# OSI Large Group Submission Guide

# General Information and Background

## Purpose

This guide provides information about the processes and standards that govern submission and review of a proposed large group major medical plan in New Mexico.

## Contact

Please direct all questions regarding submission and review processes to Brittany ODell at Brittany.ODell@osi.nm.gov.

# General Large Group Health Plan Requirements

To offer a large group health insurance plan in New Mexico a carrier must satisfy these criteria:

- Hold a New Mexico certificate of authority for its health product line.
- Meet all form and rate filing requirements and deadlines imposed by law and this guide.
- Satisfy all federal requirements for a large group health plan as specified in the Public Health Services Act as amended by the ACA.
- Submit a product form and rate filing at least 180 days prior to the effective date of the proposed rates.

## License and Good Standing

A carrier must be licensed and in good standing in New Mexico. OSI will consider any complaints it receives and other carrier oversight findings, including state enforcement findings, to determine whether a carrier is in good standing.

At a minimum, to satisfy the "good standing" requirement, a carrier must satisfy compliance standards mandated by state law, including timely submission and approval of compliance filings.

A large group plan that offers more favorable cost-sharing for benefits received from contracted providers must have an adequate provider network. Network adequacy standards and compliance filing requirements are found in the OSI Network Adequacy filing guides available on the Life & Health page of the OSI website.

If a proposed plan offers more favorable cost-sharing, or if an enrollee obtains benefits from a provider who is in a subset, or tier of all contracted providers, the Carrier must establish network adequacy for the network or network tier with the most favorable cost-sharing features. Before approving a large group plan, OSI must approve the network associated with a specific plan design. If a carrier proposes to offer multiple plan designs that will have different networks, or network tiers, approval of the network for one plan design will not satisfy approval requirement for a plan design with a different network configuration. The Carrier must obtain approval of each distinct network configuration. For tiered networks, a carrier is required to obtain an approval only for the network tier that offers the most favorable cost-sharing. Also, the Summary of Benefits and Coverage (SBC) must disclose the cost-sharing applicable to all services and benefits obtained at each in-network tier and out-of-network if applicable.

## Service Area

The EOC for a proposed large group plan must clearly identify the service area.

A carrier who proposes to change a service area after the initial data submission must petition OSI. OSI will approve a change to a service area under very limited circumstances, such as:

- To address limitations in provider contracting (the Carrier must provide substantial documentation of its contracting efforts, including a list of providers with whom the carrier attempted to contract, and the contracts offered).
- Expansions at the request of the state to address an unmet consumer need.

## Rates

A carrier must file proposed base rates for each large group plan. OSI will review proposed base rates, justifications, and actuarial memoranda for compliance with state and federal rating standards, as well as OSI issued guidance.

## Rate Manual

A Rate Manual must contain the following items:

- Table of contents.
- Insurer name on each consecutively numbered rate page.
- Identification by form number of each policy, rider, or endorsement to which the rates apply.
- Brief description of benefits, types of coverage, limitations, exclusions, and issue limits.
- Description of revised rating classes, factors, rating variables, and discounts.
- Examples of rate calculations.
- Commission schedule(s) and fees.
- Underwriting guidelines and/or underwriting manual.

A carrier shall provide base rates and a supporting actuarial memorandum for publication on OSI's rate review website as required by NMSA 1978, Section 59A-18-13.2(D). If a carrier requests confidential treatment of any part of an actuarial memorandum, the carrier must submit a complete confidentiality request form and declaration at least 30 days before the rate filing. A carrier may request confidential treatment of part of a rate filing contemporaneous with the filing. However, if the request is denied, the carrier will not be allowed to withdraw the filing and the materials will be considered a public record of OSI. The OSI will not deem any rates confidential. Also, past confidential treatment of any type of material or information does not ensure that a future filing of such material or information will be deemed confidential.

