BEFORE THE NEW MEXICO SUPERINTENDENT OF INSURANCE

IN THE MATTER OF ADOPTING AMENDMENTS TO 13.10.35 NMAC MINIMUM STANDARDS FOR DENTAL AND VISION PLANS	)))))	**Docket No. 2022-0055**

HEARING OFFICER'S FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

THIS MATTER comes before the New Mexico Office of Superintendent of Insurance ("OSI") following a public hearing for comment pursuant to the Notice of Proposed Rulemaking ("NOPR") filed in this docket and published as required by law in the New Mexico Register on August 9, 2022 and in the *Albuquerque Journal* on August 9, 2022 and distributed via OSI's Newsletter to a list of potentially interested parties.

The Hearing Officer, having reviewed the NOPR and the proposed rule, having conducted a public hearing, having reviewed the written comments submitted to the docket, and being otherwise fully informed in the premises, makes the following findings, conclusions, and recommendations:

FINDINGS:

Procedural Matters: Notice

1. The New Mexico Superintendent of Insurance ("the Superintendent") has jurisdiction over the subject matter and the parties pursuant to the New Mexico Insurance Code, NMSA 1978, Sections 59A-1-1 et seq. ("Insurance Code").

2. The Superintendent designated R. Alfred Walker as the Hearing Officer to preside over this matter.

3. The OSI issued a NOPR and published the NOPR in the New Mexico Register on August 9, 2022 and in the *Albuquerque Journal* on August 9, 2022, and OSI distributed the NOPR via OSI's Newsletter to a list of potentially interested parties.

4. The NOPR gave notice of a public hearing, scheduled for September 12, 2022, to accept oral comments on proposed amendments to Rule 13.10.35 NMAC Minimum Standards for Dental and Vision Plans.

5. The NOPR informed the parties and the public of the process by which the Hearing Officer would conduct the hearing and how parties and the public could make comments on the proposed new rule and have the comments considered.

6. The NOPR further advised that a copy of the full text of the proposed new rule was available on the OSI eDocket or the New Mexico Sunshine portal, or by requesting a copy from OSI.

7. The purpose of the proposed amendments is to clarify consumer protections and ensure that stand-alone dental or vision plans provide actuarially supported rates for the insured.

8. Statutory authority for the proposed amendments is found at NMSA 1978, Section 59A-2-9 (1997); NMSA 1978, Section 59A-23F-7 (2020); and the Short-Term Plan and Excepted Benefit Act, NMSA 1978, Sections 59A-23G-1 to -7 (2019).

Procedural Matters: Comment

9. On September 12, 2022, OSI conducted the public hearing.

10. Cassandra Brulotte, Life and Health Attorney for OSI's Life and Health Division ("L&H"); Brent Moore, Montgomery & Andrews, P.A., on behalf of America's Health Insurance Plans ("AHIP") and the American Council of Life Insurers ("ACLI"); Owen Urech, National Association of Dental Plans ("NADP"); Louis Volk III, President and Chief Executive Officer of

Delta Dental of New Mexico("DDNM"); J.P. Wieske, Executive Director of Health Benefits Institute ("HBI"); and Robert Holden, National Association of Vision Care Plans ("NAVCP"), made oral comments at the public hearing.

11. Written comments on the proposed new rule were timely submitted to OSI by Ronald Foster Seaton; Mr. Wieske on behalf of HBI; Julian Roberts, Executive Director of NAVCP; Devin L. Road, Compliance Consultant, Workplace Solutions, United of Omaha Life Insurance Company ("United of Omaha"); Mr. Volk of DDNM; Mr. Urech of NADP, Karlee Tebutt of AHIP, and Cindy Goff of ACLI (in a combined set of comments); John T. Seybert, Senior Associate General Counsel, Dearborn Life Insurance Company ("Dearborn Life"); Krista G. Maddigan, Vice President, Regulatory Affairs & Compliance, United Concordia Dental ("United Concordia"); and Keith D. Drennan, Assistant General Counsel, Blue Cross & Blue Shield of New Mexico ("BCBSNM").

12. Mr. Seaton; AHIP, ACLI, and NADP; and L&H timely submitted response comments.

13. All comments, oral and written, have been made part of the record.

14. OSI has adopted rules for rulemaking, which are applicable to this proceeding, and which state:

> The superintendent may adopt, amend, or reject the proposed rule. Any amendments to the proposed rule must fall within the scope of the current rulemaking proceeding. Amendments to a proposed rule are within the scope of the rulemaking if the amendments:
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> **(1)** are a logical outgrowth of the rule proposed in the notice; or
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> **(2)** are proposed, or are reasonably suggested, by comments made during the comment period, and the 10 day response period after the close of the comment period has been provided; and
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> **(a)** any person affected by the adoption of the rule, if amended, should have reasonably expected that any change from the published proposed rule would affect that person's interest; or
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> **(b)** the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule.

13.1.4.13(C) NMAC. The "10 day response period after the close of the comment period" is ten calendar days. 13.1.4.11(B) NMAC.

15. 13.1.4.13(C) NMAC contemplates that OSI may amend a proposed rule if the amendment is a "logical outgrowth" of the proposed rule ***or*** if the amendment is proposed during the comment period, with ten calendar days to respond to the proposed amendment.

16. The NOPR informed interested parties that the comment period ended at 4:00 p.m. on September 12, 2022 and that the response comment period ended at 4:00 p.m. on September 22, 2022. Because of a failure to post the proposed amendments on the New Mexico Sunshine Portal until September 12, 2022, the comment period was extended to October 12, 2022, and the response comment period was extended to October 24, 2022, by entry of a Supplemental Notice of Proposed Rulemaking and Extended Comment Period on September 13, 2022. Thus, the "10 day response period after the close of the comment period" was provided.

17. Although there appears to be no New Mexico case law addressing the issue, federal courts have recognized that administrative agencies may make changes to the proposed rule after the comment period without a new round of hearings, as long as the final rule is a "logical outgrowth" of the proposed rule. *Market Synergy Group, Inc. v. U.S. Dep't of Labor*, 885 F.3d 676, 681 (10th Cir. 2018); *Zen Magnets, LLC v. Consumer Prod. Safety Comm'n*, 841 F.3d 1141, 1154 (10th Cir. 2016). "A final rule qualifies as a logical outgrowth if interested parties should have anticipated that the change was possible, and thus reasonably should have filed their comments on the subject during the notice-and-comment period." *Market Synergy*, 885 F.3d at 681 (internal quotation marks omitted); *Zen Magnets*, 841 F.3d at 1154.

General Comments

18. Ms. Brulotte on behalf of L&H testified at the public hearing that the proposed amendments were developed first to address the requirement in Section 59A-23G-5 to include medical loss ratios ("MLR") in establishing rates, which was overlooked in the original adoption of the dental and vision rules. L&H also testified that OSI additionally took the opportunity to clarify some matters that come up when OSI reviews form filings, and to also conform the rule with case law and other statutes.

19. In their combined response comments, AHIP, ACLI, and NADP disagreed both with the comment that Section 59A-23G-5 requires an MLR when establishing rates and that the MLR requirement was overlooked in the original dental rulemaking in 2021. AHIP, ACLI, and NADP interpreted Section 59A-23G-5 to give the Superintendent authority to create standards for dental plans, but they do not interpret the statute to require an MLR. In addition, the commenters asserted that the MLR requirement was not overlooked in 2021 because the issue was discussed between stakeholders and OSI staff before the 2021 rule was noticed, and the commenters asserted that the MLR requirement was deliberately not included.

20. At the public hearing, Mr. Moore on behalf of AHIP, ACLI, and NADP and Mr. Urech on behalf of NADP addressed the general concern that the proposed revisions go far beyond simply adding a provision for MLR but are making extensive changes to rules that have been in effect for less than a year. Mr. Moore stated that there is not substantial evidence supporting changes other than for adopting an MLR.

21. At the public hearing, Mr. Volk, on behalf of DDNM, raised the concern that the proposed amendments to the rule do not address or alleviate concerns related to dental access and oral health equity but have the potential to limit consumer choice and increase costs for carriers and providers

which will increase premiums and significantly limit access to dental health care in New Mexico. Mr. Volk stated that the proposed amendments unfairly discriminate against monoline carriers, because the rule does not apply to health plans that cover other areas but also include dental and vision coverage in their policies.

22. In their joint written comments, AHIP, ACLI, and NADP reiterated their oral statements from the public hearing that major amendments to this rule less than a year after its initial adoption would cause significant difficulties for dental and vision carriers in New Mexico, including creating significant confusion and administrative burdens that may restrict the capacity of plans to offer coverage in New Mexico. The commenters asserted that carriers are continuing to adjust to the initial rule, which required plan revisions and alterations in several states as a result of the "extraterritorial" requirements, and the carriers have not yet seen the long-term consequences of the initial rule. The commenters also reiterated that the intended effects of the proposed amendments have not been clearly expressed, impose requirements not seen in other states, and could have unintended consequences in New Mexico; thus, there is not sufficient evidence that the proposed amendments will significantly improve dental care access.

Extraterritoriality[1]

23. At the public hearing, Mr. Wieske objected to the "extraterritorial" reach of the proposed amendments, which is achieved through the existing 13.10.35.2 NMAC. HBI, through Mr.

[1] 13.10.35 NMAC, either in its current form or as it is proposed to be amended, does not use the term "extraterritoriality." Several commenters have used this term, no doubt advisedly, perhaps to invoke Dormant Commerce Clause cases discussing the concept. Recently, Justice Gorsuch described those cases as "maybe the most dormant of our Dormant Commerce Clause jurisprudence." Transcript of Oral Argument, p. 34, l. 25 – p. 35, l. 1, *Nat'l Pork Producers Council v. Ross* (U.S. No. 21-468, Oct. 11, 2022) (comment of Gorsuch, J.); *see also Energy & Env't Legal Inst. v. Epel*, 793 F.3d 1169, 1172 (10th Cir. 2015) (Gorsuch, Cir. J.) (The "extraterritoriality principle may be the least understood of the Court's three strands of dormant commerce clause jurisprudence. It is certainly the most dormant for, though the Supreme Court has cited *Baldwin* [*v. G.A.F. Seelig, Inc.*, 294 U.S. 511 (1935),] in passing a number of times, a majority has used its extraterritoriality principle to strike down state laws only three times." (citation omitted)).

Wieske's written comments, stated that it does not have a concern with the addition of the language "whether on or off the exchange" as proposed for 13.10.35.2 NMAC. However, HBI and United of Omaha requested deletion of existing language applying the rule to a group dental or vision plan offered or sold to a New Mexico resident under a master policy delivered outside of this state (the "extraterritoriality" provision). In the alternative, HBI, United of Omaha, and Dearborn Life suggested using the language from the recently adopted replacement rule 13.10.34.2(B) NMAC (7/1/2023) (Standards for Accident-Only, Specified Disease, Hospital Indemnity, Disability Income, Supplemental, and Non-Subject Worker Excepted Benefits (the "Excepted Benefits" rule)).

24. United Concordia stated that the standards in the current rule, which have "extraterritorial" effect through 13.10.35.2 NMAC, have already disrupted dental carrier business in other states and have created a significant administrative burden to adjust multi-state products and processes to New Mexico's standards.

25. In their joint written comments, AHIP, ACLI, and NADP reiterated their oral statements from the public hearing that the rule should only apply to policies issued within New Mexico, because the needs of populations in different states may differ significantly, and requirements designed for New Mexico residents could lead to higher premiums, lower plan enrollment, and worse oral health outcomes. The commenters therefore recommended changing the language at the end of the last sentence of 13.10.35.2 NMAC from "offered or sold to a New Mexico resident under a master policy delivered outside of this state" to "situsedin the state of New Mexico."

26. Mr. Seaton responded to the comments on "extraterritoriality" by stating that the current wording of 13.10.35.2 NMAC is not an attempt for extraterritorial reach but rather a proper expression of NMSA 1978, Section 59A-1-14 (1984) which would apply whether expressed or

not. Mr. Seaton noted that insurers have had almost 40 years in which to implement changes in their practices to address any concerns raised by this provision of the Insurance Code, and he opined that carriers should not find it difficult to satisfy the concerns of regulators in all states in which they operate.

27. L&H responded to the comments on "extraterritoriality" by stating that the proposed amendment to 13.10.35.2 is not an extraterritorial amendment and does not expand the Superintendent's jurisdiction but simply clarifies that the rule applies equally to the stand-alone dental and vision plans that are sold on the New Mexico Health Insurance Exchange. L&H pointed out that the Superintendent's jurisdiction over policies issued to New Mexico residents was established by statute in 1984 by Section 59A-1-14. The Short-Term Health Plan and Excepted Benefit Act confirms this jurisdictional authority by repeatedly stating that the Act applies to plans issued or offered to residents of this state. Section 59A-23G-2; § 59A-23G-6.

28. The Hearing Officer takes administrative notice that the only change to 13.10.35.2 NMAC included in the proposed amendments published at the beginning of the notice and comment period was to add the phrase "whether on or off the exchange" to the end of the first sentence of that provision. Because the NOPR did not give notice that any other matter encompassed in 13.10.35.2 NMAC would be addressed in this rulemaking, the Hearing Officer finds that the subject matter of the requested changes or the issues determined by the changes are not the same as those in the published proposed rule. The requested changes may not be adopted because the requested changes to "extraterritoriality" fall outside the scope of the current rulemaking proceeding. The Hearing Officer recommends against adoption of the requested changes to the language of 13.10.35.2 NMAC except that proposed in the amendment which was noticed, which the Hearing Officer recommends adopting.

29. BCBSNM expressed concern with the interaction between the "extraterritoriality" provision of 13.10.35.2 NMAC and the amended rate and form filing requirements of proposed 13.10.35.9(D) and (E). BCBSNM raised the risks of conflicts between insurance departments of different states created by extraterritoriality for forms and rates: 1) the risk of inconsistent requirements by different regulators constraining the ability or timeliness of insurance offerings; 2) the risk of retaliation by other regulators, leaving carriers, groups, or members caught in the middle; 3) the risk of unintended consequences such as insurers declining to sell to employers with employees in New Mexico, employers deciding not to employ workers in New Mexico, or some carriers filing proactively in New Mexico just in case they might have plans with enrollees in New Mexico; 4) the risk that plans approved by certain groups would become unavailable because the carrier has not filed its forms and rates in New Mexico; and 5) the risk that all regulators take the same approach and carriers feel the need to file in all states in case they may have enrollees in another state. BCBSNM recommended that these issues be addressed by adding at the end of the third sentence of 13.10.35.2 NMAC: "provided, however, that the rate and form provisions of this rule do not apply to such plans."

