2027 Plan Year
Rate Filing Guidance for the Individual QHP and Small Group Markets

State of New Mexico
Office of Superintendent of Insurance

Table of Contents

Section I: Overview

Sec. 1.1: Background Information

A cornerstone philosophy of the Affordable Care Act (ACA) is that benefit plan premium variations in the individual and small group insurance markets should only reflect benefit differences between benefit plans, not differences between the population characteristics of people expected to enroll in each plan. To achieve this goal, federal law [45 CFR 156.80(d)(2)] permits limited adjustments to a market-wide index rate for a relevant state market, based only on the following actuarially justified plan-specific factors:

1. The actuarial value and cost-sharing design of the plan.
2. The plan's provider network, delivery system characteristics, and utilization management practices.
3. The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.
4. Administrative costs, excluding Exchange user fees.

Section 4.4.4 of the federal Unified Rate Review (URR) instructions emphasize this limitation.

To ensure that ACA rules are being followed, and a level regulatory playing field exists in the ACA market, OSI is prescribing pricing guidance to clarify rules and eliminate subjective variability in pricing factors and the use of other plan adjustments.

This document outlines the rate filing requirements for the ACA-compliant individual and small group market in New Mexico and is intended to provide rate filing guidance to issuers. This guidance supplements and does not contradict the 2027 URR Instructions. “ACA-compliant individual/small group market” refers to the on-exchange and off-exchange plans that are regulated under the single risk pool requirements of the ACA.

Sec. 1.2: Basis for Rate Development

Rates must be developed based on the law in effect on the date that rates are filed unless definitive guidance to the contrary is provided by the appropriate regulatory authority (state or federal). This means the 2027 plan year rate filings should reflect any changes to state law resulting from the 2026 state legislative session and any federal legislation enacted prior to the submission deadline. The Health Care Authority anticipates some program changes funded by the Health Care Affordability Fund. Please refer to the 2027 Marketplace Affordability Program Policy and Procedure Manual when it is released.

Please note, in past years, OSI has not permitted revisions of rate filing submissions, except to reflect risk adjustment changes after CMS issues the annual Risk Adjustment Report, which is usually published at the end of June. Note that changes to the filing in response to the final risk adjustment report must be approved by OSI prior to including such change

An exception to this rule may be made if there is a change in federal or state law after the submission deadline and before rates are finalized. It is the issuers' responsibility to ensure that rates reflect all laws and rules that will be effective as of January 1, 2027, or later, as applicable. If there are any questions or concerns related to this provision, please contact Brittany Odell at brittany.odell@osi.nm.gov.

Any other revisions will be at the discretion, and written direction of OSI and must relate to (1) correcting clearly inadvertent errors, (2) unforeseen circumstances that impact the industry, or (3) risk adjustment updates after the CMS Risk Adjustment Report. The revised filing must clearly state the reason(s) for the revision.

Sec. 1.3: Rate Review Timeline

2027 PY RATE REVIEW TIMELINE	
Activity	**Timeline**
Confidentiality Request	At least 10 days prior to filing submission date
Individual Form filing deadline	6/5/2026
Individual Rate and binder deadline	Two weeks from Marketplace Affordability Program guidance, no later than 6/19/2026
Small Group Form/Rate deadline (The applicable binder templates must be submitted under the Supporting Doc tab.)	6/29/2026
Risk Adjustment rate revisions	7/7/2020 - 7/14/2026
48-hour turn-around on issuer responses to Individual form and rate review objections	8/17/2026
24-hour turn-around on issuer responses to Individual form and rate review objections	8/24/2026
Approval, Certification and Transfer of Individual Plans	8/31/2026
48-hour turn-around on issuer responses to small group form and rate review objections	9/11/2026
URL Template Links and links in the plan documents to be live and active	9/15/2026
24-hour turn-around on issuer responses to small group form and rate review objections	9/18/2026

Approval of small group plans	9/25/2026
Open Enrollment Starts	11/1/2026

Please note that dates are subject to change based on factors such as delays in federal guidance, federal timelines, and System for Electronic Rate and Form Filing (SERFF) enhancements. Issuers are expected to adhere to the timeline, as specified above or in updated guidance. Issuers who fail to meet a deadline, submit an incomplete application or do not follow the processes outlined in this Guide shall be found in violation of the Insurance Code.

Penalties may be assessed pursuant to NMSA 1978, Section 59A-1-18 and 13.1.5 NMAC when an issuer demonstrates willful disregard of this guidance or of formal directives issued by OSI.

Willful disregard may include, but is not limited to:

- Refusal to implement language revisions necessary to demonstrate compliance with applicable state laws or regulations;
- Repeated failure to amend errors after notice and opportunity to cure; or
- Deliberate submission of materials that do not conform to clearly communicated requirements.

Penalties will not be assessed for inadvertent errors or good-faith compliance efforts. Penalty amounts will be determined based on the nature and severity of the willful non-compliance.

Failure to meet the deadlines noted above may result in plan disapproval and preclude plan loading onto the BeWell website. Incomplete and inaccurate submissions will not be accepted.

To ensure the binder data is sent to BeWell in a timely matter, issuers may be required to respond to binder objections sooner than the standard 5 business days.

Sec. 1.4: New and Important Information

The following highlight significant new or amended requirements:

- Sec. 1.2: The basis for rate development has been updated
- Sec. 1.3: Rate Review Timeline has been updated
- Sec. 2.2: SERFF filing submission requirements have been updated and clarified
- Sec. 3.10: Updated list of legislative changes showing the impact on premiums
- Sec. 3.22: Guidance related to the CSR defunding adjustment has been updated.
- Sec. 3.29: Additional financial information has been updated.