## Actuarial Memorandum

An Actuarial Memorandum must:

- Include the scope of the filing, and a listing of the forms to which the filing applies.
- Demonstrate that trends are adjusted due to fluctuation in large claim amounts or provide an explanation, if adjustments were not made;
- Describe the source claims data and the methodology used to develop the cost and utilization projection factors, including adjustments made to the data for inflation in unit prices of medical services; deductible leveraging; risk profile changes, and medical technology changes;
- Demonstrate that changes due to age, gender, or region were documented, supported, and are reasonable;
- Demonstrate that the changes in cost for changes in benefits are reasonable;
- Demonstrate that adjustments for anticipated changes in networks are supported; and
- Demonstrate that changes in benefits are consistent with changes in policy forms.
- Be signed by a Member of Society of Actuaries, Casualty Actuarial Society, or American Academy of Actuaries who meets "Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States" as adopted by the American Academy of Actuaries.

A Justification of Rates must include:

- Description of proposed changes in coverage, rates, networks and commissions.
- History of previous New Mexico rate revisions to the base rate as well as the average rate changes.
- Actuarial justification of proposed rates revision (increase/decrease) including any revisions to rating variables. Any rating variables must be clearly defined and consistently applied. Quantitative and qualitative support for the change in base rates. This should start with the experience data used and reflect all adjustments, including, but not limited to trend, morbidity, benefit design, etc.
- Components of the average rate change requested
    - A description as well as the quantitative impact of each component of the rate change.
    - Significant differences between the average rate change and the change in base rates must be explained.
- Non-claim expense components as a percentage of gross premium for the proposed and previously approved rates.
- Trend assumption
    - Description of the trend development process in sufficient detail so that another practicing health actuary would be able to determine the reasonableness of the trend assumption.
    - Detailed quantitative support for the trend assumption. This should demonstrate utilization and unit cost changes for medical and prescription drugs separately by service category and combined.
- Credibility methodology
    - Provide detailed description of the methodology used to determine credibility and demonstrate compliance with ASOP 25.
- Impact on rates as a result of each of the changes with actuarial justification.
- Expected loss ratio(s) after the proposed changes with actuarial justification.
- Calculation of the projected federal MLR.
- Calculation of the traditional loss ratio (incurred claims/earned premium)
- Historical comparison of traditional loss ratios and federal MLRs by year

An Actuarial Certification must state that:

- The identified certifying actuary is a Member of the American Academy of Actuaries and meet the qualification standards for rendering statements of actuarial opinion in the US (USQS) with respect to the filing of rates for health insurance products.
- The filing is compliant with all applicable laws and regulations of the State of New Mexico.
- The filing is compliant with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans.”
- The expected loss ratio meets the minimum requirements of the State of New Mexico.
- The benefits are reasonable in relation to the premiums charged.
- The rates are not unfairly discriminatory.

## Rate Report

Carriers must complete the Rate Report that’s included at the end of this guidance and upload under the “Supporting Documentation” tab. Once the filing is approved, OSI will post the report on the under the Health Rate Review portion of its website.

## Non-Discrimination

A carrier shall not discriminate based on an individual's age, expected length of life, present, or predicted disability, degree of medical dependency, quality of life, or other health conditions. NMSA (1978) § 59A-16-11. In addition, a large group plan cannot include terms that explicitly discriminate, have a discriminatory impact, or have a benefit design that has the effect of discouraging the enrollment of individuals with significant health needs.

OSI will review proposed plan documents to identify potentially discriminatory wording or impacts.

## Plan Design

Each large group plan must comply with the coverage, cost-sharing and benefit mandates of the New Mexico Insurance Code (NMSA Chapter 59A) including Section 59A- 16-13.1 NMSA 1978; Chapter 59A, Article 18 (The Insurance Contract), Chapter 59A, Article 22 (Health Insurance Contracts); Chapter 59A, Article 22A (Preferred Provider Arrangements); Chapter 59A, Article 23 (Group and Blanket Health Insurance Contracts); Chapter 59A, Article 22B (Prior Authorization), Chapter 59A, Article 23E (Health Insurance Portability); Chapter 59A, Article 57 (Patient Protection Act), Chapter 59A, Article 57A (Surprise Billing) and, as applicable, Chapter 59A, Article 46 (Health Maintenance Organizations).

