2024 Plan Year
Individual and Small Group Market
Rate Filing Guide



State of New Mexico
Office of Superintendent of Insurance

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Section I: Overview

A cornerstone philosophy of the Affordable Care Act (ACA) is that benefit plan premium variations in the individual and small group insurance markets should only reflect benefit differences between benefit plans, not differences between the population characteristics of people expected to enroll in each plan. To achieve this goal, federal law [45 CFR 156.80(d)(2)] permits limited adjustments to a market-wide index rate for a relevant state market, based only on the following actuarially justified plan-specific factors:

1. The actuarial value and cost-sharing design of the plan.
2. The plan's provider network, delivery system characteristics, and utilization management practices.
3. The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.
4. Administrative costs, excluding Exchange user fees.

The federal Unified Rate Review (URR) instructions, https://www.cms.gov/files/document/urr-py23-instructions.pdf, emphasize this limitation in Section 4.4.4.

To ensure that ACA rules are being followed and a level regulatory playing field exists in the ACA market, OSI is prescribing pricing guidance to clarify rules and eliminate subjective variability in pricing factors and the use of other plan adjustments.

This document outlines the rate filing requirements for the ACA-compliant individual and small group market in New Mexico and is intended to provide rate filing guidance to issuers. This guidance supplements and does not contradict the 2024 URR Instructions. “ACA-compliant individual/small group market” refers to the on-exchange and off-exchange plans that are regulated under the single risk pool requirements of the ACA.

Basis for Rate Development

Rates must be developed based on the law in effect on the date that rates are filed unless definitive guidance to the contrary is provided by the appropriate regulatory authority (state or federal).

Please note, OSI will only permit revisions of rate filing submissions for risk adjustment after CMS issues the annual Risk Adjustment Report. OSI will review these changes to verify that they are justified and comply with the narrow scope of allowed changes. The window for submitting

these revisions is July 14 -21, 2023. Issuers must include supporting documentation as identified under Tab #9, Risk Adjustment, in the Rates Template. Any other revisions will be at the discretion, and written direction of OSI and must relate to (1) correcting clearly inadvertent errors, (2) unforeseen circumstances that impact the industry, or (3) risk adjustment after the CMS Risk Adjustment Report. The revised filing must clearly state the reason(s) for the revision.

Section II: Required Submissions in the System for Electronic Rate and Form Filing ("SERFF")

(Please also see the 2024PY QHP Issuer Submission Guide)

For QHP certification purposes only, issuers must submit one form and rate filing per single risk pool. Issuers who offer both HMO and PPO type of products, must submit one Form/Rate filing for their HMO/EPO products, which contains the single risk pool rate and all related forms, and a separate Form/Rate filing for their PPO/POS products, with an identical single risk pool rate and all related forms. In other words, unless the products have a different network structure (HMO vs PPO) or markets (individual vs. group), there is no need to file separate product filings for the on-exchange, mirrored and off-exchange products. All forms and the single risk pool rate must be submitted together. Issuers may format their actuarial memorandum to adequately address the rates for all plans included in the single risk pool and include separate sections in the actuarial memorandum for HMO vs. PPO plans for the same carrier. EPO plans must be submitted as part of the HMO Form/Rate filing submission and POS plans must be submitted as part of the PPO Form/Rate filing submission.

On-exchange and off-exchange forms must be clearly identified using the prescribed naming convention and filed together under the Forms Schedule tab in SERFF.

SERFF Form and Rate Filing

Each rate filing submission is expected to stand on its own and must not refer to any other filing. Carriers are expected to submit a combined Form/Rate filing in SERFF, under the specific tabs listed. The documents related to the rate filing, that are included in the NM 2024PY QHP Form Checklist and 2024PY Rate Checklist must be included under specified tab. In addition, please note the following:

1) The Part II Rate Increase Justification A Part II rate change justification will be required for all rate filings, regardless of the magnitude of the change (even if it is zero or negative).

2) The unredacted actuarial memorandum should provide sufficient detail such that a qualified health actuary would be able to evaluate the submission. Narrative and quantitative support should be provided for all assumptions. Any material changes in the methodology should be disclosed. This actuarial memorandum including required exhibits, shall be prepared in accordance with applicable actuarial standards and OSI requirements, and shall address all items in the NM 2024 QHP Rate Filing Checklist.

