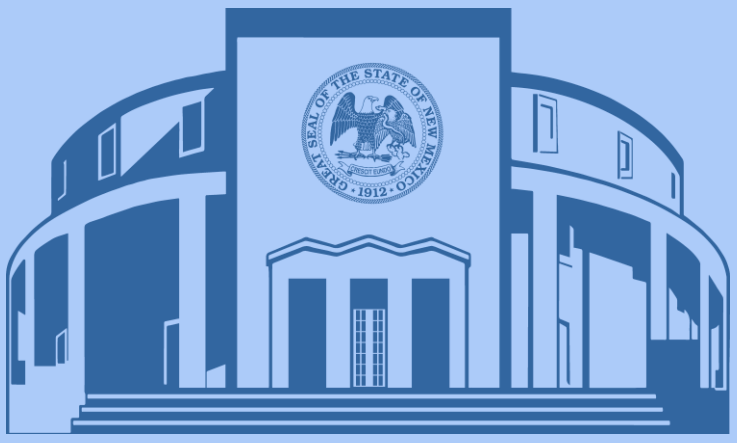
New Mexico Legislative Finance Committee
Progress Report

New Mexico Health Insurance Exchange



August 25, 2026

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NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Progress Report: New Mexico Health Insurance Exchange

REPORT SUMMARY August 2026

TOP TAKEAWAY

New Mexico has made purchasing insurance through the health insurance exchange more affordable by expanding state subsidy assistance at greater amounts and higher income levels than federal programs, allowing enrollees to pay less towards their premiums. As premium costs soar, enrollees are largely insulated from the impact because the state absorbs a greater share of health insurance costs. The state is projected to spend $190 million in 2026 on subsidies through the exchange in premium and out-of-pocket cost reductions. New Mexico may need to consider cost-containment measures, such as requiring greater cost-sharing from higher-income enrollees, to ensure the long-term sustainability of the health care affordability fund.

THE ISSUE

In response to expiring temporary federal health insurance exchange subsidies, the Legislature increased health care affordability fund (HCAF) revenues and appropriations to afford expanded state subsidy programs that maintain existing monthly premium costs for enrollees. Therefore, while the nation experienced a decline in exchange enrollment after the expiration, New Mexico reached over 80 thousand enrollees for 2026, with 90 percent of enrollees receiving state and federal subsidies. Record enrollment and expanded state subsidies increased HCAF marketplace affordability program expenditures 179 percent from 2025 to 2026, prompting HCA to plan for cost-containment measures in FY28.

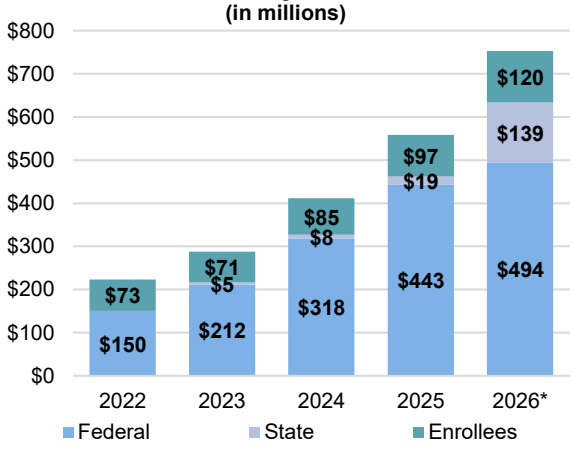
KEY FINDINGS

- Premium costs have significantly increased on the exchange, catching up to reflect premiums nationally. The rising premiums in New Mexico are largely absorbed by state-funded subsidies, not enrollees.
- Enrollment is concentrated among individuals earning less than 400 percent of the federal poverty level and older New Mexicans not yet eligible for Medicare.
- The state and federal government share the cost of premium subsidies, but the state's share increased substantially for 2026.
- Federal changes to healthcare programs may impact enrollment and increase administrative burdens.

KEY RECOMMENDATIONS

- The Health Care Authority (HCA) should consider revising the state subsidy program (New Mexico Premium Assistance income eligibility and cost-sharing structures) to improve health care affordability fund sustainability and target support to those with greatest financial need. Specifically, HCA should continue prioritizing those with incomes at or below 200 percent of the federal poverty level for the greatest cost reduction while maintaining cost sharing on a sliding scale for higher-income families on the exchange.
- The Office of Superintendent of Insurance (OSI) should collect, record, and publicly report utilization annually for major service categories on the exchange over time and by plan.
- BeWell, the health insurance exchange, should utilize state data sources to and consider implementing documentation requirements regarding whether an individual has access to affordable employer-sponsored coverage.

Total Annual Premium Spending by Payer
(in millions)



Note: 2026 total cost projected using spending through July 2026.
Source: LFC analysis of BeWell data

LFC Progress Reports are follow-ups to assess the implementation of previous recommendations.

Background

The federal Patient Protection and Affordable Care Act (ACA), enacted in 2010, sought to reduce the number of Americans without health insurance. Among its many provisions, the ACA directed states to develop health insurance marketplaces, also known as health insurance exchanges, to offer private healthcare policies to individuals who do not have access to other minimum essential coverage including Medicaid, Medicare, or an affordable health insurance option through their employer. In response, New Mexico built a state-based health insurance exchange, known as BeWell or NMHIX, and eventually created the health care affordability fund (HCAF) to connect eligible New Mexicans to qualified health plans that offer essential benefits and reduce costs to the consumer through several subsidy programs.

The primary function of the exchange is to facilitate enrollment in health insurance. State health exchanges: (1) operate web portals that allow consumers to compare and purchase coverage, (2) design and certify plans, (3) make determinations of eligibility for financial assistance, and (4) offer different forms of enrollment assistance, including brokers, navigators and call centers.

From 2015 to 2020, BeWell's enrollment modestly declined, but remained relatively stable. Following New Mexico's transition from a federally facilitated marketplace to a state-based exchange in 2021, enrollment increased substantially, reaching record highs for the state by 2026. While marketplace enrollment declined in every other state in 2026, New Mexico's enrollment continued to grow, largely due to the Legislature's decision to replace expired federal enhanced premium tax credits with state-funded subsidies. As a result, most marketplace enrollees receive financial assistance and more than one-third (approximately 30 thousand people) pay nothing for monthly premiums. Despite record enrollment and new subsidy efforts, New Mexico's current uninsured rate of 10.2 percent remains above the nation's 8.2 percent according to the Census Bureau's American Community Survey.

The policy decisions that contributed to record marketplace enrollment also create fiscal challenges for the state. Beginning in 2026, changes to federal marketplace subsidies and Medicaid eligibility are expected to increase demand for state affordability programs while raising the cost of maintaining coverage. Under current projections, maintaining existing subsidy eligibility may be unsustainable with expected health care affordability fund revenues. This progress report examines enrollment trends on the exchange and calculates the costs to the consumer and the state for health insurance through the exchange.

For plan year 2026, employer-sponsored health insurance is considered "affordable" under the Affordable Care Act if the employee's required contribution for the lowest-cost self-only plan that provides minimum value does not exceed 9.96 percent of household income.

Source: IRS.gov

According to KFF, an independent policy research organization, most recently about 4 percent of New Mexicans, or 84 thousand, get health insurance through the exchange, which is called BeWell (also referred to in this report as "NMHIX", the "Exchange," or the "Marketplace").

Table 1. Key Health Insurance Cost Terms

Term	Definition
Premiums	Payments made to insurance companies to maintain insurance coverage.
Copayments	Fixed amounts paid by the consumer for a covered healthcare service, like a $40 fee for a doctor's visit.
Deductibles	The amount a policyholder must pay for covered healthcare services before the insurance plan starts to pay.
Coinsurance	A percentage of costs shared between the policy holder and the insurer after meeting the deductible (e.g., 80/20 split). Plans with lower monthly health insurance premiums often have higher coinsurance.
Maximum out-of-pocket costs (MOOP)	A financial cap on annual medical spending for covered services (including deductibles and copays/coinsurance). Insurance pays 100 percent for covered services after the MOOP is reached.

Source: bewellnm.com and LFC files

New Mexicans can purchase qualified health plans that meet federal and state requirements through BeWell, the health insurance marketplace.

New Mexico established the New Mexico Health Insurance Exchange (NMHIX), also known as BeWell, in 2013 *(Chapter 54, Senate Bill 221)*. BeWell operates under a collaborative governance structure with the Health Care Authority (HCA) and the Office of Superintendent of Insurance (OSI). Since transitioning to a state-based exchange in 2021, New Mexico assumed primary responsibility for marketplace operations, plan certification, and affordability initiatives. All plans offered through BeWell must meet certification standards set by state and federal requirements. Enrollees on the exchange can choose from plans that balance premiums and out-of-pocket costs and apply for federal and state subsidies to reduce their healthcare costs.

Multiple state entities share responsibility for administering affordability programs, marketplace enrollment, and plan design and approval. The NMHIX Act establishes a framework for collaboration among BeWell, HCA, and OSI. The three agencies each have distinct statutory responsibilities that support the exchange's operations, consumer affordability, and regulatory oversight. BeWell is governed by a 13-member board of directors, which includes OSI's superintendent of insurance and the HCA secretary. Additionally, the governor and the Legislature each appoint members to the board. The board operates through several standing advisory committees. Additionally, BeWell and OSI each play distinct roles in annual certification and oversight of qualified health plans to ensure they comply with federal and state requirements. This process ensures the coverage offered on the exchange meets requirements and is comprehensive. (See Appendix B, BeWell revenues and expenditures.)

All plans offered through BeWell must be certified annually as qualified health plans and comply with both Affordable Care Act and state requirements. To be certified, plans must be offered by licensed insurers in good standing and cover the ACA's 10 essential health benefits. (See Appendix D, qualified health plan requirements.) New Mexico sets a statutory floor of the 10 required benefit categories, but delegates rulemaking authority to OSI to balance and define the actual scope of covered benefits and services within those categories. This is subject to a periodic review aimed at addressing coverage gaps. (See Appendix E, New Mexico benchmark plan.) For 2026, New Mexico exchange plans received an average quality rating of 3.7 out of five stars. This exceeds the national average of 3.4, with New Mexico exchange insurers rating better in plan administration and member experience, and somewhat worse for medical care. (See Appendix F, qualified health plan ratings.)

Table 2. Key Responsibilities of Agencies Administering the Exchange

BeWell
• Operates the independent, state-based marketplace under a governing board of directors, • Runs enrollment operations and publishes enrollment dashboards, • Enrolls New Mexicans in ACA-compliant health and dental plans, offering standardized options and enrollment support.
Health Care Authority
• Manages the health care affordability fund (HCAF), which supports affordability programs that lower premiums and out-of-pocket costs for eligible individuals on the exchange, • Coordinates Medicaid-to-marketplace transition for individuals losing Medicaid eligibility, • Holds a seat on BeWell's governing board.
Office of Superintendent of Insurance
• Ensures that carriers selling plans on the exchange are solvent and offer actuarially justified and non-discriminatory rates, • Reviews and approves rates, • Guarantees that plans sold on the exchange meet state and federal consumer protection requirements, • Holds a seat on BeWell's governing board.

Note: (See Appendix C, additional OSI regulatory responsibilities.)

Source: LFC Files

In 2026, New Mexico exchange plans received an average quality rating of 3.7 out of five stars. This exceeds the national average of 3.4, with New Mexico exchange insurers rating better in plan administration and member experience, and somewhat worse for medical care.

Qualified health plans are offered in three federally established metal tiers (bronze, silver, and gold) that balance monthly premiums and out-of-pocket costs. Bronze plans feature lower premiums but require members to pay more for appointments and prescriptions, while gold plans have the highest monthly premiums, but lowest out-of-pocket costs. For all three tiers, eligible enrollees can also receive state or federal subsidies, or both, that reduce monthly premiums, depending on their household incomes.

New Mexico's exchange has four medical insurance carriers and one dental carrier, offering over 70 different on-exchange plans

New Mexico also offers turquoise plans, which reduce deductibles and cost-sharing for eligible lower-income enrollees. Additionally, all participating insurers offer standardized "clear cost" plans that maintain consistent out-of-pocket costs for common services, which allows consumers to easily compare plans based on premiums, quality rating, and provider networks. (See Appendix G, BeWell plan tiers and types.)

Turquoise plans are unique to the New Mexico health insurance exchange, offering eligible individuals the most cost savings for covered care beyond federally offered cost-sharing reductions.

New Mexico supplements federal financial assistance to further lower the cost of health insurance and care to eligible enrollees.

The federal government and New Mexico both offer subsidy programs to eligible enrollees that reduce monthly premiums and out-of-pocket costs on the exchange. Subsidies are provided on a sliding scale, where more assistance is offered to those with lower incomes. A temporary expansion to the federal premium tax credits enacted during the Covid-19 pandemic (known as *enhanced* premium tax credits) that broadened eligibility and increased financial assistance for enrollees expired at the end of 2025. In response to the expiration of the federal enhanced premium tax credits, the Legislature and HCA made changes to state funded premium assistance to ensure New Mexican enrollees saw little change to their monthly cost for insurance through the exchange.

Advance premium tax credits reduce costs for eligible individuals purchasing coverage through the health insurance exchanges. The subsidy effectively caps premiums paid by the consumer at a certain percentage of their income based on a benchmarked plan's cost. The benchmark plan varies by the location, age, and family size of the enrollee. The federal government sets income caps, based on federal poverty level ranges. Enrollees are expected to contribute more as their income increases. This is known as the "sliding scale." For example, under 2026 federal advance premium tax credit guidelines, enrollees with incomes at 150 percent of the federal poverty level (FPL), or $24 thousand annually for an individual, contribute 4.19 percent of their income to health insurance premiums, while enrollees with incomes at 200 percent of the FPL, or $32 thousand annually, contribute 6.6 percent. The federal Health and Human Services Department (HHS) updates these caps annually. Advance premium tax credits (APTC) are financed through a permanent federal appropriation, which provides indefinite authority for disbursements.

Table 3. 2026 FPL Annual Income

Percent of the FPL	Individual Income	Family of Four Income
100%	$15,960	$33,000
133%	$21,227	$43,890
200%	$31,920	$66,000
300%	$47,880	$99,000
400%	$63,840	$132,000
500%	$79,800	$165,000
600%	$95,760	$198,000
700%	$111,720	$231,000

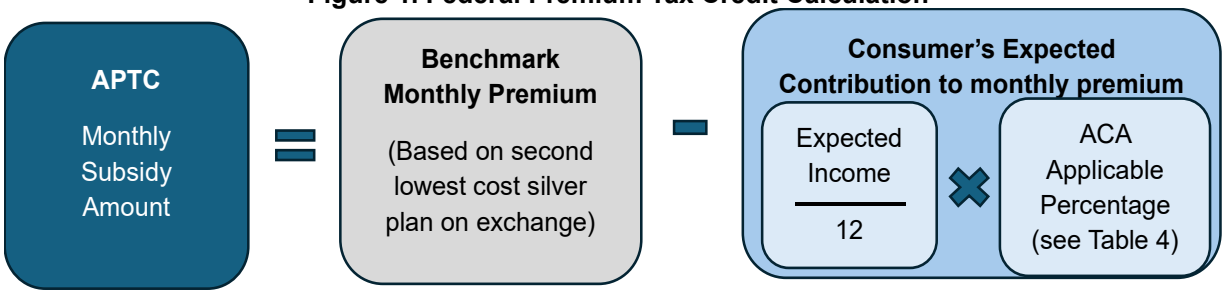
Source: United States Health and Human Services

Table 4. Federal Income Percentages for Premium Tax Credits

FPL	2026 Percentage of Income	2027 Percentage of Income
<133%	2.10%	2.15%
133%-150%	3.14%-4.19%	3.23%-4.3%
150%-200%	4.19%-6.6%	4.3%-6.78%
200%-250%	6.6%-8.44%	6.78%-8.66%
250%-300%	8.44%-9.96%	8.66%-10.22%
300%-400%	9.96%	10.22%
Above 400%	No Federal Assistance	No Federal Assistance

Source: Code of Federal Regulations

Figure 1. Federal Premium Tax Credit Calculation



Source: Internal Revenue Code Section 36B

Temporary enhanced federal premium tax credits expired at the end of 2025. During the pandemic, the federal government enacted enhanced premium tax credits as part of the American Rescue Plan Act in 2021, which were extended to the end of 2025. The enhanced tax credits extended advance premium tax credit to households with an income greater than 400 percent of the FPL, or roughly $64 thousand annually for an individual, that were previously ineligible for subsidies. They also increased the percent of the premium covered for other marketplace enrollees, even covering 100 percent for those with incomes below 133 percent of the FPL, or $21 thousand annually for an individual, and capping the percent of income paid toward premiums to no more than 8.5 percent for all eligible enrollees. The enhanced premium tax credits expired at the end of 2025 and reverted to the previous advance premium tax credit eligibility criteria, which limited subsidy eligibility to those with incomes at or below 400 percent of the FPL.

Federal Premium Tax Credit Eligibility (2026)

Individuals must:

- Be U.S. citizens or lawfully present immigrants with incomes between 100 and 400 percent of the FPL;
- Lack access to public coverage (Medicaid, the Children's Health Insurance Program, Medicare, or military coverage);
- Lack access to affordable health insurance through an employer (defined as premiums exceeding 9.96 percent of the employee's income).

In 2025, the Legislature appropriated almost $40 million, in addition to the health care affordability fund's (HCAF) recurring budget, to replace the expiring enhanced federal premium subsidies for on-exchange consumers. During the 2025 regular legislative session, the Legislature appropriated $22.3 million to maintain premium assistance for marketplace enrollees with incomes below 400 percent of the FPL, supplementing the $50 million recurring appropriation for marketplace affordability programs. During the 2025 special session, the Legislature appropriated an additional $17.3 million to extend premium assistance for enrollees with incomes above 400 percent of the FPL in the first half of the year.