## Prescription Drugs Formulary

A carrier must publish a drug formulary list for each proposed plan. OSI will review each formulary to ensure non-discrimination in prescription benefit design, step therapy and MHPEA compliance. A formulary must be up-to-date, accurate, and include a complete list of all covered drugs. The formulary must also include quantity limits, tiering structure, prior authorization, and step therapy requirements, as well as any restrictions on the manner, in which a drug can be obtained. A formulary must include and identify prescription drugs required by the ACA, as well as drugs covered as a medical benefit. A formulary must demonstrate compliance with step therapy prohibitions of medically necessary drugs approved by the FDA for the treatment of cancer and autoimmune disorders and indicate that access to qualifying prescription drugs subject to step therapy exceptions will be approved for no less than the duration of the therapeutic effect of the drug. Lastly, the formulary must demonstrate compliance with HB 53.

In addition, the drug formulary must demonstrate compliance with the following:

- Section 59A-22B-8
- Section 59A-23-16
- Section 59A-23-24
- Section 59A-23-26
- Bulletin 2021-009

Each formulary must identify all covered Behavioral Health (BH) drugs with a unique marker such as "BH" or "B" and the marker must be explained in the preface of the formulary. A carrier may submit a list of all BH drugs separately in SERFF and upload it under the Form Schedule Tab in SERFF for review and approval. The information contained in the BH list must be consistent with the information in the complete formulary.

The formulary must be published in a manner that is easily accessible. A formulary is easily accessible when it can be viewed on the plan's public website, through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy/member number. If a carrier offers different formularies for different plans, each the formulary must clearly identify the plan to which it applies. The Certificate must clearly describe the formulary coverage, the process an enrollee can follow to request access to a drug not on the formulary, and the process to appeal a carrier's denial of a request for such an exception.

## SERFF Filing Submission Requirements for Large Group Major Medical Product Filing Submissions

This section outlines the carrier and plan-level submission requirements for each large group plan. A carrier must submit complete rates, forms and supporting documents through SERFF. OSI will not begin review of a proposed large group plan until the carrier submits all associated forms and rates. All forms and rates associated with each unique plan design constitute a single package for determining fees. The OSI will not accept large group filings that include multiple EOCs, SBCs or associated rates, or that include substantive variability that is not clearly mapped.

### Readability

Submitted forms must comply with the following readability standards found under Section 59A-22-2 NMSA 1978, and Section 59A-19-4 NMSA 1978:

- The readability score must be based on the Microsoft Word Flesch Reading Ease test and have a score of 40 or higher. Forms with a Microsoft Word Flesch Reading Ease score lower than 40 will not be approved by OSI.
- Forms with more than 3,000 words printed on not more than three pages, or more than three pages of text regardless of the number of words, shall contain a table of contents.
- Each form must be printed in font size not less than 10 point font.
- Each form entered under the SERFF Forms Schedule tab shall include the form's readability score.

### Filing Fees

Pursuant to Subsections V(1) and V(2) of Section 59A-6-1 NMSA 1978, an issuer must pay a rate and form fee of $80 for each package. A package is each unique combination of EOC, SBC, Application, Enrollment form, Formulary and any Riders/Endorsements.

### Confidentiality Request Policy

OSI recognizes that carriers may consider certain information to be a trade secret or otherwise eligible for confidentiality under New Mexico law. Each confidentiality request must be submitted simultaneously in SERFF and to legal at confidentiality.requests@osi.nm.gov pursuant to Bulletin #2024-018.

Please note that expedited requests and exceptions to the process will not be accepted.

Confidentiality request forms must be complete, accurate and specify the form name of and parts of the Large Group submission that need to be kept confidential. For more information regarding permanent confidentiality requests and determinations, review Bulletin 2024-018.

It is the issuer's responsibility to ensure that:

1) Confidentiality requests are submitted timely;
2) Approved confidentiality determinations are uploaded into SERFF; and
3) Redacted versions must only redact proprietary information. OSI will object to heavily and unnecessarily redacted items.

OSI will set non-confidential and redacted items for public access when the filing is approved. Failure to adhere to the confidentiality process will result in OSI setting all items for public access.

Any inquiries regarding confidentiality requests and determinations should be directed to David Black at david.black@osi.nm.gov

## General Rules

All data in a large group filing must be complete, accurate and consistent between the EOC, SBCs and all other plan data.

A carrier must submit an existing large group plan for review annually. This requirement does not apply to products that are guaranteed renewable or under a multi-year contract unless there is a change in the forms or rates. Each large group plan submission must include the policy, certificate, SBC, formulary and riders, endorsements, application, and enrollment forms, if applicable. The policy documents, including but not limited to the Certificate of Coverage, must include all provisions enforceable under the insurance contract and specify all covered benefits, services, exclusions, limitations.

