

Rate Transparency Report

BlueCross BlueShield of New Mexico

Small Group Rate Filing

Effective January 1, 2027

I. High level narrative summarizing rate changes for 2027PY 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:

In this filing, BCBSNM proposes the following rate changes:

- The 2027 Unified Rate Review Template (URRT) average rate action across all quarters is **21.2%**.
- For groups renewing during the first quarter of 2027, the rate action is **20.3%**.
- From the fourth quarter of 2026 to the first quarter of 2027, the rate action is **14.9%**.

Actual premium rate changes will vary by plan, rating area, and quarter.

The average rate increase is calculated using the 2026 rate tables, the proposed 2027 rate tables, and the membership distribution by plan, age, and area as of April 30, 2026. This methodology excludes both new and discontinuing plans and does not apply any member mapping to alternative plan offerings.

Estimated Components of Rate Change:

Component	Impact
Trend from 2026 to 2027	7.1%
Change in Trend Assumption	5.0%
Change in Underlying Experience (excl. trend)	4.0%
Change in Morbidity Assumption	1.8%
Change in Paid to Allowed Ratio	0.9%
Change in Risk Adjustment Payments/Receipts	0.8%
Change in Exchange Fees	0.0%
Change in Non-EHB Benefits	0.0%
Change in Non-Benefit Expenses (Excl. Exchange Fees)	0.6%
Change in Provider Networks/Reimbursement	0.0%
Change in State Assessment	-0.7%
Change in ACA Insurer Fee	0.0%
Change in Profit/Contingency (after tax)	0.0%
Other Changes	0.2%
Total Impact	21.2%

- *Trend from 2026 to 2027* represents the pricing year cost and utilization trend.
- *Change in Trend Assumption* is the difference in the proposed 2025 to 2026 cost and utilization trends to those used in the prior annual filing over the same period.
- *Change in Underlying Experience (excl. trend)* is the change in the proposed index rate from the prior annual filing after removing the impacts of the trend changes described above,

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demographic changes in the projected population, projected plan mix changes, and changes in provider networks/reimbursement.

- *Change in Morbidity Assumption* represents the impact of changes in the anticipated overall health status of the single risk pool.
- *Change in Paid to Allowed Ratio* isolates the impact of leveraging and cost-sharing changes by comparing the proposed paid to allowed factors to those used in the prior annual filing weighted by the projected population.
- *Change in Risk Adjustment Payment/Receipts* measures the impact of changes in expected risk adjustment levels to those used in the prior annual filing.
- *Change in Exchange Fees* is not applicable since no plans are sold on the exchange.
- *Change in Non-EHB Benefits* is not applicable since there are no proposed changes in non-EHB benefits from the prior annual filing.
- *Change in Non-Benefit Expenses (excl. Exchange Fees)* represents the impact of changes in administrative expenses including core admin, Blue Card fees and commissions.
- *Change in Provider Networks/Reimbursement* is the change in the average calibrated area network factor calculated on the projected population. Note that the area network factors are only used for determining the statewide allowed claim level. Separate area factors, which do not vary by network, and network factors, which do not vary by area, are used to determine rates at the plan level.
- *Change in State Assessment* represents the impact of changes in taxes and fees.
- *Change in ACA Insurer Fee* is not applicable since there is no change in the proposed ACA insurer fee from the prior annual filing.
- *Change in Profit/Contingency (after tax)* represents the impact of changes in target pricing margin.
- *Other Changes* include any changes not described above. The value is calculated as the total change divided by the product of the categorized changes.

The cost relativities among products differ between the experience period and the prospective rating period due to expected non-uniform changes in network reimbursement levels. In addition, rate variations occur across plans due to differences in cost-sharing structures, which affect leveraging and utilization patterns. As a result, proposed rate changes may vary by rating area, plan, and quarter. The minimum and maximum rate increases submitted in SERFF are the minimum and maximum quarterly-weighted rate increases by SCID and rating area found in tab 8 of the Rate Filing Template.

II. High level narrative summarizing form changes for 2027PY submission

- Changes made to language mandated in Bulletin 2023-023 to reflect expanded coverage requirements set forth in HB 38.
- We made changes to the booklets regarding HB 306.
- We made changes to the Out-of-Area Services regarding the PY2027 BCBS Association Update.
- We made changes to the Out-of-Area Services regarding the PY2027 BCBS Association Update.

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- MedsYourWay language changed to confirm it may not be available in all states or pharmacies, to the extent allowed by law.
- "Recommended Clinical Review" was removed from Benefit Booklet.
- We made additions to our Prescription Drug Riders due to SB 20.
- SBCs were adjusted to reflect Federal limits based on IRS guidelines for HDHPs/HSAs.
- MBTA Expansion. This is an expansion of the Medical Benefit Therapeutic Alternatives (MBTA) language added last year for HCAPA.
- Well onTarget name was removed from booklets.
- Same Sex-Trait Modification language added. Per 13.10.41 NMAC, Specified Sex-Trait Modification Procedures added to Covered Services.
- We made changes required in the PY26 Approved LG booklets to SG where appropriate for similar language.

III. High level description of how the revised rates were determined, including general description and source of each assumption used:

The rates were determined using updated base period experience with runout through April 30, 2026. Adjustments were made to reflect expected changes between the experience period and projection period, including but not limited to changes in morbidity, trend, population demographics, network contracting, plan benefits, and expenses. These assumptions come from a variety of sources, including historical experience studies, provider contracts, market risk studies, operating budget projections, and state and federal taxes and assessments.

IV. Expected federal medical loss ratio for blocks of business in existence for at least three years:

Block of business:	Exp. MLR current year 2026	MLR last year 2025	MLR 2nd prior year 2024	MLR 3rd prior year 2023
Small Group (85%):	86.68%	101.62%	92.89%	88.48%

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:

The minimum required MLR for the small group ACA line of business is 80.0%. The projected MLR is greater than 80.0%.

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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Trend factors are developed using data from BCBSNM's existing insured and self-funded business in New Mexico. The underlying dataset consists of PPO group accounts (including small group accounts) and includes credible experience across major service categories representing inpatient, outpatient, professional, other medical services, and prescription drugs. Service categories are selected to ensure sufficient credibility and to separate materially different encounter types (e.g., emergency room visits, maternity admissions, preventive care).

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:

	Premium Revenues '000' omitted			Claims History '000' omitted			Losses '000' omitted			Reserves '000' omitted		
	2023	2024	2025	2023	2024	2025	2023	2024	2025	2023	2024	2025
Small Group	157,451	171,482	183,175	138,531	158,511	185,304	-529	-4,876	-19,920	9,325	17,741	17,210

Plan	Needed Increase	Filed Increase	Form Number	Members	Open or Closed
PPO	20.0%	20.0%	NWMC-134904896	11,503	Open
EPO	24.6%	24.6%	NM481224 (01/27)	6,590	Open
HMO	17.6%	17.6%	NM82869_G_H_OF_0127	807	Open
Total	21.2%	21.2%		18,900	