Section II: Required Submissions in the System for Electronic Rate and Form Filing (SERFF)

Sec. 2.1: General Information

(Please also see the 2027PY Individual QHP and Small Group Issuer Submission Guide)

For QHP certification purposes only, issuers must submit one form and rate filing per single risk pool. Issuers who offer both HMO and PPO type of products, must submit one Form/Rate filing for their HMO/EPO products, which contains the single risk pool rate and all related forms, and a separate Form/Rate filing for their PPO/POS products, with an identical single risk pool rate and all related forms. In other words, unless the products have a different network structure (HMO vs PPO) or markets (individual vs. group), there is no need to file separate product filings for the on-exchange, mirrored and off-exchange only products. All forms and the single risk pool rates must be submitted together. Issuers may format their actuarial memorandum to adequately address the rates for all plans included in the single risk pool and include separate sections in the actuarial memorandum for HMO vs. PPO plans for the same issuer. EPO plans must be submitted as part of the HMO Form/Rate filing submission and POS plans must be submitted as part of the PPO Form/Rate filing submission.

On-exchange and off-exchange forms must be clearly identified using the prescribed naming convention and filed together under the Form Schedule tab in SERFF.

Sec. 2.2: Program Attestations

Issuers seeking certification or recertification of a QHP plan must complete and submit, via SERFF, the 2027PY New Mexico Issuer Attestation Response form. Issuers who respond "No" to the optional attestation section of the Response Form must provide a justification for not providing a compliance plan. Issuers must upload these forms under the Supporting Documentation tab in the SERFF Plan Management module. OSI will accept electronic signatures on the Attestations. The Life and Health staff will send the Attestation to Company Licensing, though it is still the issuer's responsibility to confirm that Company Licensing receives it.

Sec. 2.3: SERFF Form and Rate Filing

Each rate filing submission is expected to stand on its own and must not refer to any other filing. Issuers are expected to submit a combined Form/Rate filing in SERFF, under the specific tabs listed. The documents related to the rate filing, that are included in the NM 2027PY QHP Form Filing Checklist and NM 2027PY Rate Filing Checklist must be included under the specified tab. In addition, please note the following:

1. The Part II Rate Increase Justification will be required for **all** rate filings, regardless of the magnitude of the change (even if it is zero or negative). This is intended to be a public document and may not be redacted. For filings with rate increases over 15%, the Part II Rate Increase Justification will also need to be filed in CMS' Health Insurance Oversight System (HIOS).

2. The Part III unredacted actuarial memorandum and the Excel version of supporting exhibits must be submitted in SERFF under the heading "Part III Actuarial Memorandum and Exhibits."

3. The redacted actuarial memorandum and the Excel version of redacted supporting Exhibits must be submitted in SERFF under the heading "Redacted Actuarial

Memorandum and Exhibits."

4. Pursuant to NMSA Section 59A-18-13.2(C), (D) and (E), issuers are required to provide certain information related to the rate filings, and that information is required to be posted on OSI's website. This Rate Transparency Report must be submitted in the format shown in Appendix A of this guidance follow the naming convention described below in Section 2.6. This report is expected to be a public document and may not be redacted.

5. The Rate Filing Checklist must be completed in its entirety and follow the standard naming convention described below in Section 2.6. The unredacted actuarial memorandum should provide sufficient detail such that a qualified health actuary would be able to evaluate the submission. Narrative and quantitative support should be provided for all assumptions. Any material changes in the methodology should be disclosed. This actuarial memorandum, including required exhibits, shall be prepared in accordance with applicable actuarial standards and OSI requirements, and shall address all items in the NM 2027 QHP Rate Filing Checklist.

6. Any exhibits supporting the information provided in the actuarial memorandum should be included as part of the actuarial memorandum, either within the body of the actuarial memorandum or as appendices. Additionally, each exhibit should be supported by detailed narrative documentation within the actuarial memorandum and should be submitted separately in Excel format with working formulas. All Excel versions of exhibits should be included in a single workbook, using the standard naming convention detailed below in Section 2.6, with tabs and headings clearly identifying the contents of the workbook.

7. The completed 2027 New Mexico ACA Rate Filing Template (NM Rate Filing Template), which requires issuers to provide data in a standardized Excel format, should be completed in its entirety, in accordance with the 2027 Plan Year Individual and Small Group Rate Filing Template Instructions.

8. The 2027 URRT should be submitted in both XML and Excel formats and comply with the 2027 URR Instructions.

9. AV Calculator screenshots for all plans, including Clear Cost and Turquoise plans, as well as support for any unique plan designs, including the unique plan design certification should be included. Any differences from the AV results included in the Plans and Benefits Template should be explained. On each page of the AV calculator screenshot for each plan, include the HIOS plan ID and the name of the corresponding SBC.

10. The Rates Template should be submitted in both XML and Excel formats. Issuers must confirm that the rates calculated in the URRT are consistent with the rates provided in the QHP Rates Template. We understand there may be minor

rounding differences with the URRT. Differences over $0.50 PMPM should be explained.

11. Each filing should make all affiliated prior submission accessible through the "View Associated Filings" feature in SERFF. This would be the previously approved form/rate filing, as well as the most recently approved compliance filings.

Please note, while OSI is not prescribing that issuers follow the URRT rate development methodology, the URRT data must match supporting documentation and the final premium rates. It is not acceptable to provide filing materials which do not match the federal templates.

