BEFORE THE NEW MEXICO OFFICE OF THE SUPERINTENDENT OF INSURANCE

IN THE MATTER OF THE PETITION OF BLUE CROSS AND BLUE SHIELD OF NEW MEXICO FOR AMENDMENT OF THE UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATING THE MEDICAL LOSS RATIO RULE	)	**Docket No. 19-00057-RULE-LH**

BLUE CROSS BLUE SHIELD OF NEW MEXICO'S PROPOSED ALTERNATE RULE AND COMMENTS IN SUPPORT OF PROPOSED ALTERNATE RULE

COMES NOW Blue Cross and Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("BCBSNM" and "Petitioner") and submits this proposed alternate rule for amending 13.10.27 NMAC. In support of this proposed alternate rule, BCBSNMs state the following:

I. Introduction

1. On November 25, 2019, BCBSNM, a licensed insurer in the State of New Mexico, submitted a petition to the Superintendent of Insurance ("Superintendent") requesting that the Superintendent initiated a rulemaking proceeding to amend and clarify 13.10.27 NMAC. BCBSNM submitted the Petition for Rulemaking pursuant to NMSA 1978, § 12-8-7, and 13.1.4.9 NMAC. BCBSNM requested that the Superintendent exercise authority to promulgate and amend rules pursuant to NMSA 1978, §§ 59A-2-8 and 59A-2-9. The OSI has rulemaking authority specific to minimum medical loss ratios ("MMLR") pursuant to NMSA 1978, § 59A-22-50(D), NMSA 1978, § 59A-23C-10(C), NMSA 1978, § 59A-46-51(D), and NMSA 1978, § 59A-47-46(D).

2. BCBSNM's original intent in filing the petition was to clarify the calculation required to satisfy the state MMLR for non-individually underwritten health product lines by amending a rule promulgated by the Office of Superintendent of Insurance ("OSI"). BCBSNM sought the amendment to clarify that the medical loss ratio for non-individually underwritten health product lines is calculated collectively and each product line does not have to separately meet the MMLR provided that the product lines meet the MMLR level collectively.

3. On December 23, 2019, the Superintendent issued an *Order Granting Petition for Rulemaking*, and that order granted BCBSNM's petition. In granting BCBSNM's petition, the Superintendent stated that the agency was willing to consider an amendment to clarify 13.10.27 NMAC, but the Superintendent wanted Staff to review the current rule and determine whether they wished to propose alternate language to amend 13.10.27 NMAC. The Superintendent provided Staff until March 31, 2020, to review BCBNSM's proposed rule change and to propose any changes to the current rule that Staff determined were appropriate.

4. On March 31, 2020, Staff filed a proposed alternative rule in *Staff's Proposed Alternative Rule and Response to BCBSNM's Petition for Rulemaking.* In this filing, Staff proposed numerous changes to 13.10.27 NMAC, including the separate calculation of medical loss ratios for the small groups and large groups, the amendment of the definition of "premium" in 13.10.27.7 NMAC, the inclusion of a definition of blanket health insurance in 13.10.27.7 NMAC, changes to the compliance requirement form contained in 13.10.27.9 NMAC, and stylistic, grammatical, and organizational changes.

5. On May 4, 2020, Staff filed an amended proposed alternative rule in *Staff's Amended Proposed Alternative Rule and Amended Response to BCBSNM's Petition for Rulemaking*. In this filing, Staff proposed three small changes, which were: (1) changing "year"

to "period" in 13.10.27.8(B) NMAC; (2) changing "April 15" to "July 31" in 13.10.27.8(E) NMAC; and (3) changing "July" to "August" in 13.10.27.8(I) NMAC.

6. On May 5, 2020, the Notice of Proposed Rulemaking ("NOPR") was filed by the Superintendent in this rulemaking docket. The NOPR provided for the publication of the two different proposals to amend the current rule, specifically the amended proposal of Staff and the original proposal of BCBSNM.

7. The NOPR provided for a public hearing on June 15, 2020, at which time the Hearing Officer would consider the two proposals.

8. Since the issuance of the NOPR, Staff and BCBSNM have engaged in several discussions and negotiations to address the differences between the two proposed rules. These discussions were conducted in an effort to reach consensus between BCBSNM and Staff as to the necessary amendments to the existing rule contained in 13.10.27 NMAC.

