Excepted Benefits
Rate Filing Guidance

State of New Mexico
Office of Superintendent of Insurance
13.10.34 NMAC effective March 8, 2023

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Section I: Overview

This guidance applies to rates related to excepted benefits products submitted to the New Mexico Office of the Superintendent of Insurance ("OSI"), in accordance with 13.10.34 NMAC, for products after the final effective date of the regulation as will be determined in Case No 2023-0007, or for products submitted for prospective review against the final regulation during the filing moratorium pursuant to Bulletin 2023-005.

Section II: General Guidance

Sec. 2.1: Applicability

This guidance is intended to apply to the following products submitted for review against the final version of 13.10.34 NMAC after March 8, 2023.

(1) accident only;
(2) specified disease or illness;
(3) hospital indemnity;
(4) other fixed indemnity;
(5) disability income;
(6) supplemental; and
(7) insurance similar to workers' compensation (non-subject worker).

Sec. 2.2: Prior Approval of Rates and Forms Required

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

A carrier shall not use rates or modified rates for an individual or group plan unless and until such rates are filed with and approved by the superintendent, except for rates for a plan issued to eligible members of an out-of-state group policyholder defined by 59A-23-3(A)(1).

Sec. 2.3: Limitation on Premium Increases

Pursuant to 13.10.34.17 (J)NMAC, a carrier shall not increase a covered person's premium under any plan, other than a disability income plan, during the first two years that the covered person's coverage is in force except in cases where one or more persons are added to the policy as covered persons during this two year period. The new premium resulting from the addition of a covered person(s) shall not change for the first two years the policy with the added lives is in force.

Sec. 2.4: Value Added Product or Service

Pursuant to 13.10.34.8(DD) NMAC, a carrier shall not provide or offer a value added product or service in connection with an excepted benefit plan if any part of the cost of providing the product or service is included in the plan rates. A carrier who proposes to offer a value added product or service must provide actuarial certification that the rates do not include the cost of providing any value .

Sec. 2.5: Prohibition on Bundling

Pursuant to 10.13.34.20 (B) NMAC, no carrier, directly or through an affiliated producer, shall market or sell a bundled combination of **individual** accident-only, specified disease, hospital indemnity and non-subject worker plans. An application that is used in connection with more than one type of plan subject to this rule shall include a conspicuous notice that the applicant cannot purchase more than one type of plan from the carrier using the same application. This provision does not preclude the same carrier from selling more than one product type to a single

purchaser as long as each policy is available at its own stated premium rate, independent of the other product types.

Pursuant to 13.10.34.20, a carrier shall not offer or provide memberships or discounts relating to health care services or products. The provisions of this subsection shall not apply to a plan sold through a group identified in Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978, or to a bona fide association.

Sec. 2.6: Group Versus Individual Coverage

Worksite plans and products are not considered to be individual plans or products if eligibility is contingent on being actively at work at a specific employer, or if there are any other provisions that tie covered individual to a specific employer, or union, or if employer contributions are used to pay premiums related to the plan or product.

Sec 2.7: Variability

Pursuant to 13.10.34.8 (Y)NMAC, a carrier who offers an individual plan with variable benefit types and levels shall submit for approval the outline of coverage and benefits that illustrates the plan design that would be available to a prospective covered person. A carrier who offers coverage to eligible covered persons under a group plan shall submit for approval an outline of coverage or certificate that corresponds with the plan design ultimately offered to those covered persons. A carrier shall comply with the variability guidance posted on the OSI website, including mapping requirements. Each distinct outline of coverage, or certificate shall be subject to a filing fee as specified in statute.

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.

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. See the Variability Guide for further details.

Additionally, pursuant to 13.10.34.17 I NMAC, a carrier shall not offer an excepted benefits plan to any person unless each possible plan design selectable by that person meets the Minimum Loss Ratio (“MLR”) requirements, described in Sections 4.7 and 5.8, below, and as reflected in an approved rate filing. For variable forms, a carrier cannot satisfy MLR requirements with average premiums for the form as a whole. The carrier must base MLR calculations on the average premium for each possible combination of benefits and levels offered by demographics used for underwriting. The superintendent reserves the right to reject a plan that has no

meaningful difference from another plan offered by the same carrier. These requirements do not apply to a non-contributory plan.

Sec. 2.8: 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 an excepted benefits submission, pursuant to Bulletin #2022-001. Issuers are expected to submit their best competitive and actuarily sound rates with their initial excepted benefits submission.

Excepted benefits carriers must use the Confidentiality Request Form and Determination Notice required by OSI, which is available online at: https://www.osi.state.nm.us/pages/bureaus/life-and-health-division/resources/confidentiality.