Sec. 2.4: Submission of Responses to Objections in SERFF

When responding to an objection letter:

- Supplemental documents submitted in response to an objection letter must be included under a heading labeled "Response to Objections Submitted MM/DD/YYYY."
- Standard revised documents must follow the standard naming convention detailed below in Section 2.6.
- Non-standard revised documents must include the revision date as part of the file name.
- Revised actuarial memoranda must have an updated signature date and a red-lined version of each revision must be submitted along with the clean version.
- Regarding proprietary information included in the objections and/or responses to objections, to ensure that proprietary information is kept confidential by OSI permanently, issuers will need to follow the procedure outlined in the Confidentiality Guidance.

Sec. 2.5: Treatment of Proprietary Information

OSI recognizes that issuers may consider certain information to be proprietary and confidential. To ensure a level playing field and encourage a competitive market, all rate filing materials will be kept confidential during the review period. To ensure that proprietary information is kept confidential by the OSI permanently, issuers must follow the procedure outlined in the Confidentiality Guidance.

Sec. 2.6: Standard Naming Convention

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

- Actuarial Memorandum
- Actuarial Memorandum Exhibits
- Medical Rate Filing Template
- Medical Rate Filing Checklist
- Rates Template
- Medical Form Filing Checklist
- Rate Transparency Report – See Appendix A for format

- Part II Rate Increase Justification
- Risk Adjustment Transfer Elements Extract (RATEE) Report
- Risk Adjustment Study
- Standardized to Non-Standardized Benefit Relativities Template
- All forms submitted under the Form Schedule Tab in SERFF

All naming conventions and terminology must be consistent between the Form/Rate filing, binder and templates.

For example, each form included in the filing should reflect the name of the plan as it is stated in the binder and listed within the PBT.

IssuerName_MMDDYYYY_mkt_ Plantype (Form Only)_Exchangetype_v#_ Filedesc.filetype

- **IssuerName**: Up to 6 Characters which identify the issuer
- **MMDDYYYY**: e.g., 01012027 for filings effective January 1, 2027
- **mkt: indicate one of the following**:
  - "i" for individual (non-group)
  - "s" for filings that include small groups only, (2 to 50 employees)
  - "l" for filings that include large groups only (more than 50 employees)
  - "g" for filings that include groups of all sizes (more than 2 employees)
- **Plantype (forms only): indicate one of the following, if there are differences between forms by plan type**.
  - PPO
  - PPO_POS
  - HMO
  - HMO_EPO
  - EPO
  - POS
- **Exchangetype: indicate one of the following**
  - MedOn (Medical On-Exchange)
  - MedOff (Medical Off-Exchange only)
- **v#**: v followed by the version number (increment for each update to the filing)
- **Filedesc**: indicate one of the following:
  - **AMR** – Actuarial Memorandum – redacted
  - **AM** – Actuarial Memorandum – unredacted
  - **AMEX** – Actuarial Memorandum Exhibits – unredacted
  - **AMEXR** – Actuarial Memorandum Exhibits – redacted
  - **BenRelX** - Standardized to Non-Standardized Benefit Relativities Template - unredacted
  - **BenRelXR**- Standardized to Non-Standardized Benefit Relativities Template – redacted
  - **RTR - Rate Transparency Report (See Appendix A for format)**
  - **RFT** – New Mexico ACA Rate Filing Template – unredacted

- **RFTR** – New Mexico ACA Rate Filing Template - redacted
- **RTCK** – Rate Filing checklist
- **PartII -** Part II Rate Increase Justification
- **RA –** Risk Adjustment Study
- **FMCK –** Form checklist
- **CER** = Certificate/EOC
- **SBC** = Summary of Benefits and Coverage
- **POL** = Policy/Contract
- **AP** = Application
- **EF** = Enrollment form
- **End** = Endorsement
- **Form**=Formulary
- **Rd** = Rider
- **ID** = ID or RX Card
- **RT** – Rates Template
- **ECP-NA -** Essential Community Providers Template

Rate Filing Example: ABC_01012027_i_MEDOn_v1_RTCK.xlsx is the initial 2027 medical rate filing checklist for the ABC Health Plans individual on Exchange filing. The Plan Type field is not required for rates as there is only one rate filing checklist submitted for each single risk pool.

Form Example: ABC_01012027_i_HMO_MEDOn_v2_Plan1_SBC.xlsx is the 2nd version of the 2027 Summary of Benefits and Coverage for the On Exchange, named Plan 1[1], offered by ABC Health Plans. The Plan Type field is used in this case as the form will vary by Plan Type, and a separate form filing checklist is required for each policy/COC/EOC form.

Section III: Actuarial Memorandum Requirements

(See also the Health Care Affordability Fund (HCAF) Health Insurance Marketplace Affordability Program – 2027 Plan Year Policy and Procedures Manual)

Sec. 3.1: General Information

The actuarial memorandum needs to comply with the instructions included in the 2027 Unified Rate Review Instructions, with particular attention to the items listed in Sections 3.2 to 3.32 below.

Issuers are encouraged to include as much detail and supporting documentation as possible in the initial filing to facilitate an efficient review process, which may include several rounds of questions from OSI. Failure to provide information on a timely basis or failure to provide accurate

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

information slows the review process and puts the issuer at risk for missing critical deadlines to offer ACA-compliant health insurance products and plans in New Mexico.