30. Mr. Seaton responded to this comment by stating that BCBSNM's contention is at best exaggerated and at worst simply false, given modern electronic data processing capabilities. L&H responded by reiterating its responses to other comments and by noting that NMSA 1978, Section 59A-18-1 (2021) extends the Superintendent's jurisdiction to "all insurance contracts … covering individuals resident, or risks located, or insurance protection to be rendered in this state[.]"

31. The Hearing Officer finds that BCBSNM has not adequately explained the difficulty raised by the proposed amendments to the rule that is any greater than that faced by nationwide insurers navigating 50+ different state, district, and territorial insurance regulatory frameworks. The

Hearing Officer reiterates the recommendation that no change be made to 13.10.35.2 except that originally offered in the proposed amendment.

The Scope of Statutory Authority

32. In their joint written comments, AHIP, ACLI, and NADP expressed concern that the proposed amendments to the rule may be beyond the scope of the authorizing statutes listed in 13.10.35.3 NMAC. The commenters asserted that Section 59A-23G-5 does not require OSI to develop an MLR but rather defines the means for OSI to establish standards for rates that are "based on generally recognized and current actuarial standards." The commenters reiterated this position in their response comments.

33. United Concordia similarly expressed concern that the scope of the proposed amendments extends beyond the scope of the authorizing statutes. United Concordia questioned the Superintendent's authority to impose an MLR that has extraterritorial application for dental and vision products issued in other states and which conflicts with the authority of other states to regulate insurers domesticated in those states.

34. Mr. Seaton responded to these comments by stating that the expressed concern that there is no statutory authority for adopting an MLR is difficult to understand when Section 59A-23G-5 requires the Superintendent to "establish standards for rates, including medical loss ratios" for dental and vision plans.

35. L&H also responded that the Legislature directed the Superintendent to "promulgate rules to establish standards for rates, including medical loss ratios" for excepted benefits plans. Section 59A-23G-5. Because the rule adopted in 2021 did not address what L&H described as a mandate and a statutory directive, the rule needed to be reopened, and OSI took the opportunity to make additional consumer protection amendments.

36. The Hearing Officer takes administrative notice that Section 59A-23G-5 states in its entirety: "The superintendent shall adopt and promulgate rules to establish standards for rates, including medical loss ratios, of short-term plans and excepted benefits plans. Rules relating to rates shall be based on generally recognized and current actuarial standards."

37. There are two ways to approach the statutory language. It is clear that the Superintendent "shall" adopt and promulgate rules to establish standards for rates of short-term plans and excepted benefits plans. That much, at least, is mandatory. *See* NMSA 1978, § 12-2A-4(A) (1997) ("'Shall' and 'must' express a duty, obligation, requirement or condition precedent"). "It is widely accepted that when construing statutes, 'shall' indicates that the provision is mandatory, and we must assume that the Legislature intended the provision to be mandatory absent a clear indication to the contrary." *Marbob Energy Corp. v. N.M. Oil Conservation Comm'n*, 2009-NMSC-013, ¶ 22, 146 N.M. 24, 206 P.3d 135. "Generally, the use of the word 'shall' imposes a mandatory requirement." *Maestas v. Town of Taos*, 2020-NMCA-027, ¶ 19, 464 P.3d 1056. There is no clear indication that the Legislature did not intend for Section 59A-23G-5 to be mandatory.

38. One way to interpret the statute is that the rates "shall" include medical loss ratios. Only the mandatory "shall" appears in the statute, and the permissive "may" is completely missing. *See* Section 12-2A-4(B) ("'May' confers a power, authority, privilege or right"); *Romero v. Tafoya*, A-1-CA-39401, slip op. ¶ 9 (N.M. Ct. App. Nov. 2, 2022) (discussing "may" in a statute as permissive and discretionary). L&H interprets the statute as mandatory in every part, and that approach is logical and straightforward. On the other hand, despite "shall" appearing at the beginning of the first sentence and in the second sentence, several commentators posit that "including medical loss ratios" is permissive and discretionary, even though no permissive language appears anywhere in the statute. That approach is less logical and somewhat convoluted.

However, even if that is correct, the Superintendent at least has discretion to include MLRs in the rule on rates. The Hearing Officer finds that Section 59A-23G-5 mandates the inclusion of MLRs in the rule on rates, but even if the inclusion is discretionary, there is no abuse of discretion in including MLRs in the rule.

39. L&H also responded to comments on the scope of the Superintendent's authority by seeking input from an actuarial firm and attaching the actuarial memorandum to its response comments. Whether that memorandum, and its timing, is sufficient to establish that the rule is "based on generally recognized and current actuarial standards," there certainly is no suggestion in the record that the rule is ***not*** based on generally recognized and current actuarial standards.

Effective Date of the Amendments

40. In his oral comments, Mr. Volk on behalf of DDNM recommended changing the effective date of the proposed amendments to January 1, 2024, to allow carriers adequate time to make the significant changes to systems, policies, procedures, and claims processing required by the proposed amendments. Carriers will be required to hire and train additional staff and amend policy forms, provider contracts, and group contracts.

41. DDNM, through its written comments, stated that the timeline for the amendments to the rule is not realistic, because it will cause significant difficulties and expense for DDNM to implement the system, procedural, and staffing changes necessary by July 1, 2023. DDNM and United Concordia requested that the amendments become effective January 1, 2024 in order to allow adequate time for adjustment as a result of the substantive proposed amendments to the rule and the fact that dental plans are often sold on a calendar year basis.

42. Mr. Seaton responded to these comments by noting that the first reporting requirement, for the plan year 2023, will not be until July 1, 2024, and the other requirements of the amendments

should not be difficult to implement; therefore, he recommended making the effective date of the amendments January 1, 2023.

43. In their combined response comments, AHIP, ACLI, and NADP stated that the timeline for implementation of the proposed amendments would cause significant difficulties for dental and vision carriers in New Mexico, particularly because of the lengthened comment period for the proposed amendments. The commenters asserted that many carriers have made business and administrative decisions for their Plan Year 2024 policies, with no clear timeline for finalization of the proposed amendment. Because of the shortened timeline and the fact that the original rule went into effect on January 1, 2022, AHIP, ACLI, and NADP recommended that the amendments should go into effect on January 1, 2025, in order to allow adequate time for adjustment as a result of the substantive changes proposed by the amendments.

44. L&H agreed with the requests to change the effective date of the amendments to January 1, 2024 and disagreed with the request to change the effective date of the amendments to January 1, 2025. The Hearing Officer finds that changing the effective date of the amendments to January 1, 2024 will give carriers sufficient time to update their plans to comply with the amendments and will allow adequate time for adjustment as a result of the substantive changes proposed by the amendments. The suggested change for an effective date of January 1, 2024 for the proposed amendments was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that the proposed amendments recommended herein become effective on January 1, 2024.

Definitions

45. Mr. Seaton recommended changing the definition in proposed 13.10.35.7(B) to read: "'Earned premiums' for a reporting year means the premium received up to the loss ratio measurement date that provided coverage during that reporting year." L&H agreed with Mr. Seaton's suggested change. The suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that the definition in proposed 13.10.35.7(B) be changed to read: "'Earned premiums' for a reporting year means the premium received up to the loss ratio measurement date that provided coverage during that reporting year."

46. Mr. Seaton recommended deleting "claims paid after the" in proposed 13.10.35.7(C), because this concept appears in proposed 13.10.35.7(I) and may therefore cause confusion by suggesting that there might be other unpaid claims reserves. L&H agreed with Mr. Seaton's suggested change. The suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends deleting "claims paid after the" in proposed 13.10.35.7(C).

47. Mr. Seaton pointed out that the definition of "loss ratio" in proposed 13.10.35.7(D) is incorrect, as it should be "incurred claims divided by earned premiums" and should be corrected. L&H agreed with Mr. Seaton's correction. The suggested change was made during the comment

period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that the definition of "loss ratio" in proposed 13.10.35.7(D) be changed to state "incurred claims divided by earned premiums".

48. Mr. Seaton stated that proposed 13.10.35.7(E) should be clarified to read: "'Loss ratio measurement date' means the date as of which the incurred claims and earned premiums for each reporting year are determined for the reporting required in Subsection 13.10.35.9.M. of this rule." L&H stated that it has no objection to Mr. Seaton's suggested change. The suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. The rule conventions of the Administrative Law Division require slightly different phrasing than offered by Mr. Seaton, but that different phrasing meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible and because the change is based on comments received during the comment period. Therefore, the Hearing Officer recommends that proposed 13.10.35.7(E) should be clarified to read: "'Loss ratio measurement date' means the date as of which the incurred claims and earned premiums for each reporting year are determined for the reporting required in subsection (M) of section 13.10.35.9 of this rule."

49. United Concordia expressed concern that proposed 13.10.35.7(H) is overly broad and could be interpreted to include advertising materials regulated under 13.10.4.1 NMAC or even

non-contractual informational materials provided as part of a new enrollee welcome kit. United Concordia recommended replacing "document" in proposed 13.10.35.7(H) with: "form that is part of an insurance policy filed with and approved by the superintendent".

50. Mr. Seaton responded to United Concordia's comment on proposed 13.10.35.7(H) by stating that, if the proposed amendments to 13.10.35.13 NMAC are adopted, then proposed 13.10.35.7(H) is not so much overly broad as it is redundant and unnecessary.

51. However, L&H agreed with United Concordia's recommendation to replace "document" in proposed 13.10.35.7(H) with: "form that is part of an insurance policy filed with and approved by the superintendent" and supported the suggested change. The suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends replacing "document" in proposed 13.10.35.7(H) with: "form that is part of an insurance policy filed with and approved by the superintendent".

52. Mr. Seaton recommended that, to prevent evasion of the minimum loss ratio requirement by repeated overstatement of estimated unpaid claims, the proposed 13.10.35.7(I) should be clarified as follows: "'Unpaid claim reserves' for a reporting year means reserves and liabilities established as of each loss ratio measurement date to account for claims that were incurred during the reporting year but were paid, or remain to be paid, after the reporting year." Mr. Seaton's suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule.

53. L&H agreed with Mr. Seaton that the current phrasing of proposed 13.10.35.7(I) may cause confusion and recommended modifying Mr. Seaton's recommendation to state: "'Unpaid claim reserves' for a reporting year means reserves and liabilities established as of the applicable loss ratio reporting year but were paid after the reporting year." This suggested change to Mr. Seaton's recommendation meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible and because the change is based on comments received during the comment period. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that proposed 13.10.35.7(I) be clarified as follows: "'Unpaid claim reserves' for a reporting year means reserves and liabilities established as of the applicable loss ratio reporting year but were paid after the reporting year."

Exclusions

54. At the public hearing, Mr. Volk, on behalf of DDNM, objected to proposed 13.10.35.8(C)(5) that would disallow exclusions except if the exclusions remove coverage for a benefit that would otherwise be covered under the policy. Based on fifty years in the dental insurance business, DDNM believes that it is important to clearly communicate what is covered and what is not covered by a policy. Mr. Wieske, on behalf of HBI, additionally raised concerns that disallowing exclusions would create a significant level of confusion for consumers, especially in conjunction with requiring prior authorization, as a consumer may not know what is or is not covered.

55. In its written comments, HBI stated that proposed 13.10.35.8(C)(5) is confusing and should be deleted, since the proposed prior authorization amendment of proposed 13.10.35.15(F) limits the insurer's ability to deny certain claims, and insurer's include exclusions for uncovered claims

to prevent confusion. For example, many policies exclude coverage for services only covered by a health benefits plan, so consumers will not be confused about what is covered.

56. In its written comments, DDNM also objected to proposed 13.10.35.8(C)(5) because, based on 50 years of experience in dental insurance, DDNM has determined that listing exclusions clarifies consumer expectations and assists carriers when supporting coverage decisions. The ability to list exclusions may also be required for some plans by the federal Employee Retirement Income Security Act of 1974 (ERISA).

57. In their written comments, AHIP, ACLI, and NADP recommended that OSI not adopt proposed 13.10.35.8(C)(5) "or clarify the intent of the provision for further discussion." United Concordia found the language of proposed 13.10.35.8(C)(5) to be confusing and recommended removal of this provision. The commenters noted that exclusions may be used as a way to indicate payment for care. For example, a carrier may exclude payments for missed appointments as a way to explain what it will not pay for, but proposed 13.10.35.8(C)(5) would not permit the carrier to make that explanation, which could be misleading and confusing to enrollees.

58. Mr. Seaton responded to the comments regarding proposed 13.10.35.8(C)(5) by suggesting that the objections are somewhat valid. Mr. Seaton recommended that the proposed provision not be stricken but be amended and limited by inserting "preexisting condition" before the word "exclusions".

59. L&H responded that including a lengthy list of excluded procedures and treatments in policies implies that those procedures and treatments would normally be covered, which would be deceptive, misleading, and confusing to consumers. L&H asserted that proposed 13.10.35.8(C)(5) would bring the rule into alignment with *United Nuclear Corp. v. Allstate Ins. Co.*, 2012-NMSC-032, 285 P.3d 644, and that the holding of in *United Nuclear Corp*. is not limited to exclusions

related to pre-existing conditions. L&H stated that "the New Mexico Supreme Court held that 'Grants of coverage should be construed broadly while exclusions are interpreted narrowly[,]'" citing *United Nuclear Corp*. However, L&H did not provide a pinpoint cite for this holding, and a review of the case indicates that, while the principle is cited in support of one of the Court's holdings, it is not itself a holding. 2012-NMSC-032, ¶ 15 (an exception to an exclusion acts as a restoration of coverage under specified conditions, citing, *inter alia*, *Bering Strait Sch. Dist. v. RLI Ins. Co.*, 873 P.2d 1292, 1295 (Alaska 1994) ("Grants of coverage should be construed broadly while exclusions are interpreted narrowly."). The Hearing Officer also does not understand how the narrow construction of exclusions militates against including them in policies.