3) Any exhibits supporting the information provided in the actuarial memorandum should be included as part of the actuarial memorandum, either within the body of

the actuarial memorandum or as appendices. Additionally, each exhibit should be supported by detailed narrative documentation within the actuarial memorandum and should be submitted separately in Excel format with working formulas.

4) The URRT should be submitted in both XML and Excel formats.

5) AV Calculator screenshots for all plans, as well as support for any unique plan designs, including the unique plan design certification should be included. Any differences from the AV results included in the Plans and Benefits Template should be explained.

6) The Rate Data Template should be submitted in both XML and Excel formats. Issuers must confirm that the rates calculated in the URRT are consistent with the rates provided in the QHP Rate Template. We understand there may be minor rounding differences with the URRT. Differences over $0.50 PMPM should be explained.

Please note, while OSI is not prescribing carriers follow the URRT rate development methodology, the URRT data must match supporting documentation and the final premium rates. It is not acceptable to provide filing materials which do not match the federal templates.

Treatment of Proprietary Information

OSI recognizes that carriers may consider certain information to be proprietary and confidential. To ensure a level playing field and encourage a competitive market, **upon request**, all rate filing materials will be kept confidential during the review period. To ensure that proprietary information is kept confidential by the OSI, temporarily or permanently, carriers will need to follow the procedure outlined in Bulletin 2022-003 and submit Confidentiality Request Form in advance of the QHP Application Submission in SERFF. See Section X of the 2024PY QHP Issuer Submission Guide for further information.

Please note that **upon request** the rates will remain confidential during the entire QHP review period. Issuers are expected to submit their best competitive and actuarially sound rates with their initial QHP application.

Standardized Naming Convention

Carriers are expected to submit the following documents using the standard naming convention, as outlined below:

- Actuarial memorandum
- Medical rate filing template
- Medical rate filing checklist
- Medical form filing checklist
- All forms submitted under the Forms Schedule Tab in SERFF

All naming conventions and terminology must be consistent between the Form/Rate filing, binder and templates.

For example, each form included in the filing should reflect the name of the plan as it is stated in the binder and listed within the PBT.

CarrierName_YYYYmkt_ Plantype (Form Only)_Exchangetype_v#_ Filedesc.filetype

- **CarrierName**: Up to 6 Characters which identify the carrier
- **MMDDYY**: e.g., 010124 for filings effective January 1, 2024
- **mkt**: **indicate one of the following**:
    - "i" for individual (non-group)
    - "s" for filings that include small groups only, (2 to 50 employees)
    - "l" for filings that include large groups only (more than 50 employees)
    - "g" for filings that include groups of all sizes (more than 2 employees)
- **Plantype (forms only): indicate one of the following, if there are differences between forms by plan type.**
    - PPO
    - PPO_POS
    - HMO
    - HMO_EPO
    - EPO
    - POS
- **Exchangetype: indicate one of the following**
    - MedOn (Medical On-Exchange)
    - MedOff (Medical Off-Exchange)
- **v#**: v followed by the version number (increment for each update to the filing)
- **Filedesc**: indicate one of the following:
    - **AMR** – Actuarial Memorandum – redacted
    - **AM** – Actuarial memorandum – unredacted
    - **RTCK** – Rate checklist
    - **FMCK** – Form checklist
    - **CER** = Certificate/EOC
    - **SBC** = Summary of Benefits and Coverage
    - **POL** = Policy/Contract
    - **AP** = Application
    - **EF** = Enrollment form
    - **End** = Endorsement
    - **Form**=Formulary

- **Rd** = Rider
- **ID** = ID or RX Card
- **RT** – Rates Template
- **ECPT -** Essential Community Providers Template

Rate Filing Example: ABC_010124_i_MEDOn_v1_RTCK. Xlsx is the initial 2024 medical rate filing checklist for the ABC Health Plans individual on Exchange filing. The Plan Type field is not required for rates as there is only one rate filing checklist submitted for each single risk pool.

Forms Example: ABC_010124_i_HMO_MEDOn_v2_Plan1_SBC.xlsx is the 2nd revision of the Summary of Benefits and Coverage for the On Exchange, named Plan 1*, offered by ABC Health Plans. The Plan Type field is used in this case as the form will vary by Plan Type, and a separate form filing checklist is required for each policy/COC/EOC form.