Sec. 3.2: Summary Description of the benefit design of each plan included in the single risk pool

- Provide a table, with the major cost sharing features of the plans reflected in the filing, including the Turquoise plan variants and the New Mexico Standardized plans
- HIOS Plan ID
- Product[2]
- Metal Tier
- AV
- Projected Enrollment for 2027
- Overall Deductible[3]
- Coinsurance[4]
- Copay
- Maximum Out-of-Pocket (MOOP)
- Standardized Plan Indicator (Yes/No)
- Turquoise Plan Indicator (Yes/No)
- Age 21 Premium (by rating area)

Issuers are welcome to include any additional information that may be helpful to the reviewer.

Sec. 3.3: Basis for Rates - Provider Reimbursement Agreements

Rates are to be determined based on provider contracts that are in effect as of the rate filing submission date. Rate revisions will not be allowed for contract changes finalized during the rate review period except under extenuating circumstances as determined by OSI. Include an exhibit, in the format shown below in Table 1, summarizing the provider reimbursement rates for 2025, 2026 and 2027.

Table 1 - Provider Reimbursement Rates

Provider Reimbursement Rates

Major Service Category	Reimbursement Rate as a Percentage of Medicare Reimbursement Rates		
	2027	2026	2025
Inpatient			
Professional			
Outpatient			

[2] HMO, PPO, EPO, POS
[3] HMO, PPO, EPO, POS
[4] Most predominant coinsurance used

Other Medical Expenses			
Total Medical			

Sec. 3.4: Rate Change Components

A narrative description and an estimate of the magnitude of all drivers of the 12-month average rate change, which total to the proposed rate change must be provided. If different than NM Rate Filing Template, please provide a reconciliation. Small Group filings should provide both the annual rate change and the proposed rate change from 4Q 2026 to 1Q 2027.

Additionally, an explanation of how the rate increase varies by product and plan per the URR instructions must be included. This explanation should document how morbidity was removed from impacting these variations.

Please also explain how the minimum and maximum rate increase included on SERFF was determined. Issuers are welcome to include any additional information that may be helpful to the reviewer.

Sec. 3.5: Credibility

An explanation of the methodology used to determine the credibility level of the experience and why it is applicable to the proposed market must be provided. Qualitative and quantitative justification must be provided if the experience data were not used as the rate basis or if the experience data are supplemented by additional data sources.

OSI will not accept references to the 24,000 Medicare Advantage (MA) credibility thresholds as justification for credibility thresholds applied to the individual and small group markets. We note that the MA 24,000 member-month credibility threshold applies to medical allowed costs only and a 60,000 member-month credibility threshold applies to prescription drug coverage.

If actuarial judgment is used, please consult requirements in ASOP #25 and provide a full explanation of the reasoning and the information used to inform the actuary's judgment.

Sec. 3.6: Manual Rate Development

If a manual rate is used, narrative and quantitative support for the manual rate development must be provided. This includes a complete narrative explanation of the appropriateness of the manual source data as well as narrative and quantitative support for all assumptions. Provide an exhibit showing the development of the manual rate, similar to the experience rate development exhibit.

Sec. 3.7: Benefit Adjustments

If there are reserves other than IBNR, confirm changes to those reserves were not considered in the rating process.

If an adjustment is made for any of the following, verify that both narrative and quantitative support

were provided, detailing all assumptions as well as explaining where the adjustment is applied:

1) Morbidity Adjustment
2) Demographic shift
3) Plan Design Changes
4) Other

Disclose **all** factor and benefit changes from the prior approved rate filing including narrative and quantitative support for each change.

There are no changes to New Mexico's EHB benchmark plan for plan year 2027. Benefit changes that are not expected to impact premiums should also be disclosed, and a discussion of the analysis performed to determine that there is no premium impact should be provided.

Sec. 3.8: Wellness Plans or Other Value-Added Products or Services

Rates shall **not** include the cost to the issuer of any wellness plans or other value-added product or service that may be offered to an enrollee. These costs shall not be treated as, or included in the general, administrative expense category. The costs of these offerings, if any, may only be borne by the member as part of a separate and express agreement.

The actuarial memorandum must include a description of any wellness plans or other value-added products or services (as authorized under 59A-16-17(G) NMSA) and explicitly state that the cost of these products or services were not reflected in the rates. If value-added products or services are offered, they must be offered with all plans, standardized and non-standardized. Complete Table 2, which details the cost of each value-added product or service.

Table 2 – Value-Added Products or Services

Value-Added Service	Cost (PMPM / % Premium)	Availability of Value-Added Service (Plans with which they will be offered)

Sec. 3.9: Riders

Optional riders are not permitted. Riders must be attached to all plans within a product, including all standardized and non-standardized plans, and are considered as part of the package.

Sec. 3.10: Recent Legislative and Regulatory Changes

Sec. 3.10.1: 2026 Legislative Changes or Regulatory Changes

Provide the cost of each of the recent legislative and regulatory changes, which were incorporated into 2027 rates, and were not included in the prior year's rates, along with substantial support for the calculation of these amounts.

These amounts should tie with the percentages reported in section D of Tab 1 of the 2027 NM Rate Fling Template:

- HB 38 – Wheelchair Coverage
- HB 306 - Prohibits Certain Health Care Facility Fees
- SB 20 – Prior Authorization & Prescription Drugs
- 2027 NPBB
    - Eligibility and Tax Credit Changes
    - Elimination of 150% of FPL Special Enrollment Periods
    - Stricter Income Verification
    - Expansion of Hardship Exemptions for Cat Plans, if applicable
    - Expanded MOOP for Bronze Plans

Note that issuers are required to explicitly state if Catastrophic plans are included and if they are expanding the MOOP for catastrophic plans. OSI will not allow multi-year catastrophic plans.