60. L&H also stated: "Such policy provisions are directly contrary to the ruling in [*United*] *Nuclear Corp*[.] that exclusions 'remove coverage for a loss that would otherwise be covered.'" The Hearing Officer is unable to find the quoted language in *United Nuclear Corp*. *But cf.* 2021-NMSC-032, ¶ 18 ("that is the very purpose of an exclusion, to restrict the scope of the policy beyond what would otherwise be covered"). Even if that language is there, the Hearing Officer remains unpersuaded that *United Nuclear Corp*. stands for the proposition that a carrier cannot make clear through exclusions that the grant of coverage is limited.

61. L&H recommended that proposed 13.10.35.8(C)(5) be re-written to track newly-adopted 13.10.34.8(E) NMAC (7/1/2023), to state: "A plan shall not exclude any type, circumstance or cause of loss that would not otherwise be covered, and the plan exclusions shall not, individually or collectively, unreasonably or deceptively alter the scope of coverage." The Hearing Officer takes administrative notice that 13.10.34.8(E) NMAC (7/1/2023) follows this language with a sentence permitting a carrier to exclude a lengthy list (14, to be exact) of conditions and circumstances, including a catch-all of "any other type, circumstance or cause of loss if the carrier

satisfies the superintendent that the exclusion promotes a legitimate underwriting or public policy objective or is required to comply with any state or federal law." 13.10.34.8(E)(11) NMAC (7/1/2023).

62. L&H further reminded all carriers that objections have been issued to policy forms under the ruling in *United Nuclear Corp*. for nearly a decade, but there has never been any confusion surrounding the objections, nor has there been any mandate that "missed appointments" be covered by default. The Hearing Officer finds this argument wide of the mark. Presumably, there has never been a dispute over whether missed appointments are covered under a policy because most, if not all, policies notify the insured by an exclusion that a missed appointment will not be paid by the carrier. Additionally, if OSI has been issuing objections to exclusions for nearly a decade and refusing to approve confusing or misleading exclusions, it is not clear why that practice cannot continue.

63. The Hearing Officer remains unconvinced that proposed 13.10.35.8(C)(5) is necessary or that the objections to proposed 13.10.35.8(C)(5) are unfounded. The Hearing Officer recommends that proposed 13.10.35.8(C)(5) not be adopted.

Dependent Coverage

64. HBI objected to the dependent coverage requirement of proposed 13.10.35.9(B)(7), which appears in ACA-compliant health care policies but is not applied to excepted benefits policies, and HBI believes that this provision should not apply to dental and vision policies. Mr. Seaton and L&H responded to this comment by stating that NMSA 1978, Section 59A-22-30.1 (2021) contains this requirement for any policy subject to this rule. Mr. Seaton also cited NMSA 1978, Section 59A-23-7.3 (2021) in support of this position; therefore, the provision should remain or be removed as redundant rather than as baseless. The Hearing Officer finds that, while proposed

13.10.35.9(B)(7) is arguably redundant as required by statute, it does no harm to keep it in the rule. The Hearing Officer recommends against removing proposed 13.10.35.9(B)(7) from the amendments.

Group Coverage Compliance

65. BCBSNM expressed a concern that the proposed amendment to 13.10.35.9(C) could be interpreted to apply to broader medical coverage that includes dental or vision coverage rather than to stand-alone dental and vision plans. BCBSNM recommended rewriting the amendment to state: "A group dental or vision plan that is separate from a health benefits plan shall comply with all sections of this rule." L&H responded that this recommended change is a redundant edit as 13.10.35.2 NMAC and the statutory authority listed in 13.10.35.3 as it is proposed to be amended make it clear that the rule only applies to stand-alone dental and vision plans. The Hearing Officer agrees with L&H's position and recommends against any change to the proposed amendment to 13.10.35.9(C).

Prior Approval of Forms and Rates

66. Mr. Urech stated that in proposed 13.10.35.9(D) "OSI is giving itself the authority to review rate filings in detail." Transcript of Public Hearing, p. 18, ll. 15-16 (OSI No. 2022-0055, Sept. 12, 2022). Mr. Urech suggested that this could be the basis for a more holistic or value-related discussion about dental plans than the MLR would permit.

67. At the public hearing, Mr. Wieske on behalf of HBI raised concerns about the prior rate filing requirement which implicates staff levels, timing of the filing requirement, significant implementation issues, and potential delays in rate filings. In its written comments, HBI expressed concern about the administrative burden on insurers required for the prior approval of forms set

forth in proposed 13.10.35.9(D), stating that it would require significant resources and delay the implementation of rate changes.

68. HBI expressed concern about the administrative burden on insurers required for the prior approval of rates set forth in proposed 13.10.35.9(E), stating that it would require significant resources and delay the implementation of rate changes.

69. Mr. Seaton responded to the comments regarding proposed 13.10.35.9(D) & (E) by stating that the approval of forms and rates is required by NMSA 1978, Section 59A-18-12 (2012). L&H also responded that Section 59A-23G-3(A)(2) authorizes the Superintendent to establish standards for policy approval.

70. The Hearing Officer takes administrative notice that the procedures of Section 59A-18-12 apply to the forms and rates subject to this rule, the statute is what gives OSI the authority to review rate filings in detail, and the filing and approval procedure of the rule cannot be different from that required by the statute. The Hearing Officer recommends no changes to the proposed amendments based on the comments of Mr. Urech or HBI.

71. DDNM recommended inserting "on an annual basis" in proposed 13.10.35.9(E) between "approved" and "by the superintendent." This recommendation is part of DDNM's alternative to the MLR requirement, discussed below.

72. Mr. Seaton responded to this comment by simply stating that filing and approval should not be restricted to an annual basis. L&H responded that rates are submitted for approval as needed, and DDNM's proposal would require an annual review of rates, even if they remained unchanged, creating a needless administrative burden for carriers.

73. The Hearing Officer takes administrative notice that the procedures of Section 59A-18-12 are not restricted to an annual basis. In fact, those procedures must be followed before a form or

rate may be used; thus, it would be counterproductive to restrict the procedure to annually. The Hearing Officer therefore recommends against the change to proposed 13.10.35.9(E) suggested by DDNM.

Minimum Loss Ratio (MLR)

74. United of Omaha agreed with other commentators that the prescribed MLR of proposed 13.10.35.9(F) through (N) is not appropriate. DDNM, AHIP, ACLI, and NADP stated that MLRs are not a useful or meaningful measure of a dental plan's value, and the proposed MLR measurement is unworkable. United Concordia also described the MLR as unworkable. In their written comments, DDNM, AHIP, ACLI, NADP, and United Concordia extensively discussed their position that the MLR concept for health plans does not translate to dental and vision plans and that loss ratios do not correlate to improved treatment. The commenters explained that using an MLR in dental policies will require carriers to reduce expenses or increase payments to providers, thus increasing costs to consumers, with little value added to the consumers. DDNM recommended that, instead of implementing an MLR requirement, OSI require annual rate filings with carriers providing actuarial memoranda with credible data, for OSI to use in determining whether the rate charged for the dental plan accurately reflects the risk undertaken by the carrier.

75. In his comments at the public hearing, Mr. Urech on behalf of NADP objected to the MLR calculation on separately offered individual and group plans that are offered in multiple states and therefore may be based predominately on experience outside New Mexico. Thus, the extraterritorial reach of the MLR would not be adequately deriving information about access or spending for New Mexico residents. Because different states have different demographics, the MLR will be influenced by factors that do not fit for New Mexico. In their joint written comments, AHIP, ACLI, and NADP reiterated these concerns.

76. Mr. Urech continued in his oral comments to raise a concern about the implementation of an MLR even for plans only specific to New Mexico. NADP does not see an MLR as a statement of the value of a plan but only as source of data which is not an indication of whether it is improving utilization, access to care, or quality of life for enrollees. In his oral comments, Mr. Volk, on behalf of DDNM, echoed NADP's concerns. The MLR for a low premium plan may be different from higher end plans but that does not reflect how the low premium plan is being used or how it is affecting an enrollee's oral health. Mr. Urech and Mr. Volk also indicated that the MLR threshold is likely to adversely affect a carrier's administrative spending on services for enrollees or raise premiums to meet increased payment requirements to providers. Mr. Volk stated that the proposed MLR does not consider expenses by carriers that develop strong networks with deep discounts, that deliver patient protections against fraud, waste, and abuse, and that educate consumers to use benefits more efficiently or for prevention. Mr. Volk recommended that these sorts of costs be included in the calculation of MLR, because without a change in the MLR calculation, it will be extremely difficult for carriers to diversify product offerings. The written comments by AHIP, ACLI, and NADP reiterated these concerns.

77. In his original comments, Mr. Seaton recommended that the minimum loss ratios for individual dental and vision plans as set forth in proposed 13.10.35.9(G) be set at sixty-five percent, based on Mr. Seaton's survey of group policy rate filings.

78. In Mr. Seaton's response comments, he stated that the proposed MLRs are considerably and appropriately relaxed compared to those required for general medical coverage, largely in recognition of the smaller premium and larger proportion of administrative expense and should not be difficult to achieve. Mr. Seaton provided an unannotated list of loss ratios claimed in selected dental and vision rate filings from major carriers for the years 2016 through 2020.

79. Also in his response comments, Mr. Seaton stated that MLRs are not intended to add value but rather to ensure a financial value relative to premium that carriers claim in their rate filings that they intend to deliver.

80. L&H responded to the comments on the MLR issues by agreeing with Mr. Seaton's comments and noting that MLRs, while not a perfect measure of value, are required by Section 59A-23G-5. L&H also stated that the majority of recent dental rate filings met or exceeded an MLR of 65% and pointed out that the commenters have not explained how carriers will be unable to meet this MLR in the future. L&H also pointed out that, if necessary, carriers may request an exemption from the MLR requirement pursuant to proposed 13.10.35.9(M)(9)(b).

81. The Hearing Officer reiterates his finding above that it is mandatory for the Superintendent to include MLR regulations in the rule. The Hearing Officer further finds that the MLR established by the proposed amendments, as modified as discussed below, is within a zone of reasonableness for dental and vision policies. *See Citizens for Fair Rates & the Env. v. N.M. Pub. Reg. Comm'n*, 2022-NMSC-010, ¶ 42, 503 P.3d 1138 ("there is a significant zone of reasonableness in which rates are neither ratepayer extortion nor utility confiscation", quoting *Pub. Serv. Co. of N.M. v. N.M. Pub. Reg. Comm'n*, 2019-NMSC-012, ¶ 10, 444 P.3d 460); *see also PNM Gas Servs. v. N.M. Pub. Ut. Comm'n (In re PNM Gas Servs.)*, 2000-NMSC-012, ¶ 12, 129 N.M. 1, 1 P.3d 383.

"Extraterritoriality" and the MLR

82. In their joint written comments, AHIP, ACLI, and NADP discussed the interaction between "extraterritoriality" and MLR, stating that other states requiring MLR for health and dental plans apply the requirement to plans sitused in their state. The commenters asserted that a multi-state plan that reports an MLR will not provide an accurate estimate of the administrative costs used only by New Mexico residents or the value of their coverage. Further, requiring plans in other

states without an MLR requirement to meet the New Mexico standard could harm dental access by limiting dental plan availability. For these reasons, AHIP, ACLI, and NADP recommend that the MLR requirement only apply to dental and vision plans that are domiciled in New Mexico. United of Omaha also recommended that the experience for annually reporting MLR exclude non-New Mexico sitused plans.

83. United Concordia similarly expressed concern with the "extraterritorial" scope of the proposed MLR requirements, which it asserted will create additional administrative complexity and confusion, will eliminate the accuracy of the calculation, and diminish any value in the use of such a standard. United Concordia also stated that, with twenty-nine other states having established requirements for rate filings and for determining that premiums are reasonable in relation to benefits, extraterritorial application of New Mexico's MLR would likely result in an irreconcilable difference in the rate assessment process, as well as erode the accuracy and value of New Mexico specific data. United Concordia recommended that OSI follow the approach of Maine which recently declined to implement an MLR but rather established reporting requirements for policies sitused in Maine.

84. L&H responded to this comment by noting that both New Mexico and Maine are among 18 jurisdictions operating state-based health insurance exchanges on their own platforms, and each of these jurisdictions is responsible for issuing its own regulatory framework to govern plans sold on the exchange. This shows that New Mexico is far from being an outlier.

85. L&H further responded that the "extraterritoriality" issue has been previously addressed, and that including the MLR in the rule is mandatory. L&H also noted that the commenters have not explained how carriers who routinely navigate regulatory schemes in multiple states would have greater difficulty meeting New Mexico's MLR requirements.

86. The Hearing Officer finds that including MLR requirements in the rule is mandatory, and the Superintendent's authority in this area is no different than his authority under any other provision of the Insurance Code. The Hearing Officer is unconvinced that meeting New Mexico's MLR requirements would cause any burden greater than meeting any other requirements in this state while meeting different requirements in other states. The Hearing Officer recommends against removing the MLR requirement of the proposed amendments.

Lifetime Loss Ratios

87. HBI urged that the MLR for group dental and vision plans of proposed 13.10.35.9(F) be designated as a lifetime MLR, because consumers will often receive treatment over multiple policy years, and vision plans may only provide a frame allowance every other year. HBI stated that the proposed MLR will make it difficult for new market entrants to appropriately price policies.

88. In his response to this comment, Mr. Seaton asserted that "lifetime loss ratios" have not worked or have been unwieldy in other contexts. L&H responded to this comment by stating that there is no actuarial support for a lifetime loss ratio and would not therefore be based on generally recognized and current actuarial standards as required by Section 59A-23G-5. The Hearing Officer finds that there is no support for the suggestion that the MLR for group dental and vision plans of proposed 13.10.35.9(F) be designated as a lifetime MLR, and the Hearing Officer therefore recommends against that change.

Application of MLR to Vision Plans

89. United of Omaha expressed concern that the 65% MLR required by proposed 13.10.35.9(F) is too high, especially for vision-only plans. United of Omaha stated that many vision care plans have very low premiums, which together with fixed administrative costs would require raising premiums to meet the MLR requirement. United of Omaha is concerned that a 65% MLR will

result in vision-only insurers leaving the New Mexico market, resulting in higher premiums with fewer plan choices. United Concordia similarly raised concerns about reducing competition and consumers declining dental coverage. United of Omaha recommended providing flexibility for low premium plans or setting a 55% MLR for vision-only plans.

