Stand Alone Dental Plans
Rate Filing Guidance

State of New Mexico
Office of Superintendent of Insurance
Effective January 1, 2024

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Section I: Overview

This guidance applies to dental premium rates submitted to the New Mexico Office of the Superintendent of Insurance ("OSI") with effective dates on or after January 1, 2024, for:

- Pediatric only and family (covering both pediatric dental and adult dental services) stand-alone dental plans sold through the New Mexico Health Insurance Exchange (beWellnm), and
- Pediatric only and family beWellnm-certified dental plans sold outside the beWellnm,

Section II: General Guidance

Sec. 2.1: Applicability

Throughout this document, references to stand-alone dental plans include all beWellnm-certified dental plans sold on the exchange, and their mirrored counterparts. Rate and form filings for SADPs must be submitted as a separate filing from the medical plans.

Stand Alone Dental plans offered outside the beWellnm only to supplement medical plans, such that the medical plans will comply with federal requirements to offer all ten Essential Health Benefits outside the beWellnm as required under the Public Health Services Act, must follow the beWellnm certification filing process.

Sec. 2.2: Prior approval of Rates and Forms Required

A carrier shall not issue, deliver, or use a form associated with applicable dental and vision plans, unless and until such form has been filed with and approved by the superintendent.

A carrier shall not use rates or modified rates for dental and vision plans unless and until such rates are filed with and approved by the superintendent.

Sec. 2.3: One Filing per Market

For QDP certification purposes only, OSI will not accept more than one SADP filing from a carrier for each market (individual or small group). Carriers offering plans on and off Exchange, or pediatric and adult plans must submit one filing per market and include all relevant information in the same Form/Rate filing. In other words, there is no need to file separate "mirror" submissions. SADP carriers may format their actuarial memorandum to adequately address their entire filing. This may include separate sections in the actuarial memorandum for HMO vs. PPO plans for the same carrier. However, separate forms must be submitted for HMO and PPO plans issued by the same carrier, within the same rate/form filing. 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.

Sec. 2.4: Guaranteed vs. Estimated Basis for Rates

Standalone dental plans are not subject to the insurance market reform provisions of the Affordable Care Act, such as guaranteed availability and renewability of coverage.

For all plans other than the SHOP plans, rates should be identified as either "guaranteed" or "estimated" in the Plans and Benefits Template and the actuarial memorandum and can either be individually age rated or family tier rated. For SHOP plans, rates must be "guaranteed" and

individually age rated. For rates that are identified as "estimated", dental carriers may make premium adjustments upon enrollment of the consumer but must indicate that rates are not guaranteed.

Although the pediatric essential health benefit ("EHB") does not need to be offered at a particular Actuarial Value (AV), the AV of the Pediatric EHB for each plan must be certified by a member of the American Academy of Actuaries. The AV compares the cost of a plan after member cost-sharing is considered against the same plan assuming 100% payment by the carrier for all covered dental services.

Sec. 2.5: Actuarial Value

The federal AV Calculator, which is used for ACA-compliant medical plans, cannot be used to determine the dental actuarial value. The certifying actuary will need to develop a dental pricing model to determine the actuarial value of the proposed pediatric dental plans. This model must use the same standard population to evaluate all the pediatric dental plans offered by the carrier. For a network dental plan, only in-network charges are counted toward the development of the actuarial value. See section 4.11 for further detail relating to this requirement.

Sec. 2.6: Essential Health Benefits (EHB)

All carriers offering stand-alone dental plans intended to cover EHBs must ensure that all plans covering pediatric dental services comply with the New Mexico Dental EHB Benchmark Plan, which may be found on the CMS website here.

Sec. 2.7: Pediatric Dental Requirements

Stand-alone dental plans that provide coverage for the pediatric dental EHB should cover members until at least the end of the month in which the member turns age 19.

Under 45 CFR 155.1065 (a)(2), referencing Section 2711 of the Public Health Service Act (42 U.S,C. 300gg-11), the pediatric dental EHB offered by stand-alone dental plans must be offered without annual and lifetime limits. Annual and lifetime limits may be used for benefits, in addition to the pediatric dental essential health benefits and for adult dental benefits.