Sec. 3.10.2: Prior Legislative Changes

Additionally, provide the cost of the following past legislative and regulatory changes, which have already been incorporated into rates in the past, and complete section E of Tab 1 of the 2027 NM Rate Fling Template. This is for informational purposes only. We understand that these items will have no impact on 2027 rates because they have already been incorporated into pricing.

- 59A-59A-1 through 7 – Increases transparency across the prescription drug supply chain, as well as reporting prescription drug prices trends to OSI
- 7-1-6.69 – Amends the distribution to the Health Care Affordability Fund
- 59A-22-53.1, 59A-22B-8, 59A-46-52.1 – Modifies the guidelines relating to step therapy for prescription drug coverage and eliminates step therapy requirements for certain conditions
- 23-7.17, 59A-46-43 – Requires coverage for certain durable medical equipment for the treatment of active diabetic foot ulcers
- 59A-22-57, 59A-23-16, 59A-46-57-Adds an exemption from the prohibition on cost-sharing for behavioral health services for certain plans
- 59A-22B-2, 59A-22B-5, 59A-22B-8-Adds more classes of drugs that are not subject to prior authorizations or step therapy protocols

- 59A-22-60, 59A-46-60–Coverage for preventive care or treatment of sexually transmitted infections should not be subject to cost sharing.
- 59A-22-59, 59A-46-59– Cost-sharing for chiropractic physician services should not exceed the cost-sharing applied to primary care services.
- 59A-22-62, 59A-46-72-Cost-sharing requirements for prosthetics and orthotics should not be more restrictive than the cost-sharing requirements applicable to the plan's medical and surgical benefits, including those for internal devices. Coverage must include most appropriate devices as determined the treating physician when medically necessary to maintain activities of daily living or essential job-related activities and meet the medical needs for physical activities such as running, biking, and swimming and maximizes upper limb function. Coverage of devices is considered habilitative and rehabilitative and includes initial and replacement devices.
- 59A-22-39.3, 59A-46-41.3 –Coverage for diagnostic and supplemental breast examinations should not be subject to cost sharing.
- 59A-22-41, 59A-46-43–Cost sharing for diabetes should be same as cost-sharing for other benefits.
- 59A-22-53.3-Cost-sharing for prescription drugs or pharmacy services obtained at a nonaffiliated pharmacy or administration of prescription drugs at different infusion sites should be the same provided that an insurer may communicate with an insured regarding lower-cost sites of service.
- 59A-22-61, 59A-46-71-Biomarker testing must be covered.
- 59A-22B-7-Prior authorization is prohibited for in-network mental health or substance use disorder services and prescription drugs, when medically necessary and provided by in- network providers.
- 59A-46-58–Prohibits insurance coverage discrimination against persons with disabilities receiving organ, eye or tissue transplants and associated care.
- 59A-22-53–Modifies the guidelines for group health plans related to step therapy for prescription drug coverage and eliminates step therapy requirements for certain conditions.

Sec. 3.11: Trend

Narrative and quantitative support for trend adjustments should be included, which include but are not limited to, the following:

1) A 5-year history, where available, of actual cost and utilization trend. (This is satisfied by completing Tab 5 of the NM Rate Filing Template)
2) Any differences in trend assumptions from the prior approved filing.

3) Discuss anticipated changes in provider contracts that differ from those underlying the experience used and the impact on medical cost trends by major service categories.
4) Explain differences in trend by benefit category.
5) Explain any adjustments to trends based on fluctuation in large claim amounts.
6) An explanation of the source data for the trends must be provided and why it is applicable to the single risk pool must be included.
7) If the projection period is more or less than 24 months, verify that "Year 1" and "Year 2" trend factors were appropriately adjusted.
8) If a leveraging factor is included, provide support for the leveraging factor, using historical or other relevant data.

Issuers are welcome to include any additional information that may be helpful to the reviewer.

Sec. 3.12: Risk Adjustment Transfer Amount

All assumptions used to complete the federal risk adjustment transfer formula must be explained narratively, for both the experience and projection period. If the federal risk adjustment formula was not used to estimate the projected risk adjustment, the alternative calculation must be supported narratively and quantitatively. Note that Tab 9 of the NM Rate Filing Template collects historical and projected statewide and issuer components of the risk adjustment formula, both estimated and actual, as applicable, as well as the estimated and actual amounts of the transfer payments, Issuers are expected to provide detailed exhibits, that demonstrate the calculation of the transfer payment amount in Excel format, and all assumptions should be explained narratively and quantitatively. It is our understanding that some issuers in New Mexico participate in a risk adjustment study performed by a consulting firm. Regardless of the methodology used to develop the risk adjustment transfer amount for pricing purposes, OSI is requiring all issuers to submit the detailed report(s), including any spreadsheets, that are provided as a result of that study, as part of the initial rate filing submission. Issuers using internal studies or other sources to inform the assumptions used in the determination of the risk transfer amount used in rate development, must provide documentation of that study or other data source.

Discuss differences in the estimated experience and projected risk adjustment results from the most recent risk adjustment report published by CMS.

The impact of the high-cost pooling mechanism and RADV must also supported narratively and quantitatively, including if no impact is included.

Sec. 3.13: Exchange Fee

The market-wide adjustment for Exchange fee should be set to 0%. The New Mexico Health Exchange (BeWell) pays the Exchange fee out of an assessment on all issuers. BeWell calculates an assessment on all issuers in the market (including off-exchange issuers), which may not be available when the rates are filed. Therefore, quantitative support for the development of the estimated assessment amount must be provided. The assessment amount should be included in the

taxes and fees.