90. Mr. Holden, on behalf of NAVCP, explained at the public hearing that vision coverage is very different from health care coverage and also very different from dental coverage. In addressing MLR, Mr. Holden pointed out that the lowest premium and most accessible plans rely on extensively negotiated discounts. Such intentionally low-cost plans may be adversely affected by the MLR requirement, especially when vision plans are optional and cost-sensitive when it comes to consumer choice.

91. In its written comments, NAVCP stated that it is most concerned with the application of MLR to vision care plans as applied by proposed 13.10.35.9(G) through (M). NAVCP noted that the ACA MLR does not apply to HIPAA-excepted dental and vision benefit plans. NAVCP pointed out that vision care plans typically cover only one medical service, which is an eye examination, and most consumers use this eye examination in conjunction with their primary goal, the purchase of eyewear. Because of this, the plans are designed to reduce the cost of eyewear to enrollees, and that is the primary value of the plan to the consumer. NAVCP expressed concern that the application of an MLR to vision care plans will drive out lower cost plan options and result in less access to vision care. Additionally, vision care plans are standalone plans that are not available on the Exchange, are completely optional, and are offered at very low cost. NAVCP commented that it believes that the MLR requirement may be disproportionate to the costs of managing the benefit and the purchase of eyewear.

92. L&H agreed that setting the MLR at 55% for vision plans is appropriate, given the positions of Mr. Seaton and L&H's actuarial consultant, Novarest, subject to further collection and analysis of data to determine whether a different MLR would be more appropriate. L&H stated that the statutory requirement for an MLR precludes exempting vision plans from an MLR requirement, but the level should be revisited if necessary. Therefore, L&H recommended re-writing proposed 13.10.35.9(F) to state: "**Minimum loss ratios for group and individual dental plans.** Benefits under dental plans shall be subject to a 65% minimum loss ratio requirement." L&H further recommended that proposed 13.10.35.9(G) be re-written to state:

> **Minimum loss ratios for group and individual vision plans.** Benefits under vision plans shall be subject to a 55% minimum loss ratio requirement.
> **(1)** The superintendent shall collect necessary and sufficient data regarding vision plans for an actuarial analysis of the 55% minimum loss ratio requirement.
> **(2)** The superintendent shall post on its website any reporting requirements that exceed those found in subsection (H) of this rule.
> **(3)** Carriers providing vision insurance shall comply with the posted reporting requirements to support the actuarial analysis.
> **(4)** The superintendent shall share the results of the actuarial analysis once completed.
> **(5)** The superintendent may seek amendment of the minimum loss ratio for vision plans upon receipt of the actuarial analysis.

93. The Hearing Officer notes that L&H's revisions to originally proposed 13.10.35.9(F) & (G) recommend raising the proposed MLR of individual dental plans from 55% to 65%. Mr. Seaton made this recommendation in his comments by quoting his comments in the 2020 rulemaking, where he said, "in light of the apparent acceptance by carriers of a fixed 65% minimum loss ratios for group policies, it makes more sense to adopt the fixed 65% minimum for individual as well, and that is the recommendation here." Thus, Mr. Seaton's recommendation to set the MLR for both group and individual dental plans at 65% was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed

rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that L&H's revision to originally proposed 13.10.35.9(F) be adopted.

94. The Hearing Officer notes that L&H's revisions to originally proposed 13.10.35.9(F) & (G) recommend lowering the proposed MLR of group vision plans from 65% to 55%. Thus, United of Omaha's recommendation to set a 55% MLR for all vision-only plans was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that at least this part of L&H's revision to originally proposed 13.10.35.9(G) be adopted. "**Minimum loss ratios for group and individual vision plans.** Benefits under vision plans shall be subject to a 55% minimum loss ratio requirement."

95. The remainder of L&H's revisions to originally proposed 13.10.35.9(G) is more problematic. No specific proposals were made during the comment period, and the Hearing Officer does not find that the proposals are a logical outgrowth of the originally proposed amendments. Revised 13.10.35.9(G)(2) & (3) require compliance with provisions not made a part of any rule and apparently not even promulgated yet. This would violate the notice and comment requirements for rulemaking. Revised 13.10.35.9(G)(1) requires the Superintendent to collect data for an actuarial analysis, but revised 13.10.35.9(G)(5) says that the Superintendent "may" seek to amend the MLR level based on the actuarial study. Revised 13.10.35.9(G)(4) requires the Superintendent to make the actuarial study public, which implies that he has no other obligation to do so, where the Insurance Code and the Inspection of Public Records Act likely impose an affirmative

obligation for the Superintendent to do exactly that. The Superintendent may collect any necessary data through a data call, and the Superintendent may request any necessary actuarial study without the need for a rule. The Superintendent may also amend any rule through the rulemaking process at any time. The Hearing Officer recommends against adoption of the remainder of L&H's suggested revisions to proposed 13.10.35.9(G).

Rate Filing Requirements

96. HBI objected to the rate filing requirements of proposed 13.10.35.9(H) through (K) as burdensome and unnecessary, because dental and vision markets are very competitive with no underwriting of the coverage.

97. In his oral comments, Mr. Volk also recommended that, if OSI does not revise or eliminate the MLR requirement, OSI should modify the reporting from the individual plan level to an aggregate level. Mr. Volk explained that many groups at the individual plan level do not have enough members to provide an actuarial sound result and that aggregating these small pools would make more sense.

98. As part of its alternative to the MLR requirement, DDNM recommended that a sentence be inserted between the first and second sentences of proposed 13.10.35.9(H) that states: "Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience." L&H agreed with the recommendation to add this sentence, although the Hearing Officer does not interpret L&H's agreement as agreement to DDNM's alternative to the MLR requirement. The recommendation to change the language was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer

recommends that it be adopted. Therefore, the Hearing Officer recommends that a sentence be inserted between the first and second sentences of proposed 13.10.35.9(H) that states: "Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience."

99. Mr. Seaton recommended that, for the sake of implementing the separate calculation of loss ratios for dental and vision benefits required in proposed 13.10.35.9(I), to prevent evasion of the minimum loss ratio requirements by arbitrary determination of the components of rate, proposed 13.10.35.9(H) should include. between "New Mexico" and "The superintendent" the sentence: "Rate filings for plans which insure both dental and vision benefits under the same policy must include a stated allocation of the premiums between the portions that will be attributed to the dental and vision coverages in calculation of their respective loss ratios."

100. L&H generally agreed with Mr. Seaton's recommendation but thought that the additional language should be: "A rate filing for a plan which provides both dental and vision benefits under the same policy must provide information in the actuarial memorandum and other supporting documentation to separately identify and support the premiums attributed to the dental and vision coverages."

101. The Hearing Officer finds that the allocation of premium is necessary, because the Hearing Officer agrees that the MLR for dental coverage should be 65% and the MLR for vision coverage should be 55%. The Hearing Officer recognizes that Mr. Seaton's proposal is a simple allocation of premium offered by the carrier. Given that the Hearing Officer agrees that the MLR for dental coverage should be 65% and the MLR for vision coverage should be 55%, it would be in a carrier's best interest to allocate as much of the premium in favor of vision coverage under Mr. Seaton's approach. L&H's approach has the benefit of requiring an actuarial basis for the

allocation of premium, reducing the likelihood of improperly maximizing the premium to vision coverage. L&H's proposed additional language meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible and because the change is based on comments received during the comment period. The Hearing Officer recommends that the opening paragraph of proposed 13.10.35.9(I) be re-written to state:

> Each carrier providing dental or vision insurance must provide an actuarial analysis in an actuarial memorandum, certified by a qualified actuary, for each individual or group plan sold in New Mexico. Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience. A rate filing for a plan which provides both dental and vision benefits under the same policy must provide information in the actuarial memorandum and other supporting documentation to separately identify and support the premiums attributed to the dental and vision coverages. The superintendent shall post on its website requirements for filing actuarial memorandums and rates for rate filing requests. These requirements may differ for:

102. Mr. Seaton offered a correction to punctuation to remove the comma between "small" and "group" in proposed 13.10.35.9(H)(2). L&H agreed with the correction. Mr. Seaton's suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed amendment may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that the comma be removed between "small" and "group" in proposed 13.10.35.9(H)(2).

103. The Hearing Officer notes that there should be a comma after "small group" in proposed 13.10.35.9(H)(2). Placing a comma there will clarify that this provision is intended to apply to three different items: individual dental and vision plans, small group dental and vision plans, and large group dental and vision plans. This amendment meets the "logical outgrowth" test

because interested parties should have anticipated that the change was possible, and the Hearing Officer recommends the change.

Calculating the Loss Ratio

104. Mr. Seaton pointed out that, in proposed 13.10.35.9(I), the proper terminology is "the ratio of the numerator ***to*** the denominator". Mr. Seaton's suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed amendment may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends the change.

105. DDNM, ACLI, AHIP, and NADP recommended that, if OSI will keep the MLR requirement despite arguments against it, the calculation of the MLR in proposed 13.10.35.9(I) should be changed. First, proposed 13.10.35.9(I)(1) should be changed to: "Numerator. The numerator is equal to: (a) the incurred claims for the loss ratio reporting year; (b) The amount spent on activities that improve dental care quality for the loss ratio reporting year; [and] (c) the amount of claims payments identified through fraud reduction efforts; for the loss ratio reporting year:". Second, proposed 13.10.35.9(I)(2) should have added at the end: "excluding federal and state taxes and licensing and regulatory fees paid and after accounting for any payments pursuant to federal law." The change to proposed 13.10.35.9(I)(1) would require adding a definition of "activities that improve dental care quality" to 13.10.35.7 NMAC, and DDNM proposed this definition:

> **Activities that improve dental care quality.** The superintendent shall define "activities that improve dental care quality" to include but not limited to services such as case management; oral health assessments; identifying and addressing ethnic, cultural, or racial disparities in effectiveness of best clinical practices and evidence-based medicine; quality reporting; and health information technology.

106. Mr. Seaton responded to these comments by stating that the "activities that improve dental care quality" are primarily, if not exclusively, rendered by providers; thus, they should only be included in the numerator of the MLR if the carrier directly pays the provider for delivery of those benefits. In other words, expenses such as "case management" are already included in "the incurred claims for the loss reporting year." Mr. Seaton further commented that including "the amount of claims payment identified through fraud reduction efforts" does not make sense to him, although paid amounts recovered by carriers through fraud reduction efforts should probably be subtracted from the claims amounts in the numerator.

107. L&H responded to the proposed definition of "activities that improve dental care quality" by stating that Section 59A-23G-5 mandates that the rule on rates include an MLR and also that the actuaries, Mr. Seaton and Novarest, both disagree with the proposal to review rates within this framework; thus, L&H stated that the proposed definition is irrelevant and unnecessary. It is not clear why L&H mentioned the MLR, since the proposal is premised on OSI keeping the MLR requirement. However, Mr. Seaton's response comments are well-taken, in that the "activities that improve dental care quality" are costs that are undoubtedly already included in the costs of claims. Further, there is no actuarial support for the proposed framework. The Hearing Officer finds that the proposed framework should not be adopted and recommends against its adoption.

108. Neither Mr. Seaton nor L&H responded to the recommendation that proposed 13.10.35.9(I)(2) should have added at the end: "excluding federal and state taxes and licensing and regulatory fees paid and after accounting for any payments pursuant to federal law." The Hearing Officer finds that the purpose of an MLR is to establish a percentage of the premium charged that is paid for covered benefits, and reducing the amount of the premium by costs incurred by the

carrier would contradict the purpose of the MLR. The Hearing Officer recommends against any change to proposed 13.10.35.9(I)(2).

Rate Revisions and Rates for New Plans

109. Mr. Seaton recommended that the phrase "shall be deemed" in proposed 13.10.35.9(J) and (K) be changed to "may be deemed" because rates may be unacceptable in spite of mere compliance with loss ratio requirements, for example, if unduly discriminatory (such as where rates vary by geographic or demographic factors). L&H agreed with Mr. Seaton's recommendation. Mr. Seaton's suggested change was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that the phrase "shall be deemed" be changed to "may be deemed" in proposed 13.10.35.9(J) and (K).

110. Mr. Seaton further recommended that following "based on expected experience in the first three years" in proposed 13.10.35.9(K) be added: "if such proposed rates are guaranteed fixed for the projected three years" to reduce the temptation for a carrier to make exaggerated projections knowing it could revise rates later with relative impunity. L&H recommended against adoption of this change because OSI is able to disapprove rates based on exaggerated projections, and a fixed three-year rating period would limit OSI's discretion and ability to monitor rating practices. The Hearing Officer agrees with L&H and recommends against Mr. Seaton's recommended change.

Disapproval of Forms and Rates

111. BCBSNM recommended that proposed 13.10.35.9(L) not be adopted, because the amendment conflicts with the reasons for disapproval of forms and rates exclusively set forth in NMSA 1978, Section 59A-18-14(A) (2012). Alternatively, and at a minimum, BCBSNM recommends striking proposed 13.10.35.9(L)(5), because determining whether a plan provision is "unfair, impractical, unnecessary, or unreasonable" would be largely subjective and would not inform the regulated person in advance of the legal standards to which the plan is being held.

112. Mr. Seaton responded to this comment by asserting that proposed 13.10.35.9(L) does in fact conform to Section 59A-18-14(A) and that proposed 13.10.35.9(L)(1) may be even more lenient in that it allows a presumptive acceptance not specified in the statute.

113. L&H responded that Section 59A-18-14(E) exempts excepted benefits plans, such as stand-alone dental or vision plans, from its requirements. L&H also stated that proposed 13.10.35.9(L)(5) reflects OSI's obligations under Article 16 of the Insurance Code to protect the consumer from unfair trade practices.

114. The Hearing Officer finds that Section 59A-18-14(E) exempts excepted benefits plans, such as stand-alone dental or vision plans, from its requirements, but Sections 59A-23G-3, -4, and -5 give the Superintendent authority to determine standards for excepted benefits plan forms and rates. The Hearing Officer further finds that there are administrative procedures available to any carrier who believes that OSI has acted in an arbitrary or capricious manner with respect to the approval or disapproval of forms or rates. The Hearing Officer therefore recommends no change to proposed 13.10.35.9(L).

Reporting Requirements

115. While HBI supported compliance with MLR requirements and filing requirements, HBI requested that proposed 13.10.35.9(M) contain language that the filings will not be made public. In Mr. Seaton's response to this comment, he stated that any carrier that can demonstrate compliance with the MLR requirement or a willingness to rectify noncompliance with a corrective action plan should be proud, rather than ashamed to make its reports public. L&H did not respond to this comment.

