Individual Market Plan Requirements

Qualified Health Plans: Part 2 of 4

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Introduction

An insurance plan that is certified by a health insurance marketplace is called a Qualified Health Plan (QHP). This certification tells consumers that a minimum of certain health benefits are included in their plan.

Main Topics

- Rating Review
- Actuarial Value (AV) and Metal Tiers
- Catastrophic Plans
- Network Adequacy
- Non-Discrimination for Health Plans

Rating Review

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- The Affordable Care Act (ACA) provides for the review of premium rate increases proposed by carriers in the individual markets.
- Rate review is the process by which state insurance departments review planned rate increases before carriers can use them.
- In New Mexico, annual rate review is conducted by the Office of Superintendent of Insurance (OSI). OSI looks at the proposed premiums and changes to plans to ensure increases are based on accurate and verifiable data and are reasonable.
- Visit the CMS State Effective Rate Review Programs page for an extensive list of ACA-required considerations.

Rating Review (Continued)

- Under the ACA, carriers in individual and small group markets are limited to setting rates for qualified health plans (QHP) based on the following factors:
  - Age
    - Carriers are allowed to vary premiums based on age but are limited to a 3:1 ratio for adults (meaning that the oldest individuals cannot pay more than three times more in premiums than the youngest individuals).
  - Geography
    - There are five rating areas in New Mexico.
    - To view the five geographic rating areas in New Mexico, visit the CMS page: New Mexico Geographic Rating Areas.

Actuarial Value and Metal Levels

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- The actuarial value (AV) of a plan is the percentage of health care costs a health insurance plan is expected to pay for those covered by the plan.
  - **Example**: If the AV of a plan is 70%, consumers can expect to pay 30% of the costs over the course of a year and insurers would expect to pay 70% of the costs.
- AV is calculated for the health plan, not for individual members on the plan.

Actuarial Value and Metal Levels (Continued)

- Health insurance carriers must design Marketplace plans to fit into one of four metal tiers. The AV of plans can vary slightly.
  - Bronze: 58% - 62%
    - Expanded Bronze: 58%-65%
  - Silver: 68% - 72%
  - Gold: 78% - 82%
  - Platinum: 88%-92%
  - **Note**: New Mexico will not offer Platinum plans for PY2025.

Catastrophic Plans

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- Some Health Insurance Marketplaces have a fifth type of plan outside of the four metal tiers. These are known as Catastrophic Plans.
- Catastrophic plans are health insurance plans with a low monthly premium and a very high annual deductible designed to protect consumers from worst-case situations, such as a serious injury or illness.
- This type of plan is available to individuals under the age 30 at the beginning of the plan year, or those who qualify for a hardship exemption.

Catastrophic Plans (Continued)

- Catastrophic Plans are required to cover:
  - The essential health benefits (EHB);
  - Certain preventive services at no cost when delivered by an in-network provider; and
  - At least three primary care visits during the plan year.
- The premium tax credit (PTC) and cost-sharing reductions (CSR) may not be used with this type of plan.
- **Note**: BeWell does not currently offer Catastrophic Plans.

Clear Cost Plans

- Starting with the 2024 Plan Year, New Mexico offers standardized health plans at the Silver, Gold, and Turquoise levels.
- Standardized health plans (also known as Clear Cost Plans) are plans all insurers in a market are required to offer that have the same out-of-pocket costs for covered benefits.
  - **Note**: Standardized health plans are referred to as "Clear Cost Plans" only in New Mexico.
- Standardized health plans simplify and streamline the shopping experience, can improve cost predictability, and encourage use of certain high-value health services by lowering out-of-pocket costs for those services.
- More information on standardized health plans can be found on the BeWell Clear Cost Plans page.

Network Adequacy

- Network adequacy refers to the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers, including primary care and specialty physicians, as well as other health care services.
- There are several requirements under the ACA and/or state laws regarding network adequacy, including:
  - Network providers must include essential community providers that serve predominantly low-income and medically-underserved individuals.
  - Consumers have reasonable and timely access to services.
  - Network adequacy applies to managed care plans, such as Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), and both health and dental care.
- **Note**: Learn more about network adequacy on OSI's website.

Key Points

- Rate review is the process in which state insurance departments review planned rate increases before carriers can use them.
- Clear Cost Plans have been offered since 2024 and provide consumers a simplified way to compare features of plans.
- Federal and state laws and regulations applicable to network adequacy can be located on the OSI website.


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