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. Excepted benefit 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:

1) Forms Schedule tab
   a) Clean copies of Policy, Certificate, Outline of Coverage, Schedule of Benefits, Rider, Endorsement, Application and Enrollment forms, as applicable
2) Rate/Rule Tab
   a) Rate manual
      i) Include base rates and details related to all of rating factors (benefit level, geography, premium class, gender, age, etc.) and how they are applied to produce the final rates.
   b) Sample rate calculation (may be included in rate manual)
3) Supporting Documentation Tab
   a) Actuarial Memorandum including required exhibits, prepared in accordance with Section IV, V or VI, as applicable.
   b) Additional supporting information/exhibits
   c) Redlined versions of all related forms:
      i) Outline of Coverage
      ii) Policy/Contract/ Evidence of Coverage
      iii) Certificate of coverage (group plans)
      iv) Rider, endorsement
   d) Redline Versions of Rate related materials, as applicable
   e) Statement of Variability
   f) Certificate of Readability
   g) Copy of approved confidentiality request (per OSI Bulletin #2022-001)
4) Filing Fee Tab
   a) Filing fees due pursuant to 59A-6-1V - $80 per package/Schedule of Benefits or Outline of Coverage

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

- Rate Manual
- All forms under the Forms Schedule Tab

All naming conventions and terminology must be consistent between the rate/form filing,

Sec. 3.2.2: Naming Convention

CarrierName_MMDDYYYYmkt_ Plantype_v#_ Filedesc.filetype

- **CarrierName**: Up to 6 Characters which identify the carrier
- **MMDDYY**: e.g., 07012024 for filings effective July 1, 2024
- **mkt**: **indicate one of the following**:
  - "i" for individual (non-group)
  - "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 (group only), so different forms may reflect different plan types.**
  - AO (Accident Only)
  - SD (Specified Disease or Illness)
  - HI (Hospital Indemnity)
  - OI (Other Fixed Indemnity
  - DI (Disability Income)
  - SUP (Supplemental)
  - OD (Other Disability) – similar to worker's compensation
- **v#**: v followed by the version number (increment for each update to the filing)
- **Filedesc**: indicate one of the following:
  - **AM** – Actuarial memorandum
  - **RM** - Rate Manual
  - **CER** = Certificate/EOC
  - **OOC** = Outline of Coverage
  - **POL** = Policy/Contract
  - **AP** = Application
  - **EF** = Enrollment form
  - **End** = Endorsement

- **Rd** = Rider

Rate Filing Example: ABC_07012023_i_SD_v1_RM. Xlsx is the initial 7/1/2023 specified disease rate manual for the ABC Life Insurance Company individual filing for specified disease coverage.

Forms Example: ABC_07012024_i_HI_v2_ _OOC.xlsx is the 2nd revision of the Outline of Coverage for the individual hospital indemnity product, effective on 7/1/2023, and offered by ABC Life Insurance Company.

Section IV: Actuarial Memorandum Requirements – Initial Rate Filing for New Products

Sec. 4.1: Overview

For new products, which have not been filed previously with OSI, provide the information listed below in the actuarial memorandum as an attachment under the Supporting Documentation tab in SERFF.

The Actuarial Memorandum instructions below provide the minimum information required to be included in the actuarial memorandum when submitting excepted benefits rate filings for new products in New Mexico.

Excepted benefits carriers are encouraged to include as much detail and supporting documentation as possible in the initial submission 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 that pertain to offering excepted benefits 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:

1. **Company Legal Name:** the organization's legal entity name.
2. **Type of entity**: the NM statute under which the legal entity is licensed.
3. **Market:** the market in which the products and plans are offered
    a. **Individual**: indicate if the coverage applies to worksite policies, or group). Note the restrictions on worksite policies stated in section 2.6.
    b. **Group:** Confirm that the group(s) to which this product will be marketed comply with Paragraphs (1) or (3) of Subsection A of 59A-

23-3 NMSA 1978 or is a bona fide association. State the size of the groups to which the product will be marketed.

4. **Effective Date:** the effective date of the rate proposal.

Sec. 4.2.2: Applicable Policy Forms

List the policy form(s), including riders, associated with the rate filing. Specify if this is an individual or group 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 summary showing high-level details of the covered services for the base policy and riders, as applicable. Sufficient information should be provided so that a reviewer would have a basic understanding of the benefits provided without a review of the Schedule of Benefits or outline of benefits.

Sec. 4.2.5: Pricing Basis:

Indicate if the product is priced on an issue age or attained age basis.

Sec. 4.2.6: Issue age Range

Indicate the issue age range for these plans.

Sec. 4.2.7: Renewability

Describe the terms under which policies or contracts may be renewed, e.g., guaranteed renewable, optionally renewable, conditionally renewable.

