "Issuer Information" and in the column under "Issuer Notes" must be filled out, including indicating "N/A," as needed. Confirm compliance with each item. If unable to confirm compliance with the requirements, indicate any additional information that provides details regarding discrepancies, etc. See additional instructions provided in the checklist.

Cover Letter – Instructions

The cover letter must, at a minimum, include the following:

- "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., PY25 – initial submission, PY24 restated submission
- Notes for reviewer related to the filing, e.g., reasons for negative SOPA, discrepancies in the number of subscriber IDs, instances where the maximum out-of-pocket is exceeded, explanation of any negative claim values, paid to allowed ratios inconsistent with the plan's AV, etc. Include examples, as applicable.

Template - Specific Instructions

01 - Issuer-Level Reporting

Total Number of Subscriber IDs in all Turquoise Plan Variants Under this HIOS ID (Column I): Note that the sum of this should be the same as is provided in Tab 02, except in some cases it may differ because Tab 02 could have multiple Subscriber and Plan combinations, whereas Tab 01 just counts unique Subscribers. If they do not match, provide a detailed explanation in the Cover Letter and/or reconciliation exhibit in the checklist.

02 - Plan-Level Reporting

SOPA Provided (Column H): The total SOPA amount provided in Tab 02 should be equal to the total positive SOPA amount reported in **Template B**, as the SOPA amounts in **Template A** are floored at zero. However, there are instances where Tabs 03 and 04 of **Template B** do not match in the breakdown of the positive and negative SOPA, yet the overall net SOPA is the same. The SOPA amount in Tab 02 should agree with the total positive SOPA from Tab 03 at the Policy Level, not the positive value from Tab 04.

Total Number of Exchange Subscriber IDs in this Plan (Column I): Note that the sum of this should be the same as was provided in Tab 01, except in some cases it may differ because Tab 02 could have multiple Subscriber and Plan combinations, whereas Tab 01 just counts unique Subscribers. If they do not match, provide a detailed explanation in the Cover Letter and/or a reconciliation exhibit in the checklist.

03 - Policy-Level Reporting

SOPA Provided (Column O): The total positive SOPA amount reported in Tab 03 should be equal to the total SOPA in Tab 02, as the SOPA amounts in **Template A** are floored at zero.

04 - Enrollee-Level Reporting

SOPA Provided (Column R): The total net SOPA amount reported in Tab 04 should be equal to the total net SOPA amount in Tab 03. However, there are instances where Tabs 03 and 04 do not match in the breakdown of positive and negative SOPA, yet the overall net SOPA is the same.

Request for Reconsideration for Error/Discrepancy Correction – Instructions

Issuers must use **Template C** to submit a request for reconsideration to correct an error or report a 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 out **Template C** (Error-Discrepancy Request for Reconsideration Template).

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 5** lists the Discrepancy Reason Codes and their definitions.

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

The "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)

The "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 5. 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	Subscriber IDs Not Submitted: Issuer did not submit 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 the 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 including 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