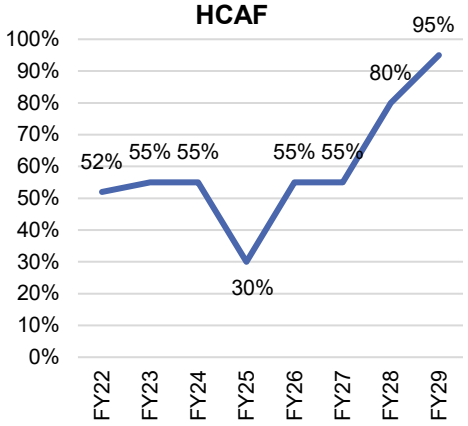
Legislative changes have modified the share of health insurance premium surtax revenue distributed to the HCAF. Most recently, 2026 legislation *(Chapter 39, House Bill 4)* amended the distribution provisions of the Tax Administration Act (Section 7-1-6 of state law) to increase the share of premium surtax revenue distributed to the HCAF from 55 percent to 95 percent beginning in September 2028. The legislation also redirects

The HCAF is funded by a portion (3.75 percent) of the health insurance premium surtax. The premium surtax is a tax levied on health insurance companies based on the premiums they collect. Because Medicaid makes up such a large share of the state's health insurance landscape, an estimated two-thirds of the surtax revenue deposited into the HCAF come from Medicaid managed care premiums. The remaining third comes from privately insured plans.

the remaining 5 percent of net surtax receipts to the state's behavioral health fund, eliminating the previous distribution of premium surtax revenue to the general fund. These changes now dedicate all premium surtax revenue to health coverage affordability and behavioral health programs rather than for general state purposes.

Programs funded through the HCAF are legislatively directed to (1) reduce healthcare premiums and cost sharing for New Mexico residents on the exchange; (2) reduce premiums for small businesses and their employees purchasing coverage in the small group market; (3) provide resources for planning, implementation, and administration of health care initiatives for uninsured New Mexicans; and (4) cover a portion of premiums for eligible state employees. To meet the goals of the health care affordability fund, OSI and HCA implemented four state-funded subsidy programs.

Chart 1. Premium Surtax Revenue Distributed to HCAF



Source: SB 317 (2021), HB 7 (2024), HB 4 (2026)

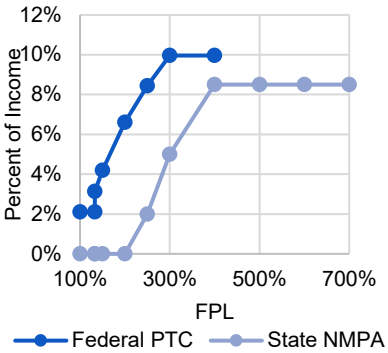
Table 5. Federal and State Health Insurance Exchange Subsidy Programs

Name	Eligibility	Funding Source	Description	Projected 2026 Cost
Advance Premium Tax Credits (APTC)	Income between 100 and 400 percent of the FPL.	Federal, available to New Mexicans	Reduces an eligible individual's (or family's) cost of purchasing health insurance coverage through the exchange, providing a larger subsidy to those with lower incomes.	$494.4 million
Cost-sharing reductions (CSR)	Income between 100 and 250 percent of the FPL.	No federal funding, cost covered with silver loading (described on page 12)	Lowers out-of-pocket costs for income eligible enrollees in silver plans on the marketplace (reducing the plan's deductible, copayments, and out-of-pocket maximum). New Mexico builds on federal CSR plans with SOPA.	N/A
New Mexico Premium Assistance (NMPA)	All income levels.	State/ HCAF	Subsidy that increases the affordability of monthly health insurance premiums on BeWell. These subsidies are built on top of the federal premium tax credits.	$147 million
State Out-of-Pocket Assistance (SOPA)	Incomes up to 400 percent of the FPL.	State/ HCAF	Subsidy to reduce the share of out-of-pocket costs that the consumer faces when using their health insurance plan (deductibles, copayments, and out-of-pocket maximus).	$39.1 million
Native American Premium Assistance (NAPA)	Income up to 400 percent of the FPL and member of a federally recognized tribe.	State/ HCAF	Provides premium assistance in addition to APTC and NMPA to create $0 plans for eligible Native Americans.	$1.1 million
Medicaid Transition Relief Program (MTRP)	Lost Medicaid eligibility and income below 400 percent of the FPL.	State/ HCAF	Subsidy that covers the first month's premium for consumers and their household. that transfer to BeWell from Medicaid	$0.9 million
Total State Subsidy Programs				$188.1 million

Source: LFC files

The New Mexico Premium Assistance subsidy further reduces monthly premiums for eligible BeWell consumers, setting affordability standards and cost sharing below federal levels. The New Mexico Premium Assistance program has the same eligibility requirements as federal advance premium tax credits, with two exceptions: in 2026, the Legislature and HCA expanded income eligibility beyond 400 percent of the FPL, or $64 thousand annual income for an individual, to backfill the expiration of the enhanced premium tax credits and New Mexico Premium Assistance is offered to those under 100 percent of the FPL, or roughly $16 thousand annually for an individual, who no longer meet immigration requirements for federal tax credits. The HCA secretary sets household contribution caps annually, which are notably lower than the federal amounts for 2026, increasing the state's subsidy amount. Enrollees with incomes at both 150 and 200 percent of the FPL are expected to pay none of their income toward health insurance premiums under HCA's caps, and the maximum contribution for any enrollee is 8.5 percent, compared with 9.96 percent for the federal subsidy.

Chart 2. 2026 State and Federal Affordability Percentages

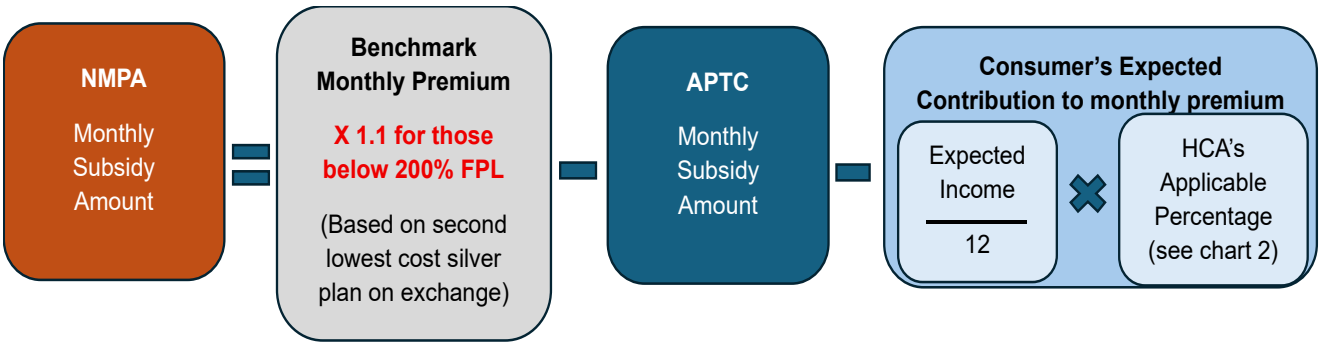


Source: Code of Federal Regulations and HCA

Since 2025, HCA calculates New Mexico Premium Assistance differently for enrollees with incomes below 200 percent of the FPL, or $32 thousand annually for an individual, increasing the benchmark silver plan premium by 10 percent. Because these enrollees contribute 0 percent of their income toward that benchmark cost, this increases the subsidy amount and makes it cheaper for them to purchase plans with more expensive premiums on the exchange.

BeWell aggregates New Mexico Premium Assistance payments for each insurer and reports the total amount to HCA monthly; HCA then issues the state subsidy payments directly to the insurance company.

Figure 2. New Mexico Premium Assistance Calculation



Source: HCA

New Mexico's state out-of-pocket assistance program replicates the federal cost-sharing reductions by lowering enrollees' out-of-pocket healthcare costs. In addition to premium assistance, the HCAF finances New Mexico's state out-of-pocket assistance program, which reduces deductibles, copayments, and other cost sharing for eligible marketplace enrollees. The program functions similarly to the federal cost-sharing reduction program by reimbursing insurers to offer enhanced silver and gold plan variants without increasing monthly premiums. These plans are called turquoise plans in New Mexico. Turquoise plans have actuarial values ranging from 90 to 99 percent—the average share of medical costs covered by the insurance plan—based on household income. Lower-income enrollees receive more generous coverage.

Figure 3. Turquoise Plans

Source: bewellnm.com

Participating insurers must submit plan variants that meet actuarial value standards established by HCA, while maintaining benefit designs that closely align with the underlying metal plans. Under the current state out-of-pocket payment approach, HCA issues monthly payments to issuers during the plan year and reconciles based on actual utilization. (See Appendix H, comparison of state out-of-pocket assistance program and federal cost-sharing reduction program.)

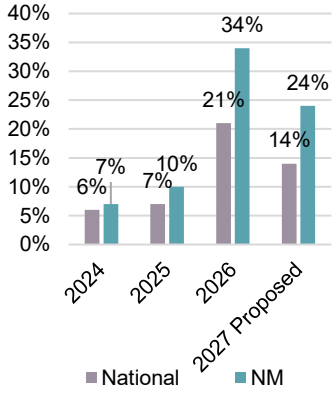
Actuarial value: the average percentage of medical costs for covered benefits that a plan pays, with the remaining share paid by the consumer. It reflects the plan's overall generosity.

Subsidies largely shielded enrollees from the impact of sharply rising premiums driven by increased healthcare utilization and medical costs.

Exchange premiums increased substantially in plan year 2026 as insurers responded to rising healthcare costs, increased utilization of medical services, and federal uncertainty. Although the Legislature appropriated funding to maintain expired federal enhanced premium tax credits, New Mexico's exchange premiums still rose faster than the national average due to increased healthcare spending and utilization. New Mexico's premiums now fall in line with national benchmarks for health insurance costs. However, due to the existing federal and expanded state premium subsidies, the individual does not feel the full burden of the rate increases.

Health insurance premiums increased across the country in 2026. According to a KFF analysis of rate filings submitted to states by health insurers participating in the ACA marketplace, average marketplace premiums increased 21 percent nationally in 2026, following a 7 percent median increase in 2025. For 2027, insurers propose another double-digit increase at a median 14 percent. In most states, insurers outside of New Mexico also incorporated the expiration of the federal enhanced premium tax credits into their rate filings because they expected the change to result in healthier enrollees opting to forgo coverage, which increases the average claim costs among those who remain insured.

Chart 3. Average Premium Increase from the Previous Year



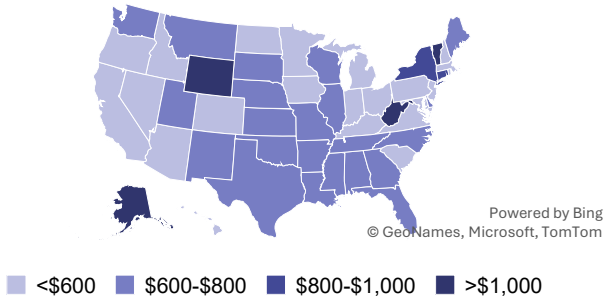
Source: KFF and Healthcare.gov

New Mexico marketplace insurers still increased premiums by an average of 34 percent for 2026, despite being the only state to fully replace the expiring federal enhanced premium tax credits. Across the four health insurance providers on the New Mexico exchange, the average approved premium increase was about 34 percent. Similar to KFF's findings in other state filings, New Mexico insurers cited increased costs of medical services, increased utilization of services, and improved technology that is more expensive to access. Some insurers also made changes to offered benefits that caused them to readjust premiums and out-of-pocket costs to meet ACA requirements. These increases reflect the full, unsubsidized premium amount. Because subsidies rise automatically to keep most enrollees' contributions flat, the majority of BeWell enrollees did not experience a proportional increase in their individual share of the premium.

The highest increase among the four marketplace insurers in the state was by United Healthcare of New Mexico, with an average premium increase of 52 percent that affected more than 12 thousand individuals, causing many to switch to different carriers. This substantial increase may have been driven by a correction after being on the New Mexico market a short period of time and then adjusting to state-specific utilization trends. (See Appendix I, New Mexico premium rate increase breakdown.)

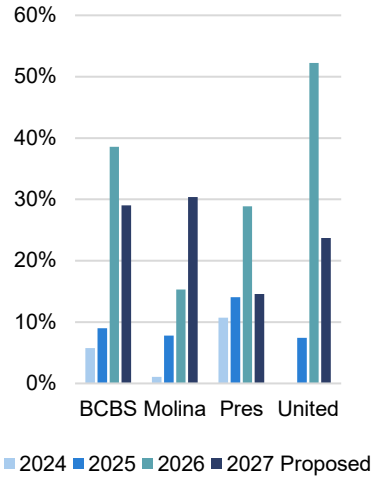
The increase in premiums also raised New Mexico's benchmark premium, increasing costs for both the federal government and state when enrollee income remains unchanged. The benchmark premium, set by federal requirements as the second-lowest cost silver plan, is an important comparison for marketplace plan costs because it is used to calculate the federal premium tax credit and New Mexico Premium Assistance amounts. Assuming an enrollee's income remains the same, a higher benchmark premium increases the costs for the federal government and the state. Since 2019, New Mexico's benchmark premium has increased 71 percent, bringing it closer to the national average after previously remaining below national benchmark premiums. On average, benchmark plans cost about $200 less per month than all marketplace plans, meaning consumers selecting more expensive plans generally pay the difference after premium subsidies are applied.

Figure 4. 2026 Average Benchmark Premiums



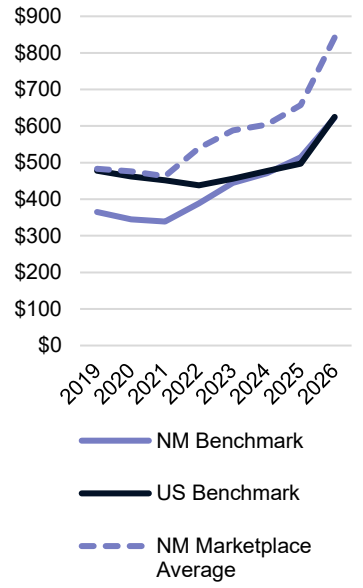
Source: KFF

Chart 4. Premium Increase from Previous Year for BeWell Insurers



Source: HealthCare.gov

Chart 5. Average Marketplace Premiums

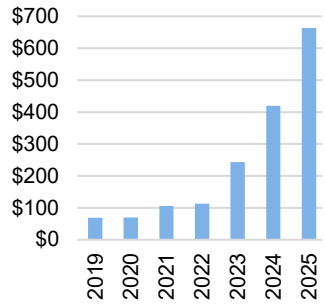


Source: KFF

Use of services on the exchange has increased significantly across all categories, driving growth in healthcare spending. OSI and LFC collected information from New Mexico's four on-exchange insurers for calendar years 2019 through 2025 that examines utilization and cost trends in the 10 essential health benefit service categories. During this period, total paid claims increased from $68.9 million in 2019 to $664.7 million in 2025. Utilization increased across all 10 essential health benefit categories, with the largest growth occurring in prescription drugs, ambulatory care, laboratory services, and mental health services.[1] The number of individuals receiving services also increased substantially, rising from approximately 134 thousand members in 2019 to 438 thousand in 2025. However, it is important to note these figures are likely to overstate the number of unique enrollees because individuals were counted separately for each essential health benefit category they used, meaning some of this growth reflects members utilizing more than one category of service, rather than purely new users.

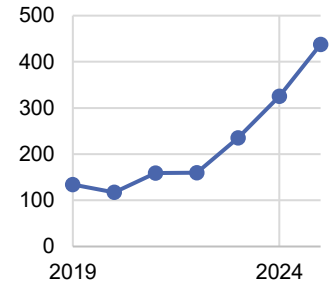
Despite broad growth in utilization, a relatively small number of service categories account for a disproportionately large share of healthcare spending. In 2025, ambulatory care, prescription drugs, and hospital services accounted for the largest share of total paid claims, with hospitalization and maternity care generating the highest average cost per user. Similar utilization trends emerged nationally, indicating these services are primary drivers of rising healthcare costs in all markets.

Chart 6. Total Paid Claims of NM Health Insurance Carriers on the Exchange
(in millions)



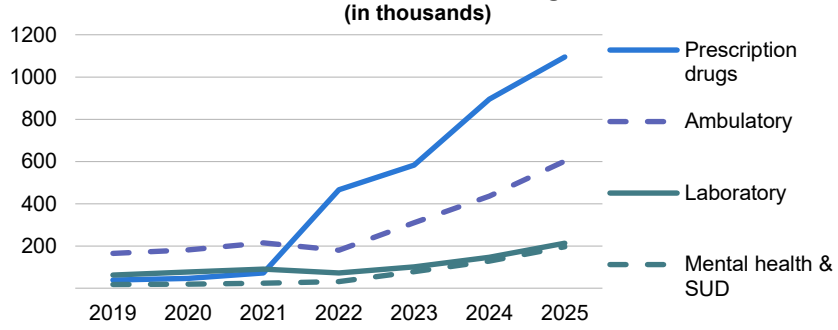
Source: NMHIX insurer utilization data provided to LFC

Chart 7. Number of Individuals Receiving Services
(in thousands)



Source: NMHIX insurer utilization data provided to LFC

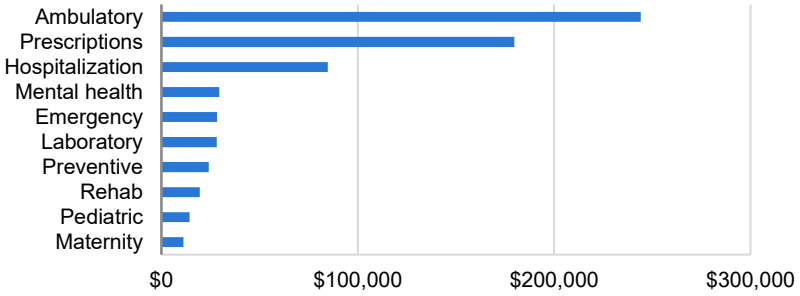
Chart 8. Number of Claims Per Year for High-Volume Services on the Exchange
(in thousands)



Source: NMHIX insurer utilization data provided to LFC

[1] The reported utilization shown in charts 6 through 8 may be greater than the actual number of unique users. While enrollment has increased over time, this utilization data was not cross-referenced with enrollment data. In some instances, an individual enrollee may have been counted more than once if that individual used more than one category of service during a visit (e.g., hospitalization and maternity care).