Sec. 4.2.8: Marketing Method

Indicate the methods used to inform consumers of the availability of the plans.

Sec. 4.2.9: Underwriting

Describe the underwriting approach, e.g., guaranteed issue

Sec. 4.3: Scope and Purpose of the Filing

In this section, the actuary must state that this is a new product, which has not been previously filed in New Mexico, and provide information related to the proposed rates, as 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: Proposed Effective Date of Rates

Indicate the proposed effective date of the rates.

Sec.4.3.3: Proposed Rates

Include a complete set of proposed rates, by each rating variable, such as age, family tier, tobacco, etc. This could be included directly in the actuarial memorandum or as an appendix/attachment/exhibit. If provided separately, include in this section a reference to that document by name (e.g., see Exhibit A).

Sec. 4.4: Rate Development

Sec. 4.4.1: Rate Development

Provide an exhibit showing the rate buildup, along with a detailed description of the methodology used to develop the rates for the products included in this filing. The methodology description should include details of the source of experience data used, its appropriateness for this purpose, credibility of the data used, as well as support for any adjustments used to develop the projected claims cost experience.

Pursuant to 13.10.34.17G(3) NMAC, a filing for a new pool shall be based on credible data from generally recognized industry sources. Therefore, for new

products, include documentation that the data used to develop the rates are credible and are derived from generally recognized industry sources.

Sec. 4.4.2: Age Factors

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

Sec. 4.4.3: Rating Adjustments

Provide all rating adjustment factors, as applicable, along with quantitative and qualitative support.

Sec. 4.5: Assumptions

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

Sec. 4.5.1: Membership

Provide expected membership (in member months)

Sec. 4.5.2: Annual Trend Rate (as applicable).

Provide qualitative and 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. This support should be provided in Excel format with working formulas.

Sec. 4.5.3: Mortality

Provide the mortality table, along with any adjustments made to reflect factors such as underwriting, and changes in incidence patterns since the development of the table. Provide support for any adjustments made to a standard mortality table.

Sec. 4.5.4: Morbidity

Provide the basis used for determining claim costs. If the experience from another product is used as the basis for claim costs for this product, provide a comparison of the relative richness of each product.

Sec. 4.5.5: Persistency

Provide a table with the lapse/termination rates, used in the development of rates, by duration. State if mortality is included in the lapse/termination rates and provide quantitative support in Excel format with working formulas.

Sec. 4.5.6: Claim Liability and Reserves

Describe the basis used to determine claim liability and reserves.

Sec. 4.5.7: Active Life Reserves

Describe the methodology used to determine active life reserves, including the interest rate and mortality rate assumptions used.

Sec. 4.5.8: Distribution of Business

Provide a table showing the expected distribution of business by the factors affecting pricing, such as gender, benefit level, age, and family tier.

Sec. 4.5.9: Expenses

Provide qualitative and quantitative support for each of the following:

1. Administrative expenses
2. Sales and marketing expenses, including commissions
3. Premium Tax
4. Other Taxes, License and Fees
5. Other Expenses.
6. Profit and Risk Margin

Sec. 4.6: Projected Experience

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

Provide best estimates for the projection period of the following:

a) Earned Premium
b) Incurred Claims
c) Expected Enrollment (Member Months)
d) Loss ratio, calculated as Incurred Claims (2)/ Earned Premiums (1),, without discounting. The loss ratio for a new pool shall be based on credible data from generally recognized industry sources.

Sec. 4.7: Minimum Loss Ratio Requirements

Pursuant to 13.10.34.17(I) NMAC a carrier shall not offer an excepted benefits plan to any person unless each possible plan design selectable by that person meets the minimum loss ratio requirements as reflected in an approved rate filing.

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.

Group and individual excepted benefits plans must satisfy a minimum loss ratio requirement, which may differ by coverage and renewal clause. Information provided in section 4.6 will be used to determine compliance with the loss ratio requirements.

§13.10.34.17I NMAC specifies that the minimum loss ratio standard applies separately to each combination of benefits.

Sec. 4.7.1: Minimum loss Ratio for Group Plans

Type of Coverage:	OR	CR	GR	NC
Medical Expense	65%	60%	60%	55%
Loss of Income and Other	65%	60%	55%	50%

Sec. 4.7.2: Minimum Loss Ratios for Individual Plans

Type of Coverage:	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

OR- Optionally Renewable: renewal is at the option of the insurance company;

CR- Conditionally Renewable: renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health;

GR- Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis;

NC- Non-cancelable: renewal cannot be declined, nor can rates be revised by the insurance company.