*Plan 1 is the name of the plan as it is stated in the title of the SBC and is listed under the Plans tab in the binder and specified as the plan name in the PBT.

Section III: Actuarial Memorandum Requirements

(See also the Health Care Affordability Fund (HCAF) Health Insurance Marketplace Affordability Program – 2024 Plan Year Policy and Procedures Manual)

The actuarial memorandum needs to comply with the instructions included in the 2024 Unified Rate Review Instructions, with particular attention to the items listed below.

Carriers are encouraged to include as much detail and supporting documentation as possible in the initial filing to facilitate an efficient review process, which may include several rounds of questions from OSI. Failure to provide information on a timely basis or failure to provide accurate information slows the review process and puts the carrier at risk for missing critical deadlines to offer ACA-compliant health insurance products and plans in New Mexico.

Summary Description of the benefit design of each plan included in the single risk pool

Include a table, with the major cost sharing features of the plans included in the filing, including the Turquoise plan variants and the New Mexico Standardized plans.

- HIOS Plan ID
- Product[1]
- Metal Tier
- On/Off Exchange indicator
- Projected Enrollment for 2024
- Overall Deductible[2]
- Coinsurance[3]
- Copay
- Maximum Out of Pocket (MOOP)
- Standardized Plan Indicator
- Turquoise Plan Indicator

Basis for Rates - Provider Reimbursement Agreements

Rates are to be determined based on provider contracts that are in effect as of the rate filing submission date. Rate revisions will not be allowed for contract changes finalized during the rate review period except under extenuating circumstances as determined by OSI.

Rate Change Components

A narrative description and an estimate of the magnitude of all drivers of the 12-month average rate change which total to the proposed rate change must be provided. If different than NM Rate

[1]HMO, PPO, EPO, POS

[2] Overall deductible, consistent with the amount reported on the SBC

[3] Most predominant coinsurance used

Filing Template, please provide a reconciliation. Small group filings should provide both the annual rate change and the proposed rate change from 4Q 2023 to 1Q 2024.

Additionally, an explanation of how the rate increase varies by product and plan per the URR instructions must be included. This explanation should document how morbidity was removed from impacting these variations.

Please also explain how the minimum and maximum rate increase included on SERFF was determined.

Credibility

An explanation of the methodology used to determine the credibility level of the experience and why it is applicable to the proposed market must be provided. Qualitative and quantitative justification must be provided if the experience data was not used as the rate basis.

If actuarial judgment is used, please consult requirements in ASOP #25 and provide a full explanation of the reasoning and the information used to inform the actuary's judgment.

Manual Rate Development

If a manual rate is used, narrative and quantitative support for the manual rate development must be provided. This includes a complete narrative explanation of the appropriateness of the manual source data as well as narrative and quantitative support for all assumptions.

Benefit Adjustments

If there are reserves other than IBNR, confirm changes to those reserves were not considered in the rating process.

If an adjustment made for any of the following, verify that both narrative and quantitative support were provided detailing all assumptions as well as explaining where the adjustment is applied:

1) COVID-19
2) American Rescue Plan Act (ARPA) or other federal legislation related to APTCs or CSRs
3) Medicaid Maintenance of Eligibility (MOE)/End of the Public Health Emergency
4) All 'Other' Adjustments – identify each component
5) Insulin Cap
6) New Mexico's Surprise Billing Statute
7) Transitional policies
8) Zero cost-share for behavioral health services
9) Other New Mexico legislative and/or regulatory changes
10) Affordability Fund Small Business Program (Small Group filings only)

Disclose all factor and benefit changes from the prior approved rate filing including narrative and quantitative support for each benefit change.

There are no changes to New Mexico's EHB benchmark plan for plan year 2024. Benefit changes that are not expected to impact premiums should also be disclosed, as well as a discussion of the analysis performed to determine a premium impact is not necessary.

Wellness Plans or Other Value-Added Products or Services

Rates shall **not** include the cost to the carrier of any wellness plans or other value-added product or service that may be offered to an enrollee. These costs shall not be treated as, or included in the general, administrative expense category. The costs of these offerings must be borne by the member as part of a separate and express agreement or shall be taken out of the carrier's profits. The actuarial memorandum must include a description of any wellness plans or other value-added products or services (as authorized under 59A-16-17(G) NMSA), and explicitly state that the cost of these products or services were not reflected in the rates.