Sec. 3.14: Projected Paid-to-Allowed Factor

Quantitative support for the projected paid to allowed factor should be included. An exhibit with the calculation of how the paid to allowed factor is developed, tying to information from historical or other experience would satisfy this requirement. Explain significant (+/- 2%) differences in the paid to allowed from the base period.

Sec. 3.15: Standardized Health Plans

All individual market issuers offering coverage on BeWell during the 2027 Plan Year must offer the Standardized Health Plans approved by the BeWell Board of Directors. Identify the plans which fulfill the Board's Standardized Health Plan requirements (this is satisfied by completing Tab 6 of the NM Rate Filing Template). Issuers must explain pricing differences between Standardized and Non-Standardized plans, including how specific features differentiate prices, and support how these features were priced. See Section 3.18 below on cost-sharing design for additional information related to the required level of support needed to justify the relative pricing of standardized and non-standardized plans.

According to BeWell's requirements related to covered prescription drugs, "An issuer may opt to offer only one Specialty tier, provided that the co-pay value is equal to the value of the Specialty Preferred tier of the approved Standardized Health Plan. An issuer must notify OSI if it intends to offer a single Specialty co-pay tier no later than May 1, 2026." Issuers offering two specialty prescription drug tiers must submit to the OSI the utilization assumptions for preferred and nonpreferred specialty medications, along with support for those assumptions. Issuers are permitted to include nonpreferred generic medications in the preferred brand name tier.

Pursuant to the HCAF Health Insurance Marketplace Affordability Program – 2027 Plan Year Policy and Procedures Manual, the actuarial value (AV) of the Silver standardized plan will determine the AV floor for non-standardized Silver plans, based on the final 2027 AV calculator.

Provide an exhibit, using the Standardized to Non-Standardized Benefit Relativities Template, that quantifies the driving factors behind the difference in benefit relativities between the on-Exchange non-standardized and standardized plans within the same metal tier by providing the benefit relativity factors for:

a. The standardized plan
b. A hypothetical plan changing each major benefit in turn,
c. The non-standardized plan

Provide qualitative and quantitative support for expected membership shifts between standardized and non-standardized plans.

Sec. 3.16: Plan Level Adjustments

Issuers are restricted to the allowable factors in 45 CFR 156.80(d)(2) to adjust the Market Adjusted Index Rate (MAIR) to calculate each Plan Adjusted Index Rate (PAIR). The URR Instructions should be followed for all allowable rating factors. The OSI has implemented stricter guidance on the allowable "actuarial value and cost-sharing design of the plan" adjustment. This adjustment is categorized into three distinct multiplicative factors. The applicable guidance is described in Section 3.18 below.

Sec. 3.17: Actuarial Value Metal Value (AV)

This factor must match the AV Metal Value on Worksheet 2 of the URRT. Additional information required to support the AV Metal Value is discussed later in this guidance.

Sec. 3.18: Cost-Sharing Design

The methodology used to determine the Cost-Sharing Design must be explained. Additionally, support (quantitative where possible) must be provided detailing the methodology for removing the impact of morbidity. Include an explanation of any plan-specific benefits that drive unusual cost-sharing design factors or relativities. See Section 3.21 below on the CSR Defunding Adjustment for details on how the CSR Defunding Adjustment should be reflected in the Cost-Sharing Design Factor. The benefit relativities between standardized and non-standardized plans should be quantitatively and qualitatively supported. Include an exhibit demonstrating the normalized cost differences between standardized and non-standardized plans. Provide qualitative and quantitative support for expected membership shifts between standardized and non-standardized plans.

Sec. 3.19: Induced Demand

Induced demand factors (IDF) for both the individual and small group market should be consistent with the metal level factors developed by the Centers for Medicare and Medicaid Services (CMS) and used in the Federal Risk Adjustment program. Additional induced demand for HSA-qualified plans is not permitted. Demonstrate that the induced demand factors are normalized to a weighted average of 1.0. (This can be done using the NM Rate Filing Template). These apply to the Turquoise plans for purposes of the federal risk adjustment program during the 2027 Plan Year:

Variant	Risk adjustment IDF
99% AV Silver	1.12
95% AV Silver	1.12
90% AV Gold*	1.07

*Includes the –13 variant.

Sec. 3.20: Network Factors

Please provide an explanation of how network factors were determined. Confirm that the rating factors for networks do not reflect morbidity or demographic differences in the populations selecting those networks. Confirm that network factors are the same for all plans with the same network. If the network factors changed from the prior filing, explain all changes. Demonstrate that the network factors are normalized to a weighted average of 1.0. (This can be done using Tab 6 of the NM Rate Filing Template).

Sec. 3.21: CSR Defunding Adjustment

Because the 2026 NBPP has an explicit focus on a cost-based CSR defunding adjustment factor that is actuarially justified, effective January 1, 2026, OSI is no longer prescribing a single CSR defunding adjustment factor. OSI is allowing issuers to develop their own CSR defunding adjustment factor based on experience data, projected enrollment and other assumptions that result in actuarially justified factors.

Rates for the individual ACA single risk pools must have actuarially justified, cost-based CSR defunding adjustment factors that:

- are applied to silver on-Exchange plans;
- are based on credible experience data;
- reflect the expected mix of enrollment in CSR plan variants; and
- do not reflect health status.