116. The Hearing Officer finds that the question whether filings may be made public is controlled by NMSA 1978, Section 59A-2-12(B) (2013), which states: "Except as otherwise provided by the Insurance Code, the papers and records [of OSI] shall be open to public inspection." The provision allows the Superintendent to classify as confidential certain records, "except that no filing required to be made with the superintendent under the Insurance Code shall be deemed confidential unless expressly so provided by law." Thus, unless there is a provision of the Insurance Code, or there is some other provision of law, that allows the Superintendent to keep confidential the filings required by the rule, the filings cannot be kept from the public. HBI has not suggested any provision of the Insurance Code or any other law that would keep the filings confidential. The Hearing Officer recommends that proposed 13.10.35.9(M) not include language making filings confidential.

117. In his original comments, Mr. Seaton recommended deleting "and shall demonstrate that each plan complies with the minimum loss ratio standards" from proposed 13.10.35.9(M), since proposed 13.10.35.9(M)(8)(b) and (9) recognize that there may be plans which do not comply and therefore cannot demonstrate that they comply. L&H recommended against adopting this change, since there is no conflict between the expectation that a plan comply

with the MLR and a plan's ability to request an exemption from the requirement. The Hearing Officer agrees with L&H and recommends against Mr. Seaton's recommended change.

118. HBI is concerned that proposed 13.10.35.9(M)(9)(a) is overly burdensome and should be deleted in favor of a provision that allows a plan to be filed and used without waiting for approval for situations that could arise such as another pandemic that could shut down access to dental and vision services. Although there was no response to this recommendation, the Hearing Officer finds that both OSI and carriers seem to have negotiated the recent pandemic relatively well, and there is no need to delete or change proposed 13.10.35.9(M)(9)(a) for that reason. The Hearing Officer recommends against HBI's recommended change to proposed 13.10.35.9(M)(9)(a).

119. United of Omaha requested explanation of terms used in proposed 13.10.35.9(M) (incorrectly designated in its comments as "(N)"). United of Omaha requested to know what "rates" and "rating schedules" mean, whether the requirement is not just for MLR but an entire manual filing, and what credibility standard is acceptable to OSI. L&H responded that it recommends no change to the proposed amendments based on these comments and that credibility is determined by actuarial standards. The Hearing Officer notes that it might be helpful for L&H to answer any specific questions a carrier may have about the proposed amendments, but the Hearing Officer cannot recommend changes to the proposed amendments without a commenter suggesting a specific change.

120. United of Omaha recommended that the MLR reporting requirement apply not at the plan level but at the product level, by certificate form number. DDNM recommended that, instead of reporting data at the plan level, which would be administratively burdensome and could result in the need to provide thousands of reports, reporting should be done at the form filing level.

Although there was no response to these recommendations, neither commenter provided specific language for the change. The Hearing Officer cannot recommend changes to the proposed amendments without a commenter suggesting a specific change.

121. As part of its alternative to the MLR requirement, DDNM recommended deleting proposed 13.10.35.9(M) in its entirety and substituting the following in its place:

> **M. Annual Filings.** A carrier shall make an annual base rate filing for each such plan with the office no later than 12 months after its previous base rate filing was approved, demonstrating that its rates are not excessive. inadequate. or unfairly discriminatory.
> (1) The filing requirements of this section shall be satisfied by one of the following methods:
> (a) A rate filing prepared by an actuary which contains documentation demonstrating that the proposed rates are not excessive. inadequate. Or unfairly discriminatory.
> (b) If no rate change is proposed, a filing which consists of a certification by an actuary that the existing rate level produces rates which are actuarially sound and which are not excessive, inadequate or unfairly discriminatory.
> (2) The superintendent, after receiving a request to be exempted from the provisions of this section. may. for good cause due to insignificant numbers of policies in force or insignificant premium volume. exempt a company, by line of coverage, from filing rates or rate certification as required by this section.
> (3) Nothing in this section limits the superintendent's authority to review rates at any time or to find that a rate or rate change is excessive, inadequate, or unfairly discriminatory.

L&H responded that removing the MLR reporting and disclosure requirements would require additional amendments to the rule. Because the Hearing Officer has found that the MLR requirement is mandatory and should not be removed from the rule, the Hearing Officer recommends against deleting proposed 13.10.35.9(M) in its entirety and substituting the above language in its place.

122. DDNM recommended that, if OSI will keep the MLR requirement despite arguments against it, proposed 13.10.35.9(M) should be changed. First, in the initial sentence of proposed 13.10.35.9(M), “individual and group business, respectively” should be substituted for

"each plan, form or certificate subject to this rule." Second, in the third sentence of proposed 13.10.35.9(M), "individual and group business" should be substituted for "each plan". Third, the measurement period of proposed 13.10.35.9(M)(3) should be changed by adding at the end: "The initial measurement period shall be the years, 2024, 2025 and 2026. 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 period shall be 2025. 2026 and 2027." Fourth, in proposed 13.10.35.9(M)(4), 2023 should be changed to 2024. Finally, proposed 13.10.35.9(M)(9) should be changed by removing "to return excess premium or increase benefits" and adding at the end: "over the measurement period."

123. In their written comments, ACLI, AHIP, and NADP recommended that the measurement period of proposed 13.10.35.9(M)(3) should be changed by adding at the end: "The initial measurement period shall be the years, 2025, 2026 and 2027. 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 period shall be 2026. 2027 and 2028." Additionally, in proposed 13.10.35.9(M)(4), 2023 should be changed to 2025. Finally, proposed 13.10.35.9(M)(9) should be changed by removing "to return excess premium or increase benefits" and adding at the end: "over the measurement period."

124. L&H responded to this recommendation by noting its agreement that the effective date of the amendments should be January 1, 2024. Therefore, L&H recommended changes to proposed 13.10.35.9(M)(3) to clarify that the first measurement period will be 2024, the second will be 2024 and 2025, and the third will be 2024, 2025, and 2026, and 2023 should be changed in proposed 13.10.35.9(M)(4) to 2024. Thus, proposed 13.10.35.9(M)(3) would be re-written to read:

> **Measurement period.** Compliance with the minimum loss ratio shall be measured over the last three calendar years of experience and for each calendar year of

> experience utilized in the rate determination process, but never less than the last three years, after the initial transition period (2024 to 2026). The initial measurement period shall be calendar year 2024; the second measurement year shall be calendar years 2024 and 2025; the third measurement period shall 2024, 2025 and 2026. 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 fourth measurement period shall be 2025, 2026, and 2027.

125. The Hearing Officer finds that re-writing proposed 13.10.35.9(M)(3) as recommended by L&H and changing the date in proposed 13.10.35.9(M)(4) to 2024 are appropriate, in that the changes allow for a transition period and require measurement of the MLR as soon as the amendments become effective, unlike the commenters' recommendation, which picks up three years in the future. The Hearing Officer finds that it would be helpful to modify "year" in L&H's additional language by adding "calendar" before it, for clarity. L&H's recommended changes, and the Hearing Officer's additional changes, meet the "logical outgrowth" test because interested parties should have anticipated that the changes were possible and because the changes are based on comments received during the comment period. Therefore, the Hearing Officer recommends the changes to proposed 13.10.35.9(M)(3) and proposed 13.10.35.9(M)(4) as offered by L&H and modified by the Hearing Officer.

126. The commenters' recommendation that proposed 13.10.35.9(M)(9) should be changed by removing "to return excess premium or increase benefits" and adding at the end: "over the measurement period" was made during the comment period and the ten-day response period was provided. The Hearing Officer finds that the subject matter of the amended rule or the issues determined by that rule are the same as those in the published proposed rule. The proposed change may be adopted, and the Hearing Officer recommends that it be adopted. Therefore, the Hearing Officer recommends that proposed 13.10.35.9(M)(9) be changed by removing "to return excess premium or increase benefits" and adding at the end: "over the measurement period."

Corrective Action Plan

127. United Concordia raised concerns about the corrective action plan of proposed 13.10.35.9(M)(9), if OSI keeps the MLR requirement. First, United Concordia stated that it is not reasonable to require a rebate of premium, as the premium for a dental plan is much smaller than for a health benefits plan, the cost to send a rebate to an individual would likely be more than the rebate itself, and group plans would require rebates to employers, who would then have the administrative burden to pass the rebates to their employees. Therefore, United Concordia recommended removal of the specific corrective actions contemplated by proposed 13.10.35.9(M)(9) and relying on each carrier to develop a corrective action plan acceptable to the Superintendent.

128. In his response to this comment, Mr. Seaton supported requiring the approval of the Superintendent for corrective action plans and stated that the proper corrective action for collection of excessive benefits is return of the premium, although reduction of future rates is a possibility.

129. L&H responded that the Superintendent has sole authority and discretion to develop fair and reasonable corrective action plans to enforce provisions of the Insurance Code. L&H also stated that there is no prohibition on a carrier from requesting an exemption from a particular regulatory requirement, participating in the process to develop a corrective action plan, or otherwise exercising a statutory right to a hearing to contest an action of the Superintendent.

130. The Hearing Officer does not understand United Concordia to be objecting to the concept of a corrective action plan; United Concordia objects to the inclusion of specific actions as part of the plan. On the other hand, the Hearing Officer notes that the actions to which United Concordia objects are permissive on the part of the Superintendent, not mandatory. The Hearing

Officer interprets proposed 13.10.35.9(M)(9) as allowing the Superintendent to work with the carrier to develop a corrective action plan, but not as requiring the Superintendent to include a refund of premium as part of the plan. The Hearing Officer recommends against any change to proposed 13.10.35.9(M)(9).[2]

Coverage Documentation

131. Mr. Seaton stated that "person" is ambiguous in 13.10.35.13(A)(1) NMAC (which is in that portion of the provision which is not proposed to be amended). Mr. Seaton stated that he does not have a proposal for correcting the paragraph but noted that there is language shown as stricken which does not appear in the existing rule. Mr. Seaton suggested a careful review of this subsection.

132. United of Omaha recommended that 13.10.35.13(A)(1) NMAC be amended to clarify that covered groups may distribute a schedule of benefits on behalf of the carrier, since "summary of benefits" was removed in the proposed amendments but "schedule of benefits" was not added back in.

133. The Hearing Officer takes administrative notice that current 13.10.35.13(A)(1) NMAC does not contain the phrase "schedule of benefits" so it cannot be added back in. The Hearing Officer further takes administrative notice, as pointed out by Mr. Seaton, that the proposed published amendment to 13.10.35.13(A)(1) NMAC contained incorrect language purportedly from the existing rule and is thus unclear as to what the proposed amendments to 13.10.35.13(A)(1)

[2] The Hearing Officer notes that L&H did not cite to any statute or case law in stating that that the Superintendent has sole authority and discretion to develop fair and reasonable corrective action plans to enforce provisions of the Insurance Code. The Hearing Officer has found no such support, although perhaps it could be implied from NMSA 1978, Section 59A-2-8(A)(4) (2021), which states that the Superintendent shall "have the powers and authority expressly conferred by or reasonably implied from the provisions of the Insurance Code[.]" Regardless, given the Superintendent's authority to suspend or revoke an insurer's certificate of authority, NMSA 1978, § 59A-5-24(A) (1984), and authority to impose fines, *see, e.g*, NMSA 1978, § 59A-1-18 (1989), any carrier would undoubtedly welcome a corrective action plan in lieu of a more stringent administrative enforcement action.

NMAC are intended to be. The Hearing Officer therefore recommends that no change be made to existing 13.10.35.13(A)(1) NMAC.

Insurance Identification Cards

134. While Mr. Volk supported adding additional information to dental insurance identification cards, he objected on behalf of DDNM to the implied requirement in proposed 13.10.35.13(D) to mail physical cards to consumers. Mr. Volk pointed out that physical cards are not required to receive dental care under a plan, and carriers often do not mail out cards. Requiring physical cards would add administrative costs without adding value to consumers, and it would be more cost-effective to allow cards to be provided electronically.

135. United Concordia noted that dentists do not rely on ID cards for care delivery, and carriers are able to provide enrollees with electronic or printed ID cards. Absent an identified issue, United Concordia stated that it dos not believe that proposed 13.10.35.13(D) is necessary. If the Superintendent decides to retain this provision, United Concordia recommended that the cards be provided through either physical or electronic means.

136. In their written comments, DDNM, ACLI, AHIP, and NADP pointed out that many people use electronic forms of identification cards available on cell phones, apps, plan portals, or websites, and therefore DDNM, ACLI, AHIP, and NADP recommended that proposed 13.10.35.13(D) be amended to state:

> **INSURANCE CARDS:** Basic consumer information, including the phone number and website of the insurer's consumer assistance bureau, shall be included on all newly-issued physical or electronic insurance cards, which may be available within the carrier's member portal or app. or, in the alternative, on an electronic or physical separate wallet-sized card, which may also be available within the carrier's member portal or app, that is issued simultaneously with the health insurance card.

137. L&H responded by noting that some parts of New Mexico remain without internet access, so an electronic copy of an insurance cared may not be practical in all circumstances. L&H

agreed that a consumer should have the option to determine which format the consumer prefers. L&H recommended that proposed 13.10.35.13(D) be amended to state: "**INSURANCE CARDS:** Basic consumer information, including the phone number and website of the insurer's consumer assistance bureau, shall be included on all newly-issued physical or digital insurance cards. Carriers may issue digital cards, but shall provide a physical card upon the request of the consumer."

138. The Hearing Officer finds that L&H's proposal meets the concerns expressed about administrative costs and lack of internet access. L&H's suggested change meets the "logical outgrowth" test because interested parties should have anticipated that the change was possible and because the change is based on comments received during the comment period. The Hearing Officer recommends that proposed 13.10.35.13(D) be amended to state: "**INSURANCE CARDS:** Basic consumer information, including the phone number and website of the insurer's consumer assistance bureau, shall be included on all newly-issued physical or digital insurance cards. Carriers may issue digital cards, but shall provide a physical card upon the request of the consumer."

Network Adequacy

139. Mr. Seaton had additional comments regarding current 13.10.35.14(A) NMAC, but he correctly noted that this provision is not part of the proposed amendments to the rule. Because the NOPR did not give notice that this provision would be amended, and therefore the comments fall outside the scope of the current rulemaking proceeding, the Hearing Officer finds that those comments cannot be addressed in this proceeding.