COVID-19

Detailed breakdown and quantitative and qualitative support for the URRT WS1 projection factors:

- Morbidity
- Unit Cost & Utilization
- Other

Detailed quantitative and qualitative support for any adjustments. Provide the experience period claims PMPM related to COVID expenditures, if applicable. If the SOA COVID model is used, all assumptions should be supported narratively and quantitatively.

Similar to benefit adjustments, if no adjustment is included for COVID-19, a discussion of the analysis performed to determine no premium impact must be included.

Trend

Narrative and quantitative support for trend adjustments should be included, which include but are not limited to, the following:

1) A 5-year history, where available, of actual cost and utilization trend. (This is satisfied by completing the NM Rate Filing Template)
2) Any differences in trend assumptions from the prior approved filing.
3) Discuss anticipated changes in provider contracts that differ from those underlying the experience used and the impact on medical cost trends by major service categories.
4) Explain differences in trend by benefit category.
5) Explain any adjustments to trends based on fluctuation in large claim amounts.
6) An explanation of the source data for the trends must be provided and why it is applicable to the single risk pool must be included.
7) If the projection period is more or less than 24 months, verify that "Year 1" and "Year 2" trend factors were appropriately adjusted.
8) If a leveraging factor is included, please provide support for the leveraging using

historical or other relevant data.

Risk Adjustment Transfer Amount

All assumptions used to complete the federal risk adjustment transfer formula must be explained narratively, for both the experience and projection period. If the federal risk adjustment formula was not used to estimate the projected risk adjustment, the alternative calculation must be supported narratively and quantitatively. Note the NM Rate Filing Template collects historical and projected statewide and issuer components of the risk adjustment formula, both estimated and actual, as applicable, as well as the estimated and actual amounts of the transfer payments, Carriers are expected to provide detailed exhibits, that demonstrate the calculation of the transfer payment amount in Excel format, and all assumptions should be explained narratively and quantitatively. It is our understanding that all carriers in New Mexico participate in a risk adjustment study performed by a consulting firm. Regardless of the methodology used to develop the risk adjustment transfer amount for pricing purposes, starting with the 2024 rate filings, OSI is requiring all carriers to submit the detailed report(s), including any spreadsheets, that are provided as a result of that study, as part of the rate filing submission.

Discuss differences in the estimated experience and projected risk adjustment results from the most recent actual risk adjustment report.

The impact of the high-cost pooling mechanism and RADV must also supported narratively and quantitatively, including if no impact is included.

Exchange Fee

The market-wide adjustment for Exchange fee should be set to 0%. The New Mexico Health Exchange (NMHIX) pays the Exchange fee out of an assessment on all carriers. NMHIX calculates an assessment on all carriers in the market (including off-exchange carriers), which may not be available when the rates are filed. Therefore, quantitative support for the development of the estimated assessment amount must be provided. The assessment amount should be included in the taxes and fees.

Projected Paid-to-Allowed

Quantitative support for the projected paid to allowed factor should be included. Explain significant (+/- 2%) differences in the paid to allowed from the base period.

Standardized Health Plans

All individual market issuers offering coverage on beWellnm during the 2024 Plan Year must offer the Standardized Health Plans adopted by the beWellnm Board of Directors. Identify the plans which fulfill the board's Standardized Health Plan requirements. Issuers must explain pricing differences between Standardized and Non-Standardized plans, including how specific features differentiate prices, and support how these features were priced. See the section below on cost-sharing design for additional information related to the required level of support needed to justify the relative pricing of standardized and non-standardized plans. [Please note that

beWellnm' s Health Benefits Committee is awaiting CMS's 2024 Actuarial Value Calculator and certain elements of the plans are subject to change if the Committee must make adjustments to reach the appropriate actuarial values for Standardized Health Plans.]

According to beWellnm' s requirements related to covered prescription drugs, "An issuer may opt to offer only one Specialty tier, provided that the co-pay value is equal to the value of the Specialty Preferred tier of the approved Standardized Health Plan. An issuer must notify OSI if it intends to offer a single Specialty co-pay tier no later than May 1, 2023." Issuers offering two specialty prescription drug tiers must submit to the OSI the utilization assumptions for preferred and nonpreferred specialty medications, along with support for those assumptions. Issuers are permitted to include nonpreferred generic medications in the preferred brand name tier.