Issuers will be required to provide extensive actuarial support to demonstrate that they meet the above criteria and result in actuarially justified rates that are neither excessive nor deficient pursuant to 45 CFR 156.80(d)(2).

This includes:

- An excel spreadsheet, with formulas intact, that demonstrates the calculation of the factor.
- An excel spreadsheet, with formulas intact, that demonstrates that the factor was applied as a post-pricing factor
- Detailed qualitative support in the actuarial memorandum as follows:
    - the load amount and detailed explanation of how it was determined;
    - an in-depth narrative describing the methodology and assumptions used, which demonstrate that the calculation of the factor aligns with the American Academy of Actuaries' 9/28/2022 comment letter to CCIIO and related PowerPoint presentation which address the calculation of actuarially sound CSR defunding factors;
    - the actual CSRs the issuer paid for enrollees for PY 2024 and 2025, along with detailed support for the calculation of this amount. OSI considers the methodology described in

the Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017, which CMS required issuers to use to calculate the value of the CSRs at that time, to be a reasonable approach to the calculation of the of the 2024 PY CSRs.

- the total estimated revenue due to the CSR load for PY2027, including detailed support for the calculation of this amount;
- an explanation of how the additional revenue collected from the applied CSR load compares to the expected amount of CSRs that will be provided to enrollees in PY 2027;
- the impact on rates of the federal funding of the CSRs (along with support) as an informational item in the actuarial memorandum.

If Congress decides to fund the CSR program, there will be no CSR defunding adjustment.

Sec. 3.22: Benefits in Addition to EHBs

Provide a description of all Benefits in addition to EHB, explain how the impact was determined (even if no impact), and provide support for the "Benefits in addition to EHB" adjustment factors. Confirm that the adjustment "Benefits in addition to EHB" was based on pooled experience for all plans with those benefits. If the "Benefits in addition to EHB" factors changed from the prior filing, provide support for changes. Provide an exhibit that includes a brief description of each benefit in addition to EHB, along with the cost of each (PMPM and as a % of premium).

Sec. 3.23: Non-Benefit Expenses

Provide support for the administrative cost (PMPM and as a percentage of premium). Provide commissions, sales and marketing expenses separately from administrative costs, provide support and the proportion of business sold on-exchange. Subject to the prohibition on including costs relating to value-added products and services, provide support for administrative costs related to programs that improve health care quality and provide support for differences from the prior approved filing.

Break out all taxes and fees and discuss how they were determined. Provide support for the BeWell assessment and confirm it is included in the taxes and fees. Provide the projected risk adjustment fee and confirm it is included in taxes and fees and not as a market-wide adjustment.

Provide support for the included profit & risk margin and discuss any changes from the prior approved filing, including an explanation of why the change is required. **Please note, varying the profit load by metal level is not permitted.** An appropriate demonstration of financial security, such as a parental guaranty, must be provided with 0% or negative profit margins.

Explain any differences in the non-benefit expenses by plan, as applicable.

All PAIR adjustments should be developed from the same population for all individual and small

group market plans. Adjustments should not use populations that vary based on issuers' expectations of unique population characteristics expected to enroll in a specific benefit plan or a metal tier. PAIR adjustments should not include expected risk adjustment transfer payments; these should be included in the MAIR in accordance with Section 2.1.3.3 of the URR instructions.

Sec. 3.24: Rating and Calibration Factors

Age Factors

Confirm the rating factor calibration is uniform for all plans. Confirm that the CMS age curve was used for the age factors. Explain whether the age calibration is based on prior or projected age distributions. If there was an adjustment for aging, the projected age distribution should be used in the age calibration. Provide support for the adjustment for the cap of three dependents under 21 and confirm it is appropriately accounted for in the age calibration.

Geographic Factors and Service Area

If an insurer offers a plan anywhere in New Mexico at a particular metal level, it must offer a statewide plan for that level. (For example, if Issuer A has submitted a plan available at all the metal levels, then they need to provide at least one statewide plan at all the metal levels. If an issuer A has only submitted plans at the Silver and Gold levels, then they only need to provide statewide plans at the Silver and Gold Levels.)

The maximum differential between the highest and lowest rated area is 40%.

Confirm that the geographic rating areas approved by CMS were used. These rating areas are as follows: 1: Albuquerque MSA (Bernalillo-Sandoval-Valencia-Torrence Counties), 2: Farmington MSA (San Juan County), 3: Las Cruces MSA (Dona Ana County), 4: Santa Fe MSA (Santa Fe County), 5: Non-MSA regions (all counties not listed above) Narrative and quantitative support for the geographic factors should be provided, including a comparison to the prior year factors, if applicable, and an explanation of why the factors have changed from the prior filing, if applicable. Confirm that the geographic factors only reflect differences in cost and utilization by geographic area due to differences in practice patterns and cost and do not reflect differences in morbidity. Provide support for the geographic rating factor calibration.

Please note, any proposed provider contracting must be finalized to be considered in the proposed rating factors.

Tobacco Use Factors

Due to mounting evidence that tobacco rating in the individual market suppresses enrollment, undermines financial protection afforded by coverage, and has disproportionate negative impacts on rural communities, OSI is requiring issuers to set the tobacco rating multiplier at 1.0 for all individual on-and-off-exchange plans offered starting with the 2023 plan year. This applies only to the individual market.

Rating materials must confirm the tobacco factors are within the required 1.5:1 range for small group offerings. Explain differences in the tobacco use factors from the prior approved filing.

Provide support for the tobacco use calibration.