For the base policy and each rider separately, and for each combination of benefits, provide an exhibit showing anticipated loss ratios that demonstrate the minimum loss ratio standard will be met within three years of product launch. See §13.10.34.17(G)(3) NMAC. This exhibit is intended to demonstrate that the product is designed to comply with the requirements of 13.10.34.17(G)(3) NMA by the end of the third year after the product is first sold in the state.

Sec. 4.7.3: Average annual premium

Pursuant to 13.10.34.17, a carrier shall determine the average annual premium per form based on the distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation). Provide an exhibit demonstrating the calculation of the average annualized premium for each combination of benefits based on distribution of business by all significant criteria having a price difference, such as age, gender, tobacco and dependent status, and for the overall average annual premium. Include a detailed narrative description of the assumptions used to determine the average premium.

Sec. 4.7.4: Determination of High and low premium forms

Pursuant to NMAC §13.10.34.17(D) and NMAC §13.10.34.17(E), for group or individual plans, respectively, the minimum loss ratio threshold should be adjusted for low or high premium forms. A filing shall not have both high and low filing forms. Provide an exhibit in Excel format with working formulas demonstrating whether this is a low or high premium form and provide the calculation of the permitted adjustment. Include in this section of the actuarial memorandum, a statement indicating whether this is a low or high premium form, and demonstrating that the loss ratio threshold was adjusted appropriately, in accordance with the following formulas ((1) or (2)), as applicable :

(1) Loss ratio adjustment for low average premium forms. For a plan form, including riders and endorsements, under which the actual average annual premium (per certificate is low (as defined below), the appropriate ratio from the table in section 4.7.1, or 4.7.2, as applicable should be adjusted downward by the following formula:

$$RN = R \times \frac{(I \times 500) + X}{(I \times 750)}$$

where: R is the table ratio (see section 4.7.1 and 4.7.2);

RN is the resulting guideline ratio;

I is the consumer price index factor; and

X is the average annual premium, determined and included in section 4.7.3 above, up to a maximum of I x 250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI- U(1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

where:

a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;

b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of labor, bureau of labor statistics based on the 1982=100 basis; The CPI-U table for 2022 and earlier is available at https://www.bls.gov/cpi/tables/supplemental-files/historical-cpi-u-202212.pdf.

c) the CPI-U for any year (N-1) is taken as the value of September.
   i. For 1982, this value was 97.9;
   ii. For filings submitted in 2022, this value is 274.310
   iii. For filings submitted in 2023, this value is 296.808

d) For rate filings submitted during calendar year:
   i. 1983, the value of I is 1.00.
   ii. 2022, the value of I is 274.310/97.9 = 2.802
   iii. 2023, the value of I is 296.808/97.9 = 3.032

e) **Low average annual premium** is defined as average annual premium less than or equal to I x 250.
   i. For filings submitted in 2022, low average premium products have an annual premium less than or equal to **$700.50**
   ii. For filings submitted in 2023, low average premium products have an annual premium less than or equal to **$758.00**

(2) **Loss ratio adjustment for high average premium forms**. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined in item (1)(f) above), the appropriate ratio from the table 4.7.1 or 4.7.2 above should be adjusted upward by the following formula:

RN = The lesser of:

a) R x $\underline{(I \times 4000) + X}$

(I x 5500)

b) R + 5 percentage points, or

c) 68% for group products, and 63% for individual products.

where: R is the table ratio (see section 4.7.1 and 4.7.2);

RN is the resulting guideline ratio

I is the consumer price index factor (as defined in (1)(d) above)

X is the average annual premium, not less than I x 1500 (**4,203.00** for filings submitted in 2022, and **4548** for filings submitted in 2023 – see (d) below).

d) **High average annual premium** is defined as an average annual premium more than or equal to I x 1500.

i. For filings submitted in 2022, high average premium products have an annual premium more than or equal to **$4,203.00.**

ii. For filings submitted in 2023, high average premium products have an annual premium more than or equal to **$4,548.00.**

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: Rating Factors

Sec. 4.9.1: 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.
2. Geographic factors.
3. Coverage tier (family composition).
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. 4.10: Actuarial justification for the proposed rating tier structure(s).

Provide actuarial support for the proposed rating tier structure, in compliance with ASOP No. 12, *Rate Classification***.**

Sec. 4.11: 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. 4.12: 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 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 statement that the rates do not reflect the cost of any wellness plan or other value added products or services
- 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: Actuarial Memorandum Requirements – Rate Revisions for Existing Products

Sec. 5.1: Overview

For existing products for which rate revisions are being requested, provide the information listed below in the actuarial memorandum as an attachment under the Supporting Documentation tab in SERFF.

The Actuarial Memorandum instructions below provide the minimum information required to be included in the actuarial memorandum when submitting excepted benefits rate filings for rate revisions in New Mexico.