Prior Authorization

140. At the public hearing, Mr. Urech and Mr. Volk also discussed the prior authorization requirements of proposed 13.10.35.15(F) by pointing out that prior authorizations are rare in dental treatment and that pretreatment estimates are much more common. NADP and DDNM are concerned that this new requirement in order for a carrier to deny a claim for medical necessity will lead to plans requiring prior authorization on a large number of dental treatments where prior authorization is not currently required. This would create an increased administrative burden on both the carriers and the providers, and it would change the way that dental care is currently delivered in New Mexico. Mr. Volk stated that when DDNM denies a claim for lack of medical necessity, the DDNM contracted provider cannot bill the insured for the expense of the treatment, which protects the consumer. Mr. Wieske raised concerns that requiring prior authorization would create a significant level of confusion for consumers, especially in conjunction with disallowing a list of exclusions, as a consumer may not know what is or is not covered. Mr. Urech and Mr. Volk suggested that there is not evidence of a problem needing the solution of prior authorization, prior authorization has not been required previously in New Mexico, and prior authorization for dental treatment is not required in any other state.

141. L&H responded at the public hearing to the prior authorization concerns by stating that proposed 13.10.35.15(F) is a consumer protection provision based on the number of complaints that OSI has received.

142. In their response comments, AHIP, ACLI, and NADP requested clarification of the scope and frequency of the consumer complaints referred to in the oral comments at the public hearing. The commenters stated that the prior authorization requirements would not ensure access to, or coverage of, dental care. Instead, the proposed amendment would alter the structure of dental

coverage to require prior authorizations to deny a claim for medical necessity, likely forcing many dental plans operating in New Mexico to begin widely utilizing prior authorization processes with dentists who are not accustomed to these requirements. As a result, many dentists would see a drastic increase in administrative costs which are in turn reflected in the overall price of care. AHIP, ACLI, and NADP requested further discussion on this issue.

143. DDNM, in its written comments by Mr. Volk, reiterated its opposition to proposed 13.10.35.15(F). DDNM stated that the amendment will require new processing policies, new procedures, changes to claims processing systems, provider contract amendments, policy form amendments, and additional staffing, for which the amendment adoption timeline does not provide enough time, and which would do nothing to protect access to oral health or address health inequity.

144. DDNM also reiterated that the ability dental plans currently have to deny claims that they deem not medically necessary allows carriers to safeguard their insured's oral health and limit waste, fraud, and abuse. Again, DDNM has agreements with network providers to hold customers harmless for amounts billed when a claim is denied because it is deemed not medically necessary. Changing this process to require a request for prior authorization before the carrier could deny the claim would expand the administrative requirements for dental providers, subscribers, and insurers, slowing the treatment of patients and increasing costs. Further, DDNM stated that it is not clear what "medical necessity" means in the dental care context, and DDNM suggested that OSI could use existing regulations for pre-treatment estimates to address medical necessity denials.

145. DDNM recommended that 13.10.35.15(B) NMAC be extensively amended to require a dental plan to honor coverage decisions included in the pre-treatment estimate, to avoid

misunderstandings about available benefits and enable providers and subscribers to make informed decisions and appropriate financial arrangements.

146. United of Omaha stated that it never requires prior authorization as a condition of payment for a covered service, although it sometimes denies a post-service claim for lack of medical necessity following clinical review. United of Omaha stated that this keeps premiums low and ensures medically appropriate dental care. United of Omaha further stated that enrollees who receive dental care from network providers are generally held harmless from balance billing if payment for services is denied for lack of medical necessity. United of Omaha expressed concern that proposed 13.10.35.15(F) would present obstacles to dental care and lead to a frustrating experience for both providers and consumers.

147. HBI stated that proposed 13.10.35.15(F) makes no sense, since it requires insurers to create a prior authorization process for all services in order to be able to deny a claim for medical necessity. Additionally, together with the requirement of proposed 13.10.35.8(C)(5) that limits exclusions, HBI stated that this provision forces an insurer to confuse a consumer. United of Omaha raised similar concerns and recommended revising 13.10.35.25(F) to state: "A dental plan must provide a pretreatment estimate of any covered dental service that is not a required minimum benefit as defined at 13.10.35.10(C) upon request."

148. In their joint written comments, ACLI, AHIP, and NADP reiterated their oral statements from the public hearing that prior authorizations are rare in dental treatment and no other state requires prior authorization for claims denial for dental plans. To prevent claims denial without prior authorization would be a significant departure from the current structure of dental care and coverage. Rather, providers use pre-treatment estimates which inform the patient what care is covered and what is not and allows carriers to deny claims they determine are not medically

necessary. According to the commenters, plans develop significant safeguards for patients to preserve their oral health and limit waste, fraud, and abuse, while retaining resources for providers. Requiring a prior authorization process before allowing claims to be denied would cause carriers to require prior authorization for most dental treatments and significantly expand administrative burdens, slow treatments, and increase spending. The commenters cited to a study showing that many medical providers report that they spend at least 16 hours a week on prior authorizations.[3]

149. United Concordia's comments on proposed 13.10.35.15(F) were very similar to the joint comments of ACLI, AHIP, and NADP. United Concordia further stated that adopting proposed 13.10.35.15(F) would force a carrier to choose among three unsustainable and costly options: 1) require prior authorization on most services, which would add significant administrative cost and complexity and could delay patient care; 2) end retrospective dental necessity denials and adjust pricing upward, which would increase premiums and cause employers and individuals to drop or reduce coverage; or 3) exit the New Mexico dental insurance market, which would reduce competition and lead to higher premiums. United Concordia stated that 13.10.35.15(D) NMAC contains sufficient safeguards, and United Concordia recommended that proposed 13.10.35.15(F) not be adopted.

150. BCBSNM recommended not adopting proposed 13.10.35.15(F) because prior authorization does not appear in the long and specific list of topics in Section 59A-23G-3(A) on which OSI relies to adopt the rule; alternatively, it should not be adopted because it is likely to lead to the carrier significantly increasing the treatment services subject to prior authorization.

[3] The Hearing Officer takes administrative notice that OSI, as well as health care providers, have cited this study in the Prior Authorization rulemaking, Docket No. 2022-0064.

151. ACLI, AHIP, and NADP recommended not adopting proposed 13.10.35.15(F) and adding a 13.10.35.15(B)(3) to state: "A dental plan may require a pretreatment estimate of any covered dental service."

152. Mr. Seaton responded to this recommendation by stating that the pretreatment estimate is required from a dental plan, not the provider. A prior authorization is required by a dental plan.

153. In his response comments, Mr. Seaton recommended removing proposed 13.10.35.15(F) and amending 13.10.35.15(B) to change "may" to "shall" in the first introductory sentence and adding "upon the request of the patient or the provider" to the end of that sentence. Also, Mr. Seaton proposed removing the second introductory sentence and adding a subparagraph (3) to state: "A plan shall not deny, on the grounds of lack of medical necessity, a claim for a service for which a pretreatment estimate was issued."

154. L&H responded to the comments on prior authorization stating that proposed 13.10.35.15(F) is authorized by NMSA 1978, Section 59A-23(G)(A)(1) as a "specific standard that sets the manner, content, and required disclosure … including standards for full and fair disclosure." L&H stated that a pretreatment estimate evaluates for medical necessity. Further, proposed 13.10.35.15(F) does not prohibit the use of pretreatment estimates nor does it require the use of prior authorization; proposed 13.10.35.15(F) simply requires that if a carrier desires to deny claims for medical necessity, the carrier must have a prior authorization process in place and use that process to protect consumers from retroactive denials of coverage. If a carrier is going to deny claims on the basis of medical necessity, it needs to have a process for informing consumers before treatment. A prior authorization process will eliminate the need for retroactive denials and will prevent fraud, as well as increase the quality and value of care for consumers. L&H stated that

post-service medical necessity review and denial is not an insurance industry standard and constitutes an unfair claims practice in violation of NMSA 1978, Section 59A-16-20.

155. The Hearing Officer finds that there is not sufficient justification for adding proposed 13.10.35.15(F) to the rule, in light of the concerns raised by the commenters, including the administrative burdens placed on both providers and carriers by prior authorization requirements. The Hearing Officer recommends against the adoption of proposed 13.10.35.15(F).

Grandfather Provision

156. HBI urged the addition of a provision allowing existing plans to be grandfathered, suggesting the addition of the language from the recently adopted replacement of the Excepted Benefits rule, 13.10.34.2(C) and (D). L&H did not respond to this suggestion. The Hearing Officer does not see a compelling interest in continuing plans that do not conform to the regulations and therefore recommends against grandfathering existing plans.

Formatting of the Amendments

157. Consistent with NMSA 1978, Section 14-4-3(A) (2017), to the extent that the Administrative Law Division may require formatting of the final rule different from originally proposed or as amended by this decision, the Hearing Officer recommends following those formatting requirements.

CONCLUSIONS:

A. The Superintendent has jurisdiction over the subject matter and the parties.

B. OSI caused the NOPR to be published on August 9, 2022 in the New Mexico Register and on August 9, 2022 in a newspaper of general circulation in compliance with NMSA 1978, Section 14-4-5.2.

C. The NOPR provided interested persons and the public appropriate notice of the hearing and the opportunity to offer oral and written comments.

D. The Hearing Officer has considered all oral and written comments.

E. The amendments to the rule should be adopted with changes set forth above, effective January 1, 2024.

WHEREFORE, in light of the findings and conclusions above, the Hearing Officer **RECOMMENDS** that the Superintendent should sign a Final Order that permanently adopts the proposed amendments to the rule attached hereto as Exhibit A.

The Hearing Officer also **RECOMMENDS** that a copy of this Hearing Officer's Findings, Conclusions, and Recommendations, with its attachments, be sent to all interested persons.

ISSUED at Santa Fe, New Mexico this 8th day of December, 2022.

OFFICE OF SUPERINTENDENT OF INSURANCE

R. Alfred Walker, Hearing Officer

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 8th day of December 2022, I filed the foregoing *Hearing Officer's Recommended Decision* through the OSI's e-filing system, https://edocket.osi.state.nm.us/home, which caused the individuals indicated below to be served by electronic means.

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Office of Superintendent of Insurance

Exhibit A

This is an amendment to 13.10.35 NMAC, Sections 2, 3, 7, 8, 9, 10, 11, 13, and 15. effective 01/01/2024.

TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 35 MINIMUM STANDARDS FOR DENTAL AND VISION PLANS

13.10.35.1 ISSUING AGENCY: Office of Superintendent of Insurance ("OSI").
[13.10.35.1 NMAC - N, 01/01/2022]

13.10.35.2 SCOPE: This rule applies to every carrier who offers or sells any individual or group dental or vision insurance plan ("plan") separately from a health benefits plan, whether on or off the exchange. This rule does not apply to any pediatric dental or vision plan, or to any prepaid dental plan. Subject to the foregoing, this rule applies to a group dental or vision plan offered or sold to a New Mexico resident under a master policy delivered outside of this state.
[13.10.35.2 NMAC - N, 01/01/2022; A, ~~07/01/2023~~01/01/2024]

13.10.35.3 STATUTORY AUTHORITY: Sections 59A-2-9, 59A-23F-7, and 59A-23G-1 et seq. NMSA 1978.
[13.10.35.3 NMAC - N, 01/01/2022; A, ~~07/01/2023~~01/01/2024]

13.10.35.4 DURATION: Permanent.
[13.10.35.4 NMAC - N, 01/01/2022]

13.10.35.5 EFFECTIVE DATE: January 1, 2022 unless a later date is cited at the end of a section. If the superintendent previously approved a subject plan, that plan shall comply with this rule no later than January 1, 2022, if issued on or after that date.
[13.10.35.5 NMAC - N, 01/01/2022]

13.10.35.6 OBJECTIVE: Establish minimum regulatory standards and sales practices relating to dental and vision plans; standardize and simplify the terms and coverages; facilitate public understanding and comparison of coverage; eliminate provisions that may be misleading or confusing in connection with the purchase and renewal of the coverages or with the settlement of claims; and require disclosures in the marketing and sale of the subject plans.
[13.10.35.6 NMAC - N, 01/01/2022]

13.10.35.7 DEFINITIONS: For definitions of terms contained in this rule, refer to 13.10.29 NMAC, unless otherwise noted below.

A. "Domestic co-insured" means a spouse or domestic partner insured under the same plan or certificate.

B. "Earned premiums" for a reporting year means the premium received up to the loss ratio measurement date that provided coverage during that reporting year~~means the portion of the premium paid in the reporting year that is intended to provide coverage during such reporting period~~.

C. "Incurred claims" for a reporting year, means the claims for which services were provided in the reporting year. This includes such claims that were paid in the reporting year plus unpaid claims reserves for such ~~claims paid after the~~ reporting year.

D. "Loss ratio" means the ~~earned premiums~~incurred claims divided by ~~incurred claims~~earned premiums, calculated pursuant to Subsection D of 13.10.35.9 NMAC.

E. "Loss ratio measurement date" means the date as of which the incurred claims and earned premiums for each reporting year are determined for the reporting required in subsection (M) of section 13.10.35.9 of this rule~~a measurement year is determined~~.

[~~B.~~] F. "Preferred provider" means a dental or vision care provider, or group of providers, who contracts with a dental or vision insurance carrier to provide dental or vision services to a covered person.

G. "Reporting year" means a calendar year during which group or individual dental coverage is provided by a policy, contract or certificate covering dental services.

H. "Schedule of benefits" means any form that is part of an insurance policy filed with and approved by the superintendent~~document~~ that contains any of the following information: coverage levels, cost sharing features, covered services, benefit maximums and exclusions.

I. "Unpaid claim reserves" for a reporting year means reserves and liabilities established as of the applicable loss ratio reporting year but were paid after the reporting year~~means reserves and liabilities established to account for claims that were incurred during the reporting year but were paid after the loss ratio measurement date for such reporting year~~.

[13.10.35.7 NMAC - N, 01/01/2022; A, 01/01/2024~~07/01/2023~~]

13.10.35.8 GENERAL PROHIBITED POLICY PROVISIONS:

A. Probationary and waiting periods. Except as otherwise expressly allowed under Sections 10 and 11 of this rule, a plan shall not include any probationary or waiting period during which no coverage is provided for a covered benefit, except an eligibility waiting period during which no premium is paid.