Under 45 CFR 156.150(a), SADPs are required to have a reasonable annual limit on pediatric dental EHB cost sharing. For 2024, a pediatric dental EHB cost sharing annual limit at or below $400 for a plan with one child enrollee, or $800 for a plan with two or more child enrollees is considered reasonable. No higher limit will be approved.

Sec. 2.8: Rating Areas

Stand-alone dental issuers in the Individual market must use the five standardized rating areas:

- Rating area 1: Bernalillo, Sandoval, Torrance, Valencia Counties (Albuquerque MSA)
- Rating area 2: San Juan County (Farmington MSA)
- Rating area 3: Dona Ana County (Las Cruces MSA)
- Rating area 4: Santa Fe County (Santa Fe MSA)
- Rating area 5: All other counties (Catron, Chaves, Cibola, Colfax, Curry, De Baca, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, McKinley, Mora, Otero, Quay, Rio Arriba, Roosevelt, San Miguel, Sierra, Socorro, Taos, Union) (Non-MSA portions of New Mexico)

An Issuer must identify the service area associated with each proposed SADP and disclose it in the EOC. An Issuer must offer at least one plan with a state-wide service area. Any other service area must cover a minimum geographic area that is at least the entire geographic area of a county, or a group of counties, unless OSI determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interests of qualified individuals and employers. 45C.F.R. § 155.1055(a). OSI will review to ensure that the service area of an SADP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the ACA, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

Sec. 2.9: Variability

Variability in Stand Alone Dental Plans will be allowed in very limited circumstances. An example of permissible variability is to allow for administrative changes such as to populate the policy number, insured's name(s) and effective date(s). All variability must be clearly described in a Statement of Variability (SOV). For specific variable language, the SOV must state the exact language as it will appear in the form that will be issued to the consumer. If language is bracketed because it will either be included or excluded, the SOV must state so and explain under what circumstances the information will be included or removed.

Stand Alone Dental Plan cost sharing cannot be variable. Exact values must be provided in each Outline of Coverage (OOC).

Nested brackets, indicating variability within the variable information is not allowed.

General and vague explanations are insufficient. Use of phrases such as "as necessary," "as negotiated by the policyholder," "flexibility in plan design," "but not limited to" or "will comply with statutory requirements" are too vague and non-descript and are not allowed.

No change in variability can be made which in any way expands the scope of the wording being changed.

Sec. 2.10: Treatment of Proprietary Information

OSI recognizes that carriers may consider certain information to be proprietary and confidential. Therefore, carriers are required to submit confidentiality requests at least 10 days in advance of a SADP Application submission, pursuant to Bulletin #2022-003. Upon the filing disposition, public access will be granted to all parts of a filing that are not approved by OSI as "confidential." Please note that upon request the rates will remain confidential during the entire review period. Issuers are expected to submit their best competitive and actuarily sound rates with their initial SADP application.

SADP carriers must use the Confidentiality Request Form and Determination Notice required by OSI and posted on its website. Any inquiries regarding confidentiality requests and determinations should be directed to Cass Brulotte, Life & Health Attorney, at cass.brulotte@osi.nm.gov.

Sec 2.11: Timeline

2024 PY QHP REVIEW TIMELINE	
Activity	**Timeline**
Confidentiality Request	30 days prior to filing submission date
QHP and SADP Application submission window opens	4/19/2023
QHP and SADP form/rate filing deadline for forms only.	05/22/2023
QHP and SADP Application submissions deadline (Complete Form/Rate Filings to include rates, Binders, as well as Transparency in Coverage and Plan ID Crosswalk data)	05/29/2023
Individual QHP and SADP Application Transfer to beWellnm (Forms and Rates)	06/05/2023
SHOP QHP and SADP Application Transfer to beWellnm (Forms and Rates)	06/05/2023
Risk Adjustment rate revisions	07/14/2023-07/21/2023
48-hour turn-around on carrier responses to form and rate review objections	07/26/2023
24-hour turn-around on carrier responses to form and rate review objections	08/02/2023
Approval, Certification and Transfer of Individual, SHOP, and SADP Plans	**08/14/2023**
URL Template Links to be live and active	09/01/2023
Open Enrollment Starts	11/01/2023

Section III: Submitting Filings in the System for Electronic Rate and Form Filing ("SERFF")

Sec 3.1: Complete submission

Each rate filing submission is expected to stand on its own and must not refer to any other filing. SADP carriers are expected to submit a combined rate/form filing in SERFF, under the specific tabs listed. The following documents must be included with each rate filing:

- Forms Schedule tab
  1. Clean copies of Policy, Certificate, Schedule of Benefits, Rider, Endorsement, Application and Enrollment forms, as applicable
- Rate/Rule Tab
  1. Rate manual
  2. Sample rate calculation
- Supporting Documentation Tab
  1. Actuarial Memorandum including required exhibits, prepared in accordance with Section IV below, and addressing all items in the SADP rate Checklist
  2. Additional supporting information/exhibits
  3. Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification
  4. Stand - Alone Dental Plans - Description of EHB Allocation
  5. Dental rate filing checklist
  6. Dental form filing Checklist
  7. Additional supporting information/exhibits
  8. Redlined versions of all related forms:
     - Outline of Coverage
     - Policy/Contract/ Evidence of Coverage
     - Certificate of coverage (group plans)
     - Rider, endorsement
  9. Redline Versions of Rate related materials
  10. Statement of Variability
  11. Certificate of Readability
  12. Copy of approved confidentiality request (per OSI Bulletin #2022-003)
- Filing Fee Tab
  1. Filing fees due pursuant to 59A-6-1V - $80 per package/Schedule of Benefits or Outline of Coverage

The following documents must be included with SERFF Binder in Plan Management:

- Associated Schedule Items
    1. All form and rate filing forms must be associated appropriately
- Templates Tab
    1. Plan and Benefit Template
    2. Network ID Template
    3. Service Area Template
    4. Essential Community Provider (ECP)/Network Adequacy Template
    5. Rate Data Template
    6. Rating Business Rules Template
    7. Transparency in Coverage Template
- Binder Supporting Documentation Tab
    1. QHP Issuer Compliance Plan and Organizational Chart Cover Sheet Template
    2. Cover Sheet
    3. Compliance Plan
    4. Organizational Chart
    5. Essential Community Provider Supplemental Response Form
    6. Statement of Detailed Attestation Responses for SBM Issuers
    7. Partial County Service Area justification if applicable
    8. Stand Alone Dental Plan Actuarial Value Supporting Documentation and Justification
    9. Stand Alone Dental Plans - Description of EHB Allocation
    10. A screen print of the output obtained from running the CMS tools
    11. Plan ID Crosswalk Template
    12. Issuer URL Template
    13. Frozen Template
    14. Administrative Data Template
    15. Network Adequacy Attestation

Sec. 3.1.1: Administrative Information

The SADP certification process requires an Issuer to submit administrative data that will be used for operational purposes. An Issuer is required to submit this information annually as part of their Binder Submission and report changes to previously reported information within 30 days. Issuers must contact OSI for details on the data elements to be collected and their method of delivery to OSI and beWellnm.

Sec. 3.1.2: HIOS Issuer ID

Prior to completing a Plan and Benefits Template and submitting an SADP application, an Issuer

must register their HIOS Product IDs via HIOS and obtain HIOS Issuer ID for Rate Review.

Sec. 3.1.3: Required Use of CMS Review Tools and Data Integrity Tool

An Issuer must use the CMS Review tools prior to submitting data to OSI and submit a screen print of the tool review outputs. Failure to identify and correct errors identified by the CMS review tools prior to submission may result in denial of an SADP certification. The review tools are available at https://www.qhpcertification.cms.gov/s/Review%20Tools.

Sec. 3.1.4: URLs

A SADP Issuer must submit CMS mandated URL data for the plan(s) it intends to offer on the Exchange. URL links in member facing materials should lead to a live, active webpage that contains accurate information by the deadlines described in Sec. 2.11. These links must be active prior to the certification due date.

Sec. 3.1.5: Alignment of Data Template information with Rate filing documentation

All data contained within an SADP Application must be complete, accurate and consistent. The information included in the policy documents, OOC, data templates, actuarial memorandum and supplemental documentation submitted as part of the application must be consistent. In addition, the information reported in HIOS and the beWellnm Plan Management portal must be consistent with the information included in the SADP Application submitted via SERFF.

Sec. 3.2: Standardized Naming Convention

Sec. 3.2.1: Documents Using Standardized Naming Convention

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

- Actuarial memorandum
- Dental rate filing checklist
- Dental form filing checklist
- Rate Manual
- All forms under the Forms Schedule Tab

All naming conventions and terminology must be consistent between the rate/form 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. In addition, the plan names should reflect if the plan is high/low and pediatric/adult.