Excepted benefits carriers are encouraged to include as much detail and supporting documentation as possible in the initial submission 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 that pertain to offering excepted benefits 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. 5.2: 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. 5.2.1: Company Identifying Information:

Provide the following information that identifies the carrier submitting the memorandum:

a) **Company Legal Name:** the organization's legal entity name, and any DBAs.
b) **Type of entity:** include the NM statute under which the legal entity is licensed.
c) **Market:** the market in which the products and plans are offered
    a. **Individual**: indicate if the coverage applies to worksite policies, or group). Note the restrictions on worksite policies stated in section 2.6.
    b. **Group:** Confirm that the group(s) to which this product will be

marketed comply with Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978 or is a bona fide association. State the size of the groups to which the product will be marketed.

d) **Effective Date:** the effective date of the rate revision proposal.

Sec. 5.2.2: Applicable Policy Forms

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

Sec. 5.2.3: 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. 5.2.4: Summary of Benefits

In this section of the Actuarial Memorandum, include summary showing high-level details of the covered services for the base policy and riders, as applicable. Sufficient information should be provided so that a reviewer would have a basic understanding of the benefits provided without a review of the Schedule of Benefits or outline of benefits. In this section, also specify any changes to the benefits offered in the current policy and riders compared to those included in the prior filing, either in the base policy or rider(s)

Sec. 5.2.5: Pricing Basis:

Indicate if the product is priced on an issue age or attained age basis.

Sec. 5.2.6: Issue age Range

Indicate the issue age range for these plans.

Sec. 5.2.7: Renewability

Describe the terms under which policies or contracts may be renewed, e.g., guaranteed renewable, optionally renewable, conditionally renewable.

Sec. 5.2.8: Marketing Method

Indicate the methods used to inform consumers of the availability of the plans.

Sec. 5.2.9: Underwriting

Describe the underwriting approach, e.g., guaranteed issue

Sec. 5.3: Scope and Purpose of the Filing

In this section, the actuary must state that this is an existing product that has been previously approved in New Mexico and that the purpose of this filing is to provide the proposed rate change(s) and information related to the proposed rate(s) and associated change(s). The information that must be provided is detailed in the sections that follow.

Sec. 5.3.1: Applicable Laws

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

Sec. 5.3.2: Requested Rate Action, and Effective Date

State the requested rate change, and the proposed effective date of the change and indicate if these rates apply to new and/or existing policyholders.

Sec. 5.3.3: Rate Change History

Provide the list of rate changes that have been approved in the past for this product. Include the approved rate change percent with a month/year effective date.

Sec. 5.3.4: Reason(s) for Rate Change

Provide the quantitative impact and a narrative description of all significant factors driving a proposed rate change and an exhibit with an estimate of the magnitude of each of the major drivers of the rate change. Provide the range of rate changes within this submission, and describe any major changes proposed in the filing, such as:

- Coverage changes
- Changes in taxes or fees imposed on the carrier
- Changes in federal or state law
- Trend

Sec. 5.3.5: Current Rates Include a complete set of current rates broken down by each rating variable, such as age, family tier, tobacco, etc. This could be included directly in the actuarial memorandum or as an appendix/attachment/exhibit.

Sec.5.3.6: Proposed Rates

Include a complete set of proposed rates, by each rating variable, such as age, family tier, tobacco, etc. This could be included directly in the actuarial memorandum or as an appendix/attachment/exhibit. If provided separately, include in this section a reference to that document by name (e.g., see Exhibit A).

Sec. 5.4: Historical Experience

Sec. 5.4.1: Experience Period

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

Sec. 5.4.2: Experience Data

Provide an exhibit showing the following New Mexico and Nationwide data for each of the last five full calendar years:

1. Earned Premium
    - Historical earned premium for each calendar year
    - Include premiums for all years, regardless of ownership of this block of business
2. Incurred Claims
    - Claims for each calendar year 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 for each full calendar year
4. Loss Ratio, calculated for each year as Incurred Claims (2) divided by Earned Premiums (1)

Sec. 5.5: Rate Development

Sec. 5.5.1: Rate Development

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

Sec. 5.5.2: Age Factors

Provide adjustment factors by age, along with quantitative and qualitative support and explain any changes made since the last rate filing.

Sec. 5.5.3: Rating Adjustments

Provide all rating adjustment factors, as applicable, along with quantitative and qualitative support, and explain any changes since the last rate filing.

Sec. 5.6: Assumptions

Sec. 5.6.1: Membership

Provide expected membership (in member months)

Sec. 5.6.2: Annual Trend Rate (as applicable).

Provide qualitative and quantitative support for the assumed annual claim trend, and any change in this assumption since the last rate filing. 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. This support should be provided in Excel format with working formulas.