For 2024, the actuarial value (AV) of the silver standardized plan will determine the AV floor for non-standardized Silver plans, based on the final 2024 AV calculator.

Plan Level Adjustments

Issuers are restricted to the allowable factors in 45 CFR 156.80(d)(2) to adjust the Market Adjusted Index Rate (MAIR) to calculate each Plan Adjusted Index Rate (PAIR). The URR Instructions should be followed for all allowable rating factors. The OSI has implemented stricter guidance on the allowable "actuarial value and cost-sharing design of the plan" adjustment. This adjustment is categorized into three distinct multiplicative factors ; the applicable guidance is described below.

Actuarial Value Metal Value (AV)

This factor must match the AV Metal Value on Worksheet 2 of the URRT. Additional information required to support the AV Metal Value is discussed later in this guidance.

Cost-Sharing Design

The methodology used to determine the Cost-Sharing Design must be explained. Additionally, support (quantitative where possible) must be provided detailing the methodology for removing the impact of morbidity. Include an explanation of any plan specific benefits that drive unusual cost-sharing design factors or relativities. See the section on the CSR Defunding Adjustment below for details on how the CSR Defunding Adjustment should be reflected in the Cost-Sharing Design Factor. The benefit relativities between standardized and non-standardized plans should be quantitatively and qualitatively supported.

Induced Demand

Induced demand factors (IDF) for both the individual and small group market should be consistent with the metal level factors developed by the Centers for Medicare and Medicaid Services (CMS) and used in the Federal Risk Adjustment program. Additional induced demand for HSA-qualified plans is not permitted. Demonstrate that the induced demand factors are normalized to a weighted average of 1.0. (This can be done using the NM Rate Filing Template). See the 2024 Plan Year Policy and Procedures Manual for the Health Care Affordability Fund (HCAF) Health Insurance

Marketplace Affordability Program for further details related to the adjustments due to the introduction of this program.

CCIIO has notified OSI that the following induced demand factors will apply to Turquoise plans for purposes of the federal risk adjustment program during the 2023 Plan Year:

Variant	Risk adjustment IDF
99% AV Silver	1.12
95% AV Silver	1.12
90% AV Gold	1.07
85% AV Gold	1.00

OSI will notify if these factors change for the 2024 Plan Year.

Network Factors

Please provide an explanation of how network factors were determined. Confirm that the rating factors for networks do not reflect morbidity or demographic differences in the populations selecting those networks. Confirm that network factors are the same for all plans with the same network. If the network factors changed from the prior filing, explain all changes. Demonstrate that the network factors are normalized to a weighted average of 1.0. (This can be done using the NM Rate Filing Template).

CSR Defunding Adjustment

If historic ACA incurred/paid claims amounts were used to develop the Cost-Sharing Design factor, the impact of CSR subsidies in the experience period is already included, and will need to be removed before applying the 1.44 CSR Defunding Adjustment. Otherwise, the impact of CSR subsidies would be double-counted in the projection period. Provide a separate exhibit to show how the Plan-Level Adjustment for Cost-Sharing Design was adjusted to remove the impact of CSR subsidies in the experience period data.

Issuers should anticipate rational consumer behavior and not expect enrollees with incomes above 200% of the Federal Poverty Level (FPL) to enroll in on-exchange silver plans. Rather than apply an estimated pricing AV as a mix of a different level of benefits, the OSI prescribes a CSR Defunding adjustment for all issuers. Accordingly, issuers' on-exchange silver premiums will reflect AV parity rather than a varying mix of AVs from subjective projections of different CSR variant distributions. To account for CSR payments not being reimbursed, a CSR Defunding Adjustment of 1.44 should be applied to on-exchange silver plans to reflect a mix of enrollment in CSR 87 and CSR 94 variants.

Please note, this 1.44 adjustment should not be normalized and therefore should not result in any impact to any plans which are not silver on-exchange plans. Only the CMS prescribed induced demand factors should be normalized. We believe that this methodology best meets OSI's market

alignment and affordability goals by requiring a 1.44 CSR load for all carriers.