Chart 9. 2025 Paid Claims by Service
(in thousands)



Source: NMHIX insurer utilization data provided to LFC

During a July 2026 LFC hearing, LFC staff, HCA, and OSI presented information on what is driving health care costs in the state and nationally. Key drivers include:

- Increased utilization,
- National inflation, and
- Expansion of covered services.

See LFC hearing resources here.

For 2026, premiums on the New Mexico marketplace range from $233 to $2,590 a month before subsidies.

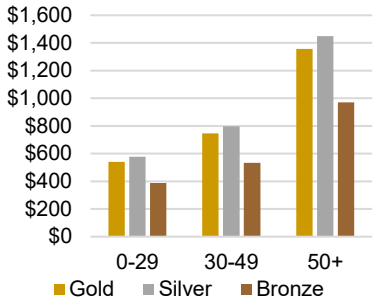
Monthly premium rates on the exchange vary by age of the consumer, plan selected, and rating region. Premiums increase with age because older enrollees are more likely to need care than younger enrollees. For example, 2026 rates average under $600 a month for enrollees under the age of 30 and over $1,000 a month for those age 50 and up. Rates also vary by rating region due to the differences in local healthcare costs and market competition. On average, monthly premiums are slightly more expensive in the rural rating region (about $890 for 2026) and least expensive in the Albuquerque rating region ($670). (See Appendix J, rating region map.) The marketplace also offers several plan designs so that consumers can find a plan that offers services that they need. While these factors create many different cost experiences on the exchange, New Mexico is relatively in line with national averages for marketplace costs. Additionally, consumers eligible for premium subsidies will pay a lower monthly cost than the rates presented below.

Consistently, the monthly premium for silver plans on the exchange are more expensive than gold and bronze plans. For a 30-year-old in 2026, the average silver plan premium available is about $670 a month compared to $630 for gold and $450 for bronze. Though gold plans are intended to have the highest premiums of the three, silver plan premiums have increased across the country due to "silver loading", the practice of increasing silver plan premiums to cover the cost of providing federal cost-sharing reductions without federal funding. The federal government now pays nothing directly for cost-sharing reductions but pays more indirectly through inflated premium tax credits. Additionally, though bronze plan premiums are significantly lower, very few bronze plans are offered on the New Mexico market.

*A **cost-sharing reduction** is a provision of the ACA that reduces out-of-pocket costs for eligible enrollees who select silver health insurance plans in the marketplace. CSRs reduce enrollees' cost sharing by lowering the health plan's out of pocket maximum and increasing the actuarial value of the plan.*

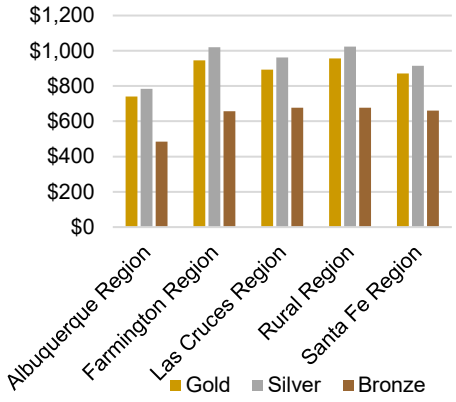
Since October 2017, insurers have been required to offer reduced-cost-sharing silver plans, but without direct reimbursement from the federal government.

Chart 10. 2026 Average Marketplace Premiums by Age Group



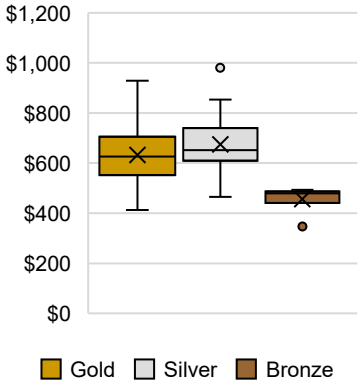
Source: LFC analysis of marketplace premiums

Chart 11. 2026 Average Marketplace Premiums by Rating Region



Source: LFC analysis of marketplace premiums

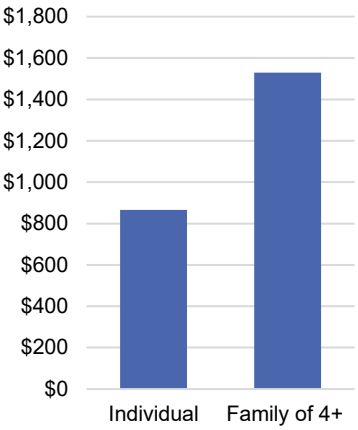
Chart 12. 2026 Marketplace Premium Distribution for a 30-Year-Old



Source: LFC analysis of marketplace premiums

Monthly premiums nearly double for family plans, averaging $1,680 a month for a family of four or more in 2026. Family premiums on the exchange are calculated by adding the individual premiums for each adult (21 and over) and up to three children (under 21). For example, for a family of four, the premium is composed of the rates for each family member. For a family of six, the premium is composed of the rates for two adults and three children; the premium for the remaining child would not be included. The benchmark premium for families is calculated the same way, so families get more in state and federal subsidies to cover more of the higher monthly premiums. At or below 240 percent of the FPL, or $79 thousand annual income for a family of four, the children under 19 years old would qualify for Medicaid even if their parents are enrolled on the exchange. Therefore, few subsidy eligible families at lower incomes are covering their children through the exchange, so family premiums (before subsidies) are somewhat cheaper at lower incomes and higher for those above 300 percent of the FPL, or $99 thousand annually for a family of four.

Chart 13. Average Monthly Premium by Family Size
(before subsidies)



Note: Household count is being used as a proxy for number of people on the plan/ "family size". These are not always the same as some people could be on different plans but living in the same house. Average premium by household count is close to, but not exactly, the true average for a family.

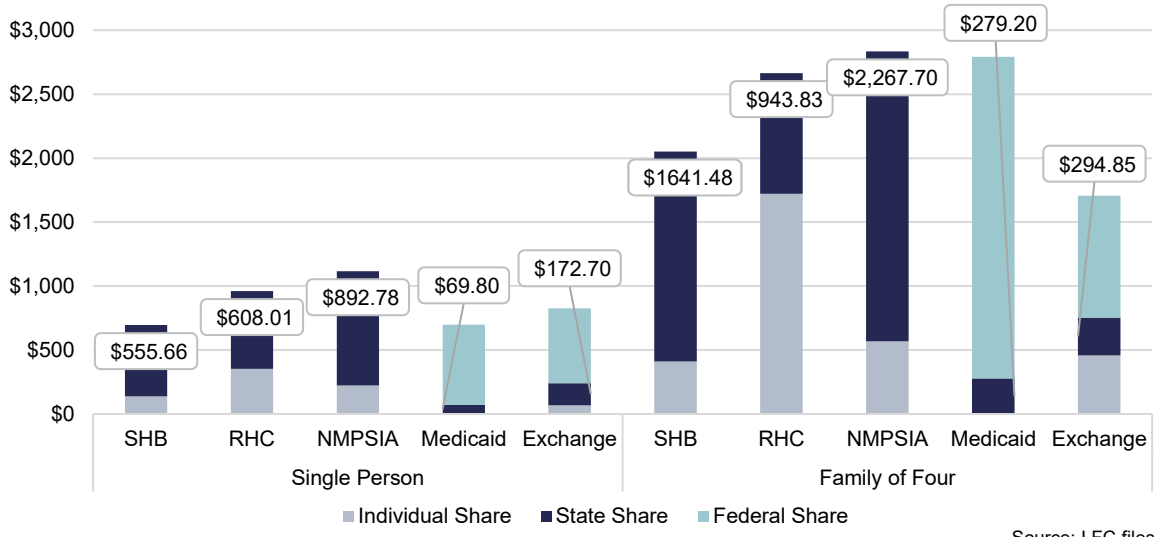
Source: LFC analysis of BeWell enrollment data

The state's share of coverage costs-per-enrollee on the exchange is generally lower than for other state-funded plans (except for Medicaid expansion plans), but the state takes on a greater share for some enrollees. Chart 14 illustrates a representative enrollee in the most commonly enrolled-in state-funded plans, an average premium and subsidy amount for individuals with incomes between 200 and 300 percent of the FPL (between $32 thousand and $48 thousand annually for an individual) on the exchange, and the per-member-per-month (PMPM) cost for a Medicaid expansion enrollee. The average premiums on the exchange are roughly comparable to monthly per-enrollee costs for other plans subsidized or funded by the state. State employee, retiree, and public school coverage are employer-sponsored plans in which the state acts as the employer and the premium is a fixed amount and does not vary by the enrollee's income or age. On the exchange, however, the federal advance premium tax credits pay the majority of the subsidy for most enrollees, and the state's share covers the remainder after the federal premium tax credits are applied. That amount varies widely based on the on-exchange enrollee's income, age, family size, and rating region. For enrollees who are ineligible for federal funding (if their income is below 100 percent of the FPL or above 400 percent of the FPL), the state takes a greater share of the premium. In these instances where the state is the primary payer for an on-exchange enrollee's subsidies, the monthly cost per single enrollee can exceed the state's monthly costs for state-funded plans. Again, because premiums vary widely on the exchange, based on the enrollees' income, age, geographic rating area, and household, Chart 14 should be interpreted as illustrative and not an exhaustive representation of funding distributions. (See Appendix K, chart 14 methodology.)

Chart 14 Legend (see next page):

SHB: State health benefits or state employee health insurance plans
RHC: Retiree health care plans
NMPSIA: New Mexico public school insurance authority plans
Medicaid: Medicaid expansion plans
Exchange: New Mexico Health Insurance Exchange enrollee

Chart 14. Monthly Coverage Costs of Most Commonly Enrolled-In Plans

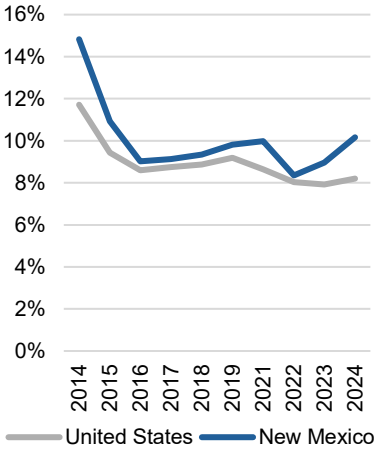


Note: Textboxes represent state share.

Source: LFC files

About 10 percent of New Mexico's population, or 211 thousand people, were uninsured in 2024 compared to 8 percent nationwide. The Affordable Care Act created health individual insurance marketplaces in an attempt to reduce uninsured rates across the county by offering affordable coverage options to low-income individuals. After implementation, the percent of people uninsured declined in the United States and New Mexico. However, New Mexico has consistently had a higher percent of people uninsured than the U.S., the eighth highest in 2024 among the 50 states.

Chart 15. Percent of Population Uninsured Over Time



Note: The survey did not release estimates for 2020 due to pandemic related disruptions.

Source: KFF

A previous LFC evaluation of NMHIX led to improvements to operations and transparency.

In 2015, the Legislative Finance Committee conducted a program evaluation of the New Mexico Health Insurance Exchange (NMHIX) focused on beginning enrollment trends, website and IT efforts, and governance structure. Though New Mexico initially elected to run a fully state-based exchange, the state failed to stand up its website before the 2013 open enrollment deadline and therefore operated its exchange on the federal platform, HealthCare.gov, until launching its own platform in the fall of 2021 for plan year 2022.

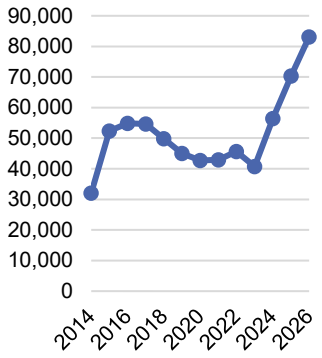
The evaluation found that while the uninsured population in New Mexico was reduced by 2015, NMHIX enrollment came in below projections and trailed national averages despite investments in marketing and outreach. NMHIX's struggle to get projects off the ground at the time was partially attributed to a lack of IT project oversight and tracking. Additionally, the evaluation highlighted a lack of oversight in the governance structure of NMHIX, noting that exemptions from most statutory and regulatory requirements likely contributed to procurement issues, noncompliance with federal rules, and higher costs.

The 2015 program evaluation made many recommendations to NMHIX and the Legislature to address these problems. Amendments made in 2019 required that NMHIX be subject to the Accountability in Government Act and Sunshine Portal Transparency Act. After moving to a state-based exchange, known as BeWell NM, the entity improved tracking and transparency with public enrollment dashboards and increased enrollment through targeted marketing and community outreach. (See Appendix A, progress on recommendations following the 2015 evaluation.)

Enrollment on the Exchange is Concentrated Among Lower-Income, Older New Mexicans

The ACA marketplace is intended to provide coverage to those most likely to be uninsured, i.e. not eligible for Medicaid or Medicare and who do not have an offer of affordable health insurance coverage from an employer. People who fall into this category are likely self-employed, unemployed, or early-retirees, and more than 90 percent of exchange enrollees earn less than 400 percent of the federal poverty level (an annual income of about $64 thousand for an individual). Exchange subsidies are offered on a sliding scale: those who make less income receive the most financial assistance for the cost of health coverage. In additional to federal financial assistance, the state offers subsidy programs for premiums and out-of-pocket costs; as a result, 37 percent of enrollees pay $0 for health care coverage. The amount enrollees pay in monthly premiums on the exchange varies based on where they live, age, income, and family size. These same factors also impact the amount the state and federal government pay to subsidize premiums through New Mexico Premium Assistance and premium tax credits. As premiums increase, state and federal subsidies must also increase to keep the enrollee's payments below certain percentages of their annual income.

Chart 16. New Mexico Marketplace Enrollment after Open Enrollment Period



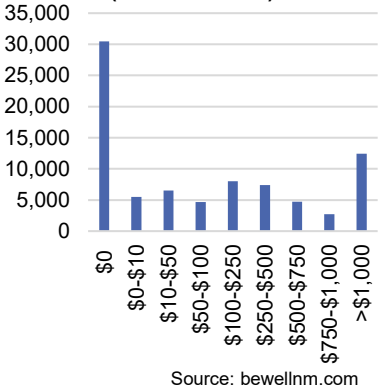
Source: KFF

Low-income enrollees are receiving subsidies that cover 100 percent of premium costs and reduce out-of-pocket costs up to 99 percent.

New Mexico uses the health care affordability fund to provide further cost reductions for enrollees on the exchange. Enrollees up to 400 percent of the FPL qualify for plans with significantly reduced out-of-pocket costs for care through turquoise plans. New Mexico also extends premium assistance, on top of federal tax credits, to all incomes on a sliding scale. This means as an individual's income decreases, the subsidies available to them increase. With subsidies geared toward the lowest income enrollees, BeWell enrollment is concentrated around 200 percent of the FPL ($32 thousand annually for an individual), who are close but not eligible for Medicaid. While individuals with lower incomes get the most assistance, premium reductions on the exchange are offered at all income levels in the state as long as the premium (before subsidy) is expensive enough to be a certain percentage of their income. Because premiums increase with age and family size, enrollment in these groups can drive the cost for subsidies.

Thirty-seven percent of BeWell enrollees pay $0 for monthly premiums after federal and state subsidies because enrollment is concentrated at lower incomes. Consistently over time, enrollees on the exchange primarily fall in the 100 to 300 percent of the FPL bracket (between $16 thousand and $48 thousand annually for an individual) making up about 75 percent of enrollees for plan year 2026. Starting in

Chart 17. 2026 Distribution of BeWell Enrollee Premium Costs (after subsidies)

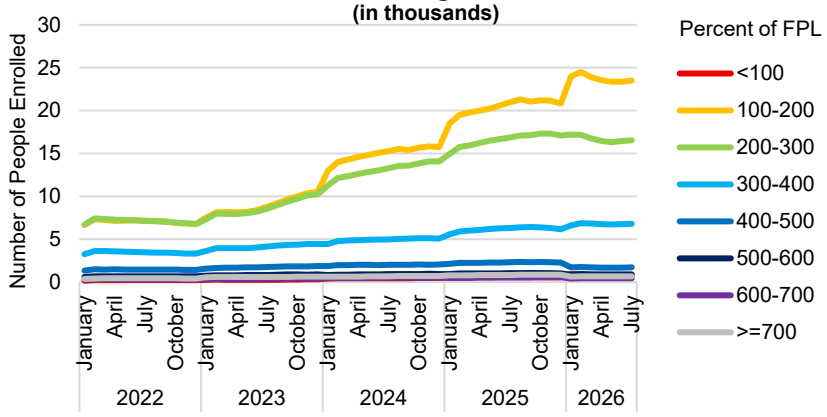


Source: bewellnm.com

2024, enrollment increased for those under 200 percent of the FPL and continued to do so through 2026. The increase in enrollees under 200 percent of the FPL may be attributed to those who lost Medicaid after Pandemic-era continuous coverage unwinding in April 2023 and BeWell's marketing and communication with this population. In 2026, 37 percent of BeWell enrollees are between 100 and 200 percent of the FPL and therefore qualify for $0 premiums through state and federal subsidies.