Sec. 5.6.3: Mortality

Provide the mortality table, along with any adjustments made to reflect factors such as underwriting, and changes in incidence patterns since the development

of the table. Provide support for any adjustments made to a standard mortality table, and explain any changes made to this assumption since the last rate filing.

Sec. 5.6.4: Morbidity

Provide the basis used for determining claim costs. If the experience from another product is used as the basis for determining claim costs for this product, provide a comparison of the relative richness of each product. Explain any significant changes in the morbidity assumption since the last rate filing

Sec. 5.6.5: Persistency

Provide a table with the termination rates, used in the development of rates, by duration. State if mortality is included in the termination rates and provide quantitative support in Excel format with working formulas. Explain any changes in the persistency assumption since the last rate filing.

Sec. 5.6.6: Claim Liability and Reserves

Describe the basis used to determine claim liability and reserves. Describe any changes in the methodology used to determine claim liability and reserves.

Sec. 5.6.7: Active Life Reserves

Describe the methodology used to determine active life reserves, including the interest rate and mortality rate assumptions used. Describe any changes in the methodology used to determine active life reserves since the last rate filing.

Sec. 5.6.8: Distribution of Business

Provide a table showing the expected distribution of business by the factors affecting pricing, such as gender, benefit level, age, and family tier. Describe and explain any changes in the distribution of business assumptions since the last rate filing.

Sec. 5.6.9: Expenses

Provide qualitative and quantitative support for each of the following:

1. Administrative expenses
2. Sales and marketing expenses, including commissions
3. Net cost of private reinsurance, if applicable
4. Premium Tax
5. Other Taxes, License and Fees
6. Other Expenses.
7. Profit and Risk Margin

Describe and explain any changes in the distribution of business assumptions since the last rate filing.

Sec. 5.7: Projected Experience

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

a) **With 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), without discounting

b) **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),, without discounting.

Sec. 5.8: Minimum Loss Ratio Requirements

Pursuant to 13.10.34.17(I) NMAC a carrier shall not offer a plan subject to this rule to any person unless each possible plan design selectable by that person meets the minimum loss ratio requirements as reflected in an approved rate filing.

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.

Group and individual excepted benefits plans must satisfy a minimum loss ratio requirement, which may differ by coverage and renewal clause. Information provided in sections 5.4 and 5.6 will be used to determine compliance with the loss ratio requirements.

§13.10.34.17I NMAC specifies that the minimum loss ratio standard applies separately to each combination of benefits.

Sec. 5.8.1: Minimum loss Ratio for Group Plans

Type of Coverage:	OR	CR	GR	NC
Medical Expense	65%	60%	60%	55%
Loss of Income and Other	65%	60%	55%	50%

Sec. 5.8.2: Minimum Loss Ratios for Individual Plans

Type of Coverage:	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

OR- Optionally Renewable: renewal is at the option of the insurance company;

CR- Conditionally Renewable: renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health;

GR- Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis;

NC- Non-cancelable: renewal cannot be declined, nor can rates be revised by the insurance company.

For the base policy and each rider separately, and for each combination of benefits based on distribution of business by all significant criteria, provide an exhibit showing actual experience (incurred claims, earned premiums), without discounting, that demonstrate the minimum loss ratio requirements for each possible plan design.

Sec. 5.8.3: Average annual premium

Pursuant to 13.10.34.17, a carrier shall determine the average annual premium per form based on the distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all certificates (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation). Provide an exhibit demonstrating the calculation of the average annualized premium for each combination of benefits based on distribution of business by all significant criteria having a price difference, such as age, gender, tobacco, and dependent status, and for the overall average

annual premium. Include a detailed narrative description of the assumptions used to determine the average premium.

Sec. 5.8.4: Determination of High and low premium forms

Pursuant to NMAC §13.10.34.17(D) and NMAC §13.10.34.17(E), for group or individual plans, respectively, the minimum loss ratio threshold should be adjusted for low or high premium forms. A filing shall not have both high and low filing forms. Provide an exhibit in Excel format with working formulas demonstrating whether this is a low or high premium form and provide the calculation of the permitted adjustment. Include in this section of the actuarial memorandum, a statement indicating whether this is a low or high premium form, and demonstration that the loss ratio threshold was adjusted appropriately, in accordance with the following formulas ((1) or (2)), as applicable :

(1) **Loss ratio adjustment for low average premium forms.** For a plan form, including riders and endorsements, under which the actual average annual premium (per certificate is low (as defined below), the appropriate ratio from the table in section 4.7.1, or 4.7.2, as applicable should be adjusted downward by the following formula:

$$RN = R \times \frac{(I \times 500) + X}{(I \times 750)}$$

where: R is the table ratio (see section 4.7.1 and 4.7.2);