9. Based upon discussions between Staff and BCBSNM, it is the understanding of BCBSNM that Staff does not object to the proposed amendments to 13.10.27 NMAC that are contained in this proposed alternate rule. Most importantly, it is BCBSNM's understanding that Staff no longer objects to the continuation of the collective calculation approach for non-individually underwritten policies (i.e., small group plans and large group plans) as contained in the current rule, specifically 13.10.27.8(G) NMAC.

10. BCBSNM hereby files this proposed alternate rule in an effort: (1) to simplify the public hearing in this docket; (2) provide proposed alternate language based on the discussions and negotiations of Staff and BCBSNM; (3) provide comments in support of the proposed alternate language; and (4) to allow all interested persons the opportunity to review the proposed alternate rule and the reasons supporting the alternate rule.

II. New Mexico Law on Minimum Medical Loss Ratios

11. On March 9, 2010, after the New Mexico Legislature passed House Bill 12 (*Health Insurer Service Reimbursement*), Governor Bill Richardson signed the bill into law. 2010 N.M. Session Laws, 2nd Sess., Chap. 94, §§ 1-4 (H.B. 12). The new law enacted state based MMLRs, which were compiled into the New Mexico Insurance Code. NMSA 1978, § 59A-22-50; NMSA 1978, § 59A-23C-10; NMSA 1978, § 59A-46-51; and NMSA 1978, § 59A-47-46. The new law was signed into law just prior to the passage of the federal Patient Protection and Affordable Care Act ("PPACA"). *See* Pub. L. No. 111–148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–152, 124 Stat. 1029.

12. The new state law set the MMLR reimbursement level at 85% across all health product lines, except individually underwritten health insurance policies. *See* NMSA 1978, § 59A-22-50(A); NMSA 1978, § 59A-23C-10(A); NMSA 1978, § 59A-46-51(A); and NMSA 1978, § 59A-47-46(A).

13. The new law provided that the MMLR reimbursement level for individual policies was to be established by the Superintendent after a notice and informal hearing. *See* NMSA 1978, § 59A-22-50(B); NMSA 1978, § 59A-46-51(B); and NMSA 1978, § 59A-47-46(B).

14. As set forth in an OSI Bulletin in 2011, the Superintendent adopted an 80% MMLR level for individual policies. *See* OSI Bulletin 2011-006 (April 8, 2011). This level was consistent with the MMLR standards under the PPACA. Under PPACA, policies in the individual and small group markets have an MMLR of 80% whereas policies in the large group market have an MMLR of 85%. *See* 45 C.F.R. § 158.210. The Bulletin further stated that "[f]or

rate filings affecting small and large group markets, [an] 85% MLR as well as the definitions of market classifications contained in the Insurance Code shall apply." *See* OSI Bulletin 2011-006.

15. On November 30, 2012, the OSI promulgated the current rule adopting the MMLR standards contained in the Insurance Code and Bulletin 2011-006. *See* 13.10.27 NMAC. The rule states that the "minimum loss ratio for individually underwritten health policies shall be 80%" and the "minimum loss ratio for other policies, *calculated collectively*, shall be 85%." *See* 13.10.27.8(G) NMAC (emphasis added).

16. The current compliance requirement form found in 13.10.27 NMAC indicates on its face that "Individually Underwritten Policies" must satisfy a total medical loss ratio of 80% and that "All Other Policies" must have a total medical loss ratio of 85%. *See* 13.10.27.9 NMAC. This reporting requirement is consistent with the collective calculation requirement contained in 13.10.27.8(G) NMAC.

III. Proposed Alternate Rule

In an effort to simplify the public hearing in this rulemaking docket and to allow all interested persons the opportunity to review the proposed alternate rule contained herein and the reasons supporting the alternate rule, BCBSNM proposes the following changes to 13.10.27 NMAC.

A. Proposed Amendment to the title of 13.10.27.1 NMAC

17. BCBSNM proposes the following amendment to 13.10.27.1 NMAC:

> **13.10.27.1 ISSUING AGENCY:** [~~New Mexico Public Regulation Commission, Insurance Division~~] New Mexico Office of Superintendent of Insurance.

18. In support of the proposed amendment to 13.10.27.1 NMAC, BCBSNM states the following:

- While the Superintendent of Insurance was previously part of the Public Regulation Commission (the PRC's Insurance Division) at the time of the original promulgation of 13.10.27 NMAC, the OSI is no longer part of the Public Regulation Commission. The Office of Superintendent of Insurance was constitutionally created as of July 1, 2013. *See* Art.11, § 20 of the New Mexico Constitution. The OSI became an independent agency with the passage of this constitutional amendment. The OSI will be promulgating amendments to 13.10.27 NMAC pursuant to its own statutory authority contained in NMSA 1978, § 59A-2-9, NMSA 1978, § 59A-22-50(D), NMSA 1978, § 59A-23C-10(C), NMSA 1978, § 59A-46-51(D), and NMSA 1978, § 59A-47-46(D).

B. Proposed Amendment to 13.10.27.3 NMAC

19. BCBSNM proposes the following amendment to 13.10.27.3 NMAC:

> **13.10.27.3 STATUTORY AUTHORITY:** Sections [~~8-8-4,~~] 59A-2-9, 59A-22-50, 59A-23C-10, 59A-46-51 and 59A-47-46 NMSA 1978.

20. In support of the proposed amendment to 13.10.27.3 NMAC, BCBSNM states the following:

- The proposed deletion of the statutory reference is to a section of the Public Regulation Commission Act, NMSA 1978, §§ 8-8-1 *et. seq*. While the Superintendent of Insurance was part of the Public Regulation Commission (the PRC's Insurance Division) at the time of the original promulgation of 13.10.27 NMAC, the OSI is no longer part of the Public Regulation Commission. The Office of Superintendent of Insurance was constitutionally created as of July 1, 2013. *See* Art. 11, § 20 of the New Mexico Constitution. The OSI became an independent agency with the passage of this constitutional amendment. The OSI will be promulgating amendments to 13.10.27 NMAC pursuant to its own statutory authority contained in NMSA 1978, § 59A-2-9, NMSA 1978, § 59A-22-50(D), NMSA

1978, § 59A-23C-10(C), NMSA 1978, § 59A-46-51(D), and NMSA 1978, § 59A-47-46(D).

C. Proposed Amendment to 13.10.27.7 NMAC

21. BCBSNM proposes the following amendments to 13.10.27.7 NMAC:

13.10.27.7 DEFINITIONS: As used in this [~~definition~~]rule:

A. "health insurer" means a person duly authorized to transact the business of health insurance in the state pursuant to the Insurance Code but does not include a person that only issues [~~a limited benefit~~]an excepted benefit policy intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;

B. "direct services" means services rendered to an individual by a health insurer or a health care practitioner, facility or other provider, including case management, disease management, health education and promotion, preventive services, quality incentive payments to providers and any portion of an assessment that covers services rather than administration and for which an insurer does not receive a tax credit pursuant to the Medical Insurance Pool Act or the Health Insurance Alliance Act; provided, however, that "direct services" does not include care coordination, utilization review or management or any other activity designed to manage utilization or services;

C. "health care plan" means a nonprofit corporation authorized by the superintendent of [~~the~~] insurance [~~division~~] to enter into contracts with subscribers and to make health care expense payments but does not include a person that only issues [~~a limited benefit~~]an excepted benefit policy intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;

D. "health maintenance organization" means any person who undertakes to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments or deductibles, but does not include a person that only issues a [~~a limited benefit~~]an excepted benefit policy or contract intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;

E. "premium" means all income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests less any premium tax paid pursuant to [~~Section 59A-6-2 NMSA 1978~~] the Insurance Premium Tax Act, NMSA 1978, Sections 7-40-1 to 10, and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance; [~~these premiums shall be gross of any reinsurance;~~]

F. "individually underwritten" means any health care policy, plan or contract issued to an individual or family reflecting the characteristics of the family members covered; these characteristics include, but are not limited to, place of residence, age, gender, and health status;

G. "carrier" [~~shall mean collectively,~~] means health maintenance organization, health care plan, and health insurer;

H. "minimum medical loss ratio" means the percentage determined in accordance with section 13.10.27.8 NMAC;

I. "health product lines" means:

(1) all programs utilized by a health insurer for the offering of products, including but not limited to:

(a) all private programs, including individual, small group and large group;

(b) all public programs, including all medicaid and medicare and any related or future programs or products;

(c) all other arrangements for the procurement of health coverage, including capitated arrangements, self-funded arrangements; and

(d) such other programs or arrangements that the superintendent of the insurance division may designate by order or bulletin; but not

(2) programs of [~~HIPPA~~]HIPAA-excepted benefits intended to supplement major medical coverage, including medicare supplement, vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or policies for long-term care or disability income;

J. "product" [~~shall~~] means any policy, plan or contract related to the provision of health care services offered, arranged or facilitated by an insurer, including blanket health insurance; and

K. "blanket health insurance" means that form of health insurance covering special groups of not fewer than ten (10) persons as enumerated in one of the following paragraphs:

(1) under a policy or contract issued to a common carrier, which shall be deemed the policyholder, covering a group defined as all persons who may become passengers on the common carrier;

(2) under a policy or contract issued to an employer that shall be deemed the policyholder, covering a group of employees defined by reference to exceptional hazards incident to employment;

(3) under a policy or contract issued to a college, school or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder, covering students and teachers;

(4) under a policy or contract issued in the name of a volunteer fire department or first aid or other such volunteer group, which shall be deemed the policyholder, covering all of the members of the department or group; or

(5) under a policy or contract issued to any other substantially similar group that, in the discretion of the superintendent, may be subject to the issuance of a blanket health policy or contract.

22. In support of the proposed amendment to 13.10.27.7 NMAC, BCBSNM states the following:

- Substitution of the term “definition” for the term “rule” is appropriate, because the terms defined in Section 7 of 13.10.27 NMAC are used in the “rule” and not use in the “definition”. The proposed change is grammatical in nature.

23. In support of the proposed amendment to 13.10.27.7(A) NMAC, BCBSNM states the following:

- The term “limited-benefit” is proposed for replacement with the term “excepted benefit”. This change is proposed in order to be consistent with the recent amendments to the

Insurance Code contained in Short-Term Health Plan and Excepted Benefit Act, NMSA 1978, §§ 59A-23G-1 *et. seq*.

24. In support of the proposed amendment to 13.10.27.7(C) NMAC, BCBSNM states the following:

- The reference to the "Insurance Division" is proposed for removal. While the Superintendent of Insurance was previously part of the Public Regulation Commission (the PRC's Insurance Division) at the time of the original promulgation of 13.10.27 NMAC, the OSI is no longer part of the Public Regulation Commission. The Office of Superintendent of Insurance was constitutionally created as of July 1, 2013. *See* Art. 11, § 20 of the New Mexico Constitution.
- The term "limited-benefit" is proposed for replacement with the term "excepted benefit". This change is proposed in order to be consistent with the recent amendments to the Insurance Code contained in Short-Term Health Plan and Excepted Benefit Act, NMSA 1978, §§ 59A-23G-1 *et. seq*.

25. In support of the proposed amendment to 13.10.27.7(D) NMAC, BCBSNM states the following:

- The phrase "a limited-benefit" is proposed for replacement with the term "an excepted benefit". This change is proposed in order to be consistent with the recent amendments to the Insurance Code contained in Short-Term Health Plan and Excepted Benefit Act, NMSA 1978, §§ 59A-23G-1 *et. seq*.

26. In support of the proposed amendment to 13.10.27.7(E) NMAC, BCBSNM states the following:

- The changes to the definition of "premium" are proposed in order to make the definition consistent with the statutory definition of premium contain in NMSA 1978, § 59A-22-50(E)(3), NMSA 1978, § 59A-23C-10(D)(3), NMSA 1978, § 59A-46-2(Y), and NMSA 1978, § 59A-47-3(O). The addition of "recoveries from third parties or other insurers" is proposed, because this phrase occurs in the statutory definitions of premium cited above.
- The reference to the premium tax is updated to reflect the transfer of premium tax collection from the OSI to the New Mexico Taxation & Revenue Department. *See* 2018 N.M. Session Laws, 2nd Sess., Chap. 57, §§ 1-32 (H.B. 223).
- The removal of the phrase "these premiums shall be gross of any reinsurance" is proposed, because the phrase does not occur in the statutory definition of "premium" contained in NMSA 1978, § 59A-22-50(E)(3), NMSA 1978, § 59A-23C-10(D)(3), NMSA 1978, § 59A-46-2(Y), and NMSA 1978, § 59A-47-3(O).

27. In support of the proposed amendment to 13.10.27.7(G) NMAC, BCBSNM states the following:

- The deletion of the phrase "shall mean collectively," and the insertion of the term "means" is proposed to make 13.10.27.7(G) NMAC consistent with the other definitions contained in the Section 7 of 13.10.27 NMAC. The proposed changes are grammatical and organizational in nature.

28. In support of the proposed amendment to 13.10.27.7(I) NMAC, BCBSNM states the following:

- The insertion of an "s" after "mean" is proposed to make 13.10.27.7(I) NMAC consistent with the other definitions contained in the Section 7 of 13.10.27 NMAC. The proposed change is grammatical and organizational in nature.

- The change of "HIPPA" to "HIPAA" is a correction of the acronym that refers to the federal Health Insurance Portability and Accountability Act of 1996.

29. In support of the proposed amendment to 13.10.27.7(J) NMAC, BCBSNM states the following:

- The deletion of the phrase "shall" and the insertion of an "s" after "mean" are proposed to make 13.10.27.7(J) NMAC consistent with the other definitions contained in the Section 7 of 13.10.27 NMAC. The proposed changes are grammatical and organizational in nature.
- The inclusion of the phrase "blanket health insurance" within the definition of the term "product" is proposed to ensure that blanket health insurance is included within the definition of the term "product". The inclusion of the blanket health insurance in the definition of the term "product" will ensure that references to "all health product lines" include blanket health insurance when calculating medical loss ratios. *See* NMSA 1978, § 59A-22-50(A); NMSA 1978, § 59A-23C-10(A); NMSA 1978, § 59A-46-51(A); and NMSA 1978, § 59A-47-46(A).

30. In support of the new proposed 13.10.27.7(K) NMAC, BCBSNM states the following:

- The inclusion of a definition for "blanket health insurance" is proposed to provide specificity to the references to this type of insurance. With the proposed inclusion of "blanket health insurance" in the definition of "product", health insurers should be provided reasonable guidance as to the products included in the calculation of medical loss ratios. The proposed definition mirrors the statutory definition contained in NMSA 1978, 59A-23-2 (2017).

D. Proposed Amendment to 13.10.27.8 NMAC

31. BCBSNM proposes the following amendments to 13.10.27.8 NMAC:

13.10.27.8 MINIMUM MEDICAL LOSS RATIOS FOR ALL HEALTH PRODUCT LINES[~~, EXCEPT INDIVIDUALLY UNDERWRITTEN HEALTH PRODUCT LINES~~]:

A. General requirement. Carriers shall meet the minimum medical loss ratio established, and in the manner calculated, under this rule.

B. Measurement period. Compliance with the minimum medical loss ratio shall be measured over a rolling three year period. The initial measurement period shall be the years, 2010, 2011 and 2012. Each year thereafter, the subsequent year shall be added to the rolling three year period and the oldest [~~year~~]period shall be removed. For example, the second measurement year shall be 2011, 2012 and 2013.

C. Aggregation. [~~Loss~~] Medical loss ratios shall be calculated on a consolidated level within a state, with experience allocated to state based upon the situs of the contract. Experience of all affiliates shall be accumulated to the following levels:

(1) individually underwritten health policies; [~~and~~]

(2) [~~all other policies~~]small group policies;

(3) large group policies and all other policies; and

(4) total of all group policies combined.

D. Frequency. [~~Loss~~] Medical loss ratios shall be calculated annually by carriers that issue products through health product lines, beginning in 2013 covering the period 2010 through 2012.

E. Timeline. [~~Loss~~] Medical loss ratios shall be calculated using claim data incurred during the three year measurement period and paid before April 1 of the year following the that period. No adjustment may be made for incurred but not reported (IBNR) claims. The compliance requirement form set forth in 13.10.27.9 NMAC shall be the basis for the medical loss ratio calculation and will be filed with the [~~insurance division~~] Office of Superintendent of Insurance by [~~April 15~~] July 31 of the year following the measurement period. [~~This form is first due on April 15, 2013.~~]

F. Calculation. The numerator of the medical loss ratio calculation shall be direct services, as defined by this rule. The denominator of the calculation shall be premium, as defined by this rule. This calculation is deemed to be fully credible due to the three year time period used and the aggregation levels required. The New Mexico reimbursements for small group, large group, and all other policies shall be calculated collectively across all health product lines. The federal reimbursements paid or due pursuant to 45 CFR Part 158 shall be subtracted from the New Mexico reimbursement to calculate the final New Mexico reimbursement, which cannot be lower than zero.

G. Minimum medical loss ratio levels. [~~The minimum loss ratio for individually underwritten health policies shall be 80%. The minimum loss ratio for other policies, calculated collectively, shall be 85%.~~] The minimum medical loss ratio levels applicable to the policy aggregation in Subsection (C) of 13.10.27.8 NMAC shall be as follows:

(1) the minimum medical loss ratio level for individually underwritten policies shall be eighty percent (80%);

(2) the minimum medical loss ratio level for small group policies shall be eighty percent (80%);

(3) the minimum medical loss ratio level for large group policies and all other policies shall be eighty-five percent (85%); and

(4) the minimum medical loss ratio level for the total of all group policies shall be eighty-five percent (85%).

H. Compliance with minimum medical loss ratio. With compliance requirement form set forth in 13.10.27.9 NMAC, each carrier shall submit to the [~~insurance division~~] Office of Superintendent of Insurance either:

(1) a statement signed by a qualified actuary that the minimum medical loss ratio requirements have been met; or

(2) a plan to [~~return excess premium charged~~] make the required reimbursements to policyholders.

I. Actions required upon noncompliance with requirements. [~~The plan to return excess premiums shall provide prospective premium credits to each policyholder in the affected segment (i.e., individually underwritten health policies or all other policies). The premium credits shall cover July through December of the year following the measurement period. At the end of this period, and no later than March 31 of the year following the premium credits, the carrier shall demonstrate that refunds in the required amount have been made. The prospective refund shall be made on a per subscriber basis, unless an alternative basis is approved by the superintendent of the insurance division, and shown separately on the policyholder's monthly (or other frequency) bill. This credit may reflect the family composition of the rating structure used for each policyholder.~~] The plan to make the required reimbursements to policyholders shall provide either prospective premium credits or refunds to each policyholder who was enrolled in the affected segment (i.e., individually underwritten health policies, small group, or all other policies) during the last year of the measurement period and provide that any such refund for a policyholder be reduced by the amount of any rebate owing to the policyholder for a medical loss ratio reporting year pursuant to 45 CFR Part 158 that coincides with such measurement period. The premium credits or refunds shall be reflected in either a one-time payment or premium credit or in multiple payments or premium credits. Any such credits or refunds must be provided no later than the end of December of the year following the applicable measurement period. The deadline for reimbursement may be extended if the premium credits exceed the monthly premiums due by the end of December of the year following the applicable measurement period. Any overage may be applied to succeeding premium payments until the full amount of any refund has been credited. No later than March 31st of the second year following the applicable measurement period the carrier shall demonstrate that the refunds in the required amounts have been made or that premium credits are being applied until such time as the full amount on the refund has been credited. The prospective premium credits or refunds shall be made on a per subscriber basis, unless an alternative basis is approved by the superintendent of insurance and shown separately on the policyholder's monthly (or other frequency) bill. This credit may reflect the family composition of the rating structure used for each policyholder. Any premium credit or refund to policyholders shall be based only upon the medical loss ratios calculated for individually underwritten policies and for the total of all group policies calculated collectively across all group health product lines.

32. In support of the proposed amendment to the title of 13.10.27.8 NMAC, BCBSNM states the following:

- The deletion of the "EXCEPT INDIVIDUALLY UNDERWRITTEN HEALTH PRODUCT LINES" is appropriate, because 13.10.27.8 NMAC provides requirements for the calculation of medical loss ratios for individually underwritten health product lines. The title as currently promulgated is inaccurate.

33. In support of the proposed amendment to 13.10.27.8(B) NMAC, BCBSNM states the following:

- The deletion of the term “year” and the insertion of the term “period” are proposed to provide clarity as to the period of time for which the measurement is performed.

34. In support of the proposed amendment to 13.10.27.8(C) NMAC, BCBSNM states the following:

- The deletion of the term “Loss” and the addition of the words “Medical loss” to 13.10.27.8(C) NMAC ensure the use of “medical loss ratio” as opposed to the term “loss ratios”.
- The proposed expansion of the list contained in 13.10.27.8(C) NMAC provides clarity to insurers as to the categories of polices that must be aggregated, which are specifically: (1) individually underwritten health policies; (2) small group policies; (3) large group policies and all other polices; and (4) total of all group policies combined.

35. In support of the proposed amendment to 13.10.27.8(D) NMAC, BCBSNM states the following:

- The deletion of the term “Loss” and the addition of the words “Medical loss” to 13.10.27.8(D) NMAC ensure the use of “medical loss ratio” as opposed to the term “loss ratios”.

36. In support of the proposed amendment to 13.10.27.8(E) NMAC, BCBSNM states the following:

- The deletion of the term “Loss” and the addition of the words “Medical loss” to 13.10.27.8(E) NMAC ensure the use of “medical loss ratio” as opposed to the term “loss ratios”.
- The addition of the word “medical” before “loss ratio calculation” ensures the use of “medical loss ratio” as opposed to the term “loss ratio”.

- The reference to the "insurance division" is proposed for removal. While the Superintendent of Insurance was previously part of the Public Regulation Commission (the PRC's Insurance Division) at the time of the original promulgation of 13.10.27 NMAC, the OSI is no longer part of the Public Regulation Commission. The Office of Superintendent of Insurance was constitutionally created as of July 1, 2013. *See* Art. 11, § 20 of the New Mexico Constitution.
- The deletion of the date "April 15" and the insertion of the date "July 31" are proposed to extend the period of time each calendar year for the filing deadline for the compliance requirement form required by 13.10.27.9 NMAC. The proposed change to July 31st will allow carriers to incorporate the latest year's risk adjustment results, which are typically released by the federal CMS on June 30th each year.
- The proposed deletion of "This form is first due on April 15, 2013." is appropriate, because this first filing deadline is no longer relevant for compliance with 13.10.27.8 NMAC.

37. In support of the proposed amendment to 13.10.27.8(F) NMAC, BCBSNM states the following:

- The addition of the words "medical" before "loss ratio calculation" to 13.10.27.8(F) NMAC ensures the use of "medical loss ratio" as opposed to the term "loss ratio".
- The proposed new language provides greater detail on the required calculations and the potential refunds for the small group policies and large group and all other policies. This new language addresses the calculation of refunds with consideration of the federal requirements for refunds.

- The proposed new language continues to provide for the continuation of the collective calculation approach for non-individually underwritten policies (i.e., small group plans and large group plans) as required by the current rule contained in 13.10.27.8(G) NMAC. The New Mexico Insurance Code provides the continuing basis for the collective calculation approach with its requirement that insurers provide "reimbursement for direct services at a level not less than eighty-five percent of premiums *across all health product lines*". NMSA 1978, § 59A-22-50(A); NMSA 1978, § 59A-23C-10(A); NMSA 1978, § 59A-46-51(A); and NMSA 1978, § 59A-47-46(A) (emphasis added). These cited statutory provisions, on a collective basis, support the continuation of the "calculated collectively" approach in this rule. The proposed amendment is intended to continue to allow non-individually underwritten product lines to collectively achieve an 85% MMLR.

38. In support of the proposed amendment to 13.10.27.8(G) NMAC, BCBSNM states the following:

- The addition of the word "medical" before "loss ratio" ensures the use of "medical loss ratio" as opposed to the term "loss ratio".
- The proposed new language provides specific minimum medical loss ratio levels for the four categories of policies. These minimum medical loss ratio levels are contained in either state law (individually underwritten policies and total of all group policies) (NMSA 1978, § 59A-22-50, NMSA 1978, § 59A-23C-10, NMSA 1978, § 59A-46-51, and NMSA 1978, § 59A-47-46) and in federal law (individual, small group, and large group) (42 U.S.C. § 300gg-18 and 45 C.F.R § 158.210).

- The proposed new language continues to provide for the continuation of the collective calculation approach for non-individually underwritten policies (i.e., small group plans and large group plans) as required by the current rule contained in 13.10.27.8(G) NMAC. The New Mexico Insurance Code provides the continuing basis for the collective calculation approach with its requirement that insurers provide "reimbursement for direct services at a level not less than eighty-five percent of premiums *across all health product lines*". NMSA 1978, § 59A-22-50(A); NMSA 1978, § 59A-23C-10(A); NMSA 1978, § 59A-46-51(A); and NMSA 1978, § 59A-47-46(A) (emphasis added). These cited statutory provisions, on a collective basis, support the continuation of the "calculated collectively" approach in this rule. The proposed amendment is intended to continue to allow non-individually underwritten product lines ("<u>total of all group policies</u>") to collectively achieve an 85% MMLR.

39. In support of the proposed amendment to 13.10.27.8(H) NMAC, BCBSNM states the following:

- The addition of the word "medical" before "loss ratio" ensures the use of "medical loss ratio" as opposed to the term "loss ratio".
- The reference to the "insurance division" is proposed for removal. While the Superintendent of Insurance was previously part of the Public Regulation Commission (the PRC's Insurance Division) at the time of the original promulgation of 13.10.27 NMAC, the OSI is no longer part of the Public Regulation Commission. The Office of Superintendent of Insurance was constitutionally created as of July 1, 2013. *See* Art. 11, § 20 of the New Mexico Constitution.

- The deletion of the phrase "return excess premium charged" and the addition of the phrase "make the required reimbursements" is proposed to remove the undefined phrase of "excess premium" and add language that mirrors the statutory requirements that health insurers make reimbursements. *See* NMSA 1978, § 59A-22-50; NMSA 1978, § 59A-23C-10; NMSA 1978, § 59A-46-51; and NMSA 1978, § 59A-47-46 (emphasis added). Under these relevant statutes, the reimbursement of policyholders takes the form of dividends or credits.

40. In support of the proposed amendment to 13.10.27.8(I) NMAC, BCBSNM states the following:

- The changes proposed will make implementation of the rule by the health plans more effective and benefit policyholders. The proposed new language provides greater detail on calculations for the potential refunds for group policies and addresses the calculation of refunds with consideration of the federal requirements for refunds. The changes are proposed to more closely align state and federal law, provide clarity to carriers as to refunds, avoid potential conflicts between state and federal law, and avoid duplicative payments.
- Any premium credit or refund to policyholders shall be based upon the medical loss ratios calculated for individually underwritten policies (Section I of the compliance requirement form) and for the total of all group policies calculated collectively across all group health product lines (Section IV of the compliance requirement form).
- Carriers continue to be required to meet the federal standard of 80% MMLR for the small group market, but the proposal clarifies that the state MMLR requirement is satisfied with a small group MMLR below 85% as long as the carrier's collective MMLR for non-

individually underwritten health product lines achieves 85%. A carrier may comply with both the federal standard of 80% MMLR for the small group market and the New Mexico requirement of an aggregate MMLR of 85% for all policies other than individual policies.

E. Proposed Amendment to 13.10.27.9 NMAC

41. BCBSNM proposes the amendment of 13.10.27.9 NMAC as contained in Attachment 1.

42. In support of this alternate rule for 13.10.27.9 NMAC, BCBSNM states the following:

- The proposed amended Compliance Requirement Form contained in Attachment 1 provides for the calculation of medical loss ratios in a manner consistent with the proposed rules changes in this proposed alternate rule.
- The proposed amended Compliance Requirement Form provides for calculations that any premium credit or refund to policyholders shall be based only upon the medical loss ratios calculated for individually underwritten policies and for the total of all group policies calculated collectively across all group health product lines.

IV. Conclusion

WHEREFORE, BCBSNM respectfully requests that the Superintendent amend 13.10.27 NMAC in manner consistent with the proposed alternate rule offered by BCBSNM.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing *Blue Cross Blue Shield of New Mexico's Proposed Alternate Rule and Comments in Support of Proposed Alternate Rule* was sent via electronic mail to the following individuals, as indicated below, on June 14, 2020.

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NEW MEXICO MEDICAL LOSS RATIO REPORTS

13.10.27.9 COMPLIANCE REQUIREMENT FORM.

Submitting Entity:	
Covered Affiliates:	

		SECTION I				SECTION II				SECTION III				SECTION IV			
		Individually Underwritten Policies				Small Group Policies				Large Group and All Other Policies				Total Group Policies			
	update years as needed	**2015**	**2016**	**2017**	**Total**	**2015**	**2016**	**2017**	**Total**	**2015**	**2016**	**2017**	**Total**	**2015**	**2016**	**2017**	**Total**
A	Premium*				0				0				0	0	0	0	0
B	Premium Tax				0				0				0	0	0	0	0
C	Fees Associated with Health Insurance Exchanges				0				0				0	0	0	0	0
D	SUBTOTAL (A - B - C)				0				0				0				0
E	Incurred and Paid Claims **				0				0				0	0	0	0	0
F	Case Management Fees Paid to Providers				0				0				0	0	0	0	0
G	Disease Management Fees Paid to Providers				0				0				0	0	0	0	0
H	Health Education/Promotion Fees Paid to Providers				0				0				0	0	0	0	0
I	Preventive Services				0				0				0	0	0	0	0
J	Quality Incentive Payments to Providers				0				0				0	0	0	0	0
K	Assessments ***				0				0				0	0	0	0	0
L	Pharmacy Rebates				0				0				0	0	0	0	0
M	SUBTOTAL (E + F + G + H + I + J + K - L)				0				0				0				0
N	Calculated Loss Ratio (M / D)				0.0%				0.0%				0.0%				0.0%
O	Minimum Allowed Loss Ratio				80.0%				80.0%				85.0%				85.0%
P	If O > N, then O - N, else zero				80.0%				80.0%				85.0%				85.0%
Q	Rebates Paid or Due per 45 CFR Part 158																0
R	Refund Due [(P x D entry for Latest Year) - Q] if >0, else 0				0	**The NM MLR Refund for group policies is based on the medical loss ratio calculated collectively for all group policies.**											0

* All income received from individuals and private and public payers or sources for the procurement of health coverage, including capitated payments, self-funded administrative fees, self-funded claim reimbursements, recoveries from third parties or other insurers and interests.
** Includes capitation payments
*** Portion that covers claim costs rather than administration for which the insurer did not receive a tax credit.

ATTACHMENT 1