Benefits in Addition to EHBs

Provide a description of all Benefits in addition to EHB, explain how the impact was determined (even if no impact), and provide support for the "Benefits in addition to EHB" adjustment factors. Confirm that the adjustment "Benefits in addition to EHB" was based on pooled experience for all plans with those benefits. If the "Benefits in addition to EHB" factors changed from the prior filing, provide support for changes.

Non-Benefit Expenses

Provide support for the administrative cost (PMPM and as a percentage of premium). Provide commissions, sales and marketing expenses separately from administrative costs, provide support and the proportion of business sold on-exchange. Subject to the prohibition on including costs relating to value added products and services, provide support for administrative costs related to programs that improve health care quality and provide support for differences from the prior approved filing.

Break out all taxes and fees and discuss how they were determined. Provide support for the NMHIX assessment and confirm it is included in the taxes and fees. Provide the projected risk adjustment fee and confirm it is included in taxes and fees and not as a market-wide adjustment.

Provide support for the included profit & risk margin and discuss any changes from the prior approved filing, including an explanation of why the change is required. Please note, profit may not vary by metal level. Varying the profit load by metal level is not permitted. An appropriate demonstration of financial security, such as a parental guaranty, must be provided with 0% or negative profit margins.

All PAIR adjustments should be developed from the same population for all individual and small group market plans. Adjustments should not use populations that vary based on issuers' expectations of unique population characteristics expected to enroll in a specific benefit plan or a metal tier. PAIR adjustments should not include expected risk adjustment transfer payments; these should be included in the MAIR in accordance with Section 2.1.3.3 of the URR instructions.

Rating and Calibration Factors

Age Factors

Confirm the rating factor calibration is uniform for all plans. Confirm that the CMS age curve was used for the age factors. Explain whether the age calibration is based on prior or projected age distributions. If there was an adjustment for aging, the projected age distribution should be used in the age calibration. Provide support for the adjustment for the cap of three dependents under 21 and confirm it is appropriately accounted for in the age calibration.

Geographic Factors and Service Area

If an insurer offers a plan anywhere in New Mexico at a particular metal level, it must offer a statewide plan for that level. . (For example, if Carrier A has submitted a plan available at all the

metal levels, then they need to provide at least one statewide plan at all the metal levels. If Carrier A has only submitted plans at the Silver and Gold levels, then they only need to provide statewide plans at the Silver and Gold Levels.)

The cap on a maximum differential between the highest and lowest rated area is 40%.

Confirm that the geographic rating areas approved by CMS were used. These rating areas are as follows: 1: Albuquerque MSA (Bernalillo-Sandoval-Valencia-Torrence Counties), 2: Farmington MSA (San Juan County), 3: Las Cruces MSA (Dona Ana County), 4: Santa Fe MSA (Santa Fe County), 5: Non-MSA regions (all counties not listed above) Narrative and quantitative support for the geographic factors should be provided, including a comparison to the prior year factors, if applicable, and an explanation of why the factors have changed from the prior filing, if applicable. Confirm that the geographic factors only reflect differences in cost and utilization by geographic area due to differences in practice patterns and cost and do not reflect differences in morbidity. Provide support for the geographic rating factor calibration.

Please note, any proposed provider contracting must be finalized to be considered in the proposed rating factors.

Tobacco Use Factors

Due to mounting evidence that tobacco rating in the individual market suppresses enrollment, undermines financial protection afforded by coverage, and has disproportionate negative impacts on rural communities, OSI is requiring issuers to set the tobacco rating multiplier at 1.0 for all individual on-and-off-exchange plans that will be offered starting with the 2023 plan year. This applies only to the individual market.

Rating materials must confirm the tobacco factors are within the required 1.5:1 range for small group offerings. Explain differences in the tobacco use factors from the prior approved filing. Provide support for the tobacco use calibration.

Medical Loss Ratio

Provide support for the projected one-year federal MLR. Demonstrate that the appropriate formula was used. Confirm that the projected MLR meets the minimum requirements. If the one-year federal MLR is below 80%, provide the calculation of the projected federal three-year MLR calculation.

Indicate federal MLR rebates to be paid in the experience period.

Provide a comparison of the MLR information, in the format shown below for 2019 through 2021, which are the most recent three years for which complete MLR information is available and provide an explanation of any significant differences between the actual and pricing MLR and member months.