RN is the resulting guideline ratio;

I is the consumer price index factor; and

X is the average annual premium, determined and included in section 4.7.3 above, up to a maximum of I x 250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI- U(1982)}} = \frac{\text{CPI-U, Year (N-1)}}{97.9}$$

where:

a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;

b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of labor, bureau of labor statistics based on the 1982=100 basis; The CPI-U table for 2022 and earlier is available at

https://www.bls.gov/cpi/tables/supplemental-files/historical-cpi-u-202212.pdf.

c) the CPI-U for any year (N-1) is taken as the value of September.
   i. For 1982, this value was 97.9;
   ii. For filings submitted in 2022, this value is 274.310
   iii. For filings submitted in 2023, this value is 296.808

d) For rate filings submitted during calendar year:
   i. 1983, the value of I is 1.00.
   ii. 2022, the value of I is 274.310/97.9 = 2.802
   iii. 2023, the value of I is 296.808/97.9 = 3.032

e) **Low average annual premium** is defined as average annual premium less than or equal to I x 250.
   i. For filings submitted in 2022, low average premium products are defined as have an annual premium less than or equal to **$700.50**
   ii. For filings submitted in 2023, low average premium products are defined as have an annual premium less than or equal to **$758.00**

(2) **Loss ratio adjustment for high average premium forms**. For a plan form, including riders and endorsements, under which the actual average annual premium per certificate is high (as defined in item (1)(f) above), the appropriate ratio from the table 4.7.1 or 4.7.2 above should be adjusted upward by the following formula:

RN = The lesser of:

a) $R \times \frac{(I \times 4000) + X}{(I \times 5500)}$

b) R + 5 percentage points, or

c) 68% for group products, and 63% for individual products.

where: R is the table ratio (see section 4.7.1 and 4.7.2);
RN is the resulting guideline ratio

I is the consumer price index factor (as defined in (1)(d) above)

X is the average annual premium, not less than I x 1500 (**4,203.00** for filings submitted in 2022, and **4,548** for filings submitted in 2023 – see (d) below).

d) **High average annual premium** is defined as average annual premium more than or equal to I x 1500.
   i. For filings submitted in 2022, high average premium products are defined as have an annual premium more than or equal to **$4,203.00.**
   ii. For filings submitted in 2023, high average premium products are defined as have an annual premium more than or equal to **$4,548.00.**

Sec. 5.9: 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. Explain any changes in the credibility methodology since the last rate filing.

Sec. 5.10: Rating Factors

Sec. 5.10.1: Rating Factors

Identify which rating factors are used for this product and provide support for the proposed factors, including, but not limited to:

a) Age factors.
b) Geographic factors.
c) Coverage tier (family composition).
d) 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. Explain and provide support for any changes in the rating factors.

Sec. 5.11: Actuarial justification for the proposed rating tier structure(s).

Provide actuarial support for the proposed rating tier structure, in compliance with ASOP No. 12, *Rate Classification***.**

Sec. 5.12: 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. 5.13: 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 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 statement that the rates do not reflect the cost of any wellness plan or other value added products or services
- 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 VI: Annual Rate Certification Filing Requirements

Sec. 6.1: Overview

Pursuant to 13.10.34.17G NMAC, carriers not filing new or updated premium rates in any given plan year shall file an actuarial memorandum demonstrating that minimum loss ratios have been met for all products. The following guidance applies to the information required to be included in the actuarial memorandum supporting the annual rate certification.

Sec. 6.2: 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. 6.2.1: 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 Excepted Benefits 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. Life insurer
    c. Health insurer
    d. Fraternal Benefit Societies (NMRS 59A-44)
    e. Other
4. Market: the market in which the products and plans are offered (individual - indicate if the coverage applies to worksite policies, or group). Note the restrictions on worksite policies stated in section 2.5. For group plans, confirm that the group(s) to which this product will be marketed comply with Paragraphs (1) or (3) of Subsection A of 59A-23-3 NMSA 1978, or is a bona fide association.
5. Effective Date: the effective date of the rate proposal.

Sec. 6.2.2: Applicable Policy Forms

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

Sec. 6.2.3: 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. 6.2.4: Summary of Benefits

In this section of the Actuarial Memorandum, include summary showing high-level details of the covered services for the base policy and riders, as applicable. Sufficient information should be provided so that a reviewer would have a basic understanding of the benefits provided without a review of the Schedule of Benefits or outline of benefits.

Sec. 6.2.5: Pricing Basis

Indicate if the product is issued and priced on an issue age or attained age basis.

Sec. 6.2.6: Issue age Range

Indicate the issue age range for these policy forms.

Sec. 6.2.7: Renewability

Describe the terms under which policies or contracts may be renewed.

Sec. 6.2.8: Marketing Method

Indicate the methods used to inform consumers of the availability of the plans.

Sec. 6.3: Scope and Purpose of the Filing

The actuary must clearly state that the purpose of this filing is to satisfy the annual rate certification requirements of 13.10.334.17G NMAC. State the level of aggregation of policies for purposes of this certification.

Sec. 6.4: Measurement Period

The actuary must clearly state the measurement period. Compliance with the minimum loss ratio shall be measured over all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years). Separate filings shall be made for separate rating pools.

Sec. 6.5: Minimum Loss Ratio Requirements

Provide an exhibit, in pdf and Excel formats, showing the calculation of the loss ratios

Sec. 6.5.1: Demonstration of Compliance with Minimum Loss Ratio Requirements

Provide an exhibit showing the following historical data for New Mexico and Nationwide for each full calendar year since inception:

1. Earned Premium
    - Historical earned premium for each calendar year
    - Include premiums for all years, regardless of ownership of this block of business
2. Incurred Claims
    - Claims should exclude active life reserves ("ALR"), as applicable and exclude loss adjustment expenses ("LAE")
    - For the most recent year, include estimated incurred and unpaid (IBNP) claims and indicate the runout date.
    - Include all claims regardless of ownership of this block of business
3. Member months
4. Actual Loss Ratio
    - The loss ratio is calculated as Incurred Claims divided by Earned Premiums with no discounting
5. Expected loss ratio
    - for each year, the expected loss ratio is calculated using expected incurred claims and earned premiums used in the original pricing of the product
6. Accumulated Actual Loss Ratio
    - This is the actual loss ratio accumulated over the measurement period, calculated as the total actual

incurred claims accumulated over the measurement period, divided by the total actual earned premium accumulated over the measurement period.

7. Accumulated Expected loss ratio
    - This is the expected loss ratio for the measurement period, calculated as the total expected incurred claims, based on the original pricing assumptions and accumulated over the measurement period, divided by the total expected earned premiums based on the original pricing assumptions and accumulated over the measurement period.
8. The Ratio of Actual Loss Ratio to Expected Loss Ratio
    - This is calculated as item 6 above divided by item 7 above.

Sec. 6.6: 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 ASOP No. 25, *Credibility Procedure*s. Additionally, provide quantitative development of the credibility formula, as applicable, in Excel format with working formulas.

Sec. 6.7: 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. 6.8: 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 in accordance with the appropriate 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.

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 statement that the earned premiums and incurred claims do not reflect the cost of any wellness plan or other value added products or services.
- A certification that the loss ratios are calculated:
    1. In compliance with all applicable state and federal statutes and regulations.
    2. The actual loss ratio meets the minimum loss ratio requirements of the State of New Mexico.
    3. In compliance with the applicable Actuarial Standards of Practice.

Section VII: Waiver Requirements

Sec. 7.1: Waivers of the annual certification requirement

Pursuant to 13.10.34.17(G)(7), for noncredible blocks of business on a nationwide basis, the company may request a waiver of the annual certification requirement. The request shall be made annually and must be accompanied by a letter, signed by an officer of the company, indicating the following:

1) Nature of the filing
   a) Market (individual or group)
   b) A statement that this is a request for a waiver of the annual certification requirement
   c) The period to which the waiver, if granted, will apply
2) The type of product, including the affected forms
3) Reason for the request.
   a) A detailed description of the reason for the request
   b) The basis for the determination that the data is noncredible, on a nationwide basis.
      i) Credibility basis, including demonstration of compliance with ASOP No. 25, C*redibility Procedures*, and any information supporting the request.
      ii) The credibility methodology used for purposes of this certification must be consistent with the credibility methodology used for pricing.
   c) An exhibit with the following information using actual data for each completed calendar year, on a New Mexico and Nationwide basis, the current partial year, and projected estimates for the three calendar years following the last completed calendar year:
      i) Enrollment (member months)
      ii) Number of claims
      iii) Premiums by year,
      iv) Incurred claims
      v) Loss ratios (not discounted)
   d) Certification by a qualified actuary. This may be incorporated into the letter requesting the waiver, if it is signed by the responsible actuary, or it may be a separate attachment (signed and dated).

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 estimates 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. 23, Data Quality.

- ASOP No. 25, Credibility Procedures.
- ASOP No. 41, Actuarial Communications

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 statement that the earned premiums and incurred claims do not reflect the cost of any wellness plan or other value added products or services.
- A certification that the loss ratios are calculated:
    1. In compliance with all applicable state and federal statutes and regulations.
    2. The actual loss ratio meets the minimum loss ratio requirements of the State of New Mexico.
    3. In compliance with the applicable Actuarial Standards of Practice.