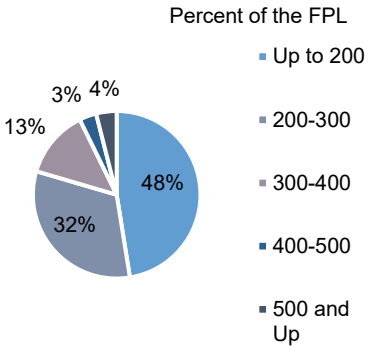
When people no longer qualify for Medicaid, HCA sends BeWell the consumer's application information and notifies the individual of the coverage loss, directing them to exchange. It is then the individual's responsibility to enroll, which could explain the lag over time.

Chart 18. Exchange Enrollment Over Time by FPL Range
(in thousands)



Source: LFC analysis of BeWell data

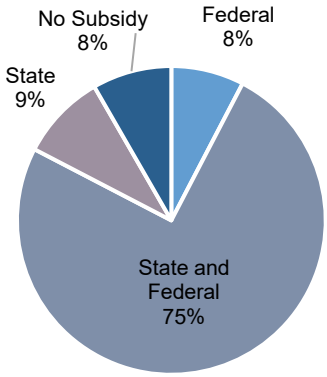
Chart 19. 2026 BeWell Enrollment by FPL



Source: LFC analysis of BeWell data

Enrollees on the exchange can receive a combination of premium subsidies based on eligibility. While 83 percent of enrollees receive premium reductions from the federal advance premium tax credit, 74 percent of enrollees receive both the federal tax credit and New Mexico Premium Assistance. With these subsidies, and a large proportion of individuals on the exchange below 400 percent of the FPL (making below $64 thousand annually for an individual) and therefore eligible for all cost reductions

Chart 20. 2026 Subsidy Breakdown by Members



Source: bewellnm.com

Table 6. 2026 Average Premiums and Subsidies
(for single enrollees)

FPL	Premium Before Subsidy	Federal Subsidy	State Subsidy	Premium After Subsidy	Count of Single Members
<100	$752	$30	$721	$77	677
100-200	$869	$736	$121	$10	15,763
200-300	$818	$575	$172	$67	10,445
300-400	$882	$481	$151	$251	3,486
400-500	$894	$1	$502	$449	828
500-600	$942	$0	$509	$547	387
600-700	$954	$0	$499	$612	208
>=700	$969	$0	$393	$793	255
Unsubsidized Enrollees	$776	$0	$0	$776	1,926

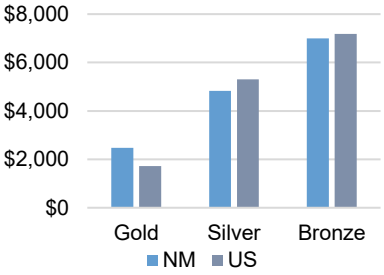
Note: Following the expiration of pandemic-era subsidies, the federal government no longer provides a subsidy above 400 percent of the FPL.

Source: LFC analysis of BeWell data

including federal tax credits, almost half of those enrolled in medical insurance plans pay a monthly premium of less than $10 a month, with 37 percent paying $0 despite premium increases.

The majority of enrollment on the exchange is within the turquoise plans which have reduced out-of-pocket costs for enrollees. Turquoise plans are offered to individuals and families on the New Mexico health insurance exchange with incomes up to 400 percent of the of the FPL (up to $64 thousand annually for an individual) and cover up to 99 percent of healthcare costs to the consumer. The base gold, silver, and bronze plans have much higher out-of-pocket costs than turquoise variants, including copayments, coinsurance, and deductibles. The turquoise plans with the most cost-reductions offer up to $0 deductibles and $0 copays for some services. In comparison, Medicaid will start requiring up to $35 copays for certain services in October 2028 in response requirements in the 2025 federal budget reconciliation legislation. Based on KFF data, New Mexico standard metal plan deductibles for individuals are slightly lower than the national average for silver and bronze plans in 2026, but higher for gold plans ($2,500 in New Mexico compared to $1,700 nationally).

Chart 21. 2026 NM v. US Average Marketplace Plan Deductibles



Source: LFC analysis of KFF and OSI data

Table 7. 2026 Average Out-of-Pocket Costs for Exchange Plans

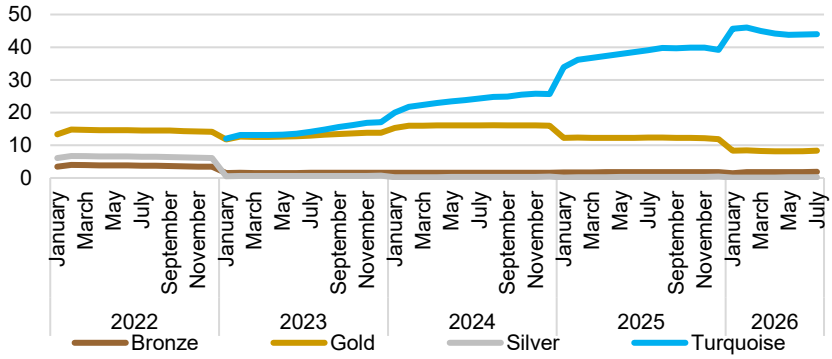
Row Labels	Actuarial Value	Average Individual MOOP	Average Family MOOP	Average Individual Deductible	Average Family Deductible	Average Primary Care Visit Copay*
Turquoise 1	99%	$158.64	$317.27	$0	$0	$1.20
Turquoise 2	95%	$1,029.55	$2,059.09	$172.73	$345.45	$5.73
Turquoise 3	90%	$2,433.33	$4,866.67	$612.50	$1,172.50	$10.25
Gold	80%	$7,641.67	$15,283.33	$2,479.00	$4,958.00	$23.33
Silver	70%	$9,663.64	$19,327.27	$4,823.00	$9,645.00	$51.00
Bronze	60%	$10,150.00	$20,300.00	$7,000.00	$14,000.00	$42.50

*Primary care visit to treat illness or injury.
Note: MOOP stands for maximum out-of-pocket.
Note: (See Appendix L, average prescription drug out-of-pocket costs.)

Source: LFC analysis of OSI data

Reduced out-of-pocket costs for turquoise plans on the exchange are paid directly to insurers by the HCAF through the state out-of-pocket assistance program. Increased enrollment in turquoise plans has increased annual state out-of-pocket assistance costs to a projected total of almost $40 million in 2026; a 352 percent increase from 2023 compared to what HCA is projected to spend on the program in 2026 based on program spending data through March.

Chart 22. Exchange Enrollment by Plan Type
(in thousands)



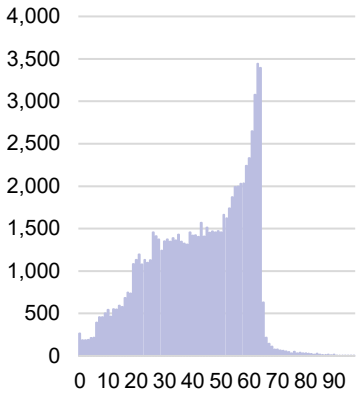
Source: LFC analysis of BeWell data

Turquoise plans are unique to New Mexico and since they became available on the exchange in 2023, enrollment has moved toward and grown in those plans. BeWell's open enrollment data for 2026 indicates that 90 percent of those enrolled in medical plans have incomes less than or equal to 400 percent of the federal poverty level. All these individuals are therefore eligible for the subsidized turquoise plans on top of the federal tax credits and other New Mexico cost reduction programs they may be eligible for.

Turquoise plans are silver and gold tiered plans, so they have higher base premiums than bronze plans, but the enrollees receive premium assistance to reduce their monthly costs. New Mexico's movement toward plans with higher premiums (before subsidies) is unique in the nation after the expiration of enhanced federal premium tax credits. Data from the Centers for Medicare and Medicaid Services on national marketplace trends shows a 10-percentage-point increase in bronze plan enrollment from 2025 to 2026, from about 30 percent of plan selections to 40 percent. Meanwhile, bronze plan enrollment in New Mexico remained flat at only 3 percent of enrollment in 2026.

Exchange enrollment is concentrated among enrollees between the ages of 50 and 64; premiums for these middle-aged and older adults are higher and therefore more expensive to subsidize. Since 2022, enrollment on the exchange is concentrated among individuals between 50 and 64, before dropping sharply at 65 when people typically qualify for Medicare. Benchmark premiums used for state and federal subsidies increase with age. For enrollees ages 55 and older, the benchmark plan used to calculate premium subsidies is close to double the benchmark premium of those age 40. As an example, in the Santa Fe rating area, the benchmark premium is approximately $1,163 a month for enrollees age 55. The premium is even lower for those aged 21 or under. Early retirees can be enrolled and subsidized on the exchange if their offer of retiree coverage is over 9.96 percent of their income, the federal standard for affordability. Older enrollees not eligible for federal premium assistance rely on state subsidies only, costing the HCAF an estimated $19.2 million annually.

Chart 23. 2026 Exchange Enrollment by Age



Source: LFC Analysis of BeWell Data

Table 8. 2026 NM Benchmark Premiums
(The Second Lowest Cost Silver Plan)

Rating Area	Age	Benchmark Premium
Albuquerque	21	$410.35
	40	$524.43
	55	$915.08
Farmington	21	$556.69
	40	$711.45
	55	$1,241.43
Las Cruces	21	$537.97
	40	$687.53
	55	$1,199.68
Santa Fe	21	$521.72
	40	$666.76
	55	$1,163.43
Rural	21	$574.49
	40	$734.20
	55	$1,281.11

Source: 2026 Individual Market Rate Sheet

Table 9. Premium Assistance for Individual by Income and Age
(Santa Fe Rating Area)

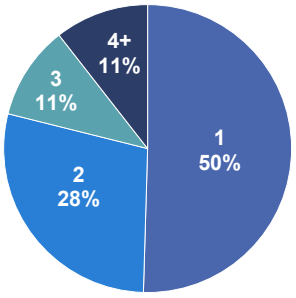
FPL	Age	Feds Pay	State Pays	Individual Pays
200%	21	$346.16	$227.73	$0.00
	40	$491.20	$242.24	$0.00
	55	$987.87	$291.90	$0.00
400%	21	$0.0	$69.52	$452.20
	40	$136.89	$77.67	$452.20
	55	$633.56	$77.67	$452.20
600%	21	$0.00	$0.00	$521.72
	40	$0.00	$0.00	$666.76
	55	$0.00	$485.13	$678.30

Note: Premiums increase by an assigned factor every year of age.
Source: LFC Analysis of BeWell data

Though 50 percent of exchange enrollees are individuals, family plans cost the state more to subsidize, especially at higher income levels. Exchange enrollment is concentrated among lower-income, single enrollees. In 2026, 33 thousand subscribers are single member households, costing an estimated $54 million to the New Mexico Premium Assistance program annually.[2] For lower income groups, the state pays a smaller share of the total premium subsidy for individuals because the federal advance premium tax credit covers the majority of the individual's premium. When an enrollee does not qualify for federal premium tax credits based on income, the state pays more to keep premiums at certain income thresholds. However, individual premiums may not reach the threshold of more than 8.5 percent of the enrollee's income, which is the threshold New Mexico establishes to cap premium costs as a share of income. As premiums on the exchange become more expensive, more individuals could qualify for New Mexico Premium Assistance because the premium may exceed the New Mexico cap on 8.5 percent of income.

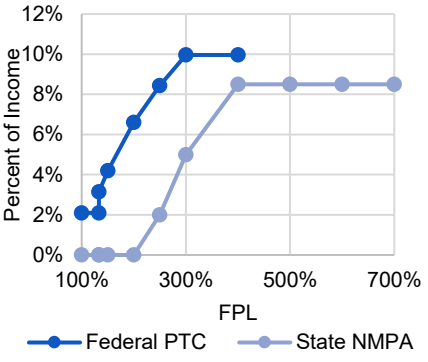
Since a family's monthly premium is significantly more expensive than an individual's, families still qualify for New Mexico Premium Assistance at higher incomes, but they do not receive federal premium assistance. For these families above 400 percent of the FPL (for example, this could be a family of four with an annual income of $132 thousand), the state is paying up to $1,000 a month to subsidize and reduce their monthly premium to only 8.5 percent of their income.

Chart 24. 2026 Exchange Enrollment by Household Size



Source: LFC analysis of BeWell data

Chart 25. 2026 State and Federal Affordability Percentages



Source: Code of Federal Regulations and HCA

[2] Household count may not always equal plan members. Members may live separately on the same plan, or multiple single subscribers can live together. Household count and true number of members on the plan is close but varies slightly.

Table 10. Individual Monthly Cost-Share by FPL
(Benchmark Premium $666.76)

FPL	Annual Income	Feds Pay	State Pays	Individual Pays
>133	$ 21,226	$ 629.61	$ 103.82	$ 0
200	$ 31,920	$ 491.20	$ 175.56	$ 0
300	$ 47,880	$ 269.36	$ 197.90	$ 199.50
400	$ 63,840	$ 136.89	$ 77.67	$ 452.20
500	$ 79,800	$ 0	$ 101.51	$ 565.25
600	$ 95,760	$ 0	$ 0	$ 666.76
700	$ 111,720	$ 0	$ 0	$ 666.76

Note: Calculated using a 40-year-old in Santa Fe.

Source: LFC analysis

Table 11. Family of 4 Monthly Cost Share by FPL
(Benchmark Premium $2,131.75)

FPL	Annual Income	Feds Pay	State Pays	Family Pays
>133	$ 43,889	$ 2,054.95	$ 289.98	$ 0
200	$ 66,000	$ 1,768.75	$ 363.00	$ 0
300	$ 99,000	$ 1,310.05	$ 409.20	$ 412.50
400	$ 132,000	$ 1,036.15	$ 160.60	$ 935.00
500	$ 165,000	$ 0	$ 963.00	$ 1,168.75
600	$ 198,000	$ 0	$ 729.25	$ 1,402.50
700	$ 231,000	$ 0	$ 495.50	$ 1,636.25

Note: Calculated using two 40-year-olds and two children under 15 in Santa Fe.

Source: LFC analysis

New Mexico was the only state to experience enrollment growth on the exchange in 2026, while the nation experienced an overall decline.

New Mexico was the only state to completely backfill the expiration of the enhanced premium tax credits. The state's decision to backfill led to a unique increase in marketplace enrollment in New Mexico, while the rest of the country saw a decline. The enhanced federal tax credits provided more premium assistance to all exchange enrollees and extended eligibility to all incomes. With the expiration, New Mexico not only faced increased costs to maintain the previous state premium assistance structure but also made a legislative decision to provide subsidies to all incomes on the exchange, previously capped at 400 percent of the FPL, or $64 thousand annually for an individual. This change to state subsidies maintained monthly premium payments for exchange enrollees, while across the nation some enrollees experienced a more than double increase in costs. It is not yet clear, however, whether the backfill has been successful in improving the state's high uninsured rate.

At least 10 states are using their own funds to help residents afford marketplace coverage amid federal changes and rising premiums, but New Mexico is the only one to keep subsidies available to all income levels. State-based marketplaces can offer state-funded tax credits and subsidies to those enrolled in their exchange. A recently published article (February 2026) details that California, Colorado, Connecticut, Maryland, Massachusetts, New Jersey, New Mexico, New York, Vermont, and Washington have all put extra state funds forward to at least partially replace the federal tax credits that expired at the end of 2025 and address rising premium costs. For many of these states, this means maintaining subsidy levels for the lowest incomes and providing partial replacement for higher incomes.

BeWell's enhanced marketing and outreach has also positively impacted exchange enrollment in New Mexico.

BeWell has rebranded as a year-round, community presence rather than a pop-up during open enrollment. Several campaigns and community partners have connected more people to health insurance marketplace:

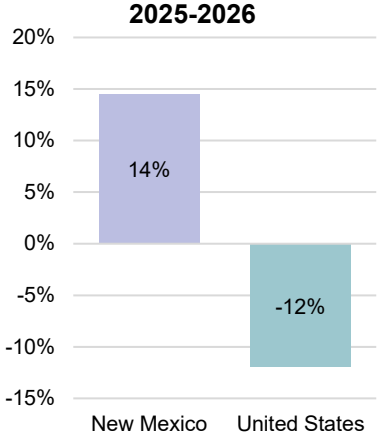
- Billboards and Commercials with "What's The Best That Can Happen" campaign.
- Sponsorships: Isotopes, Boots in the Park, FIFA world cup games.
- Community office hours: CNM, Goodwill, HCA offices, ABQ international library.
- Community events during open enrollment: Farmers markets, public schools, college events.
- Native American community partners: Go Red for Native Women, Acoma Health Council, Navajo Nation Health Fair.

Source: BeWell Board Meeting

For example, Maryland's premium assistance program fully replaces the federal aid for enrollees earning below 200 percent of the FPL and partially replaces it for those earning between 200 and 400 percent of the FPL (between $32 thousand and $64 thousand annually for an individual). Other states, like Washington and New York, are only offering state subsidies to those below certain FPL thresholds. New Mexico is the only state dedicating increasing state funds to maintain subsidies to individuals on the exchange above 400 percent of the FPL.

More than 80 thousand New Mexicans sought health coverage through BeWell during open enrollment in late 2025 and early 2026, following a consistent increase since 2023. New Mexico's enrollment trend stands out among other states, being the only state that saw any increase at all this year while the remainder experienced an average decline of 14 percent. Overall, national enrollment in health insurance exchanges declined by 12 percent from February 2025 to February 2026. (See Appendix M, 2026 exchange enrollment by county.)

