

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

13.10.27.1 ISSUING AGENCY: Office of Superintendent of Insurance
[13.10.27.1 NMAC - Rp, 13.10.27.1 NMAC, 06/23/2026]

13.10.27.2 SCOPE: This rule applies to all health care insurers, health maintenance organizations, or health care plans that are required to obtain a certificate of authority or licensure in this state or which provide, offer or administer managed health care plans.
[13.10.27.2 NMAC - Rp, 13.10.27.2 NMAC, 06/23/2026]

13.10.27.3 STATUTORY AUTHORITY: Sections 14-4-1 et seq. NMSA 1978, State Rules Act, and Sections 59A-2-9, 59A-4-3, 59A-22-50, and 59A-23C-10 NMSA 1978.
[13.10.27.3 NMAC - Rp, 13.10.27.3 NMAC, 06/23/2026]

13.10.27.4 DURATION: Permanent.
[13.10.27.4 NMAC - Rp, 13.10.27.4 NMAC, 06/23/2026]

13.10.27.5 EFFECTIVE DATE: June 23, 2026, unless a later date is cited at the end of a section.
[13.10.27.5 NMAC - Rp, 13.10.27.5 NMAC, 06/23/2026]

13.10.27.6 OBJECTIVE: The purpose of this rule is to clarify statutory requirements that insurers issue reimbursement for direct services at certain levels across all health product lines by providing guidance and establishing uniform definitions and standardized methodologies for the calculation of the medical loss ratio for each calendar year of experience utilized in the rate determination process, but never less than the last three calendar years.
[13.10.27.6 NMAC - Rp, 13.10.27.6 NMAC, 06/23/2026]

13.10.27.7 DEFINITIONS: As used in this rule:

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

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

C. "health care plan" has the definition found in Subsection J of Section 59A-47-3 NMSA 1978;

D. "health maintenance organization" has the definition found in Subsection O of Section 59A-46-2 NMSA 1978;

E. "premium" has the definition found in Paragraph (3) of Subsection F of Section 59A-22-50 NMSA 1978;

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

G. "carrier" means health maintenance organization, health care plan, and health insurer;

H. "minimum medical loss ratio" means the percentage determined in accordance with Section 8 of this rule;

I. "health product lines" means:

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

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

(b) all public programs, including all Medicaid and Medicare and any related or future programs or products;

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

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

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

J. "OSI" means the office of superintendent of insurance;

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

L. "blanket health insurance" has the definition found in Subsection A of Section 59A-23-2 NMSA 1978.

[13.10.27.7 NMAC - Rp, 13.10.27.7 NMAC, 06/23/2026]

13.10.27.8 MINIMUM MEDICAL LOSS RATIOS FOR ALL HEALTH PRODUCT LINES:

A. General requirement. Carriers shall meet the minimum medical loss ratio established, in the manner calculated, under this rule. The inclusion of the medical loss ratio for product lines that do not fall under the superintendent's jurisdiction or product lines that adhere to a medical loss ratio requirement addressed in a separate rule is for informational purposes only. If a product line that is subject to a different rule does not meet the loss ratio requirements for that product line, the superintendent will address non-compliance in the filing submitted pursuant to the applicable rule.

B. Measurement period. Compliance with the minimum medical loss ratio shall be measured over a rolling three-year period. The measurement period shall be a rolling three-year period beginning with the three calendar years prior to the effective date of this rule. If a carrier collects no premium in the most recent year of the three-year measurement period, an MLR report will not be required to be submitted by the issuer. For example, if a carrier ceases collecting premium in mid-2026, an MLR report shall be submitted for the measurement period (2024 - 2026) ending in calendar year 2026. However, no report shall be required for the measurement period 2025 - 2027 or beyond.

C. Medical loss ratio. Medical loss ratios shall be calculated on an entity level within a state, with experience allocated to the state based upon the situs of the contract. The experience of each individual carrier shall be submitted to the OSI on a form prescribed by the OSI as posted on the OSI website, including:

- (1) individual health policies;
- (2) small group policies, excluding self-funded plans;
- (3) large group policies, excluding self-funded plans;
- (4) For OSI's informational purposes only:
 - (a) medicare supplement - individual policies;
 - (b) medicare supplement - group policies;
 - (c) dental policies;
 - (d) vision policies;
 - (e) excepted benefits policies other than dental and vision;
 - (f) long-term care policies; and
 - (g) optionally, any other policies not addressed above and not regulated by the

Superintendent including medicaid policies and medicare advantage policies;

D. Frequency. Medical loss ratios shall be calculated annually by carriers that issue products through health product lines.

E. Timeline. Medical loss ratios shall be calculated using claim data incurred during the three-year measurement period and paid before July 31 of the year following the measurement period. No adjustment may be made for incurred but not reported (IBNR) claims. The compliance requirement form set forth in Section 9 of this rule shall be the basis for the medical loss ratio calculation and will be filed with the superintendent by September 30 of the year following the measurement period.

F. Calculation. The numerator of the loss ratio calculation shall be direct services, as defined by this rule less pharmacy rebates and incurred or paid claims associated with self-funded plans and capitated contracts. The denominator of the calculation shall be premium, as defined by this rule less capitated contract premiums, self-funded administrative fees, self-funded claim reimbursements any premium tax paid pursuant to the Insurance Premium Tax Act, and fees associated with participating in a health insurance exchange that serves as a clearinghouse for insurance. This calculation is deemed to be fully credible due to the three-year time period used and the aggregation levels required. The New Mexico reimbursements and medical loss ratios for small group, large group, and all other policies shall be calculated collectively across all health product lines. The federal reimbursements paid or due pursuant to 45 CFR Part 158 shall be subtracted from the New Mexico reimbursement to calculate the final New Mexico reimbursements which cannot be lower than zero.

G. Minimum medical loss ratio levels. The minimum medical loss ratio levels applicable to the policy aggregation in Subsection C of this section shall be as follows:

- (1) the minimum medical loss ratio level for individual health policies shall be eighty percent;
 - (2) the minimum medical loss ratio level for small group policies shall be eighty percent;
- and
- (3) the minimum medical loss ratio level for large group policies shall be eighty-five percent.

H. Compliance with minimum medical loss ratio. With the compliance requirement form set forth in Section 9 of this rule, each carrier shall submit to the superintendent either:

- (1) a statement signed by a qualified actuary that the minimum medical loss ratio requirements have been met; or
- (2) a plan to make the required reimbursements to policyholders, which shall include:
 - (a) the total reimbursement amount;
 - (b) the manner in which the reimbursement will be made (one-time payment or premium credit or in multiple payments or premium credit); and
 - (c) the date by which payment will be made.

I. Actions required upon noncompliance with requirements. The plan to make the required reimbursements to policyholders shall provide either prospective premium credits or reimbursements to each policyholder who was enrolled in the affected segment i.e., individual health policies, small group, or all other policies) during the last year of the measurement period and provide that any such reimbursement for a policyholder be reduced by the amount of any rebate owing to the policyholder for a medical loss ratio reporting year pursuant to 45 CFR Part 158 that coincides with such measurement period.

J. Timing and manner of payment. The premium credits or reimbursement shall be reflected in either a one-time payment or premium credit or in multiple payments or premium credits. Any such credits or reimbursement must be provided no later than the end of December of the year following the applicable measurement period. The deadline for reimbursement may be extended if the premium credits exceed the monthly premiums due by the end of December of the year following the applicable measurement period. Any overage may be applied to succeeding premium payments until the full amount of any reimbursement has been credited. No later than March 31st of the second year following the applicable measurement period the carrier shall demonstrate that the reimbursements in the required amounts have been made or that premium credits are being applied until such time as the full amount on the reimbursement has been credited.

K. Documentation of payment. No later than March 31 of the second year following the applicable measurement period the carrier shall demonstrate in a filing to the superintendent that the reimbursements in the required amounts have been made or that premium credits are being applied until such time as the full amount on the reimbursement has been credited.

(1) The prospective premium credits or reimbursements shall be made on a per subscriber basis, unless an alternative basis is approved by the superintendent of insurance and shown separately on the policyholder's monthly (or other frequency) bill.

(2) This credit may reflect the family composition of the rating structure used for each policyholder.

(3) Any premium credit or reimbursement to policyholders shall be based only upon the medical loss ratios calculated for individual health policies and for small and large group policies.

[13.10.27.8 NMAC - Rp, 13.10.27.8 NMAC, 06/23/2026]

13.10.27.9 COMPLIANCE REQUIREMENT FORM:

- A.** An insurer shall use an OSI approved form to submit minimum loss ratios.

B. The form shall be posted to the OSI website.
[13.10.27.9 NMAC - Rp, 13.10.27.9 NMAC, 06/23/2026

HISTORY OF 13.10.27 NMAC:

13.10.27 NMAC - Uniform Definitions and Standardized Methodologies for Calculating the Medical Loss Ratio, filed 11/30/1012 was repealed and replaced by 13.10.27 NMAC - Uniform Definitions and Standardized Methodologies for Calculating the Medical Loss Ratio, effective 06/23/2026.