TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 27 UNIFORM DEFINITIONS AND STANDARDIZED METHODOLOGIES FOR CALCULATING THE MEDICAL LOSS RATIO

13.10.27.1 ISSUING AGENCY: New Mexico Public Regulation Commission, Insurance Division.
[13.10.27.1 NMAC - N, 11/30/12]

13.10.27.2 SCOPE: This rule applies to all health care insurers, health maintenance organizations, or health care plans that are required to obtain a certificate of authority or licensure in this state or which provide, offer or administer managed health care plans.
[13.10.27.2 NMAC - N, 11/30/12]

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.
[13.10.27.3 NMAC - N, 11/30/12]

13.10.27.4 DURATION: Permanent.
[13.10.27.4 NMAC - N, 11/30/12]

13.10.27.5 EFFECTIVE DATE: November 30, 2012, unless a later date is cited at the end of a section.
[13.10.27.5 NMAC - N, 11/30/12]

13.10.27.6 OBJECTIVE: The purpose of this rule is to clarify statutory requirements that insurers make reimbursement for direct services at certain levels across all product lines by providing guidance and establishing uniform definitions and standardized methodologies for the calculation of the medical loss ratio for plan years 2010, 2011, 2012 and unless this rule is repealed, for plan years thereafter.
[13.10.27.6 NMAC - N, 11/30/12]

13.10.27.7 DEFINITIONS: As used in this definition:

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 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 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 limited-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, and interests less any premium tax paid pursuant to Section 59A-6-2 NMSA 1978 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, 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"** mean:

(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-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 mean any policy, plan or contract related to the provision of health care services offered, arranged or facilitated by an insurer.

[13.10.27.7 NMAC - N, 11/30/12]

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 shall be removed. For example, the second measurement year shall be 2011, 2012 and 2013.

C. **Aggregation.** 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.

D. **Frequency.** 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 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 loss ratio calculation and will be filed with the insurance division by April 15 of the year following the measurement period. This form is first due on April 15, 2013.

F. **Calculation.** The numerator of the 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.

G. **Minimum 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%.

H. **Compliance with minimum loss ratio.** With compliance requirement form set forth in 13.10.27.9 NMAC, each carrier shall submit to the insurance division either:

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

(2) a plan to return excess premium charged 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.
[13.10.27.8 NMAC - N, 11/30/12]

13.10.27.9 COMPLIANCE REQUIREMENT FORM.

Measurement Period
January 1, 20xx - December 31, 20xx

Submitting Entity: ________________________
Covered Affiliates: ________________________

		Individually Underwritten Policies	All Other Policies
A	Premium	$ __________	$ __________
B	Self-Funded Claim Administrative Fees	$ __________	$ __________
C	Self-Funded Administrative Fees	$ __________	$ __________
D	Premium Tax	$ __________	$ __________
E	Fees Associated with Health Insurance Exchanges	$ __________	$ __________
F	**Subtotal (A+B+C-D-E)**	80.0%	$ 85.0%
G	Minimum Allowed Loss Ratio	$ __________	$ __________
H	G x F	$ __________	$ __________
I	Incurred and Paid Claims*	$ __________	$ __________
J	Case Management Fees Paid To Providers	$ __________	$.__________
K	Disease Management Fees Paid to Providers	$.__________	$ __________
L	Health Education/Promotion Fees Paid to Providers	$ __________	$.__________
M	Preventive Services	$ __________	$.__________
N	Quality Incentive Payments to Providers	$ __________	$.__________
O	Assessments**	$ __________	$ __________
P	Pharmacy Rebates	$ ___________	$ __________

Q	**Subtotal (I+J+L+M+N+O-P)**	$ ___________	$ __________
	REFUND DUE (H-Q), **if greater than zero**	**$ __________**	**$ __________**
	CALCULATED LOSS RATIO **(Q divided byF)**	**__________ %**	__________ %

* Includes capitation payments.
** Portion that covers claim costs rather than administration for which the insurer did not receive a tax credit.
[13.10.27.9 NMAC - N, 11/30/12]

HISTORY OF 13.10.27 NMAC: [RESERVED]