Chart 26. Marketplace Enrollment Change 2025-2026



Source: CMS

New Mexico's increase is largely attributed to HCAF programs and legislative changes that maintained premium subsidy amounts to all enrollees after the enhanced federal premium tax credits expired at the end of 2025. Therefore, while other marketplace consumers dropped coverage in the face of increased premium payments, New Mexican enrollees experienced a less substantial change in their monthly healthcare bill. BeWell's enhanced and expanded marketing and outreach efforts likely also contributed to increased exchange enrollment.

New Mexico should monitor the impact of HCAF programs on the state's uninsured rate. The Congressional Budget Office projects an increase in the uninsured population across the nation from 7.2 percent in 2023 to 8.9 percent in 2034 due to Medicaid unwinding and the expiration of enhanced marketplace subsidies. Although New Mexico had a higher uninsured rate than the nation in 2024 (about 10 percent compared with 8.2 percent nationally), backfilling expired federal subsidies helped boost state marketplace enrollment in 2026. The state does not consistently track the percentage of the population that is uninsured to show whether increased state subsidies have been successful in reducing the rate. To better assess the impact of state-funded marketplace affordability programs, this report recommends that HCA track and respond the number of uninsured New Mexicans that are eligible for HCAF-supported subsidies and report those numbers to BeWell for publication on their dashboards.

Recommendations

The Health Care Authority should:

- Track the number of uninsured New Mexico residents that are eligible for HCAF supported subsidies and report to BeWell for publication on their enrollment dashboards.

The State and Federal Government Share the Cost of Premium Subsidies, but the State's Share Increased Substantially for 2026

In 2026, New Mexico assumed a greater share of the subsidy costs to maintain enrollees' monthly premiums as federal subsidies declined and the state expanded programs. As a result, monthly state premium subsidy payments increased from an average of $1.6 million in 2025 to $12.3 million in 2026. While program expansion boosted the state's exchange enrollment, current subsidy levels could be unsustainable with projected health care affordability fund (HCAF) revenue. However, changes to assistance levels could prompt people to drop coverage. HCA projects program costs and determines eligibility criteria, including the affordability thresholds to enrollee cost-sharing, and the system could benefit from greater transparency and reporting as the state manages the sustainability of the HCAF.

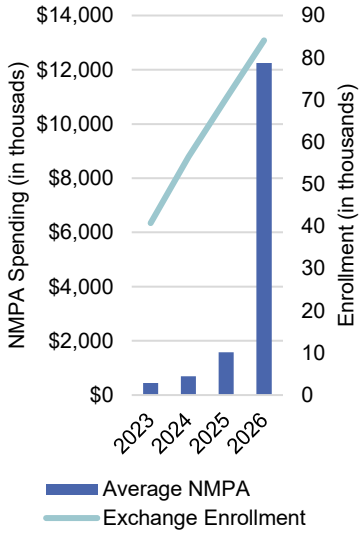
Backfilling the expired federal subsidies and increased enrollment on New Mexico's exchange has increased the annual cost for New Mexico Premium Assistance from about $19.2 million during 2025 to a projected $147.6 million in 2026.

The state's annual costs increased by more than 600 percent due to cuts to federal assistance and the expansion of state-funded subsidy programs.

Premium costs on the exchange are paid for by three payers: the federal government, the state, and the enrollees. Both expanded state subsidies and increased marketplace enrollment have led to a significant increase in the cost to the state, through the healthcare affordability fund, in premium assistance. For individuals with incomes eligible for federal premium tax credits, the federal government pays a majority of the subsidy share. However, since enrollment is concentrated among lower incomes, these enrollees still cost the state the most annually to subsidize. Additionally, enrollees that are not eligible for federal subsides (those with incomes below 100 percent of the FPL and above 400 percent of the FPL) cost the state the most per person, though there are fewer of these individuals and families enrolled. While enrollees' share of the premium increases with income, they saw a less substantial increase in their total costs in 2026 due to expanded state assistance.

Average monthly New Mexico Premium Assistance (NMPA) payments increased 674 percent from 2025 to 2026 to $12.3 million, due to the state backfilling the enhanced federal tax credits when they expired. When implemented in 2023, New Mexico Premium Assistance mirrored the federal premium tax credits in calculation but only provided extra assistance to those between 100 and 400 percent of the FPL (or between $16 thousand and $64 thousand annually for an individual.) From 2021 to

Chart 27. Average Monthly New Mexico Premium Assistance Payments and Total BeWell Enrollment



Note: LFC analysis used spending data avaiable through March 2026.

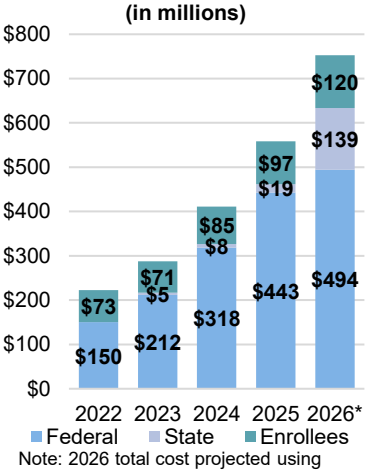
Source: HCA and KFF

the end of 2025, the federal advance premium tax credits were available to those above 400 percent of the FPL and the percent of premium covered was increased from ACA original levels; covering 100 percent for those with incomes below 133 percent of the federal poverty level and capping the percent of income paid toward premiums to no more than 8.5 percent for all eligible enrollees. The expansion, known as enhanced premium tax credits, expired December 31, 2025 and returned to original levels, but New Mexico passed legislation and redistributed funding allowing HCA to maintain premium subsidy amount in 2026 and beyond. Not only does this increase the amount the state pays to subsidize people with incomes between 100 and 400 percent of the FPL, because the state pays the gap between federal tax credit income caps and state set caps, but the state is the only subsidizer of those over 400 percent of the FPL, capping their contribution to 8.5 percent of their income. Backfilling the expired federal subsidies and increased enrollment on New Mexico's exchange has increased the cost for New Mexico Premium Assistance from $1.6 million a month on average (or about $19.2 million annually) during 2025 to $12.3 million in 2026 (about $147.6 million annually).

The federal government pays most of the total annual premium subsidies, despite the expiration of the enhanced premium tax credits, but the state's share has increased from 3 percent in 2025 to 18 percent in 2026. The federal government, the state, and the enrollees share the total premium costs on the exchange. From 2022 to 2025, total annual spending on premiums increased from $223 million to $560 million. The increase can be attributed to growth in enrollment and specific increases in lower income and older enrollees that qualify for more premium assistance. Between this time, the state's share of the total cost increased from 0 percent in 2022 (before marketplace affordability programs began) to 3 percent (or $19 million) in 2025. The state's share of premium subsidies then increased significantly in 2026 following the expiration of the enhanced federal premium tax credits and the state's own expansion of the New Mexico Premium Assistance program to backfill the subsidy loss. In the first seven months of 2026, the state spent over $81 million on state funded premium subsidy programs. LFC projects total premium subsidy spending for New Mexico could total $150 million for 2026, and up to $190 million with out-of-pocket assistance. Meanwhile, the enrollees' share of premium spending has declined over time, from 33 percent of total spending in 2022 to 16 percent of total spending in 2026.

The state spends more in total to subsidize lower-income enrollees but spends more per person to subsidize higher-income enrollees. The exchange's enrollment is concentrated among incomes between 100 and 300 percent of the FPL, between an annual income of $16 thousand to $48 thousand for an individual. These enrollees are eligible for all state and federal subsidy programs, which include premium assistance and the cost-share reduced plans. Premium subsidies for these enrollees are projected to cost roughly $530 million in 2026, $88 million of which is from state subsidies. Total projected spending for the other income levels is less because there are fewer enrollees at those incomes, totaling $55.2 million

Chart 28. Total Annual Premium Spending by Payer
(in millions)



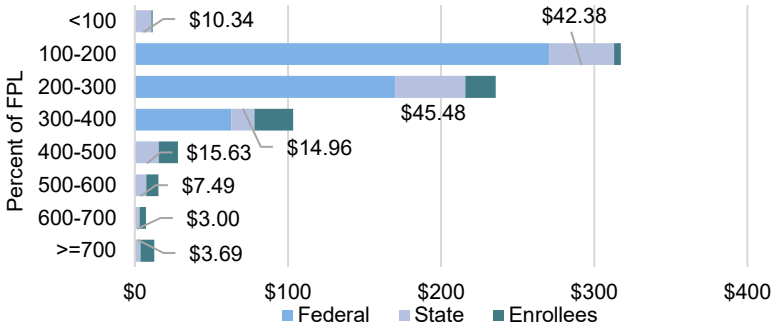
Note: 2026 total cost projected using spending through July 2026
Source: LFC analysis of BeWell data

The enrollees' share of premium spending has declined from 33 percent of total spending in 2022 to 16 percent of total spending in 2026 due to subsidy program expansion.

In total, the federal government is projected to spend $494.4 million on exchange premium subsidies for New Mexicans and the state is projected to spend up to $150 million.

annually for the state and $118.8 million annually for the federal government.

Chart 29. 2026 Projected Total Premium Costs by FPL and Payer
(state share labeled in millions)

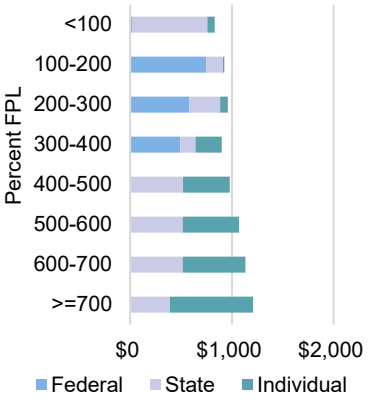


Note: Projected annual spending based on January 2026 enrollment.
Source: LFC analysis of BeWell data

The state **spends more in total** to subsidize lower-income enrollees but **spends more per enrollee** to subsidize higher-income enrollees.

Though total spending is less at income levels not eligible for premium tax credits, the state spends more per person below 100 percent of the FPL and above 400 percent. Enrollees below 100 percent of the FPL cost the state $735 a month each on average for New Mexico Premium Assistance to cover the enrollees' entire premium.[3] For individuals with incomes between 400 and 700 percent of the FPL (between $64 thousand and $112 thousand annually), each individual costs the state about $520 a month to keep their premium below 8.5 percent of their income. For the enrollees above 700 percent of the FPL, the state is paying almost $400 a month each for premium assistance. Individuals who are ineligible for federal assistance pay an average of $450 to $800 per month after state subsidies.

Chart 30. 2026 Average Monthly Premium Spending per Person by FPL and Payer



Note: Based on January 2026 enrollment and spending.
Source: LFC analysis of BeWell data

For those that do qualify for New Mexico Premium Assistance, the state pays between $120 and $175 per month on average for single enrollees with New Mexico Premium Assistance while the federal government pays between $500 and $750 for federal advance premium tax credits depending on the income of the individual. After open enrollment, BeWell reported about 850 enrollees receiving Native American premium assistance, averaging $50 per enrollee for those with incomes between 100 to 200 percent of the FPL, and $130 per enrollee for those with incomes between 200 and 300 percent of the FPL. (See Appendix N, Native American enrollment and subsidies on the exchange.)

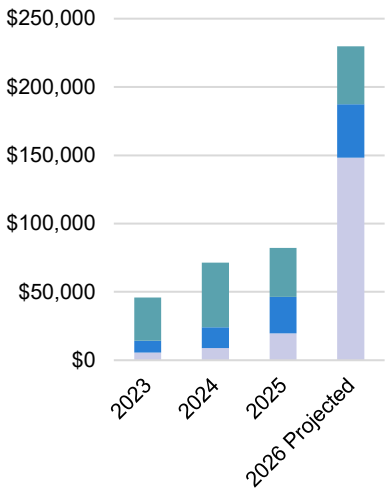
[3] Typically, an individual below 100 percent of the FPL (or $16 thousand annually for an individual) would be on Medicaid, however federal changes have made certain lawfully present noncitizens ineligible for 2026. In response, HCA created a program, "Puente Health" to provide these individuals premium assistance on the exchange.

As currently implemented, the state subsidy programs may be unsustainable with current projected HCAF revenues.

The Health Care Authority (HCA) has held the level of subsidies and cost-sharing steady even while the federal government's contributions have decreased, increasing the state's share of spending on premium subsidies and cost reduction amounts. As currently structured the projected health care affordability fund (HCAF) revenues may be insufficient to sustain existing subsidy levels over the long term. The HCAF finances state programs that reduce health insurance costs for eligible New Mexicans purchasing coverage through the marketplace and other statutorily authorized health coverage initiatives. HCA holds the administrative authority to establish and adjust income-based eligibility and program parameters, which allows the agency to manage program spending as fiscal conditions change. HCA is currently considering cost-containment measures that would modify eligibility and benefit parameters to extend the HCAF's solvency through fiscal year (FY) 29.

While expired temporary enhanced federal subsides caused a significant jump in HCAF spending, HCA has expanded income eligibility and cost reduction amounts for marketplace subsidy programs since 2023. For New Mexico Premium Assistance, HCA removed the income eligibility cap in 2026 where it was previously limited to those under 400 percent of the FPL, or $64 thousand annually for an individual. Additionally, starting in 2025, the New Mexico Premium Assistance calculation included a 10 percent increase in the benchmark plan amount for enrollees under 200 percent of the FPL (under $32 thousand annually for an individual), increasing their subsidy amount. Starting in 2024, HCA also reduced the maximum out-of-pocket cost for some turquoise plans from $1,500 to $500, meaning the plan will cover all costs after the enrollee reaches $500 paid, and prohibited insurers from applying the deductible to primary care and generic drugs for all turquoise plans. Moreover, the following year, HCA made it so that the state out-of-pocket assistance program is available to those on the exchange with incomes up to 400 percent of the FPL, where it was previously limited at 300 percent of the FPL. Program expansion and the expiration of the enhanced federal tax credits drove substantial spending growth since implementation, with projected 2026 total spending increasing of 352 percent for out-of-pocket cost reductions and 2,580 percent for premium assistance since 2023.

Chart 31. HCAF Program Spending
(in thousands)



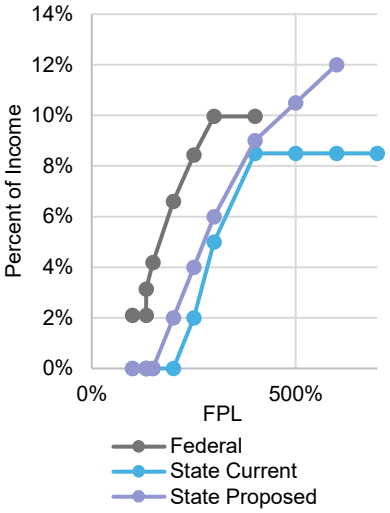
Note: 2026 spending projected based on average spending though March.
Source: LFC analysis of HCA data

Absent any changes to program costs or eligibility, LFC projects the HCAF may be insolvent by FY28. HCA analysis of the 2026 legislation that changed HCAF revenue distributions (HB4) projected total HCAF expenditures will grow from $306.2 million in FY26 to $472.3 million by FY30. This is due to the special session legislation that expanded use of the fund for marketplace affordability programs. Even with HB4's increased revenue to the HCAF, HCA estimates the fund will run a shortfall of $85.3 million starting in FY28 and increasing to $273.3 million by FY30. Based

on this analysis, maintaining subsidy programs at their current levels will exhaust the fund regardless of HB4's additional surtax revenue. HCA acknowledges that additional cost containment will be necessary to maintain the fund's sustainability and is planning cost containment measures for the next program year.

With HCA's proposed cost-containment measure, the HCAF is projected to remain solvent through FY29. As noted previously, New Mexico goes beyond federal definitions of affordability to lower premium and out-of-pocket costs for enrollees on the exchange. Analysis presented to HCA provides options to reduce HCAF program spending through changes to the premium assistance parameters starting January 1, 2028. Projections of HCAF balances assume sustainability measures for marketplace affordability programs would take effect in FY27. HCA is considering reducing the sliding scale income contribution caps used to calculate New Mexico Premium Assistance and capping New Mexico Premium Assistance for enrollees with incomes above 600 percent of the FPL, or $96 thousand annually for an individual. These changes will shift costs onto enrollees, particularly those with higher incomes, and could reduce enrollment for households near the income caps as they lose eligibility for state assistance. Reduced enrollment could mean higher premiums set by issuers if healthier individuals are the ones to drop coverage.

Chart 32. Current and Proposed Premium Subsidy Affordability Percentages



Source: Code of Federal Regulations and HCA

A health insurance risk pool is a group of individuals whose medical costs are combined to calculate premiums. Pooling risk together allows the higher costs of the less healthy individuals to be offset by the relatively lower costs of the health, either in a plan overall or within a premium rating category. In general, the larger the risk pool, the more predictable and stable premiums can be. As premiums rise, healthier individuals tend to drop coverage before those in need of or using healthcare, leaving the risk pool "sicker." This creates even more upward pressure on premiums.

Source: actuary.org

Table 12. Health Care Affordability Fund Actuals and Projections

(in millions)

	FY23 actual	FY24 actual	FY25 actual	FY26 actual*	FY27 budget	FY28 projection	FY29 projection
Beginning Balance	$72	$147.1	$211	$200.1	$115.5	$26.5	$61.5
Revenue	$151.6	$175.6	$97.8	$196.9*	$215.4	$293	$342.4
Expenditure	$124.7	$109.4	$108.7	$281.9*	$294.4	$258	
EOY Balance	$98.9	$213.2	$211	$115.1*	$26.5	$61.5	

*Note: Actual amounts were pulled from SHARE on 7/1/26 (no adjustment for FY26).

Source: SHARE

Projected amounts were provided by Lewis & Ellis' 2026 preliminary actuarial report provided to HCA

Table 13. HCA Proposals for HCAF Program Sustainability

Option/Timing	Program/Area	Proposed Change	Estimated Impact (millions)	Consequence/ Possible Enrollment Impact
Option 1 PY2028	Premium assistance benchmark	Reduce the enhanced benchmark multiplier for eligible consumers under 200% of the FPL from 10% to 5%	$19.0	Would decrease the amount of New Mexico Premium Assistance or those under 200 percent of the FPL, thought they would still have $0 premium options. This could decrease low-income enrollment as a result.
Option 2 PY 2028	Premium contribution scale	Adopt the Inflation Reduction Act premium sliding scale up to 300% of the FPL and increase required contributions for higher income ranges up to 600% of the FPL	$55.6	Would decrease the amount of New Mexico Premium Assistance for all enrollees, increasing the costs to the consumer. Would also remove all premium assistance for those over 600 percent of the FPL. Could result in coverage loss, especially for those above 600 percent of the FPL.

Source: Lewis & Ellis' 2026 preliminary actuarial report provided to HCA

HCA retains broad discretion in decision-making for affordability criteria, which may substantially impact fund spending. State law authorizes HCA to establish and adjust income-based eligibility criteria for premium and cost-sharing assistance based on available funding (Section 59A-23F-11-12 of state law). More specifically, Rule 8.401.2.8 NMAC governs which affordability criteria and income eligibility parameters HCA may and must consider for marketplace affordability program eligibility. HCA must annually report to legislative committees on the affordability criteria applied, enrollment outcomes, and cost savings by income level, county, and coverage type, but HCA is not currently required to formally document the process by which it establishes eligibility criteria.

Table 14. Eligibility Criteria for Marketplace Affordability Programs

Affordability Criteria: the factors used to determine the amount of premium assistance that will be provided from the fund on behalf of an eligible individual.	
Discretionary	**Mandatory**
The secretary **may consider** these factors for premium assistance criteria: (a) Enrollee's income % per federal standards; (b) % of income needed to buy the state benchmark plan; (c) % of NM residents at/below a given FPL; (d) Federal premium sliding scale.	The secretary **will consider** these factors for out-of-pocket assistance criteria: (a) Enrollee's income; (b) Plan type/metal tier; (c) Actuarial values of qualifying plans; (d) Availability of sufficient appropriations.
The secretary **may consider** these factors for income eligibility parameters: (1) Income distribution of current enrollees; (2) Income distribution of uninsured eligible individuals; (3) Market stability/year-over-year premium trends.	**If funding is insufficient, the secretary must prioritize:** Households under 200%

Source: 8.401.2 NMAC (2026) and NMSA 1978, Section 59A-23F-11-12 (2021)

Because the secretary retains broad discretion in selecting factors to apply to the subsidy programs and income eligibility parameters, the choices made in exercising that discretion can impact program costs as well as who bears them. Accordingly, HCA should document its process for calculating eligibility limits and income contribution caps for marketplace affordability programs, specifically citing the weight of specific factors

considered, and include this in their annual report to the Legislature to promote consistency and transparency.

Additionally, tracking exchange-based utilization data may help policymakers evaluate whether rising HCAF expenditures are primarily driven by enrollment growth, healthcare utilization, or increases in healthcare prices. Utilization of, and experience with, healthcare services on the exchange is not regularly tracked or reported, making it difficult to identify on-exchange services driving healthcare expenditures and assess trends over time. Gathering data on service use by major benefit category could help HCA and the Legislature assess the value of marketplace subsidies by identifying cost drivers. This knowledge can help to inform future decisions regarding affordability program design parameters. Accordingly, this report recommends that moving forward, OSI collect, record, and publicly report utilization measures by major service category and qualified health plan.

Recommendations

The Health Care Authority should:

- Create and document internal policies and procedures for annual program eligibility determinations including actuarial analysis of cost projections under different eligibility options;
- Revise New Mexico Premium Assistance income eligibility and cost sharing structures to improve HCAF sustainability and target support to those with the greatest need. Specifically, HCA should consider prioritizing those at or below 200 percent of the FPL while maintaining some cost sharing for higher-income families on the exchange;

The Office of Superintendent of Insurance should:

- Collect, record, and publicly report utilization for major service categories over time and by plan on the exchange.

Federal Changes to Healthcare Programs May Impact Enrollment and Increase Administrative Burdens

Changes enacted through the 2025 federal budget reconciliation legislation (House Resolution 1 or H.R.1), federal marketplace regulations, and the 2027 Notice of Benefit and Payment Parameters require new eligibility verification, redeterminations, and program integrity activities while increasing uncertainty about future enrollment and subsidy costs. These changes are likely to increase administrative workload for agencies managing the exchange while requiring the state to budget for additional financial obligations and strengthen oversight of marketplace subsidies.

Recent federal rule changes and litigation create significant uncertainty for marketplace enrollment and state budget planning.

Together, H.R.1, the 2025 Marketplace Integrity and Affordability Rule, related litigation, and the 2027 Notice of Benefit and Payment Parameters are expected to reduce marketplace enrollment and shift costs to states. While litigation has stalled or blocked the implementation of some of the new federal provisions, uncertainty around federal policy complicates state planning for marketplace enrollment and budgeting for state subsidy programs.

H.R.1 makes significant changes to Medicaid and marketplace programs that are projected to reduce enrollment, increase uninsured rates, and shift additional costs to states. H.R.1, passed into law by the federal government in July 2025, will make changes to Medicaid in New Mexico in 2026 and 2027. By October 2026, HCA estimates about two thousand non-citizens, like refugees and asylees, will likely be disenrolled permanently. HCA will offer premium subsidies to these individuals through the Puente Health Program, funded by the HCAF. Beginning in 2027, work or activity requirements for Medicaid begin (80 hours per month of work, school, training, or community service), and the state must conduct identity and residency verification of enrollees using addresses and social security numbers. HCA estimates that the work requirements could permanently disenroll approximately 89 thousand adults. H.R.1 does prohibit individuals who are not enrolled in Medicaid because of failure to satisfy new work requirements from receiving any federally funded subsidies. HCA reported in a public BeWell board meeting that it does not currently plan to extend state premium subsidies to these individuals.

In August 2025, CMS issued the federal Marketplace Integrity and Affordability Rule, which directs states to strengthen eligibility review and program integrity. Key provisions included stricter income verification requirements, reinstatement of the requirement that enrollees file taxes and reconcile premium tax credits within one year to retain subsidy eligibility, elimination of the monthly special enrollment period (SEP) for individuals with incomes below 150 percent of the federal poverty level (or an annual income of $24 thousand for an individual) , pre-enrollment verification for many SEPs in federally facilitated marketplaces, a shortened open enrollment period beginning with plan year 2027, and a requirement that certain automatically re-enrolled, fully subsidized enrollees pay at least $5 per month toward premiums pending eligibility redetermination. The rule also excluded Deferred Action for Childhood Arrivals (DACA) recipients from marketplace eligibility and modified actuarial value standards and the treatment of certain essential health benefits. CMS characterized these changes as necessary to reduce unauthorized enrollments, improve risk pool stability and limit improper federal spending, while estimating 725 thousand to 1.8 million individuals would lose marketplace coverage nationally as a result. Many of the program integrity provisions were adopted as temporary measures scheduled to sunset after the 2026 plan year. In response to these provisions, a lawsuit was filed and key provisions of the rule were stayed, causing uncertainty surrounding their implementation and effect on marketplaces. (See Appendix O, table summarizing the status of proposed changes.)

City of Columbus v. Kennedy

In 2025, the Marketplace Integrity and Affordability Rule was challenged; with plaintiffs arguing the rule violated the Affordable Care Act and created administrative burdens for low-income individuals that would result in coverage losses. On August 22, 2025, the U.S. District Court for the District of Maryland stayed several provisions, finding plaintiffs were likely to succeed and faced irreparable harm.

This litigation created implementation uncertainty and stalled/stayed provisions.

(See Appendix O, information about the ongoing litigation and rule changes.)

Uncertainty was further exacerbated by the Center for Medicare and Medicaid Services' (CMS) delayed release of the Proposed Notice of Benefit and Payment Parameters (NBPP) for plan year 2027. This year, CMS released the proposed NBPP for 2027 for comment in early February and did not finalize it until May 15, 2026, giving marketplaces and regulators significantly less time to implement rules and certify plans before open enrollment begins.

Under the finalized NBPP for plan year 2027, New Mexico will face a complex mix of administrative burdens, enrollment pressures, and significant new financial obligations, particularly around benefit defrayal. The finalized Notice of Benefit and Payment Parameters implements provisions of H.R.1 and revisits the 2025 Marketplace Integrity and Affordability rule. Combined, its provisions are projected to reduce national marketplace enrollment by 1.2 million to 2 million people and lower federal premium tax credit spending by up to $10.15 billion in 2027. Notably, one provision of the finalized Notice of Benefit and Payment Parameters would require a retrospective analysis dating to 2011 to calculate the state's responsibility for defraying the cost of benefits offered beyond the benchmark essential health benefits. While the fiscal impact of the defrayal is currently unknown, it is likely a significant obligation.

The Notice of Benefit and Payment Parameters is a document that sets standards for health insurance marketplaces, as well as for insurers, brokers, and agents. It is typically posted late in the calendar year, to allow for a required 30-day comment period when stakeholders can voice concerns and provide recommendations, before it is finalized around January prior to the year it covers.

BeWell could take steps to strengthen program integrity on the exchange.

While BeWell has improved marketplace operations and transparency, recent federal emphasis on program integrity highlights opportunities to strengthen eligibility verification. BeWell's current enrollment process does not verify whether applicants have access to affordable employer-sponsored insurance beyond the applicant's attestation. Lacking access to affordable employer-sponsored insurance is a key eligibility criterion for marketplace subsidies. In addition, BeWell relies primarily on federal data sources to verify applicant information and could improve eligibility determinations by incorporating available state employment and income records. (See Appendix P, details regarding BeWell application process.)

BeWell is not checking for an offer of affordable coverage from an employer during the application process. CMS is responsible for the oversight and monitoring of state exchanges pursuant to federal regulation (45 Code of Federal Regulations Section 155.1200, general program integrity and oversight responsibilities, and 45 CFR Section 155.1210, maintenance of records). Under these provisions, state exchanges are required to conduct a defined set of oversight activities to track and monitor how they are meeting ACA program integrity standards. In addition, state exchanges are required to comply with exchange-related policies and operational requirements set forth in statute, regulations, and guidance. The State-based Marketplace Annual Reporting Tool (SMART) was developed to monitor and evaluate state-based exchange compliance with applicable regulations and guidance.

Table 15. BeWell Application Process

Timing and Eligibility: Open enrollment runs November 1 – January 15. (Applicants otherwise need a Qualifying Life Event for Special Enrollment Period)
Individuals may apply online, by phone, or by mail using BeWell's designated application. (Certified assisters are available to help at no cost)
In their application, individuals attest to the truth of the information provided; BeWell verifies information using trusted data sources (IRS) and (SSA) to determine eligibility for financial assistance
If information provided by the individual cannot be verified, BeWell will give the individual 90 days to provide additional information. The individual will be determined conditionally eligible, pending submission and verification of requested documentation
Enrollees must make binder payments directly to their health plan insurance carrier to complete enrollment and effectuate coverage (the binder payment is the first month's full premium)

Source: BeWell

The most recent completed SMART audit (for 2025) showed that BeWell is generally following CMS requirements; however, BeWell is not verifying eligibility related to enrollment in or offer of an eligible employer-sponsored plan beyond the enrollee's attestation. Starting in 2026, BeWell uses the federal Employees Health Benefits database to double check the applicant's attestation of no employer sponsored coverage and is allowed by federal rules to rely on attention when data is unavailable. However, without further verification, exchange enrollees could receive state and federal subsidies even though they have an offer of employer sponsored coverage that does not exceed 9.96 percent of their income. BeWell should consider creating a form that applicants with W-2 income would complete during the application process to verify their employer does not offer sufficient and affordable health insurance coverage. Virginia's insurance marketplace requires such documentation, providing a form the applicant can have signed by the employer or accepting letters from employers stating coverage is not offered or is unaffordable by federal standards.

CMS also gives state-based exchanges the option of further verifying enrollee attested information against state collected sources. For example, the New Mexico Workforce Solutions departments collect New Mexico specific employment and income data. BeWell does not currently use state

sources for enrollment verification checks but could add this source as a way to ensure the most current income information when checking for subsidy eligibility and expedite the application process for some enrollees.

Recommendations

BeWell should:

- Enhance income verification with state data from the Workforce Solutions Department (WSD); and
- Consider and evaluate the implications of adding documentation of an enrollee's no-offer of affordable employer-sponsored coverage.

Appendix A. Progress on Past Recommendations

Table 16. Relevant Recommendations from the 2015 LFC Program Evaluation of NMHIX

Recommended Entity	Related Finding	Significant Recommendation	Known Progress to Date
Legislature	Oversight of NMHIX could be improved.	Require OSA review and approve NMHIX annual financial audit.	NMHIX conducts and publishes financial audits.
Legislature	Transparency could be improved.	Require NMHIX reporting subject to the Accountability in Government Act and Sunshine Portal.	2019 amendments required NMHIX be subject to the AGA and Sunshine Portal Transparency Act. (SB 294).
NMHIX	Enrollment for individuals remains low.	Develop targets, outcome measures, tracking, and reporting tied to enrollment, determine minimum enrollment and other measures justifying NMHIX format/operations.	Enrollment in the exchange has hit record numbers for 2026. BeWell maintains a public dashboard of key enrollment metrics. Public Board meetings are held quarterly, where financial, marketing and operational activities are presented.
NMHIX	Expensive marketing had limited impact.	Prioritize key outlays in outreach and education for targeted groups, including additional walk-in centers and hours.	BeWell is now a year-round brand, with better target marketing and outreach activities, enhanced affordability, more enrollment periods, and a special emphasis on reaching Native American communities. Extended walk-in and call center hours during Open Enrollment Period, as well as the addition of chat option via BeWell's new platform, broaden options for prospective and current customers.
NMHIX	Risk for procurement issues.	Develop administrative policies and procedures to detail the procurement process, from planning to product or service delivery, documentation of selection committee, and train responsible parties.	NMHIX is now subject to the Procurement Code following SB 294 (2019) and has implemented structured processes and procedures to support the procurement function. Six staff members have completed training and are certified as Certified Procurement Officers (CPOs) through the NM EDGE program, ensuring procurement activities align with established standards and best practices.
NMHIX	Transparency could be improved.	Improve website content and keep it up to date; post committee meetings and minutes.	Committees and the full board are in full compliance with Open Meetings Act requirements for meeting noticing, agenda posting, and minutes posting following meetings. Enrollment data is also publicly available on the website and updated monthly during the year and weekly during Open Enrollment.

Source: LFC files and BeWell

Appendix B. BeWell Revenues and Expenditures

BeWell operations are funded through a fee assessed to insurance carriers. BeWell is funded primarily through carrier assessments, or fees charged to health insurance companies that participate in the exchange. Fees must not exceed the costs of operating the exchange. When assessments exceeded operating costs in 2023, BeWell reduced assessments, which totaled $23 million in 2025. Carrier assessment revenues are to be an amount necessary solely for the operating cost of the exchange. BeWell reduced carrier assessments for 2024 and 2025 due to decreased operating expenses associated with changed billing practices. See below for BeWell revenues and expenditures since 2022.