Sec. 3.2.2: Naming Convention

CarrierName_MMDDYYYYmkt_ Plantype_v#_ Filedesc.filetype

- **CarrierName**: Up to 6 Characters which identify the carrier
- **MMDDYY**: e.g., 01012024 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 (at least 2 employees)
- **Plantype: indicate one of the following for the rate filing materials (actuarial memorandum, rate filing checklist, etc.). Different forms may be filed for different plan types in the same filing, so different forms may reflect different plan types.**
  - SADPF (Family dental coverage – pediatric and adult)
  - SADPP (Pediatric only coverage)
  - NSADPF (Non SADP - Family)
  - NSADPA (Non SADP – Adult only)
  - NSADPP (Non SADP - Pediatric only)
- **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
  - **RM** – Rate manual
  - **RTCK** – Rate checklist
  - **FMCK** – Form checklist
  - **CER** = Certificate/EOC
  - **OOCH** = Outline of Coverage (High)
  - **OOCL =** Outline of Coverage (Low)
  - **POL** = Policy/Contract
  - **AP** = Application
  - **EF** = Enrollment form
  - **End** = Endorsement
  - **Rd** = Rider
  - **ID =** ID Card
  - **ECPT -** Essential Community Providers Template

Rate Filing Example: ABC_010124_i_SADPF_v1_RTCK. Xlsx is the initial 2024 SADP rate filing checklist for the ABC Health Plans individual filing for both pediatric and adult coverage.

Forms Example: ABC_010124_i_SADPP_v2_Plan1_OOCH.xlsx is the 2nd revision of the

Outline of Coverage for the High individual Pediatric Only Plan, named Plan 1*, offered by ABC Health Plans.

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

Section IV: Actuarial Memorandum Requirements

Sec. 4.1: Overview

Provide the information listed below in the actuarial memorandum as an attachment under the Supporting Documentation tab in SERFF. If a filing includes more than one type of product, e.g., dental and vision, or HMO and PPO, a separate actuarial memorandum is required to be submitted for each different type of product.

The Actuarial Memorandum instructions below provide the minimum information required to be included in the actuarial memorandum when submitting dental rate filings in New Mexico. Dental 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 dental products and plans in New Mexico.
If any information provided is not broadly applicable to all products and plans included in the submission, please clearly indicate to which products and plans the information applies.

Sec. 4.2: General Information

This section of the Actuarial Memorandum should include general information about the carrier and the policies which are the subject of the submission. The information provided pursuant to this section should include at least the following:

Sec. 4.2.1: Company Identifying Information:

Provide the following information that identifies the carrier submitting the memorandum. The information must be the same as the entries in the general information section of the Dental rate filing checklist:

1. Company Legal Name: the organization's legal entity name.
2. State: the state that has regulatory authority over the policies (NM).
3. Type of entity, including the NM statute under which the legal entity is licensed.
    a. Life & health insurer
    b. HMOs (NMRS 59A-46)
    c. Prepaid dental – (NMRS 59A-48, NMAC 13.10.6.)
    d. Nonprofit Health Care Plans (NMRS 59A-47)
    e. PPO (NMRS 59A-22A)
    f. Fraternal Benefit Societies (NMRS 59A-44)
4. HIOS Issuer ID: the HIOS ID assigned to the legal entity.
5. Market: the market in which the products and plans are offered (individual or small

group).

6. Effective Date: the effective date of the rate proposal.

Sec. 4.2.2: Applicable Policy Forms

List the policy form(s) associated with the rate filing.

Sec. 4.2.3: Company Contact Information

Provide the following information detailing how OSI should contact the company if additional information is needed to complete the review. The certifying actuary should be one of the contacts, although not necessarily the primary. Please feel free to include as many secondary contacts as needed and include the indicated information.