During the review process, all objections must be addressed timely, and the responses must be complete and comprehensive. Statements such as "We have revised the EOC" will not suffice as a response. A response comment must explain what revisions were made and flag, by page number or other readily identifiable citation, the revisions in the amended filing. The amended filing must highlight or redline the change.

### Policy and Certificate

Each Policy and/or Certificate of Coverage must meet the following criteria:

- Provide a list of all benefits and services that require prior authorization or provide a direct link to a webpage that includes this information.
- Provide a list of all benefits and services that are excluded under the plan. An exclusion shall only identify services and benefits that would be covered but for the exclusion. An exclusion that is redundant of another limitation or condition shall not be allowed.
- Include any standard language prescribed by OSI.
- Identify the Service Area
- Define Emergency Services no more restrictively than the definition in the Patient Protection Act.
- Include the maternity notice required by 13.10.2 NMAC.
- Demonstrate compliance with OSI Bulletin 2021-009. Unless the plan is HSA eligible, the policy language must indicate that no cost sharing applies to covered behavioral health services and drugs
- Identify and list the USPSTF preventive services that are available at no charge.
- Include a statement regarding no-cost sharing for Covid 19 testing, treatment, and vaccinations.
- A proposed plan must demonstrate compliance with the 2023 legislative changes related to:
    - No Cost-Sharing for Sexually Transmitted Infection Treatment
    - Anatomical Gifts Discrimination Prohibited
    - Chiropractic Services Insurance Cost Sharing Limits

- Prosthetic and orthotic devices coverage and cost-sharing requirements
- Insurance coverage for Breast Exam
- Insurance coverage for Persons with Diabetes
- Insurance Coverage for Biomarker Testing
- Prescription Drug Cost-Sharing
- Diabetes standardized language in Bulletin 2024-014
- Value Added Services may be described in the Policy and Certificate. However, the carrier must still comply with OSI Bulletin No. 2021-014 by filing a separate Value-Added Notice From. Please note that the Value-Added Notices must be filed separately for auditing and tracking purposes and added to the "Associated Filings" feature in SERFF.
- Include an explanation clarifying how an additional facility fees are treated.

## SBCs

An SBC must comply with the standards set forth in in 45 C.F.R. Section 147.200, and the requirements stated below.

**The SBC cannot be used to add substantive provisions to the contract other than cost-sharing elements. All substantive plan provisions must be clearly stated in the EOC. The SBC can only summarize the plan features and specify cost-sharing features.**

Each SBC must meet the following criteria:

- A separate SBC must be submitted for each unique plan.
- Each SBC must show the beginning and end dates for the applicable coverage period. If the coverage period end date is not known when the SBC is prepared, the plan or issuer is permitted to insert only the beginning date of the coverage period. For example: "Coverage Period: Beginning on or after 01/01/2025".
- Must be appropriately labeled and reflect the plan name and whether the plan is an HSA eligible High Deductible Health Plan (HDHP).
- Must have a unique form number and be listed as a separate item under the Forms Schedule tab of the SERFF filing submission.
- All URL links included on the SBC must be readily obtainable (that is, without requiring logging into a website, entering a policy number, clicking through several web pages, or creating user accounts, memberships, or registrations) to consumers and link directly to the information referenced on the SBC.
- Each SBC must state the name of the network that is being used and link the provider network to the URL address to the plan-specific provider directory. For example, "See [*insert actual network name*] Network at *www.xxx.com* or call [*1-xxx-xxxx*] for a list of network providers."
- Each SBC must provide a direct link to the plan-specific formulary under the "If you need drugs to treat your illness or condition" section.
- Each separate network tier and associated cost-sharing must be properly identified in the SBC.
- All terms included in CMS's Uniform Glossary shall be underlined and hyperlinked in the SBC.
- The SBC must contain a disclosure stating that facility fees may apply, and the insured should check with their provider.
- The "Are there services covered before you meet your deductible?" section of the SBC should

correctly list the services that are covered before the deductible.