Table 17. BeWell Revenues and Expenditures
(in thousands)

	2022	2023	2024	2025
Operating Revenues				
Carrier assessments	$26,061.0	$28,074.9	$25,914.8	$23,000
Operating Expenses				
Technology and project management	$14,730.1	$14,023.8	$10,390.5	$13,791.7
Salaries and employee benefits	$3,818.0	$5,156.4	$6,220.5	$6,775.4
Operations	$1,763.3	$2,008.7	$3,053.6	$2,814.9
Consumer and stakeholder engagement and support	$3,201.3	$2,426.0	$2,021.3	$2,621.0
Plan management	$565.0	$398.7	$400.0	$400
Professional services and board	$1,509.6	$635.0	$379.4	$282.3
Total Operating Expenses	**$25,587.3**	**$24,648.6**	**$22,465.3**	**$26,685.2**
Non-operating Revenues (Expenses)				
Investment income (loss)	$(1,774.3)	$1,398.1	$1,389.4	$2,229.8
Grant revenue	$650.0	$0	$0	$0
Gain (loss) on sale of capital assets	$(1.7)	$0.5	$0	$0
Interest expense	$(11.6)	$(14.2)	$(38.2)	$(30.9)
Contractual subsidy	$200.0	$250.0	$0	$0
Other	$0	$0	$21.7	$(16.4)
Total Non-operating Revenues (Expenses)	**$(937.7)**	**$1,634.4**	**$1,372.9**	**$2,182.4**

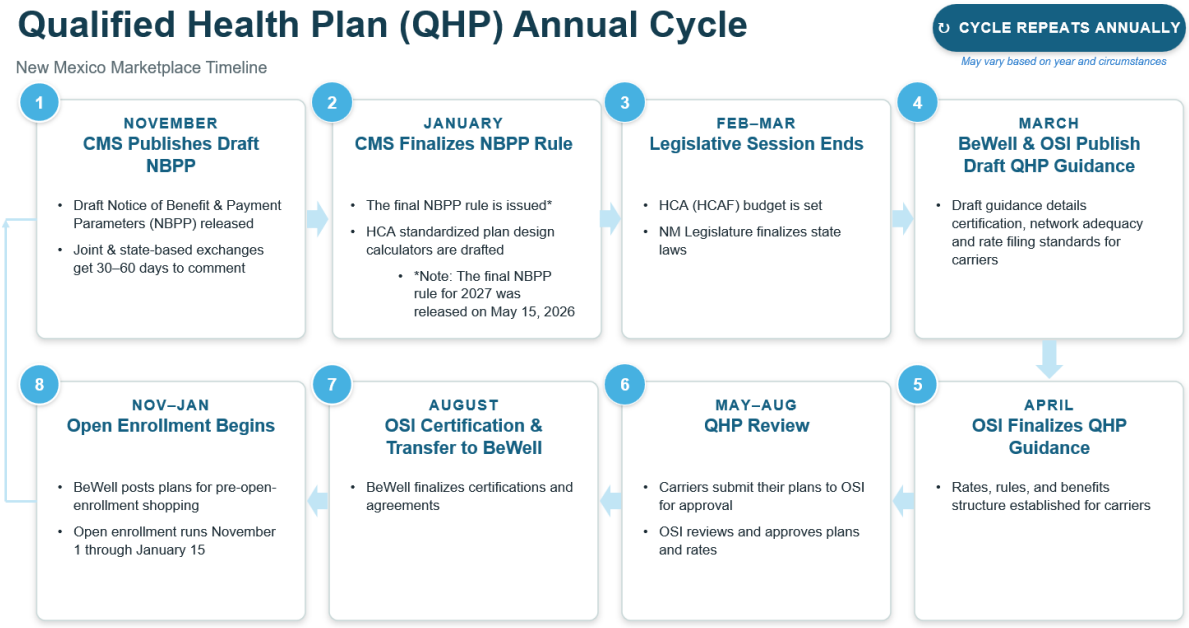
Source: BeWell Financial Audit

Appendix C. Office of the Superintendent's Regulatory Responsibilities

In addition to rate review and plan approval, OSI is responsible for a number of broader regulatory functions, such as rate and form review, network adequacy oversight, and commercial market product regulation. NMSA 1978, Section 59A-23F-3(B) states "the Exchange shall not duplicate, impair, enhance, supplant, infringe upon or replace, in whole or in any part, the powers, duties, or authority of the Superintendent, including the Superintendent's authority to review and approve premium rates pursuant to the Insurance Code." See also NMSA 1978, Sections 59A-18-13.2 and 59A-18-13.3 related to health care plan rates filing requirements and ground and procedures for approval and disapproval, 59A-23F-18-16.2 related to the health insurance plan form and rate filings and compliance with federal law. See also NMSA 1978, Section 59A-23F-6.1(A) requiring the Board of Directors of the Exchange and the Superintendent to consult regarding "(1) establishing policies and procedures for the review and recommendation of health benefits plans to be offered on the exchange; (2) determine additional minimum requirements for a health insurance issuer to be considered for participation in the exchange; and (3) determine standards and criteria for health benefits plans to be offered through the exchange that offer an optimal level of choice, value, quality and service and that are in the best interests of qualified individuals and qualified small employers.

Appendix D. Qualified Health Plan Certification Process

Qualified health plans are health insurance plans that meet federal requirements established by the Affordable Care Act (ACA). Qualified health plans are the only plans that can be offered through an ACA marketplace. Pursuant to federal statute, a qualified health plan is one that has received certification from an exchange; provides the essential health benefits package; is offered by a licensed issuer in good standing; and meets additional requirements established by the U.S. Department of Health and Human Services. In New Mexico, four medical insurance carriers and one dental carrier are offering plans on the exchange for the 2026 plan year. The medical carriers are Blue Cross Blue Shield of New Mexico (BCBSNM), Presbyterian Health Plan, Molina Healthcare, and United Healthcare, offering over 70 different on-exchange health plans for 2026. Qualified health plans are reviewed and certified annually.



Source: BeWell

Appendix E. New Mexico Benchmark Plan and 10 Essential Health Benefits

All health insurance plans offered through BeWell must cover 10 essential health benefits (EHB). Specific services in each benefit category can vary by plan and carrier, but consumers can see whether plans offered through BeWell cover certain prescription medications or specific benefits before they enroll. Notably, these essential benefits do not include dental or vision care.

Each state exchange has a benchmark health insurance plan that serves as a baseline for the minimum scope of benefits that plans offered on the exchange must cover at equal or greater value. After the ACA was implemented, states chose their benchmark plan from the most popular plans that included the 10 essential health benefits. In 2020, the Centers for Medicare and Medicaid Services (CMS) provided states with the option to select a set of benefits that would become the state's benchmark plan, allowing OSI to add benefits beyond the 10 essential health benefits.

Table 18. 10 Essential Health Benefits

1	Pregnancy, maternity, and newborn care
2	Mental health and substance use disorder services
3	Pediatric services
4	Prescription drugs
5	Rehabilitative and habilitative services and devices
6	Preventative and wellness services and chronic disease management
7	Emergency services
8	Hospitalization
9	Laboratory services
10	Ambulatory patient services

Source: Section 42 U.S.C. § 18022(b) and NMSA 1978, Section 59A-18-16.2(B)

BeWell Dental Plans

BeWell offers stand-alone dental plans for exchange enrollees, costing between $10 to $35 a month on average. After 2026 open enrollment, about 24 thousand people are enrolled in a dental plan. Ninety-three percent of those enrollees have both a medical and dental plan. Premium and cost-share subsidies are not offered for dental plans because adult dental services are not an essential health benefit.

Table 19. NM Benchmark Plan Coverage

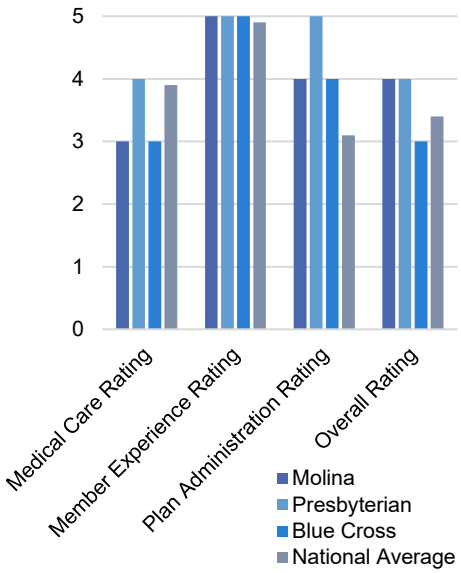
Benefit Category	Coverage?	Benefit	Coverage?
Abortions-Elective	Not Covered	Laboratory Outpatient and Professional Services	Covered
Cosmetic Services	Not Covered	Maternity Care- Delivery and Impatient Services	Covered
Dental- Major Dental Adult	Not Covered	Mental Health/ Behavioral Health Inpatient	Covered
Dental- Routine Adult	Not Covered	Mental Health/ Behavioral Health Outpatient	Covered
Nursing Home Care - Long Term/ Custodial	Not Covered	Nutritional Counseling/ Support	Covered
Orthodontia - Adult	Not Covered	Other Practitioner Visit	Covered
Private Duty Nursing	Not Covered	Orthodontia - Child	Covered
Routine Eye Exam for Adults	Not Covered	Outpatient Facility Fee	Covered
Routine Foot Care	Not Covered	Outpatient Surgery	Covered
Acupuncture Treatment	Covered	Parental and Postnatal Care	Covered
Allergy Testing and Treatment	Covered	Preventative Care/ Screening/ Immunization	Covered
Ambulance Services	Covered	Primary Care Visits	Covered
Bariatric Surgery	Covered	Prosthetic Devices	Covered
Chemotherapy	Covered	Radiation	Covered
Chiropractic Care	Covered	Reconstructive Surgery	Covered
Dental- Basic Care for Children	Covered	Rehabilitative Occupational and Rehabilitative Physical Therapy	Covered
Dental- Check-up for Children	Covered	Rehabilitation Services- Outpatient	Covered
Dental- Major Dental Child	Covered	Routine Eye Exam for Children	Covered
Dental- Accidental Injury	Covered	Skilled Nursing Facility	Covered
Diabetes Education	Covered	Specialist Visit	Covered
Dialysis	Covered	Speech Therapy	Covered
Durable/Home Medical Equipment	Covered	Substance Use Inpatient Services	Covered
Emergency Services	Covered	Substance Use Outpatient Services	Covered
Eyeglasses for Children	Covered	Temporomandibular Joint Disorder	Covered
Habilitative Services	Covered	Transplants	Covered
Hearing Aids	Covered	Urgent Care	Covered
Home Health Servies	Covered	Weight loss programs	Covered
Hospice Services	Covered	Well-baby visits and care	Covered
Imaging and Diagnostic	Covered	X-rays and diagnostic imaging	Covered
Infertility Treatment	Covered	Generic Prescription Drugs	Covered
Infusion Therapy	Covered	Non-preferred brand drugs	Covered
Inpatient Hospital Services	Covered	Preferred brand drugs	Covered
Impatient Physician and Surgical Services	Covered	specialty drugs	Covered
		weight reduction drugs	Covered

Source: CMS

Appendix F. 2026 Average Qualified Health Plan Quality Rating by State

In New Mexico, health plans on the exchange earned a quality rating of 3.7 out of five stars for 2026, slightly above the national average of 3.4. The ACA requires the U.S. Department of Health and Human Services to administer an enrollee satisfaction survey that assesses consumer experience with health plans offered on the exchange. CMS reports the survey results in three categories: member experience, medical care, and plan administration. New Mexico exchange insurers rate best for member experience and somewhat worse for medical care, remaining close to the national average in both categories. For plan administration, however, New Mexico is well above the national average.

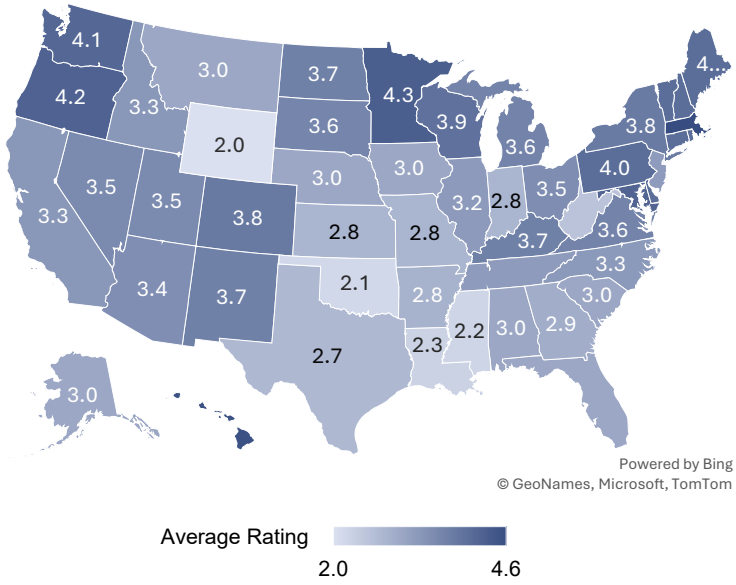
Chart 33. 2026 QHP Quality Rating by Issuer
(out of five)



Note: United Healthcare is not rated for 2026 because they have only been on the New Mexico exchange for two years. They will be rated after three consecutive years.

Source: CMS

Figure 4. Average QHP Quality Rating 2026
(out of five)



Source: CMS

Appendix G. BeWell Plan Tiers and Types

Qualified health plans offered through BeWell are grouped into cost levels, or metal tiers, with varying monthly premiums and out-of-pocket costs. The Affordable Care Act requires three levels of plans on the BeWell marketplace, at a minimum: gold, silver, and bronze. These metal tiers trade off monthly premiums against out-of-pocket costs for care. Gold plans have the highest monthly premiums but the lowest out-of-pocket costs, while bronze plan consumers pay less each month in premiums but more for appointments, prescriptions, and other services. For all three metal tiers, eligible enrollees can also receive state or federal subsidies, or both, that reduce monthly premiums, depending on their household incomes.

New Mexico also offers additional plans for enrollees with incomes up to 400 percent of the FPL, or $64 thousand annually for an individual. Turquoise plans, which are the state's version of the federal platinum tier, cover at least 90 percent of costs by reducing out-of-pocket expenses such as deductibles and copays.

Clear cost plans are standardized health insurance plans offered by all insurance carriers with the same fixed out-of-pocket costs for primary care visits, generic prescriptions, and emergency services. Clear cost plans allow consumers to compare plans within a tier based on premiums, benefits, and provider networks while other costs stay constant.

Figure 5. BeWell Health Insurance Plan Tiers

Source: bewellnm.com

Appendix H. Federal Cost-Sharing Reductions and New Mexico State Out-of-Pocket Assistance Comparison

Table 20. Federal CSRs vs. NM SOPA

	Federal CSRs	New Mexico SOPA
Core Purpose	Reduce deductibles, copays, coinsurance, and out-of-pocket maximums for eligible enrollees	Reduce deductibles, copays, coinsurance, and out-of-pocket maximums for eligible enrollees
Mechanism	Insurers offer enhanced plan variants with increased actual value	Insurers offer enhanced plan variants (turquoise plans) with increased actuarial value
Enrollment	Must enroll through ACA marketplace; must qualify for premium tax credits	Must enroll through BeWell; must qualify for federal premium tax credits
Payment to Insurers	No payment to plans from the federal government	Monthly advance payments + annual reconciliation based on actual utilization
Out-of-Network Claims	Generally not eligible for cost-sharing reductions	Generally not eligible for SOPA reductions
Income Eligibility	Up to 250% of the FPL	Up to 400% of the FPL (expanded from 300% in 2025)
Eligible Plan Tiers	Silver plans only	Silver plans (<200% of the FPL); Gold plans (200-400% of the FPL)
Actuarial Value Range	73%, 87%, or 94% depending on income band	90%, 95%, or 99% depending on income band
Funding Source	Direct federal appropriations from 2014-2017; Currently indirectly financed using "silver loading" mechanism	NM Health Care Affordability Fund (HCAF) funded by state health insurance premium surtax
Administration	Federal HHS & IRS	New Mexico Health Care Authority and BeWell

Note: Blue cells represent similarities between Federal CSRs and NM SOPA. Pink cells represent how these programs differ.

Source: Healthinsurance.org and HCA

HCA pays state out-of-pocket assistance payments directly to the issuer in the form of monthly advance payments, subject to bi-annual reconciliation. In 2024, there were two state out-of-pocket assistance reconciliation cycles. During the first reconciliation cycle in 2024, insurers owed back $507 thousand dollars. However, the amount owed back to insurers was $3.2 million dollars, meaning in sum, the state owed back a total of $2.7 million dollars. During the second reconciliation cycle in 2024, only one insurer owed money back: meaning the remaining carriers were owed a collective $1.2 million. The payments are calculated by multiplying the gross member-level premium (before any subsidies) by the applicable SOPA variant multiplier shown in Table 21.

Table 21. 2026 SOPA Variant Multipliers

Income (FPL)	Turquoise Variant	Metal Tier	SOPA AV	SOPA Variant Multiplier
Up to 150%	Turquoise 1	Silver	99%	.042
150 – 200%	Turquoise 2	Silver	95%	.066
200 - 400%	Turquoise 3	Gold	90%	.079

Source: HCA

Table 22. Federal CSR Actuarial Values
(Originally 70% AV)

FPL	CSR AV
Below 150	94
Between 150 and 200	87
Between 200 and 250	73

Source: ACA Section 1402

Appendix I. Breakdown of 2026 Rate Increases on the New Mexico Marketplace

Table 23. 2026 Rate Increases by Reason

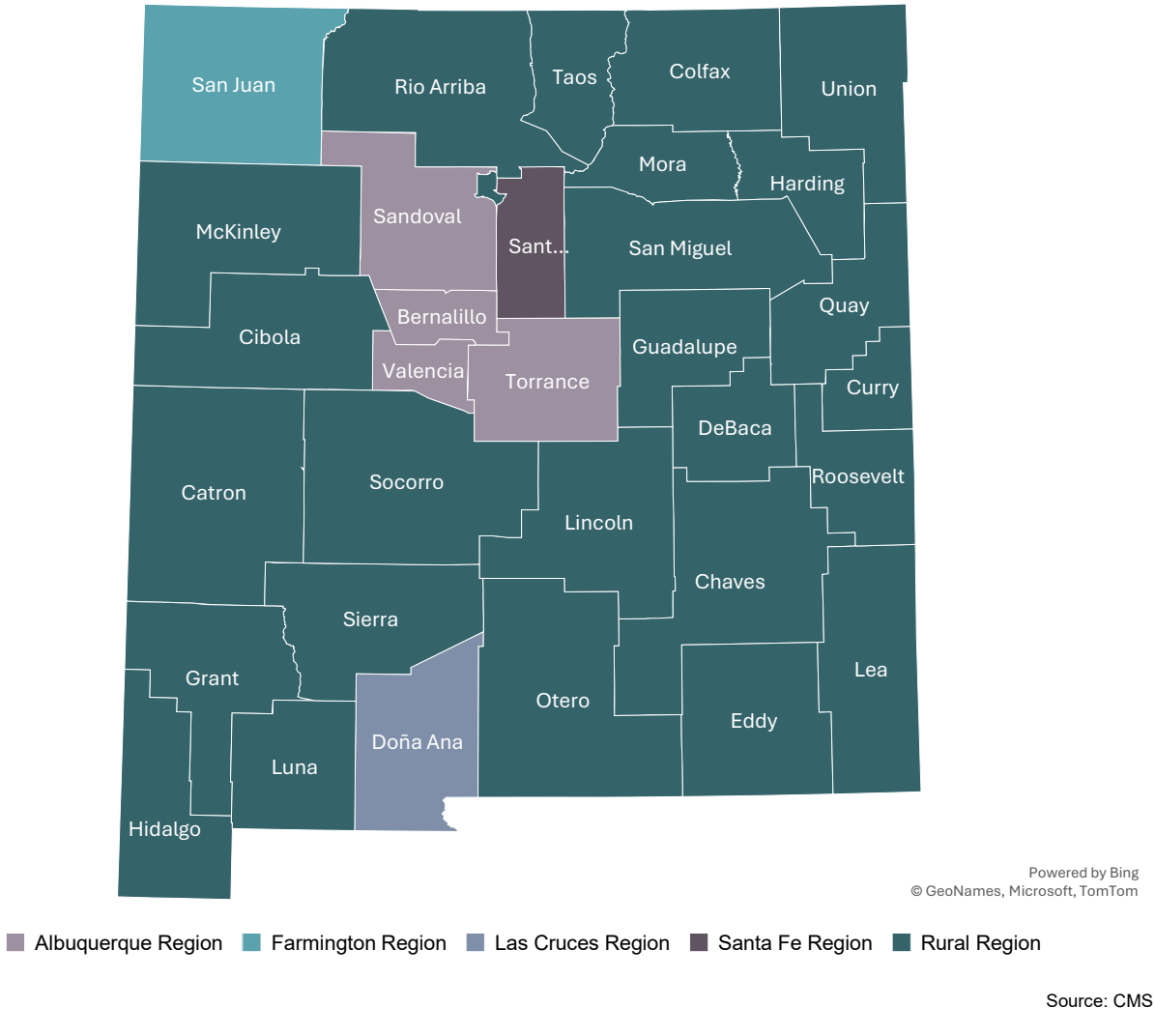
Reason	BCBS	Presbyterian	United	Molina
Change in Claims Experienced (Utilization)	30.9%	20.5%	69.7%	16.3%
Population/Demographic adjustments	1.5%	2.9%	3%	-9.0%
Federal Regulation Adjustments	0.0%	0.8%	0%	0%
State Regulation Adjustments	-0.6%	-1.8%	0%	-1.0%
Change in administrative cost	0.1%	3.2%	1.3%	-2.6%
Drug/ Medical Costs	0.4%	-1.5%	0%	-1.8%
Other	3.2%	3.8%	-17.3	6.2%
Total*	38.6%	27.5%	52.25%	15.3%

Note: The individual rate change factors don't add up to the total average increase because the overall increase is calculated using weighted and compounding effects, not simple addition.

Source LFC analysis of issuer actuarial memorandums.

Appendix J. New Mexico Geographic Rating Regions

Figure 6. Geographic Rating Areas for Marketplace



Source: CMS

Appendix K. Methodology for Monthly Coverage Cost for Most Commonly Enrolled-In Plans Chart

This chart compares the monthly cost of premiums for these four plans: 1) state employee health insurance plans (SHB), 2) non-Medicare plans on retiree health care (RHC), 3) New Mexico Public School Insurance Authority (NMPSIA), and 4) the New Mexico Health Insurance Exchange (Exchange). Because Medicaid recipients do not pay a premium, Medicaid cost is estimated using per-member-per-month (PMPM) spending rather than a premium amount, with assumptions detailed below used to approximate an individual and a family cost.

Premium and cost data for the five insurance categories were compiled from publicly available data published by the state, with exchange data drawn from BeWell enrollment data provided to LFC staff. Rather than capture the full range of plan options available within each category, this analysis relies on representative plans reflecting a typical enrollee. Because eligibility structures, benefit designs, and cost-sharing rules differ substantially across these programs, the comparison presented here reflects premium cost alone and does not account for differences in covered benefits, deductibles, or out-of-pocket maximums. With the exception of Medicaid, this chart should be interpreted as a comparison of monthly premium costs, rather than the total overall cost of coverage. Data reflects rates published for State Fiscal Year 2026 and are current as of July 1, 2026.

State Health Insurance (SHB): Reported figures reflect the published per-pay-period contribution amounts of the most commonly enrolled plan, the HMO. This analysis assumes a standard 80/20 premium split, with the state covering 80 percent of the cost and the employee covering the remaining 20 percent. The HMO's gross bi-weekly premium rate is $347.29 for individuals and $1,025.92 for families; multiplying by two pay periods to yield a monthly cost of $694.58 and $2,051.84 respectively.

Retiree Health Care (RHC): Reported figures reflect the published per-pay-period contribution amount for the most commonly enrolled plan, the Premier (Non-Medicare) plan. The Premier plan's monthly premium cost is $960.82 for individuals and $2,664.68 for a family of four. The amount the state covers varies with years of service; this report assumed 25 years plus, which is a 63/37 split.

New Mexico Public School Insurance Authority (NMPSIA): Reported figures reflect the premium costs for a single person and a family of four on the most popular plan. This analysis assumes that the state covers 80 percent of the premium costs, while the individual/families pick up the remaining 20 percent. The most popular plan on NMPSIA has a $960 monthly premium cost for individuals and a $2,834.62 monthly premium cost for families.

Medicaid: Medicaid costs were derived from published per-member-per-month (PMPM) figures rather than a premium, since most Medicaid enrollees do not pay a premium for coverage. For the individual estimate, the PMPM cost reflects a Medicaid expansion adult. This funding distribution for this amount was determined using an assumed Federal Medical Assistance Percentage (FMAP) blend of 90 percent federal and 10 percent state to isolate the state's share of the total cost. For the family estimate, coverage was modeled using four Medicaid expansion adults, again using an FMAP blend of 90 percent federal and 10 percent state funding.

New Mexico Health Insurance Exchange (NMHIX or Exchange): Reported figures reflect the average premium and subsidy amounts paid for a 2026 Turquoise 3 plan for individuals between federal poverty level (FPL) 200-300, or $32 thousand to $48 thousand annually, because this is where enrollment is clustered. For a family of four, the report used the average premium and subsidy amounts paid for a Turquoise 3 plan for enrollees with an FPL 300 and 400, between $99 thousand to $132 thousand annually, to avoid reporting misleading data (since children under 240 percent of the FPL are eligible for Children's Medicaid).

Note on the comparability of state share: SHB, RHC, and NMPSIA receive no federal funding; the state's share is a fixed contractual percentage of the full premium and is identical for every enrollee in the plan, regardless of age, income, or location. Medicaid receives federal funding at a fixed matching rate. For the exchange, federal support is income-conditioned, and the state's share is calculated per enrollee as the difference between the benchmark premium and the sum of the enrollee's income-based contribution and any federal premium tax credit. The exchange figure shown in Chart 14 therefore represents one point on a wide distribution and is not directly comparable to the fixed shares used for the other programs. See Tables 11 and 12 for the range of state contributions across income levels.

Appendix L. Exchange Plans Out-of-Pocket Drug Costs

Table 24. Average Out-of-Pocket Drug Costs for 2026 Exchange Plans

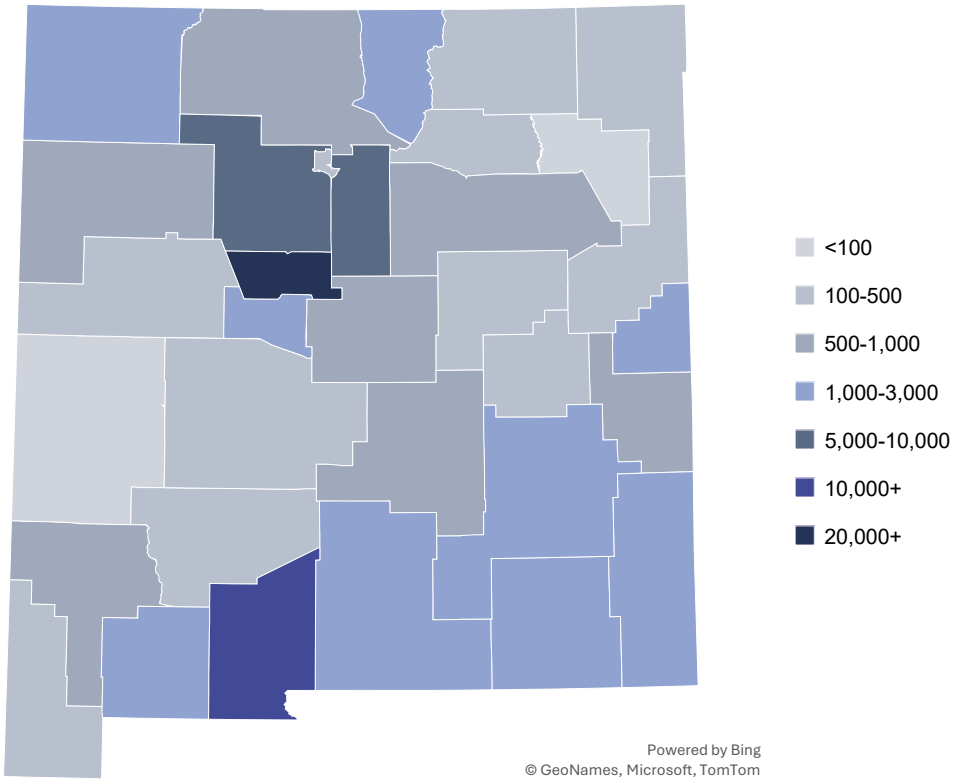
	Generic		Preferred Brand		Non-Preferred Brand		Specialty	
	Copay	Coinsurance	Copay	Coinsurance	Copay	Coinsurance	Copay	Coinsurance
Turquoise 1	$ 1.00	0%	$ 5.63	20%	$ 11.29	21%	$ 8.57	25%
Turquoise 2	$ 3.22	N/A	$ 11.50	20%	$ 50.00	16%	$ 25.00	18%
Turquoise 3	$ 6.00	N/A	$ 17.50	20%	$ 100.00	24%	$ 50.00	26%
Gold	$ 14.18	N/A	$ 36.00	20%	$ 100.00	33%	$ 75.00	40%
Silver	$ 24.89	20%	$ 69.50	30%	$ 250.00	33%	$ 100.00	42%
Bronze	$ 10.00	20%	N/A	30%	N/A	35%	N/A	45%

Note: All in-network.
Note: Plan will require either a copay or coinsurance, not both for one service. Coinsurance for drugs is often after the deductible is reached. Copay is often after deductible for specialty drugs.

Source: LFC analysis of OSI data

Appendix M. 2026 Exchange Enrollment by County

Figure 6. 2026 Enrollment by County



Note: As of January 2026

Source: LFC analysis of BeWell data

Table 25. 2026 Enrollment by County

County	Count of Members	County	Count of Members	County	Count of Members
Harding	16	Colfax	451	Eddy	1,851
Catron	97	Cibola	474	Taos	1,893
Union	115	Torrance	516	Otero	1,973
De Baca	118	Roosevelt	554	San Juan	2,088
Hidalgo	128	Mckinley	630	Lea	2,143
Mora	145	San Miguel	795	Chaves	2,443
Guadalupe	152	Rio Arriba	838	Valencia	2,498
Quay	259	Grant	891	Sandoval	5,267
Socorro	374	Lincoln	975	Santa Fe	8,074
Los Alamos	375	Luna	1,125	Dona Ana	10,795
Sierra	413	Curry	1,256	Bernalillo	25,698

Note: As of January 2026

Source: LFC analysis of BeWell data

Appendix N. BeWell Native American Enrollment and Subsidies

Native American enrollment on the exchange has increased from less than 500 individuals in 2022 to over 3,000 in 2026. BeWell plans supplement Indian Health Services (IHS) and Tribal Health Care Center coverage by paying for care at providers outside the IHS and Tribal Health Care Center service area. Native American Premium Assistance (NAPA) program provides enhanced premium assistance for Native Americans who are members of a federally recognized Tribe. Specifically, NAPA provides:

- Free premium options for individuals and families with incomes up to 300 percent of the FPL (or $48 thousand annually for an individual); and
- Reduced premiums for individuals and families with incomes between 300 and 400 percent of the FPL (between $48 thousand and $64 thousand for an individual).

Zero Cost Sharing Plans are available to members of federally recognized Tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders whose income is between 100 and 300 percent of the federal poverty level and qualify for premium tax credits. Enrollees in these plans don't pay copayments, deductibles, or coinsurance when getting care from an Indian healthcare provider or when getting essential health benefits with the plan.

Appendix O. Status of Proposed Changes for Plan Year 2027 Notice of Benefit and Payment Parameters

Table 26. Provisions of the 2025 Marketplace Integrity and Affordability Rule Challenged by *City of Columbus v. Kennedy*

Provision of Rule	What it would have done	Outcome
Automatic Re-enrollment Penalties	Charged $5/month to consumers in $0-premium plans who did not actively update their eligibility information.	Stayed
Past-Due Premium Coverage Denials	Allowed insurers to deny guaranteed issue coverage to applicants with past-due premiums from prior plans.	Stayed
Failure to Reconcile (FTR) Rule	Cut off advance premium tax credits (APTC) after one year of failing to file/reconcile taxes, rather than two consecutive years.	Stayed
SEP Eligibility Verification	Required pre-enrollment documentation for special enrollment period (SEP) applicants.	Stayed
Shortened Open Enrollment Period	Cut the open enrollment window from the 45 days (Nov 1 – Jan 15) to 45 days ending Dec 15, eliminating the January extension.	Stayed
Data Matching / Income Verification	Required additional documentation from applicants under 100% of the FPL or without available tax data to verify income attestations.	Stayed
Actuarial Value (AV) Calculations	Widened allowed deviation from AV thresholds, permitting plans to offer less generous coverage than current rules require.	Stayed
Premium Adjustment Percentage Formula	Changed the method for calculating the premium adjustment percentage, raising maximum out-of-pocket costs and premium caps for enrollees.	Not Stayed
Elimination of 60-day income inconsistency extension	Removed the automatic 60-day period given to enrollees to resolve discrepancies in household income data.	Not Stayed

Source: City of Columbus v. Kennedy 1:26-cv-02215

Table 27. NBPP Final Rule: Policy Changes, Effective Dates, and Applicability

Provision	Changes from Proposed to Final Rule, if any	Effective Date	Applies to SBMs?
New Expectations for Marketplaces and State Insurance Regulation			
Verification of data matching inconsistencies	Finalized as proposed	2027	Yes
Loss of eligibility for failure to file and reconcile tax data	Finalized as proposed	2027	Yes
State Exchange Improper Payment Measurement	Finalized as proposed	2027	Yes
Expanded eligibility for catastrophic plans	Finalized as proposed	2027	Yes
Standards for state defrayal of essential health benefits	Finalized with modifications	2028	Yes
Coverage of routine adult dental services	Finalized as proposed	2027	Yes
Reporting of cost-sharing reduction load	Regulatory text not finalized but insurers required to report	2027	Yes
New Optional Policies for States			
Higher cost-sharing for bronze and catastrophic plans	Finalized as proposed	2027 for bronze plans 2027 for catastrophic plans	Yes, at state option
Multi-year catastrophic plans	Finalized with modifications	2027	Yes, at state option
Non-network plans	Finalized with modifications	2027 for SBMs and SBMs on the federal platform 2028 for the federally-facilitated marketplace	Yes, at state option
Network adequacy standards	Finalized with modifications	2027 for SBMs and SBMs on the federal platform 2028 for the federally-facilitated marketplace	Yes, at state option
Standards for essential community providers	Not finalizing reduction in access threshold; other provisions finalized as proposed	2027	Yes, at state option
Additional Rule Provisions Applying to Marketplaces			
Narrowing eligibility for non-citizens	Finalized as proposed	2027 [2026 for non-citizens with income below 100% of the FPL]	Yes
Elimination of low-income special enrollment period	Finalized as proposed	Already in effect through 2026; final rule extends permanently	Yes
Requirements for SMB transitions	Finalized as proposed	Effective date of final rule	N/A
Eliminating standardized plans and plan limits	Finalized as proposed	2027	No
SBMs and enhanced direct enrollment	Not finalized	N/A	N/A
User fees	Reduced from proposed rule	2027	No
Verification of special enrollment period eligibility	Finalized as proposed	2027	No
Additional Rule Provisions Relating to Insurance Regulation			
Premium payment thresholds	Finalized as proposed	Already in effect for 2026; final rule extends permanently	Yes
New requirements for brokers	Finalized with minor modifications	2028 (for open enrollment in fall of 2027)	No

Source: State Health & Value Strategies

Appendix P. BeWell's Application Process

BeWell uses a single streamlined application for enrollment in marketplace health insurance coverage, which individuals may submit online, by phone, or by mail. BeWell uses the information collected to determine an individual's eligibility to enroll in medical and dental coverage and to apply for financial assistance from both the federal government and state. The same application can also be used to apply for Medicaid. To enroll in coverage on the exchange at all, an individual must be a New Mexico resident, must be a U.S. citizen, national, or lawfully present non-citizen, and must not be incarcerated. To receive financial assistance, applicants must additionally meet criteria related to household income, tax filing status, and lack of access to other minimum essential coverage, like Medicaid, Medicare, or affordable employer-sponsored insurance.

BeWell verifies exchange subsidy eligibility and amounts. When individuals apply for marketplace coverage, they attest to the truth of the information provided by signing the application. BeWell then checks that information against trusted data sources such as the Internal Revenue Service and the Social Security Administration to determine eligibility to purchase coverage, and if applicable, eligibility for marketplace subsidy programs. If an applicant attests to meeting eligibility criteria but it cannot be verified, BeWell sends a notice to request additional documentation. BeWell considers applicant's attestations to be "reasonably compatible" with the data sources if the amount attested to is no more than 50 percent or $12,000 lower (whichever is greater) than the information provided by the data sources. Reported income that is higher than information from the trusted data source will be accepted. However, if the data returned is deemed not reasonably compatible, the individual will be asked to provide further documentation to verify income. Enrollees are required to report any changes that affect eligibility for coverage or financial assistance, such as employer-sponsored coverage or changes to income. BeWell also periodically rechecks enrollee data, and premiums and subsidy amounts may change if a redetermination finds eligibility has changed.