- Primary contact (required)
    1. Primary Contact Name: Provide the name of the person at the company who will serve as the primary contact for the submission. The regulator will contact this person if there are questions related to the information submitted, or if additional information is needed.
    2. Primary Contact Telephone Number: Provide the phone number for the primary contact.
    3. Primary Contact Email Address: Provide the email address for the primary contact.
- Secondary contact(s) (optional):
    1. Secondary Contact Name:
    2. Secondary Contact Telephone Number:
    3. Secondary Contact Email Address:

Sec. 4.2.4: Summary of Benefits

In this section of the Actuarial Memorandum, include a benefit chart showing high-level details of the covered services and applicable member cost-sharing (copays, deductibles, coinsurance, out-of-pocket maximums, waiting periods and annual year limits) for each Plan. Sufficient information should be provided so that a reviewer would have a basic understanding of the benefits provided for each Plan without a review of the Schedule of Benefits. The information provided in this section must demonstrate compliance with the required minimum benefits provisions of 13.10.35.10 NMAC and may be provided in a separate exhibit and referenced in this section.

- Provide separate charts for Adult and Pediatric benefits if they vary.
- At a minimum, the benefit chart should contain a row for each Service Category (Diagnostic, Preventive, Basic, Major, Orthodontia).
- If there are multiple levels of member responsibility within a Service Category, please indicate the Range.
- Provide details describing member cost-sharing for the most common services such as oral evaluations, bitewing x-rays, prophylaxis, topical fluoride, sealants, simple

extractions, and composite filings.

Sec. 4.2.5: Issue age Range
Indicate the issue age range for these plans.

Sec. 4.2.6: Renewability
Describe the terms under which policies or contracts may be renewed.

Sec. 4.2.7: Marketing Method
Indicate the methods used to inform consumers of the availability of the plans. State if plans will be offered on and/or off the beWellnm.

Sec. 4.3: Scope and Purpose of the Filing
In this section, the actuary must provide the proposed rate change(s) and information related to the proposed rate(s) and associated change(s). If the proposed rate adjustment varies by product, the information provided should clearly identify which proposed adjustments apply to which products. Include all products which are intended to be part of this filing, including those products for which no rate adjustment is being proposed. The information that must be provided is detailed in the sections that follow.

Sec. 4.3.1: Applicable Laws
Provide the applicable federal and/or state law(s) with which the filing is intended to comply.

Sec. 4.3.2: Plans offered
In this section, provide all HIOS Plan IDs and specify which plans were offered in 2023 and which plans will be offered in 2024. Specify if any plans are new or terminated from the prior year. Also, include the specific marketing names for each plan.

Sec. 4.3.3: Proposed effective date of rate change.
Indicate the proposed effective date of the rate change.

Sec. 4.3.4: Rate change history
Provide the list of rate changes that have been approved in the past, separately for adult and child plans. Include the approved rate change percent with a month/year effective date.

Sec. 4.3.5: Reason for Rate Change(s)
Provide the quantitative impact and a narrative description of all significant factors driving a proposed rate increase. As an example, these factors could include:

- Trend
- Benefit design changes
- Changes in taxes or fees imposed on the carrier
- Changes in federal or state law
- Impact of COVID
- Other

Sec. 4.3.6: Rate change by plan

Provide an exhibit detailing the rate change by plan. If the requested rate change is not the same across all products and plans, provide an explanation as to why the rate changes vary. Provide in broad terms the aggregate rate change being requested. Provide the range of changes for all plans within this submission, and indicate any major changes proposed in the filing, such as changes in benefits. For existing plans that will discontinue in the projection period, please apply appropriate mapping of membership for purposes of calculating the average rate change.

Sec. 4.3.7: Rate change drivers

Provide a narrative description and an estimate of the magnitude of each component of the rate change.

Sec. 4.3.8: Variation of rate change by product

Provide an explanation of the variation in rate increase by product and plan, as applicable.

Sec. 4.3.9: Current Rates (For Rate Revisions) Include a complete set of current rates by rating area, separately for adult and child.

Sec.4.3.10: Proposed Rates

Include a complete set of proposed rates, separately for adult and child, by rating area and indicate if these rates apply to new and/or existing policyholders.

Sec. 4.4: Historical Experience (For Rate Revisions)

Sec. 4.4.1: Experience Period

Indicate experience period, including the runout date for claims, and explain the source of the experience period data.