Sec. 3.25: Medical Loss Ratio

Provide support for the projected one-year federal MLR. Demonstrate that the appropriate formula was used. Confirm that the projected MLR meets the minimum requirements. If the one-year projected federal MLR for 2027 is below 80%, provide the calculation of the projected federal three-year MLR calculation.

Indicate federal MLR rebates expected to be paid for the experience period.

Provide a comparison of the MLR information, in the format shown in Table 3 below for 2020 through 2024, which are the five most recent years for which complete MLR information is available, as well as the estimated MLR used in pricing for the experience period. Also provide an explanation of any significant differences between the actual pricing MLR and member months. The MLR should be on a single year's basis.

Table 3 – Actual and Pricing MLR comparison

Calendar	MLR		MLR Rebates ($)	Member Months	
Year	Actual (%)	Pricing (%)		Actual	Pricing
2020					
2021					
2022					
2023					
2024					
2025	N/A			N/A	

Sec. 3.26: Actuarial Value

Provide AV screenshots for all plans. Confirm the AV is consistent with the URRT AV. Confirm that the URRT AV is close (within +/- 0.1%) to the one in the QHP Plans and Benefits template or explain differences. Confirm the AV for each metal plan is within the appropriate range

If an Alternative Methodology was used:

1) Demonstrate that the plan design is in fact unique.
2) Provide support for all adjustments to the AVC input.

Sec. 3.27: Membership Projection

Summarize the current projected and experience period membership and provide an explanation of

any significant changes in membership projections from the current membership numbers provided on worksheet 2 of the URRT. OSI does not have specific parameters around what constitutes a "significant change." Issuers are encouraged to review their data and provide explanations of changes that are larger than would ordinarily be expected.

Sec. 3.28: Financial Information

Include a section that addresses the overall financial health of the company and this line of business. Attach a copy of the company's most recent Annual Statement filed with OSI and the National Association of Insurance Commissioners (NAIC). In addition, attach a copy of the 2025 Supplemental Health Care Exhibit, and the quarterly statement for the first quarter of 2026.

Sec. 3.29: Limits on the Number of On-Exchange Non-Standardized Silver Plans Offered by Each Issuer

In the individual, on-exchange market, issuers must offer at least one Gold and one Silver plan, and issuers may offer only two non-standardized Silver plans, in addition to the standardized Silver plan in any rating area. If the two non-standardized Silver metal level plans are offered in the same area and produce similar rates (e.g., within +/- $10 PMPM for a 21-year-old), significant support must be provided explaining why plans are priced so similarly. OSI will consider allowing additional Silver metal level plans only if there are significant differences between the plans' provider networks. An example of a "significant difference" between networks is a broad network vs. a narrow network. Issuers may offer only two non-standardized Gold plans in addition to the standardized Gold plan in any rating area. No additional requirements apply to Gold plans.

There is no limitation to the number of Silver or Gold plans that can be offered in the individual off-exchange market or small group market.

Sec. 3.30: Broker Commissions

The Actuarial Memorandum must contain the commission amounts that will be paid to brokers. The commission structure must comply with Section 59A-16-3 NMSA 1978.

Sec. 3.31: Reliance

Pursuant to section 3.4.4 of Actuarial Standard of Practice No. 41, Actuarial Communications (ASOP 41), please indicate if you are using any assumptions or methods chosen by another party, including the rating assumptions required by the New Mexico OSI, and provide any required disclosures, subject to sections 3.4.4(a) or 3.4.4(b) of ASOP 41, and section 4.1 of ASOP 8, as appropriate.

Sec. 3.32: Actuarial Certification

The Actuarial Certification must, at a minimum, certify compliance with the following Actuarial Standards of Practice:

- 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. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
- ASOP No. 41, Actuarial Communications
- ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

Regarding, ASOP No. 41, any assumptions or methods chosen by another party, including New Mexico OSI, should be documented in the Actuarial Memorandum.

Additionally, the Actuarial Certification must include a statement that:

1. the rates do not reflect the cost of any wellness plan or other value-added products or services, and
2. The rates do not reflect the cost of services related to sex trait modification, and
3. The rates do not reflect the cost of services related to elective abortions

Section IV: Reporting Requirements

Pursuant to NMSA Section 59A-18-13.2(C), (D) and (E), issuers are required to provide certain information related to the rate filings, and that information is required to be posted on OSI's website. OSI is requiring all issuers to provide the required information in the format prescribed by OSI as part of the rate filing submission. This information will be publicly available and should not be redacted. Please see Appendix A for the required format.

Appendix A: Rate Transparency Report

I. High level narrative summarizing rate changes for 2027PY submission and the main drivers of the rate change (e.g., trend, benefit changes, etc.), along with a table showing the numerical rate change for each of the drivers identified and the overall rate change:
II. High level narrative summarizing form changes for 2027PY submission:
III. High level description of how the revised rates were determined, including general description and source of each assumption used:
IV. Expected federal medical loss ratio for blocks of business in existence for at least three years:
V. High level narrative of the supporting information that demonstrates how the blocks of business will meet the requirements for medical loss ratio in state and federal law:
VI. Medical costs, including utilization and compensation rates trend, justifying the rate increase. Identify the aggregate types of expenditures in those categories that support the premium rate increase in the geographic area covered. This section does not need to include provider compensation, only the trend:
VII. High level description of blocks of business in existence for at least three years, premium revenues, claims history, losses and reserves for the three years preceding the date of filing. Provide supporting documentation and whether the insurer has ceased to actively offer or sell to new applicants a block of business for which it seeks a rate increase: