NEW MEXICO

ATTACHMENT C

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #: 1421991520000 Grant Award: $1 million

Applicant: The New Mexico Public Regulation Commission

Primary Contact Person, Name: Craig Dunbar, Deputy Superintendent of Insurance

Telephone Number: (505)827-4309 Fax number: (505)827-4734

Email address: craig.dunbar@state.nm.us

APPENDIX 1

NMSA (1978) §59A-23C-5.1 Adjusted community rating. (1998)

A. A health benefit plan that is offered by a carrier to a small employer shall be offered without regard to the health status of any individual in the group, except as provided in the Small Group Rate and Renewability Act [Chapter 59A, Article 23C NMSA 1978]. The only rating factors that may be used to determine the initial year's premium charged a group, subject to the maximum rate variation provided in this section for all rating factors, are the group members':

(1) ages;

(2) genders;

(3) geographic areas of the place of employment; or

(4) smoking practices.

B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than twenty percent of the lower rate, and no person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a carrier from offering rates that differ depending upon family composition.

C. The provisions of this section do not preclude a carrier from using health status or occupational or industry classification in establishing the amount an employer may be charged for coverage under a group health plan.

D. As used in Subsection C of this section, "health status" does not include genetic information.

E. The superintendent shall adopt regulations to implement the provisions of this section.

APPENDIX 2

SB 148 Approved March 9, 2010 - LAWS 2010 Chapter 95

AN ACT
RELATING TO HEALTH INSURANCE; ELIMINATING GENDER AS A HEALTH INSURANCE RATING FACTOR.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Chapter 95 Section 1 Laws 2010

Section 1. Section 59A-18-13.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 26, as amended) is amended to read:

"59A-18-13.1. ADJUSTED COMMUNITY RATING.--

A. Every insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan that provides primary health insurance or health care coverage insuring or covering major medical expenses shall, in determining the initial year's premium charged for an individual, use only the rating factors of age, gender pursuant to Subsection B of this section, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment.

B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:

(1) twenty percent for calendar year 2010;

(2) fifteen percent for calendar year 2011;

(3) ten percent for calendar year 2012; and

(4) five percent for calendar year 2013.

C. No person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan from offering rates that differ depending upon family composition.

D. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit health care plan from using health status or occupational or industry classification in establishing:

(1) rates for individual policies; or

(2) the amount an employer may be charged for coverage under the group health plan.

E. As used in Subsection D of this section, "health status" does not include genetic information.

F. The superintendent shall adopt regulations to implement the provisions of this section."

Chapter 95 Section 2 Laws 2010

Section 2. Section 59A-23B-1 NMSA 1978 (being Laws 1991, Chapter 111, Section 1) is amended to read:

"59A-23B-1. SHORT TITLE.--Chapter 59A, Article 23B NMSA 1978 may be cited as the "Minimum Healthcare Protection Act"."

Chapter 95 Section 3 Laws 2010

Section 3. Section 59A-23B-6 NMSA 1978 (being Laws 1991, Chapter 111, Section 6, as amended) is amended to read:

"59A-23B-6. FORMS AND RATES--APPROVAL OF THE SUPERINTENDENT--ADJUSTED COMMUNITY RATING.--

A. All policy or plan forms, including applications, enrollment forms, policies, plans, certificates, evidences of coverage, riders, amendments, endorsements and disclosure forms, shall be submitted to the superintendent for approval prior to use.

B. No policy or plan may be issued in the state unless the rates have first been filed with and approved by the superintendent. This subsection shall not apply to policies or plans subject to the Small Group Rate and Renewability Act.

C. In determining the initial year's premium or rate charged for coverage under a policy or plan, the only rating factors that may be used are age, gender pursuant to this subsection, geographic area of the place of employment and smoking practices, except that for individual policies the rating factor of the individual's place of residence may be used instead of the geographic area of the individual's place of employment. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:

(1) twenty percent for calendar year 2010;

(2) fifteen percent for calendar year 2011;

(3) ten percent for calendar year 2012; and

(4) five percent for calendar year 2013.

D. No person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit an insurer, society, organization or plan from offering rates that differ depending upon family composition.

E. The provisions of this section do not preclude an insurer, fraternal benefit society, health maintenance organization or nonprofit healthcare plan from using health status or occupational or industry classification in establishing:

(1) rates for individual policies; or

(2) the amount an employer may be charged for coverage under a group health plan.

F. As used in Subsection E of this section, "health status" does not include genetic information.

G. The superintendent shall adopt regulations to implement the provisions of this section."

Chapter 95 Section 4 Laws 2010

Section 4. Section 59A-23C-5.1 NMSA 1978 (being Laws 1994, Chapter 75, Section 33, as amended) is amended to read:

"59A-23C-5.1. ADJUSTED COMMUNITY RATING.--

A. A health benefit plan that is offered by a carrier to a small employer shall be offered without regard to the health status of any individual in the group, except as provided in the Small Group Rate and Renewability Act. The only rating factors that

may be used to determine the initial year's premium charged a group, subject to the maximum rate variation provided in this section for all rating factors, are the group members':

(1) ages;

(2) genders pursuant to Subsection B of this section;

(3) geographic areas of the place of employment; or

(4) smoking practices.

B. In determining the initial and any subsequent year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rate in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:

(1) twenty percent for calendar year 2010;

(2) fifteen percent for calendar year 2011;

(3) ten percent for calendar year 2012; and

(4) five percent for calendar year 2013.

C. No person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen or children aged nineteen to twenty-five who are full-time students may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a carrier from offering rates that differ depending upon family composition.

D. The provisions of this section do not preclude a carrier from using health status or occupational or industry classification in establishing the amount an employer may be charged for coverage under a group health plan.

E. As used in Subsection D of this section, "health status" does not include genetic information.

F. The superintendent shall adopt regulations to implement the provisions of this section."

Chapter 95 Section 5 Laws 2010

Section 5. Section 59A-56-6 NMSA 1978 (being Laws 1994, Chapter 75, Section 6, as amended) is amended to read:

"59A-56-6. BOARD--POWERS AND DUTIES.--

A. The board shall have the general powers and authority granted to insurance companies licensed to transact health insurance business under the laws of this state.

B. The board:

(1) may enter into contracts to carry out the provisions of the Health Insurance Alliance Act, including, with the approval of the superintendent, contracting with similar alliances of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

(2) may sue and be sued;

(3) may conduct periodic audits of the members to assure the general accuracy of the financial data submitted to the alliance;

(4) shall establish maximum rate schedules, allowable rate adjustments, administrative allowances, reinsurance premiums and agent referral, servicing fees or commissions subject to applicable provisions in the Insurance Code. In determining the initial year's rate for health insurance, the only rating factors that may be used are age, gender pursuant to this section, geographic area of the place of employment and smoking practices. In any year's rate, the difference in rates in any one age group that may be charged on the basis of a person's gender shall not exceed another person's rates in the age group by more than the following percentage of the lower rate for policies issued or delivered in the respective year; provided, however, that gender shall not be used as a rating factor for policies issued or delivered on or after January 1, 2014:

(a) twenty percent for calendar year 2010;

(b) fifteen percent for calendar year 2011;

(c) ten percent for calendar year 2012; and

(d) five percent for calendar year 2013.

No person's rate shall exceed the rate of any other person with similar family composition by more than two hundred fifty percent of the lower rate, except that the rates for children under the age of nineteen may be lower than the bottom rates in the two hundred fifty percent band. The rating factor restrictions shall not prohibit a member from offering rates that differ depending upon family composition;

(5) may direct a member to issue policies or certificates of coverage of health insurance in accordance with the requirements of the Health Insurance Alliance Act;

(6) shall establish procedures for alternative dispute resolution of disputes between members and insureds;

(7) shall cause the alliance to have an annual audit of its operations by an independent certified public accountant;

(8) shall conduct all board meetings as if it were subject to the provisions of the Open Meetings Act;

(9) shall draft one or more sample health insurance policies that are the prototype documents for the members;

(10) shall determine the design criteria to be met for an approved health plan;

(11) shall review each proposed approved health plan to determine if it meets the alliance-designed criteria and, if it does meet the criteria, approve the plan; provided that the board shall not permit more than one approved health plan per member for each set of plan design criteria;

(12) shall review annually each approved health plan to determine if it still qualifies as an approved health plan based on the alliance-designed criteria and, if the plan is no longer approved, arrange for the transfer of the insureds covered under the formerly approved plan to an approved health plan;

(13) may terminate an approved health plan not operating as required by the board;

(14) shall terminate an approved health plan if timely claim payments are not made pursuant to the plan; and

(15) shall engage in significant marketing activities, including a program of media advertising, to inform small employers and eligible individuals of the existence of the alliance, its purpose and the health insurance available or potentially available through the alliance.

C. The alliance is subject to and responsible for examination by the superintendent. No later than March 1 of each year, the board shall submit to the superintendent an audited financial report for the preceding calendar year in a form approved by the superintendent."

Senate Bill 148
Approved March 9, 2010

APPENDIX 3

NMSA (1978) §59A-18-14 Grounds, procedure for disapproval. (1987)

A. The superintendent shall review any filing made pursuant to Section 59A-18-12 or 59A-18-13 NMSA 1978 within sixty days of the filing date. The superintendent shall approve any form or rate if he finds that it complies with the Insurance Code, and disapprove any form or rate only on any one or more of the following grounds:

(1) if the form is in any respect in violation of or does not comply with the Insurance Code;

(2) if the form contains, or incorporates by reference where such incorporation is otherwise permissible, any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract, or which encourages misrepresentation of the policy or its benefits;

(3) if the benefits offered are unreasonably restricted in relation to the premium charged;

(4) if the form has any title, heading or other indication of its provisions which is misleading, or if the form is printed in such type or manner of reproduction as to be difficult to read; or

(5) if purchase of the form is being solicited by advertising, communication or dissemination of information which is deceptive or misleading.

B. If the superintendent disapproves any such form during the sixty-day review period, he shall give the insurer written notice of the disapproval, stating the grounds therefor.

C. After expiration of the sixty-day review period referred to in Section 59A-18-13 NMSA 1978 [Subsection A of this section], or at any time after having approved a form, the superintendent may, after a hearing thereon, disapprove a form or withdraw a previous approval on any of the grounds stated in Subsection A of this section. The superintendent's order issued on such hearing shall state the grounds for disapproval or withdrawal of previous approval and the date, not less than twenty days after the date of the order, when disapproval or withdrawal of approval shall become effective.

APPENDIX 4

NMSA (1978) §59A-18-12 Filing of forms and classifications; review of effect upon insured. (2009)

A. An insurance policy or annuity contract shall not be delivered or issued for delivery in this state, nor shall an assumption certificate, endorsement, rider or application that becomes a part of a policy be used, until a copy of the form and the classification of risks pertaining to the policy have been filed with the superintendent. A filing shall be made at least sixty days before its proposed effective date. A filing made pursuant to this section shall not become effective nor shall it be used until approved by the superintendent pursuant to Section 59A-18-14 NMSA 1978, at which time it may be used. A filing for any kind of insurance other than life insurance or health insurance, as defined in the Insurance Rate Regulation Law [59A-17-1 NMSA 1978], shall be deemed to meet the requirements of Chapter 59A, Article 18 NMSA 1978 to become effective unless disapproved pursuant to Section 59A-18-14 NMSA 1978 by the superintendent before the expiration of the waiting period or an extension of the waiting period. Provided, that:

(1) this subsection shall not apply as to policies, contracts, endorsements or riders of unique and special character not for general use or offering but designed and used solely as to a particular insured or risk;

(2) if the superintendent has exempted a person or a class of persons or a market segment from a part or all of the provisions of the Insurance Rate Regulation Law pursuant to Subsection C of Section 59A-17-2 NMSA 1978, the superintendent also may exempt by rule that person, class of persons or market segment from a part or all of the provisions of this subsection;

(3) an insurer subject to the Insurance Rate Regulation Law may authorize an advisory organization to file policy forms, endorsements and other contract language and related attachment rules on its behalf. Reference filings shall be made prior to their use or by other methods the superintendent may allow by rule; and

(4) the superintendent may, by rule, exempt various lines and kinds of commercial insurance, as defined in the Insurance Rate Regulation Law, from some or all of the requirements of this subsection.

B. A workers' compensation insurance policy covering a risk arising from the employment of a worker performing work for an employer in New Mexico when that employer is not domiciled in New Mexico shall not be issued or become effective, nor shall any endorsement or rider covering such a risk be issued or become effective, until a copy of the form and the classification of risks pertaining thereto have been filed with the superintendent.

C. An insured may in writing request the insurer to review the manner in which its filing has been applied as to insurance afforded the insured. If the insurer fails to make a review and grant appropriate relief within thirty days after the request is received, the insured may file a written complaint and request for a hearing with the superintendent, stating grounds relied upon. If the complaint charges a violation of the Insurance Code and the superintendent finds that the complaint was made in good faith and that the

insured would be aggrieved if the violation is proved, the superintendent shall hold a hearing, with notice to the insured and insurer stating the grounds of complaint. If upon the hearing the superintendent finds the complaint justified, the superintendent shall order the insurer to correct the matter complained of within a reasonable time specified but not less than twenty days after a copy of the order was mailed to or served upon the insurer.

D. All filings submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

APPENDIX 5

NMSA (1978) §59A-18-13 Approval or disapproval of health insurance forms. (2009)

A. With policy, endorsement, rider and application forms and classification of risks filed by the insurer with the superintendent under Section 59A-18-12 NMSA 1978 as to health insurance, the insurer shall also file with the superintendent its premium rates applicable to such health insurance forms. An insurer shall not use any such form or premium that has not been approved by the superintendent or that is not in effect in accordance with Section 59A-18-14 NMSA 1978.

B. An increase in a health insurance premium shall not be effective without sixty days' written notice to the policyholder.

C. All filings submitted pursuant to this section shall be filed electronically. The superintendent may designate an entity to receive the electronic filings submitted pursuant to this section.

APPENDIX 6

NMSA (1978) § 14-2-8 Procedures for Requesting Records

A. Any person wishing to inspect public records may submit an oral or written request to the custodian. However, the procedures set forth in this section shall be in response to a written request. The failure to respond to an oral request shall not subject the custodian to any penalty.

B. Nothing in the Inspection of Public Records Act [14-2-4 NMSA 1978] shall be construed to require a public body to create a public record.

C. A written request shall provide the name, address and telephone number of the person seeking access to the records and shall identify the records sought with reasonable particularity. No person requesting records shall be required to state the reason for inspecting the records.

D. A custodian receiving a written request shall permit the inspection immediately or as soon as is practicable under the circumstances, but not later than fifteen days after receiving a written request. If the inspection is not permitted within three business days, the custodian shall explain in writing when the records will be available for inspection or when the public body will respond to the request. The three-day period shall not begin

until the written request is delivered to the office of the custodian.

E. In the event that a written request is not made to the custodian having possession of or responsibility for the public records requested, the person receiving the request shall promptly forward the request to the custodian of the requested public records, if known, and notify the requester. The notification to the requester shall state the reason for the absence of the records from that person's custody or control, the records' location and the name and address of the custodian.

F. For the purposes of this section, "written request" includes an electronic communication, including email or facsimile; provided that the request complies with the requirements of Subsection C of this section.

APPENDIX 7 (Submitted Separately)

APPENDIX 8

NMSA (1978) § 59A-4-15 Hearings; in general

A. The superintendent may hold a hearing, without request by others, for any purpose within the scope of the Insurance Code.

B. The superintendent shall hold a hearing:

(1) if required by any other provision of the Insurance Code; or

(2) upon written request for a hearing by a person aggrieved by any act, threatened act or failure of the superintendent to act or by any report, rule, regulation or order of the superintendent, other than an order for the holding of a hearing or order on hearing or pursuant to such an order on a hearing of which such person had notice.

C. The request for a hearing shall briefly state the respects in which the applicant is so aggrieved, the relief to be sought and the grounds to be relied upon as basis for relief.

D. If the superintendent finds that the request is made in good faith, that the applicant would be so aggrieved if the stated grounds are established and that such grounds otherwise justify the hearing, the superintendent shall commence the hearing within ninety days after filing of the request, unless postponed by mutual consent.

E. Pending the hearing and decision thereon, the superintendent may suspend or postpone the effective date of the action as to which the hearing is requested. If upon request the superintendent refuses to grant such suspension or postponement, the person requesting the hearing may apply to the district court of Santa Fe county for a stay of the superintendent's action or proposed action pending the hearing and the superintendent's order thereon.

F. Except as otherwise expressly provided, this section does not apply to hearings relative to matters arising under Chapter 59A, Article 17 NMSA 1978.

APPEDIX 8 & 9 (Submitted Separately).

Health Care Insurance Premium Budget Narrative

Overall Budget

The New Mexico Insurance Division's total budget for fiscal year 2011 is $17,612,300 which is funded from various insurance fees, assessments and physician's surcharges. $5,404,900 of this overall budget is allocated to fund the insurance operation cost center.

Budget Breakdown

Assessments are collected to fund the Insurance Fraud and Title Insurance Bureaus. In Fiscal Year 2011, $1,062,600 has been appropriated for the Insurance Fraud Bureau and $315,600 for the Title Insurance Bureau. The Patients' Compensation Fund is funded through physician's surcharge and for State Fiscal Year 2011 the approved budget is $10,829,200. The total revenue collected by the Insurance Division for fiscal year 2010 was over $240,000,000, most of which was derived from premium taxes and becomes state revenue as part of the general fund.

Currently there are two staff members, Life and Health Actuary and an Actuarial Assistant that are responsible for reviewing life and health rates. DOI expends $239,711.00 annually on salaries and employee benefits for both of these two positions. These two positions spend an average of 30 percent of their time on rate reviews.

Breakdown of Proposed Budget and Allocation

Activity	Proposed Allocation
Personnel	230,000.00
Fringe Benefits	70,000.00
Travel	12,000.00
Equipment	35,000.00
Supplies	8,000.00
Contractual	625,000.00
Other	20,000.00

NEW MEXICO PUBLIC REGULATION COMMISSION

To: Office of Consumer Information and Insurance Oversight July 2, 2010

RE: Health Care Insurance Premium Review Cycle 1 Grant Proposal

The New Mexico Public Regulation Commission (NMPRC) regulates utilities, motor carriers and insurance industries to ensure fair and reasonable rates, and to assure reasonable and adequate services to the public as provided by law.

Under the NMPRC, the Division of Insurance's main role is to provide consumers convenient access to reliable insurance products which are underwritten by dependable and financially sound companies. We strive to ensure that these companies have a history of fair and reasonable rates and are represented by fair and trustworthy and qualified agents. We are committed to consumer protection and fraud prosecution and deterrence.

Therefore, the Public Regulation Commission through its Division of Insurance (DOI), is applying for the above captioned Grant with the endorsement of New Mexico Governor Bill Richardson. The DOI will manage and coordinate the activities of the Grant through its assigned Task Force, which designed the attached plan.

Designated Project Manager shall be:
Craig Dunbar, Chief Deputy Superintendent of Insurance
New Mexico Department of Insurance
1120 Paseo de Peralta
Santa Fe, New Mexico 87504
(505)827-8115
Craig.dunbar@state.nm.us

Respectfully Submitted,

Craig Dunbar
Deputy Superintendent of Insurance
New Mexico Department of Insurance

NAIC

National Association of Insurance Commissioners

Model # 134

Guidelines for Filing of Rates for Individual Health Insurance Forms

Regulator Use

NAIC
National Association of Insurance Commissioners

The NAIC is the authoritative source for insurance industry information. Our expert solutions support the efforts of regulators, insurers and researchers by providing detailed and comprehensive insurance information. The NAIC offers a wide range of publications in the following categories:

Accounting & Reporting
Accountants, members of the insurance industry and educators will find relevant information about statutory accounting practices and procedures.

Consumer Information
Consumers, educators and members of the insurance industry will find important answers to common questions in guides about auto, home, health and life insurance.

Financial Regulation
Accountants, financial analysts and lawyers will find handbooks, compliance guides and reports on financial analysis, state audit requirements and receiverships.

Legal
State laws, regulations and guidelines apply to members of the legal and insurance industries.

NAIC Activities
Insurance industry members will find directories, newsletters and reports affecting NAIC members.

Special Studies
Accountants, educators, financial analysts, members of the insurance industry, lawyers and statisticians will find relevant products on a variety of special topics.

Statistical Reports
Insurance industry data directed at regulators, educators, financial analysts, insurance industry members, lawyers and statisticians.

Supplementary Products
Accountants, educators, financial analysts, insurers, lawyers and statisticians will find guidelines, handbooks, surveys and NAIC positions on a wide variety of issues.

Securities Valuation Office
Provides insurers with portfolio values and procedures for complying with NAIC reporting requirements.

White Papers
Accountants, members of the insurance industry and educators will find relevant information on a variety of insurance topics.

For more information about NAIC publications, view our online catalog at:

http://store.naic.org

Printed in the United States of America

NAIC Executive Office
444 North Capitol Street NW, Suite 701
Washington, DC 20001
202.471.3990

NAIC Central Office
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662
816.842.3600

NAIC Securities Valuation Office
48 Wall Street, 6th Floor
New York, NY 10005-2906
212.398.9000

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

Table of Contents

Section 1. General

A. Every policy, rider or endorsement form affecting benefits that is submitted for approval shall be accompanied by a rate filing unless the rider or endorsement form does not require a change in the rate. Any subsequent addition to or change in rates applicable to the policy, rider or endorsement shall also be filed.

B. General Contents of All Rate Filings

The purpose of this guideline, including its Appendix, is to provide appropriate guidelines for the submission and the filing of individual health insurance rates and to establish standards for determining the reasonableness of the relationship of benefits to premiums. Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called "anticipated loss ratio," of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Interest shall be used in the calculation of this loss ratio. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary's knowledge and judgment the entire rate filing is in compliance with the applicable laws and regulations of the state to which it is submitted and that the benefits are reasonable in relation to premiums.

Drafting Note: Assumptions applying to the future "period for which rates are computed" should be reasonable in relation to the circumstances. For example, if future rates of inflation are a major factor, the period of projection of such rates normally should be short, such as three to five years only. Other assumptions, however, may still appropriately apply over the entire future policy renewal period, particularly in cases where the basic rate structure is one of level premiums based on original issue age.

C. Previously Approved Forms

Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

(1) A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form;

(2) A statement as to whether the filing applies only to new business, only to in force business, or both, and the reasons therefore;

(3) A history of the experience under existing rates, including at least the data indicated in Section 1D. The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to

the assumptions underlying the existing rates. Additional data might include: substitution of actual claim run-offs for claim reserves and liabilities, determination of loss ratios with the increase in policy reserves subtracted from premiums rather than added to benefits, accumulation of experience fund balances, substitution of net level policy reserves for preliminary term policy reserves, reserve adjustments arising because of select period loss experience, adjustment of premiums to an annual mode basis, or other adjustments or schedules suited to the form and to the records of the company. All additional data shall be reconciled, as appropriate, to the required data; and

(4) The date and magnitude of each previous rate change, if any.

D. Experience Records

(1) Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms that are used with the policy form, on the same basis, including all reserves, as required for the Accident and Health Policy Experience Exhibit. Separate data may be maintained for each rider of endorsement form to the extent appropriate. Subject to approval of the commissioner, experience under forms that provide substantially similar coverage and provisions that are issued to substantially similar risk classes and that are issued under similar underwriting standards, may be combined for purposes of evaluating experience data in relation to premium rates and rate revisions, particularly where statistical credibility would be materially improved by the combination. Once such a combining of forms is adopted, however, the insurer may not afterward again separate the experience, except with approval of the commissioner.

(2) The data shall be for all years of issue combined and for each calendar year of experience utilized in the rate determination process (but never less than the last three years). For example, for policies originally filed under this guideline, experience since inception would be required because of the utilization of the rule in Section 2B(2)(b)(ii). Here, it is permissible to combine experience for calendar years prior to the most recent five.

E. Evaluating Experience Data

In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

(1) Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency;

(2) Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience;

(3) The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios

are expected to be substantially lower than at later policy durations. Where this consideration is pertinent, ratios of actual to expected claims, on a select basis, will often be appropriate for an adequate evaluation; and

(4) The mix of business by risk classification.

Section 2. Reasonableness of Benefits in Relation to Premiums

A. New Forms

(1) With respect to a new form under which the average annual premium as defined in Paragraph (5) below, is expected to be at least as large as the maximum $X in Paragraph (3) below but not more than the minimum $X in Paragraph (4) below, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause			
	OR	CR	GR	NC
Medical Expense	60%	55%	55%	50%
Loss of Income and Other	60%	55%	50%	45%

(2) Definitions of Renewal Clause

OR - Optionally Renewable: renewal is at the option of the insurance company.

CR - Conditionally Renewable: renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health.

GR - Guaranteed Renewable: renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC - Non-Cancelable: renewal cannot be declined nor can rates be revised by the insurance company.

(3) Low Average Premium Forms

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is low (as defined below), the appropriate ratio from the table above should be adjusted downward by the following formula:

$$RN = R \times \frac{(I \times 500) + X}{(I \times 750)}$$

Where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor
X is the average annual premium up to a maximum of I .250.

The factor I is determined as follows:

$$I = \frac{\text{CPI-U, Year (N-1)}}{\text{CPI-U, (1982)}} = \frac{\text{CPI-U, Year (N-1)}}{293.3}$$

where:

(a) (N-1) is the calendar year immediately preceding the calendar year (N) in which the rate filing is submitted in the state;

(b) CPI-U is the consumer price index for all urban consumers, for all items, and for all regions of the U.S. combined, as determined by the U.S. Department of Labor, Bureau of Labor Statistics;

(c) The CPI-U for any year (N-1) is taken as the value of September. For 1982, this value was 293.3;

(d) Hence, for rate filings submitted during calendar year 1983, the value of I is 1.00.

(4) High Average Premium Forms

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is high (as defined below), the appropriate ratio from the table above should be adjusted upward by the following formula:

$$RN = R \times \frac{(I \times 4000) + X}{(I \times 5500)}$$

Where: R is the table ratio
RN is the resulting guideline ratio
I is the consumer price index factor (as defined in Paragraph (3) above), or

X is an average annual premium exceeding I . 1500.

In no event, however, shall RN exceed the lesser of:

(a) R + 5 percentage points, or

(b) 63%.

(5) Determination of Average Premium

The average annual premium per policy shall be estimated by the insurer based on an anticipated distribution of business by all significant criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The value of X should be determined on the basis of the rates being filed. Thus, where this adjustment is applicable to a rate revision under Section 2B of these guidelines, rather than to a new form, X should be determined on the basis of anticipated average size premium immediately after the revised rates have fully taken effect.

(6) Medicare Supplement Forms

For Medicare supplement policies, benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least sixty percent (60%).

(7) Conflict with Specific Statutes or Regulations

The above anticipated loss ratio standards do not apply to a class of business where the standards are in conflict with specific statutes or regulations.

(8) Forms with Indexing of Benefits

Certain policy forms provide for automatic indexing of benefits in relation to some base that is not subject to control by the insurer or the insured. Medicare supplement plans under which benefits automatically adjust in response to changes in the Part A or Part B deductibles under federal Medicare are a common example. Other possibilities exist, under disability income, major medical and other forms of coverage.

In such cases, the insurer should be permitted to file rates on a basis that provides for automatic adjustment of premiums, on an actuarial basis appropriate in relation to the automatic adjustment in the benefits. While such premium adjustment would thus be considered "pre-filed," to apply "automatically," it should nevertheless be subject to ongoing monitoring of the continuing loss experience and there should be some agreement with the insurer that the commissioner may require, from time to time, renewed justification that the automatic premium adjustments remain appropriate and reasonable.

B. Rate Revisions

(1) With respect to filing of rate revisions for a previously approved form, or a group of previously approved forms combined for experience, benefits shall be deemed reasonable in relation to premiums, provided the revised rates meet the standards applicable to the prior rate filing for the form or forms.

In general, the rule that applies is that any rate revision is subject to the guideline basis under which the previous rates were filed (with consideration of all relevant rating factors: morbidity, expenses, persistency, interest, etc.), and to those regulatory guidelines, if any, that were in effect at the time of the filing. Where there was no written guideline applicable to the prior rate filing, the regulatory benchmark then generally recognized, such as the 1953 NAIC benchmark (1953 *Proceedings of the NAIC*, Vol. II, p. 542), will continue to govern rate revisions of the prior rate filings.

(2) With respect to filings of rate revisions for a form approved subject to these guidelines, benefits will be deemed reasonable in relation to premiums provided both the following loss ratios meet the standards in Section 2A of these guidelines:

(a) The anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage;

Drafting Note: Assumptions applying to the future "period for which rates are computed" should be reasonable in relation to the circumstances. For example, if future rates of inflation are a major factor, the period of projection of such rates normally should be short, such as three to five years only. Other assumptions, however, may still appropriately apply over the entire future policy renewal period, particularly in cases where the basic rate structure is one of level premiums based on original issue age.

(b) The lifetime anticipated loss ratio derived by dividing (i) by (ii) where (i) is the sum of the accumulated benefits from the original effective date of the form to the effective date of the revision, and the present value of future benefits, and (ii) is the sum of the accumulated premiums from the original effective date of the form to the effective date of the revision, and the present value of future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and the accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

C. Anticipated loss ratios lower than those indicated in Subsection B(2)(a) and (2)(b) will require justification based on the special circumstances that may be applicable.

(1) Examples of coverages requiring special consideration are as follows:

(a) Accident only;

(b) Short term non-renewable, e.g., airline trip, student accident;

(c) Specified peril, e.g., cancer, common carrier;

(d) Other special risks.

(2) (a) Examples of other factors requiring special consideration are as follows:

(i) Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;

(ii) Extraordinary expenses, or, in the case of a rate increase, expenses in excess of those expected under the previous rate filing;

(iii) High risk of claim fluctuation because of the low loss frequency or the catastrophic, or experimental nature of the coverage;

(iv) Product features such as long elimination periods, high deductibles and high maximum limits; and

(v) The industrial or debit method of distribution.

(b) Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing exceptionally large rate increases.

Appendix. Rate Filing Guidelines

A basic actuarial requirement in the establishment of a premium rate scale is that the benefits provided be reasonable in relation to premiums. This requirement has been incorporated in the statutes of many jurisdictions and in the regulations and operating rules, formal and informal, of the insurance departments of probably all jurisdictions.

One of the principal objectives of these guidelines is to establish a basis for assisting both those filing rates and those responsible for regulatory review of filings in deciding whether a premium rate filing meets this requirement.

The individuals who drafted these guidelines recognized that the guidelines would be applicable to the wide range of products marketed by a diversity of methods under the general title "Individual Health Insurance." For this reason, they decided it would be inappropriate to establish rigid rules or inflexible standards. It should be recognized, therefore, that the guidelines are intended to be only guidelines, and they must be interpreted and applied flexibly.

Section 2A of the guidelines includes a table of numerical values representing loss ratios that "shall be deemed reasonable in relation to premium." This "deemer level" of loss ratio is meant to be the initial guideline test for establishing the reasonableness of the premiums in relation to benefits. Satisfying this test establishes that the premiums are reasonable in relation to benefits. However, premium rates not meeting this test may still have benefits that are reasonable in relation to premiums based on further considerations.

Other parts of Section 2, and particularly Subsection C, give examples of situations where considerations beyond the initial test would be appropriate in determining the reasonableness of premiums in relation to benefits.

Although expenses are not addressed in detail in the guidelines, the variations in loss ratio benchmarks by average annual premiums per policy is clearly intended to provide for the fact that a substantial amount of general expense is not a function of premium but is flat per policy. Thus, the

guidelines intend to make realistic provision for actual expenses as incurred. As inflation causes unit expenses to rise, despite the gains from improved productivity through greater mechanization, etc., the possibility of lower loss ratios may have to be confronted for some forms.

One of the purposes of Section 1 of the guidelines is to set the requirements for rate filings. The usefulness of this section is enhanced by showing herein the minimum requirements as to the documentation of these rate filings.

In developing the checklist below, consideration was merely given to pointing out some of the factors that may be involved in calculating the rates, e.g., interest, mortality, morbidity, selection, lapse, expenses, inflation, etc., and spell out how those factors might be used in such calculations. It was felt, however, that this approach would produce details not always necessary to justify or review the rate filing while leaving out possibly essential information.

The checklists are separate for filing of rates for a new product and filing of rate increases.

Checklist of Items to be included in Individual Health Insurance Rate Filing Submissions

Rates for a New Product

I. Policy Form, application, and endorsements required by State Law.

II. Rate Sheet

III. Actuarial Memorandum

A. Brief description of the type of policy, benefits, renewability, general marketing method, and issue age limits.

B. Brief description of how rates were determined, including the general description and source of each assumption used. For expenses, include percent of premium, dollars per policy or dollars per unit of benefit, or both.

C. Estimated average annual premium per policy.

D. Anticipated loss ratio, including a brief description of how it was calculated.

E. Anticipated loss ratio presumed reasonable according to the guidelines.

F. If Subsection D is less than Subsection E, supporting documentation for the use of the proposed premium rates.

G. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

[IV. A statement as to the status of this rate filing in the company's home state.]

Rate Increases for an Existing Product for which Rates are Subject to this Guideline

I. New Rate Sheet

II. Actuarial Memorandum

A. Brief description of the type of policy, benefits, renewability, general marketing method and issue age limits.

B. Scope and reason for rate revision including a statement of whether the revision applies only to new business, only to in force business, or to both, and outline of all past rate increases on this form.

C. Estimated average annual premium per policy, before and after rate increase. Descriptive relationship of proposed rate scale to current rate scale.

D. Past experience, as specified in Section 2D of the guidelines, any other available data the insurer may wish to provide.

E. Brief description of how revised rates were determined, including the general description and source of each assumption used. For expenses, include percent of premium, dollars per policy, or dollars per unit of benefit, or both.

F. The anticipated future loss ratio and description of how it was calculated.

G. The anticipated loss ratio that combines cumulative and future experience, and description of how it was calculated.

H. Anticipated loss ratio presumed reasonable according to the guidelines.

I. If Subsection F or G is less than Subsection H, supporting documentation for the use of such premium rates.

J. Certification by a qualified actuary that, to the best of the actuary's knowledge and judgment, the rate submission is in compliance with the applicable laws and regulations of the state and the benefits are reasonable in relation to the premiums.

The test in Section 2B(2) is an innovation of these guidelines. It seems appropriate, therefore, that this appendix include an example of how it works.

The first test in Section 2B(2)(a) is the same for a new form, new business on an existing form, or experience on existing business following a rate revision. Suppose that we are talking about an OR form with an average annual premium exceeding $X, defined in the guidelines, and the new rates are originally set to provide the benchmark loss ratio of sixty percent (60%).

When the new rates are applied to existing business in force and we calculate the present value of future premiums and benefits, we obtain the following results.

Table 1 - Future Projection

	Present Value at Current Volume from next year anniversaries
Premiums	$30,000,000
Benefits	18,000,000
Loss Ratio	.60

Then we look at the accumulated experience for the past. Suppose it can be summarized as follows: The poor recent experience has prompted the need for the current increase request.

Table 2 - Accumulated Experience

	Prior to 3 years	Last 3 years	From last year end to next anniversary	Total
Premiums	$50,000,000	$10,000,000	$10,000,000	$70,000,000
Benefits	20,000,000	9,000,000	11,000,000	40,000,000
Loss Ratio	.400	.900	1.100	.571

When the accumulated and present value figures are combined, the following results appear.

Table 3 - Combined Experiences

	Accumulated	Present Value	Total
Premiums	$70,000,000	$30,000,000	$100,000,000
Benefits	40,000,000	18,000,000	58,000,000
Loss Ratio	.571	.600	.580

The test in Section 2B(2)(b) is not met.

With respect to future premiums on the existing volume, the rates proposed must be reduced so that the .58 result is increased to .60. Since the benefits are what they are and the present value is settled, we can work backwards to determine that the total premiums must be $96,666,667 ($58,000,000 - .60). Thus the present value of future premiums must be $26,666,667 and the proposed rates, applicable to new business, must be reduced by one-ninth, with respect to the existing volume. The new table which meets the Section 2B(2)(b) test is as follows.

Table 4 - Revised Combined Experiences

	Accumulated	Present Value	Total
Premiums	$70,000,000	$26,666,667	$96,666,667
Benefits	40,000,000	18,000,000	58,000,000
Loss Ratio	.571	.675	.600

The next rate increase request will depend on how experience develops, if the company wishes to charge the same rates for new business and renewal, one way it could do so would be by reducing the rates otherwise proposed for new business. An alternative approach would be to combine the experience under new and existing business in a similar analysis to arrive at a single rate structure applying to both.

If the early experience under the form was poor, the losses would not be recoverable. Suppose, for instance, that only the last three years and the estimate for the last year-end to the next year's anniversary in the above example existed and the proposed new business rates applied. Then, the following test from Section 2B(2)(b) appears:

Table 5 - Alternate Combined Experiences

	Accumulated	Present Value	Total
Premiums	$20,000,000	$30,000,000	$50,000,000
Benefits	20,000,000	18,000,000	38,000,000
Loss Ratio	1.000	.600	.760

While the present value of future premiums could be increased under the Section 2B(2)(b) test to recover past losses and still meet the 60% benchmark, the test in Section 2B(2)(a) would preclude such an increase.

It is believed that this test will be rather simple to apply, in practice, from readily available records. It will be an effective tool in reviewing the reasonableness of rate increases.

Section 2B, as amended, is not intended to substitute new standards retroactively in place of standards in effect before the date of these guidelines. It is not intended that the rules be changed in the middle of the contract period. On the other hand, the principles of these guidelines may have been implicit in a state's former rules and guidelines.

It should be emphasized again that the tests in Section 2A and 2B have to do with benchmarks, not legal minimums. Section 2C mentions some situations in which lower loss ratios may be justifiable. If, however, a rate submission meets the benchmark standards and includes full documentation as described in the guidelines and this appendix, the requirement that benefits be reasonable in relation to premiums should be considered met.

Legislative history (all references are to the Proceedings of the NAIC)

1980 Proc. I 29, 38, 406, 410, 413, 416-425 (adopted).
1983 Proc. I 6, 35, 644, 652-659 (revised).
1983 Proc. II 16, 22, 638, 644, 646-655 (amended and reprinted).

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

This state page does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the laws cited should be consulted. The NAIC attempts to provide current information; however, due to the timing of our publication production, the information provided may not reflect the most up to date status. Therefore, readers should consult state law for additional adoptions and subsequent bill status.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	NO ACTION TO DATE	
Alaska	NO ACTION TO DATE	
American Samoa	NO ACTION TO DATE	
Arizona		ARIZ. ADMIN. CODE § 20-6-607 (1981) (Similar to NAIC model; the differences are explained in a circular letter dated 7/24/81).
Arkansas		BULLETIN 12-81 re loss ratios.
California		CAL. CODE REGS. tit. 10, §§ 2219 to 2220.28 (1972) (Standards for review).
Colorado		4 COLO. CODE REGS. § 2-11 (1992/2010); BULLETIN 07-01 (2001).
Connecticut		CONN. AGENCIES REGS. §§ 38a-481-1 to 38a-481-4 (1990/2006) (amendments included in the Connecticut Law Journal).
Delaware		DEL. CODE ANN. tit. 18, § 1305; §§ 2501 to 2531 (1953) § 3333 (1953) BULLETIN 79-1 (As amended); BULLETIN 71-15 (Filing procedures).
District of Columbia	NO ACTION TO DATE	

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Florida	FLA. ADMIN. CODE ANN. r. 69O-149.002 to 69O-149.010 (1985/2006); 69O-149-022 (2005); 69O-149-205 to 69O-149-207 (2005/2006).	*See* Memorandum 2006-012.
Georgia	NO ACTION TO DATE	
Guam	NO ACTION TO DATE	
Hawaii		HAW. REV. STAT. §§ 431:14F-101 to 431:14F-113 (2003/2006).
Idaho	NO ACTION TO DATE	
Illinois	NO ACTION TO DATE	
Indiana	NO ACTION TO DATE	
Iowa	IOWA ADMIN. CODE r. 191-36.9 to 191-36.12 (1982).	
Kansas	KAN. ADMIN. REGS. § 40-4-1 (1981/2003) (Adopted by reference subject to stated exceptions).	
Kentucky	806 KY. ADMIN. REGS. 17:070 (1982/1995).	806 K.Y. ADMIN. REGS. 14:007 (2002/2008).
Louisiana	NO ACTION TO DATE	
Maine		ME REV. STAT. ANN. tit. 24-A, § 2736 (1979) (Rate filing required); 940 ME. CODE R. (2000).
Maryland		MD. CODE REGS. 31.10.01.02 (1965/1993) (Filing procedures).
Massachusetts		211 MASS. CODE REGS. 41.06 (1997/2002).
Michigan		MICH. ADMIN. CODE r. 500.801 to 500.806 (1974) (Includes standards for review).

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Minnesota	NO ACTION TO DATE	
Mississippi		73 Miss. Ins. Reg. 4 (1973) (Filing procedures).
Missouri	NO ACTION TO DATE	
Montana	NO ACTION TO DATE	
Nebraska	NO ACTION TO DATE	
Nevada		BULLETIN 87-4 (1987) (Filing procedures).
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. § 401.01(c) (1982/2008) (Model will serve as guide for review).	N.H. CODE ADMIN. R. ANN. INS. §§ 401.02 to 401.03 (1982/1993) (Includes standards for review).
New Jersey		N.J. ADMIN. CODE §§ 11:4-18.1 to 11:4-18.10 (1980/1996) (Includes standards for review).
New Mexico	NO ACTION TO DATE	
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.40 to 52.42 (Regulation 62) (1983/1996) (Filing procedures).
North Carolina	NO ACTION TO DATE	11 N.C. ADMIN. CODE § 16.0205 (1992/2005).
North Dakota	NO ACTION TO DATE	
Northern Marianas	NO ACTION TO DATE	
Ohio	NO ACTION TO DATE	
Oklahoma	NO ACTION TO DATE	
Oregon		OR. ADMIN. R. 836-010-0011 (1994/2002).
Pennsylvania		PA. CODE § 89.83 (1975) (Standards for review).

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Puerto Rico	NO ACTION TO DATE	
Rhode Island		27-23 R.I. CODE R. §§ 1101 to 1107 (1979) (Filing procedures).
South Carolina	S.C. CODE ANN. § 38-71-310 (1988/1989) (Model adopted by reference).	
South Dakota	NO ACTION TO DATE	
Tennessee	TENN. COMP. R. & REGS. 0780-1-20 (1981/1994).	
Texas	NO ACTION TO DATE	
Utah	UTAH ADMIN. CODE r. 590-85 (1980/2003).	UTAH ADMIN. CODE r. 590-220-1 to 590-220-18 (2004/2009); Bulletin 96-2 (1996).
Vermont	NO ACTION TO DATE	
Virgin Islands	NO ACTION TO DATE	
Virginia	14 VA. ADMIN. CODE 5-130-10 to 5-130-100 (1981).	
Washington		WASH. ADMIN. CODE §§ 284-60-010 to 284-60-100 (1983) (Standards for review).
West Virginia	NO ACTION TO DATE	
Wisconsin		WIS. ADMIN. CODE INS. 3.13(6) (1958/2009) (Filing requirements).
Wyoming	NO ACTION TO DATE	

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the NAIC model in a uniform and substantially similar manner. This requires states to adopt the model in its entirety but does allow for minor variations in style and format.

RELATED STATE ACTIVITY: States that have citations identified in this column have **not** adopted the NAIC model in a uniform and substantially similar manner. Examples of Related State Activity include: An older version of the NAIC model, portions of the NAIC model, legislation or regulation derived from other sources, Bulletins and Administrative Rulings.

NO ACTION TO DATE: No state activity on the topic as of the date of the most recent update.

GUIDELINES FOR FILING OF RATES FOR INDIVIDUAL HEALTH INSURANCE FORMS

This page is intentionally left blank

Formed in 1871, the National Association of Insurance Commissioners (NAIC) is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia and five U.S. territories. The NAIC has three offices: Executive Office, Washington, D.C.; Central Office, Kansas City, Mo.; and Securities Valuation Office, New York City.

The NAIC serves the needs of consumers and the industry, with an overriding objective of supporting state insurance regulators as they protect consumers and maintain the financial stability of the insurance marketplace.

For more information, visit **www.naic.org**.

ACTUARIAL STANDARDS BOARD

Actuarial Standard of Practice No. 8

Regulatory Filings for Health Plan Entities

Revised Edition

Developed by the
Task Force to Revise ASOP No. 8 of the
Health Committee of the
Actuarial Standards Board

Adopted by the
Actuarial Standards Board
December 2005

(Doc. No. 100)

TABLE OF CONTENTS

December 2005

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Regulatory Filings for Health Plan Entities

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice (ASOP) No. 8

This booklet contains the final version of the revision of ASOP No. 8, now titled *Regulatory Filings for Health Plan Entities.*

Background

The ASB originally adopted ASOP No. 8, *Regulatory Filings for Rates and Financial Projections for Health Plans* (Doc. No. 010), in 1989. Under the guidance of the ASB Health Committee, the Task Force to Revise ASOP No. 8 has prepared this revision to be consistent with the current ASOP format and to reflect current, generally accepted actuarial practices with respect to regulatory filings for health plan entities.

Exposure Draft

The exposure draft of this ASOP was issued in September 2004 with a comment deadline of March 31, 2005. Fourteen comment letters, showing thoughtful insight of the issues, were received and considered in developing the final ASOP. For a summary of the substantive issues contained in the exposure draft comment letters and the responses, please see appendix 2.

The most significant changes since the exposure draft were as follows:

1. The language on applicable law in section 1.2 was updated to be consistent with current boilerplate language to be used in other ASOPs and removed from section 2.1.

2. The task force modified the language regarding section 3.2.2, Consistency with Business Plans (now section 3.2.3, Use of Business Plans to Project Future Results), to address commentators' concerns regarding the actuary's use of any relevant information from any business plan(s) as part of the process of setting assumptions and methodologies used in the filing. The task force also removed the requirement of consistency in assumptions between the business plan and the filing.

3. The task force modified section 3.2.3, Reasonableness of Assumptions, in the exposure draft and moved it to the last section within 3.2, Issues and Recommended Practices for Health

Filings. The language clarifies the requirements when the actuary reviews the reasonableness of assumptions.

4. The task force modified the language in section 3.2.6, New Plans or Benefits, to address the issues regarding data raised by the commentators.

5. The task force modified section 3.3, Reliance on Others (now Reliance on Data or Other Information Supplied by Others), to use language consistent with other recent ASOPs.

6. The task force changed the language in section 4.3, Deviation from Standard, to be consistent with that used in other recent ASOPs.

The Health Committee thanks all those who commented on the exposure draft.

The ASB voted in December 2005 to adopt this standard.

Task Force to Revise ASOP No. 8

Paul R. Fleischacker, Chairperson

Timothy D. Courtney	Julia T. Philips
John M. Friesen	William H. Phillips
Michael R. Gross	William R. Sarniak
James M. Gutterman	John W.C. Stark

Health Committee of the ASB

Alan D. Ford, Chairperson

Michael S. Abroe	John M. Friesen
Gary L. Brace	James M. Gutterman
Robert G. Cosway	Mary J. Murley
Paul R. Fleischacker	John W.C. Stark

Actuarial Standards Board

Michael A. LaMonica, Chairperson

Cecil D. Bykerk	William A. Reimert
William C. Cutlip	Lawrence J. Sher
Lew H. Nathan	Karen F. Terry
Godfrey Perrott	William C. Weller

ACTUARIAL STANDARD OF PRACTICE NO. 8

REGULATORY FILINGS FOR HEALTH PLAN ENTITIES

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries when performing professional services with respect to preparing or reviewing required regulatory filings for health plan entities and health benefit plans provided by health plan entities.

1.2 Scope—This standard applies to actuaries when performing professional services with respect to preparing or reviewing health filings, as defined in section 2.3, required by and made to state insurance departments, state health departments, the federal government, and other regulatory bodies. Health filings require projection of future contingent events and can be categorized into two broad categories: rate or benefit filings and financial projection filings. Some of these filings are made on behalf of health plan entities, such as filings made in conjunction with applications for licensure. Other filings are required for health benefit plans provided by health plan entities, such as filings for approval of rates. Such filings may be required for new and existing health plan entities, for new health benefit plans, and for revisions to existing health benefit plans.

The filings covered by this standard do not include filings to certify compliance with rating methods and other actuarial practices applicable to carriers for small employer health benefit plans (see ASOP No. 26, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans*); statements of actuarial opinion relating to statutory financial statements of health plan entities (see ASOP No. 22, *Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers*, and ASOP No. 28, *Compliance with Statutory Statement of Actuarial Opinion Requirements for Hospital, Medical, and Dental Service or Indemnity Corporations, and for Health Maintenance Organizations*); and filings that are solely experience reports and do not require projection of future contingent events.

This standard is not meant to provide a complete set of recommended practices for the determination of health rates, financial projection entries, or other numerical information required to be included in health filings. It represents areas of inquiry and analysis that an actuary should consider when preparing or reviewing a required health filing for purposes of compliance with applicable law.

The actuary should satisfy the requirements of applicable law (statutes, regulations, case law, and other legally binding authority) and this standard. However, to the extent

applicable law conflicts with this standard, compliance with such applicable law shall not be deemed a deviation from this standard, provided the actuary discloses that the actuarial assignment was performed in accordance with the requirements of such applicable law.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard is effective for all applicable filing work performed on or after May 1, 2006.

Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice.

2.1 Financial Projection—A projection of covered lives, premiums, claims, expenses, capital and surplus, or other financial quantities that may be required by applicable law.

2.2 Health Benefit Plan—A contract or other financial arrangement providing hospital, medical, prescription drug, dental, vision, disability income, accidental death and dismemberment, long-term care, or other health-related benefits, whether on a reimbursement, indemnity, or service benefit basis, irrespective of the type of health plan entity that provides the benefits.

2.3 Health Filing—A required regulatory filing, at least one element of which requires projection of future contingent events, for rates or benefits, or financial projections.

Rate or benefit filings include, but are not limited to, the following:

a. filings of manual rates and rating factors;

b. filings of rating methodology, such as experience rating formulas and factors;

c. statements of actuarial soundness or rate adequacy, as may be defined by the regulatory body, for future rating periods;

d. certification of benefit values; and

e. other filings of similar nature as may be required by the regulatory body.

Financial projection filings include, but are not limited to, any filings in which the financial projections are a stand-alone requirement, such as those for licensure

requirements, or are a requirement of a broader filing, such as a rate filing or projections of future capital and surplus or other regulatory benchmark requirements.

2.4 Health Plan Entity—An insurance company, health maintenance organization, hospital or medical service organization, self-insured health benefit plan sponsor, governmental health benefit plan sponsor, or any other health benefit plan sponsor from which health filings are required.

2.5 Regulatory Benchmark—A measurement, such as a loss ratio or capital ratio, specified by applicable law, which is used by the regulatory authority as a basis upon which to evaluate a health filing.

2.6 Time Value of Money—The principle that an amount of money available at an earlier point in time has different usefulness and value than the same amount of money has at a later point in time.

Section 3. Analysis of Issues and Recommended Practices

3.1 Introduction—Many jurisdictions require health filings that demonstrate compliance with applicable law, which may vary considerably as to the requirements and procedures for these filings. In many cases, such law may be silent as to the assumptions and methodology to be used, thus giving the actuary significant discretion to exercise professional judgment in preparing and reviewing the filings.

3.2 Issues and Recommended Practices for Health Filings—The actuary should consider the following:

3.2.1 Purpose of Filing—When preparing a filing, the actuary should include in the filing a statement of its purpose, identifying the applicable law it is intended to comply with. For example, the actuary might state, "The only purposes of this rate filing are to document the rates and to demonstrate that the anticipated loss ratio of this product with those rates meets the minimum requirements of Section XX of the statutes of [name of state]. This filing may not be appropriate for other purposes."

If, in the actuary's professional judgment, applicable law is ambiguous, the actuary should describe how the actuary interpreted the requirements when preparing the filing. For example, the statute may say, "Provide a business plan demonstrating future solvency." The actuary then might state, "This projection of financial results is intended to demonstrate that the business plan reasonably anticipates surplus exceeding $XX million for the following Y years."

3.2.2 Assumptions—The actuary should consider which assumptions are necessary for the filing. Such assumptions may include the following:

a. premium levels and future rate changes;

b. enrollment projections;

c. morbidity, mortality, and lapsation levels and trends;

d. expenses, commissions, and taxes;

e. investment earnings and the time value of money;

f. health cost trends;

g. expected financial results, such as profit margin, surplus contribution, and surplus level;

h. expected impact of contractual arrangements with health care providers and administrators; and

i. expected impact of reinsurance and other financial arrangements.

3.2.3 Use of Business Plans to Project Future Results—The actuary should request and review any existing and relevant business plans for the health plan entity or health benefit plan that is the subject of the filing. The actuary should consider the information therein along with any other information relevant to the business plan as a part of the setting of the assumptions and methodologies used in the filing.

3.2.4 Use of Past Experience to Project Future Results—When setting assumptions, the actuary should adjust past experience for any known or expected changes that, in the actuary's professional judgment, are likely to materially affect expected future results. These may include, but are not limited to, changes in the following:

a. selection of risks;

b. demographic and risk characteristics of the insured population;

c. policy provisions;

d. business operations;

e. premium rates, claim payments, expenses, and taxes;

f. trends in mortality, morbidity, and lapse; and

g. administrative procedures.

The actuary should make adjustments to past experience based on earned premiums and incurred claims, as appropriate, in a way that reasonably matches claim experience to exposure. For example, the actuary should not use ratios of paid claims to collected premiums to project future incurred loss ratios except with appropriate adjustment.

The actuary should update prior earned premium and incurred claim estimates to reflect premium and claim development experience to date when, in the actuary's professional judgment, the difference is material.

The actuary may express past experience in terms of aggregate premium, claim, and reserve amounts, or in terms of unit results, such as incidence rates and average premium and claim amounts.

The actuary should consider the applicability and statistical credibility of the data and make appropriate modifications, if necessary.

3.2.5 Recognition of Plan Provisions—The actuary should consider pertinent plan documents or contracts and, as described to the actuary, established administrative procedures, any plan interpretations that are not written in the plan documents, and any arrangements with providers of health care.

3.2.6 New Plans or Benefits—The actuary should consider available data relevant to new plans or benefits. If using a model (for example, in the absence of sufficient data), the actuary should use a model that is reasonable and consistent with similar benefits or plans of coverage, if any, and that, if appropriate for the plan or benefit, takes into account the general characteristics of the health care delivery system.

3.2.7 Projection of Future Capital and Surplus—As part of a health filing, the actuary may be called upon to project future capital and surplus for the entire health plan entity or a portion of it, such as a business unit. In doing so, the actuary should base the projection on reasonable assumptions that take into account any internal or external future actions as described to the actuary that, in the actuary's professional judgment, are likely to have a material effect on capital or surplus.

3.2.8 Regulatory Benchmark—The actuary may be called upon to project results in relation to a regulatory benchmark for the entire health plan entity or a portion of it, such as a line of business. The actuary should base the projection on appropriate available information about the relevant book of business.

3.2.9 Reasonableness of Assumptions—The actuary should review the assumptions employed in the filing for reasonableness. The assumptions should be reasonable in the aggregate and for each assumption individually. The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary. This information

may include, but is not limited to, business plans; past experience of the health plan entity or the health benefit plan; and any relevant industry and government studies that are generally known and reasonably available to the actuary. The actuary should make a reasonable effort to become familiar with such studies.

3.3 Reliance on Data or Other Information Supplied by Others—When relying on data or other information supplied by others, the actuary should refer to ASOP No. 23, *Data Quality*, for guidance.

3.4 Documentation—The actuary should prepare and retain documentation in compliance with the requirements of ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*, if applicable, and ASOP No. 41, *Actuarial Communications*. The actuary should also prepare and retain documentation to demonstrate compliance with the disclosure requirements of section 4.1.

Section 4. Communications and Disclosures

4.1 Communications and Disclosures—When issuing actuarial communications relating to regulatory filings for health plan entities, the actuary should refer to ASOP No. 23 and ASOP No. 41. In addition, such actuarial communications should disclose the following:

a. the sources of information;

b. any material information supplied by others and the extent of the actuary's reliance on such information;

c. any unresolved concerns the actuary may have about the information that could have a material effect on the actuarial work product;

d. limitations on the use of the actuarial work product;

e. any conflicts arising from applicable law; and

f. any assumptions or methods prescribed by applicable law.

4.2 Prescribed Statement of Actuarial Opinion—This ASOP does not require a prescribed statement of actuarial opinion as described in the *Qualification Standards for Prescribed Statements of Actuarial Opinion* promulgated by the American Academy of Actuaries. However, law, regulation, or accounting requirements may also apply to an actuarial communication prepared under this standard, and as a result, such actuarial communication may be a prescribed statement of actuarial opinion.

4.3 Deviation from Standard—The actuary must be prepared to justify to the actuarial profession's disciplinary bodies, or to explain to a principal, another actuary, or other intended users of the actuary's work, the use of any procedures that depart materially

from those set forth in this standard. If a conflict exists between this standard and applicable law or regulation, compliance with applicable law or regulation is not considered to be a deviation from this standard.

Appendix 1

Background and Current Practices

Note: This appendix is provided for informational purposes but is not part of the standard of practice.

Background

Many jurisdictions require the filing of actuarial memoranda or similar documents in connection with health plan entities. An actuary may be involved in the preparation or review of these filings. The applicable laws differ as to their content, scope, and requirements. Many laws are silent as to procedures and assumptions to be employed, thus giving the actuary significant discretion to exercise professional judgment in these areas.

Current Practices

The previous ASOP No. 8 had been in place since 1989. Although the task force believes that the previous standard represented generally accepted practice, this revision more accurately reflects current practices.

Appendix 2

Comments on the Exposure Draft and Responses

The exposure draft of this revised actuarial standard of practice (ASOP), *Regulatory Filings for Health Plan Entities,* was issued in September 2004, with a comment deadline of March 31, 2005. Fourteen comment letters were received, some of which were submitted on behalf of multiple commentators, such as by firms or committees. For purposes of this appendix, the term "commentator" may refer to more than one person associated with a particular comment letter. The Task Force to Revise ASOP No. 8 carefully considered all comments received. Summarized below are the significant issues and questions contained in the comment letters and responses to each, which may have resulted from ASB, Health Committee, or task force discussion. Unless otherwise noted, the section numbers and titles used below refer to those in the exposure draft.

GENERAL COMMENTS	
Comment	One commentator questioned whether credit disability filings were subject to ASOP No. 8 since typically such filings require only that the actuary conform to the state's published "prima facie" rates and, thus, the filings are not "projections of future contingent events." The commentator questioned whether ASOP No. 8 should exclude credit disability in these situations.
Response	The task force did not think such a specific exclusion was appropriate and believed the general description of inclusions and exclusions was sufficient.
Comment	One commentator noted that some other standards (for example, ASOP Nos. 26 and 28) describe specific "regulatory filings for health plan entities" and that, either the relationship between these standards and ASOP No. 8 needed to be clarified in the latter, or that the name of the proposed standard was too broad and needed to be replaced.
Response	The task force noted that these filings are already specifically excluded in the second paragraph of section 1.2 and that these exclusions should adequately address these concerns.
Comment	One commentator was concerned that the scope of the proposed ASOP was too broad, stating individual health insurance carriers are often asked by regulators about the benefit cost(s) of mandates and that, depending on what the definition of a benefit filing is, almost every request could require more work or even an actuarial memorandum. Also, in many cases, the regulatory entity has a prescribed form that does not lend itself to many of the proposed requirements. For example, many states have electronic forms that allow for entering only a number or a few numbers; in most cases, there is not room to provide all of the qualifications or caveats that could be included. In addition, there is often no means to follow up with a full report.
Response	The task force believes that the definition of section 2.4 adequately addresses these concerns. The task force does not believe requests for information regarding, for example, benefit cost(s) of mandates would fall under the category of required filings.
Comment	One commentator suggested adding materiality criteria in the section that discusses reasonableness of assumptions.
Response	The task force chose not to make a distinction between levels of materiality of assumption. The task force did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.

SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.1, Purpose	
Comment	One commentator stated that "required regulatory filings" is less clear than the language in the prior standard. One of the most common types of filings is a filing for a rate increase. Most often, the filing is made to increase rates, not to meet a regulatory requirement to file. The commentator suggested striking the work "required" and striking it in the second to last paragraph of section 1.2.
Response	The task force noted that it had previously considered this issue and concluded purposely to insert the word "required" to differentiate between filings that are required by regulatory authorities, such as those required when filing for a rate increase, and other information that actuaries may submit to health regulators, such as a regulator's request for an estimate of the cost impact of a proposed regulation.
Section 1.2, Scope	
Comment	The transmittal memorandum of the exposure draft asked whether the scope was appropriate. One commentator agreed it was but believed that the second sentence could be clearer if worded as follows: "Health filings covered by this standard are filings that require projection of future contingent events in order to meet the given regulatory requirements. These health filings can be categorized into two broad categories: rate or benefit filings and financial projection filings."
Response	The task force believes that these concerns are adequately covered in sections 1.2 and section 2.3. The task force noted that most of the commentators on the first three questions asked in the transmittal memorandum agreed that the scope was appropriate and that the ASOP was clear as to whom it applied and to what types of health filings were covered.
Comment	The transmittal memorandum of the exposure draft asked whether the ASOP was clear that it applies to projections relating to capital and surplus requirements, which would include, for example, minimum risk-based capital and surplus requirements in states that have adopted the NAIC Risk-Based Capital (RBC) for Health Organizations Model Act. One commentator stated that, if the ASB wishes to further emphasize application to projections related to capital and surplus requirements, then it could include the example given above.
Response	The task force believed the descriptions were sufficiently clear to provide guidance on which filings were subject to the standard, noting that two other commentators agreed with this.
Comment	One commentator was concerned with the last paragraph regarding conflict with applicable law and believed that the last phrase should be strengthened to require the actuary to disclose items such as the nature of the departure from the requirements of the standard, the financial effects thereof, and the specific provisions of the applicable law.
Response	The task force updated the wording to be consistent with the current language to be used in other ASOPs and believed the revised language more closely addressed some of the commentator's concerns. The task force did not agree that the standard should specify what the actuary's disclosure should contain in the event of the standard conflicting with applicable law and believed that the revised wording, in combination with section 4, Communications and Disclosures, provided adequate guidance.
Comment	One commentator was concerned that including "case law" and "statutes" in a definition of applicable law might unreasonably require the actuary to be knowledgeable about court interpretations or even require the unauthorized practice of law.
Response	The definition of "applicable law" was deleted since it is now defined in "boilerplate" language in section 1.2. The task force does not believe the definition puts actuaries in the position of unauthorized practice of law, but the standard does require actuaries to be knowledgeable of applicable law germane to the actuarial assignment.

Comment	One commentator suggested that a discussion of any conflict between the standard and applicable law should be placed in the body of the standard rather than in the scope.
Response	The task force believed the current placement was appropriate and consistent with other ASOPs.
SECTION 2. DEFINITIONS	
Section 2.2, Financial Projection (now section 2.1)	
Comment	One commentator suggested inserting "covered" before "expenses."
Response	The task force believed that, if this word were added, the actuary could interpret it to mean expenses covered, for example, by premiums. Financial projections should include all expenses, which may or may not be covered by premiums. As such, the task force concluded not to add this word.
Comment	One commentator stated that a projection of covered lives in the absence of financial quantities was not considered a "financial projection" and that "covered lives" should be removed from the list. The commentator also suggested changing "administrative expenses" to "expenses" since claims are expenses too and noted that in other places in the standard "expenses" means "administrative expenses."
Response	The task force believed that covered lives often are included in financial projections and should be included in the projection. The task force also believed that "expenses" as a general term provided adequate guidance, particularly since claims are mentioned as a separate item.
Section 2.3, Health Benefit Plan (now section 2.2)	
Comment	One commentator expressed concern that "health benefit plan" is a defined term in numerous state insurance laws, but the ASOP defines it differently. The commentator suggested substituting a term such as "health coverage plan."
Response	The task force believed that the definition needed to be sufficiently broad and inclusive to cover all states' requirements and that definition contained in the exposure draft was sufficiently clear to avoid confusion with statutory language. The task force noted that terms in section 2 are defined only for their use within this standard and may depart from definitions used in other actuarial literature.
Comment	One commentator suggested adding "hospital" before "medical" and adding this sentence to the end of the paragraph: "A discount-only plan is not a health benefit plan."
Response	The task force agreed and made the first suggested change. On the second suggestion, the task force noted that, at this time, this type of product would not be subject to this ASOP since it would not require a health filing as defined under section 2.4 and believed it was unnecessary to add this sentence.
Section 2.4, Health Filing (now section 2.3)	
Comment	One commentator suggested that a definition of "manual rates" be included and that ASOP No. 8 should be expanded to cover the derivation and proper use of manual rates.
Response	The task force believed the term "manual rates" was well enough understood in the context of health filings and did not need to be defined in this ASOP. The task force did not believe that a discussion of the derivation or use of manual rates was an appropriate subject for this ASOP.

Comment	One commentator was concerned that the definition was too restrictive and questioned whether the phrase "certification of benefit values" includes filings where an actuary certifies that two sets of benefits are equivalent, which would not always require a projection into the future and may be strictly based on the current experience.
Response	The task force intends that, for a filing to be subject to this ASOP, the filing be required by a regulatory authority and that at least one element of the filing requires projection of future contingent events. If the filing does not have both of these requirements, the filing is not subject to this ASOP. In the example given by the commentator, if the benefit equivalence calculation requires a projection of future contingent events, and the actuary chooses to use current experience with zero trend, and the filing is required by a regulatory authority, the filing would be subject to this ASOP.
Comment	One commentator suggested striking the phrase "as may be defined by the regulatory body" because it does not help to strengthen the section and may in fact do harm, as applicable law can define anything as "actuarial soundness" or "rate adequacy." The power of the "regulatory body" should not be defined to dictate unsound practice.
Response	The task force noted that it had previously considered this issue and had intentionally concluded to add this language. The task force had discussed including a definition of "actuarial soundness" in this ASOP but concluded that "actuarial soundness" is a broader industry issue and decided to limit its inclusion to cover those situations in which states have specific requirements, for example, that the actuary opine that the rates are reasonable in relation to the benefits provided or that the rates meet mandated minimum loss ratio requirements.
Comment	One commentator recommended replacing the last paragraph of the section with the following: "A financial projection or business plan filing includes, but is not limited to, any filings in which the financial projections are a stand-alone requirement, such as those for licensure requirements, or are a requirement of a broader filing, such as a rate filing or projections of future capital and surplus or other regulatory benchmark requirements."
Response	The task force noted that the suggested wording was basically the same as that contained in the exposure draft except adding the wording about business plan. The task force did not believe the reference to business plan in this paragraph was necessary.
Comment	One commentator stated that the term "health filing" is based on the undefined term "required regulatory filing." As a result, the scope of the definition is left unclear. No distinction is made between a legal requirement and an administrative request that is unsupported by statute or regulation. The commentator suggested adding the following definition of a required regulatory filing: "A required regulatory filing is a filing required by statute or regulation."
Response	The task force believed the definition of "health filing" in the exposure draft provided adequate guidance and that the proposed definition was circular.
Section 2.7, Time Value of Money (now section 2.6)	
Comment	One commentator suggested dropping the phrase "usefulness and" and leaving the term defined in terms of value only, perhaps by adding the word "monetary" before "value." Another commentator believed the definition and references to "earlier" and "later" in particular were not clear.
Response	The task force considered the wording in light of the comments but concluded that the definition, which is used in other ASOPs, was sufficiently clear.

SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.2.1, Purpose of Filing	
Comment	One commentator noted that the example in the second paragraph appeared to provide more precision than appeared to be implied by the requirement in the first sentence of this paragraph, which required the actuary only to "describe" the interpretation of the regulatory requirements. The commentator questioned what level of precision is appropriate for the description and believed that "describe" does not provide any notion of the degree of completeness needed.
Response	The task force believed the wording was appropriate and did not believe the standard should be too prescriptive.
Section 3.2.2, Consistency With Business Plan (now section 3.2.2, Assumptions, and section 3.2.3, Use of Business Plans to Project Future Results)	
Comment	One commentator suggested alternative language that would require assumptions to be consistent with contemporaneous health filings relating to the health benefit plan subject to the current filing; one commentator suggested strengthening the requirement that "the actuary should use assumptions and methodologies that are consistent with the business plan...."
Response	Section 3.2.2 from the exposure draft was reorganized into new sections 3.2.2, Assumptions, and 3.2.3, Use of Business Plans to Project Future Results, to better address these different but connected issues.
Comment	One commentator noted that the term "persistency" appears without definition. While the term has an unambiguous meaning in an individual life insurance setting, it could have multiple applications in the health insurance arena.
Response	The task force considered this and believed that the meaning should be clear within the context of each filing. The task force did not believe a definition was necessary.
Comment	One commentator stated that, in any given filing, certain assumptions may not be material and that this should be so noted in the ASOP.
Response	The task force did not believe such a statement was necessary. As noted in the task force's response to the last comment under General Comments, the task force chose not to make a distinction between levels of materiality of assumptions and did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.
Comment	Several commentators expressed concerns and raised important issues and questions on the opening paragraph of this section, including the following: One commentator found that certain terms such as "business plan," "sales results," and "overall" in "overall business results" were undefined. One commentator questioned whether the relevant sections of the business plan should be disclosed in the actuarial communication. One commentator believed the phrase "as known to the actuary" was too lenient and that the actuary should review the components of the business plan that are relevant to the determination of reasonable assumptions. One commentator noted that business plans developed by health plans to support the internal plan management serve a different purpose than the projections used to support pricing and regulatory filings. For example, they are often intended to set challenging performance goals rather than most likely outcome. The commentator stated that it would be inappropriate to base pricing assumptions on such projections, as there is no guarantee that they represent a reasonable expectation of future experience. Further, the commentator suggested that business plans subject to regulatory filing and review should be included in the definition of a health filing.

Response	The task force agreed with many of the comments and renamed the title and rewrote the section to address these issues. It is recognized there are many types of business plans, ranging from formal written documents to informal verbal discussions. To avoid being prescriptive, the language was changed to require the consideration of relevant information from whatever business plan exists and included wording about requesting such plan, although obvious. The task force removed references to consistent assumptions. The task force believed that the issue regarding documentation is adequately covered in sections 3.4 and section 4.1.
Comment	One commentator found that sections 3.2.2 and 3.2.3 of the exposure draft when read together were troublesome. Section 3.2.2 would have required consistency with the business plan. Section 3.2.3. would have described a review for reasonableness versus, among other factors, the business plan. The commentator proposed several changes to both sections, including a proposed redraft of section 3.2.2.
Response	The task force substantially rewrote sections 3.2.2 and 3.2.3, (now sections 3.2.2, 3.2.3, and 3.2.9, Reasonableness of Assumptions) and believes that these revisions adequately address the concerns mentioned.
Section 3.2.3, Reasonableness of Assumptions (now section 3.2.9)	
Comment	One commentator questioned whether the actuary should state the extent to which the assumptions are the actuary's own or that he or she is reviewing those of some other technician (who may or may not be an actuary) and perhaps assessing them to meet only the lower standard of "not unreasonable" or "in a reasonable range." The commentator stated that two aspects should be reported: (a) the applicable standard of reasonableness; and (b) who the author is. The commentator noted that, in assessing anything prepared by an actuary, the actuary's assessment is going to be strongly affected by whether the assumptions were devised by the signing actuary or by someone else and, for that matter, whether the actuary was independent or employed by the organization from which the assumptions came and questioned whether that should be the case.
Response	The task force rewrote this section and believes that this revision addresses many of the commentator's concerns.
Comment	One commentator stated that two ideas seem important here. First, the model chosen can be important because some models make assumptions explicit while other models make the same assumptions implicit. Second, it seems inappropriate to exempt implicit assumptions from the same scrutiny as the explicit assumptions. The commentator suggested renaming the section "Reasonableness of Projection Model and Assumptions."
Response	The task force believed that no change was necessary since this section applies to all assumptions, both implicit and explicit.
Comment	Two commentators raised the issue regarding materiality of assumptions and suggested wording changes to the effect that "each material assumption should be reasonable."
Response	The task force believed that it was important that all assumptions be identified and that the support for reasonableness of the assumptions be based on the actuary's professional judgment. As noted in the task force's response to the last comment under General Comments, the task force chose not to make a distinction between levels of materiality of assumptions and did not want to include a formal definition of materiality in this standard, as materiality is a subjective concept and often depends on professional judgment.
Comment	One commentator recommended retaining the old language in this section requiring assumptions to be reasonable based on all information available to the actuary and suggested replacing the last two sentences with the following: "The support for reasonableness should be determined based on the actuary's professional judgment, using relevant information available to the actuary. This information may include, but is not limited to, past experience of the health plan entity or the health benefit plan, and any relevant industry and government studies."
Response	The task force substantially agreed with most of the commentator's comments and made appropriate changes to this section while adding another sentence outlining the actuary's duty to make a reasonable effort to become familiar with relevant studies.

Section 3.2.4, Use of Past Experience to Project Future Results	
Comment	One commentator suggested striking "in the actuary's professional judgment," citing it extraneous.
Response	The task force believed that decisions about materiality often depend on the actuary's professional judgment and, as such, concluded not to strike those words.
Comment	One commentator suggested that, in 3.2.4(d) the comma between "benefit" and "expense" be replaced with the word "and."
Response	The task force clarified this section (now section 3.2.4 (e)) with revised wording.
Comment	One commentator recommended including the concept of "known" changes in the first paragraph and noted that there may be changes that have taken place between the end of the experience period and the date of the filing that are known and will materially affect expected future results.
Response	The task force agreed and made the change.
Comment	One commentator noted the wording of item 3.2.4(e) is potentially confusing and recommended using either "trends in mortality and morbidity" or "trends in mortality and in the utilization and cost of services."
Response	The task force agreed and revised the section (now section 3.2.4(f)) for clarity.
Comment	One commentator stated that the discussion in the second paragraph refers to paid and incurred "claims" and to "earned premiums," etc., and yet the principles are more general and extend beyond premiums and claims to any financial flows with similar characteristics, for example, capitation income and payments, government subsidy or "reinsurance" payments, risk adjustments, state risk pool assessments, etc. The commentator asked whether more general language should be used.
Response	The task force believed that more general language was not necessary. The items mentioned are, for the most part, an element of premiums or incurred claims, for example, capitation income would be part of earned premiums and capitation payments are a part of incurred claims.
Section 3.2.5, Recognition of Plan Provisions	
Comment	One commentator stated that the phrase "as described to the actuary" in this context should be acceptable only if such descriptions are carefully documented with sufficient specificity to designate the contract provisions precisely.
Response	The task force believed that this is adequately covered with the requirements in sections 3.4 and section 4.1.
Comment	One commentator found the meaning "plan documents" unclear and questioned whether it could include employer contracts, employee certificates, group administration manuals, provider contracts, etc.
Response	The task force believed that plan documents and unwritten procedures, such as those mentioned by the commentator, can provide useful information about the plan. The task force believed that further clarification was not necessary.

Section 3.2.6, New Plans or Benefits	
Comment	One commentator suggested that the first sentence could be shortened to say, "The actuary should consider available relevant data," because the wording as it stands almost limits the paragraph to an actuary on the filing end and excludes the actuary on the reviewing end.
Response	The task force agreed and rewrote this sentence to clarify the language.
Comment	One commentator recommended rewording the second sentence of this section as follows: "In the absence of such data, the actuary should use a reasonable model that is consistent with similar benefits or plans of coverage offered by the health plan entity and that, if appropriate for the plan or benefit, takes into account the general characteristics of the health care delivery system." Another commentator believed that the second sentence was incomplete in that the model, by itself, does nothing and that the standard should state what to do with the model. The commentator believed that the standard meant that the actuary should consider the elements of the new benefits, find other existing coverages that have matching benefits to the new plan, see if the experience would apply to the new plan, and, if it does not, keep looking until a match is found.
Response	This section was rewritten. Although the wording is very similar, the phrasing has been rearranged somewhat for clarification. With regards to the second comment, the task force means that the actuary is to select a model that is intended to develop data that can be used for estimating the value of new plans or benefits from data on existing plans, when directly relevant data on the new plan are not available. The language does not require that the benefits and the experience match exactly. As with all other items under section 3.2, the results of such a model would be considered for the health filing.
Section 3.2.7, Projection of Future Capital and Surplus	
Comment	One commentator stated that the phrase "as described to the actuary" should not be used without a requirement to document what was described to the actuary.
Response	The task force believes that this is adequately covered with the requirements in sections 3.4 and section 4.1.
Section 3.2.8, Investment Income	
Comment	One commentator recommended revising section 3.2.8 of the exposure draft by substituting "reasonable earnings rates" for "a reasonable earnings rate." This would (a) allow for earnings rates varying by the average duration of liabilities; and (b) leave room for stochastic interest rate studies (admittedly rare at present, but a concern for very long-term products such as LTC). The present wording seems to require use of a single rate.
Response	This section was deleted but the term "investment earnings" has been included without further description in the list of assumption in new section 3.2.2, Assumptions.
Section 3.2.9, Regulatory Benchmark (now section 3.2.8)	
Comment	One commentator believed that the second sentence was a general statement that applied to any filing and, thus, belonged in section 3.2.4. The commentator suggested that, if it is desirable to mention regulatory benchmark in the standard, it should be done in section 3.2.1.
Response	The task force believed that sections 3.2.4 and 3.2.6 already provide for the use of appropriate relevant information in their respective descriptions. The task force considered the commentator's second suggestion regarding having regulatory benchmark be a part of section 3.2.1. The task force concluded to keep it as a separate subsection under section 3.2 because of the importance and relative uniqueness of these types of projections.

Section 3.3, Reliance On Others (now Reliance on Data or Other Information Supplied by Others)	
Comment	One commentator recommended that the word "descriptions" be included so that it would read, "...on information, including data and descriptions...." Another commentator expressed concern about the reliance on information supplied by others and any due diligence the actuary should perform on that information.
Response	The task force revised this section to be consistent with language used in other current ASOPs and notes that ASOP No. 23, *Data Quality*, provides expanded guidance on these issues.
SECTION 4. COMMUNICATIONS AND DISCLOSURES	
Section 4.1, Communication and Disclosures	
Comment	One commentator expressed concern with item 4.1(b), stating actuaries will adopt blanket boilerplate statements that absolve them of the responsibility to inform the employer or client who may rely on their judgments and what they relied on.
Response	The task force agreed and modified the language.
Comment	One commentator expressed a concern about whether the actuary has been required to estimate the extent that adopting an assumption dictated by laws or regulations has changed the results of the calculations. The commentator suggested that one way to do this would be to make section 4.1(e) more explicit, for example, by stating, "any conflicts arising from applicable law or regulations and their effects on the calculations."
Response	The task force decided not to change the language from that contained in the exposure draft. The task force believed that this suggested requirement would put a greater burden on the actuary and does not necessarily reflect generally accepted practice. It may be a good thing to know but would not be part of a required regulatory filing.

BlueCross BlueShield of New Mexico
Individual Rate Filing

Effective: April 1, 2010

Products

Blue Direct
BlueChoice Plus
BlueChoice
BlueEdge Individual H.S.A.
Blue Transitions
New Mexico Major Medical
Number One
Conversions

BlueCross BlueShield of New Mexico
Individual Rate Filing

Table of Contents

BlueCross BlueShield of New Mexico
Individual Rate Filing

Actuarial Memorandum

I. Introduction

My name is Kevin P. Carr and I am an actuary at BlueCross BlueShield of New Mexico. I am also a member of the American Academy of Actuaries. As such, I meet the qualification standards necessary to prepare and certify rate filings for hospital and medical service corporations. To the best of my knowledge, I have prepared this actuarial memorandum in accordance with the applicable statutes of New Mexico, as well as the Actuarial Standards of Practice as adopted by the Actuarial Standards Board.

II. Purpose of Filing

The purpose of this filing is to establish new rates for BlueCross BlueShield of New Mexico's individual products, and to describe how and why rate revisions are being requested.

The filed changes will be effective April 1, 2010.

III. General Description of Products

Shown below are the requested rate changes for each product along with the respective form number and current membership.

Benefit Plans	Indicated Rate Incr	Filed Rate Incr	Members @ 7/2009	Form Number
BlueDirect A	60.5%	29.5%	4,176	NM80286_A
BlueDirect B	53.0%	29.5%	17,860	NM80287_B
BlueDirect C	19.1%	19.1%	1,586	NM80288_C
BlueChoice Plus	23.1%	23.1%	5,280	M626
BlueChoice 20	21.6%	21.6%	5,681	M494
BlueChoice 30	3.5%	10.0%	2,456	M494
BlueEdge Individual HSA	72.6%	29.5%	2,085	NM80010
BlueEdge 100 HDHP	72.6%	29.5%	0	81076
BlueTransitions	8.3%	10.0%	235	NM80013
New Mexico Major Med	33.0%	29.5%	227	L061
Number One	-14.3%	0.0%	57	M287
Conversion	-17.3%	0.0%	25	M146,M496
Total	**36.9%**	**24.6%**	**39,668**	

BlueCross BlueShield of New Mexico recently filed rates for a new series of plans within the BlueDirect product called Basic, Enhanced and Premier. These new plans will be marketed for effective dates beginning 1/1/2010. With the exception of the BlueEdge plans and Blue Transitions all of the plans in this rate filing will be closed to new sales beginning 1/1/2010. However, we will continue to allow current members in these plans to transition to a different plan through an application process.

BlueCross BlueShield of New Mexico
Individual Rate Filing

In an effort to provide more flexibility to members in these plans we are filing some additional higher deductible options.

1. **BlueDirect**

BlueDirect A is a PPO plan with in-network deductibles of $100, $250, $500, and $1000 each with a $1000 out of pocket expense, excluding the deductible. Family deductible and out of pocket maximums are three times that for the individual. Out-of-network deductibles and out-of-pocket expense are twice that for in-network. There are copayments of $20 for all office visits, $30 for urgent care visits, $100 for emergency room visits, and there is $400 annual wellness benefit. All other services are subject to deductible and member coinsurance levels of 10% for in-network and 30% for out-of-network. Each deductible option has a 4-tier prescription drug benefit with copayments of $7 for generics, $30 for brand formulary, $60 for brand non-formulary, and 15% coinsurance for specialty drugs up to a maximum of $250 per script.

BlueDirect B is a PPO plan with in-network deductibles of $250, $500, $1000, $2000 and $5000 each with a $2000 out of pocket expense, excluding the deductible. We are filing additional deductible options of $3500 and $7500. Family deductible and out of pocket maximums are 2.5 times that for the individual. Out-of-network deductibles and out-of-pocket expense are twice that for in-network. There are copayments of $20 for all office visits, $30 for urgent care visits, $150 for emergency room visits, and there is $400 annual wellness benefit. All other services are subject to deductible and member coinsurance levels of 20% for in-network and 40% for out-of-network. Each deductible option (except the $5000 deductible) has a 4-tier prescription drug benefit with copayments of $10 for generics, $35 for brand formulary, $75 for brand non-formulary, and 15% coinsurance for specialty drugs up to a maximum of $250 per script. The $5000 deductible option covers mandated benefits only.

BlueDirect C is a PPO plan with in-network deductibles of $500, $1000, $2000, and $5000 each with a $5000 out of pocket expense, excluding the deductible. We are filing additional deductible options of $3500, $7500 and $10,000. Family deductible and out of pocket maximums are three times that for the individual. There are copayments of $40 for all primary care physician office visits, $55 for specialist office visits, $100 for urgent care visits, and $300 for emergency room visits. All other services are subject to deductible and a member coinsurance level of 30%. Out of network deductibles are twice those of in-network and member coinsurance is 50%. Each deductible option (except the $5000 deductible) has a 2-tier prescription drug benefit with 25% member coinsurance for generics and 50% member coinsurance for brand name drugs. For generics there is a minimum copayment of $20 with a maximum copayment of $75. For brand drugs, there is a minimum copayment of $40 with a maximum copayment of $125.

2. BlueEdge H.S.A.

BlueEdge Individual HSA is a High Deductible Health Plan with a Health Savings Account (HSA). This is a high-deductible PPO plan with a member-funded health savings account (HSA). This HSA is used to offset the member's own medical expenses. This product has three different plans called Basic, Enhanced, and Premier. After the deductible has been met, all three plans pay 80% of eligible charges when preferred providers are used, and 60% of eligible charges when non-preferred providers are used. Each plan has one aggregate deductible which applies regardless of provider preferred status. The three deductibles (individual/family) are $2600/$5150, $1700/$3450, and $1200/$2400 for the Basic, Enhanced, and Premier plans, respectively. The out-of-pocket expense limits (individual/family) are $5000/$10000, $3000/$6000, and $2000/$4000 for in-network, respectively. The out of pocket maximums include deductible and coinsurance. This product offers our two-tier coinsurance prescription drug plan.

3. BlueEdge 100 High Deductible Plan

BlueEdge 100 is a High Deductible Health Plan with a Health Savings Account (HSA). This is a high-deductible PPO plan with a member-funded health savings account (HSA). This HSA is used to offset the member's own medical expenses on a tax preferred basis. This product has two different plan options. The in-network deductible (individual/family) options are $3500/$7000 and $5000/$10000.

This plan has an "embedded" deductible which means that after the individual deductible has been met, each plan option pays 100% of eligible charges when preferred providers are used, and 80% of eligible charges when non-preferred providers are used.

The out-of-network deductibles (individual/family) are $5000/$10000 and $7500/$15000 for each plan, respectively.

The out-of-pocket maximums equal the deductible for in-network while for out-of-network they are $7500 individual ($15000 family) and $10000 individual ($20000 family), for each plan respectively.

Each plan has an integrated drug plan which pays 100% after the deductible is met.

4. Blue Transitions

Blue Transitions is a Short-Term Limited Duration Insurance product. There are three basic plan designs with deductibles of $500, $1000, and $2000; and, each plan has an out-of-pocket maximum of $2000, excluding the deductible. Each of these plans also includes member coinsurance of 30%, with a maximum prescription drug benefit of $500 per benefit period. Members may pick a benefit period of from one to six months. The policy is non-renewable.

5. BlueChoice Plus

This is a closed pool, and is a PPO product with a choice of five deductible options: $250, $500, $1,000, $2,000, and $5,000. We are filing additional deductible options of $3500 and $7500. It has coinsurance levels of 80% (member pays 20%) in-network and 60% (member pays 40%) out-of-network. A member's individual out-of-pocket expense limit (excluding the deductible) is $2,000 in-network and $4,000 out-of-network. A family's corresponding out-of-pocket expense limit is $5,000 and $10,000, in-network and out-of-network, respectively. This product has a $400 in-network adult wellness benefit ($250 for children). This product also has a two-tier coinsurance prescription drug plan of 25% for generic and 50% for brand, except for the $5,000 deductible which has a limited prescription drug plan (see prescription drug rider M631).

6. BlueChoice

This is a closed pool, and is a PPO product with a choice of four deductible options: $250, $500, $1,000, and $2,000. We are filing additional deductible options of $3500, $5000, $7500, and $10,000 to the 30 plan. Each plan option has a $10,000 stop-loss amount.

There are two variations on this product. The first has coinsurance levels of 80%/20% in-network and 60%/40% out-of-network. It also has a $20 office visit copayment. We are changing the prescription drug plan option from the current three-tier copayment plan of $20/$30/$45 (generic/brand/non-formulary) to a four-tier plan of $10/$35/$75/15% (generic/brand/non-formulary/specialty). The specialty tier has a maximum copayment of $250. This change will occur on a member's renewal. This new plan provides a much lower generic copayment but higher copayments for the brand drugs. There is only a minimal impact to the projected drug costs reflected in this filing.

The second has coinsurance levels of 70%/30% in-network and 50%/50% out-of-network. It also has a $30 office visit copayment, as well as a two-tier coinsurance prescription drug benefit.

7. New Mexico Major Med

This is a closed pool. It is an indemnity product that also has four deductible options: $250, $500, $1,000 and $2,000. It has a coinsurance level of 80%/20% and also has a $10,000 stop-loss amount. The prescription drug benefit for this product is a single tier $20 copayment.

8. Number One

This is a closed pool. It is an indemnity product with deductible options of $500, $750, $1,500 and $2,500. It has coinsurance of 80%/20% and a stop-loss amount of $10,000.

9. Group Conversions

BlueCross BlueShield of New Mexico has two group conversion products. One is an indemnity plan modeled after the Number One product, while the other is a PPO plan. The indemnity product has a $750 deductible, 80%/20% coinsurance, and a $10,000 stop-loss amount. The PPO product has a choice of two deductibles: $1,000 and $2,000. It has coinsurance levels of 80%/20% in-network and 60%/40% out-of-network, while the stop-loss amounts are $10,000 in-network and $20,000 out-of-network. Only the PPO product is marketed.

BlueEdge Individual HSA, Blue Edge 100 HDHP, and Blue Transitions are each sold direct, and also through brokers. New enrollees in each of these products go through underwriting with the use of a health questionnaire. Underwriting is not performed again at renewal. Underwriting is required again for members who request an upgrade to their current benefit level.

IV. Rate Development and Reasonableness of Assumptions

1. Baseline Data

All premium, claim, and member data for each product line was used in the development of the rates in this filing. The experience period reviewed was the twelve-month period ending July 31, 2009. Claims are on an incurred basis and are paid through September 30, 2009. An estimated outstanding claim liability, based on actual historical payment patterns, was added to the incurred claims to bring the claims to a fully incurred basis.

2. Cost of Care Trend

Actual historical claim trends pertaining to BlueCross BlueShield of New Mexico individual under 65 business as well as our corporate individual under 65 business were analyzed and considered in setting the trends for this rate filing.

Overall, the trend factors used in this rate filing to project total medical and prescription drug costs were 10.0% for all plans. Durational adjustments were made to each plan and are shown in the attached rate level analysis. A deterioration adjustment of 3.06% was made to each plan with the exception of BlueTransition and Conversion.

3. Retention Loads

The retention loads, on a percent of premium basis, for each of the product lines are:

Benefit Plan	Administrative Expenses	Broker Commissions	Premium Tax/Assess	Reserve Contribution	Total Retention
BlueDirect	15.5%	5.7%	5.3%	5.0%	31.5%
BlueTransitions	24.2%	5.7%	5.3%	5.0%	40.2%
BlueChoice Plus	15.4%	5.7%	5.3%	5.0%	31.4%
BlueEdge HSA	16.4%	5.7%	5.3%	5.0%	32.4%

BlueChoice	14.3%	5.7%	5.3%	5.0%	30.3%
NMMM	13.1%	5.7%	5.3%	5.0%	29.1%
Number One	13.0%	5.7%	5.3%	5.0%	29.0%
Conversions	12.9%	5.7%	5.3%	-43.9%	-20.0%

The total retention for our conversion products is shown as -20.0% of premium as we have used a Desired Loss Ratio of 120.0% per NAIC requirements.

a) Administrative Expenses

The administrative expense loads are based on the current 2010 budgeted expenses and are designed to equal projected expenses for the individual product category.

b) Broker Commissions

The broker commission loads are based on the current 2010 budgeted projection for broker commissions across all of these product lines.

c) Premium Taxes / Assessments

The required 4% premium tax is included in all product lines. We have also included 1.3% to cover risk pool assessments. The premium tax credit is reflected as an offset to the projected assessments.

d) Reserve Contribution

An overall 5.0% reserve contribution amount has been included for all product lines. However, the rate analysis shows the overall indicated rate change is a 36.9% increase. Since we recognize this increase is significant we are filing an overall increase of 24.6%. Since this is much less than indicated our expected reserve contribution based on these filed rates will be -2.0% overall.

4. Rating Variables

For all products, with the exception of BlueChoice Plus, BlueDirect and BlueEdge, individual members for each product are rated on an age/gender basis, as well as by region and smoking practice. BlueChoice Plus, BlueDirect, and BlueEdge also use age, gender and region, but not smoking. BlueChoice Plus, BlueDirect and BlueEdge have different rating tiers which can be applied for various health risks as determined by the underwriters, including smokers. The presence of these rating tiers allows us to offer coverage to individuals who might otherwise be declined. No changes to the previously filed factors are being made in this filing. Please note that the range of rating factors when combining age, gender, and region within each product and within each rating tier from lowest to highest falls within 250% as required by law.

BlueCross BlueShield of New Mexico
Individual Rate Filing

V. Rate Change

The overall proposed rate change for our individual under 65 products is an average increase of 24.6%. We are filing increases of 29.5% for BlueDirect A, BlueDirect B, Blue Edge HSA and New Mexico Major Medical. Each of these plans shows indicated increases which are much higher than 29.5%. For BlueDirect C, BlueChoice 20, and BlueChoice Plus we are filing the indicated increases of 19.1%, 21.6%, and 23.1% respectively. For BlueTransitions and BlueChoice 30 where the level of membership is rather low and the results are not credible we are filing modest increases of 10.0%. For Number One and Conversions we are not filing any changes to the current rates.

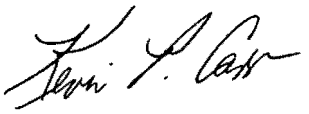
VI. Supporting Rating Data

Several exhibits are attached to this filing. These exhibits show historical loss experience and rate change histories for each product, as well as rate change developments for each of the products.

Also attached are a set of factors for each product which are used to develop the rate tables. The only exceptions to this are the Number One and Conversion products which show rate tables only. Please note that for BlueDirect and BlueTransitions where the rates are shown in whole numbers, the actual percentage increase or decrease may vary from the percentage filed for each plan due to rounding. However, the actual filed change as applied to the underlying base rates are demonstrated in the Rating Factors exhibits.

VII. Actuarial Opinion

I certify that in accordance with actuarial standards of practice using reasonable assumptions that the filed rates developed in this filing are reasonable in relation to the benefits. These rates are not excessive, inadequate, nor unfairly discriminatory. I also certify that the assumptions used represent my best judgement as to the expected values for each assumption and that they are consistent with BlueCross BlueShield of New Mexico's business plan. I also certify that to the best of my knowledge this rate filing complies with the applicable laws of New Mexico.



11/04/2009

Kevin P. Carr, A.S.A., M.A.A.A.
Actuary
Health Care Service Corporation - BlueCross BlueShield of New Mexico
(505) 816-2208
Kevin_Carr@bcbsnm.com

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

TOTAL INDIVIDUAL

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
1998/07 - 1999/06	98,039	10,041,535	6,166,068	3,875,467	61.4%
1999/07 - 2000/06	154,313	15,788,959	9,806,241	5,982,718	62.1%
2000/07 - 2001/06	209,611	23,258,489	13,783,722	9,474,767	59.3%
2001/07 - 2002/06	272,116	33,363,804	20,176,570	13,187,235	60.5%
2002/08 - 2003/07	342,620	46,113,792	31,808,763	14,305,029	69.0%
2003/06 - 2004/05	370,479	54,270,363	38,163,835	16,106,528	70.3%
2004/06 - 2005/05	359,730	58,613,058	45,295,278	13,317,780	77.3%
2005/07 - 2006/06	372,373	65,271,019	51,389,201	13,881,818	78.7%
2006/06 - 2007/05	390,958	70,627,366	52,113,780	18,513,586	73.8%
2007/07 - 2008/06	451,510	79,786,749	62,761,514	17,025,235	78.7%
2008/08 - 2009/07	474,060	85,445,644	73,489,794	11,955,850	86.0%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
1998/07 - 1999/06	8,170.0	102.42	62.89	39.53
1999/07 - 2000/06	12,859.4	102.32	63.55	38.77
2000/07 - 2001/06	17,467.6	110.96	65.76	45.20
2001/07 - 2002/06	22,676.3	122.61	74.15	48.46
2002/08 - 2003/07	28,551.7	134.59	92.84	41.75
2003/06 - 2004/05	30,873.3	146.49	103.01	43.47
2004/06 - 2005/05	29,977.5	162.94	125.91	37.02
2005/07 - 2006/06	31,031.1	175.28	138.00	37.28
2006/06 - 2007/05	32,579.8	180.65	133.30	47.35
2007/07 - 2008/06	37,625.8	176.71	139.00	37.71
2008/08 - 2009/07	39,505.0	180.24	155.02	25.22

* Incurred during period with three months of paid runout.

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

BLUE DIRECT

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
2006/09 - 2007/05	22,983	2,948,861	1,881,827	1,067,034	63.8%
2007/07 - 2008/06	170,167	21,834,660	16,768,099	5,066,561	76.8%
2008/08 - 2009/07	257,544	35,638,780	32,125,942	3,512,838	90.1%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
2006/09 - 2007/05	1,915.3	128.31	81.88	46.43
2007/07 - 2008/06	14,180.6	128.31	98.54	29.77
2008/08 - 2009/07	21,462.0	138.38	124.74	13.64

Rate Change History

2006/09	Product Introduced
2008/03	Average of 8.01% across plans
2009/03	19.5% increase on each plan.

BLUE TRANSITIONS

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
2006/06 - 2007/05	645	130,426	35,831	94,595	27.5%
2007/07 - 2008/06	1,581	321,756	46,352	275,404	14.4%
2008/08 - 2009/07	2,052	193,351	44,781	148,570	23.2%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
2006/06 - 2007/05	53.8	202.21	55.55	146.66
2007/07 - 2008/06	131.8	203.51	29.32	174.20
2008/08 - 2009/07	171.0	94.23	21.82	72.40

Rate Change History

2005/11	Product Introduced
2008/03	Decrease of 10%
2009/03	Decrease of 20%

---

* Incurred during period with three months of paid runout.

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

BLUE CHOICE PLUS

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
2004/01 - 2004/05	4,335	509,465	247,597	261,868	48.6%
2004/06 - 2005/05	42,488	5,287,332	2,798,476	2,488,856	52.9%
2005/07 - 2006/06	101,285	12,732,933	9,395,888	3,337,045	73.8%
2006/06 - 2007/05	127,156	16,912,315	11,444,951	5,467,364	67.7%
2007/07 - 2008/06	99,378	14,686,336	12,339,207	2,347,129	84.0%
2008/08 - 2009/07	73,392	12,455,006	10,872,718	1,582,288	87.3%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
2004/01 - 2004/05	361.3	117.52	57.12	60.41
2004/06 - 2005/05	3,540.7	124.44	65.87	58.58
2005/07 - 2006/06	8,440.4	125.71	92.77	32.95
2006/06 - 2007/05	10,596.3	133.00	90.01	43.00
2007/07 - 2008/06	8,281.5	147.78	124.16	23.62
2008/08 - 2009/07	6,116.0	169.71	148.15	21.56

Rate Change History

2004/01	Product Introduced
2005/03	3.9% increase
2006/03	7.9% increase
2007/03	16.5% increase
2008/03	9.14% increase
2009/03	24.0% increase

* Incurred during period with three months of paid runout.

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

BlueEdge Individual HSA

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
2004/06 - 2005/05	23	7,954	365	7,589	4.6%
2005/07 - 2006/06	5,951	715,747	159,752	555,995	22.3%
2006/06 - 2007/05	14,260	1,667,170	807,924	859,246	48.5%
2007/07 - 2008/06	20,018	2,226,111	1,382,422	843,689	62.1%
2008/08 - 2009/07	23,124	2,617,105	2,610,266	6,839	99.7%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
2004/06 - 2005/05	1.9	345.83	15.87	329.96
2005/07 - 2006/06	495.9	120.27	26.84	93.43
2006/06 - 2007/05	1,188.3	116.91	56.66	60.26
2007/07 - 2008/06	1,668.2	111.21	69.06	42.15
2008/08 - 2009/07	1,927.0	113.18	112.88	0.30

Rate Change History

2005/01	Product Introduced
2006/03	4.9% Increase
2007/03	7.50% Decrease
2008/03	No change
2009/03	0.6% increase

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

BLUE CHOICE

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
1998/07 - 1999/06	62,179	5,131,056	2,577,495	2,553,561	50.2%
1999/07 - 2000/06	125,459	11,384,915	6,630,703	4,754,212	58.2%
2000/07 - 2001/06	184,782	19,065,404	10,354,976	8,710,428	54.3%
2001/07 - 2002/06	249,697	28,862,333	16,516,766	12,345,568	57.2%
2002/08 - 2003/07	321,352	41,616,977	27,723,443	13,893,534	66.6%
2003/06 - 2004/05	347,552	49,137,356	34,522,189	14,615,167	70.3%
2004/06 - 2005/05	303,033	49,083,743	38,582,493	10,501,250	78.6%
2005/07 - 2006/06	253,917	48,113,561	38,244,986	9,868,575	79.5%
2006/06 - 2007/05	216,847	45,592,256	34,113,665	11,478,591	74.8%
2007/07 - 2008/06	154,066	37,798,585	29,091,399	8,707,186	77.0%
2008/08 - 2009/07	113,520	32,036,402	24,855,984	7,180,418	77.6%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
1998/07 - 1999/06	5,181.5	82.52	41.45	41.07
1999/07 - 2000/06	10,454.9	90.75	52.85	37.89
2000/07 - 2001/06	15,398.5	103.18	56.04	47.14
2001/07 - 2002/06	20,808.1	115.59	66.15	49.44
2002/08 - 2003/07	26,779.3	129.51	86.27	43.23
2003/06 - 2004/05	28,962.7	141.38	99.33	42.05
2004/06 - 2005/05	25,252.8	161.97	127.32	34.65
2005/07 - 2006/06	21,159.8	189.49	150.62	38.87
2006/06 - 2007/05	18,070.6	210.25	157.32	52.93
2007/07 - 2008/06	12,838.8	245.34	188.82	56.52
2008/08 - 2009/07	9,460.0	282.21	218.96	63.25

Rate Change History (last four actions)

2004/03	14.5% increase
2005/03	16.2% increase
2006/03	13.9% increase
2007/03	16.5% increase
2008/03	9.14% increase
2009/03	19.6% average increase

* Incurred during period with three months of paid runout.

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

NM Major Medical

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
1998/07 - 1999/06	23,134	2,200,408	1,143,088	1,057,320	51.9%
1999/07 - 2000/06	19,607	2,135,476	1,168,307	967,169	54.7%
2000/07 - 2001/06	17,540	2,075,602	1,502,929	572,673	72.4%
2001/07 - 2002/06	17,226	2,428,956	1,816,189	612,767	74.8%
2002/08 - 2003/07	17,289	2,908,228	2,180,046	728,182	75.0%
2003/06 - 2004/05	15,315	3,013,101	2,091,050	922,051	69.4%
2004/06 - 2005/05	11,608	2,755,794	2,452,879	302,915	89.0%
2005/07 - 2006/06	9,150	2,365,121	2,333,683	31,438	98.7%
2006/06 - 2007/05	7,242	2,116,203	2,416,013	(299,810)	114.2%
2007/07 - 2008/06	4,787	1,749,577	1,945,979	(196,402)	111.2%
2008/08 - 2009/07	3,288	1,495,838	2,186,011	(690,173)	146.1%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
1998/07 - 1999/06	1,927.8	95.12	49.41	45.70
1999/07 - 2000/06	1,633.9	108.92	59.59	49.33
2000/07 - 2001/06	1,461.7	118.34	85.69	32.65
2001/07 - 2002/06	1,435.5	141.01	105.43	35.57
2002/08 - 2003/07	1,440.8	168.21	126.09	42.12
2003/06 - 2004/05	1,276.3	196.74	136.54	60.21
2004/06 - 2005/05	967.3	237.40	211.31	26.10
2005/07 - 2006/06	762.5	258.48	255.05	3.44
2006/06 - 2007/05	603.5	292.21	333.61	(41.40)
2007/07 - 2008/06	398.9	365.49	406.51	(41.03)
2008/08 - 2009/07	274.0	454.94	664.85	(209.91)

Rate Change History (last four actions)

2004/03	20.0% increase
2005/03	5.8% increase
2006/03	13.9% increase
2007/03	21.5% increase
2008/03	20.0% increase
2009/03	24.7% increase

* Incurred during period with three months of paid runout.

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

Number One

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
1998/07 - 1999/06	10,643	1,890,994	1,583,209	307,785	83.7%
1999/07 - 2000/06	8,107	1,645,958	1,099,451	546,507	66.8%
2000/07 - 2001/06	6,200	1,482,141	1,243,427	238,714	83.9%
2001/07 - 2002/06	4,185	1,363,217	1,288,228	74,989	94.5%
2002/08 - 2003/07	3,466	1,242,192	1,508,240	(266,048)	121.4%
2003/06 - 2004/05	2,812	1,248,012	934,148	313,864	74.9%
2004/06 - 2005/05	2,237	1,148,144	1,258,093	(109,949)	109.6%
2005/07 - 2006/06	1,700	969,969	921,676	48,293	95.0%
2006/06 - 2007/05	1,435	892,052	882,011	10,041	98.9%
2007/07 - 2008/06	1,109	794,146	823,881	(29,735)	103.7%
2008/08 - 2009/07	768	628,768	360,478	268,290	57.3%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
1998/07 - 1999/06	886.9	177.67	148.75	28.92
1999/07 - 2000/06	675.6	203.03	135.61	67.41
2000/07 - 2001/06	516.7	239.06	200.56	38.50
2001/07 - 2002/06	348.7	325.77	307.85	17.92
2002/08 - 2003/07	288.8	358.39	435.15	(76.76)
2003/06 - 2004/05	234.3	443.82	332.20	111.62
2004/06 - 2005/05	186.4	513.25	562.40	(49.15)
2005/07 - 2006/06	141.7	570.57	542.16	28.41
2006/06 - 2007/05	119.6	621.64	614.64	7.00
2007/07 - 2008/06	92.4	716.09	742.90	(26.81)
2008/08 - 2009/07	64.0	818.71	469.37	349.34

Rate Change History (last four actions)

2004/03	20.0% increase
2005/03	10.1% increase
2006/03	13.9% increase
2007/03	21.5% increase
2008/03	20.0% increase
2009/03	22.0% increase

* Incurred during period with three months of paid runout.

BlueCross BlueShield of New Mexico

Individual Under 65 Rate Filing

Experience Analysis by Line of Business

Conversion

Experience Period*	Member Months	Earned Premium	Incurred Claims	Gross Margin	Loss Ratio
1998/07 - 1999/06	2,084	819,077	862,276	(43,199)	105.3%
1999/07 - 2000/06	1,140	622,610	907,780	(285,170)	145.8%
2000/07 - 2001/06	1,089	635,342	682,390	(47,048)	107.4%
2001/07 - 2002/06	1,008	709,298	555,387	153,911	78.3%
2002/08 - 2003/07	513	346,395	397,034	(50,639)	114.6%
2003/06 - 2004/05	465	362,429	368,851	(6,422)	101.8%
2004/06 - 2005/05	341	330,091	202,972	127,119	61.5%
2005/07 - 2006/06	370	373,688	333,216	40,472	89.2%
2006/06 - 2007/05	390	368,083	531,558	(163,475)	144.4%
2007/07 - 2008/06	404	375,578	364,175	11,403	97.0%
2008/08 - 2009/07	372	380,394	433,614	(53,220)	114.0%

Experience Period*	Average Members	Earned Premium	Incurred Claims	Gross Margin
1998/07 - 1999/06	173.7	393.03	413.76	(20.73)
1999/07 - 2000/06	95.0	546.15	796.30	(250.15)
2000/07 - 2001/06	90.8	583.42	626.62	(43.20)
2001/07 - 2002/06	84.0	703.50	550.85	152.65
2002/08 - 2003/07	42.8	675.23	773.95	(98.71)
2003/06 - 2004/05	38.8	779.42	793.23	(13.81)
2004/06 - 2005/05	28.4	968.01	595.23	372.78
2005/07 - 2006/06	30.8	1,009.97	900.58	109.38
2006/06 - 2007/05	32.5	943.80	1,362.97	(419.17)
2007/07 - 2008/06	33.7	929.65	901.42	28.23
2008/08 - 2009/07	31.0	1,022.56	1,165.63	(143.06)

Rate Change History (last four actions)

2004/03	12.9% increase
2005/03	4.7% decrease
2006/03	no change
2007/03	no change
2008/03	20.0% increase
2009/03	decrease of 10%

Experience Period: 8/2008 - 7/2009
Rating Period: 4/2010 - 3/2011

Products	Total U65	Blue Direct Plan A	Blue Direct Plan B	Blue Direct Plan C	BlueEdge HSA	BLUE TRANSITION S	Blue Choice PPO 20	Blue Choice PPO 30	Blue Choice Plus Standard	NMMM	NUMBER ONE	CONVERSION
Average Contracts	26,103	2,920	10,218	831	1,096	118	5,113	1,459	4,057	218	46	28
Average Members	39,506	4,281	15,954	1,227	1,927	171	7,280	2,180	6,116	274	64	31
Jul 09 Members	39,668	4,176	17,860	1,586	2,085	235	5,681	2,456	5,280	227	57	25
Earned Premium	$85,445,644	$9,199,918	$25,083,420	$1,355,441	$2,617,105	$193,351	$25,910,022	$6,126,380	$12,455,006	$1,495,838	$628,768	$380,394
Prem PMPM	$180.24	$179.09	$131.02	$92.04	$113.17	$94.04	$296.59	$234.20	$169.70	$455.08	$816.58	$1,017.10
Incurred Claims	$73,489,794	$9,195,264	$22,129,142	$801,536	$2,610,266	$44,781	$21,286,891	$3,569,093	$10,872,718	$2,186,011	$360,478	$433,614
Incurred Claims PMPM	$155.02	$179.00	$115.59	$54.43	$112.88	$21.78	$243.67	$136.44	$148.14	$665.05	$468.15	$1,159.40
Incurred Loss Ratio	86.0%	99.9%	88.2%	59.1%	99.7%	23.2%	82.2%	58.3%	87.3%	146.1%	57.3%	114.0%
Proj Rating Period Premium												
Jul 09 Prem PMPM	$187.98	$194.42	$141.79	$100.68	$114.78	$81.95	$334.87	$249.93	$185.84	$521.17	$925.27	$1,032.33
Latest Renewal Increase	19.8%	19.5%	19.5%	19.5%	0.6%	-20.0%	21.0%	10.0%	24.0%	24.7%	22.0%	-10.0%
Percent Renewed	67%	53%	53%	67%	81%	42%	88%	88%	45%	99%	100%	75%
Avg Mthly Attained Age Increase	0.28%	0.28%	0.28%	0.28%	0.28%	0.00%	0.28%	0.28%	0.28%	0.28%	0.28%	0.28%
Months of Attained Age Increase	14	14	14	14	14	14	14	14	14	14	14	14
Proj Prem PMPM	$207.14	$218.89	$159.56	$110.69	$119.48	$71.58	$355.58	$262.77	$216.29	$543.43	$962.07	$1,044.38
Proj Rating Period Claims												
Annual Base Trend	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%	10.0%
Annual Deductible Leverage	1.1%	0.6%	1.3%	1.8%	1.8%	0.0%	1.0%	1.5%	1.2%	0.0%	0.0%	0.0%
Months of Trend	22	23	23	22	21	23	21	21	23	20	20	21
Trend Factor	1.2145	1.2114	1.2281	1.2307	1.2195	1.2048	1.1987	1.2093	1.2301	1.1729	1.1722	1.1839
Duration Adjustment	1.0519	1.1047	1.1238	1.1210	1.0767	1.0000	1.0000	1.0000	1.0004	1.0000	1.0000	1.0000
Deterioration Adjustment	1.0304	1.0306	1.0306	1.0306	1.0306	1.0000	1.0306	1.0306	1.0306	1.0306	1.0306	1.0000
Pooled Claims above $100,000	$4,845,225	$346,810	$878,769	$0	$387,182	$0	$1,045,759	$93,812	$1,300,491	$702,126	$0	$90,276
# of Large Claimants	57	6	14	0	4	0	15	2	10	5	0	1
Pooling Charge PMPM	$10.22	$5.75	$5.75	$5.75	$5.75	$16.71	$16.71	$16.71	$16.71	$16.71	$16.71	$16.71
Projected Claims PMPM	$195.43	$244.18	$166.71	$85.59	$139.32	$46.38	$302.63	$186.86	$182.63	$512.50	$585.71	$1,036.10
Expenses												
Operating Expenses	15.1%	14.5%	15.7%	19.1%	16.5%	24.2%	14.0%	15.3%	15.4%	13.1%	13.0%	12.9%
Commission	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%	5.7%
Premium Tax / Assessments	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%
Total Expenses	26.1%	25.5%	26.7%	30.1%	27.4%	35.2%	25.0%	26.3%	26.4%	24.1%	24.0%	23.9%
Pricing Margin	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	-43.9%
Desired Loss Ratio	68.9%	69.5%	68.3%	64.9%	67.6%	59.8%	70.0%	68.7%	68.6%	70.9%	71.0%	120.0%
Desired Prem PMPM	$283.55	$351.43	$244.14	$131.81	$206.21	$77.51	$432.37	$272.05	$266.20	$723.00	$824.38	$863.41
Indicated Rate Change	**36.9%**	**60.5%**	**53.0%**	**19.1%**	**72.6%**	**8.3%**	**21.6%**	**3.5%**	**23.1%**	**33.0%**	**-14.3%**	**-17.3%**
Proposed Rate Change	**24.6%**	**29.5%**	**29.5%**	**19.1%**	**29.5%**	**10.0%**	**21.6%**	**10.0%**	**23.1%**	**29.5%**	**0.0%**	**0.0%**
Expected Premium	$122,839,912	$14,204,974	$44,284,671	$2,508,573	$3,871,126	$222,031	$29,475,202	$8,518,717	$16,866,263	$1,916,985	$658,057	$313,315
Expected Premium PMPM	$258.06	$283.46	$206.63	$131.81	$154.72	$78.73	$432.37	$289.04	$266.20	$703.74	$962.07	$1,044.38
Expected Margin %	-2.0%	-12.3%	-8.1%	5.0%	-19.0%	6.1%	5.0%	9.2%	5.0%	3.0%	15.3%	26.0%
Expected Margin PMPM	-$5.21	-$34.90	-$16.76	$6.59	-$29.45	$4.82	$21.62	$26.73	$13.31	$21.28	$147.53	$271.40

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueDirect

Rating Factors

Effective 04/01/2010

Base Rate

	Approved	Effective 4/1/2010	
	03/01/2009	Filed Change	Filed Rate
BlueDirect A	325.66	29.50%	421.73
BlueDirect B	220.55	29.50%	285.61
BlueDirect C	144.97	19.10%	172.66

Plan Factors

	$100 Ded	$250 Ded	$500 Ded	$1000 Ded	$2000 Ded	$3500 Ded	$5000 Ded	$7500 Ded	$10000 Ded
BlueDirect A	1.0000	0.8595	0.6671	0.5796	0.4651				
BlueDirect B		1.0000	0.8327	0.7235	0.5806	0.4809	0.4061	0.3719	
BlueDirect C			1.0000	0.8489	0.6812	0.5642	0.4765	0.4303	0.3939

Demographic Factors

Age Band	Male	Female
00-01	0.7885	0.7885
02-06	0.3709	0.3709
07-18	0.4209	0.4209
19-24	0.5301	0.6349
25-29	0.6033	0.7238
30-34	0.7037	0.8443
35-39	0.8519	1.0222
40-44	1.0000	1.1999
45-49	1.1641	1.3968
50-54	1.3332	1.4930
55-59	1.4999	1.4999
60-64	1.5916	1.5916
65 & Over	1.6819	1.6819
Dep. Child	0.4156	0.4156

Area Factors

Albuquerque	Other
1.0000	1.1000

Tier Factors

Preferred	Tier I	Tier II	Tier III	Tier IV
1.0000	1.0500	1.1000	1.1500	1.2000
Tier V	**Tier VI**	**Tier VII**	**Tier VIII**	**Tier IX**
1.2500	1.3000	1.3500	1.4000	1.4500
Tier X	**Tier XI**	**Tier XII**		
1.5000	1.7500	2.0000		

Premium Rate = Base Rate x Plan Factor x Demographic Factor x Area Factor x Tier Factor

Example: Male age 33, BlueDirect B $500 Deductible, Santa Fe, Preferred Rates

Base Rate	285.61
Plan Factor	0.83270
Demographic	0.70370
Area Factor	1.10000
Tier Factor	1.00000
Premium	**$184**

BlueCross BlueShield of New Mexico

Individual Rate Filing

Premium Rates Effective 04/01/2010

(Increase of 29.50% Over Current Rates)

BlueDirect A

PREFERRED RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$100 Deductible		$250 Deductible		$500 Deductible		$1000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
00-01	$333	$333	$286	$286	$222	$222	$193	$193
02-06	$156	$156	$134	$134	$104	$104	$91	$91
07-18	$178	$178	$153	$153	$118	$118	$103	$103
19-24	$224	$268	$192	$230	$149	$179	$130	$155
25-29	$254	$305	$219	$262	$170	$204	$147	$177
30-34	$297	$356	$255	$306	$198	$238	$172	$206
35-39	$359	$431	$309	$371	$240	$288	$208	$250
40-44	$422	$506	$362	$435	$281	$338	$244	$293
45-49	$491	$589	$422	$506	$328	$393	$285	$341
50-54	$562	$630	$483	$541	$375	$420	$326	$365
55-59	$633	$633	$544	$544	$422	$422	$367	$367
60-64	$671	$671	$577	$577	$448	$448	$389	$389
65 & Over	$709	$709	$610	$610	$473	$473	$411	$411
Dep. Child	$175	$175	$151	$151	$117	$117	$102	$102

High Cost Area (Rural and Santa Fe, 87300 - 88499)*

	$100 Deductible		$250 Deductible		$500 Deductible		$1000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
00-01	$366	$366	$314	$314	$244	$244	$212	$212
02-04	$172	$172	$148	$148	$115	$115	$100	$100
05-18	$195	$195	$168	$168	$130	$130	$113	$113
19-24	$246	$295	$211	$253	$164	$196	$143	$171
25-29	$280	$336	$241	$289	$187	$224	$162	$195
30-34	$326	$392	$281	$337	$218	$261	$189	$227
35-39	$395	$474	$340	$408	$264	$316	$229	$275
40-44	$464	$557	$399	$478	$309	$371	$269	$323
45-49	$540	$648	$464	$557	$360	$432	$313	$376
50-54	$618	$693	$532	$595	$413	$462	$358	$401
55-59	$696	$696	$598	$598	$464	$464	$403	$403
60-64	$738	$738	$635	$635	$493	$493	$428	$428
65 & Over	$780	$780	$671	$671	$520	$520	$452	$452
Dep. Child	$193	$193	$166	$166	$129	$129	$112	$112

*** Subscribers with zip codes outside of the above ranges will be rated as high.**

BlueCross BlueShield of New Mexico
Individual Rate Filing
Premium Rates Effective 04/01/2010
(Increase of 29.50% Over Current Rates)

BlueDirect B

PREFERRED RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$225	$225	$188	$188	$163	$163	$131	$131	$108	$108	$91	$91	$84	$84
02-06	$106	$106	$88	$88	$77	$77	$62	$62	$51	$51	$43	$43	$39	$39
07-18	$120	$120	$100	$100	$87	$87	$70	$70	$58	$58	$49	$49	$45	$45
19-24	$151	$181	$126	$151	$110	$131	$88	$105	$73	$87	$61	$74	$56	$67
25-29	$172	$207	$143	$172	$125	$150	$100	$120	$83	$99	$70	$84	$64	$77
30-34	$201	$241	$167	$201	$145	$174	$117	$140	$97	$116	$82	$98	$75	$90
35-39	$243	$292	$203	$243	$176	$211	$141	$170	$117	$140	$99	$119	$90	$109
40-44	$286	$343	$238	$285	$207	$248	$166	$199	$137	$165	$116	$139	$106	$127
45-49	$332	$399	$277	$332	$241	$289	$193	$232	$160	$192	$135	$162	$124	$148
50-54	$381	$426	$317	$355	$275	$309	$221	$248	$183	$205	$155	$173	$142	$159
55-59	$428	$428	$357	$357	$310	$310	$249	$249	$206	$206	$174	$174	$159	$159
60-64	$455	$455	$379	$379	$329	$329	$264	$264	$219	$219	$185	$185	$169	$169
65 & Over	$480	$480	$400	$400	$348	$348	$279	$279	$231	$231	$195	$195	$179	$179
Dep. Child	$119	$119	$99	$99	$86	$86	$69	$69	$57	$57	$48	$48	$44	$44

High Cost Area (Rural and Santa Fe, 87300 - 88499)*

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$248	$248	$206	$206	$179	$179	$144	$144	$119	$119	$101	$101	$92	$92
02-04	$117	$117	$97	$97	$84	$84	$68	$68	$56	$56	$47	$47	$43	$43
05-18	$132	$132	$110	$110	$96	$96	$77	$77	$64	$64	$54	$54	$49	$49
19-24	$167	$199	$139	$166	$120	$144	$97	$116	$80	$96	$68	$81	$62	$74
25-29	$190	$227	$158	$189	$137	$165	$110	$132	$91	$109	$77	$92	$70	$85
30-34	$221	$265	$184	$221	$160	$192	$128	$154	$106	$128	$90	$108	$82	$99
35-39	$268	$321	$223	$267	$194	$232	$155	$186	$129	$154	$109	$130	$100	$119
40-44	$314	$377	$262	$314	$227	$273	$182	$219	$151	$181	$128	$153	$117	$140
45-49	$366	$439	$305	$365	$265	$317	$212	$255	$176	$211	$149	$178	$136	$163
50-54	$419	$469	$349	$391	$303	$339	$243	$272	$201	$226	$170	$190	$156	$174
55-59	$471	$471	$392	$392	$341	$341	$274	$274	$227	$227	$191	$191	$175	$175
60-64	$500	$500	$416	$416	$362	$362	$290	$290	$240	$240	$203	$203	$186	$186
65 & Over	$528	$528	$440	$440	$382	$382	$307	$307	$254	$254	$215	$215	$197	$197
Dep. Child	$131	$131	$109	$109	$94	$94	$76	$76	$63	$63	$53	$53	$49	$49

*** Subscribers with zip codes outside of the above ranges will be rated as high.**

BlueCross BlueShield of New Mexico
Individual Rate Filing
Premium Rates Effective 04/01/2010
(Increase of 19.10% Over Current Rates)

BlueDirect C

PREFERRED RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible		$10000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$136	$136	$116	$116	$93	$93	$77	$77	$65	$65	$59	$59	$54	$54
02-06	$64	$64	$54	$54	$44	$44	$36	$36	$31	$31	$28	$28	$25	$25
07-18	$73	$73	$62	$62	$50	$50	$41	$41	$35	$35	$31	$31	$29	$29
19-24	$92	$110	$78	$93	$62	$75	$52	$62	$44	$52	$39	$47	$36	$43
25-29	$104	$125	$88	$106	$71	$85	$59	$71	$50	$60	$45	$54	$41	$49
30-34	$122	$146	$103	$124	$83	$99	$69	$82	$58	$69	$52	$63	$48	$57
35-39	$147	$176	$125	$150	$100	$120	$83	$100	$70	$84	$63	$76	$58	$70
40-44	$173	$207	$147	$176	$118	$141	$97	$117	$82	$99	$74	$89	$68	$82
45-49	$201	$241	$171	$205	$137	$164	$113	$136	$96	$115	$86	$104	$79	$95
50-54	$230	$258	$195	$219	$157	$176	$130	$145	$110	$123	$99	$111	$91	$102
55-59	$259	$259	$220	$220	$176	$176	$146	$146	$123	$123	$111	$111	$102	$102
60-64	$275	$275	$233	$233	$187	$187	$155	$155	$131	$131	$118	$118	$108	$108
65 & Over	$290	$290	$247	$247	$198	$198	$164	$164	$138	$138	$125	$125	$114	$114
Dep. Child	$72	$72	$61	$61	$49	$49	$40	$40	$34	$34	$31	$31	$28	$28

High Cost Area (Rural and Santa Fe, 87300 - 88499)*

	$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible		$10000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$150	$150	$127	$127	$102	$102	$84	$84	$71	$71	$64	$64	$59	$59
02-04	$70	$70	$60	$60	$48	$48	$40	$40	$34	$34	$30	$30	$28	$28
05-18	$80	$80	$68	$68	$54	$54	$45	$45	$38	$38	$34	$34	$31	$31
19-24	$101	$121	$85	$102	$69	$82	$57	$68	$48	$57	$43	$52	$40	$47
25-29	$115	$137	$97	$117	$78	$94	$65	$78	$55	$66	$49	$59	$45	$54
30-34	$134	$160	$113	$136	$91	$109	$75	$90	$64	$76	$58	$69	$53	$63
35-39	$162	$194	$137	$165	$110	$132	$91	$110	$77	$93	$70	$84	$64	$76
40-44	$190	$228	$161	$193	$129	$155	$107	$129	$90	$109	$82	$98	$75	$90
45-49	$221	$265	$188	$225	$151	$181	$125	$150	$105	$126	$95	$114	$87	$104
50-54	$253	$284	$215	$241	$172	$193	$143	$160	$121	$135	$109	$122	$100	$112
55-59	$285	$285	$242	$242	$194	$194	$161	$161	$136	$136	$123	$123	$112	$112
60-64	$302	$302	$257	$257	$206	$206	$171	$171	$144	$144	$130	$130	$119	$119
65 & Over	$319	$319	$271	$271	$218	$218	$180	$180	$152	$152	$137	$137	$126	$126
Dep. Child	$79	$79	$67	$67	$54	$54	$45	$45	$38	$38	$34	$34	$31	$31

*** Subscribers with zip codes outside of the above ranges will be rated as high.**

BlueCross BlueShield of New Mexico
Individual Rate Filing
BlueEdge HSA
Rating Factors
Effective 04/01/2010

	Approved	Effective 4/1/2010	
Base Rate*	03/01/2009	Filed Change	Filed Rate
	119.52	29.50%	154.78

Plan Factors				New HSA 100 Options (Approved Effective 8/1/2009)	
	Premier*	Enhanced*	Basic*	100 $3500	100 $5000
	1.00444	0.86684	0.74223	0.84519	0.72146

Demographic Factors*

Age Band	Male	Female
00-01	0.66923	0.66923
02-04	0.61107	0.61107
05-18	0.55284	0.55284
19-24	0.52908	0.63492
25-29	0.60332	0.72378
30-34	0.70369	0.84433
35-39	0.85185	1.02213
40-44	1.00000	1.19993
45-49	1.16400	1.39685
50-54	1.33322	1.49298
55-59	1.49992	1.49992
60-64	1.59164	1.59164
65 & Over	1.68344	1.68344
Dep. Child	0.41555	0.41555

Area Factors*

Albuquerque	Other
1.00000	1.10000

Tier Factors*

Standard	Tier I	Tier II	Tier III
1.00000	1.10000	1.25000	1.50000

Premium Rate = Base Rate x Plan Factor x Demographic Factor x Area Factor x Tier Factor

Example: Male age 33, $3500 Plan, Santa Fe, Tier I Rates

Base Rate	154.78
Plan Factor	0.84519
Demographic	0.70369
Area Factor	1.10000
Tier Factor	1.10000
Premium	**111.39**

BlueCross BlueShield of New Mexico
Individual Rate Filing
BlueEdge 100 High Deductible Plans
Premium Rates Effective 04/01/2010
(29.50% Increase Over Current Rates)

STANDARD RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$88	$88	$75	$75
02-04	$80	$80	$68	$68
05-18	$72	$72	$62	$62
19-24	$69	$83	$59	$71
25-29	$79	$95	$67	$81
30-34	$92	$110	$79	$94
35-39	$111	$134	$95	$114
40-44	$131	$157	$112	$134
45-49	$152	$183	$130	$156
50-54	$174	$195	$149	$167
55-59	$196	$196	$167	$167
60-64	$208	$208	$178	$178
65 & Over	$220	$220	$188	$188
Dep. Child	$54	$54	$46	$46

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$96	$96	$82	$82
02-04	$88	$88	$75	$75
05-18	$80	$80	$68	$68
19-24	$76	$91	$65	$78
25-29	$87	$104	$74	$89
30-34	$101	$121	$86	$104
35-39	$123	$147	$105	$126
40-44	$144	$173	$123	$147
45-49	$168	$201	$143	$172
50-54	$192	$215	$164	$183
55-59	$216	$216	$184	$184
60-64	$229	$229	$196	$196
65 & Over	$242	$242	$207	$207
Dep. Child	$60	$60	$51	$51

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

* Filed and approved effective 3/1/2009 for BlueEdge Individual HSA

BlueCross BlueShield of New Mexico
Individual Rate Filing
BlueEdge 100 High Deductible Plans
Premium Rates Effective 04/01/2010
(29.50% Increase Over Current Rates)

TIER I RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$96	$96	$82	$82
02-04	$88	$88	$75	$75
05-18	$80	$80	$68	$68
19-24	$76	$91	$65	$78
25-29	$87	$104	$74	$89
30-34	$101	$121	$86	$104
35-39	$123	$147	$105	$126
40-44	$144	$173	$123	$147
45-49	$168	$201	$143	$172
50-54	$192	$215	$164	$183
55-59	$216	$216	$184	$184
60-64	$229	$229	$196	$196
65 & Over	$242	$242	$207	$207
Dep. Child	$60	$60	$51	$51

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$106	$106	$90	$90
02-04	$97	$97	$83	$83
05-18	$88	$88	$75	$75
19-24	$84	$101	$71	$86
25-29	$95	$115	$82	$98
30-34	$111	$134	$95	$114
35-39	$135	$162	$115	$138
40-44	$158	$190	$135	$162
45-49	$184	$221	$157	$189
50-54	$211	$236	$180	$202
55-59	$237	$237	$203	$203
60-64	$252	$252	$215	$215
65 & Over	$266	$266	$227	$227
Dep. Child	$66	$66	$56	$56

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico
Individual Rate Filing
BlueEdge 100 High Deductible Plans
Premium Rates Effective 04/01/2010
(29.50% Increase Over Current Rates)

TIER II RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$109	$109	$93	$93
02-04	$100	$100	$85	$85
05-18	$90	$90	$77	$77
19-24	$87	$104	$74	$89
25-29	$99	$118	$84	$101
30-34	$115	$138	$98	$118
35-39	$139	$167	$119	$143
40-44	$164	$196	$140	$167
45-49	$190	$228	$162	$195
50-54	$218	$244	$186	$208
55-59	$245	$245	$209	$209
60-64	$260	$260	$222	$222
65 & Over	$275	$275	$235	$235
Dep. Child	$68	$68	$58	$58

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$120	$120	$103	$103
02-04	$110	$110	$94	$94
05-18	$99	$99	$85	$85
19-24	$95	$114	$81	$97
25-29	$109	$130	$93	$111
30-34	$127	$152	$108	$130
35-39	$153	$184	$131	$157
40-44	$180	$216	$154	$184
45-49	$209	$251	$179	$214
50-54	$240	$269	$205	$229
55-59	$270	$270	$230	$230
60-64	$286	$286	$244	$244
65 & Over	$303	$303	$258	$258
Dep. Child	$75	$75	$64	$64

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico
Individual Rate Filing
BlueEdge 100 High Deductible Plans
Premium Rates Effective 04/01/2010
(29.50% Increase Over Current Rates)

TIER III RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$131	$131	$112	$112
02-04	$120	$120	$102	$102
05-18	$108	$108	$93	$93
19-24	$104	$125	$89	$106
25-29	$118	$142	$101	$121
30-34	$138	$166	$118	$141
35-39	$167	$201	$143	$171
40-44	$196	$235	$168	$201
45-49	$228	$274	$195	$234
50-54	$262	$293	$223	$250
55-59	$294	$294	$251	$251
60-64	$312	$312	$267	$267
65 & Over	$330	$330	$282	$282
Dep. Child	$82	$82	$70	$70

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$3500 Ded		$5000 Ded	
	Male	Female	Male	Female
Age Band				
00-01	$144	$144	$123	$123
02-04	$132	$132	$113	$113
05-18	$119	$119	$102	$102
19-24	$114	$137	$97	$117
25-29	$130	$156	$111	$133
30-34	$152	$182	$130	$156
35-39	$184	$221	$157	$188
40-44	$216	$259	$184	$221
45-49	$251	$302	$214	$257
50-54	$288	$322	$246	$275
55-59	$324	$324	$276	$276
60-64	$344	$344	$293	$293
65 & Over	$363	$363	$310	$310
Dep. Child	$90	$90	$77	$77

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueEdge Individual HSA

Premium Rates Effective 04/01/2010

(29.50% Increase Over Current Rates)

STANDARD RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$104	$104	$90	$90	$77	$77
02-04	$95	$95	$82	$82	$70	$70
05-18	$86	$86	$74	$74	$64	$64
19-24	$82	$99	$71	$85	$61	$73
25-29	$94	$113	$81	$97	$69	$83
30-34	$109	$131	$94	$113	$81	$97
35-39	$132	$159	$114	$137	$98	$117
40-44	$155	$187	$134	$161	$115	$138
45-49	$181	$217	$156	$187	$134	$160
50-54	$207	$232	$179	$200	$153	$172
55-59	$233	$233	$201	$201	$172	$172
60-64	$247	$247	$214	$214	$183	$183
65 & Over	$262	$262	$226	$226	$193	$193
Dep. Child	$65	$65	$56	$56	$48	$48

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$114	$114	$99	$99	$85	$85
02-04	$105	$105	$90	$90	$77	$77
05-18	$95	$95	$82	$82	$70	$70
19-24	$90	$109	$78	$94	$67	$80
25-29	$103	$124	$89	$107	$76	$91
30-34	$120	$144	$104	$125	$89	$107
35-39	$146	$175	$126	$151	$108	$129
40-44	$171	$205	$148	$177	$126	$152
45-49	$199	$239	$172	$206	$147	$177
50-54	$228	$255	$197	$220	$168	$189
55-59	$257	$257	$221	$221	$190	$190
60-64	$272	$272	$235	$235	$201	$201
65 & Over	$288	$288	$248	$248	$213	$213
Dep. Child	$71	$71	$61	$61	$53	$53

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueEdge Individual HSA

Premium Rates Effective 04/01/2010

(29.50% Increase Over Current Rates)

TIER I Rates

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$114	$114	$99	$99	$85	$85
02-04	$105	$105	$90	$90	$77	$77
05-18	$95	$95	$82	$82	$70	$70
19-24	$90	$109	$78	$94	$67	$80
25-29	$103	$124	$89	$107	$76	$91
30-34	$120	$144	$104	$125	$89	$107
35-39	$146	$175	$126	$151	$108	$129
40-44	$171	$205	$148	$177	$126	$152
45-49	$199	$239	$172	$206	$147	$177
50-54	$228	$255	$197	$220	$168	$189
55-59	$257	$257	$221	$221	$190	$190
60-64	$272	$272	$235	$235	$201	$201
65 & Over	$288	$288	$248	$248	$213	$213
Dep. Child	$71	$71	$61	$61	$53	$53

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$126	$126	$109	$109	$93	$93
02-04	$115	$115	$99	$99	$85	$85
05-18	$104	$104	$90	$90	$77	$77
19-24	$100	$119	$86	$103	$74	$88
25-29	$113	$136	$98	$118	$84	$101
30-34	$132	$159	$114	$137	$98	$117
35-39	$160	$192	$138	$166	$118	$142
40-44	$188	$226	$162	$195	$139	$167
45-49	$219	$263	$189	$227	$162	$194
50-54	$251	$281	$216	$242	$185	$208
55-59	$282	$282	$244	$244	$209	$209
60-64	$299	$299	$258	$258	$221	$221
65 & Over	$317	$317	$273	$273	$234	$234
Dep. Child	$78	$78	$67	$67	$58	$58

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueEdge Individual HSA

Premium Rates Effective 04/01/2010

(29.50% Increase Over Current Rates)

TIER II Rates

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$130	$130	$112	$112	$96	$96
02-04	$119	$119	$102	$102	$88	$88
05-18	$107	$107	$93	$93	$79	$79
19-24	$103	$123	$89	$106	$76	$91
25-29	$117	$141	$101	$121	$87	$104
30-34	$137	$164	$118	$142	$101	$121
35-39	$166	$199	$143	$171	$122	$147
40-44	$194	$233	$168	$201	$144	$172
45-49	$226	$271	$195	$234	$167	$201
50-54	$259	$290	$224	$250	$191	$214
55-59	$291	$291	$252	$252	$215	$215
60-64	$309	$309	$267	$267	$229	$229
65 & Over	$327	$327	$282	$282	$242	$242
Dep. Child	$81	$81	$70	$70	$60	$60

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$143	$143	$123	$123	$106	$106
02-04	$131	$131	$113	$113	$97	$97
05-18	$118	$118	$102	$102	$87	$87
19-24	$113	$136	$98	$117	$84	$100
25-29	$129	$155	$111	$134	$95	$114
30-34	$150	$180	$130	$156	$111	$133
35-39	$182	$218	$157	$189	$135	$161
40-44	$214	$257	$184	$221	$158	$190
45-49	$249	$299	$215	$258	$184	$221
50-54	$285	$319	$246	$275	$211	$236
55-59	$321	$321	$277	$277	$237	$237
60-64	$340	$340	$294	$294	$251	$251
65 & Over	$360	$360	$311	$311	$266	$266
Dep. Child	$89	$89	$77	$77	$66	$66

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueEdge Individual HSA

Premium Rates Effective 04/01/2010

(29.50% Increase Over Current Rates)

TIER III Rates

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$156	$156	$135	$135	$115	$115
02-04	$143	$143	$123	$123	$105	$105
05-18	$129	$129	$111	$111	$95	$95
19-24	$123	$148	$106	$128	$91	$109
25-29	$141	$169	$121	$146	$104	$125
30-34	$164	$197	$142	$170	$121	$145
35-39	$199	$238	$171	$206	$147	$176
40-44	$233	$280	$201	$241	$172	$207
45-49	$271	$326	$234	$281	$201	$241
50-54	$311	$348	$268	$300	$230	$257
55-59	$350	$350	$302	$302	$258	$258
60-64	$371	$371	$320	$320	$274	$274
65 & Over	$393	$393	$339	$339	$290	$290
Dep. Child	$97	$97	$84	$84	$72	$72

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	Premier		Enhanced		Basic	
	Male	Female	Male	Female	Male	Female
Age Band						
00-01	$172	$172	$148	$148	$127	$127
02-04	$157	$157	$135	$135	$116	$116
05-18	$142	$142	$122	$122	$105	$105
19-24	$136	$163	$117	$141	$100	$120
25-29	$155	$186	$134	$160	$114	$137
30-34	$181	$217	$156	$187	$133	$160
35-39	$219	$262	$189	$226	$161	$194
40-44	$257	$308	$221	$266	$190	$227
45-49	$299	$358	$258	$309	$221	$265
50-54	$342	$383	$295	$331	$253	$283
55-59	$385	$385	$332	$332	$284	$284
60-64	$408	$408	$352	$352	$302	$302
65 & Over	$432	$432	$373	$373	$319	$319
Dep. Child	$107	$107	$92	$92	$79	$79

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico
Blue Transitions - Short Term Limited Duration Insurance
Effective 04/01/2010

Base Rate	$500	$1,000	$2,000
03/01/2009	89.45	76.14	66.02
Filed Increase	10.00%	10.00%	10.00%
04/01/2010	98.40	83.75	72.62

Demographic Factors

Age Band	Male	Female
Under 1	1.46250	1.58750
01-04	0.54690	0.42980
05-12	0.47500	0.35040
13-19	0.50300	0.57400
20-24	0.63800	0.82500
25-29	0.66300	0.87800
30-34	0.73200	0.99000
35-39	0.83750	1.13000
40-44	1.00000	1.28300
45-49	1.20400	1.45500
50-54	1.45700	1.64100
55-59	1.91600	1.82500
60-64	2.42800	2.07500
65 & Over	2.71250	2.55000
Dep. Child	0.50880	0.50880

Area Factors

	Albuquerque	Other
	1.00000	1.10000

BlueCross BlueShield of New Mexico

Blue Transitions - Short Term Limited Duration Insurance

Effective 04/01/2010

(Increase of 10.0% Over Current Rates)

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female
Age Band						
Under 1	$144	$156	$122	$133	$106	$115
01-04	$54	$42	$46	$36	$40	$31
05-12	$47	$34	$40	$29	$34	$25
13-19	$49	$56	$42	$48	$37	$42
20-24	$63	$81	$53	$69	$46	$60
25-29	$65	$86	$56	$74	$48	$64
30-34	$72	$97	$61	$83	$53	$72
35-39	$82	$111	$70	$95	$61	$82
40-44	$98	$126	$84	$107	$73	$93
45-49	$118	$143	$101	$122	$87	$106
50-54	$143	$161	$122	$137	$106	$119
55-59	$189	$180	$160	$153	$139	$133
60-64	$239	$204	$203	$174	$176	$151
65 & Over	$267	$251	$227	$214	$197	$185
Dep. Child	$50	$50	$43	$43	$37	$37

High Cost Area (All Other Zip Codes)

	$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female
Age Band						
Under 1	$158	$172	$134	$146	$117	$127
01-04	$59	$46	$51	$40	$44	$34
05-12	$52	$37	$44	$32	$37	$28
13-19	$54	$62	$46	$53	$41	$46
20-24	$69	$89	$58	$76	$51	$66
25-29	$72	$95	$62	$81	$53	$70
30-34	$79	$107	$67	$91	$58	$79
35-39	$90	$122	$77	$105	$67	$90
40-44	$108	$139	$92	$118	$80	$102
45-49	$130	$157	$111	$134	$96	$117
50-54	$157	$177	$134	$151	$117	$131
55-59	$208	$198	$176	$168	$153	$146
60-64	$263	$224	$223	$191	$194	$166
65 & Over	$294	$276	$250	$235	$217	$204
Dep. Child	$55	$55	$47	$47	$41	$41

BlueCross BlueShield of New Mexico
Individual Rate Filing
Rating Factors
Effective 04/01/2010
BlueChoice Plus

Base Rate

03/01/2009	264.01
Filed Increase	23.10%
04/01/2010	325.00

Plan Factors

	$250 Ded	$500 Ded	$1000 Ded	$2000 Ded	$3500 Ded	$5000 Ded	$7500 Ded
	1.0000	0.7960	0.7090	0.6040	0.5060	0.4330	0.3980

Demographic Factors

Age Band	Male	Female
00-01	0.6692	0.6692
02-04	0.6111	0.6111
05-18	0.5529	0.5529
19-24	0.5291	0.6349
25-29	0.6033	0.7238
30-34	0.7037	0.8443
35-39	0.8518	1.0222
40-44	1.0000	1.1999
45-49	1.1640	1.3968
50-54	1.3332	1.4930
55-59	1.4999	1.4999
60-64	1.5916	1.5916
65 & Over	1.6834	1.6834
Dep. Child	0.4156	0.4156

Area Factors

	Albuquerque	Other
	1.0000	1.1000

Tier Factors

	Standard	Tier I	Tier II	Tier III
	1.0000	1.1000	1.2500	1.5000

Premium Rate = Base Rate x Plan Factor x Demographic Factor x Area Factor x Tier Factor

Example: Male age 33, $500 Deductible, Santa Fe, Tier I Rates

Base Rate	325.00
Plan Factor	0.79600
Demographic	0.70370
Area Factor	1.10000
Tier Factor	1.10000
Premium	**220.28**

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueChoice Plus

Premium Rates Effective 04/01/2010

(Increase of 23.10% over current rates)

STANDARD RATES

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$217	$217	$173	$173	$154	$154	$131	$131	$110	$110	$94	$94	$87	$87
02-04	$199	$199	$158	$158	$141	$141	$120	$120	$100	$100	$86	$86	$79	$79
05-18	$180	$180	$143	$143	$127	$127	$109	$109	$91	$91	$78	$78	$72	$72
19-24	$172	$206	$137	$164	$122	$146	$104	$125	$87	$104	$74	$89	$68	$82
25-29	$196	$235	$156	$187	$139	$167	$118	$142	$99	$119	$85	$102	$78	$94
30-34	$229	$274	$182	$218	$162	$195	$138	$166	$116	$139	$99	$119	$91	$109
35-39	$277	$332	$220	$264	$196	$236	$167	$201	$140	$168	$120	$144	$110	$132
40-44	$325	$390	$259	$310	$230	$276	$196	$236	$164	$197	$141	$169	$129	$155
45-49	$378	$454	$301	$361	$268	$322	$228	$274	$191	$230	$164	$197	$151	$181
50-54	$433	$485	$345	$386	$307	$344	$262	$293	$219	$246	$188	$210	$172	$193
55-59	$487	$487	$388	$388	$346	$346	$294	$294	$247	$247	$211	$211	$194	$194
60-64	$517	$517	$412	$412	$367	$367	$312	$312	$262	$262	$224	$224	$206	$206
65 & Over	$547	$547	$435	$435	$388	$388	$330	$330	$277	$277	$237	$237	$218	$218
Dep. Child	$135	$135	$108	$108	$96	$96	$82	$82	$68	$68	$58	$58	$54	$54

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$239	$239	$190	$190	$170	$170	$145	$145	$121	$121	$104	$104	$95	$95
02-04	$218	$218	$174	$174	$155	$155	$132	$132	$111	$111	$95	$95	$87	$87
05-18	$198	$198	$157	$157	$140	$140	$119	$119	$100	$100	$86	$86	$79	$79
19-24	$189	$227	$151	$181	$134	$161	$114	$137	$96	$115	$82	$98	$75	$90
25-29	$216	$259	$172	$206	$153	$183	$130	$156	$109	$131	$93	$112	$86	$103
30-34	$252	$302	$200	$240	$178	$214	$152	$182	$127	$153	$109	$131	$100	$120
35-39	$305	$365	$242	$291	$216	$259	$184	$221	$154	$185	$132	$158	$121	$145
40-44	$358	$429	$285	$341	$253	$304	$216	$259	$181	$217	$155	$186	$142	$171
45-49	$416	$499	$331	$397	$295	$354	$251	$302	$211	$253	$180	$216	$166	$199
50-54	$477	$534	$379	$425	$338	$378	$288	$322	$241	$270	$206	$231	$190	$212
55-59	$536	$536	$427	$427	$380	$380	$324	$324	$271	$271	$232	$232	$213	$213
60-64	$569	$569	$453	$453	$403	$403	$344	$344	$288	$288	$246	$246	$226	$226
65 & Over	$602	$602	$479	$479	$427	$427	$363	$363	$305	$305	$261	$261	$240	$240
Dep. Child	$149	$149	$118	$118	$105	$105	$90	$90	$75	$75	$64	$64	$59	$59

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueChoice Plus

Premium Rates Effective 04/01/2010

(Increase of 23.10% over current rates)

TIER I RATES (110% of Standard Rates)

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$239	$239	$190	$190	$170	$170	$145	$145	$121	$121	$104	$104	$95	$95
02-04	$218	$218	$174	$174	$155	$155	$132	$132	$111	$111	$95	$95	$87	$87
05-18	$198	$198	$157	$157	$140	$140	$119	$119	$100	$100	$86	$86	$79	$79
19-24	$189	$227	$151	$181	$134	$161	$114	$137	$96	$115	$82	$98	$75	$90
25-29	$216	$259	$172	$206	$153	$183	$130	$156	$109	$131	$93	$112	$86	$103
30-34	$252	$302	$200	$240	$178	$214	$152	$182	$127	$153	$109	$131	$100	$120
35-39	$305	$365	$242	$291	$216	$259	$184	$221	$154	$185	$132	$158	$121	$145
40-44	$358	$429	$285	$341	$253	$304	$216	$259	$181	$217	$155	$186	$142	$171
45-49	$416	$499	$331	$397	$295	$354	$251	$302	$211	$253	$180	$216	$166	$199
50-54	$477	$534	$379	$425	$338	$378	$288	$322	$241	$270	$206	$231	$190	$212
55-59	$536	$536	$427	$427	$380	$380	$324	$324	$271	$271	$232	$232	$213	$213
60-64	$569	$569	$453	$453	$403	$403	$344	$344	$288	$288	$246	$246	$226	$226
65 & Over	$602	$602	$479	$479	$427	$427	$363	$363	$305	$305	$261	$261	$240	$240
Dep. Child	$149	$149	$118	$118	$105	$105	$90	$90	$75	$75	$64	$64	$59	$59

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$263	$263	$209	$209	$187	$187	$159	$159	$133	$133	$114	$114	$105	$105
02-04	$240	$240	$191	$191	$170	$170	$145	$145	$122	$122	$104	$104	$96	$96
05-18	$217	$217	$173	$173	$154	$154	$131	$131	$110	$110	$94	$94	$87	$87
19-24	$208	$250	$166	$199	$148	$177	$126	$151	$105	$126	$90	$108	$83	$99
25-29	$237	$285	$189	$227	$168	$202	$143	$172	$120	$144	$103	$123	$94	$113
30-34	$277	$332	$220	$264	$196	$235	$167	$201	$140	$168	$120	$144	$110	$132
35-39	$335	$402	$267	$320	$237	$285	$202	$243	$169	$203	$145	$174	$133	$160
40-44	$393	$472	$313	$376	$279	$335	$238	$285	$199	$239	$170	$204	$157	$188
45-49	$458	$549	$364	$437	$325	$389	$276	$332	$232	$278	$198	$238	$182	$219
50-54	$524	$587	$417	$467	$372	$416	$317	$355	$265	$297	$227	$254	$209	$234
55-59	$590	$590	$470	$470	$418	$418	$356	$356	$298	$298	$255	$255	$235	$235
60-64	$626	$626	$498	$498	$444	$444	$378	$378	$317	$317	$271	$271	$249	$249
65 & Over	$662	$662	$527	$527	$469	$469	$400	$400	$335	$335	$287	$287	$263	$263
Dep. Child	$163	$163	$130	$130	$116	$116	$99	$99	$83	$83	$71	$71	$65	$65

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueChoice Plus

Premium Rates Effective 04/01/2010

(Increase of 23.10% over current rates)

TIER II RATES (125% of Standard Rates)

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$272	$272	$216	$216	$193	$193	$164	$164	$138	$138	$118	$118	$108	$108
02-04	$248	$248	$198	$198	$176	$176	$150	$150	$126	$126	$107	$107	$99	$99
05-18	$225	$225	$179	$179	$159	$159	$136	$136	$114	$114	$97	$97	$89	$89
19-24	$215	$258	$171	$205	$152	$183	$130	$156	$109	$131	$93	$112	$86	$103
25-29	$245	$294	$195	$234	$174	$208	$148	$178	$124	$149	$106	$127	$98	$117
30-34	$286	$343	$228	$273	$203	$243	$173	$207	$145	$174	$124	$149	$114	$137
35-39	$346	$415	$275	$331	$245	$294	$209	$251	$175	$210	$150	$180	$138	$165
40-44	$406	$487	$323	$388	$288	$346	$245	$294	$206	$247	$176	$211	$162	$194
45-49	$473	$567	$376	$452	$335	$402	$286	$343	$239	$287	$205	$246	$188	$226
50-54	$542	$607	$431	$483	$384	$430	$327	$366	$274	$307	$235	$263	$216	$241
55-59	$609	$609	$485	$485	$432	$432	$368	$368	$308	$308	$264	$264	$243	$243
60-64	$647	$647	$515	$515	$458	$458	$391	$391	$327	$327	$280	$280	$257	$257
65 & Over	$684	$684	$544	$544	$485	$485	$413	$413	$346	$346	$296	$296	$272	$272
Dep. Child	$169	$169	$134	$134	$120	$120	$102	$102	$85	$85	$73	$73	$67	$67

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$299	$299	$238	$238	$212	$212	$181	$181	$151	$151	$129	$129	$119	$119
02-04	$273	$273	$217	$217	$194	$194	$165	$165	$138	$138	$118	$118	$109	$109
05-18	$247	$247	$197	$197	$175	$175	$149	$149	$125	$125	$107	$107	$98	$98
19-24	$236	$284	$188	$226	$168	$201	$143	$171	$120	$144	$102	$123	$94	$113
25-29	$270	$323	$215	$257	$191	$229	$163	$195	$136	$164	$117	$140	$107	$129
30-34	$314	$377	$250	$300	$223	$268	$190	$228	$159	$191	$136	$163	$125	$150
35-39	$381	$457	$303	$364	$270	$324	$230	$276	$193	$231	$165	$198	$151	$182
40-44	$447	$536	$356	$427	$317	$380	$270	$324	$226	$271	$193	$232	$178	$213
45-49	$520	$624	$414	$497	$369	$443	$314	$377	$263	$316	$225	$270	$207	$248
50-54	$596	$667	$474	$531	$422	$473	$360	$403	$301	$338	$258	$289	$237	$266
55-59	$670	$670	$534	$534	$475	$475	$405	$405	$339	$339	$290	$290	$267	$267
60-64	$711	$711	$566	$566	$504	$504	$430	$430	$360	$360	$308	$308	$283	$283
65 & Over	$752	$752	$599	$599	$533	$533	$454	$454	$381	$381	$326	$326	$299	$299
Dep. Child	$186	$186	$148	$148	$132	$132	$112	$112	$94	$94	$80	$80	$74	$74

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueChoice Plus

Premium Rates Effective 04/01/2010

(Increase of 23.10% over current rates)

TIER III RATES (150% of Standard Rates)

Low Cost Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$326	$326	$260	$260	$231	$231	$197	$197	$165	$165	$141	$141	$130	$130
02-04	$298	$298	$237	$237	$211	$211	$180	$180	$151	$151	$129	$129	$119	$119
05-18	$270	$270	$215	$215	$191	$191	$163	$163	$136	$136	$117	$117	$107	$107
19-24	$258	$310	$205	$246	$183	$219	$156	$187	$131	$157	$112	$134	$103	$123
25-29	$294	$353	$234	$281	$209	$250	$178	$213	$149	$179	$127	$153	$117	$140
30-34	$343	$412	$273	$328	$243	$292	$207	$249	$174	$208	$149	$178	$137	$164
35-39	$415	$498	$331	$397	$294	$353	$251	$301	$210	$252	$180	$216	$165	$198
40-44	$488	$585	$388	$466	$346	$415	$294	$353	$247	$296	$211	$253	$194	$233
45-49	$567	$681	$452	$542	$402	$483	$343	$411	$287	$345	$246	$295	$226	$271
50-54	$650	$728	$517	$579	$461	$516	$393	$440	$329	$368	$281	$315	$259	$290
55-59	$731	$731	$582	$582	$518	$518	$442	$442	$370	$370	$317	$317	$291	$291
60-64	$776	$776	$618	$618	$550	$550	$469	$469	$393	$393	$336	$336	$309	$309
65 & Over	$821	$821	$653	$653	$582	$582	$496	$496	$415	$415	$355	$355	$327	$327
Dep. Child	$203	$203	$161	$161	$144	$144	$122	$122	$103	$103	$88	$88	$81	$81

High Cost Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band														
00-01	$359	$359	$286	$286	$254	$254	$217	$217	$182	$182	$155	$155	$143	$143
02-04	$328	$328	$261	$261	$232	$232	$198	$198	$166	$166	$142	$142	$130	$130
05-18	$296	$296	$236	$236	$210	$210	$179	$179	$150	$150	$128	$128	$118	$118
19-24	$284	$340	$226	$271	$201	$241	$171	$206	$144	$172	$123	$147	$113	$136
25-29	$324	$388	$258	$309	$229	$275	$195	$234	$164	$196	$140	$168	$129	$154
30-34	$377	$453	$300	$360	$268	$321	$228	$273	$191	$229	$163	$196	$150	$180
35-39	$457	$548	$364	$436	$324	$389	$276	$331	$231	$277	$198	$237	$182	$218
40-44	$536	$643	$427	$512	$380	$456	$324	$389	$271	$326	$232	$279	$213	$256
45-49	$624	$749	$497	$596	$443	$531	$377	$452	$316	$379	$270	$324	$248	$298
50-54	$715	$801	$569	$637	$507	$568	$432	$484	$362	$405	$310	$347	$285	$319
55-59	$804	$804	$640	$640	$570	$570	$486	$486	$407	$407	$348	$348	$320	$320
60-64	$853	$853	$679	$679	$605	$605	$516	$516	$432	$432	$370	$370	$340	$340
65 & Over	$903	$903	$719	$719	$640	$640	$545	$545	$457	$457	$391	$391	$359	$359
Dep. Child	$223	$223	$177	$177	$158	$158	$135	$135	$113	$113	$97	$97	$89	$89

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico
Individual Rate Filing
Rating Factors
Effective 04/01/2010
BlueChoice

Base Rate	BlueChoice	BlueChoice Alt
03/01/2009	491.95	491.95
Filed Increase	21.60%	10.00%
04/01/2010	598.21	541.15

Plan Factors

	$250 Ded	$500 Ded	$1000 Ded	$2000 Ded	$3500 Ded	$5000 Ded	$7500 Ded	$10000 Ded
80% / 60%	1.0000	0.7963	0.7097	0.6043				
70% / 50%	0.7756	0.6104	0.5426	0.4540	0.3945	0.3463	0.3130	0.2889

Demographic Factors

Age Band	Male	Female
00-01	0.6693	0.6693
02-04	0.6111	0.6111
05-18	0.5530	0.5530
19-24	0.5291	0.6350
25-29	0.6033	0.7238
30-34	0.7037	0.8445
35-39	0.8518	1.0222
40-44	1.0000	1.2000
45-49	1.1640	1.3969
50-54	1.3334	1.4930
55-59	1.5000	1.5000
60-64	1.5000	1.5000
65 & Over	1.5000	1.5000
Dep. Child	0.4155	0.4155

Area Factors

	Albuquerque	Other
	0.9000	1.0000

Tier Factors

	non-Smoking	Smoking
	0.9000	1.0000

Premium Rate = Base Rate x Plan Factor x Demographic Factor x Area Factor x Tier Factor

Example: BlueChoice, Male age 33, $500 Ded (80% Coins), Santa Fe, Smoking

Base Rate	598.21
Plan Factor	0.79630
Demographic	0.70370
Area Factor	1.00000
Tier Factor	1.00000
Premium	**335.21**

BlueCross BlueShield of New Mexico

Individual Rate Filing

BlueChoice

Premium Rates Effective 04/01/2010

(Increase of 21.60% over Current Rates)

Coinsurance level: 80% In-network , 60% out-of-network /// Office visit copayment: $20 /// Prescription Drug Benefit: $20/$30/$45

Non-Smoking / High Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
00-01	$360	$360	$287	$287	$256	$256	$218	$218
02-04	$329	$329	$262	$262	$233	$233	$199	$199
05-18	$298	$298	$237	$237	$211	$211	$180	$180
19-24	$285	$342	$227	$272	$202	$243	$172	$207
25-29	$325	$390	$259	$310	$231	$277	$196	$235
30-34	$379	$455	$302	$362	$269	$323	$229	$275
35-39	$459	$550	$365	$438	$325	$391	$277	$333
40-44	$538	$646	$429	$514	$382	$459	$325	$390
45-49	$627	$752	$499	$599	$445	$534	$379	$454
50-54	$718	$804	$572	$640	$509	$570	$434	$486
55-59	$808	$808	$643	$643	$573	$573	$488	$488
60-64	$808	$808	$643	$643	$573	$573	$488	$488
65 & Over	$808	$808	$643	$643	$573	$573	$488	$488
Dep. Child	$224	$224	$178	$178	$159	$159	$135	$135

Non-Smoking / Low Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
00-01	$324	$324	$258	$258	$230	$230	$196	$196
02-04	$296	$296	$236	$236	$210	$210	$179	$179
05-18	$268	$268	$213	$213	$190	$190	$162	$162
19-24	$256	$308	$204	$245	$182	$218	$155	$186
25-29	$292	$351	$233	$279	$207	$249	$177	$212
30-34	$341	$409	$272	$326	$242	$290	$206	$247
35-39	$413	$495	$329	$394	$293	$352	$249	$299
40-44	$485	$581	$386	$463	$344	$413	$293	$351
45-49	$564	$677	$449	$539	$400	$480	$341	$409
50-54	$646	$723	$514	$576	$459	$513	$390	$437
55-59	$727	$727	$579	$579	$516	$516	$439	$439
60-64	$727	$727	$579	$579	$516	$516	$439	$439
65 & Over	$727	$727	$579	$579	$516	$516	$439	$439
Dep. Child	$201	$201	$160	$160	$143	$143	$122	$122

Smoking / High Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
00-01	$360	$360	$287	$287	$256	$256	$218	$218
02-04	$329	$329	$262	$262	$233	$233	$199	$199
05-18	$298	$298	$237	$237	$211	$211	$180	$180
19-24	$317	$380	$252	$302	$225	$270	$191	$230
25-29	$361	$433	$287	$345	$256	$307	$218	$262
30-34	$421	$505	$335	$402	$299	$359	$254	$305
35-39	$510	$611	$406	$487	$362	$434	$308	$370
40-44	$598	$718	$476	$572	$425	$509	$361	$434
45-49	$696	$836	$554	$665	$494	$593	$421	$505
50-54	$798	$893	$635	$711	$566	$634	$482	$540
55-59	$897	$897	$715	$715	$637	$637	$542	$542
60-64	$897	$897	$715	$715	$637	$637	$542	$542
65 & Over	$897	$897	$715	$715	$637	$637	$542	$542
Dep. Child	$224	$224	$178	$178	$159	$159	$135	$135

Smoking / Low Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
00-01	$324	$324	$258	$258	$230	$230	$196	$196
02-04	$296	$296	$236	$236	$210	$210	$179	$179
05-18	$268	$268	$213	$213	$190	$190	$162	$162
19-24	$285	$342	$227	$272	$202	$243	$172	$207
25-29	$325	$390	$259	$310	$231	$277	$196	$235
30-34	$379	$455	$302	$362	$269	$323	$229	$275
35-39	$459	$550	$365	$438	$325	$391	$277	$333
40-44	$538	$646	$429	$514	$382	$459	$325	$390
45-49	$627	$752	$499	$599	$445	$534	$379	$454
50-54	$718	$804	$572	$640	$509	$570	$434	$486
55-59	$808	$808	$643	$643	$573	$573	$488	$488
60-64	$808	$808	$643	$643	$573	$573	$488	$488
65 & Over	$808	$808	$643	$643	$573	$573	$488	$488
Dep. Child	$201	$201	$160	$160	$143	$143	$122	$122

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico
Individual Rate Filing
BlueChoice ®
Premium Rates Effective 04/01/2010
(Increase of 10.00% over Current Rates)

Coinsurance level: 70% in-network , 50% out-of-network /// Office visit copayment: $30 /// Prescription Drug Benefit: 25% / 50%

Non-Smoking / High Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible		$10000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band																
00-01	$253	$253	$199	$199	$177	$177	$148	$148	$129	$129	$113	$113	$102	$102	$94	$94
02-04	$231	$231	$182	$182	$161	$161	$135	$135	$117	$117	$103	$103	$93	$93	$86	$86
05-18	$209	$209	$164	$164	$146	$146	$122	$122	$106	$106	$93	$93	$84	$84	$78	$78
19-24	$200	$240	$157	$189	$140	$168	$117	$140	$102	$122	$89	$107	$81	$97	$74	$89
25-29	$228	$273	$179	$215	$159	$191	$133	$160	$116	$139	$102	$122	$92	$110	$85	$102
30-34	$266	$319	$209	$251	$186	$223	$156	$187	$135	$162	$119	$142	$107	$129	$99	$119
35-39	$322	$386	$253	$304	$225	$270	$188	$226	$164	$196	$144	$172	$130	$156	$120	$144
40-44	$378	$453	$297	$357	$264	$317	$221	$265	$192	$231	$169	$202	$152	$183	$141	$169
45-49	$440	$528	$346	$415	$308	$369	$257	$309	$224	$268	$196	$236	$177	$213	$164	$197
50-54	$504	$564	$396	$444	$352	$395	$295	$330	$256	$287	$225	$252	$203	$228	$188	$210
55-59	$567	$567	$446	$446	$396	$396	$332	$332	$288	$288	$253	$253	$229	$229	$211	$211
60-64	$567	$567	$446	$446	$396	$396	$332	$332	$288	$288	$253	$253	$229	$229	$211	$211
65 & Over	$567	$567	$446	$446	$396	$396	$332	$332	$288	$288	$253	$253	$229	$229	$211	$211
Dep. Child	$157	$157	$124	$124	$110	$110	$92	$92	$80	$80	$70	$70	$63	$63	$58	$58

Smoking / High Area (Rural and Santa Fe, 87300 - 88499)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible		$10000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band																
00-01	$253	$253	$199	$199	$177	$177	$148	$148	$129	$129	$113	$113	$102	$102	$94	$94
02-04	$231	$231	$182	$182	$161	$161	$135	$135	$117	$117	$103	$103	$93	$93	$86	$86
05-18	$209	$209	$164	$164	$146	$146	$122	$122	$106	$106	$93	$93	$84	$84	$78	$78
19-24	$222	$267	$175	$210	$155	$186	$130	$156	$113	$136	$99	$119	$90	$108	$83	$99
25-29	$253	$304	$199	$239	$177	$213	$148	$178	$129	$155	$113	$136	$102	$123	$94	$113
30-34	$295	$354	$232	$279	$207	$248	$173	$207	$150	$180	$132	$158	$119	$143	$110	$132
35-39	$358	$429	$281	$338	$250	$300	$209	$251	$182	$218	$160	$192	$144	$173	$133	$160
40-44	$420	$504	$330	$396	$294	$352	$246	$295	$213	$256	$187	$225	$169	$203	$156	$188
45-49	$489	$586	$384	$461	$342	$410	$286	$343	$248	$298	$218	$262	$197	$237	$182	$218
50-54	$560	$627	$440	$493	$392	$438	$328	$367	$285	$319	$250	$280	$226	$253	$208	$233
55-59	$630	$630	$495	$495	$440	$440	$369	$369	$320	$320	$281	$281	$254	$254	$235	$235
60-64	$630	$630	$495	$495	$440	$440	$369	$369	$320	$320	$281	$281	$254	$254	$235	$235
65 & Over	$630	$630	$495	$495	$440	$440	$369	$369	$320	$320	$281	$281	$254	$254	$235	$235
Dep. Child	$157	$157	$124	$124	$110	$110	$92	$92	$80	$80	$70	$70	$63	$63	$58	$58

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico
Individual Rate Filing
BlueChoice
Premium Rates Effective 04/01/2010
(Increase of 10.00% over Current Rates)

Coinsurance level: 70% in-network , 50% out-of-network /// Office visit copayment: $30 /// Prescription Drug Benefit: 25% / 50%

Non-Smoking / Low Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible		$10000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band																
00-01	$228	$228	$179	$179	$159	$159	$133	$133	$116	$116	$102	$102	$92	$92	$85	$85
02-04	$208	$208	$164	$164	$145	$145	$122	$122	$106	$106	$93	$93	$84	$84	$77	$77
05-18	$188	$188	$148	$148	$132	$132	$110	$110	$96	$96	$84	$84	$76	$76	$70	$70
19-24	$180	$216	$142	$170	$126	$151	$105	$126	$91	$110	$80	$96	$73	$87	$67	$80
25-29	$205	$246	$161	$194	$143	$172	$120	$144	$104	$125	$92	$110	$83	$99	$76	$92
30-34	$239	$287	$188	$226	$167	$201	$140	$168	$122	$146	$107	$128	$97	$116	$89	$107
35-39	$290	$348	$228	$274	$203	$243	$170	$203	$147	$177	$129	$155	$117	$140	$108	$129
40-44	$340	$408	$268	$321	$238	$285	$199	$239	$173	$208	$152	$182	$137	$165	$127	$152
45-49	$396	$475	$311	$374	$277	$332	$232	$278	$201	$242	$177	$212	$160	$192	$147	$177
50-54	$453	$508	$357	$399	$317	$355	$265	$297	$231	$258	$202	$227	$183	$205	$169	$189
55-59	$510	$510	$401	$401	$357	$357	$299	$299	$259	$259	$228	$228	$206	$206	$190	$190
60-64	$510	$510	$401	$401	$357	$357	$299	$299	$259	$259	$228	$228	$206	$206	$190	$190
65 & Over	$510	$510	$401	$401	$357	$357	$299	$299	$259	$259	$228	$228	$206	$206	$190	$190
Dep. Child	$141	$141	$111	$111	$99	$99	$83	$83	$72	$72	$63	$63	$57	$57	$53	$53

Smoking / Low Area (Albuquerque Metro, 87000 - 87299)

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible		$3500 Deductible		$5000 Deductible		$7500 Deductible		$10000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Age Band																
00-01	$228	$228	$179	$179	$159	$159	$133	$133	$116	$116	$102	$102	$92	$92	$85	$85
02-04	$208	$208	$164	$164	$145	$145	$122	$122	$106	$106	$93	$93	$84	$84	$77	$77
05-18	$188	$188	$148	$148	$132	$132	$110	$110	$96	$96	$84	$84	$76	$76	$70	$70
19-24	$200	$240	$157	$189	$140	$168	$117	$140	$102	$122	$89	$107	$81	$97	$74	$89
25-29	$228	$273	$179	$215	$159	$191	$133	$160	$116	$139	$102	$122	$92	$110	$85	$102
30-34	$266	$319	$209	$251	$186	$223	$156	$187	$135	$162	$119	$142	$107	$129	$99	$119
35-39	$322	$386	$253	$304	$225	$270	$188	$226	$164	$196	$144	$172	$130	$156	$120	$144
40-44	$378	$453	$297	$357	$264	$317	$221	$265	$192	$231	$169	$202	$152	$183	$141	$169
45-49	$440	$528	$346	$415	$308	$369	$257	$309	$224	$268	$196	$236	$177	$213	$164	$197
50-54	$504	$564	$396	$444	$352	$395	$295	$330	$256	$287	$225	$252	$203	$228	$188	$210
55-59	$567	$567	$446	$446	$396	$396	$332	$332	$288	$288	$253	$253	$229	$229	$211	$211
60-64	$567	$567	$446	$446	$396	$396	$332	$332	$288	$288	$253	$253	$229	$229	$211	$211
65 & Over	$567	$567	$446	$446	$396	$396	$332	$332	$288	$288	$253	$253	$229	$229	$211	$211
Dep. Child	$141	$141	$111	$111	$99	$99	$83	$83	$72	$72	$63	$63	$57	$57	$53	$53

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

New Mexico Major Medical Rating Factors

Effective 04/01/2010

Base Rate

03/01/2009	712.87
Filed Increase	29.5%
04/01/2010	923.17

Plan Factors

	$250 Ded	$500 Ded	$1000 Ded	$2000 Ded
NMMM	1.0000	0.7965	0.7095	0.6041

Demographic Factors

Under 25	0.5291	0.6349
25-29	0.6032	0.7238
30-34	0.7037	0.8445
35-39	0.8519	1.0223
40-44	1.0000	1.2000
45-49	1.1640	1.3969
50-54	1.3333	1.4932
55-59	1.4999	1.4999
60-64	1.4999	1.4999
65 & Over	1.4999	1.4999
Dep. Child	0.4154	0.4154

Area Factors

Albuquerque	Other
0.90000	1.00000

Tier Factors

non-Smoking	Smoking
0.90000	1.00000

Premium Rate = Base Rate x Plan Factor x Demographic Factor x Area Factor x Tier Factor

Example: Male age 33, Enhanced Plan, Santa Fe, Tier I Rates

Base Rate	923.17
Plan Factor	0.79650
Demographic	0.70370
Area Factor	1.00000
Tier Factor	1.00000
Premium	517.43

BlueCross BlueShield of New Mexico

Individual Rate Filing

New Mexico Major Med

Premium Rates Effective 04/01/2010

(Increase of 29.5% over Current Rates)

Non-Smoking / High Cost Area

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
Under 25	$440	$528	$350	$420	$312	$374	$266	$319
25-29	$501	$601	$399	$479	$356	$427	$303	$363
30-34	$585	$702	$466	$559	$415	$498	$353	$424
35-39	$708	$849	$564	$677	$502	$603	$428	$513
40-44	$831	$997	$662	$794	$589	$707	$502	$602
45-49	$967	$1,161	$770	$924	$686	$823	$584	$701
50-54	$1,108	$1,241	$882	$988	$786	$880	$669	$749
55-59	$1,246	$1,246	$993	$993	$884	$884	$753	$753
60-64	$1,246	$1,246	$993	$993	$884	$884	$753	$753
65 & Over	$1,246	$1,246	$993	$993	$884	$884	$753	$753
Dep. Child	$345	$345	$275	$275	$245	$245	$208	$208

Non-Smoking / Low Cost Area

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
Under 25	$396	$475	$315	$378	$281	$337	$239	$287
25-29	$451	$541	$359	$431	$320	$384	$272	$327
30-34	$526	$631	$419	$503	$373	$448	$318	$381
35-39	$637	$764	$507	$609	$452	$542	$385	$462
40-44	$748	$897	$596	$715	$531	$637	$452	$542
45-49	$870	$1,045	$693	$832	$618	$741	$526	$631
50-54	$997	$1,117	$794	$889	$707	$792	$602	$675
55-59	$1,122	$1,122	$893	$893	$796	$796	$678	$678
60-64	$1,122	$1,122	$893	$893	$796	$796	$678	$678
65 & Over	$1,122	$1,122	$893	$893	$796	$796	$678	$678
Dep. Child	$311	$311	$247	$247	$220	$220	$188	$188

Smoking / High Cost Area

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
Under 25	$488	$586	$389	$467	$347	$416	$295	$354
25-29	$557	$668	$444	$532	$395	$474	$336	$404
30-34	$650	$780	$517	$621	$461	$553	$392	$471
35-39	$786	$944	$626	$752	$558	$670	$475	$570
40-44	$923	$1,108	$735	$882	$655	$786	$558	$669
45-49	$1,075	$1,290	$856	$1,027	$762	$915	$649	$779
50-54	$1,231	$1,378	$980	$1,098	$873	$978	$744	$833
55-59	$1,385	$1,385	$1,103	$1,103	$982	$982	$836	$836
60-64	$1,385	$1,385	$1,103	$1,103	$982	$982	$836	$836
65 & Over	$1,385	$1,385	$1,103	$1,103	$982	$982	$836	$836
Dep. Child	$345	$345	$275	$275	$245	$245	$208	$208

Smoking / Low Cost Area

	$250 Deductible		$500 Deductible		$1000 Deductible		$2000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female
Age Band								
Under 25	$440	$528	$350	$420	$312	$374	$266	$319
25-29	$501	$601	$399	$479	$356	$427	$303	$363
30-34	$585	$702	$466	$559	$415	$498	$353	$424
35-39	$708	$849	$564	$677	$502	$603	$428	$513
40-44	$831	$997	$662	$794	$589	$707	$502	$602
45-49	$967	$1,161	$770	$924	$686	$823	$584	$701
50-54	$1,108	$1,241	$882	$988	$786	$880	$669	$749
55-59	$1,246	$1,246	$993	$993	$884	$884	$753	$753
60-64	$1,246	$1,246	$993	$993	$884	$884	$753	$753
65 & Over	$1,246	$1,246	$993	$993	$884	$884	$753	$753
Dep. Child	$311	$311	$247	$247	$220	$220	$188	$188

Note: Subscribers with zip codes outside of the above ranges will be rated as high.

BlueCross BlueShield of New Mexico

Individual Rate Filing

Number One (Non-Smoker)

Premium Rates Effective 04/01/2010

(Increase of 0.0% over Current Rates)

	Non-Smoker / Low Cost Area				Non-Smoker / High Cost Area			
Individual Male								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$788.14	$593.73	$470.62	$349.84	$870.21	$655.58	$519.67	$386.22
30-34	$1,032.25	$777.60	$616.43	$458.15	$1,139.77	$858.56	$680.61	$505.90
35-39	$1,256.76	$946.77	$750.54	$557.83	$1,387.75	$1,045.38	$828.71	$615.95
40-44	$1,486.98	$1,120.09	$888.00	$659.96	$1,641.89	$1,236.78	$980.47	$728.78
45-49	$1,733.90	$1,306.16	$1,035.46	$769.60	$1,914.46	$1,442.13	$1,143.34	$849.77
50-54	$1,898.47	$1,430.08	$1,133.71	$842.63	$2,096.17	$1,579.07	$1,251.81	$930.43
55-59	$2,190.00	$1,649.72	$1,307.85	$972.04	$2,418.08	$1,821.53	$1,444.08	$1,073.31
60 & Over	$2,213.67	$1,667.62	$1,322.00	$982.59	$2,444.28	$1,841.30	$1,459.68	$1,084.91
Individual Female								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$945.74	$712.43	$564.81	$419.83	$1,044.28	$786.62	$623.65	$463.53
30-34	$1,238.70	$933.09	$739.71	$549.87	$1,367.69	$1,030.31	$816.78	$607.10
35-39	$1,507.92	$1,135.91	$900.51	$669.32	$1,665.00	$1,254.22	$994.32	$739.02
40-44	$1,784.10	$1,343.95	$1,065.44	$791.93	$1,969.87	$1,483.97	$1,176.40	$874.39
45-49	$2,079.81	$1,566.72	$1,242.00	$923.17	$2,296.37	$1,729.91	$1,371.39	$1,019.31
50-54	$2,184.41	$1,645.52	$1,304.47	$969.56	$2,411.94	$1,816.90	$1,440.37	$1,070.54
55-59	$2,190.00	$1,649.72	$1,307.85	$972.04	$2,418.08	$1,821.53	$1,444.08	$1,073.31
60 & Over	$2,213.67	$1,667.62	$1,322.00	$982.59	$2,444.28	$1,841.30	$1,459.68	$1,084.91
Husband								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$941.21	$788.22	$639.38	$503.13	$1,039.27	$870.25	$705.99	$555.58
30-34	$1,024.90	$853.60	$689.46	$537.06	$1,131.62	$942.47	$761.27	$592.93
35-39	$1,093.19	$903.46	$725.25	$556.33	$1,207.12	$997.55	$800.78	$614.36
40-44	$1,168.05	$959.04	$765.79	$579.90	$1,289.71	$1,058.97	$845.59	$640.28
45-49	$1,270.12	$1,036.54	$823.59	$615.78	$1,402.41	$1,144.53	$909.39	$679.98
50-54	$1,412.39	$1,149.52	$911.25	$677.39	$1,559.60	$1,269.28	$1,006.20	$747.95
55-59	$1,658.14	$1,349.54	$1,069.77	$795.23	$1,830.90	$1,490.13	$1,181.25	$878.08
60 & Over	$2,148.54	$1,748.69	$1,386.16	$1,030.39	$2,372.34	$1,930.77	$1,530.55	$1,137.70
Wife								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$1,064.13	$888.18	$718.60	$562.08	$1,174.96	$980.65	$793.44	$620.60
30-34	$1,171.65	$973.10	$784.19	$607.44	$1,293.71	$1,074.43	$865.83	$670.74
35-39	$1,270.43	$1,047.69	$839.53	$641.35	$1,402.79	$1,156.87	$926.98	$708.14
40-44	$1,376.83	$1,128.95	$900.51	$679.98	$1,520.23	$1,246.52	$994.32	$750.79
45-49	$1,515.80	$1,236.56	$982.12	$733.70	$1,673.73	$1,365.38	$1,084.38	$810.12
50-54	$1,623.34	$1,321.16	$1,047.33	$778.51	$1,792.46	$1,458.83	$1,156.40	$859.69
55-59	$1,658.14	$1,349.54	$1,069.77	$795.23	$1,830.90	$1,490.13	$1,181.25	$878.08
60 & Over	$1,934.32	$1,574.31	$1,247.96	$927.65	$2,135.84	$1,738.29	$1,377.94	$1,024.35
Dependent Child	$443.75	$361.01	$286.24	$212.80	$489.99	$398.60	$316.02	$234.97

BlueCross BlueShield of New Mexico

Individual Rate Filing

Number One (Smoker)

Premium Rates Effective 04/01/2010

(Increase of 0.0% over Current Rates)

	Smoker / Low Cost Area				Smoker / High Cost Area			
Individual Male								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$887.70	$668.77	$530.10	$393.99	$980.17	$738.36	$585.28	$435.09
30-34	$1,162.62	$875.78	$694.28	$515.99	$1,283.68	$967.03	$766.60	$569.78
35-39	$1,415.55	$1,066.40	$845.37	$628.29	$1,563.02	$1,177.41	$933.50	$693.77
40-44	$1,674.80	$1,261.60	$1,000.12	$743.39	$1,849.25	$1,393.02	$1,104.30	$820.73
45-49	$1,952.93	$1,471.10	$1,166.21	$866.83	$2,156.28	$1,624.36	$1,287.71	$957.10
50-54	$2,138.25	$1,610.74	$1,276.93	$949.14	$2,360.93	$1,778.55	$1,409.93	$1,047.93
55-59	$2,466.57	$1,858.06	$1,473.08	$1,094.84	$2,723.56	$2,051.63	$1,626.50	$1,208.84
60 & Over	$2,493.36	$1,878.23	$1,489.03	$1,106.71	$2,752.99	$2,073.85	$1,644.10	$1,221.99
Individual Female								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$1,065.18	$802.41	$636.18	$472.82	$1,176.18	$886.01	$702.42	$522.11
30-34	$1,395.13	$1,050.99	$833.16	$619.27	$1,540.40	$1,160.42	$919.99	$683.76
35-39	$1,698.40	$1,279.39	$1,014.20	$753.76	$1,875.25	$1,412.66	$1,119.86	$832.37
40-44	$2,009.43	$1,513.72	$1,200.02	$891.88	$2,218.74	$1,671.38	$1,325.02	$984.81
45-49	$2,342.45	$1,764.62	$1,398.90	$1,039.76	$2,586.45	$1,948.41	$1,544.61	$1,148.04
50-54	$2,460.33	$1,853.36	$1,469.26	$1,092.00	$2,716.61	$2,046.40	$1,622.31	$1,205.80
55-59	$2,466.57	$1,858.06	$1,473.08	$1,094.84	$2,723.56	$2,051.63	$1,626.50	$1,208.84
60 & Over	$2,493.36	$1,878.23	$1,489.03	$1,106.71	$2,752.99	$2,073.85	$1,644.10	$1,221.99
Husband								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$1,018.81	$851.33	$689.37	$540.39	$1,124.94	$940.02	$761.26	$596.68
30-34	$1,118.00	$929.40	$749.54	$581.71	$1,234.53	$1,026.14	$827.60	$642.31
35-39	$1,205.69	$994.95	$797.72	$610.32	$1,331.29	$1,098.59	$880.80	$673.90
40-44	$1,299.93	$1,066.40	$850.86	$643.07	$1,435.31	$1,177.41	$939.52	$710.05
45-49	$1,425.16	$1,162.78	$923.65	$690.22	$1,573.63	$1,283.93	$1,019.85	$762.18
50-54	$1,590.83	$1,294.75	$1,026.39	$762.91	$1,756.59	$1,429.57	$1,133.26	$842.41
55-59	$1,867.61	$1,520.00	$1,204.93	$895.63	$2,062.14	$1,678.31	$1,330.40	$988.98
60 & Over	$2,419.91	$1,969.54	$1,561.23	$1,160.56	$2,671.97	$2,174.64	$1,723.87	$1,281.45
Wife								
Age Band	$500	$750	$1,500	$2,500	$500	$750	$1,500	$2,500
Under 30	$1,157.22	$963.92	$778.68	$606.73	$1,277.78	$1,064.35	$859.78	$669.88
30-34	$1,283.37	$1,063.96	$856.21	$661.01	$1,417.03	$1,174.79	$945.39	$729.90
35-39	$1,405.32	$1,157.45	$926.54	$706.03	$1,551.68	$1,278.05	$1,023.03	$779.59
40-44	$1,535.00	$1,257.71	$1,002.54	$755.80	$1,694.92	$1,388.70	$1,106.93	$834.57
45-49	$1,701.92	$1,388.02	$1,102.20	$822.94	$1,879.21	$1,532.67	$1,216.96	$908.66
50-54	$1,828.45	$1,488.13	$1,179.64	$876.88	$2,018.86	$1,643.11	$1,302.47	$968.19
55-59	$1,867.61	$1,520.00	$1,204.93	$895.63	$2,062.14	$1,678.31	$1,330.40	$988.98
60 & Over	$2,178.65	$1,773.10	$1,405.59	$1,044.86	$2,405.58	$1,957.81	$1,552.04	$1,153.68
Dependent Child	$443.75	$361.01	$286.24	$212.80	$489.99	$398.60	$316.02	$234.97

BlueCross BlueShield of New Mexico

Individual Rate Filing

Group Conversion PPO

Premium Rates Effective 04/01/2010

(Increase of 0% Over Current Rates)

Non-Smoking / High Cost Area

	$1,000 Deductible		$2,000 Deductible	
	Male	Female	Male	Female
Age Band				
Under 25	$502.08	$602.62	$427.52	$513.16
25-29	$572.33	$687.01	$487.36	$585.00
30-34	$667.80	$801.43	$568.61	$682.52
35-39	$808.37	$970.23	$688.22	$826.06
40-44	$948.98	$1,138.88	$807.97	$969.80
45-49	$1,104.53	$1,325.69	$940.51	$1,128.93
50-54	$1,265.34	$1,417.10	$1,077.28	$1,206.70
55-59	$1,423.35	$1,423.35	$1,211.99	$1,211.99
60-64	$1,423.35	$1,423.35	$1,211.99	$1,211.99
65 & Over	$1,423.35	$1,423.35	$1,211.99	$1,211.99
Dep. Child	$396.43	$396.43	$337.52	$337.52

Non-Smoking / Low Cost Area

	$1,000 Deductible		$2,000 Deductible	
	Male	Female	Male	Female
Age Band				
Under 25	$451.88	$542.36	$384.76	$461.84
25-29	$515.09	$618.30	$438.62	$526.52
30-34	$601.01	$721.27	$511.77	$614.25
35-39	$727.51	$873.22	$619.40	$743.45
40-44	$854.06	$1,025.01	$727.17	$872.85
45-49	$994.10	$1,193.15	$846.46	$1,016.06
50-54	$1,138.80	$1,275.38	$969.53	$1,086.03
55-59	$1,281.02	$1,281.02	$1,090.76	$1,090.76
60-64	$1,281.02	$1,281.02	$1,090.76	$1,090.76
65 & Over	$1,281.02	$1,281.02	$1,090.76	$1,090.76
Dep. Child	$356.78	$356.78	$303.75	$303.75

Smoking / High Cost Area

	$1,000 Deductible		$2,000 Deductible	
	Male	Female	Male	Female
Age Band				
Under 25	$557.87	$669.56	$475.02	$570.17
25-29	$635.94	$763.33	$541.53	$650.00
30-34	$741.98	$890.48	$631.82	$758.34
35-39	$898.18	$1,078.02	$764.69	$917.88
40-44	$1,054.39	$1,265.43	$897.73	$1,077.55
45-49	$1,227.27	$1,473.03	$1,045.00	$1,254.41
50-54	$1,405.93	$1,574.51	$1,196.96	$1,340.78
55-59	$1,581.49	$1,581.49	$1,346.66	$1,346.66
60-64	$1,581.49	$1,581.49	$1,346.66	$1,346.66
65 & Over	$1,581.49	$1,581.49	$1,346.66	$1,346.66
Dep. Child	$396.43	$396.43	$337.52	$337.52

Smoking / Low Cost Area

	$1,000 Deductible		$2,000 Deductible	
	Male	Female	Male	Female
Age Band				
Under 25	$502.08	$602.62	$427.52	$513.16
25-29	$572.33	$687.01	$487.36	$585.00
30-34	$667.80	$801.43	$568.61	$682.52
35-39	$808.37	$970.23	$688.22	$826.06
40-44	$948.98	$1,138.88	$807.97	$969.80
45-49	$1,104.53	$1,325.69	$940.51	$1,128.93
50-54	$1,265.34	$1,417.10	$1,077.28	$1,206.70
55-59	$1,423.35	$1,423.35	$1,211.99	$1,211.99
60-64	$1,423.35	$1,423.35	$1,211.99	$1,211.99
65 & Over	$1,423.35	$1,423.35	$1,211.99	$1,211.99
Dep. Child	$356.78	$356.78	$303.75	$303.75

BlueCross BlueShield of New Mexico
Individual Rate Filing
Group Conversion Indemnity ($750 Deductible)
Premium Rates - Current and Filed

	Current Rates - Approved Effective 03/01/2009		Filed Rates* Effective 04/01/2010	
Individual Male	High	Low	High	Low
Age Band	Cost	Cost	Cost	Cost
Under 30	$445.89	$403.88	$445.89	$403.88
30-34	$584.11	$529.09	$584.11	$529.09
35-39	$711.18	$644.20	$711.18	$644.20
40-44	$841.41	$762.15	$841.41	$762.15
45-49	$980.96	$888.53	$980.96	$888.53
50-54	$1,074.60	$973.37	$1,074.60	$973.37
55-59	$1,239.58	$1,122.80	$1,239.58	$1,122.80
60 & Over	$1,252.95	$1,134.93	$1,252.95	$1,134.93
Individual Female	High	Low	High	Low
Age Band	Cost	Cost	Cost	Cost
Under 30	$535.07	$484.65	$535.07	$484.65
30-34	$700.90	$634.89	$700.90	$634.89
35-39	$853.40	$773.00	$853.40	$773.00
40-44	$1,009.44	$914.37	$1,009.44	$914.37
45-49	$1,177.09	$1,066.19	$1,177.09	$1,066.19
50-54	$1,235.97	$1,119.55	$1,235.97	$1,119.55
55-59	$1,239.56	$1,122.77	$1,239.56	$1,122.77
60 & Over	$1,252.91	$1,134.88	$1,252.91	$1,134.88
Husband	High	Low	High	Low
Age Band	Cost	Cost	Cost	Cost
Under 30	$581.18	$526.34	$581.18	$526.34
30-34	$631.62	$572.02	$631.62	$572.02
35-39	$671.88	$608.48	$671.88	$608.48
40-44	$716.25	$648.67	$716.25	$648.67
45-49	$777.17	$703.85	$777.17	$703.85
50-54	$863.42	$781.97	$863.42	$781.97
55-59	$1,013.63	$918.05	$1,013.63	$918.05
60 & Over	$1,313.41	$1,189.49	$1,313.41	$1,189.49
Wife	High	Low	High	Low
Age Band	Cost	Cost	Cost	Cost
Under 30	$656.28	$594.36	$656.28	$594.36
30-34	$721.34	$653.28	$721.34	$653.28
35-39	$780.19	$706.60	$780.19	$706.60
40-44	$843.86	$764.25	$843.86	$764.25
45-49	$927.39	$839.92	$927.39	$839.92
50-54	$992.37	$898.78	$992.37	$898.78
55-59	$1,013.63	$918.05	$1,013.63	$918.05
60 & Over	$1,182.47	$1,070.91	$1,182.47	$1,070.91
Dependent Child	$257.62	$233.30	$257.62	$233.30

*Increase of 0% over current rates.

State of New Mexico
Office of the Governor

Bill Richardson
Governor

June 29, 2010

Secretary Kathleen Sebelius
Secretary of Health & Human Services
US Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Sebelius:

I appreciated meeting with you earlier this year and discussing states' implementation of the Patient Protection and Affordable Care Act. Your willingness to be flexible in addressing states' needs is to be commended.

I am pleased to endorse New Mexico's grant application for the proposed health insurance rate review activities. New Mexico's Public Regulation Commission and its Division of Insurance are applying to use these grant funds to enhance their current capacity to review and, to the extent permitted by state law, approve or deny rate increases in the health insurance individual and group markets. New Mexico also intends to use these funds to improve our data collection and transparency with information about rate trends in health insurance coverage.

Insurers must be held accountable for unreasonable insurance rate increases that have made coverage unaffordable for many families in New Mexico, while simultaneously ensuring a fair and reasonable market that promotes competition and coverage. Strengthening the New Mexico Public Regulation Commission and its Division of Insurance's oversight of insurance premiums as well as data collection and transparency are crucial to this endeavor and in assuring greater consumer protections.

Thank you again for the opportunity to apply for this grant funding to further improve and enhance New Mexico's health insurance premium rate review processes.

Sincerely,

Bill Richardson

Bill Richardson
Governor of New Mexico

BR/fl

A. Current Health Insurance Rate Review Capacity and Process

1. General Health Insurance Rate Regulation Information

Health Insurance Products

All comprehensive health insurance products for small group, large group and individual markets and non-profits, multiple employer welfare arrangements (MEWAs), Health Maintenance Organizations (HMOs), associations, and fraternal associations are licensed and regulated by the New Mexico Insurance Division (DOI) of the New Mexico Public Regulation Commission (NMPRC).

Rating Rules

The adjusted community rating is statutorily required for small group comprehensive major medical insurance (See Appendix 1). Only the rating factors of age, geographic area of the place of employment (or place of residence for individual) and smoking practices may be used. Where permitted, health insurers use rating factors such as age, health status, geography and gender to determine the premiums for their products. With the passage of Senate Bill 148 (Chapter 95), policies or contracts for individual or group health coverage sold under the New Mexico Insurance Code, Minimum Healthcare Protection Act, Small Group Rate and Renewability Act and Health Insurance Alliance Act may no longer use gender as a health insurance rating factor after January 1, 2014. The 20% maximum differential between genders permitted in the current rating scheme — where all other factors such as age or geography are the same — will be reduced to 15% in calendar year 2011, 10% in 2012 and 5% in 2013 before being eliminated entirely in 2014 (Appendix 2).

2. Health Insurance Rate Review and Filing Requirements

Standardized Filing Format

All medical plans approved for sale in New Mexico must file rate increase requests via the electronic filing system known as SERFF (NAIC's system for electronic rate & form filing). This system was designated as the electronic filing system for New Mexico by the Superintendent of Insurance. Staff is alerted to the rate increase request through the SERFF system. A sample health insurance rate filing submission and memorandum is found at Appendix 8 and 9).

Comprehensive Filing Description of Rate Review Process

The data required to be included in rate increase request filings by the insurer include a minimum of three years past experience on a premiums earned, loss incurred basis. In addition, the insurer's projections of future experience with and without the increase are required in accordance with the NAIC Model Law. All rate requests are subject to the rate review process. The items required to be included with the filings are checked to ensure the filing is complete and in accordance with the filing format, includes filing fees, an actuarial justification memorandum and, earned premium and incurred claims historical exhibits. Next, the actuarial memorandum is reviewed. The following items are required: 1. purpose of the request; 2. description of the benefits; 3. applicable rating elements (such as structure, classes, model factors, geographic variation, and trend); 4. anticipated loss ratios; 5. adjustment to gross premium rates for current filing (rate level adjustment, method, past implemented rate increases); 6. actuarial justification (experience data for New Mexico policies, discussions); 7. rate increase implementation plan; 8. estimated average premiums; 9. ultimate lifetime loss ratio; 10.

certification; 11. attachments of exhibits of data and graphs of loss experience (national data and New Mexico state data).

The DOI Actuarial Assistant reassesses the projected loss ratio (incurred claims/earned premiums) as well as the requested rate increase impact on New Mexico consumers. Using approved NAIC tests staff determines if the benefits offered are unreasonably restricted in relation to the premiums charged. This is New Mexico's statutory standard (See Appendix 3). In addition to the statutory guideline, NAIC rate filing guidelines (See Enclosure 1 – NAIC Model Law 134 Guidelines) and Actuarial Standard of Practice 8 (See Enclosure 2) have been traditionally used in assessing the reasonableness of the increased rates for requested rate increases. The NAIC Guideline Ratio of 60% (high premium guaranteed renewable health care policies) was previously used as the guideline, however New Mexico has recently adopted a guideline of approximately 71% as a result of a new law passed this year by the state legislature.

Legal Authority

NMSA 1978, § 59A-18-13 of the New Mexico Insurance Code, states that the Superintendent shall review any filing made pursuant to NMSA 1978, §§ 59A-18-12 (Appendix 4) or 59A-18-13 (See Appendix 5) within 60 days of the filing date and approve any form or rate if he finds that it complies with the Insurance Code, and disapprove any form or rate only on one or more of five grounds. Of the five, the following applies to rates: "(3) If the benefits offered are unreasonably restricted in relation to the premium charged."

Grounds for Rate Review

The grounds for rate approval, modification, or rejection are found in the rate process request described above. Medical loss ratios are based on the "lifetime loss ratio" as originally defined in the NAIC Model Law adopted as our standard and now modified by the new statutorily required loss ratios. DOI looks at the developed claims trend in addition to the Medical Care Cost Index. Staff reviews the financials of the company occasionally if the claims data appears out of perspective with previous filings or if there is a question of the need the requested increase. The previous rate changes are recorded from the filing and are used to modify the trend calculations.

If the rate increase requested is 5% or less, the Actuarial Assistant will make a decision and implement it. The Chief Life & Health Actuary is consulted with all rate increase requests over five percent. DOI's internal policy currently requires the Superintendent or Deputy Superintendent of DOI to be involved in decisions regarding rate increases in excess of 15%. The Chief Life & Health Actuary verifies the overall analysis of the requested average increase and the DOI has chosen to use the method of "least squares" to trend the historical loss ratios for the increases requiring higher approval authority. The total indicated rate increase for each plan is compared to the requested increase and expected consequent loss ratio for that plan and the estimates of underlying parameters are reviewed for reasonableness. In addition, the potential monetary impact to the solvency of the company is assessed, in case the requested increase is disallowed.

Consumer Rebates

The law requires the insurer to notify a policyholder if the rate increase pushes the new rate higher than the New Mexico Medical Insurance Pool (NMMIP) rate for comparable coverage, so that the policyholders may seek coverage at the lower NMMIP rate. If the DOI discovers that the notice was not given, DOI requires the insurer to refund to the policyholder all the excess premiums collected.

Rate Modification

- New Mexico has both statutory and regulatory authority in rate reviews. The rate requests must either be approved or disapproved. Staff often suggests a modification prior to approval.

3. An Explanation of Current Level of Resources and Capacity: IT and System Capacity

Current IT Systems

The System for Electronic Rate and Form Filing (SERFF) is a smart Internet application designed to provide a process for electronic rate and form filing submissions and facilitate electronic storage, management analysis and communication regarding filings and dispositions. Using SERFF, insurance companies submit rate and form filings to state insurance departments to request approval of newly developed products ready to go on the market, or rate or other changes to existing products.

4. An Explanation of Current Level of Resources and Capacity: Staffing

Qualification of Rate Review Staff

There are currently two staff members that are responsible for reviewing health care premium rate increase request reviews. One is the Life and Health Chief Actuary, who is a Fellow of the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA) and holds a Bachelor's Degree in Mathematics from The University of Louisville. The other is the Actuarial Assistant, who holds a Ph.D. in Probability and Statistics, a Master's Degree in Probability and Statistics, and a Bachelor's Degree in Statistics, Mathematics, and Physics.

Volume of Insurance Filings & Review Time

The total number of health insurance rate filings that are received per year is approximately 163 or an average of 14 filings per month. The average number of days from filing date until disposition is 46.

5. Consumer Protections

In New Mexico, health care insurance rate filings are available to the public upon request and are subject to the right to Inspection of Public Records Act. Currently, there is not a disclosure mechanism in place to allow for public access without a request for the filing or filings.

Public Disclosure

Requests to inspect public records must satisfy the criteria contained in NMSA 1978, § 14-2-8 (Appendix 6). A filing and supporting information shall, as soon as filed, be open to

public inspection at a reasonable time. A copy of a filing and supporting information may be obtained by a person on request to the Superintendent and payment of a reasonable charge.

Rate Summaries

- Summaries of rate changes are not currently posted by DOI for public access. There is a process to provide additional information regarding the merits of the approved rate increase upon a policyholder's request from the insurer. The DOI does require that managed health insurers writing individual policies disclose additional explanation after the required notice is issued with a policyholder's request within 10 days of the request. It is further required that the insurers in designing the layout and content of these disclosures should strike a reasonable balance between detail and ease of understanding, bearing in mind that the goal of these disclosures is to provide inquiring policyholders with a layman's understanding of why their premium increased and to avoid a level of technical detail that could confuse policyholders and engender additional questions.

- On April 13, 2009, DOI issued Insurance Bulletin 2009-002 (Appendix 7) to Managed Health Care Insurers writing individual policies that explained the disclosure explanation requirements including a list that itemizes the rating elements that contributed to the premium change and provides the dollar amount of premium change attributable to each item. The DOI further ordered that items are to be listed and quantified separately whenever possible including the effects of claims incurred and utilization during the rating period and changes in membership. Elements contained in a rate filing (e.g. trend use in the previous rating period and the current rating, rate changes due to age, zip code, changes in administrative expense, changes in reserves or increase in commission) may be combined and described as "filed rate change, effective *[date]*."

In situations where missed premium increases are due to the rate change after the policy anniversary date, the carrier has the option of comparing the increased premium to either the policy's original premium or else to what the policy's premium would have been if the anniversary date of the policy had occurred before the approved rate change, using whatever corresponding explanations are necessary.

Consumer Notice

An increase in a health insurance premium shall not be effective without sixty days written notice to policyholders. Health care insurers are required to file with the Superintendent premium rates prior to approval unless deemed as approved by no response within the review standards.

Public Meeting/Hearings

NMSA 1978, § 59A-4-15 (Appendix 8) requires the Superintendent to hold a hearing if required by any provision of the Insurance Code or upon written request for a hearing by a person aggrieved by any act, threatened act or failure of the Superintendent to act or by any report, rule, regulation or order of the Superintendent. A request for a hearing shall state the respects in which the applicant would be aggrieved if the stated grounds are established and that such grounds otherwise justify the hearing; the Superintendent shall commence the hearing within ninety days after the filing of the request, unless postponed by mutual consent. Pending the hearing and decision, the Superintendent may suspend or postpone the effective date of the action as to which the hearing is being requested.

Summary of Complaints and Nature of Concern

In December 2009, the Insurance Division's, Life and Health staff approved an average rate increase of 24.6% for twelve individual health care products offered by one health carrier in New Mexico (See Appendix 9 & 10).

Timely notice was provided to the 39,668 impacted consumers to be effective April 1, 2010, for an overall rate of 24.6% across all products in a range of 10% to 29.5%. There were 229 complaints and inquires that were submitted to NMPRC with two common main concerns, the first being that the cost over the past two years had increased premiums at a combined rate of 50% or higher for these products without additional benefits. The second stated concern in the majority of complaints was that in order to afford medical insurance coverage the individual or family would have to move to a policy or plan with higher deductibles and/or less benefits.

6. Examination and Oversight

NMSA 1978, § 59A-4-4 (Appendix 9) provides that, in order to carry out the statutory mandate and responsibility for insurance consumer protection, the Superintendent shall examine or investigate the affairs, transactions, accounts, records, and assets of each insurer, or proposed insurer, and any person transacting insurance in the state, and of any other person as to any matter which the Superintendent in his sole discretion has determined to be relevant to the examination. There are currently 11 New Mexico domestic health insurers, and six non-domiciled health insurers. In the past two plan years there have not been any examinations conducted of health insurers on premium rate and/or related matters. The Examination Bureau has not received any referrals for examination, investigation and other audit functions from the

Health Rate & Form Bureau, the Managed Care Bureau, the Consumer Complaint Bureau or the actuarial staff.

B. Proposed Enhancements and Actions

While health care costs must be controlled before New Mexicans will see significant changes in the accessibility to and affordability of health insurance, the following proposed changes are intended to promote competition among carriers, curb excessive rate increases, provide accurate data on factors driving insurance costs, and generally allow the public to participate in and understand the health insurance rate review process.

The NMPRC will seek legislation to bring transparency and stronger standards to its rate review process in the 2011 Legislative Session. The 2011 Legislature will be asked to pass a bill:

1.) making rate filings public,

2.) requiring the division to post rate filings on its Web site and,

3.) set forth the authority to release information to the public, which will be required by insurers to provide.

Expanding the Scope of Current Review & Approval Activities

DOI intends to develop a Consumer and Business Services Bureau in the Insurance Division. This unit will be responsible for approving rates for individual, small group, and portability health insurance markets. In recent years, double-digit rate increases have state policymakers and insurance regulators concerned and the NMPRC have moved to increase public access to rate filings and to arm regulators with additional tools to curb rate increases.

The DOI process will identify "potentially unreasonable" increases, and will trigger further review to determine any mitigating or exacerbating factors and to decide whether the increase is actually unreasonable. Any increase that is necessary to avoid a future financial loss on the block of business is usually considered reasonable, unless there are compelling reasons to determine that it is unreasonable. Rates that produce a financial loss can affect consumers by impairing the financial soundness of the insurer, reducing the insurer's incentive to provide good customer service, reducing the insurer's incentive to continue providing coverage and shifting costs to other blocks of business.

Improving Rate Filing Requirements

There has been recent legislation in New Mexico that requires insurers to make reimbursement for direct services at a level not less than eighty-five percent of premiums across all health product lines over the preceding three calendar years as determined by reports filed with the DOI. Insurers failing to comply with the eighty-five percent reimbursement requirement shall issue a dividend or a credit against future premiums to all policyholders in an amount sufficient to assure that the benefits paid in the preceding three calendar years plus the amount of dividends or credits equal eighty-five percent of premiums collected in the preceding three calendar years. Along with federal regulations and guidance which will define "potentially unreasonable rates", the rate provisions that the DOI will seek will strengthen the process by developing procedures that incorporate federal regulations and state laws.

Enhancing Rate Review Process – Staffing

NMPRC will seek additional staff and contracts to achieve the enhanced rate review and public disclosure of premium rate increase requests. This would include an actuarial contract for

a period of one year to review on going rate requests and provide recommendations to the Superintendent. This will add an additional professional review rather than relying one internal opinion before a decision is rendered. There will be additional resources such as IT equipment and development to properly store and track the rate requests and history for reporting purposes. A contract for web development and design will be sought to provide a vehicle for disclosure to consumers, as well as other community outreach efforts. In addition the following four staffing positions are recommended in addition to current staff to enhanced process and required reporting:

- Hearing Officer
- Financial Analyst
- Consumer Analyst
- IT Analyst

Enhancing Rate Review Process – IT Capacity

Description of SERFF Deliverables & Cost:

1) An estimated $18,808 to cover the expenses associated with modifying SERFF to address data collection and reporting requirements, such as:
    a. State options to indicate premium review grant participation.
    b. Company profile changes to incorporate company type.
    c. State-maintained indicator for rate filing requests meeting the HHS threshold for "unreasonable."
    d. Addition of a field to indicate product types.
    e. Company-maintained product information including product name, HHS ID, and product status that will allow the companies to track products and apply them to filings.

f. A new set of fields added to the Rate/Rule schedule items to provide HIPR data on a policy form basis.

g. Changes to the State API to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API.

2) Incorporating the submission of a federally mandated Rate Filing Disclosure Form and Justification that is required to be filed under provisions of the Affordable Care Act if a rate request falls under the definition of 'unreasonable'. The estimate provided by the NAIC would also allow the Rate Filing Disclosure Form, or similar document, to be filed regardless of whether the rate request falls under the definition of 'unreasonable' in the event the states wanted to include this in their submission requirements to facilitate meeting the requirement that consumer friendly descriptions of rate filings be made available publicly.

3) Additional SERFF state training that will support the grant requirements.

4) Support for making non-confidential consumer friendly rate disclosures and/or rate filing information available publicly, as required and permitted.

5) Support the ability to satisfy reporting requirements of the uniform template for data reporting within the SERFF system, if HHS will accept reports directly from SERFF, including basic trending reports.

The workflow on a Health filing that requires the enhanced data reporting fields will vary from the existing SERFF workflow. Each state will set preferences that will indicate the level of data they would like to require. Fields exposed to the industry during the filing creation process are determined by these state preferences. The overall workflow will be changed in that the filer will now be required to tie schedule items (such as rates and

policy forms) to a specific product. This will allow for the reporting of data based on the product the consumer will ultimately be offered. A significant portion of the project hours will be devoted to aggregating the collected data into the reports required by HHS. An interface to allow HHS to get reports from SERFF is included within the estimate, should become a requirement.

Enhancing Consumer Protections Standards

The process will require DOI to post rate filings for individual, portability, and small-employer plans, (up to 100 employees) on the agency Web site once the rate increase request has been deemed to be complete. All information submitted as part of an insurance company's rate request will be posted. DOI staff will have ten days from receipt of a filing to determine if the filing is, in fact, complete. A required feature of the filing will be a plain-language summary highlighting the insurer's request and a five-year history of rate increases for that line of insurance. The posting of the filing on the Web site triggers two key timelines:

- A 30-day public comment period. Policyholders may sign up on the NMPRC Web site to receive an e-mail when their insurer files a rate request and then again once the DOI makes a decision. Consumer comments will be posted on the NMPRC Web site.
- A 40-day timeline for DOI to review filings and issue decisions. The Superintendent must issue a decision within ten days of the close of the public comment period.

DOI will make several concrete changes to enhance consumer protections in the premium review process and will enable consumers to have access to rate review requests online and to submit comments to DOI about the requests.

In addition, DOI will create a consumer/stakeholder advisory committee that will meet at least quarterly to plan, implement, and evaluate work under this grant and to discuss potential

legislative and regulatory changes addressed below. The initial advisory committee will consist of the stakeholders who reviewed and gave input into this grant proposal. Among other issues, DOI and the Advisory Committee will address the needs of New Mexicans in low-income and rural communities who do not have access to the internet to develop mechanisms for consumer input and communication in those communities as the Affordable Care Act is implemented.

Future legislation must provide that the Superintendent has explicit authority to consider factors such as:

- an insurer's investment income, surplus, and cost containment,
- quality improvement efforts when reviewing a rate filing, and
- the insurer's overall profitability rather than just the profitability of a particular line of insurance.

With proper statutory authority, DOI staff must develop rules and procedures to provide that insurers separately report and justify changes in administrative expenses by line of business, and provide details about what they spend on salaries, commissions, marketing, advertising, and other administrative expenses.

The bureau shall create a worksheet through the SERFF enhancements specifying what should be reported and requiring a five-year history of these expenses from which the bureau files a plain-language summary on the Web site listing key factors underlying each rate filing decision.

NEW MEXICO

Craig Dunbar

(b)(6)

BUSINESS DEVELOPMENT/SALES MANAGEMENT

Exemplary record providing the vision and leadership necessary to implement full sales, business development, and operational directives while managing yearly revenues up to $12 million. Expertise in directing field and in-house sales professionals, building highly productive teams, and establishing processes and controls that facilitate smooth operations during periods of major change and significant growth. Recognized for fostering long-term relationships, attention to detail, managing multiple projects under time sensitive deadlines, quickly revising tactics to achieve goals within aggressive time frames.

CORE COMPETENCIES:

- **Business & Market Development**
- **Major Account Management**
- **Strategic & Operational Planning**
- **Customer & Public Relations**
- **Product Development & Introduction**
- **Training Development & Presentations**
- **Sales Forecasting**
- **Budgets, Cost & Internal Controls**
- **Policies, Processes & Procedures**
- **Organizational Development**

SELECTED BUSINESS CONTRIBUTIONS

- Directed eight owned corporations, in Texas and Oklahoma. Conducted monthly meeting to uncover and resolve any issues preventing each location from profitability. Result: Under my direction, all offices became profitable after three months turning a ($275,000) annual loss to making a profit the first year of $50,000 and now exceeding $3,000,000 net annually.

- Conducted budgetary meetings with each Manager teaming with others to interpret each budget and make changes as needed, and approved and forwarded in two days instead of the old process that took up to two months. The cost to each office was less than $200, but with time involved it saved approximately $10,000. These realistic budgets have been exceeded each year by all offices and districts.

- Upon acquisition, there were not any systems or organization of duties. A Process Flow of each department provided the knowledge needed for the company to expand. Duties of each associate were developed and presented to the entire organization as well as the Process Flow Charts. Management decided priorities of needs and reported the progress weekly. Market share increased 5 % the first month and10 % the second. After the first year, it was the top in profitability of the Region at 72%.

- Developed a Business Plan incorporating weekly and monthly production and financial reports, an annual budget and three and five year goals. All employees were empowered to be sales representatives and awarded bonuses for results. Community and organizational involvement was a large factor in increasing market share from less than 10% to over 40% within 3 years.

- The marketing program was broke and it needed to be fixed. Nine "marketing" personnel were eliminated saving $270,000 in salaries. Production personnel were placed in the marketing and sales capacity along with their other functions. They were paid a commission on new customers and retained customers, a budget was produced with each as it was unlimited before, and a reporting

system was devised. Total savings was a net of $200,000, with $40,000 to commissions and $70,000 in sales expenses. Market share grew 5% immediately.

PROFESSIONAL EXPERIENCE

New Mexico Department of Insurance **May 2010-Present**
Chief Deputy Superintendent of Insurance
Interim Superintendent of Insurance

Camino Real Abstract and Title, LLC., Las Cruces, New Mexico **August-Dec, 2009**
Vice-President

- **Manager** of a start up title company in Dona Ana County, New Mexico
- **Development** of a customer base from existing contacts when previously managed a title company in Las Cruces.
- **Learned** new automation systems in order to compete with existing companies.
- **Establish** a marketing plan and budget for the company. Hiring of experienced personnel and locating an office

Stewart Title Guaranty Company, Ft. Worth, Texas, Region Office, **1988-2008**
President, Vice-President and Associate Region Manager

- **Chairman** of the Board, or Board Member of nine company owned independently operated corporations in Lubbock, Amarillo, Wichita Falls, Texarkana, Granbury and Abilene, Texas, Oklahoma City, Ardmore, and Lawton, Oklahoma. Negotiated the purchase of three of the above corporations and assisted with others. Established company ethics and policies, and turned each into profit centers. Worked strongly with each corporation's President and management teams as counselor, mentor and adviser. Held monthly, on site, management meetings as well as numerous telephonic and electronic discussions.
- **Supervised** six agency District Managers who oversaw 140 independent agency companies in Texas and Oklahoma.
- **Organized** and lead annual Budget and Goals meetings with Presidents and Controllers as a group for discussion of common situations, problems, and practices. Moderated National Annual Budget and Goals Meeting for four years.
- **Initiated** and coordinated expansion and consolidation, of companies, branches, and departments as needed, after through investigation of savings, growth and logistics.
- **Assisted** and advised implementation and tracking of Marketing and Sales Plans for affiliated offices, independent agencies, customers, attorneys, developers, builders, real estate agents, brokers, banks and lending institutions.
- **Advised,** managed, negotiated, mediated, and was involved with internal and external claims.
- **Region** Leadership Team, Chairman of the international Rewards and Recognition Team Chairman of the Forms Modification Team, Quality Control Team, Chairman of the Regional Claims Team, Chairman of the Agency Development Team.
- **Exceeded** mandatory continued education criteria by 60 hours each year through company provided training and outside sources.

- **Qualified** for "Magnificent Managers Award" 20 straight years.

Southwestern Abstract and Title, Las Cruces, New Mexico **1976-1987**
President, Vice- President, Manager

- Managed all aspects of the company, making it the largest in Dona Ana County, New Mexico.

Additional Positions Held: Agency Representative, Escrow and Marketing Officer, in Albuquerque, New Mexico

EDUCATION

Sandia High School, Albuquerque, New Mexico
Eastern New Mexico University, Portales, New Mexico

Bachelor of Arts degrees in Sociology and Psychology

References Provided Upon Establishment Of Mutual Interest.

Kimberley Scott

(b)(6)

Profile Summary

- Ability to direct complex projects from concept to fully operational status.
- Goal-oriented individual with strong leadership capabilities.
- Organized, highly motivated, and detail-directed problem solver.
- Proven ability to work in unison with staff, customers, and upper management.

Experience

New Mexico Public Regulation Commission – Insurance Division, 2006 – current
Managed Health Care Bureau Chief: Responsible for bureau operations in resolving complaints, review insurers' compliance, providing public education and outreach and overseeing external review hearings. Lead the Superintendent's Regulation Task force to review rule making changes and needs.

New Mexico Human Services Department – Fair Hearings Bureau, 2006
Administrative Law Judge: Responsible for conducting fair hearings, reviewing testimony and regulations, preparing recommendations and final decisions.

New Mexico Human Services Department – Income Support Division, 2003 – 2006
Line Manager: Responsible for supervision and mentoring eligibility staff for public assistance programs. Assigned as part of a department legislative workgroup. Provided regional cash assistance training and tracking.

New Mexico Human Services Department – Medical Assistance Division, 2002 – 2003
Utilization Review (UR) Contract Manager: Responsible for prioritizing division requests and reviewing Utilization Review Board activities and budget for New Mexico fee-for-service Medicaid. Established database for information exchange between UR contactor and the Department. Coordinated and lead monthly status meeting on UR assignments and division and other agencies needs.

New Mexico Human Services Department – Income Support Division, 2001
Management Analyst: A member of the Quality Improvement Section responsible for field offices Food stamp program federal compliance reviews and Civil Rights complaints. Assigned as lead for division training initiatives. Participated with state legislative bill tracking team.

New Mexico Human Services Department – Income Support Division, 1998 – 2001
Family Assistance Analyst Senior: Assisted management with staff trainings, responsible for training Medicaid providers and cash assistance case management staff. Maintained a full caseload to include the more difficult and/or complex cases.

Education

Currently enrolled with the University of Phoenix, Master's of Health Administration Program

M.P.A., Public Manager, University of New Mexico, Albuquerque, NM
B.A., Criminal Justice, New Mexico State University, Las Cruces, NM

Professional Organizations

National Association of Insurance Commissioners (NAIC) Designation Program, 2008 – current
Voted Association of Professional Mangers President – 2006
Association of Professional Managers – Regional Representative, 2004-2005

References and salary history are available upon request.

Project Abstract

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA). The legislation is designed to expand health care coverage within the United States by extending health care insurance to more citizens, stabilizing health insurance markets by requiring broader participation, enhancing regulation and consumer protections, and improving the affordability and quality of health care.

Much of the responsibility for implementation of the PPACA provisions has been delegated to states. Grant opportunities to assist states in working with the federal government to implement comprehensive health reform are included in the provisions of PPACA. Section 2794 of the Public Health Service Act (PPACA Section 1003) – "Ensuring That Consumers Get Value for Their Dollars" – is designed to help make private health insurance more accessible and affordable as well as to increase the transparency of the health insurance system by providing new oversight of health insurance companies.

During the first cycle of grant funding for the Health Insurance Premium Review Grant Program, each state is eligible for up to $1 million. New Mexico Governor Bill Richardson has endorsed the New Mexico Public Regulation Commission (NMPRC) and its Division of Insurance (DOI) to apply for the $1 million funding opportunity in order to enhance the current capacity in reviewing rate increase requests for individual and small group health insurance markets in the State of New Mexico.

The DOI's mission is to provide consumers convenient access to reliable insurance products, which are underwritten by dependable and financially sound companies. The DOI endeavors to ensure that insurance companies have a proven history of fair and reasonable rates, are represented by trustworthy and qualified agents and provide for consumer protection and fraud prosecution and deterrence. The use of awarded funds for this specific project would allow the DOI to strengthen the current review process and create a process for public disclosure that is accessible, consumer friendly and provides the citizens of New Mexico an opportunity to present feedback on factors of concern related to a rate increase request prior to a determination.

The DOI proposes to create a separate bureau that would be devoted to improving and expanding the current scope and rate review request process with additional reporting requirements and added expertise to develop and establish review standards that will provide a comprehensive recommendation to the Superintendent of Insurance. The same bureau will be responsible for providing consumer education, outreach and the development of a website and other vehicles to disclose critical information to consumers.

In an effort to address data collection and reporting requirements set forth by Health and Human Services, DOI will also seek additional enhancements to its existing form and rate filing system – the System for Electronic Rate and Form Filing (SERFF) – through the National Association of Insurance Commissioners.

GRANTS.GOV

Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

☐ **This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.**

*** Application Filing Name:** NM PRC - Insurance Division

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

Optional Documents

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

1 Enter a name for the application in the Application Filing Name field.

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

2 Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 Click the "Save & Submit" button to submit your application to Grants.gov.

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

ERROR!

This application package has been opened and saved with a version of Adobe Acrobat or Adobe Reader that is not compatible with Grants.gov.

THIS PACKAGE IS NO LONGER VALID AND CANNOT BE SUBMITTED.

To download the Grants.gov required version visit:
http://www.grants.gov/help/download_software.jsp#adobe811

For more information: http://grants.gov/help/general_faqs.jsp#adobe

Also the Contact Center is available for further assistance. The Contact Center hours of operation are Monday-Friday, 7 a.m. to 9 p.m., Eastern Time; closed on Federal Holidays.

Email: support@grants.gov

Phone: 1-800-518-4726

ERROR!

You have attempted to open this document with a version of Adobe Acrobat or Adobe Reader that is not compatible with Grants.gov.

YOU CANNOT PROCEED WITH THIS DOCUMENT!

You are using the incorrect version: 9.304

Install the required version and try again.

To download the Grants.gov required version visit:
http://www.grants.gov/help/download_software.jsp#adobe811

For more information: http://grants.gov/help/general_faqs.jsp#adobe

Also the Contact Center is available for further assistance. The Contact Center hours of operation are Monday-Friday, 7 a.m. to 9 p.m., Eastern Time; closed on Federal Holidays.

Email: support@grants.gov

Phone: 1-800-518-4726

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: New Mexico Public Regulation Commission - Insurance Division

* b. Employer/Taxpayer Identification Number (EIN/TIN): 85-6000565

* c. Organizational DUNS: 1421991520000

d. Address:

* Street1: P.O. Box 1269

Street2:

* City: Santa Fe

County/Parish:

* State: NM: New Mexico

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 87504-1269

e. Organizational Unit:

Department Name: N M Public Reg. Commission

Division Name: Insurance

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Mr.

* First Name: Craig

Middle Name:

* Last Name: Dunbar

Suffix:

Title: Deputy Superintendent of Insurance

Organizational Affiliation:

* Telephone Number: (505) 827-4309

Fax Number: (505) 827-4734

* Email: craig.dunbar@state.nm.us

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

NM Insurance Division - Grants to State for Health Insurance Premium Review

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: 3 | b. Program/Project: NM-all

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/09/2010 | * b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,000,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☐ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☐ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: | * First Name: Matthew

Middle Name:

* Last Name: Lovato

Suffix:

* Title: Chief Financial Officer

* Telephone Number: (505) 827-4042 | Fax Number:

* Email: matthew.lovato@state.nm.us

* Signature of Authorized Representative: Completed by Grants.gov upon submission. | * Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

New Mexico Public Regulation Commission - Insurance Division

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:**

Prefix:

* First Name:

Middle Name:

* Last Name:

Suffix:

Title:

Organizational Affiliation:

* Street1:

Street2:

* City:

County:

* State:

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code:

* Telephone Number:

Fax:

* Email:

Delete Entry | Previous Person | Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

NM Insurance Division - Grants to State for Health Insurance Premium Review

* Year:

* Funding Agency Goal:

* Objective:

* Results or Benefits Expected:

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:**

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:**

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1.		$	$	$	$	$
2.						
3.						
4.						
5. Totals		$	$	$	$	$

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY (1)	(2)	(3)	(4)	Total (5)
a. Personnel	$	$	$	$	$
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual					
g. Construction					
h. Other					
i. Total Direct Charges (sum of 6a-6h)					$
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$	$	$	$	$
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$	$	$	$	$
14. Non-Federal	$				
15. TOTAL (sum of lines 13 and 14)	$	$	$	$	$

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS)			
	(b)First	(c) Second	(d) Third	(e) Fourth
16.	$	$	$	$
17.				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Chief Financial Officer
* APPLICANT ORGANIZATION	* DATE SUBMITTED
New Mexico Public Regulation Commission - Insurance Division	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name*

** Street 1* *Street 2*

** City* *State* *Zip*

Congressional District, if known:

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix ** First Name* *Middle Name*

** Last Name* *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

b. Individual Performing Services (including address if different from No. 10a)

Prefix ** First Name* *Middle Name*

** Last Name* *Suffix*

** Street 1* *Street 2*

** City* *State* *Zip*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix* ** First Name* *Middle Name*

** Last Name* *Suffix*

Title: **Telephone No.:** **Date:** Completed on submission to Grants.gov

OMB Number: 2125-0611
Expiration Date: 03/31/2010

Basic Work Plan

1. Estimated date of established funding agreement with State:

Note: Tasks starting before this date are not eligible for funding, and cannot be counted toward matching funds.

Describe the tasks in the work plan:

2 a. Describe this task or milestone:

b. Name of person or organization responsible for carrying out task:

c. How long will this task take to complete? months

d. Justify how this project task contributes to project completion: (800 character limit - about 133 words)

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

Program Announcement (CFDA)

93.511

*** Program Announcement (Funding Opportunity Number)**

RFA-FD-10-999

*** Closing Date**

07/07/2010

*** Applicant Name**

New Mexico Public Regulation Commission - Insurance Division

*** Length of Proposed Project**

Application Control No.

Federal Share Requested (for each year)

*** Federal Share 1st Year**

$

*** Federal Share 2nd Year**

$

*** Federal Share 3rd Year**

$

*** Federal Share 4th Year**

$

*** Federal Share 5th Year**

$

Non-Federal Share Requested (for each year)

*** Non-Federal Share 1st Year**

$

*** Non-Federal Share 2nd Year**

$

*** Non-Federal Share 3rd Year**

$

*** Non-Federal Share 4th Year**

$

*** Non-Federal Share 5th Year**

$

*** Project Title**

NM Insurance Division - Grants to State for Health Insurance Premium Review

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Project Abstract Summary

*** Project Summary**

*** Estimated number of people to be served as a result of the award of this grant.**

Other Attachment File(s)

*** Mandatory Other Attachment Filename:**

Add Mandatory Other Attachment | Delete Mandatory Other Attachment | View Mandatory Other Attachment

To add more "Other Attachment" attachments, please use the attachment buttons below.

Add Optional Other Attachment | Delete Optional Other Attachment | View Optional Other Attachment

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
[b] a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	[a] a. bid/offer/application b. initial award c. post-award	[a] a. initial filing b. material change **For Material Change Only:** year _____ quarter _____ date of last report _____

4. Name and Address of Reporting Entity:
☒ Prime ☐ Subawardee
Tier _____, *if known*:
New Mexico Public Regulation
Commission Insurance Division
P.O. Box 1269 Santa Fe, NM 87504
Congressional District, *if known*:

5. If Reporting Entity in No. 4 is a Subawardee, Enter Name and Address of Prime:
Congressional District, *if known*:

6. Federal Department/Agency:

7. Federal Program Name/Description:
Health Insurance Premium Review
Cycle I 93.511
CFDA Number, *if applicable*: _____

8. Federal Action Number, *if known*:

9. Award Amount, *if known*:
$ 1,000,000

10. a. Name and Address of Lobbying Entity
(*if individual, last name, first name, MI*):

b. Individuals Performing Services (*including address if different from No. 10a*)
(*last name, first name, MI*):

(attach Continuation Sheet(s) SF-LLLA, if necessary)

11. Amount of Payment (*check all that apply*):
$ _____ ☐ actual ☐ planned

12. Form of Payment (*check all that apply*):
☐ a. cash
☐ b. in-kind; specify: nature _____
value _____

13. Type of Payment (*check all that apply*):
☐ a. retainer
☐ b. one-time fee
☐ c. commission
☐ d. contingent fee
☐ e. deferred
☐ f. other; specify: _____

14. Brief Description of Services Performed or to be Performed and Date(s) of Service, including officer(s), employee(s), or Member(s) contacted, for Payment Indicated in Item 11:

(attach Continuation Sheet(s) SF-LLLA, if necessary)

15. Continuation Sheet(s) SF-LLLA attached: ☐ Yes ☒ No

16. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less that $10,000 and not more than $100,000 for each such failure.

Signature: _____
Print Name: CRAIG E DUNBAR
Title: DEPUTY SUPERINTENDENT OF INSURANCE
Telephone No.: (505) 827-4299 Date: 7/7/2010

Federal Use Only:

Authorized for Local Reproduction
Standard Form LLL (Rev. 7-97)

OMB Approval No. 4040-0007
Expiration Date 04/30/2008

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL Completed on submission to Grants.gov	* TITLE Chief Deputy Superintendent
* APPLICANT ORGANIZATION NM PRC Insurance Division	* DATE SUBMITTED July 7, 2010 Completed on submission to Grants.gov

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☒ Cover Sheet
- ☒ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:
- ☒ SF-424: Application for Federal Assistance
- ☒ SF-424A: Budget Information
- ☒ SF-424B: Assurances-Non-Construction Programs
- ☒ SF-LLL: Disclosure of Lobbying Activities
- ☒ Additional Assurance Certifications
- ☒ Required Letter of support and Memorandum of Agreement
- ☒ Applicant's Application Cover Letter
- ☒ Project Abstract
- ☒ Project Narrative
- ☒ Work plan and Time Line
- ☒ Proposed Budget (Narrative/Justifications)
- ☒ Required Appendices
- ☒ Resume/Job Description for Project Director and Assistant Director

Health Care Insurance Premium Review Work Plan & Timeline

Cycle I Timeline	Action Item	Responsible Staff
August 2010	Draft Contract for Consulting Services & SERFF Updates	Craig Dunbar
September 2010	Create and Posting Job Requirements for Four Temporary Positions	Craig Dunbar
	Meet with the Consumer Advisory Board on Future Goals	Kimberley Scott
October 2010	Draft Proposed NM Legislation & Rule Changes for 2011 Session	David Barton
November 2010	SERFF Upgrades & Regulation Review for Procedure Development & Training	Craig Dunbar
	Internal Web Page Development for Disclosure	
December 2010	Select Vendor for Actuary Services & IT Design	Superintendent of Insurance
	Draft Cycle 2 Proposal	
January 2011	2011 Legislative Session	All Staff
February 2011	Request Emergency Clause to allow legislative change to be effective upon signature of the Governor for Disclosure & Stronger Rate Review Provisions	Superintendent of Insurance or General Counsel David Barton
March 2011	Begin Consumer Outreach & Education	Kimberley Scott
April 2011	Public Disclosure & Comments Period Implemented	Craig Dunbar
May 2011	Internal Review of Public Comments	Superintendent of Insurance
June 2011	Hearing Procedures Established	Kimberley Scott
July 2011	HHS Reporting and Staff Training	Craig Dunbar
August 2011	Audit Process and Review Necessary Improvements	Superintendent of Insurance
September 2011	Consider Revision and Actions of Improvement with Consumer Advisory Board	Superintendent of Insurance

The SERFF enhancements incorporating HHS reporting requirements will be implemented in a phased approach with the first release to occur within 3 months of the receipt of HHS requirements for the uniform template for reporting. The initial release will focus on implementing the means for data collection; subsequent releases will incorporate reporting needs. Releasing functionality in this manner will allow a period of time during which data can then be submitted by insurers prior to any required reporting to HHS, thus avoiding manual data collection processes. Based on the requirements known at this time, the development will occur over an 8 month period beginning when the NAIC receives the reporting template and supporting documentation.

There are several task force groups and subcommittees reviewing the needs of law changes and new legislation that will provide recommendations to the Senate, House and the Governor's Office based on health care reform initiatives that will support the goal of this work plan. Activities involving consumer education and new criteria for rate review will be established with contracts for web design and actuary services as well as four positions that will be recruited and hired. A Consumer Advisory Board will be created from the stakeholder task force membership that review and provided comments to this proposal.