Sec. 4.4.2: Experience Data

- Provide an exhibit showing the following New Mexico and Nationwide data for the last five full calendar years:
    1. Earned Premium by plan and rating area, separate for adult and child
        - Historical earned premium for each calendar year

- Include premiums for all years, regardless of ownership of this block of business

2. Incurred Claims by plan and rating area, separate for adult and child
    - Claims should exclude active life reserves ("ALR"), as applicable and exclude loss adjustment expenses ("LAE")
    - For the most recent year, include IBNP and indicate the runout date.
    - Provide the historical incurred claims for each calendar year from inception (for at least the past three full calendar years)
    - Include all claims regardless of ownership of this block of business
3. Member months by plan and rating area, separate for adult and child
4. Loss Ratio by plan and rating area, separate for adult and child
    - The loss ratio is calculated as Incurred Claims divided by Earned Premiums

Sec.4.4.3: Current Period Data

Provide an exhibit showing the following information as of a recent date (please specify the "as of" date), separately for adult and child:

1. Earned Premiums
2. Incurred Claims.
3. Member Months by plan and rating area
4. Loss ratio, calculated as Incurred Claims (2)/ Earned Premiums (1)

Sec. 4.5: Rate Development

Provide an exhibit showing the rate buildup, along with a detailed description of the methodology used to develop the rates for the plans/products included in this filing. This should include details of the data used as well as any adjustments used to develop the projected claims experience.

Sec. 4.5.1: COVID 19 Adjustment

Provide detailed quantitative and qualitive support for any adjustments to the experience data or to the projected claims to reflect the impact of COVID-19.

Sec. 4.5.2: Age Factors

Provide adjustment factors by age, along with quantitative and qualitative support.

Sec. 4.5.3: Rating Area Adjustments

Provide rating area adjustment factors, along with quantitative and qualitative support.

Sec. 4.6: Projected Experience

All projections should be submitted in Excel format with working formulas. All assumptions used in the projections should be clear.

- **With Requested Rate Change (For Rate Revisions).** Provide best estimates for the projection period of the following:
    1. Earned Premium, using best estimate assumptions, for the projection period.
    2. Incurred Claims, using best estimate assumptions, for the projection period.
    3. Expected Enrollment (Member Months)
    4. Loss ratio, calculated as Incurred Claims (2)/ Earned Premiums (1)
- **Without Requested Rate Change.** Provide best estimates for the projection period of the following:
    1. Earned Premium, using best estimate assumptions, for the projection period.
    2. Incurred Claims, using best estimate assumptions, for the projection period.
    3. Expected Enrollment (Member Months)
    4. Loss ratio, calculated as Incurred Claims (2)/ Earned Premiums (1)

Sec. 4.7: Loss Ratio Requirements

Rates that are discriminatory, or not based on generally recognized and current actuarial standards of practice will not be approved. Carriers are required to provide a detailed description of the data source and methodology used to develop the expected loss ratio and provide quantitative support.

Pursuant to 13.10.35.9 F and I, effective on January 1, 2024, adult group and individual dental plans must meet a 65% minimum loss ratio. Information provided in section 4.6 will be used to determine compliance with the loss ratio requirements.

Sec. 4.8: Credibility of Experience Data

Include a statement related to the credibility of the experience data, explain the methodology used to determine such credibility, and the reasonableness of the methodology used, in compliance with actuarial standard of practice (ASOP) No. 25, Credibility Procedures. Additionally, provide quantitative development of the credibility formula, as applicable, in Excel format with working formulas.

Sec. 4.9: Assumptions

Provide detailed quantitative support along with a detailed description of the basis for each major assumption used in pricing, including:

- Expected membership (in member months).
- Annual Trend Rate.
    1. Provide quantitative support for the assumed annual claim trend. Appropriate quantitative support will include utilization as well as cost per unit. Indicate if the

trend support is based on Nationwide or New Mexico experience, and the basis for that experience (i.e., Individual market, Small Group market, etc.). This support should be provided in Excel format with working formulas.