Calendar	MLR	Member Months

Year	Actual[4]	Pricing[5]	Actual[2]	Pricing[3]
2019				
2020				
2021				

Actuarial Value

Provide AV screenshots for all plans. Confirm the AV is consistent with the URRT AV. Confirm that the URRT AV is close (within +/- 0.5%) to the one in the QHP Plans and Benefits template or explain differences. Confirm the AV for each metal plan in fact within the appropriate range

If an Alternative Methodology was used:

1) Demonstrate that the plan design is in fact unique.
2) If included adjustments to the AVC input, provide support for all adjustments.
3) If included adjustments to the AV calculated by the AVC, provide support for all adjustments.
4) Provide the required actuarial certification.

Limits on the Number of On-Exchange Non-Standardized Silver Plans Offered by Each Issuer

In the individual, on-exchange market, carriers must offer at least one Gold and one Silver plan and carriers may offer only two non-standardized Silver plans, in addition to the standardized Silver plan in any rating area. If the two non-standardized Silver metal level plans are offered in the same area and produce similar rates (*e.g.*, within +/- $10 PMPM for a 21-year-old), significant support must be provided explaining why plans are priced so similarly. OSI will consider additional plans in the Silver metal level only if there are significant differences between the plans' provider networks. An example of a "significant difference" between networks is a broad network vs. a narrow network. Carriers may offer only two non-standardized Gold plans in addition to the standardized Gold plan in any rating area. No additional requirements apply to Gold plans.

There is not a limitation to the number of Silver or Gold plans that can be offered in the individual off-exchange market or small group off-or-on exchange market.

Reliance

Pursuant to section 3.4.4 of Actuarial Standard of Practice No. 41, Actuarial Communications

[4] Actual is the final information which was filed for the specified calendar year.

[5] Pricing is the information which was projected in the final annual filing for the given year (i.e., the 2021 pricing information is from the plan year 2021 annual filing submitted in 2020).

(ASOP 41), please indicate if you are using any assumptions or methods chosen by another party, including the rating assumptions required by the New Mexico OSI, and provide any required disclosures, subject to sections 3.4.4(a) or 3.4.4(b) of ASOP 41, and section 4.1 of ASOP 8, as appropriate.

Actuarial Certification

The Actuarial Certification must, at a minimum, certify compliance with the following Actuarial Standards of Practice:

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits
- ASOP No. 12, Risk Classification
- ASOP No. 23, Data Quality
- ASOP No. 25, Credibility Procedures
- ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

Regarding, ASOP No. 41, any assumptions or methods chosen by another party, including New Mexico OSI, should be documented in the Actuarial Memorandum.

Additionally, the Actuarial Certification must include a statement that the rates do not reflect the cost of any wellness plan or other value-added products or services.

OSI will approve rates that the certifying actuary deems to be excessive, solely due to guidance provided by the OSI, if the actuarial certification includes disclosures required under actuarial standards of practice.

Section IV: Reporting Requirements

Pursuant to NMSA Section 59A-18-13.2(C), (D) and (E) , carriers are required to provide certain information related to the rate filings, and that information is required to be posted on OSI's website. Starting with the 2024 rate filings, OSI is requiring all carriers to provide the required information in the format prescribed by OSI as part of the rate filing submission. Please see Appendix A for the required format.

Appendix A: Rate Report

I. High level narrative summarizing rate changes for 2024PY submission and the main drivers of the rate change (e.g., trend, benefit changes, etc.), along with a table showing the numerical rate change for each of the drivers identified and the overall rate change:
II. High level narrative summarizing form changes for 2024PY submission:
III. High level description of how the revised rates were determined, including general description and source of each assumption used:
IV. Expected federal medical loss ratio for blocks of business in existence for at least three years:
V. High level narrative of the supporting information that demonstrates how the blocks of business will meet the requirements for medical loss ratio in state and federal law:
VI. Medical costs, including utilization and compensation rates trend, justifying the rate increase. Identify the aggregate types of expenditures in those categories that support the premium rate increase in the geographic area covered. This section does not need to include provider compensation, only the trend:
VII. High level description of blocks of business in existence for at least three years, premium revenues, claims history, losses and reserves for the three years preceding the date of filing. Provide supporting documentation and whether the insurer has ceased to actively offer or sell to new applicants a block of business for which it seeks a rate increase: