TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 27 UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATING THE MEDICAL LOSS RATIO

13.10.27.1 ISSUING AGENCY: New Mexico Office of Superintendent of Insurance.
[13.10.27.1 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.2 SCOPE: This rule applies to all health care insurers, health maintenance organizations, or health care plans that are required to obtain a certificate of authority or licensure in this state or which provide, offer or administer managed health care plans.
[13.10.27.2 NMAC - N, 11/30/2012]

13.10.27.3 STATUTORY AUTHORITY: Sections 59A-2-9, 59A-22-50, 59A-23C-10, 59A-46-51 and 59A-47-46 NMSA 1978.
[13.10.27.3 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.4 DURATION: Permanent.
[13.10.27.4 NMAC - N, 11/30/2012]

13.10.27.5 EFFECTIVE DATE: November 30, 2012, unless a later date is cited at the end of a section.
[13.10.27.5 NMAC - N, 11/30/2012]

13.10.27.6 OBJECTIVE: The purpose of this rule is to clarify statutory requirements that insurers make reimbursement for direct services at certain levels across all product lines by providing guidance and establishing uniform definitions and standardized methodologies for the calculation of the medical loss ratio for plan years 2010, 2011, 2012 and unless this rule is repealed, for plan years thereafter.
[13.10.27.6 NMAC - N, 11/30/2012]

13.10.27.7 DEFINITIONS: As used in this rule:

A. **"health insurer"** means a person duly authorized to transact the business of health insurance in the state pursuant to the Insurance Code but does not include a person that only issues an excepted benefit policy intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;

B. **"direct services"** means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

C. **"health care plan"** has the definition found in Subsection J of Section 59A-47-3 NMSA 1978;

D. **"health maintenance organization"** has the definition found in Subsection O of Section 59A-46-2 NMSA 1978;

E. **"premium**" has the definition found in Paragraph (3) of Subsection E of Section 59A-22-50 NMSA 1978;

F. **"individually underwritten"** means any health care policy, plan or contract issued to an individual or family reflecting the characteristics of the family members covered; these characteristics include, but are not limited to, place of residence, age, gender, and health status;

G. **"carrier"** means health maintenance organization, health care plan, and health insurer;

H. **"minimum medical loss ratio"** means the percentage determined in accordance with section 8 of this rule;

I. **"health product lines"** means:

(1) all programs utilized by a health insurer for the offering of products, including but not limited to:

(a) all private programs, including individual, small group and large group;

(b) all public programs, including all Medicaid and Medicare and any related or future programs or products;

(c) all other arrangements for the procurement of health coverage, including capitated arrangements, self-funded arrangements; and

(d) such other programs or arrangements that the superintendent may designate by order or bulletin; but not

(2) programs of HIPAA excepted benefits intended to supplement major medical coverage, including Medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or policies for long-term care or disability income;

J. **"product"** means any policy, plan or contract related to the provision of health care services offered, arranged or facilitated by an insurer, including blanket health insurance; and

K. **"blanket health insurance"** has the definition found in Subsection A of Section 59A-23-2 NMSA 1978.

[13.10.27.7 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.8 MINIMUM MEDICAL LOSS RATIOS FOR ALL HEALTH PRODUCT LINES:

A. General requirement. Carriers shall meet the minimum medical loss ratio established, and in the manner calculated, under this rule.

B. Measurement period. Compliance with the minimum medical loss ratio shall be measured over a rolling three-year period. The initial measurement period shall be the years, 2010, 2011 and 2012. Each year thereafter, the subsequent year shall be added to the rolling three-year period and the oldest year shall be removed. For example, the second measurement period shall be 2011, 2012 and 2013.

C. Aggregation. Medical loss ratios shall be calculated on a consolidated level within a state, with experience allocated to state based upon the situs of the contract. Experience of all affiliates shall be accumulated to the following levels:

(1) individually underwritten health policies;

(2) small group policies;

(3) large group policies and all other policies; and

(4) total of all group policies combined.

D. Frequency. Medical loss ratios shall be calculated annually by carriers that issue products through health product lines, beginning in 2013 covering the period 2010 through 2012.

E. Timeline. Medical loss ratios shall be calculated using claim data incurred during the three-year measurement period and paid before June 30 of the year following the that period. No adjustment may be made for incurred but not reported (IBNR) claims. The compliance requirement form set forth in Section 9 of this rule shall be the basis for the medical loss ratio calculation and will be filed with the superintendent by July 31 of the year following the measurement period.

F. Calculation. The numerator of the loss ratio calculation shall be direct services, as defined by this rule less pharmacy rebates and incurred or paid claims associated with self-funded plans and capitated contracts. The denominator of the calculation shall be premium, as defined by this rule less capitated contract premiums, self-funded administrative fees, self-funded claim reimbursements, any premium tax paid pursuant to the Insurance Premium Tax Act, and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance. This calculation is deemed to be fully credible due to the three-year time period used and the aggregation levels required. The New Mexico reimbursements and medical loss ratios for small group, large group, and all other policies shall be calculated collectively across all health product lines. The federal reimbursements paid or due pursuant to 45 CFR Part 158 shall be subtracted from the New Mexico reimbursement to calculate the final New Mexico reimbursement, which cannot be lower than zero.

G. Minimum medical loss ratio levels. The minimum medical loss ratio levels applicable to the policy aggregation in Subsection C of this section shall be as follows:

(1) the minimum medical loss ratio level for individually underwritten policies shall be eighty percent;

(2) the minimum medical loss ratio level for small group policies shall be eighty percent;

(3) the minimum medical loss ratio level for large group policies and all other policies shall be eighty-five percent; and

(4) the minimum medical loss ratio level for the total of all group policies shall be eighty-five percent.

H. Compliance with minimum medical loss ratio. With compliance requirement form set forth in section 9 of this rule, each carrier shall submit to the superintendent either:

(1) a statement signed by a qualified actuary that the minimum medical loss ratio requirements have been met; or

(2) a plan to make the required reimbursements to policyholders.

I. Actions required upon noncompliance with requirements. The plan to make the required reimbursements to policyholders shall provide either prospective premium credits or refunds to each policyholder who was enrolled in the affected segment (i.e., individually underwritten health policies, small group, or all other policies) during the last year of the measurement period and provide that any such refund for a policyholder be reduced by the amount of any rebate owing to the policyholder for a medical loss ratio reporting year pursuant to 45 CFR Part 158 that coincides with such measurement period. The premium credits or refunds shall be reflected in either a one-time payment or premium credit or in multiple payments or premium credits. Any such credits or refunds must be provided no later than the end of December of the year following the applicable measurement period. The deadline for reimbursement may be extended if the premium credits exceed the monthly premiums due by the end of December of the year following the applicable measurement period. Any overage may be applied to succeeding premium payments until the full amount of any refund has been credited. No later than March 31st of the second year following the applicable measurement period the carrier shall demonstrate that the refunds in the required amounts have been made or that premium credits are being applied until such time as the full amount on the refund has been credited. The prospective premium credits or refunds shall be made on a per subscriber basis, unless an alternative basis is approved by the superintendent of insurance and shown separately on the policyholder's monthly (or other frequency) bill. This credit may reflect the family composition of the rating structure used for each policyholder. Any premium credit or refund to policyholders shall be based only upon the medical loss ratios calculated for individually underwritten policies and for the total of all group policies calculated collectively across all group health product lines.

[13.10.27.8 NMAC - N, 11/30/2012; A, 8/1/2020]

13.10.27.9 COMPLIANCE REQUIREMENT FORM:

A. An Insurer shall use an OSI approved form to submit minimum loss ratios.

B. The form shall be posted to the OSI website.

[13.10.27.9 NMAC - N, 11/30/2012; A, 8/1/2020]

HISTORY OF 13.10.27 NMAC: [RESERVED]