B. Riders and other supplements. Any rider, amendment, endorsement or other supplement shall explicitly state which terms of coverage the carrier has amended or supplemented from the original plan.

C. Exclusions. A plan that includes [~~a preexisting condition~~] any exclusions shall comply with these requirements:

(1) each plan application shall include a prominent notice that the plan includes a preexisting exclusion, and display either the full text of the exclusion or directions as to how to obtain a copy of that text.

(2) the carrier shall not enforce a preexisting condition exclusion if an enrollee renews coverage under a plan offered by the same carrier.

(3) a plan application shall not request family member health information unless the family member is also seeking coverage under the plan; and

(4) a plan may exclude benefits for the replacement of a tooth that the covered person lost prior to the covered person's plan effective date unless the covered person had coverage from a prior carrier.

~~**(5)** a plan shall only list exclusions that remove coverage for a benefit or loss that would otherwise be covered under the terms of the policy.~~

D. Evidence of coverage. Upon request, a carrier shall provide a current or former enrollee evidence of that person's current or former coverage under a plan.

E. Marketing of blanket or group coverages. A carrier shall not sell any blanket coverage to a group that is not described in Section 59A-23-2 NMSA 1978, or group coverage that is not identified or described in Section 59A-23-3 NMSA 1978.

F. Arbitration provisions. A plan shall not require a covered person to submit a dispute to mediation or arbitration.

G. Plan governance. A covered person's rights under any plan shall be governed by the terms of the plan approved by the superintendent, and by applicable state and federal law.

H. Discrimination. No plan shall discriminate in eligibility for coverage or benefits on the basis of sex, sexual orientation, gender, race, religion, or national origin

I. Conversion privileges. A carrier shall not offer a conversion plan that is not approved by the superintendent.

J. Gag rule. A plan shall not include, and a carrier shall not otherwise impose, a gag rule or practice that prohibits a dental or vision service provider from discussing a treatment option with a covered person.

[13.10.35.8 NMAC - N, 01/01/2022~~; A, 07/01/2023~~]

13.10.35.9 GENERAL STANDARDS FOR POLICIES AND BENEFITS:

A. For individual plans. The following general standards apply to individual plans.

(1) An individual plan shall have a minimum term of 12 months.

(2) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" individual plan shall not provide for termination of coverage of the domestic co-insured solely because of the occurrence of an event specified for termination of coverage of the covered person, other than nonpayment of premium. In addition, the plan shall provide that in the event of the covered person's death, the domestic co-insured of the covered person, if covered under the plan, shall become a covered person with the issuance of a new policy and completed agreement.

(3) An individual plan shall protect consumer rights as follows:

(a) The terms "noncancellable" or "noncancellable and guaranteed renewable" may only be used in an individual dental or vision plan if the covered person has the right to continue the coverage by timely paying premiums, until the age of 65 or until eligibility for Medicare, whichever is later, during which time the carrier has no unilateral right to change any provision of the plan.

(b) The term "guaranteed renewable" may only be used in a plan where the covered person has the right to continue in force, by timely paying premiums, until the age of 65 or until eligibility for Medicare, whichever is later, during which period the carrier has no unilateral right to change any provision of the plan, other than changes in premium rates by classes.

(c) A plan shall not terminate the coverage of a covered person except for "good cause," as follows:

(i) failure of the covered person or subscriber to pay the premiums and other applicable charges for coverage;

(ii) material failure to abide by the rules, policies or procedures of the plan;

(iii) fraud or misrepresentation affecting coverage;

(iv) policyholder request for cancellation;

(v) policy term ends; or

(vi) a reason for termination or failure to renew that the superintendent determines is not objectionable.

(4) If an individual plan covers domestic co-insureds, the age of the younger insured shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older insured upon attainment of the stated age so long as the policy may be continued in force as to the younger spouse to the age or for the durational period specified in the policy.

B. For individual and group plans. The following general standards apply to both individual and group plans.

(1) A carrier may not terminate a plan unless it provides written notice of termination to a covered person one month prior to the coverage renewal date. A notice of termination shall:

(a) be in writing and dated;

(b) state the reason(s) for termination, with specific references to the clauses of the dental or vision plan giving rise to the termination;

(c) state that a covered person's plan cannot be terminated because of health status, need for services, race, gender, or sexual orientation of covered persons under the contract. Age may only be a factor in termination of coverage as outlined in Paragraph (4) of Subsection A and Paragraph [~~(7)~~] (8) of Subsection B of this section;

(d) state that a covered person who alleges that an enrollment has been terminated or not renewed because of the covered person's health status, need for health care services, race, gender, age or sexual orientation may file a complaint with the superintendent of by phone or on OSI's website; and

(e) state that in the event of termination by either the covered person or the plan, except in the case of fraud or deception, the plan shall, within 30 calendar days, return to the covered person or subscriber the pro rata portion of the money paid to the plan that corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due to the plan, provided, however, that the superintendent may approve other reasonable reimbursement practices.

(2) A plan shall include a notice prominently printed on or attached to the first page of the plan stating that the covered person shall have the right to return the plan within 30 days of its delivery, and to have the premium and any required membership fees refunded, if after examination of the plan the covered person is not satisfied for any reason, provided no claim has been paid.

(3) If a plan includes a conversion privilege, the provision shall be captioned, "Conversion Privilege." The provision shall specify who is eligible for conversion and the circumstances that govern conversion, or may state that the conversion coverage will be provided as an approved plan form used by the carrier for that purpose.

(4) If a carrier requires submission of a claim form as a condition of payment, the carrier, upon receipt of notice of a claim, shall furnish to the covered person a form to be delivered in the manner offered by the carrier that is preferred by the covered person. If the carrier does not furnish a claim form within 15 days after notice of a claim, the claimant shall be deemed to have complied with the requirement to provide proof of loss if the notice of claim contains written proof describing the claim, including the character and extent of the loss of which the claim is made. Adequate proof of loss must be in the possession of the insurance company at the time funds are disbursed in payment of claims.

(5) A grace period of at least 10 days for a monthly premium plan and at least 31 days for any plan billed less frequently shall be granted for the payment of each premium falling due after the first premium. During this grace period, the plan shall continue in force.

(6) A carrier shall not use any untrue statement or inducement not specified in a policy to solicit a prospective plan enrollee.

(a) A statement shall be deemed untrue if it does not conform to fact in any respect and would be considered significant to a person contemplating enrollment with a plan.

(b) Inducements shall meet the requirements of Subsections G and H of Section 59A-16-17 NMSA 1978.

(7) If coverage of dependents is provided, a carrier shall not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's twenty-sixth birthday, regardless of whether the dependent is enrolled in an educational institution.

[~~(7)~~] (8) A plan may terminate the coverage of a dependent due to limiting age for a dependent per the plan's contracted age limits. However, a plan must offer coverage to dependents, regardless of age, who are physically or mentally disabled prior to reaching the limiting age and are incapable of self-sustaining employment. Coverage for a child who is physically or mentally disabled prior to reaching the limiting age and incapable of self-sustaining employment on the date the child would otherwise age out of coverage shall continue if the child depends on the covered person for support and maintenance. The plan may require that within 31 days of the date the company receives proof of the child's incapacity, the covered person may elect to continue the plan in force with respect to the child.

C. For group coverage. [~~A group plan shall comply with Sections 8, 9, 11, and 12 of 13.10.5 NMAC, and Subsection D of 13.10.5.10 NMAC~~]. A group plan that offers dental or vision coverage shall comply with all sections of this rule.

D. Prior approval of forms required. A carrier shall not issue, deliver, or use a form associated with applicable dental and vision plans, unless and until such form has been filed with and approved by the superintendent.

E. Prior approval of rates required. A carrier shall not use rates or modified rates for dental and vision plans unless and until such rates are filed with and approved by the superintendent.

F. Minimum loss ratios for group and individual dental ~~and vision~~ plans. Benefits ~~under group~~ dental ~~and vision~~ plans shall be subject to a sixty-five percent minimum loss ratio requirement.

G. Minimum loss ratios for group and individual ~~dental and~~ vision plans. Benefits under ~~individual dental and~~ vision plans shall be subject to a fifty-five percent minimum loss ratio requirement.

H. Rate filing requirements. Each carrier providing dental or vision insurance must provide an actuarial analysis in an actuarial memorandum, certified by a qualified actuary, for each individual or group plan sold in New Mexico. Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience. A rate filing for a plan which provides both dental and vision benefits under the same policy must provide information in the actuarial memorandum and other supporting documentation to separately identify and support the premiums attributed to the dental and vision coverages. The superintendent shall post on its website requirements for filing actuarial memorandums and rates for rate filing requests. These requirements may differ for:

(1) dental and vision plans;

(2) individual, small~~,~~ group, and large group dental and vision plans;

(3) dental and vision plans sold on and off the health benefits Exchange.

I. Calculating the loss ratio for individual and group dental and vision plans. The loss ratio is calculated as the ratio of the numerator ~~and~~ to the denominator, as defined in Paragraphs (1) and (2) below. The loss ratio shall be calculated separately for dental and vision coverages, even if both dental and vision benefits are included in a single policy or contract.

(1) Numerator. The numerator is equal to the incurred claims for the loss ratio reporting year

(2) Denominator. The denominator is the earned premiums for the loss ratio reporting year.

J. Rate revisions. The following requirements shall apply to rate revision requests: With respect to filing rate revisions for a previously approved form, or a group of previously approved forms combined for experience, benefits ~~shall~~ may be deemed reasonable in relation to premiums provided the revised rates meet the minimum loss ratio requirements of Subsections F or G of this rule, as applicable, and most current standards applicable to rate filings as prescribed by the superintendent, pursuant to Subsection I above based on actual experience and expected experience in the rating period,

K. Rates for new plans. The following requirements shall apply to rates for dental and vision plans not previously offered for sale in New Mexico: With respect to filing rates for a new plan, benefits ~~shall~~ may be deemed reasonable in relation to premiums provided the proposed rates meet the minimum loss ratio requirements

of this rule, as applicable, and most current standards applicable to rate filings as prescribed by the superintendent, based on expected experience in the first three years.

L. Disapproval of forms and rates. The superintendent shall issue a disapproval:

(1) if the benefits provided therein are unreasonable in relation to the premium charged. For purposes of this rule, a dental or vision plan that meets the minimum loss ratio requirements will be considered to have benefits that are reasonable in relation to the premium charged;

(2) If there is misrepresentation of the benefits, advantages, conditions or terms of any plan or if the plan is characterized as more favorable to the covered person than the actual terms of the plan, such as naming coverage for services or conditions for which the primary forms of treatment are listed as exclusions;

(3) If there are false or misleading statements;

(4) If the name or title of a form is misrepresenting the true nature thereof; or

(5) If the plan contains provisions that are contrary to law, discriminatory, deceptive, unfair, impractical, unnecessary or unreasonable.

M. Disclosure and reporting compliance with minimum loss ratio requirements. By July 31st following each reporting year, carriers providing dental or vision benefit coverage must submit to the superintendent an actuarial memorandum prepared by a qualified actuary, which discloses the actual loss ratio for each plan, form or certificate subject to this rule. The annual filing shall, at a minimum, include rates, rating schedules, and supporting documentation, including ratios of incurred claims to earned premiums for each calendar year since issue. Information shall be in the form prescribed by the superintendent and shall demonstrate that each plan complies with the minimum loss ratio standards. Carriers that provide dental or vision insurance coverage that acquire a line or block of business from another carrier during a reporting year are responsible for submitting the required information and reports for the assumed business, including for that part of the reporting year that preceded the acquisition.

(1) General. Carriers shall meet the minimum loss ratio established, and in the manner calculated, under this Section of the rule.

(2) Aggregation. Experience data may be aggregated for those policies or certificates that are rated together due to noncredible experience.

(3) Measurement period. Compliance with the minimum loss ratio shall be measured over the last three calendar years of experience and for each calendar year of experience utilized in the rate determination process, but never less than the last three calendar years, after the initial transition period (2024 to 2026). The initial measurement period shall be calendar year 2024; the second measurement year shall be calendar years 2024 and 2025; the third measurement period shall calendar years 2024, 2025 and 2026. Each year thereafter, the subsequent calendar year shall be added to the rolling three-year period and the oldest calendar year shall be removed. For example, the fourth measurement period shall be calendar years 2025, 2026, and 2027.

(4) Frequency. Loss ratios shall be calculated annually by carriers that issue vision or dental plans specified in this rule, beginning with the ~~2023~~ 2024 reporting year.'

(5) Timeline. The evidence of compliance with the minimum loss ratio requirements shall be filed with the superintendent by July 31 of the year following the reporting year. For noncredible blocks of business, the company may request a waiver of the requirement. The request shall be made annually and must be accompanied by a letter indicating the nature of the filing, the type of plan, and the reason for the request.

(6) Methodology. For existing plans, actual loss ratios shall be calculated using company historical claim data including an estimate for claims incurred but not reported, as appropriate.

(a) The superintendent shall assure that reserves are reasonable and based on sound actuarial principles with respect to the aggregate dollar amount of reserves for claims that are incurred but not yet paid, and for claims that are incurred but not yet reported.

(b) The claims will be reported for each calendar year of experience utilized in the rate determination process, but never less than the last three years after the third year of experience is available.

(c) A plan shall be deemed to comply with the purposes of this section if the expected losses in relation to expected premiums over the entire period for which the plan is rated comply with the requirements of this section and either of the following applies:

(i) For policies or certificates that have been in force for three years or more, for the last three years, the ratio of incurred losses to earned premiums is greater than or equal to the minimum loss ratios established by this rule.

(ii) For policies or certificates that have been in force for fewer than three years, the expected third year loss ratio can be demonstrated to be greater than or equal to the minimum loss ratio.

(7) Credibility. The certifying actuary shall include a statement related to the credibility of the data and the methodology used to determine such credibility in accordance with the applicable actuarial standards of practice.

(8) Compliance with minimum loss ratios. Each carrier shall submit to the superintendent an exhibit showing the calculation of the applicable loss ratios and:

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

(b) a rate filing to justify the rates, revise rates, modify benefits through a benefit endorsement or to return excess premium.

(9) Corrective action plan. The superintendent may require a corrective action plan to return excess premiums or increase benefits if the minimum loss ratio requirements are not met.

(a) A carrier shall not return excess premiums per the above guidelines, until the carrier files a corrective action plan and obtains approval of such plan by the superintendent.

(b) If, in the opinion of the superintendent, a plan's failure to meet the minimum loss ratio requirements is due to unusual reserve fluctuations, economic conditions, or other nonrecurring conditions, the superintendent may elect not to issue a corrective action plan. Any such exemption shall be in writing.

[13.10.35.9 NMAC - N, 01/01/2022; A, 01/01/2024~~07/01/2023~~]

13.10.35.10 DENTAL PLANS:

A. Applicability. This section applies only to subject dental plans.

B. Definitions. For purposes of this section:

(1) "Dental plan" is a policy, contract, agreement or arrangement under which an entity undertakes to reimburse claims for the cost of dental services and dental supplies.

(2) "Dental service" means a professional service rendered by a person duly licensed under the laws of this state to practice dentistry or dental therapy, or dental hygienists or dental hygienists certified in collaborative practice and any service constituting the practice of dentistry under state law.

C. Required minimum benefits. A dental plan shall, at a minimum, provide each covered person benefits for the following dental services and dental supplies.

(1) Diagnostic services. A dental plan shall cover the following diagnostic services [~~with a waiting period of no longer than six consecutive months~~] with no waiting period:

(a) one clinical oral examination twice per plan year;

(b) clinical oral examinations when performed as a part of an emergency service to relieve pain and suffering.

(2) Radiology services. A dental plan shall cover the following radiology services with a waiting period of no longer than six consecutive months:

(a) Bitewing x-rays at least once a year unless greater frequency is deemed medically necessary; and

(b) Panoramic films or an intraoral-complete series, at least once every five consecutive years.

(3) Preventive services. A dental plan shall cover the following services with no waiting period, subject to the following limitations:

(a) Prophylaxis. A dental plan shall cover at least two prophylaxis services every plan year.

(b) Fluoride treatment. A dental plan shall cover at least one fluoride treatment per calendar year furnished in a health care setting for children up to 14 years old or older as medically necessary.

(c) Molar sealants. A dental plan shall cover one treatment of molar sealant per tooth every five consecutive years as medically necessary. A dental plan may exclude coverage where an occlusal restoration has been completed on the tooth. A dental plan may apply a waiting period of six consecutive months for medically necessary sealants.

(4) Cavities. A dental plan shall cover necessary fillings for cavities. A dental plan may not apply a waiting period for cavity fillings.

[~~**(5)** Craniomandibular and temporomandibular joint disorders. A dental plan sold in conjunction with a qualified health plan shall cover the diagnosis and treatment of craniomandibular and temporomandibular joint disorders, if such coverage is not offered by the qualified health plan.~~]

D. Maximum out-of-pocket. To be certified for sale on New Mexico's health insurance exchange, a dental plan shall comply with any federally mandated maximum out-of-pocket limits for dental plans.

[13.10.35.10 NMAC - N, 01/01/2022; A, 01/01/2024~~07/01/2023~~]

13.10.35.11 VISION PLANS:

A. Applicability. This section only applies to subject vision plans.

B. Definitions. For purposes of this section:

(1) "covered materials" means materials that are reimbursable by a vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation;

(2) "covered services" means services that are reimbursable by a vision plan vision plan to a vision care provider subject to any deductible, copayment, coinsurance, or other plan limitation;

(3) "materials" means ophthalmic devices, including;

(a) lenses;

(b) frames;

(c) contact lenses; and

(d) spectacle or contact lens treatments and coatings;

(4) "noncovered materials" means materials that are not covered by a vision plan;

(5) "noncovered services" means services that are not covered by a vision plan.

(6) "vision services" means services provided by a vision care provider;

(7) "vision plan" is a policy, contract, agreement or arrangement under which an entity undertakes to reimburse claims for the cost of vision services or vision materials; and

(8) "vision care provider" means an individual licensed under state law as an optometrist or ophthalmologist.

C. Required minimum benefits. A vision plan shall provide each covered person benefits for the following vision services and vision materials. [~~A pediatric vision plan sold in conjunction with a qualified health plan shall provide vision coverage mandated by law for the qualified health plan, or the benefits mandated by this rule, whichever are most favorable to the member~~].

(1) Examinations. At least once every consecutive two-year period for adults and once every 12-month consecutive period for children under the age of 19, a comprehensive vision examination. The comprehensive vision examination shall include a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities.

(2) Lenses. If the vision examination indicates that corrective lenses are necessary, each covered person is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, and lenticular as medically necessary and up to the stated benefit limit of the plan. This benefit may be limited to once each two-year consecutive period, unless medical necessity requires increased frequency, and may be subject to a maximum one month waiting period.

(3) Contact lenses shall be covered as follows:

(a) Medically necessary contact lenses shall be covered in full, up to a benefit maximum, subject to prior authorization from the vision plan [~~if dispensed or provided by an in-network provider or vendor.~~]

(b) A vision plan shall provide an elective contact lens allowance up to the stated benefit limit of the plan.

(c) This benefit may be limited to once each 12-month consecutive period, and may be subject to a maximum one month waiting period.

D. Noncovered services and materials. A vision plan may exclude coverage for the following services and materials:

(1) any that are not medically necessary;

(2) any that were not obtained in compliance with the requirements of the vision plan;

(3) any medical or surgical treatment of the eyes;

(4) vision therapy; and

(5) two pairs of glasses in lieu of bifocals.

[13.10.35.11 NMAC - N, 01/01/2022; A, 01/01/2024~~07/01/2023~~]

13.10.35.12 COORDINATION AND COMBINATION OF BENEFITS:

A. A dental or vision plan shall only coordinate or combine benefits as permitted under state or federal law and as specified in the plan.

B. A carrier and plan that offers both dental and vision benefits is subject to both the dental and vision provisions of this rule.

[13.10.35.12 NMAC - N, 01/01/2022]

13.10.35.13 COVERAGE DOCUMENTATION:

A. Coverage forms and benefits disclosures.

(1) A carrier shall issue a policy, certificate of coverage or summary of benefits to each covered person on or before the effective date of coverage or of a change in coverage. Covered groups may distribute a certificate of coverage or summary of benefits on behalf of the carrier.~~A carrier shall issue a policy, certificate of coverage [or summary and schedule of benefits, if issued separately] and a schedule of benefits, to each covered person on or before the effective date of coverage or of change in coverage. Covered groups may distribute a certificate of coverage [or summary of] benefits on behalf of the carrier.~~

(2) The policy, certificate of coverage or [~~summary~~] schedule of benefits shall include a clear and complete statement of:

(a) the covered services, supplies and materials;

(b) any limitations or exclusions including any charge, deductible or copayment feature;

(c) cost sharing features must be written from the perspective of the insured.

[~~**(c)**~~] **(d)** where and in what manner information is available as to how services may be obtained;

[~~**(d)**~~] **(e)** a clear and understandable description of the method for resolving a covered person's complaint.

[~~**(e)**~~] **(f)** **[**~~conditions for renewal and reinstatement~~] a reinstatement provision which states that when premium is not paid within the applicable grace period, a subsequent acceptance of premium by the insurer or their agent without requiring an application for reinstatement, shall reinstate the policy. However, if the insurance company requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application, lacking such approval, upon the thirtieth day following the date of such conditional receipt unless the insurance company has previously notified the insured in writing of its disapproval of such application;

[~~(f)~~] (g) a clear and understandable description of the conditions for renewal;

[~~(g)~~] (h) procedures for filing claims;

[~~(h)~~] (i) statement of the amounts payable to the carrier by a covered person and the times at which the amounts shall be paid;

[~~(i)~~] (j) the period during which the plan is effective; and

[~~(j)~~] (k) on the front page, the identity of the carrier.

(3) Any subsequent change in coverage or premium shall be explained in a separate document delivered to the covered person.

(4) PPO and indemnity plans cannot be combined and must be submitted in separate product filings.

B. Notice required. If the company sends a separate schedule of benefits to the insured, the following language shall be provided [~~in a summary of benefits~~] in the separately issued schedule of benefits: READ YOUR PLAN CAREFULLY - THIS BENEFITS SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU [~~UPON YOUR REQUEST TO US~~].

C. Contact information. The policy, certificate [~~or summary of benefits~~] and schedule of benefits, if issued separately, shall state the plan's contact information and the website and phone number of the office of superintendent of insurance.

D. INSURANCE CARDS: Basic consumer information, including the phone number and website of the insurer's consumer assistance bureau, shall be included on all newly-issued physical or digital insurance cards. Carriers may issue digital cards, but shall provide a physical card upon the request of the consumer~~insurance cards, or, in the alternative, on a separate wallet-sized card that is issued simultaneously with the health insurance card~~.

[13.10.35.13 NMAC - N, 01/01/2022; A, 01/01/2024~~07/01/2023~~]

13.10.35.14 NETWORK ADEQUACY: Each dental or vision plan that in any way conditions coverage on the provision of services by a preferred provider shall maintain an adequate network of such providers:

A. Attestation. A carrier shall submit to the superintendent annually an attestation of compliance with all of the criteria of this section by October 1, 2022 and every year thereafter.

(1) That, in population areas of 50,000 or more residents, two dental or vision care providers are available in any county within no more than 20 miles or 20 minutes' average driving time for ninety percent of the enrolled population, or, in population areas of less than 50,000, whether two dental or vision care providers are available in any county or service area within no more than 60 miles or 60 minutes' average driving time for ninety percent of the enrolled population. For remote rural areas, the superintendent shall consider on a case by case basis whether the dental or vision plan has made sufficient providers available given the number of residents in the county or service area and given the community's standard of care.

(2) That the dental or vision plan provides reasonable and reliable access for its covered persons to qualified health care professionals in those specialties that are covered by the dental or vision plan.

(3) Any major deficiencies in the dental or vision plan's provider network and a description of current activities to remedy network deficiencies.

B. Provider lists. A dental or vision carrier must maintain a list on its website of all providers contracted with the plan.

(1) The list shall be updated monthly and shall;

(a) include specialty providers;

(b) identify the providers who are not currently accepting new patients; and

(c) be available to both covered persons and plan applicants.

(2) The dental or vision plan shall audit its provider list for accuracy on an annual basis.

C. Out of state providers. A carrier is permitted to enter contracts or other arrangements with out of state providers to meet the access requirements of this rule.

D. Provider grievances. A dental or vision carrier shall accept, investigate and resolve provider grievances about plan operations pursuant to 13.10.16 NMAC.

E. Emergency care. If a covered person receives emergency care for a covered dental or vision service specified in this rule and cannot reach a preferred dental or vision provider, as judged by the perspective of a reasonable person in the same or similar circumstances or after prior authorization, the plan shall reimburse the covered person as if the care was provided in-network.

F. Preferred provider arrangements. A dental or vision carrier that delivers services through a preferred provider arrangement shall comply with the preferred provider arrangements law, Section 59A-22A-2 NMSA 1978.

[13.10.35.14 NMAC - N, 01/01/2022]

13.10.35.15 UTILIZATION MANAGEMENT DETERMINATIONS:

A. Denial of services. A benefit denial that is based on a determination that a dental or vision service is not medically necessary, and that is the result of a formal prior authorization review process, shall be supported by a contemporaneous opinion of a provider licensed to provide the requested service. Any such determination shall be made in accordance with medical necessity standards and appropriate clinical guidelines.

B. Pretreatment Estimates. A carrier may issue a non-binding pretreatment estimate for the coverage and reimbursement of proposed dental or vision services. A pretreatment estimate does not determine medical necessity and does not serve as a prior authorization.

(1) A pretreatment estimate shall include a statement that clearly indicates to the covered person that the estimate is not a guarantee of coverage.

(2) A pretreatment estimate shall clearly identify the services that require an approved prior authorization for coverage and shall include a statement that the covered person may be liable for the full cost of the service if an approved prior authorization is not obtained.

C. Timeliness of determinations. A carrier shall make all prior authorization determinations as required by the exigencies of the situation and in accordance with sound medical principles, and in no more than five business days. If after five business days the carrier does not expect to be able to complete the determination due to unforeseen circumstances or missing information, the carrier shall inform the covered person or their provider of the circumstances or the information missing and the need to extend the determination timeframe.

D. Post-authorization denials. A carrier shall not deny any claim subsequently submitted for procedures specifically included in an approved prior authorization unless the date of service is within 18 months and at least one of the circumstances below applies for each denied procedure:

(1) benefit limitations, such as annual maximums and frequency limitations not applicable at the time of prior authorization are reached due to utilization subsequent to the issuance of prior authorization;

(2) documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

(3) if, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would no longer be considered medically necessary based on the prevailing standard of care;

(4) if, after the issuance of the prior authorization, new care is rendered to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued;

(5) another payer is responsible for the payment;

(6) another payer has already paid the claim;

(7) the claim was submitted fraudulently or the prior authorization was based on whole or material part on erroneous information provided to the carrier by the provider, covered person or other person not related to the carrier; or

(8) the person receiving care was not eligible for covered benefits on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known of the person's eligibility status.

E. Notice of denial. If a carrier denies a request for prior authorization, it shall deliver to the covered persons a written explanation of the basis for the denial within 24 hours of the determination for emergency care and within 10 calendar days for all other care.

~~**F. Prior authorization.** If a plan does not require prior authorization, policy document must clearly state that the plan shall not subsequently deny claims on the basis of medical necessity.~~

[13.10.35.15 NMAC - N, 01/01/2022~~; A, 07/01/2023~~]

13.10.35.16 CONSUMER COMPLAINTS: A carrier shall state in all plan documents that a covered person who cannot resolve a complaint with the plan may contact the office of the superintendent of insurance.
[13.10.35.16 NMAC - N, 01/01/2022]

13.10.35.17 PENALTIES: In addition to any applicable suspension, revocation or refusal to continue any certificate of authority or license under the Insurance Code, a penalty for any material violation of this rule may be imposed against a health care insurance carrier by the superintendent in accordance with Sections 59A-1-18 and 59A-46-25 NMSA 1978.
[13.10.35.17 NMAC - N, 01/01/2022]

13.10.35.18 SEVERABILITY: If any section of this rule, or the applicability of any section to any person or circumstance, is for any reason held invalid by a court of competent jurisdiction, the remainder of the rule, or the applicability of such provisions to other persons or circumstances, shall not be affected.
[13.10.35.18 NMAC - N, 01/01/2022]

History of 13.10.35 NMAC: [RESERVED]