2. Provide qualitative support for the assumed claim trend.

- Morbidity – If you are using another product as a guideline for claim costs for this product, please provide a comparison of the relative richness of each plan.
- Lapse Rates (Provide quantitative support, by duration, for actual historic lapse rates and projected lapse rates as used in the projection. Quantitative support should be provided in Excel format with working formulas.)
- Claim liability and reserves.
- Active life reserves.
- Underwriting.
- Expected distribution of business.
    1. Pediatric.
    2. Adult.
- Non-Benefit Expenses
    1. Administrative expenses. Provide qualitative and quantitative support for administration expenses used in the rate development
    2. Sales and marketing expenses, including commissions.
    3. Net cost of private reinsurance, if applicable.
    4. Premium Tax.
    5. Other Taxes, License and Fees. The market-wide adjustment for Exchange fee should be set to 0%. beWellnm pays the Exchange fee out of an assessment on the carriers. BeWellnm 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.
    6. Other Expenses.
- Profit and Risk Margin. Provide support for the included profit & risk margin and discuss any changes from the prior approved filing.

Sec. 4.10: Rating Factors

- Identify which rating factors are used for this product and provide support for the proposed factors, including, but not limited to:
    1. Age factors. Explain any differences in the age factors from the prior approved filing.
    2. Geographic factors. Explain any differences in the geographic rating factors from the prior approved filing.

3. Family composition. Explain any differences in the family composition factors from the prior approved filing.
4. Benefit plan factors.

- Provide a detailed description of the data source and methodology used to determine each of these factors and provide quantitative support where appropriate.

Sec. 4.11: Actuarial justification for the proposed rating tier structure(s).

Provide actuarial support for the proposed rating tier structure**.**

Sec. 4.12: Actuarial Value

Sec. 4.12.1: AV Pricing Model

Include a discussion of the model used to develop the actuarial value ("AV") along with an exhibit(s) showing the development of the AV for the pediatric EHB part of any stand-alone dental plan. In the derivation of the AV, show the claim cost used for each service classification (Diagnostic & Preventive, Basic, Major restorative, and Orthodontics, etc.). The AV Model demonstration should be provided in Excel format with working formulas.

Sec. 4.12.2: AV Certification

Attach the required AV certification in a separate document.

Sec. 4.13: EHB Apportionment for Pediatric Dental

Sec. 4.13.1: Pediatric EHB Apportionment

Provide the dollar amount of the expected premium allocated for the pediatric dental EHB. This amount will be used in calculations for advance payments of the premium tax credit (APTC). This amount may not be changed after certification, even if the rate is estimated. Provide qualitative and quantitative support for the determination of this amount.

Sec. *4.13.2*: Pediatric EHB Apportionment Certification

Attach the required certification in a separate document.

Sec. 4.14: Guaranteed vs. Estimated Rate

As excepted benefits, stand-alone dental plans have additional flexibility to adjust premiums based on other rating factors. The federal dental plan and benefits template includes a data field for the dental carrier to indicate whether it is committing to the rates in the template (guaranteed) and is thereby voluntarily complying with the rating rules, or whether the issuer reserves the right to make further premium adjustments (estimated).

Indicate if the rate for the submitted stand-alone dental plan is on a guaranteed or an estimated basis. The rates a consumer sees are calculated by beWellnm using the rate tables and the Business

Rules template. By indicating that the rate is a "guaranteed rate," the carrier is committing to charging the premium shown in the rate tables template.

Sec. 4.15: Reliance on Others

If, in preparing the rate filing submission, the certifying actuary relied on any information or underlying assumptions provided by another individual, the information relied upon and the name of the individual providing that information should be disclosed, along with a description of the steps taken to ascertain the reasonableness of the data being relied upon.

Sec. 4.16: Actuarial Certification

The certifying actuary must be a member of the American Academy of Actuaries, in good standing, and have the education and experience necessary to perform the work. The actuary must develop rates in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs may apply, particular emphasis is placed on the following:

- 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. 41, Actuarial Communications.
- ASOP No. 56, Modeling

At a minimum, the actuarial certification must include the following:

- Identification of the certifying actuary.
- A statement that he/she is a member of the American Academy of Actuaries and meets the "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States".
- A certification that the proposed rates are:
    1. In compliance with all applicable state and federal statutes and regulations.
    2. The expected loss ratio meets the minimum loss ratio requirements of the State of New Mexico.
    3. Developed in compliance with the applicable Actuarial Standards of Practice.
    4. Reasonable in relation to the benefits provided and the population anticipated to be covered.
    5. Neither excessive nor deficient.
    6. Not unfairly discriminatory.

Section V: Marketplace Certification

Sec. 5.1: SADP Certification Requirements

All SADPs intended to be sold on the Exchange must be approved and certified by beWellnm. An Issuer may apply to offer a SADP that includes coverage of pediatric dental essential health benefits. An Issuer may also apply to offer a SADP that includes both pediatric and adult dental benefits, or adult-only coverage.

Only a SADP certified by OSI can be offered through beWellnm. Each SADP must be certified annually and satisfy these general requirements:

- Issuer is licensed and in good standing;
- Issuer complies with non-discrimination rules;
- SADP meets service area and network access requirements, including ECPs; and
- SADP complies with benefit design standards such as cost-sharing limits, actuarial value requirements and essential health benefits designed for an SADP.

Sec. 5.2: Filing Fees

NMSA 1978, §59A-6-1(V) requires a rate filing fee to be submitted for each SADP variation. This means that a $50 fee is due for the rates associated with each OOC. A package submission fee must be paid for each combination of a single policy, its associated application, OOC, and riders or endorsements. For example, if the filing submission includes 1 Policy, 1 Certificate and 10 OOCs, the total fees due would be 10 x (50+30)=$800.

Sec. 5.3: Certification and Recertification of an SADP

An Issuer must submit SERFF filings and the associated Binder to OSI by the applicable submission deadline. The Plan Management Binder must be accurately associated with the form and rate filing and contain all templates and requested SADP data elements.

Sec. 5.4: Outline of Coverage

An Issuer must provide an Outline of Coverage (OOC) for each SADP. The file name for each OOC must indicate if the plan provides adult or pediatric dental coverage and whether it is a high or low plan. In addition, the terms used in the OOC must be consistent with the terms used in the policy forms, binder and template. For example, an Outline of Coverage should not use the terms “Basic”, “Intermediate” and “Major Services”, when the P&B template uses the terms “Routine Dental Services”, “Dental Check-Up”, “Basic Dental Care”, “Orthodontia” and “Major Dental Care”.

As with all forms, each OOC must have a form number in the lower left corner and a HIOS Plan Standard Component ID in the right lower corner of the form.

Sec. 5.5: Community Provider (ECP) Requirement

An SADP network must include ECPs as required in 45 C.F.R. §156.235, as long as that ECP provides dental services.

Sec. 5.6: Actuarial Value

A pediatric SADP must provide the pediatric dental EHB mandated by the NM Benchmark plan and meet the actuarial value requirement specified in 45 C.F.R. § 156.150.

Adult dental benefits are not subject to any actuarial value requirement.

Sec. 5.7: Non-Discrimination

An Issuer and its SADP must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation, and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. 45 C.F.R. § 156.200(e) and 156.225(b). OSI will review information contained in the contract, Plans and Benefits Template, OOC and all relevant documents, including, but not limited to the "explanations" and "exclusions" sections, to identify potentially discriminatory anomalies or wording.

Sec. 5.8: Licensing and Good Standing

An SADP Issuer must be licensed and in good standing in New Mexico. 45 C.F.R. § 156.200(b)(4). OSI, in consultation with CMS and beWellnm, will consider any complaints it receives and other QHP issuer oversight findings, including state enforcement findings, to determine whether an Issuer is in good standing.

Sec. 5.9: Service Area

An Issuer must identify the service area associated with each proposed SADP and disclose it in the OOC. An Issuer must offer at least one plan with a state-wide service area. Any other service area must cover a minimum geographic area that is at least the entire geographic area of a county, or a group of counties, unless OSI determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interests of qualified individuals and employers. 45 C.F.R. § 155.1055(a). OSI will review to ensure that the service area of an SADP has been established without regard to racial, ethnic, language, or health status-related factors as specified under section 2705(a) of the Public Health Service Act (42 USC § 300gg-4(a)), including medical history and genetic information, or other factors that exclude specific high utilizing, high cost or medically underserved populations.

Section VI: Definitions

- Stand Alone Dental Plan or "SADP" means a dental plan that provides pediatric oral services established as an essential health benefit under ACA § 1302(b) and defined under the New Mexico Benchmark plan.
- Service Area – the geographical area where the insurer's members can get covered care under their plan.
- Qualified Dental Plan or "QPD" means a Stand-Alone Dental Plan certified to be sold through the New Mexico Health Insurance Exchange, beWellnm.
- Outline of Coverage or "OOC" is the schedule pages or summary of benefits and coverage that includes the cost-sharing features of the plan.