- An SBC must reflect the following:
    - $25 cap on insulin
    - No cost-sharing for COVID tests, services, and vaccines
    - No prior- authorizations for gynecological or obstetrical ultrasounds
    - No cost sharing for behavioral health services and drugs (unless HSA eligible)
    - Physical therapy cost-sharing cannot exceed the cost-sharing charged for a PCP visit
    - Balance Billing is not allowed for out-of-network emergency care
    - Emergency Services must have the same cost-sharing in and out-of-network.
    - A Large Group plan must count third-party payments (such as drug manufacturer's coupons towards the insured's deductible and maximum-out-of-pocket.

If there is no cost to the insured, the SBC must reflect the term "No Charge" ($0 & 0% cannot be represented in lieu of the term). Additional SBC instructions, templates and related materials can be found on the DOL website at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers- and-advisers/sbc-instructions-for-completing-the-group-health-plan-coverage-new.pdf.

## Customized Large Group Plan SBCs

An SBC cannot contain variable provisions. A carrier who wants to issue a customized SBC shall submit the custom SBC for review and approval separately from the form and rate filing. Submission of a customized SBC is subject to these requirements:

- The customized SBC must be submitted as soon as reasonably possible and at least 10 days prior to the anticipated approval date.
- OSI review staff must be notified of the submission via e-mail. The notification must contain the number of the SERFF filing submission containing the customized SBC.
- Each customized SBC must be filed separately.
- Each filing submission must contain the appropriate amount of filling fees, which is $80 per SBC.
- Objections to a custom design SBC must be responded to within 48 hours to ensure timely approval of the SBC.
- A customized SBC must relate to a previously approved package of forms and base rates. A new actuarial memorandum is not required if the rates are allowed under the associated and approved plan and rates.

## Wellness Plans or Other Value-Added Products or Services

Rates shall not include the cost to the carrier of any value-added product or service, such as wellness plans 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. A value-added product or service notice must be submitted via SERFF separately. The statutory guidelines for value added products or services can be found in Section 59A-16-17(G) NMSA 1978. Value added offerings must be described in detail in the filing description and rating materials.

## Variability

Any information appearing in the form that is considered variable and subject to change must be bracketed to denote variability. The submission must include a Statement of Variability and maps that identify the conditions under which each variable item may change, all alternative content, and every interrelated variable substantive plan provision. The exact language as it will appear in the form that will be issued to the consumer, along with the explanation for language variability, must be included in the Statement of Variability. The Bureau is sensitive to speed to market considerations and recognizes the need to include variable items in certain submissions. However, excessive variability and inadequate mapping that prevents the OSI from readily determining each possible plan configuration precludes meaningful review and will result in plan disapproval.

Variable language must meet the following criteria:

- Each variable item must be denoted in square [ ] brackets. Use of another character may be requested with an explanation. Any character must be consistently used.
- If contract language is bracketed because it will either be included or removed, the Statement of Variability must provide such information and explain under what circumstances the information will be included or removed.
- The Statement of Variability must present reasonable and realistic ranges for each item. For all numeric values, minimum and maximum amounts must be presented. All variable items must be defined sufficiently so that compliance with statutory or regulatory requirements can be determined.
- The Statement of Variability must include an explanation of the variability provided in the same order in which it appears in the form (i.e. by page number and paragraph).
- 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.
- Different types of benefits may be variable only for inclusion or exclusion within the form.
- The use of brackets within the brackets is not permitted, except when variability is necessary to identify a period or other numeric values.
- An SBC cannot contain variability.

## Identification Cards (ID) Cards

ID cards must be submitted for review and approval. The ID cards should have OSI’s Managed Health Care Bureau’s website and phone number on the card, so a consumer knows where to file a complaint. In addition, the cards must include the plan marketing name as shown on the SBC and indicate that there is no cost-sharing for covered behavioral health care services. Issuers may mark the plan name, as well as other administrative information as variable, as long as they provide an SOV describing the variability.

# Rate Transparency Report

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| I. High level narrative summarizing rate changes for 2025 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: |
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| II. High level narrative summarizing form changes for 2025 submission: |
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| III. High level description of how the revised rates were determined, including general description and source of each assumption used: |
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| IV. Expected federal medical loss ratio for blocks of business in existence for at least three years: |
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| 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: |
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| 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: |
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| 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: |
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